District of Columbia Government
Child and Family Services Agency

FY 2020 Needs Assessment




October 1, 2020

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INTRODUCTION

The District of Columbia (DC) Child and Family Services Agency (CFSA or Agency) completes an annual comprehensive *Needs Assessment* that directly informs CFSA's *Resource Development Plan*. The *Needs Assessment* assists child welfare decision-makers in identifying the resources and services that are essential to improving the safety, well-being and permanency of children in the District of Columbia's child welfare system. Additionally, the *Needs Assessment* and *Resource Development Plan* will help to inform development of CFSA's fiscal year (FY) 2022 budget.[1] In compliance with the requirement of the *LaShawn v. Bowser* Exit and Sustainability Plan (ESP), CFSA submits both documents to the court monitor by October 1, 2020.

CFSA STRATEGIC AGENDA AND PRIORITIES

As a part of CFSA's continuous quality improvement (CQI) initiative, the *Needs Assessment* provides a means to review data and to assess how services and supports facilitate the implementation of the Agency's commitment to the values-based *Four Pillars Strategic Framework.* Established in 2012, the following four key practice areas are included in the framework:

- **Narrowing the Front Door:** Families stay together safely.
- **Temporary Safe Haven:** Children and youth are placed with families whenever possible and planning for permanence begins the day a child enters care.
- **Well Being:** Children and youth in foster care maintain good physical and emotional health, get an appropriate education and meet expected milestones. Youth in foster care pursue activities that support their positive transition to adulthood.
- **Exit to Permanence:** Children and youth leave the child welfare system quickly and safely. Youth actively prepare for adulthood.

In 2018, CFSA incorporated the following four priorities (Four Ps) into the Agency's practice vision. Each of the Four Ps aligns with the focus of the *Needs Assessment* and complements the *Framework*:

- **Prevention:** Strengthening and focusing CFSA's support of the Agency's contracted partners, the community-based Healthy Families Thriving Communities Collaboratives' social services serving families before they become involved with CFSA.
- **Placement Stability:** Developing an array of options to meet the needs of children and youth, encouraging the first placement as the best placement, increasing the number of kinship placements, improving wraparound services, and increasing support for resource parents.[2]

[1] The fiscal year runs from October 1, 2021 – September 30, 2022.

[2] In the *Needs Assessment,* the term "resource parent" is used as an umbrella term to refer to traditional foster parents, kinship caregivers, and pre-adoptive parents.

- **Permanence:** Redoubling efforts to work with birth parents, either to speed reunification or to gain early recognition of the need for an alternative permanency goal through concurrent planning.
- **Practice:** Providing education, support and coaching for front-line supervisors to improve critical thinking and clinical focus.

APPROACH TO DOCUMENT

Assessing Needs

The Needs Assessment is divided into four sections: Narrowing the Front Door, Temporary Safe Haven, Well Being and Exit to Permanence. Each section explores administrative and program data that will help inform gaps in resource needs to be describer in the FY 2021 and FY 2022 Resource Development Plan (RDP). To develop the document, the Performance Accountability and Quality Improvement Administration (PAQIA) and other staff members within the Office of Policy, Planning and Program Support (OPPPS) met with executive leadership and managers from CFSA's Community Partnerships, Entry Services (includes Child Protective Services and In-Home Administration), the Permanency Administration, and the Office of Youth Empowerment (OYE) to identify the areas to present.

Guiding Questions

OPPPS staff focused on two particular areas to inform the data collected for each section of the *Needs Assessment*: (1) demographics and the number of children and families involved in the District's child welfare system, and (2) the child welfare system's services and placement array. The areas covered in the report will include guiding questions.

METHODOLOGY

OPPPS staff used multiple quantitative and qualitative data sources to inform the *Needs Assessment.*[3] The main data sources included, but were not limited to, the following:

- CFSA's statewide automated child welfare information system (SACWIS), which is known locally as FACES.NET and is the central repository for all client-level information
- Manual databases to capture program-specific information
- The Healthy Families Thriving Communities Collaboratives' data
- Surveys, focus groups and interviews (with both internal and external stakeholders)
- Qualitative case reviews and quantitative analysis

Unless otherwise specified, data covers the time frame of FY 2019 through FY 2020-Q2 (October 1, 2018 to March 31, 2020).

[3] Due to rounding, percentages in charts throughout the Needs Assessment may not total 100 percent.

Surveys and Focus Groups

CFSA gathered internal and external stakeholder input and feedback through focus groups and on-line surveys. CFSA uses findings to inform the 2020 Needs Assessment and this year's Annual Progress and Services Report (APSR).

Through CFSA's Office of Public Information, OPPPS distributed two self-administered online surveys. One survey captured the voices of youth, birth parents and resource parents while a second survey captured the voices of child welfare professionals, both within and outside of CFSA. The process and survey questions were similar to last year's questions for the purpose of tracking feedback and monitoring progress across the same variables over time. Surveys were sent to 384 participants and 196 (51 percent) of respondents completed the survey, and 188 partially completed the survey. Respondents included: youth, birth parents, and resource parents (110) and child welfare professionals (274).

While the surveys and focus groups provide valuable insight, they are not a representative sample and the information cannot be generalized across the population. The full qualitative findings will be shared with external stakeholders in various venues such as Parent Advisory Council (PAC) meetings, town halls and other forums.

Data Limitations and Gaps

Data limitations impacting the Needs Assessment analysis mostly include the absence of data fields that are either not required fields or absent both from FACES and the data captured in manual databases, such as Quickbase, Efforts to Outcomes (ETO, used by the Collaboratives), or Excel spreadsheets created by program areas. Resultantly, the analysis may limit overall generalizations for the full population served by CFSA, private agencies and the Collaboratives, referenced in the document where relevant.

SECTION 1: NARROWING THE FRONT DOOR

For the past decade, CFSA has been on a journey of transformation, moving purposefully away from a system primarily focused on foster care to one that supports and strengthens families. CFSA's investments in community-based prevention and its partnerships with sister health and human services agencies have resulted in a 65 percent reduction in the number of children and youth in foster care from a high of 2,092 in FY 2010 to 731 as of the end of FY 2020 Quarter 3, even as the city's population has increased by 100,000 residents.

The federal government passed the Family First Act on February 9, 2018. The District's Family First Prevention Services Five-Year Plan was approved by the Children's Bureau on October 22, 2019, with implementation having already begun on October 1, 2019. As a result of Family First, prevention services changed for DC in FY 2020. Implementation highlights included referrals to the Healthy Families Thriving Communities Collaboratives (the Collaboratives) to provide families with additional resources to prevent entry into foster care. In addition, referrals included evidence-based programs provided by the District's Department of Health and Department of Behavioral Health Services. These evidence-based services support family preservation and reunification and include parenting and home visiting programs, mental health treatment services, and substance abuse treatment. Currently, the Family First services include Motivational Interviewing (utilized by CFSA social workers and the Collaboratives), and the parenting program Parents as Teachers (provided by DC Health). CFSA also plans to seek approval for Healthy Families America (also provided by the DC Health) as part of Family First. The remaining prevention services provided are part of the prevention plan but beyond Family First.

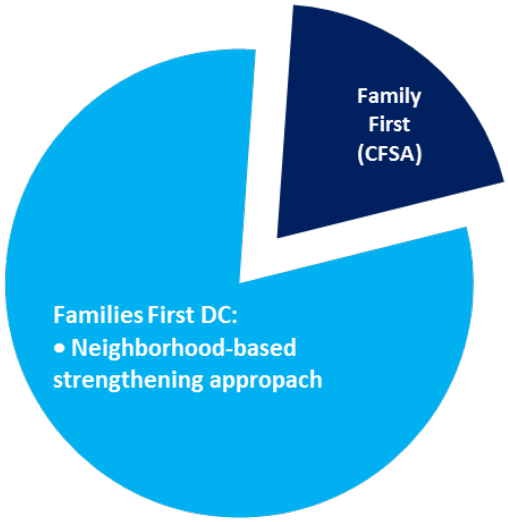
CFSA also refers families to evidence-based, evidence-informed, supported, and promising home visiting programs that are either funded through the Maternal Infant Early Childhood Home Visiting (MIECHV) Program, Community-Based Child Abuse Prevention (CBCAP) grants or local dollars. The home visiting programs provide new and expectant parents with support to build their basic caregiving skills and assist parents and other primary caregivers in bonding with children to encourage healthy child development and a positive home environment. They address issues such as maternal and child health, positive parenting practices, safe home environments, and access to services.

CFSA has utilized CQI practices to examine data regarding all prevention service referrals in real-time and make adjustments as needed on an ongoing basis. CQI processes have uncovered the

need to have clear and immediate feedback regarding whether a client is eligible for a service, a need for ongoing communication with service providers to decrease delays in processing new referrals, and other actions to improve data quality. CFSA continues to closely collaborate with the Collaboratives and sister agencies to address all identified data quality issues and thus enhance the ability to complete a robust evaluation on the usage and impact of prevention services.

FAMILIES FIRST DC: PRIMARY PREVENTION STRATEGY

Locally, DC has embraced a family-strengthening vision that is broader and bolder than Family First, and Mayor Muriel Bowser has reinforced that vision with a companion initiative: Families First DC. In the FY 2020 budget, the Mayor funded 10 Family Success Centers in targeted neighborhoods in Wards 7 and 8, where approximately three-quarters of the children and families served by CFSA live.[4] The Family Success Centers are an upstream prevention approach to support children and families with needed resources driven by community input. The Family Success Centers will provide neighborhood-based support and resources to help prevent families from becoming involved with CFSA.



The Family Success Centers[5] will open in October 2020. During FY 2020, CFSA led the District in the planning phase for Families First DC, which included hiring central office staff, announcing the grantees for the 10 Family Success Centers, establishing Community Advisory Councils for each center, collaborating with sister agencies in District government to prevent duplication of services, and conducting needs assessments to determine each neighborhood's grantee-specific service array. Across all centers, the following needs were identified: behavioral and mental health, physical and nutritional health, education and early learning, employment, housing, and access to technology.

[4] All ten neighborhoods are located in Wards 7 and 8. Data analysis was conducted to select these neighborhoods based on social determinants of health, violence prevention priority areas, and substantiated reports of child abuse and neglect.

[5] The Family Success Centers data are not included in the Needs Assessment due to being in the planning phase.

PRIMARY, SECONDARY AND TERTIARY PREVENTION

CFSA's approach to prevention activities focuses on populations identified as being in the Front Yard or on the Front Porch (defined below). CFSA bases its identification of vulnerable populations on systemic experience and research that shows, all but for an intervention, there is the potential for the child to end up in foster care.

Primary Prevention: Front Yard – Families not known to CFSA

Families in the Front Yard have no child welfare involvement but nonetheless face challenges that could put them at risk of coming to the Agency's attention. Two primary examples of these Front Yard families include young (under age 25) homeless families with young children and "grandfamilies" (i.e., grandparents responsible for caring for their children's children). Although these families are not currently connected to the child welfare system, they may be connected to one of CFSA's five contracted community-based Healthy Families Thriving Communities Collaboratives (Collaboratives).[6] Part of the District's broader child welfare system, the Collaboratives often take the lead on connecting families to other District and community resources to address specific needs such as housing, employment and mental health.

Secondary & Tertiary Prevention: Front Porch[7] – Families known to CFSA, both with and without an open case

Secondary Prevention families have experienced a Child Protective Services (CPS) investigation or a family assessment (FA) response to a CPS Hotline allegation. Although CFSA discontinued FA responses in April of 2019 (see "Secondary Prevention" section below), these assessments formerly served families with allegations of abuse or neglect that had safety or risk levels not rising to the level of opening an in-home case or child removal. The families were often referred to the Collaboratives to provide family stabilization and other support for their specific needs.

Tertiary Prevention families include families with either an open in-home case who are working towards case closure or an open Family Court-involved out-of-home (foster care) case and are working toward reunification. At times, families may have short-term needs requiring additional community-based supports provided by a Collaborative. Collaboratives provide these specific services and team with the CFSA social worker to support the successful closure of the CFSA case.

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[6] The Collaboratives are strategically located in five neighborhoods in the District that have high representation of families in contact with the child welfare system. CFSA co-locates social workers and community-based nurses to serve the local neighborhoods.

[7] In past years, families receiving secondary prevention services were considered to be Front Porch families and families receiving tertiary prevention services were considered Front Door families. However, CFSA made the determination to include tertiary prevention beneficiaries as part of the Front Porch population for FY 2020. The present Needs Assessment reflects CFSA's decision to combine the Front Porch and Front Door populations as part of the Collaboratives' contractual framework.

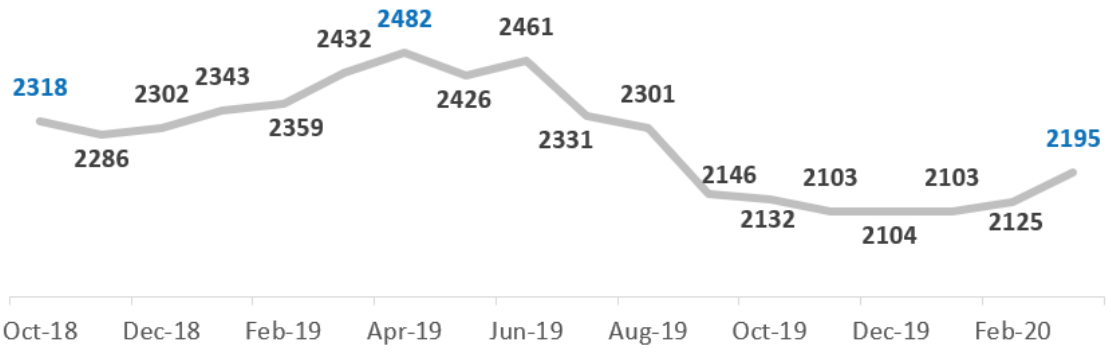
DEMOGRAPHICS AND NUMBER OF FAMILIES SERVED

How many children and families are being served overall?

Recent Trends

Overall, the total number of children served (in-home and in foster care, cumulative over the course of the month) has fallen between FY 2019 Q4 and FY 2020 Q2. Throughout FY 2019, the Agency served the most children during the month of May 2019. In FY 2020, the number of children served fell in Q1 and rose in Q2, reaching a total of 2,195 children being served during the month of March.

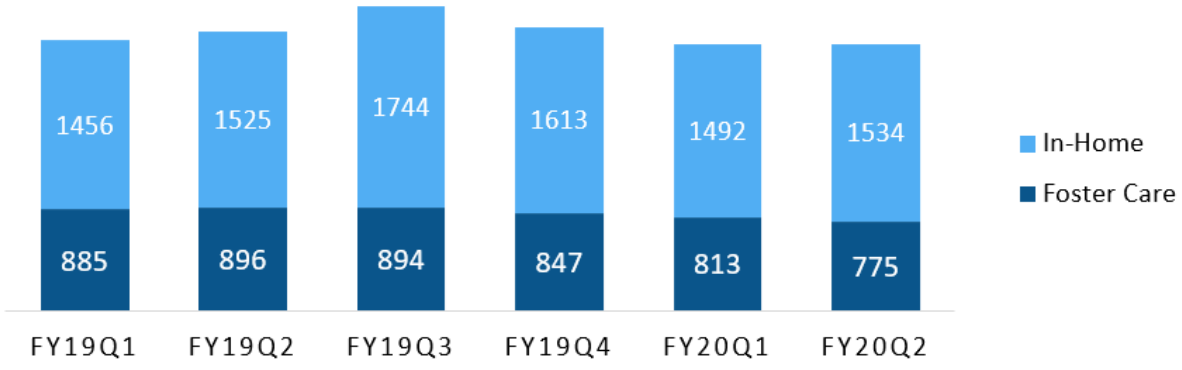
Since the peak of the 2,482 total children served, the number served has decreased.



Source: Birst – Total Children Served

In FY 2020, through Q2, on average each month, CFSA served a total of **1,513 children in their homes (in-home services) and 794 children in foster care (out-of-home services).** The total number of children receiving foster care services has decreased each quarter and in-home services is still less than it was at the end of FY 2019.

The number of children served in-home has decreased after peaking in FY 2019 Q3.



Source: Birst – Total Children Served

Families Served by the Community-Based Collaboratives

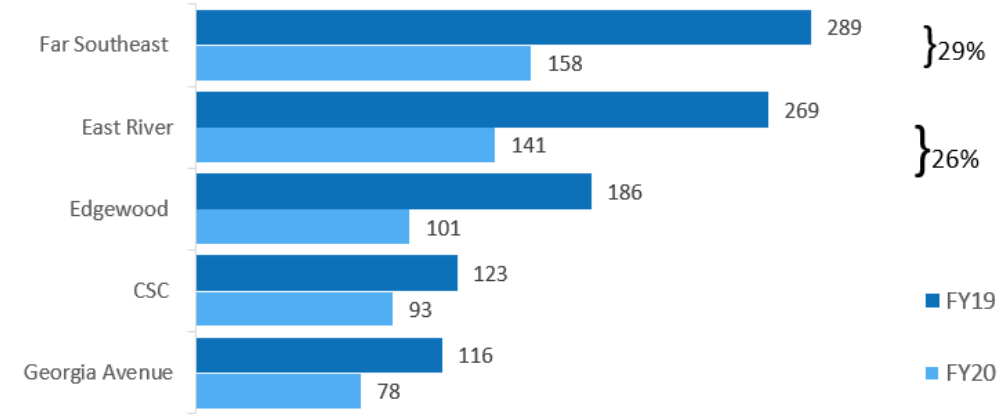
CFSA's five contracted community-based Healthy Families Thriving Communities Collaboratives (Collaboratives) serve all eight wards and are strategically located in five neighborhoods in the District that have high representation of families in contact with the child welfare system.

Healthy Families Thriving Communities Collaboratives	Wards Served
Collaborative Solutions for Communities (CSC)[8]	1, 2, 3
Georgia Avenue Family Support Collaborative (GAFSC)	4
Edgewood/Brookland Family Support Collaborative (EBFSC)	5, 6
East River Family Strengthening Collaborative, Inc. (ERFSC)	7
Far Southeast Family Strengthening Collaborative (FSFSC)	8

The Healthy Families Thriving Communities Collaboratives (Collaboratives) served a total of 1,351 families between October 2018 and June 2020 in the Front Yard and Front Porch categories of prevention services (FY 2019 and FY 2020 through Q3; see page 2 for descriptions of each category).[9] Data on Collaborative referrals come from three pathways:

- Referrals from a CFSA or private agency social worker for Front Porch cases
- Referrals from other District agencies (e.g., DC Public Schools or the DC Department of Human Services) for Front Yard families
- Self-referrals (including walk-ins) for Front Yard families.

East River and Far Southeast Collaboratives served approximately 55 percent of Front Yard and Front Porch families served by all of the Collaboratives in the District of Columbia.



Source: Community Partnerships Collaborative Data

[8] Some tables indicate that the Georgia Avenue Collaborative serves Ward 3. However, Ward 3 is served by Collaborative Solutions for Communities. This error will be corrected prior to posting the document.

[9] Six families received both Front Porch and Front Yard services between FY19 and FY20. Data on the category of services received was missing for one family.

Primary Prevention Recipients (Front Yard)

Research shows that risk factors for child abuse and neglect fall into several categories: **child risk factors, parent and family risk factors, and community risk factors**.[10] As part of its research and data analysis, CFSA identified the following two vulnerable Front Yard populations more likely to be at risk for child welfare involvement due to a lack of available or accessible primary prevention services:

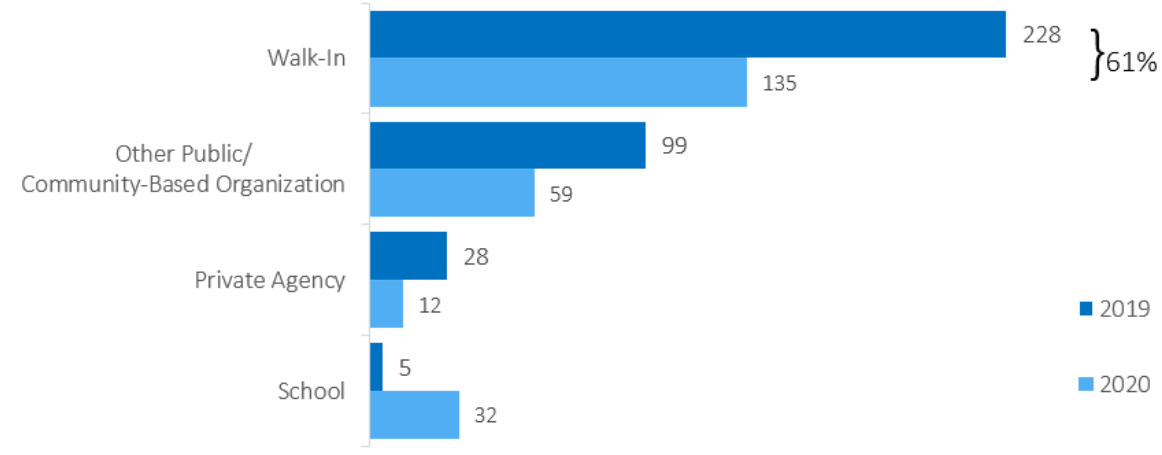
- **Families with young children experiencing homelessness:** Provide services to prevent homelessness and children from entering the child welfare system.
  - Parents ages 17-25 with young children ages birth-to-6.
  - Families with housing instability but no current safety concerns.
- **Grandfamilies:** Offer community-based supports and services to prevent out of home placement.
  - Grandparents as well as close relatives providing long-term placement and caregiving.

The five Collaboratives individually provide access to prevention services for those families without CFSA involvement, i.e., those who independently seek services or are referred from other organizations.

How many families are served in the Front Yard?

Of the total 1,351 families served between October 2018 and June 2020, the Collaboratives served **514 families** with Front Yard primary prevention services (e.g., individualized case management, parent education courses on child development, support services for housing and employment). **The majority of families resided in Wards 7, 5, and 4**.

Most families served at the Front Yard were walk-in clients (61 percent) between October 2018 and June 2020.

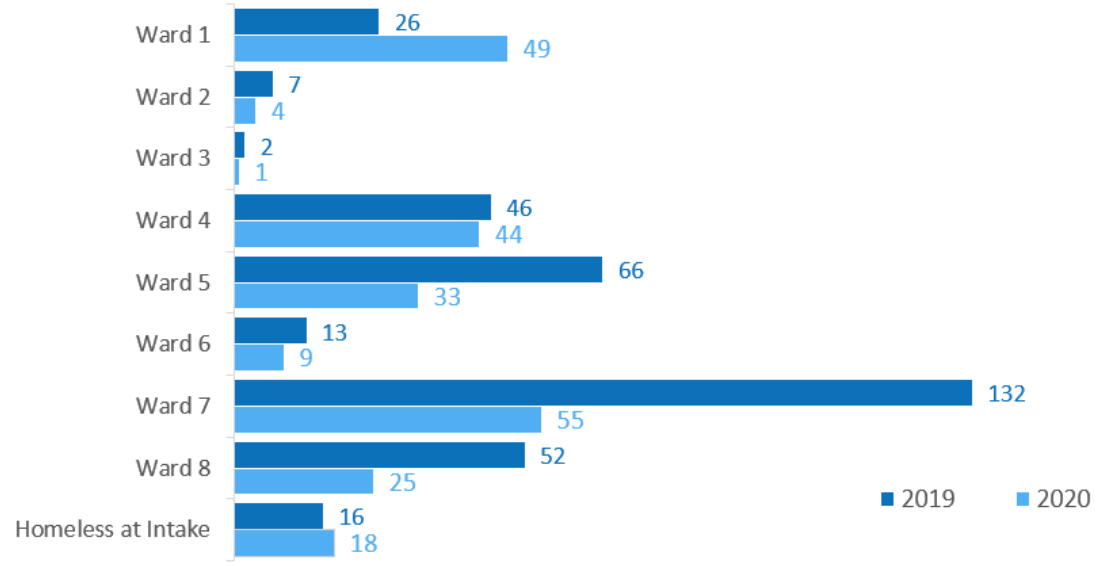


Source: Community Partnerships Collaborative Data

[10] https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html

Of note, the graph below shows that **the number of Ward 1, Front Yard families served by the Collaboratives increased by 88 percent during the first three quarters of FY 2020**, from 26 families in FY 2019 to 49 families in FY 2020 through Q3. Collaborative Solutions for Communities (CSC) explained this increase in the number of Front Yard families from Ward 1 **as a result of low resources in the communities throughout the COVID-19 crisis, with a total of 21 walk-in families in the month of June 2020.** Other community-based organizations located in Ward 1 requested and obtained assistance from CSC. **Due to the pandemic, Ward 1 community-based organizations referred a higher number of clients to CSC for services, supplies, and resources.** DC coronavirus data also shows that Columbia Heights, a Ward 1 neighborhood, has the highest rate of cumulative incidence of COVID-19 by DC Health Planning Neighborhood.[11] Another neighborhood in the top ten of the cumulative incidence, Petworth, lies partially within Ward 1 boundaries. Conversely, in wards 5, 7 and 8[12] there was a decrease in families served in the Front Yard. This is attributed to the shift in operations required by the COVID-19 pandemic. All five Collaboratives shut down their in-person/in-office operations in March 2020 and began teleworking and providing virtual support to families. In addition, a central business line was established for residents to call when supportive services were needed. These significant changes to operating practices required time to begin working in an efficient manner. CFSA leadership held three Re-Opening meetings with Collaborative leadership in July and August 2020 to discuss their plans for operations going forward and will continue to assess the situation.

Between October 2018 – June 2020, the Collaboratives served 514 Front Yard families, mostly from Wards 7, 5, and 4.



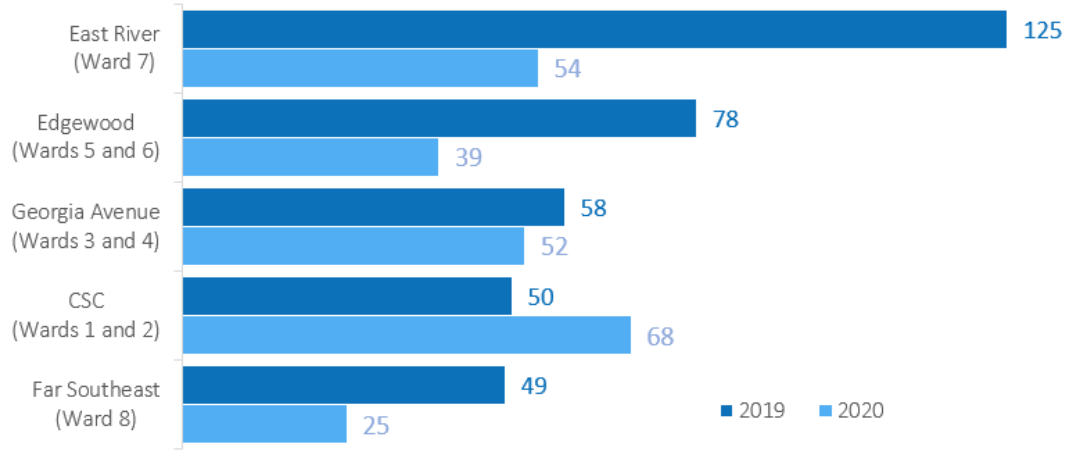
Source: Community Partnerships Collaborative Data

[11] https://coronavirus.dc.gov/release/coronavirus-data-june-30-2020

[12] Wards 2, 3, 4 and 6 had comparable numbers of families referred in Q1-Q3 of FY 2019 and FY 2020.

Families typically receive services in the ward where they reside. However, if the family needs a service that is not available through their ward's Collaborative, the family may receive services from a Collaborative located in another ward. The graph below shows the distribution of Front Yard families among the Collaboratives. **The Collaborative Solutions for Communities served the greatest number of Front Yard Families in FY 2020 through Q3. This contrasts with last year, where East River Family Strengthening Collaboratives served the most Front Yard families.**

The Collaborative Solutions for Communities (Wards 1 & 2) served 29 percent of Front Yard families in FY 2020.



Source: Community Partnerships Collaborative Data[13]

Secondary and Tertiary Prevention Recipients (Front Porch)

CFSA and the Collaboratives make every effort to direct and serve families within their ward of origin. There are exceptions for special services that may only be available from a Collaborative outside of the ward where the family resides. At the Front Porch, Collaboratives are able to provide secondary and tertiary level prevention services to "intercept" families with identified risk factors and to avert the recurrence of child abuse and neglect for those families referred from CFSA or those who may be closing an in-home or out-of-home case. The following case criteria are included for families at the Front Porch:

- CPS Investigation (CPS) referrals closing with any risk level but with unfounded or inconclusive dispositions, where additional short-term assistance to families is needed to promote family stability.
- CPS Investigation (CPS) referrals with a low-to-moderate risk but with substantiated dispositions, where additional short-term assistance to families is needed to prevent out-of-home placement.

[13] The Collaborative data on services requested as compared to services received was not available in FY 2020 and is on track for availability in FY 2021.

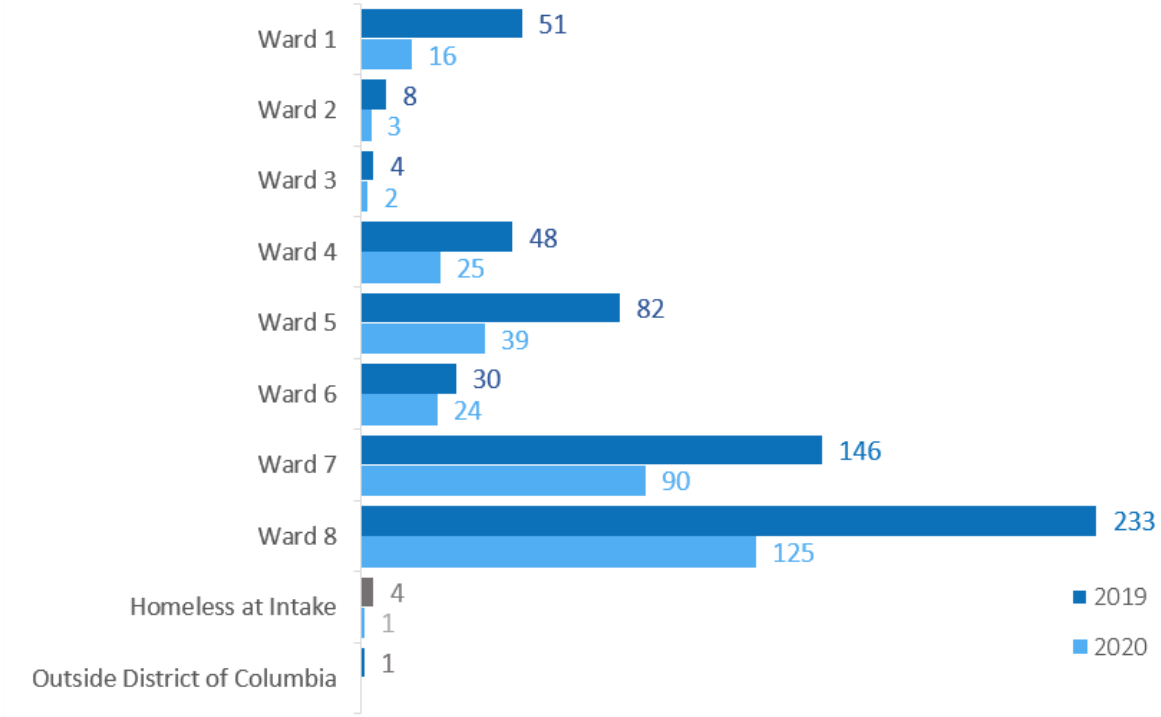
Collaboratives are also able to provide tertiary level prevention services for families where child maltreatment may have already occurred, and services can help mitigate the impact of maltreatment. Tertiary prevention services focus on 1) preventing initial entry into foster care, or 2) preventing re-entry or recurrence of child abuse and neglect for those families referred from CFSA. Families may have an open case or may be in the process of closing an in-home or out-of-home case. CFSA and the Collaborative social workers work together on in-home and out-of-home cases. The following case criteria apply to tertiary prevention services:

- **Entry Services (in-home):** The children are safe; the risk level is low-to-moderate and the case is nearing closure. There is a demonstrated need for additional services and support to stabilize the family, maintain children in the home, and prevent removal.
- **Permanency (out-of-home):** The children are safe and have been reunified; the court case has been closed but there is a demonstrated need for additional services and support to ensure sustainable reunification and connections to community resources.

How many families are served on the Front Porch?

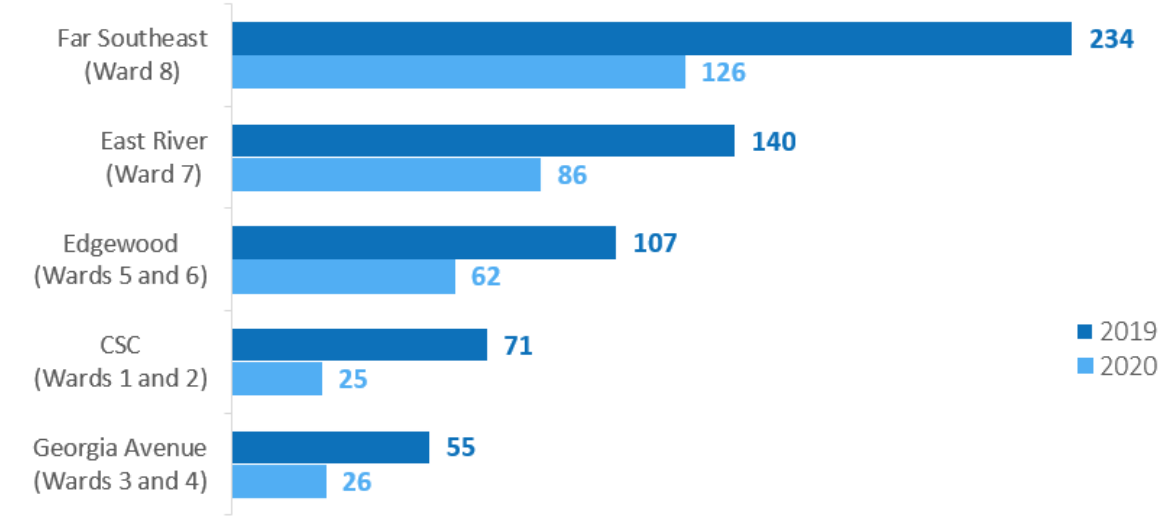
Between October 2018 and June 2020, **842 families received secondary and tertiary prevention services. The majority of those families resided in Wards 7 and 8.**

Most Front Porch families are served in Wards 7 and 8.



Source: Community Partnership Collaborative Data

Far Southeast served the highest number of Front Porch families in FY19 and FY20.

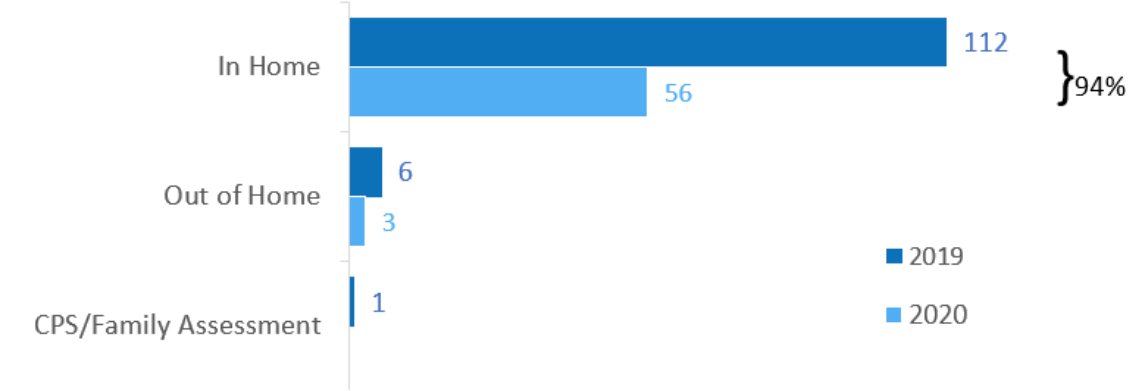


Source: Community Partnership Collaborative Data

There has been a decline in families served by the Collaboratives from the Front Porch. Community Partnerships and the Collaboratives attribute this to the following reasons: decrease in foster care population, reduction in calls to hotline during COVID-19 pandemic, cases remaining open longer with the Collaboratives.

Additionally, staff needed to adapt to the transition from paper referrals to a completely web-based case transfer process through which families were referred to the Collaboratives which slowed the referral process for a period of time in FY 2020. The Community Partnerships Administration has responded by providing additional training, tip sheets, redesigned forms, and completed a Lean[14] event in September 2020 to design a more efficient process for completing referrals to the Collaboratives. Now that CFSA and the Collaboratives are operating in a web-based capacity due to Covid-19, it is anticipated that the web-based referral system will see better adoption in subsequent months.

CFSA's In-Home Administration referred 94 percent of families for step-down services.



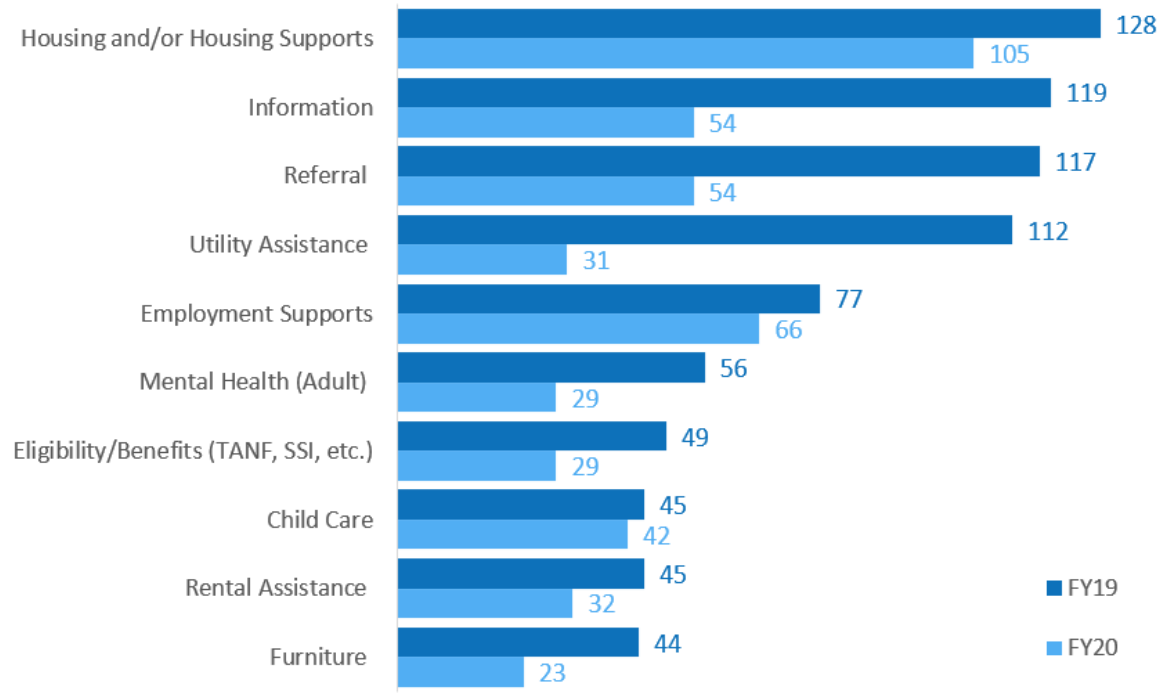
Source: Community Partnership Collaborative Data

[14] Lean is a structured process management and improvement framework that seeks to identify and reduce waste and inefficiency in organizations.

What services are requested for families?

CFSA asks each Collaborative to report on the services that families request directly to them, as well as services recommended by the agency.[15] Overall, the top requested service by CFSA and families in both the Front Yard and the Front Porch was for housing and/or housing supports. For Front Porch families, the remaining two services in the top three were both employment and mental health. For the Front Yard families, the second and third most requested services were different, with CFSA requesting employment and utility assistance, and the families requesting information (providing education about available resources and services) and referrals (connecting a family with a specific service by providing them the contact and intake information).

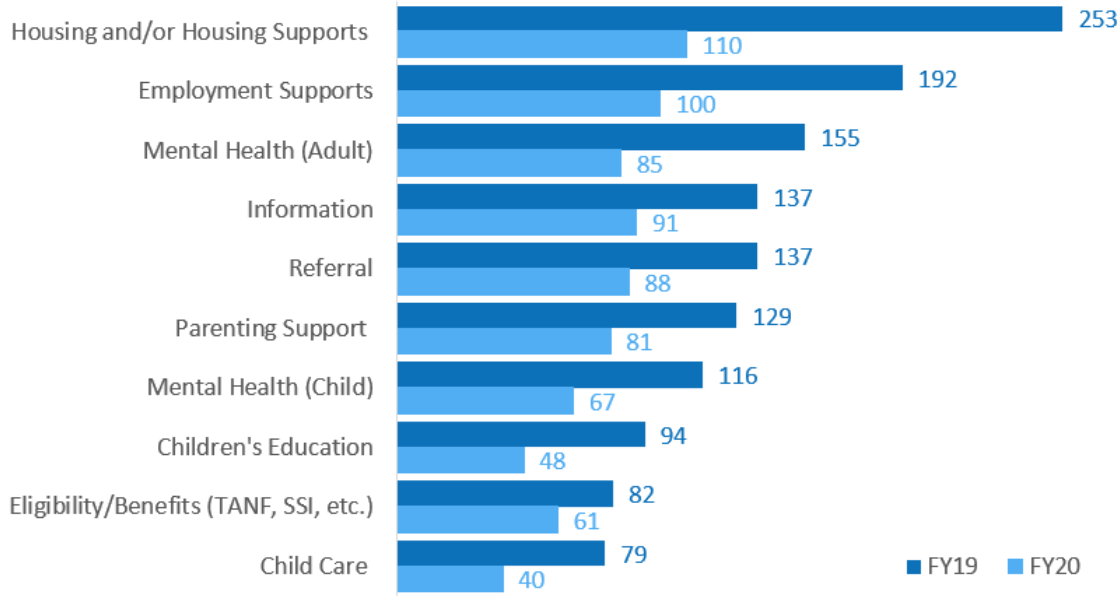
Of the top 10 Collaborative services, families being served in the Front Yard most frequently requested housing supports, followed by information and referrals in FY19 and FY20.



Source: Community Partnerships Collaborative Data

[15] The Collaborative data on services requested as compared to services received was not available in FY 2020 and is on track for availability in FY 2021.

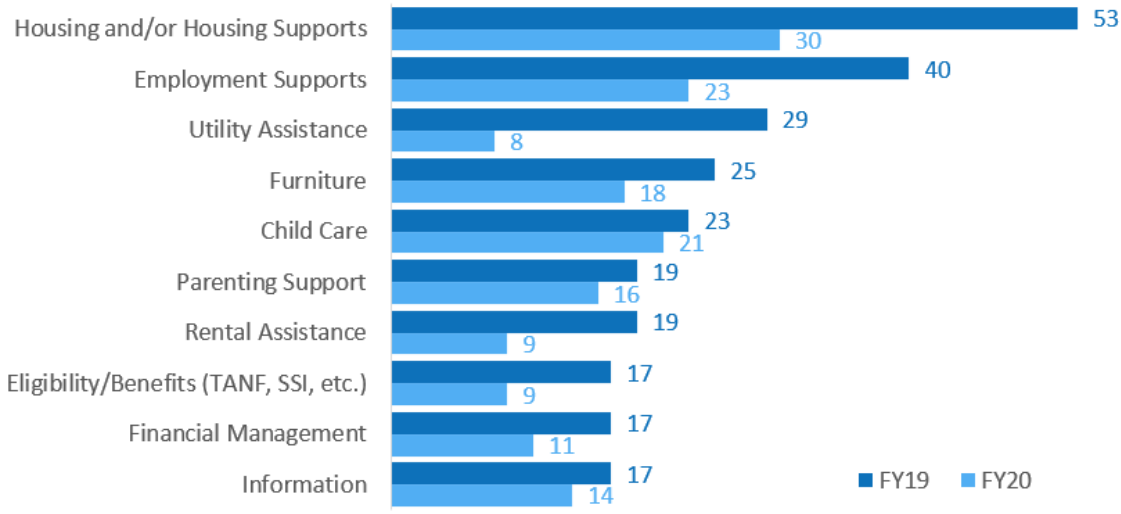
Of the top 10 Collaborative services, families being served in the Front Porch most frequently requested housing, followed by employment and mental health supports in FY19 and FY20.



Source: Community Partnerships Collaborative Data

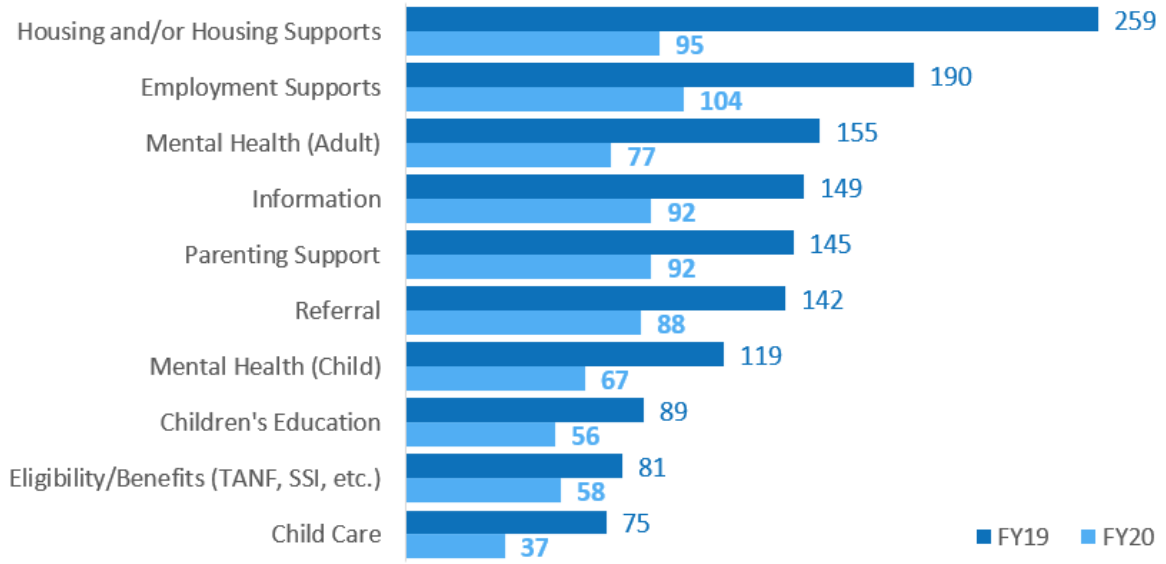
The services requested by CFSA were similar for families in the Front Yard and Front Porch, with housing and employment as the top two requested services. For families in the Front Yard, utility assistance was the third most requested service and for families on the Front Porch mental health assistance was the third most requested service.

Of the top 10 Collaborative services, CFSA most frequently requested housing and employment supports in FY19 and FY20 for families in the Front Yard.[16]



Source: Community Partnerships Collaborative Data

Of the top 10 Collaborative services, CFSA most frequently requested housing and employment supports in FY19 and FY20 for families on the Front Porch.[16]



Source: Community Partnerships Collaborative Data

Conclusion and Needs to be Considered

In FY 2020, there was an increase in Front Yard families (families not known to CFSA) being served by CSC due to the COVID-19 pandemic, and CSC served the greatest portion of Front Yard families of any Collaborative during FY 2020. However, there was a decrease in Front Yard families being served in Wards 5, 7, and 8 as well as a decrease in Front Porch families being served. The decrease in Front Yard families in those three wards is attributed to the COVID-19 pandemic and the adjustments to full time telework and providing support virtually. CFSA will continue to support the Collaboratives in planning for operations moving forward. The decrease in Front Porch families served is attributed to some changes with the population and with the process by which families are being referred to the Collaboratives with the introduction of electronic referrals through FACES in October 2019. The Community Partnerships Administration is closely watching these trends and addressing the need to improve efficiencies in the referral system. Community Partnerships is also examining the trend of cases staying open longer with the Collaboratives by examining caseloads. Community Partnerships will assess possible resource needs at select Collaboratives.

While the new supportive upstream prevention services available in FY 2021 through the new Family Success Centers will be focused on Wards 7 and 8, this data indicates that there continues to be a need for upstream prevention across the city. The majority of Front Porch families (families

[16]The Federal government provides grants to States to run the Temporary Aid for Needy Families (TANF) program. Supplemental Security Income (SSI) is a Federal income supplement program designed to help individuals who are aged, blind, and disabled and who have little or no income.

known to CFSA through an open CPS investigation or open in-home or foster care case) continued to mostly reside in Wards 7 and 8 and are served by Far Southeast and East River Family Strengthening Collaboratives. Across both the Front Porch and Front Yard families the top requested services in FY 2019 and FY 2020 were housing and/or housing supports and employment supports. With the continued pandemic, the need for these services is likely to continue to be significant in FY 2021.

What is the profile for families currently receiving in-home services?

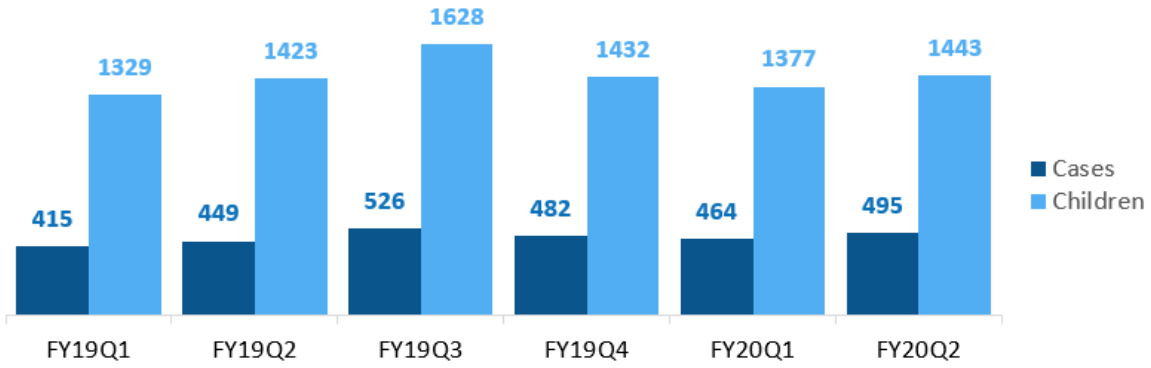
When families are served in their homes through an open child welfare case, they are served through several different administrations within CFSA and CFSA-contracted agencies. The In-Home Administration within Entry Services serves the largest portion (75 percent) of this population.[17] In-home cases are opened when an investigation is closed with a substantiated allegation and a determination has been made that the children can safely be served within their birth family, i.e., a removal of the child is not necessary to protect the child's safety. Children who continue to reside with their birth parents may be served by social workers outside of the In-Home Administration within Entry Services under two circumstances: when a child is reunified with a parent after spending time in foster care, or when at least one child is removed due to immediate safety concerns but CFSA determines that other siblings may remain safely in the home. In those instances, the child remaining in the home would also be served by the social worker from Program Operations, Office of Youth Empowerment, or the private agency that serves the child in foster care.

As of the end of FY 2020 Q2, demographic information about children and families served through the In-Home Administration include:

- There is a median of two children per family.
- 38 percent of caregivers are ages 31-40 years old, followed closely by caregivers ages 21-30 years old (37 percent).
- Gender breakdowns are largely equal between male (51 percent) and female children (49 percent).

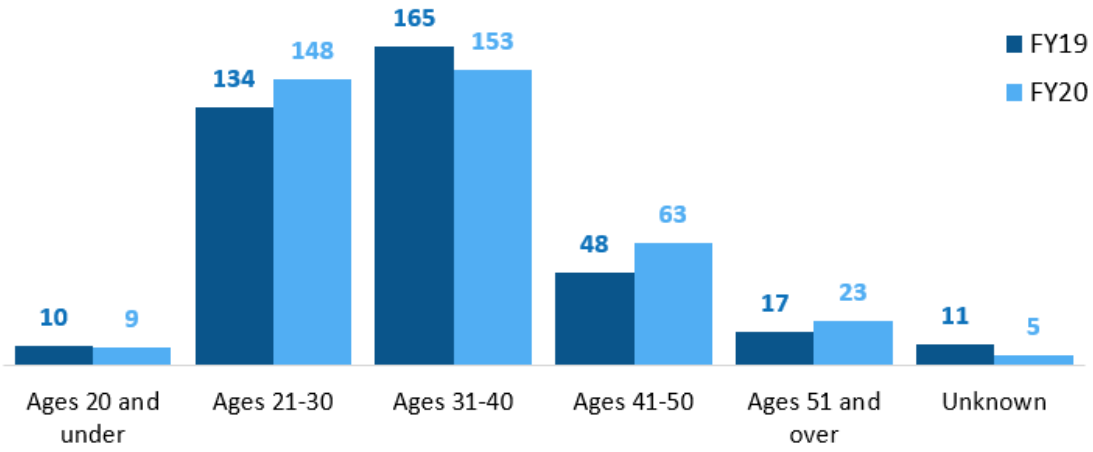
[17] In April 2018, CFSA added the In-Home Administration (formerly Community Partnerships) to the Office of Entry Services, creating the "Ongoing CPS Services" (In-Home) Unit.

After peaking in FY 2019 Q3, the number of cases and children served by the In-Home Administration has decreased.[18]



Source: FACES Management Report CMT404

On average, most parents are 21-30 years old and 31-40 years old.

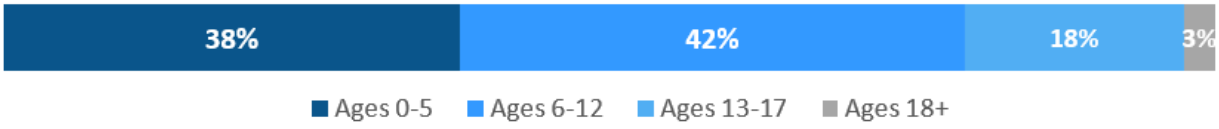


Source: FACES Management Report CMT404

While most parents fall between the ages of 21-40, parents ages 41-50 are the fastest growing population of parents with an in-home case, with a 31 percent increase between FY 2019 and the first two quarters of FY 2020. The portion of parents ages 21-30 also grew 10 percent between FY 2019 and FY 2020 through Q2.

Of the children served in FY 2020 Q2, over one-third (42 percent) were between the ages of 6 to 12 years old, followed by children birth to 5 years old (38 percent), 13 to 17 years old (18 percent), and finally, older youth 18+ (three percent). The In-Home Administration only provides services to young adults ages 18 and older if the youth is under court monitoring through community papering.

80 percent of families with an open case with the In-Home Administration have children 12 and under.



Source: FACES Management Report CMT404

Conclusion and Needs to be Considered

While the ages of parents with open cases has shifted slightly, this does not impact the delivery or type of services needed. The comprehensive array of services is flexible enough to meet the demographic profiles of the clients served.

SERVICES TO PREVENT ENTRY INTO FOSTER CARE

What services are offered?

The following section describes the services CFSA offers to families to help prevent children from entering foster care.

Services Available to Families to Prevent Children's Entry into Care

Case Management
CFSA and private agency social workers manage in-home and foster care cases. Case management is a process to plan, seek, advocate for, and monitor services from different social services or health care organizations on behalf of a client.

Emergency Family Flexible Funds
Upon request by a social worker, the Collaborative should provide funds within 36 hours to address needs that can prevent disruption. Such needs may include rental assistance, transportation, utilities, food, housing search, or temporary placement.

Rapid Housing Program (RHP)
CFSA manages the RHP to provide short-term rental payments to families in need of stable housing.

Medical Support
CFSA has four community-based nurse care managers to serve all Collaboratives and to case manage according to social worker referrals. Social workers can submit a nurse referral at any time throughout the life of a case, including at the point of case closure.

Educational Workshops
CFSA facilitates and coordinates training for parents and caregivers to provide critical education and information to promote support for the children in their care.

Parent Cafes through DC Children's Trust Fund
Trained facilitators guide support group meetings biological families.

Whole Family Enrichment
Structured group activities create a safe environment for at-risk families. These structured groups and activities help build a sense of community and belonging that promotes family stability, resiliency and social connections.

Community and Other District Agency Supports: Mental Health & Substance Use
CFSA utilizes the Department of Behavioral Health city-wide provider agencies for children, youth and adults for mental and behavioral health services and substance use services. CFSA contracts with the Collaboratives to provide a variety of services including and in addition to Family First services. In-home families may also be referred to CFSA's short term mental health unit.

Domestic Violence (DV) Services
CFSA utilizes community-based organizations for DV services, including DC SAFE (Survivors and Advocates for Empowerment), My Sister's Place, and House of Ruth.

What do the FY 2020 Quality Service Review results tell us about mental health needs of families who receive in-home services?

The Quality Service Review (QSR) is one of CFSA's primary qualitative approaches to continuous quality improvement of service delivery and implementation of CFSA's Practice Model. The QSR assesses how system partners work together as a team to ensure that services for children and families are tailored and appropriate to their needs. This case-specific and system wide process includes reviews of hard copy case records in addition to face-to-face and telephone interviews with team members.

The QSR team reviewed a total of 42 cases for the In-Home Administration between January through May 2020. A request was made by In-Home leadership to identify the mental health service providers working with families and the number of families who participated in services along with any psychotropic medications taken by the family. There was a total of 14 parents and 6 children who participated in mental health services during the review period. **Forty-three percent (n=6) of parents and one out of three children (n=2) who received mental health services were on psychotropic medications.** Diagnoses for the 14 parents were bipolar, depression, PTSD and/or schizophrenia. Diagnoses for the six children were depression, ADHD and/or PTSD.

There were 10 agencies providing services to families; of which a few were new providers. The QSR review team found that, **in most instances, service delivery was maintained.**

- Services moved to tele-health due to COVID, with minimal disruption
- Community support workers continue to visit with families even with COVID restrictions
- Parents were satisfied with their treatment and felt it was beneficial

Conclusion and Needs to be Considered

During both fiscal years the number of cases being served the In-Home Administration and number of children within those cases has experienced fluctuations but there were not any steady upward or downward trends. The majority of caretakers are between the ages of 21-40 with a growing population of caretakers aged 41-50 and very few caretakers age 20 and younger. The children are primarily under age 12, and approximately evenly split between the birth to 5 age group and 6-12 age group. However, approximately two in ten children are 13 years old or older. This demonstrates that the services for in-home families need to be applicable to a wide range of ages for both children and parents. During the QSR review of families served by In-Home during 2020, there was a total of 14 parents and six children who were receiving mental health services; service delivery was maintained for most of these individuals.

SECTION 2: TEMPORARY SAFE HAVEN

Foster care is a temporary living situation for children who come to CFSA's attention due to imminent safety risk as the result of parents or other relatives being unable to provide care for the children. When children enter foster care, CFSA prioritizes placement with relatives whenever possible. If willing and able relatives are not available, CFSA will place children in a family-based foster home with non-relatives. To a much lesser extent, CFSA may place older youth in congregate care facilities.

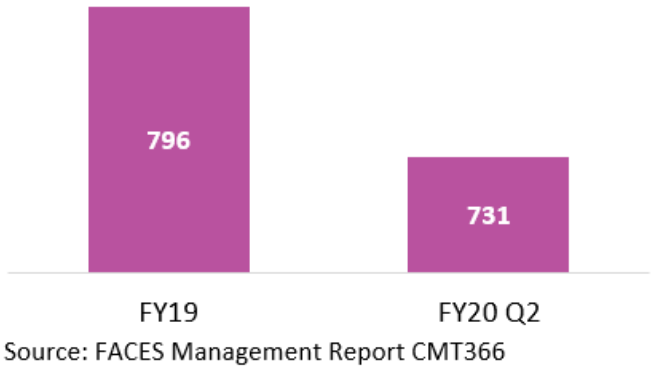
Foster care is intended to provide a stable and caring environment for the child while the parents address the reasons for involvement with the child welfare system. A permanency goal is identified and documented in each child's case plan. The preferred permanency goal for children is reunification with their family as quickly but as safely as possible. When safe reunification is not possible, CFSA seeks to find a safe and loving, permanent home through adoption or legal guardianship, or to successfully transition older youth to adulthood in the case of those with a goal of Another Planned Permanent Living Arrangement (APPLA).

Demographics and Number of Children Served

How many children are being served in foster care?

As of March 31, 2020, there were 731 children placed in foster care. The District has observed a steady decline of its foster care population since FY 2006. Between the beginning of FY 2019 (October 31, 2019) and FY 2020 Q2 (March 31, 2020), the number of children served in foster care has continued to decrease, by 15 percent during this period.[18]

In FY 2020, the District's foster care population has continued to decline.



Source: FACES Management Report CMT366

[18] There were 858 children in foster care at the start of FY19 and 731 children in foster care as of March 31, 2020.

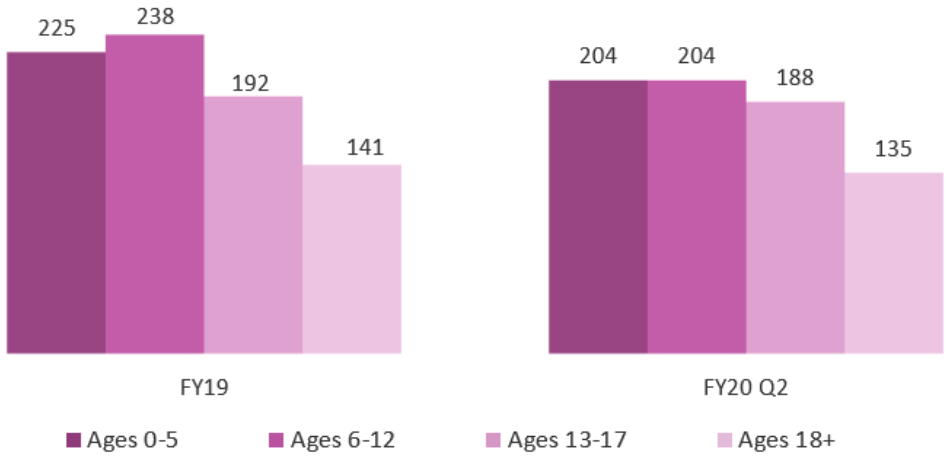
CFSA has worked to reduce the number of children placed in congregate care and the percentage remains steady at approximately 10% annually.

Fiscal Year FY19 (as of 9/30/2019)	# of children in congregate care	% of children in congregate care	Total # of children in care
Diagnostic & Emergency Care	6	1%	
Group Homes	47	6%	
Independent Living	8	1%	**796**
Residential Treatment	26	3%	
Total	**87**	**11%**	
Fiscal Year FY20 Q2 (as of 3/31/2020)	**# of children in congregate care**	**% of children in congregate care**	**Total # of children in care**
Diagnostic & Emergency Care	4	1%	
Group Homes	39	5%	
Independent Living	9	1%	**731**
Residential Treatment	23	3%	
Total	**75**	**10%**	

Source: FACES Management Report CMT232

What is known about the ages of children in foster care?

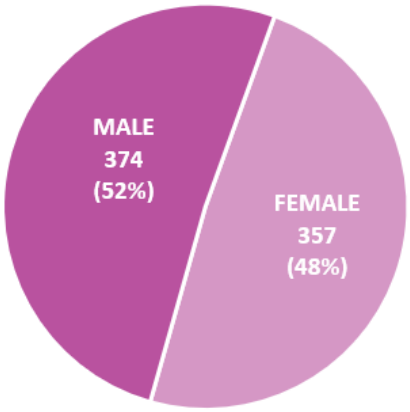
In FY 2020 through Quarter 2, the majority of children (56 percent) in foster care are equally ages 0-5 and 6-12 years old. On average, younger children make up at least half, children ages 13-21 make up 25 percent and youth ages 18-20 make up less than 20 percent of the population.



Source: FACES Report PLC156, point in time data as of September 30 for FY19 and March 31 for FY20 Q2.

What is known about the gender of children in foster care?

The number of male children is slightly greater than the number of female children in foster care as of FY 2020 Q2.

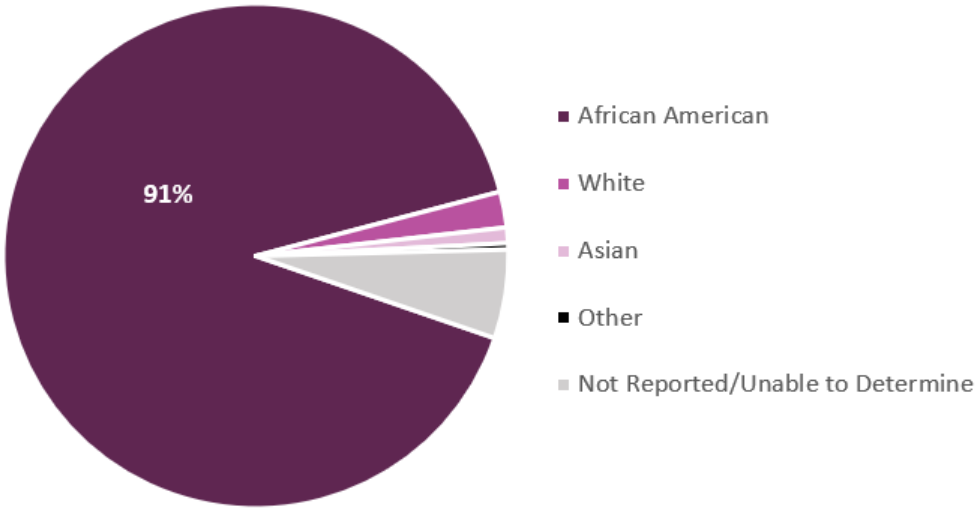


Source: FACES Report PLC156

What is known about the race and ethnicity of children in foster care?

In regard to race, Black/African American children accounted for 91 percent of the children, White children were two percent, Asian children were one percent and "other" were less than one percent. The race of six percent of the children was not reported or unable to be determined.

The overwhelming majority of the District's children in foster care are black.



Source: FACES Report CMT366 as of March 31, 2020

Although most children in foster care identified their ethnicity as non-Hispanic, **107 (15%) children identify as Hispanic/Latinx.**

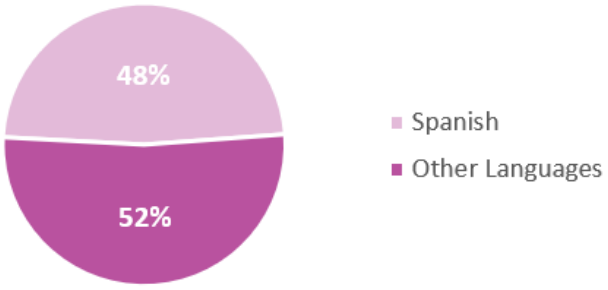
Ethnicity	Primary Race	#	%
Hispanic/Latinx	Black/African American	65	8.9%
	Unknown/Unable to Determine	23	3.1%
	White	16	2.2%
	Native Hawaiian or Pacific Islander	2	0.3%
	American Indian/Alaskan Native	1	0.1%
	Hispanic Total	***107***	***14.6%***
Non-Hispanic/Latinx	Black/African American	564	77.2%
	Unknown/Unable to Determine	5	0.7%
	Asian	4	0.5%
	Non-Hispanic Total	***573***	***78.4%***
Unknown/Unable to Determine	Black/African American	36	4.9%
	Unknown/Unable to Determine	14	1.9%
	White	1	0.1%
	Unknown/Unable to Determine Total	***51***	***7.0%***
Grand Total		**731**	**100.0%**

Source: FACES Report CMT366 as of March 31, 2020

What is known about the primary languages of children in foster care?

As of March 31, 2020, CFSA identified **43 children (2 percent) whose primary language was other than English**. Of those children, 33 were in foster care.[19] Of the 33 children in foster care, **16 (48 percent) were Spanish speaking. Of those 16 children, 12 were Spanish-dominant.** The majority of non-English proficient children in care are identified as Unaccompanied Refugee Minors (URM) and placed with Lutheran Social Services (LSS) as the federally-selected provider for all URM children in the District.

Spanish is the predominant language of children who speak a language other than English.



Source: FACES Management Report CMT320 as of March 31, 2020

[19] The remaining 10 children were receiving in-home services.

Of the Spanish-dominant children, four of the five non-URM children were placed in Spanish-Speaking/Latinx homes.

Placement Type	# of Children
LAYC Resource Home	4
NCCF Resource Home	1
LSS Resource Home	7
TOTAL	**12**

Source: FACES Look-up

Seventeen children (52 percent) spoke other languages. Other languages included, French (three children; nine percent), American Sign Language (two children; six percent) and other non-English languages (12 children; 36 percent). Besides French and ASL, **other non-English languages included Somali, Swahili, Oromo, Dari, Tigrinya and Eritrean sign language**.

Primary Language	# of Children	Placement
French	3	CFSA, Catlin's Place, Boys Town
American Sign Language	2	CFSA, NCCF
Somali/Swahili	2	LSS
Oromo	1	LSS
Dari	4	LSS
Tigrinya / Eritrean	3	LSS
Eritrean Sign Language	1	LSS
Not Specified[20]	1	LSS
TOTAL	**17**	

Source: FACES look-up

Conclusion and Needs to be Considered

Spanish is the predominant language of those children who have a primary home language other than English. CFSA maintains a contract with the Latin American Youth Center (LAYC) for both placement of and case management for Spanish-speaking children and families. With LSS as the provider for all children designated as URMs, there is a very limited need to identify resource parents who speak the less common home languages of the non-URM children. However, the recruitment team will consider these needs in order to strengthen the placement array for immigrant families involved in the foster care system.

[20] The youth came from the Democratic Republic of Congo. A specific language was not provided, but youth has some command of English.

What is known about the sexual orientation and gender identity of children in foster care?

CFSA only knows what is disclosed by the youth. CFSA does not formally track youth who self-identify as Lesbian, Gay, Bisexual Transgender or Questioning (LGBTQ). If a youth discloses their sexual orientation or gender identity preference, they might not want this information to be a part of their record. As of FY 2020 Q2, **there are 21 youth across CFSA and NCCF who self-identify as LGBTQ in current placements**. Four of these youth identified as transgender in their foster care placement.

CFSA maintains collaborations with LGBTQ community partners and businesses to host events, post recruitment information, and disseminate collateral materials. For example, CFSA has placed advertisements and articles in Gay Parent Magazine, and provided a feature story, to Rainbow Families' newsletter, about a transgender youth with a goal of adoption. Between FY19 and FY20 there were 10 new families licensed who identified as LGBTQ or LGBTQ-friendly.

The Agency continues to explore strategies for developing a pool of resource parents who are supportive and willing to provide foster care for this population. The Child Welfare Training Academy (CWTA) offers workshops and webinars related to parenting LGBTQ youth as a support for resource families. In FY 2020, the Recruitment team, with the assistance of the Office of Planning, Policy and Program Support, conducted a literature review to understand best practices for placing LGBTQ youth, specifically transgender youth.[21]

Conclusion and Needs to be Considered

Based on the most recent demographic data captured by the Resource Parent Support Unit, **33 percent (N= 51 out of 157) of the current traditional home pool of CFSA resource parents self-identify as LGBTQ or LGBTQ-friendly,** for placement of LGBTQ youth.[22] While there are sufficient numbers of resource parents who will accept LGBTQ youth, per the Placement Administration, CFSA does have difficulty finding homes for transgender youth.

What is known about siblings in foster care?

The average percentage of sibling groups for FY 2020 Q2 was 51 percent, with 378 children on average being part of a sibling group.

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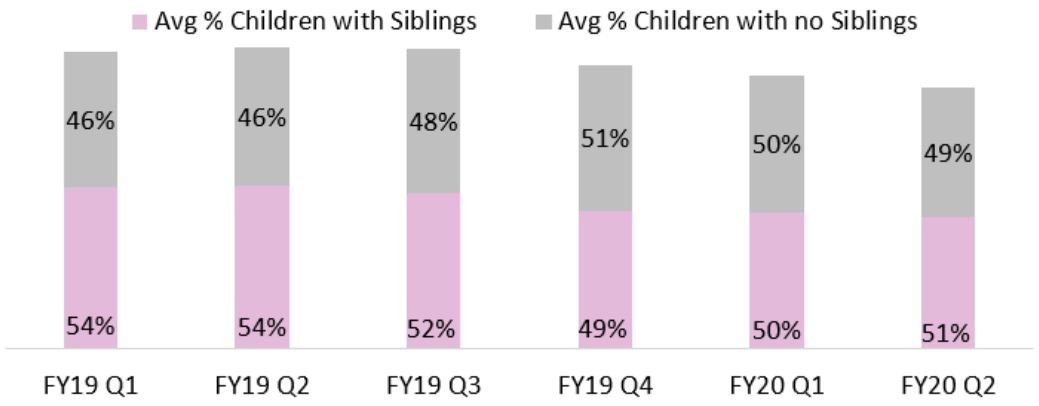
[21] Toolkit to Support Child Welfare Agencies in Serving LGBTQ Children, Youth, and Families. Capacity Building Center for States. https://capacity.childwelfare.gov/pubPDFs/cbc/toolkit-serving-lgbtq-cp-00122.pdf.

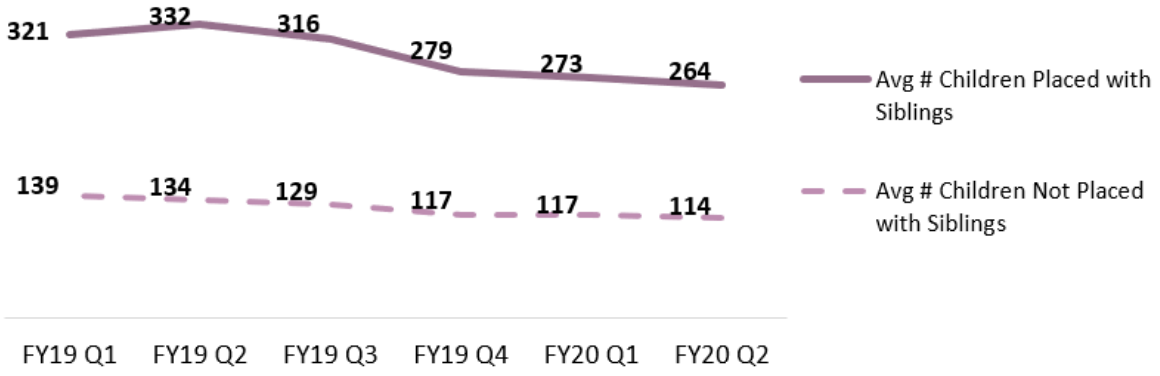
[22] CFSA has 211 licensed resource parents. Of this count, there are 54 two-parent households (total of 108 unique persons) and 103 single-parent households for a total of 157 traditional resource homes.

As of March 31, 2020, fifty-two percent of the foster care population was part of a sibling set.



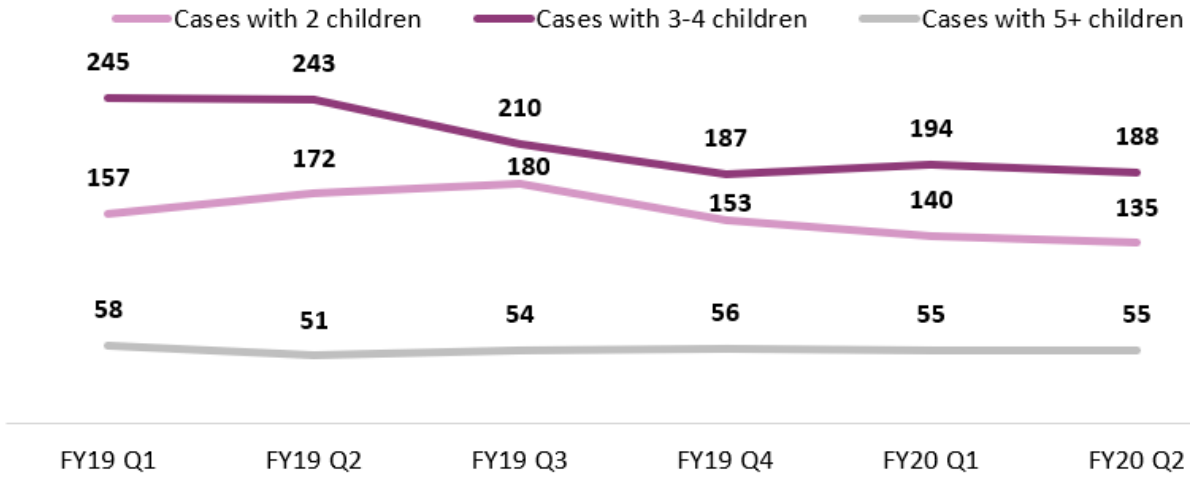
Source: FACES management report PLC003

Although there is a **larger proportion of children with siblings in foster care** than those without, the **number and percentage of sibling groups has been declining**, consistent with the decline in the overall foster care population.



Source: FACES management report PLC003

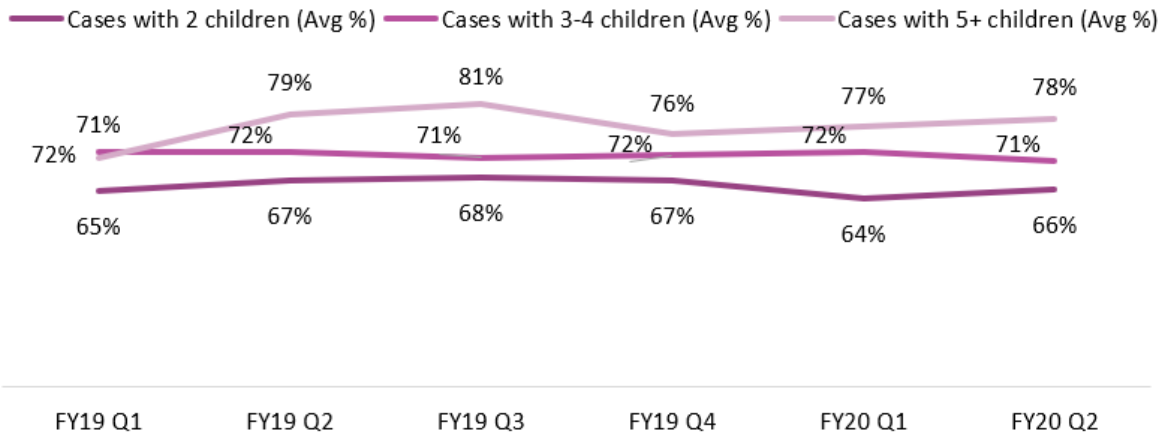
The number of families with larger sibling sets (5+) remain steady.



Source: FACES management report PLC003

Since FY 2019 Q3, the number of cases with only two siblings in foster care has steadily dropped. However, the number of cases with three-to-four children in foster care rose during FY 2019 Q2 then began to stabilize after FY2019 Q4. As of the end of FY 2020 Q2, there were 229 sibling groups of three or more, and 63 of those sibling groups (28 percent) were not placed together, however, the majority are placed together.

Approximately 70 percent of children with a sibling in foster care continue to be placed together.



Source: FACES management report PLC003

In a survey of 17 **birth parents**, 13 **indicated their children experienced barriers to finding the right placement, which included the perception that there was a lack of foster homes especially for sibling groups. Birth parents stated that siblings need to be kept together** and birth parents need to feel comfortable with the foster parents. In a survey of 274 child welfare professionals, 81 indicated this placement type is lacking in placement array. One reoccurring request, echoing that of birth parents, was **a need for more homes that can accommodate large sibling groups (traditional and adoptive).**

Conclusion and Needs to be Considered

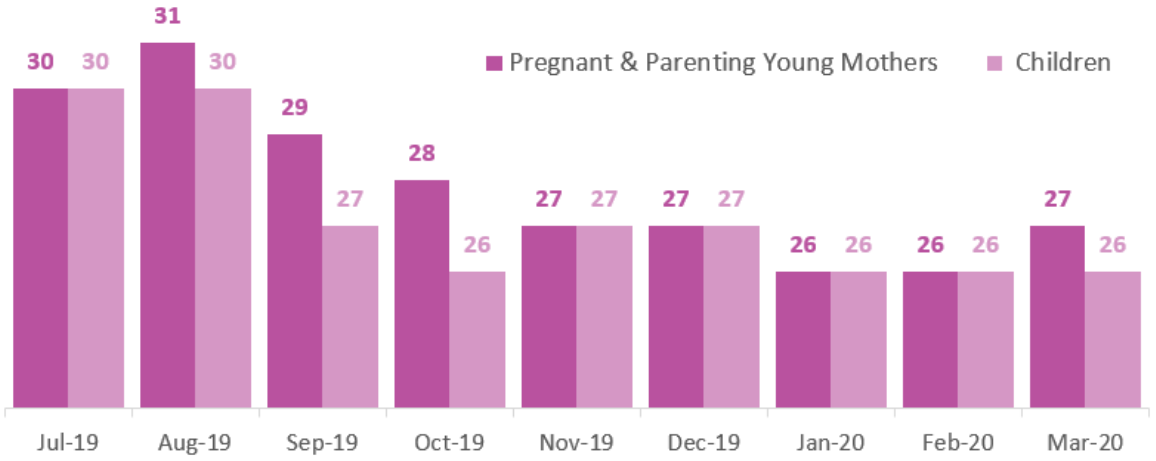
Sixty-nine percent of children in care are placed with one or more of their siblings. There are typically limited barriers to placing two siblings together, however, there is an ongoing need to identify resource parents with enough capacity to accept sibling groups of three or more.

What is known about pregnant and parenting youth in foster care?

The graph below shows that as of March 2020, CFSA reported a count of **27 females (23 parenting and 4 pregnant), ages 15 to 20, who were pregnant or parenting. Seven of the 23** youth were already mothers when they entered foster care while **14 (61 percent) became mothers after entering care. An additional two youth were already mothers when they entered care and gave birth after entering care.** Among the 23 young mothers in March 2020, there were 26 children

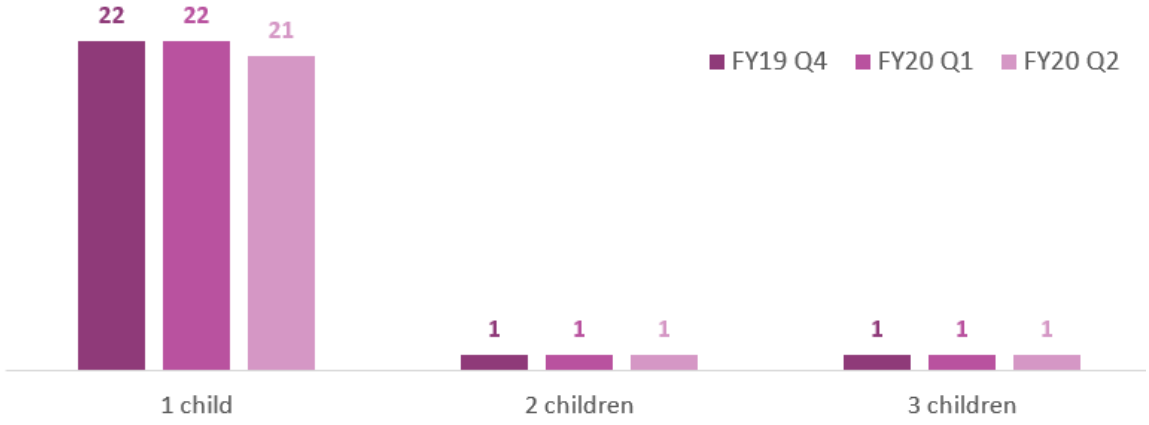
total. In both FY 2019 and FY 2020 through Q3, there have been no young fathers in care who are parenting their child. However, young fathers in care are eligible for home visiting services.

On average each month, there are 28 young mothers in foster care with 27 children among the mothers.



Source: OYE monthly report

Almost all of the young mothers in foster care have only one child.



Source: OYE monthly report

All but one of the young mothers in foster care have a child under age 5 as of FY 2020 Q2.

Child's Age	# of Children
Pregnant teen	4
Birth – 1	16
2	2
3	7
4	0
5	1
TOTAL	**30**

Source: OYE monthly report

Of the 27 young pregnant and parenting youth in care at the end of FY 2020 Q2, most were placed in family-based settings.

Placement Type	# of Teen Parents
The Mary Elizabeth House	8
Professional Foster Parent	3
Traditional Resource Home	10
Caitlin's Place	2
Other[23]	4
TOTAL	**27**

Source: OYE monthly report

Conclusion and Needs to be Considered

For the relatively small number of pregnant and parenting teens in care, there has not been a challenge to finding appropriate placements. The three professional foster parent beds licensed last year for the teen moms have proven to be successful and at full capacity. In FY 2021, CFSA will increase those beds by two.

What is known about children who may have been involved in sex-trafficking?

An administrative issuance on commercial sexual exploitation and sex trafficking identification and response was approved in 2017 which addresses provisions of the Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183. Over the past three years, through the Commercial Sexual Exploitation of Children (CSEC) multi-disciplinary team, efforts have been made to clarify the referral criteria and process for reporting suspected sex trafficking, in particular:

- To ensure that workers know the difference between sexual abuse and sex trafficking so as not to over-assign the allegation
- To ensure that when sex trafficking is identified during the course of an investigation, if not the primary reason for the initial hotline call, the allegation is called back into the hotline.

In FY 2018 CFSA had 149 referrals, in FY 2019 there were 107 referrals and in FY 2020 as of March 2020 there were 68 referrals. In FY 2019, CFSA accepted and investigated 103 referrals of sex trafficking concerning 89 unique alleged victims. As of FY 2020 Q2, CFSA accepted and investigated 61 unique referrals of sex trafficking concerning 50 unique alleged victims.

[23] Of the four youth in "Other", three were in runaway status and one was in a DYRS placement.

On average, 27% of referrals that have been submitted since FY 2018 have been substantiated for sex trafficking.

Status	FY18	FY19	FY20 (as of 3/20)
Referrals Received	149	107	68
Referrals Accepted	141	103	61
Accepted and Linked	15	14	0
Substantiated	36	33	13
Unfounded[24]	62	35	31
Inconclusive	15	16	7
Incomplete (no finding)	13	5	10

Source: FACES management report INV148

In FY 2019 and FY 2020 to Q2 combined, approximately 86 percent (n=120/139) of alleged victims were referred based on sexual exploitation/sex trafficking of a child (by a non-caregiver). Forty-eight percent (n=67) of the alleged victim universe have been unfounded, 24 percent (n=34) have been substantiated, 17 percent (n=24) inconclusive, 7 percent (n=10) had no findings and at the end of March 2020, three percent (n=4) of the investigations were still open. Twenty-two of the victims had an open case (8 in-home and 14 out-of-home).

Demographics of Alleged Victims (n=139):

- Average and Median Age: 15 years old
- Age Range: birth to 20 years old; despite younger children being sexually exploited[25], substantiations for sex trafficking are seen on children 6 and older in this universe
- Gender: 120 female (86 percent), 18 male (13 percent), one gender unidentified (one percent)
- Residency: 38 DC residents; 12 non-DC residents *(data captured starting FY 2020)*
- Citizenship Status: 37 US Citizen, one undocumented, 101 unknown/not indicated *(data captured starting FY 2020)*
- Race: 89 (64 percent) African American; 37 (27 percent) unknown; eight (six percent) White; and five (three percent) Other
- Ethnicity: 27 (18 percent) Hispanic[26]; 66 (47 percent) Non-Hispanic; and 48 (35 percent) unknown

[24] "Unfounded report" means a report, made pursuant to § 4-1321.03, which is made maliciously or in bad faith or which has no basis in fact.

[25] An infant or underage child may be associated with a home considered a "trap" house or may be transacted as a commodity for drugs or sex; this may be indicated as sexual exploitation of a child by a caregiver.

[26] The count of 27 children identifying Hispanic as ethnicity includes 17 referrals listing Hispanic as the race and 10 unknowns for race.

Where are the 22 children in foster care who have been involved in sex-trafficking placed?

Of the 22 children in care at the end of FY 2020 Q2, half were placed in family-based resource homes.

Placement Type	# of Children
Traditional Home	8
Kinship Home	3
Congregate Care	1
Residential Treatment	6
Missing, Absent (Runaway)	4
TOTAL	**22**

Source: FACES management report INV148

Conclusion and Needs to be Considered

As staff and community members have increased their awareness of the signs of sex trafficking and have gained familiarity with the reporting requirements, the number of unfounded allegations has decreased. CFSA offers training and refresher training designed to provide resource parents with information regarding the unique development needs, parenting practice, and ways to best support children who may be a victim of sex trafficking. To date, there have not been challenges finding placements for youth who have been involved in sex-trafficking.

What is known about children in foster care with complex medical needs including those identified as medically fragile?[27]

CFSA provides services to youth with more complex medical needs that require a higher level of medical case management, including nursing and behavioral supports, through the Nurse Care Manager (NCM) program. The nurse care manager can facilitate the development of a high-functioning team to address the children's needs, including providing assistance in applying for

[27] Medically fragile is defined as a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled nursing intervention is medically necessary and is characterized by one or more of the following:

- There is a life-threatening condition characterized by a reasonably frequent period of acute exacerbation, which requires frequent medical supervision, and/or physician consultation, and which in the absence of such supervision or consultation, would require hospitalization.
- The individual requires frequent time-consuming administration of specialized treatments, which are medically necessary.
- The individual is dependent on medical technology and/or assistive devices such that without the device or technology, a reasonable level of health could not be maintained.

Health Care for Children with Special Needs (HSCSN).[28] Nurse care managers can be assigned regardless of insurance and terminate services when a child is stable in their condition (including children with HSCSN insurance who may still have a care manager through HSCSN services).

An examination of NCM data provides information on the number of children in foster care who are medically fragile, however this is not a comprehensive number since some children classified as medically fragile will not have a nurse care manager. It should also be noted that the categories of medically fragile, diagnosed with autism, and diagnosed with cognitive and/or developmental disabilities are not mutually exclusive, and children may fall into multiple categories and be eligible for NCM services.

As of the end of FY 2020 Q3, there were **five children in foster care classified as medically fragile and actively receiving NCM services**. Of the five current clients, two children had entered foster care less than six months ago and were in the birth-5 age group. Both children were placed in a hospital setting as of the end of FY 2020 Q3, however could be moved into a family-based setting when an appropriate home was identified and the right training was provided. Children with complex medical needs are placed in family-based resource homes, when appropriate, with NCM services or HSCSN support as needed.

One of these youth had a goal of reunification and the other youth had a goal of adoption. The remaining three children were ages 6 to 12 and all been in care for longer than five years. Two children with a goal of adoption were residing in a foster home. The third child had a goal of APPLA of and was residing in a hospital setting. This child could be discharged and placed in a foster home, however has been presented multiple times and an appropriate setting has not been identified.

As of the end of FY 2020 Q3, there were five children in foster care classified as medically fragile and actively receiving Nurse Care Manager (NCM) services from CFSA.

Child	Age	Time in Care	Goal	Placement
1	Birth - 5	< 6 months	Reunification	Hospital
2	Birth - 5	< 6 months	Adoption	Hospital
3	6 – 12	> 5 years	APPLA	Hospital
4	6 – 12	> 5 years	Adoption	Resource Home
5	6 – 12	> 5 years	Adoption	Resource Home

Source: Quickbase NCM data

[28] HSCSN is a complete healthcare plan in the District of Columbia for children and young adults with disabilities and complex medical needs. Children may enroll in HSCSN if they are under 26 years of age, DC residents, and receiving Supplemental Security Income (SSI) benefits or have an SSI-related disability. Children enrolled in HSCSN receive a care manager who works with them and their caregivers to coordinate care for the child's medical needs. All children with HSCSN insurance also have a primary care provider (PCP).

One additional child was discharged from NCM services upon the child's death. At the time of the child's death she was two years old, had been in care for two years, had a goal of adoption and was residing in a hospital setting.

What is known about children in foster care diagnosed with autism and/or with cognitive and developmental disabilities?

Children in foster care with cognitive and developmental disabilities and/or diagnosed with autism are also able to utilize NCM services. According to program data as of the end of FY 2020 Q2, a total of **10 foster care children receiving NCM services have a diagnosis of autism.** An additional two children in foster care with a diagnosis of autism had been discharged from the NCM program in FY 2020. One child had been residing in a Psychiatric Residential Treatment Facility (PRTF), and the other children had been residing in a family-based setting.

Pursuant to CFSA's goal of expanding its placement array, CFSA contracted with Innovative Life Solutions (ILS) to provide six group home beds for males who are intellectually disabled or developmentally delayed. As of June 2020, four youth are placed in ILS (they are not reflected in table below because they are not receiving NNCM services at this time). CFSA has also contracted with Community Services for Autistic Adults and Children (CSAAC) for placement of two youth with a diagnosis of autism in a CSAAC group home. As of June 2020, two children are placed in the facility. Additionally, CFSA has referred resource parents to its Child Welfare Training Academy for specific training sessions on serving children on the autism spectrum to support children in family-based placements.

Of the 10 children in care, receiving NCM services and diagnosed with autism at the end of FY 2020 Q2, most were placed in family-based resource homes.

Placement Type	# of Children
Traditional	6
Kinship	1
Community Services for Autistic Adults and Children (CSAAC)	3
TOTAL	**10**

Source: OWB Quickbase data

As of the end of FY 2020 Q3, **a total of 52 children in foster care receiving NCM services were diagnosed with cognitive and/or developmental disabilities**, and a total of 30 children with cognitive and/or developmental disabilities had been discharged from NCM services.

Of the 52 children in care receiving NCM services and diagnosed with cognitive and/or developmental disabilities at the end of FY 2020 Q3, most were placed in traditional foster homes.

Placement Type	# of Children
Traditional	37
Kinship	9
Hospital	4
Congregate Care Facility	2
TOTAL	**52**

Source: OWB Quickbase data

Conclusion and Needs to be Considered

There is no identified need in terms of Nurse Care Manager assignment. However, from time to time, there is a need for additional placements that can accept children with significant medical needs. As of the end of FY 2020 Q2, three children identified as medically-fragile needed a family-based placement. By the end of FY 2020 Q4, all three children were placed in a family-based resource home.

There is an ongoing need to increase the number of resource parents able to care for children on the autism spectrum and with cognitive and/or developmental disabilities. The two group homes, ILS and CSAAC, have been positive additions to the placement array. The ILS home serves only males and staff have identified a need for congregate care beds for females with cognitive and/or developmental disabilities. Conversations are underway with ILS to explore options for meeting this need for females who need a higher level of care than a family-based home can provide.

What is known about trends in foster care disruptions?

The following information reviews youth that had either run away[29] or experienced a disruption during FY 2020 Q2 (January 1 – March 30, 2020), and re-examines the analysis completed for the *Strengthening our Safe Haven (SOSH) Placement Array* workgroup in FY 2019, which covered October 1, 2018 – February 12, 2019.

[29] Runaway episodes were also included in this analysis since they can be an early indicator of a potential placement disruption/placement instability.

Eighty-nine percent of the youth in this sample experienced two or fewer episodes of a placement disruption and/or being missing/absent/runaway.

# of Disruptions and/or Missing/Absent/Runaway Episodes	Ages 0-5	Ages 6-12	Ages 13-17	Ages 18+	Total #	Total %
2 or fewer	14	16	39	23	92	89%
3-4	0	1	8	0	9	9%
5	0	0	2	0	2	2%
Total	**14**	**17**	**49**	**23**	**103**	**100%**

Source: Manual Disruption Data

A total of 103 children (13 percent) out of a total of 812 children served in foster care during FY 2020 Q2 had at least one placement disruption and/or episodes of being missing, absent or runaway (together referred to as disruptions throughout this document). The remaining 709 children (87 percent) were stable without any placement disruptions and/or episodes of being missing, absent, or runaway during FY 2020 Q2. Between January – March 2020, **nine in 10 children (89 percent) had two or fewer disruptions.** While a direct comparison cannot be made since the timeframe examined here was one quarters worth of data compared to just over four months in the SOSH analysis, this analysis suggests slightly more stability than the SOSH analysis, in which 72 percent of children had two or fewer disruptions.

In this analysis, almost half of the children (48 percent) that experienced at least one disruption were teens (age 13-17). **When looking at the 13-17-year-olds and 18+ youth combined, teens and young adults represent 70 percent of disruptions.** This represents **increased challenges with achieving placement stability for the teen and young adult years.** In the analysis last year, 34 percent of the youth were ages 13-17 and 25 percent were ages 6-12, and 24 percent were ages 18 and over. In both analyses, the smallest group of children are the children ages birth-5, with 14 percent of children in this age group having at least one placement disruption in FY 2020 Q2 (no children in this age group had an episode of being missing, absent or runaway). Last year, 17 percent of the children falling into the population were ages birth-5.

Characteristics of Children/Youth (n=103)	# of Children/Youth with Disruptions	% of Children/Youth with Disruptions
Behavioral and/or Psychiatric Concerns	56	54%
Substance Abuse	27	26%
CSEC	13	13%
Criminal Justice Involvement	13	13%

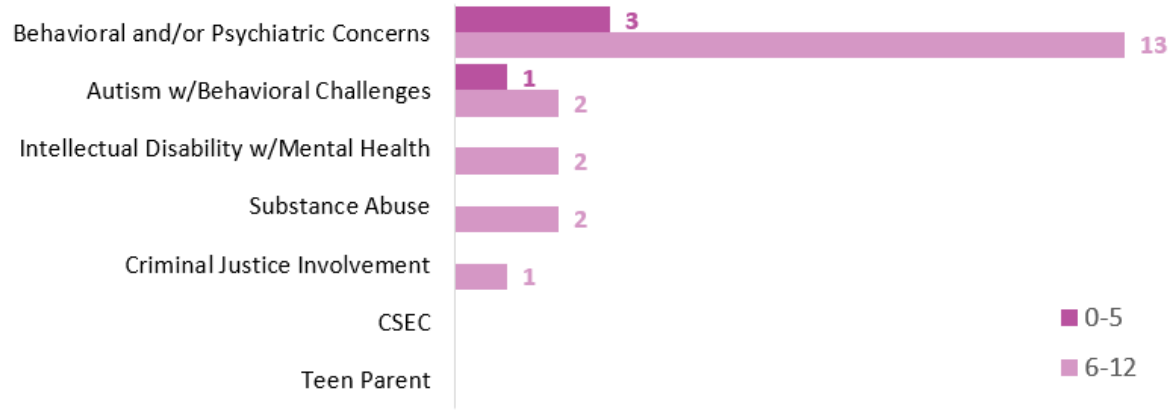
Characteristics of Children/Youth (n=103)	# of Children/Youth with Disruptions	% of Children/Youth with Disruptions
Teen Parent[30]	11	11%
Intellectual Disability w/ Mental Health Challenges	6	6%
Autism w/ Behavioral Challenges	3	3%

Source: Manual Disruption Data

The characteristics that the youth presented that contributed to the disruptions were also examined and was manually provided by program staff. The intention of this is not to blame the youth, but to identify current pressing contributing factors to placement instability and identify where additional resources may need to be developed to support these youth. As found last year, **the most prevalent characteristic in this population was behavioral and/or psychiatric concerns** (54 percent), which also impacted approximately half of the population last year (46 percent). **The next highest categories were substance abuse** (impacting 26 percent of population, higher than last year when it was 15 percent), **children having concerns related to commercial sexual exploitation of children** (CSEC, 13 percent, comparable to last year at 10 percent), and **criminal justice involvement** (impacting 13 percent of the population, comparable to last year at 11 percent).

The prevalence of characteristics was also examined by age group. For children ages birth-12, behavioral and/or psychiatric concerns were the most prevalent characteristic, especially for children ages 6-12. Autism with behavioral and intellectual disability with mental health were also experienced by two children each in the six to 12 age group, and autism with behavioral was a characteristic for one child in the birth to five age group.

Among children ages birth-12, behavioral and psychiatric concerns were the greatest factor contributing to placement instability.

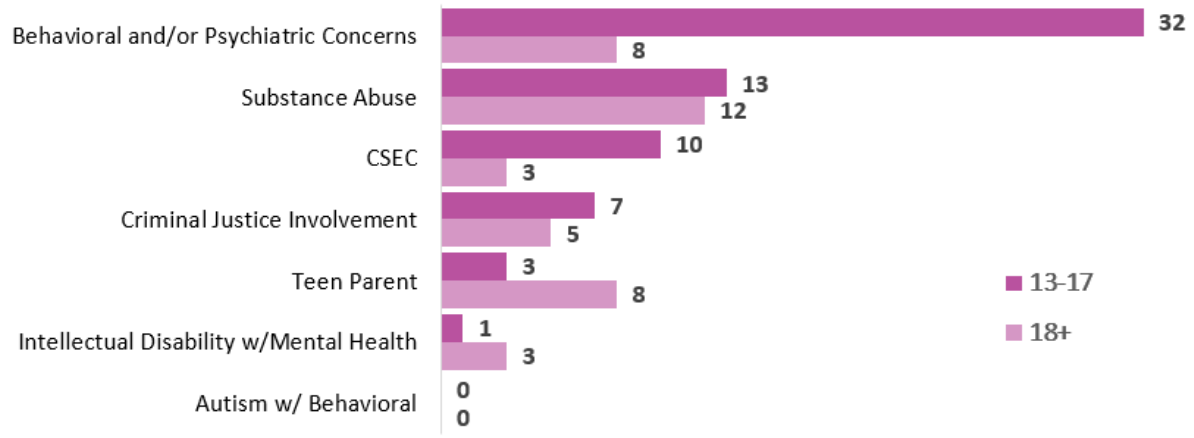


Source: Manual Disruption Data

[30] Teen pregnancy contributed to, but was not the driving factor for, placement instability for these youth. Trafficking, substance use and behavioral and/or psychiatric concerns were the driving factors.

For youth and young adults ages 13-21, behavioral and/or psychiatric concerns were the most prevalent characteristic for the children ages 13-17 (n=31) but impacted fewer of the young adults 18+ (n=8). Substance abuse impacted approximately equal numbers of youth ages 13-17 (n=13) and 18+ (n=12), and CSEC impacted more youth ages 13-17 (n=10) than young adults 18+ (n=3). Criminal justice involvement impacted slightly more youth ages 13-17 (n=7) than young adults ages 18+ (n=5). Youth who had children and their status as teen parents contributed to their placement disruption tended to be older teens, with eight young adults ages 18+ having this as a characteristic and three teens ages 13-17 having this as a characteristic.

Among children ages 13-17, behavioral and/or psychiatric concerns were the greatest factors contributing to placement instability. For children ages 18+, substance abuse was the most prevalent characteristic contributing to placement instability.



Source: Manual Disruption Data

Most youth exhibit one of the characteristics tied to placement disruptions.

Count of Youth Characteristics	0-5		6-12		13-17		18+		Total	
	#	%	#	%	#	%	#	%	#	%
No Characteristics	10	71%	2	12%	11	23%	6	26%	28	27%
One Characteristic	4	29%	11	65%	19	39%	4	17%	41	40%
Two Characteristics	0	0%	3	17%	10	20%	6	26%	18	17%
Three Characteristics	0	0%	1	6%	9	18%	5	22%	14	14%
Four Characteristics	0	0%	0	0%	0	0%	2	9%	2	2%
Total	**14**	**100%**	**17**	**100%**	**49**	**100%**	**23**	**100%**	**103**	**100%**

Source: Manual Disruption Data

Finally, children could have varying numbers of these characteristics that impacted their placement stability. Overall, **four in ten children had one characteristic that presented a barrier to placement stability** identified by program staff. Youth ages six to twelve had 71 percent of children only have one characteristic, and **older youth and young adults experience a greater share of having multiple characteristics that impact their placement stability**. **Overall, 27 percent of youth did not have any of these characteristics** marked as contributing to their disruptions. This suggests that the categories developed during the SOSH workgroup may not be comprehensive enough, and **additional themes regarding characteristics may need to be defined**. The findings from last year were similar, with the majority of children (35 percent) having one characteristic, and the number of characteristics applicable rising as the children got older. There were also 37 percent of children in that population that did not have any characteristics.

Conclusion and Needs to be Considered

During FY 2020 Q2, a total of 103 children experienced at least one placement disruption and/or episode of being missing, absent or runaway. Almost nine in ten of children had two or fewer disruptions, and almost half the children experiencing a disruption were ages 13-17. More than half of the children had behavioral and/or psychiatric concerns listed as a characteristic contributing to their placement instability, and this was also the top reason when examining the characteristic by most age groups as well. The only age group where behavioral and/or psychiatric concerns was not the top characteristic was the 18+ age group, where substance abuse was the most prevalent characteristic. Four in ten children had one applicable characteristic, however more work needs to be done in this area since for 27 percent of the children no characteristics were selected as contributing to their disruptions by placement staff.

The Agency has identified the need to enhance the placement array by including resource providers who are adept in managing children and youth with a disability, complex medical, behavioral and/or psychiatric concerns.

As part of ongoing effort to minimize placement disruptions, CFSA made the following adjustments to its placement array over the past year:

- CFSA contracted with the Maryland-based private agency, Children's Choice, for an intensive family-based foster care program for 36 youth whose needs are more intensive than in a traditional resource parent home. These homes serve children from ages birth-21 who are appropriate for a family-based setting but are experiencing (or likely to experience) placement instability. This instability may be due to a history of physical or verbal aggression, stepping down from a diagnostic or psychiatric residential treatment facility, current mental health diagnosis, or several other situations.
- CFSA established two SOAR (Stabilization, Observation, Assessment, and Respite Care) professional resource parent homes with 2 beds each to provide temporary care for up to 90 days. SOAR homes are appropriate for children who need comprehensive assessments completed before the Agency can identify the best placement match for their exact placement needs. SOAR resource parents collaborate with CFSA to identify barriers and

resolutions to service provision for the child. This collaboration includes assisting the team in observing and assessing children to determine appropriate service and placement needs, as well as supporting the team by initiating and maintaining family relationships and services to meet educational, vocational needs, mental and physical health needs. This resource replaces the need for interval homes (i.e., short-term placements) which CFSA no longer provides. In exchange, the SOAR homes provide an enhanced role and provisions of support for children and youth.

- As of March 31, 2020, CFSA had ended both the Mockingbird and Family Connections resource parent "cluster" programs in favor of developing one equitable and sustainable parent support program called the BOND (Bridge, Organize, Nurture and Develop) program. BOND is CFSA's new "hub" model for engaging and supporting resource parents through peer networks led by experienced and committed BOND parents. Services offered via the BOND program include but are not limited to peer support, resource parent networking and respite services. CFSA assigns resource families to a BOND squad of 10-12 peer resource parents. Each squad has an assigned BOND lead family with an experienced and committed resource parent who will provide leadership of the squad. The BOND lead family's role is to provide peer support to assigned resource families, coordinate special activities and provide and assisting with providing and coordinating respite care. Each BOND Squad leader has one bed available for respite stays for families with their "squad". In addition, there is a resource parent support worker assigned as the BOND program coordinator, who is solely dedicated to managing the program and providing support to all identified BOND lead families. The BOND lead families and program coordinator ensure that the program appropriately addresses the needs of resource parents and the children in their care.

Resource Parent Profiles

What is known about the race of resource parents?

As of March 31, 2020, African American children represent 91 percent of the population of children in foster care, which is a three percent increase from the same point in time as last year. African Americans represent 76 percent of the resource parents, which is a seven percent decrease over FY 2019.

While Black/African American resource parent applicants are the majority, there is a growing number of Caucasian resource parent applicants becoming licensed in the District.[31]

FY 2019	Resource Parent Applicant #	Resource Parent Applicant %	Resource Parent Licensed #	Resource Parent Licensed %
Asian/Pacific Islander	2	1%	0	0

[31] The drop-off in applicants from recruitment to licensing occurs for a variety of reasons. CFSA is developing an enhanced resource parent tracker to better collect and analyze data on resource parents from recruitment through licensing. Additionally, CFSA's REACH campaign is being launched in October 2020 to improve recruitment outcomes.

FY 2019	Resource Parent Applicant #	Resource Parent Applicant %	Resource Parent Licensed #	Resource Parent Licensed %
Bi-Racial	3	2%	0	0
Black/African American	**80**	**52%**	**18**	**26%**
Caucasian	**54**	**35%**	**7**	**10%**
Hispanic/Latinx	2	1%	1	2%
No Race Indicated	14	9%	43	62%
TOTAL	**155**	**100%**	**69**	**100%**

FY 2020 (as of July 2020)	Resource Parent Applicant #	Resource Parent Applicant %	Resource Parent Licensed #	Resource Parent Licensed %
Asian/Pacific Islander	3	3%	0	0
Bi-Racial	2	2%	1	2.6%
Black/African American	**43**	**40%**	**12**	**32%**
Caucasian	**26**	**24%**	**12**	**32%**
Hispanic/Latinx	2	2%	0	0
Middle Eastern	1	.9%	0	0
Native American	1	.9%	0	0
No Race Indicated	30	28%	13	34%
TOTAL	**108**	**100%**	**38**	**100%**

Source: Manual databases from the Recruitment and Licensing units. In some places we did not roundup but carried out to the tenth decimal place to show that the percent equals 100.

Fiscal year 2020 focus group and survey responses revealed that **training on "transracial parenting" would enhance feelings of competency for resource parents**. For example, in a focus group of 11 resource parents, almost half of the families, who identified as White, requested transracial parenting training to understand how to parent an African American child especially teenagers and process the Black Lives Matter movement. The same sentiment was found in a survey of 40 resource parents, thirteen indicated training needs including mentions of transracial parenting and cultural competency specific to parenting youth used to an urban city and lifestyle.

Moreover, in a survey of 274 child welfare professionals, 132 respondents offered examples of additional mental health service needs for the District's child welfare population such as the **need for culturally competent therapy (e.g., for African American, Spanish-speaking and African immigrant community)** as well as the need for **providers who use a racial equity lens in behavioral and wellness services.** As last year's Needs Assessment addressed, resource parents desire more parenting and shared parenting 101 practical courses. Also requested were courses

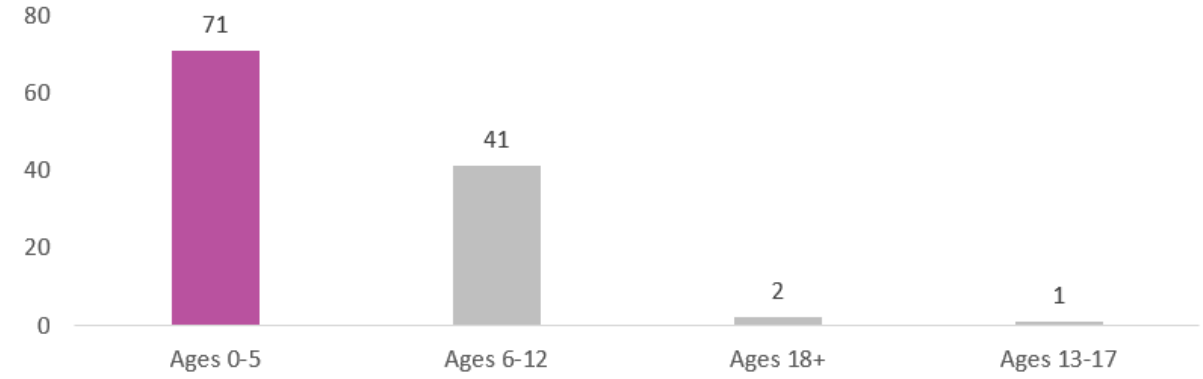
that teach about **caring for kids that don't look like you, how to keep kids connected to their culture at every age, how to advocate for kids and their families, how to team, how to establish good relationships with birth families who don't look and may not think like you.**

What is known about the age preferences of resource parents?

While CFSA licenses every resource home for clients ages birth to 21, resource parents may indicate an age preference of birth to 5, or 6 to 21 years old. The groupings below are estimates; a resource parent's actual age preferences may cross ranges. Additionally, a parent can prefer multiple age groupings below (i.e., 0-5 years old and 6-12 years old); the data below was broken down by parents who indicated flexible preferences and those who requested fixed age groups. The former has been organized by developmental stage.

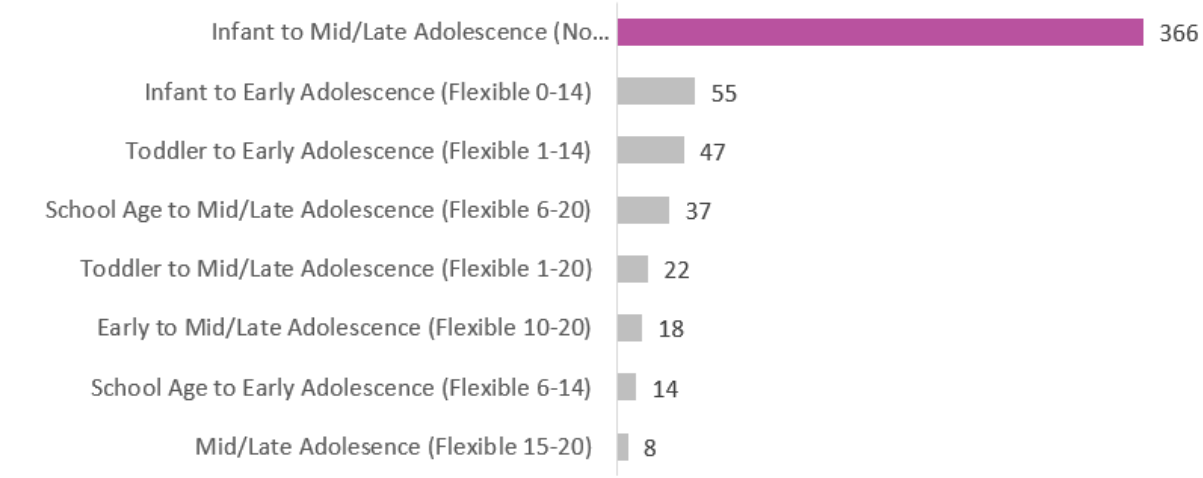
As of March 31, 2020, of the unique 682 resource parents, 567 indicated flexibility in the age ranges of children they were willing to foster; 115 parents were more fixed in the age ranges of birth to 5, 6 to 12, 13 to 17 and 18 and older.

Resource Parents who stated a preferred age range were more likely to prefer children ages birth to 5.



Source: FACES Management Report PRD141, includes CFSA, NCCF, and LAYC homes as of March 31, 2020

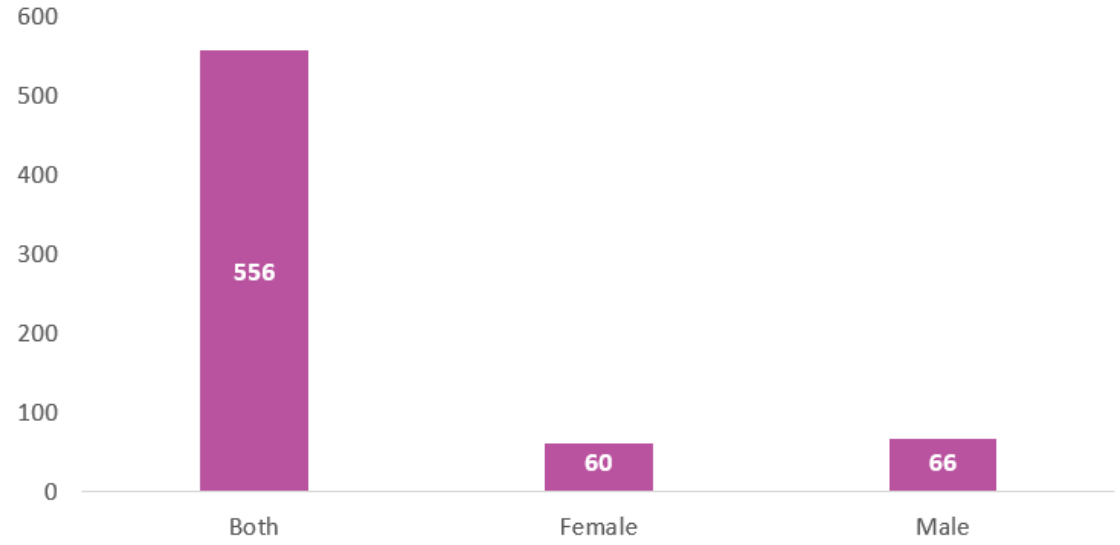
Resource Parents who were more flexible in the preferred ages of children were willing to accept infants to youth in late adolescence.



Source: FACES Management Report PRD141, includes CFSA, NCCF, and LAYC homes as of March 31, 2020

What is known about the gender preferences of resource parents?

Most resource parents have no preference regarding the gender of children placed in their homes.



Source: FACES Management Report PRD141, includes CFSA, NCCF, and LAYC homes as of March 31, 2020

FOSTER CARE Placement Array

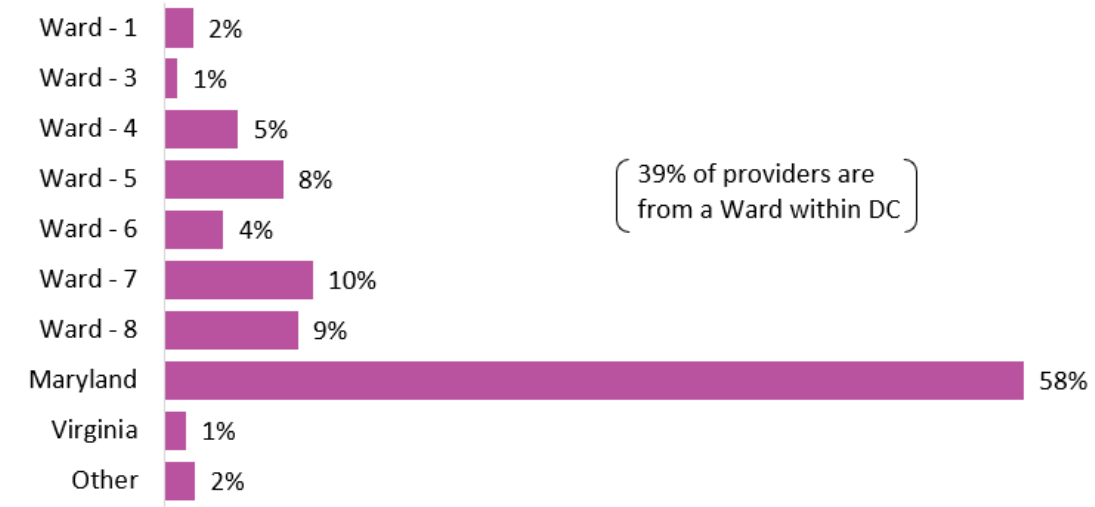
CFSA believes that children and youth belong in family-based foster care, and moreover, that kinship care provides the most connection to family. CFSA works to have the first placement with kin, and when not available, CFSA strives to have the best match with a family-based resource parent. However, the placement array must accommodate a variety of level of care needs. Some youth might need the additional structure and round-the-clock support of a group home or a more

restrictive level of care to meet his or her therapeutic needs. In addition, CFSA acknowledges that for some children, particularly those who are new to the foster care system, an observation period is advisable to better determine their needs and make an informed decision about the placement match that will maximize placement stability.

What is the number of beds in the placement array?

On March 31, 2020, CFSA's family-based placement capacity included 535 resource homes with a known capacity of 884 beds.[32] For congregate care facilities, CFSA had a contracted capacity of 83. In all, CFSA has capacity for 967 paid placements. Given that there were 731 children in care as of March 31, 2020, CFSA has an adequate number of placements available to children in foster care. While we have more beds than children in care, CFSA is working to improve the array of specialized beds to better meet the needs of our children.

Wards 5, 7 and 8 had the most DC family-based beds which mirrors the Wards from which most children enter the foster care system.



Source: FACES Management Report PRD141

What are the placement trends?

The number of **children in family-based care has remained consistent between 79-84 percent** since FY 2019. Within family-based settings there has been an **increase in kinship providers from 25 percent to 31 percent in FY 2020**.[33] Kinship placement rates continue to rise. As of March 31,

[32] 34 homes had no capacity listed in the source file and were counted as having a capacity of one; however, their actual capacity may be greater than one.

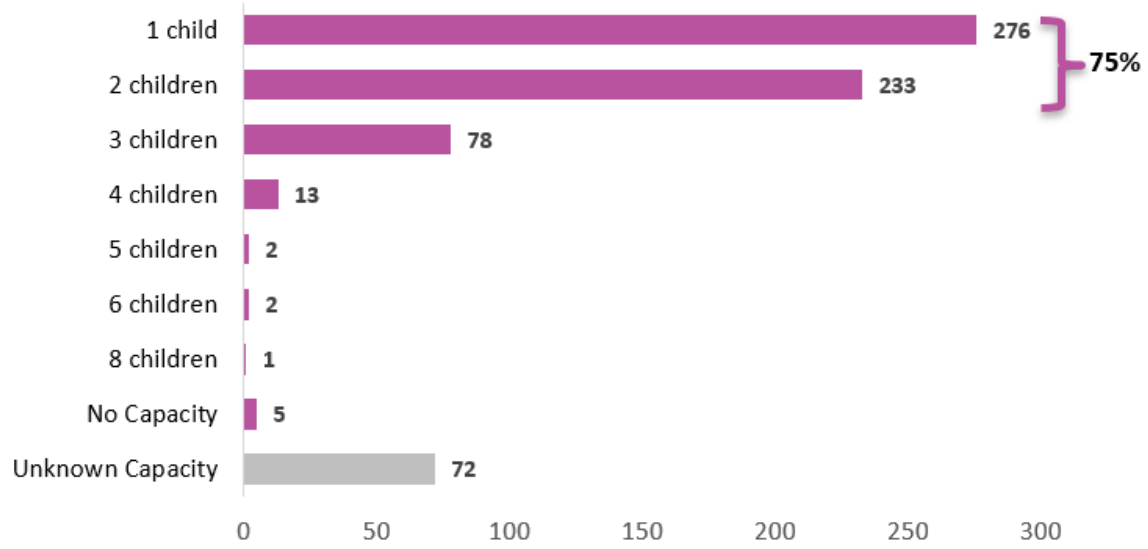
[33] Family-based counts ranged from 355 to 484 and kinship counts from 211 to 241. The counts/percentages of traditional family-based homes are separated out from kinship because they are separate service lines and we want to see specifically the increase in kinship homes versus traditional foster homes per the Agency's focus/initiative on placing with kin.

2020, kin placement was at 31 percent, which represents an increase of four percentage points over last year.

What is known about capacity for siblings in foster care?

Resource homes in the District may be licensed for no more than three beds. When a sibling group is in need of placement, a waiver may be requested to allow for placement over the licensed capacity. In Maryland, the regulations allow for no more than two children younger than 2 years old in the home; no more than six children including the foster parent's birth children and adopted children; a total of eight children if the foster care children include a sibling group. In Maryland, treatment providers can place a sibling group of up to three but a sibling group of four or more requires an exception packet.

75 percent of resource parents are licensed for the placement of one-to-two children.



Source: FACES Management Report PRD141 as of March 31, 2020

What is the budgeted capacity for family-based and congregate care?

CFSA's FY 2021 Projection for Utilization includes a budget for 850 paid placements at any one time. **Most placements are family-based (90%)** with 761 family-based and 89 congregate placements, not including a projected 55 youth in other, non-paid settings at any given time. CFSA will maintain a 10 percent surplus of bed capacity over the foster care census. The FY 2021 budgeted capacity is based on the utilization-to-capacity ratio, utilization trends over the past three years, demographics of client entries and exits, projected number of youth aging out, and other significant placement issues.

Placement Type	FY20 Budgeted Capacity	FY20 # Utilization (on 6/30/20)	FY20 % Utilization (on 6/30/20)	FY21 Budgeted Capacity
Traditional	190	112	59%	169
Kinship	140	140	100%	150
Special Opportunities for Youth (SOY)	30	12	40%	20
Stabilization, Observation, Assessment and Respite Services (SOAR)	4	4	100%	2
Professional Resource Parent (PRP) for Pregnant/Parenting Youth[34]	3	3	100%	5
CFSA Sub-Total	***367***	***271***	***74%***	***346***
National Center for Children & Families	350	244	70%	350
Latin American Youth Center	10	14	140%	15
Children's Choice (Intensive Foster Care)	36	13	36%	30
Lutheran Social Services (URM)	20	21	105%	20
Contracted Sub-Total	***416***	***292***	***70%***	***415***
Group Home - Traditional	42	37	88%	56
Group Home - Therapeutic[35]	24	2	8%	2
Group Home - Intellectual/Development Disability	8	4	50%	4
Group Home - Autism Spectrum	6	2	33%	3
Teen Parent Independent Living Program	14	9	64%	8
PRTF/Diagnostic/Residential	13	17	131%	13
Emergency Shelter	4	2	50%	3
Congregate Sub-Total	***112***	***73***	***66%***	***89***
Grand Total[36]	**895**	**112**	**71%**	**850**

Source: Placement Services Administration utilization projections

[34] Not all teen parents are placed with professional foster parents; most are placed in traditional homes.

[35] While there was a therapeutic contract in place for 24 beds in FY 2020, CFSA was only able to place 2 children. With the additional intensive family-based providers implemented in FY 2020, the level of need for therapeutic group home beds has decreased.

[36] On June 30, 2020, there were 51 youth in an "Other" setting (e.g., abscondence, hospital, college, detention facility) which are not counted in the budgeted bed capacity.

What kind of specialized, family-based placement types does CFSA have available?

- **Special Opportunities for Youth (SOY) Homes.** SOY homes provide a planned placement in a resource home with specially-trained providers for CFSA youth ages 11-20, who need a higher level of support for challenging needs. The SOY homes have been shown to stabilize these youth with the additional support. CFSA will have 20 SOY beds in FY 2021.
- **Stabilization, Observation, Assessment and Respite Services (SOAR) Homes.** SOAR homes are professional resource parent homes that provide temporary care for children who need comprehensive assessments to identify appropriate placement needs. Placement capacity allows for one to two youth between the ages of 6-20 for up 90 days, and CFSA has two SOAR professional foster parents with two beds each.
- **Professional Resource Parents (PRP).** CFSA professional resource parents are paid a salary to provide intensive, culturally-informed support and services to pregnant and parenting youth. Professional resource parents may not work more than 20 hours outside of the home. The youth placed in PRP homes may have additional needs in the areas of behavioral, emotional, physical, substance use, and concerns for their ability to parent. CFSA will have three PRP beds in FY 2021.
- **Intensive Foster Care.** Intensive foster care serves up to 36 children from ages birth through 21 who are appropriate for a family-based setting but are experiencing (or likely to experience) placement instability, as indicated by, but not limited to, the following histories:
  - Multiple incidents of physical or verbal aggression, persistent failure to follow household rules, destruction or stealing of property, or pending criminal charges
  - Placement instability prior to entering care, i.e., frequent moves among relatives, kin or friends; repeated placement in juvenile, congregate or residential treatment settings
  - Significant foster care placement disruptions (2+ moves)

What kind of congregate care placement types does CFSA have available?

While CFSA believes that family-based foster home placements are the best option for children, which is evidenced by CFSA having a small number of youth in a congregate care placement, a placement array must have sufficient services that meets different types of needs. The following congregate care settings are included in CFSA's placement array.

- **Group Homes.** Boys Town for male and females, God's Anointed New Generation (GANG) for males, Caitlin's Place for females, Umbrella for males, and Mary Elizabeth's House Independent Living for Teen Parents
- **Specialized Group Home for Youth with Developmental and Cognitive Delays.** Innovative Life Solutions provides for males who are intellectually disabled or developmentally delayed
- **Specialized Group Home for Youth on the Autism Spectrum.** Community Services for Autistic Adults and Children provides for males who are on the Autism spectrum.
- **Therapeutic Group Homes.** Children's Guild for males and females

What kind of psychiatric treatment facilities does CFSA have available in the District of Columbia Metro Area?

The District of Columbia does not have a PRTF in the DC metro area. In October 2019, CFSA identified several younger children new to foster care who required a more restrictive level of care based on their needs, and who experienced a significant number of placement disruptions, until the youth were approved for and admitted into a PRTF facility. CFSA determined a need for a local PRTF for younger children. CFSA will contract with a provider to develop aspecialized psychiatric residential treatment facility (PRTF) for children and youth in foster care within 50 miles of the District of Columbia. The procurement process will begin in FY 2020 Q4. The PRTF will meet nationally recognized standards and have a capacity to serve up to eight children between the ages of 8 and 12. The contracted provider will have experience designing, staffing, and operating a residential treatment program with educational programming and evidence-based behavioral health treatment services.

What kind of short-term shelter does CFSA have available?

- **Emergency Shelter (Sasha Bruce Youthwork).** Sasha Bruce provides immediate placement in a licensed group home setting to youth ages 13-18 in need of an unplanned replacement in a different foster care setting. The goal is to provide stabilization services and intervention to the youth while a more permanent or appropriate placement setting is secured. The Sasha Bruce placement is intended to last for no more than 10 days but can last up to 30 days. In FY 2020 through Q2, a total of 28 children have been placed at Sasha Bruce.

What is CFSA doing to expand its placement array?

CFSA has developed a new comprehensive recruitment and retention campaign called REACH (Recruit, Engage, Advocate, Collaborate, Help) led by a dedicated program specialist. Developed in FY 2020 and being launched in early FY 2021, the campaign includes a variety of strategies and CQI measures, including but not limited to:

Recruitment

- Addition of a dedicated recruitment position
- Establishment of targets for recruitment categories
- Enhancement of the FosterDCKids.org website and social media platforms
- Conducting media outreach
- Enhanced coordination across Agency teams
- Establishment of a Recruitment Ambassador Program

Retention

- Holding monthly Fellowship & Feedback Forums for resource parents
- Increased acknowledgment and recognition of all resource parents
- Engaging staff in nationally-recognized training for recruitment and retention
- Hired two additional resource parent workers for evening and weekend hours
- Increased support through parent coaching

Conclusion and Needs to be Considered

CFSA has been expanding its placement array with a variety of provider types to meet the needs of the children in care. The Agency continues to build on this array, adding specialized bed types and targeting recruitment for youth. Family-based beds were added to accommodate Spanish-speaking children and pregnant and parenting teens; specialized recruitment is underway for youth who identify as LGBTQ – specifically youth who identify as transgender and medically-fragile. There is a need for CFSA to continue its recruitment efforts focused on creative strategies to reach more families.

Services TO SUPPORT CHILDREN AND RESOURCE PROVIDERS

What services and supports are available for resource parents to support children in foster care?

CFSA continues to offer the following services and supports to resource providers for their ongoing development and to maintain and stabilize placements.

BOND Model. As of March 31, 2020, CFSA has merged the benefits of both former hub systems (Mockingbird and Family Connections) into one equitable and sustainable parent support program called the BOND program (Bridge, Organize, Nurture and Develop). The BOND program also uses a "hub" model which is composed of a "squad" of 10-12 peer resource parents supported by an experienced and committed BOND lead – a resource parent who provides peer support, coordinates special activities and provides or assists with coordinating respite care. CFSA's BOND program coordinator is a recently transitioned resource parent support worker who is solely dedicated to managing the program and providing support to all identified BOND lead families. The lead families work in partnership with the program coordinator to ensure that resource parents and the children in their care have their needs appropriately addressed. Services offered include but are not limited to peer support, resource parent networking and respite services.

BOND Respite Support. Each BOND lead has one respite bed in addition to other licensed beds. BOND members support each other for respite needs and will use the dedicated BOND lead respite bed when necessary.

Case Management. A social worker "case manages" with resource parents to plan, seek, advocate for, and monitor services from different social services or health care organizations and staff on behalf of a client.

Child Care Vouchers and Subsidies. Child care vouchers (full cost) and subsidies (pre-determined rate) are available to help all families pay for child care. Child care vouchers are provided by the Office of the State Superintendent for Education, while child care subsidies are administered through CFSA. CFSA has a child care specialist who helps resource parents identify child care centers; and the emergency child care contract with PSI.

Child Welfare Training Academy. CFSA's Child Welfare Training Academy (CWTA) provides resource parents with the knowledge, skills, support, and coaching that effectively promote the safety, permanence, and well-being of children and families in the District of Columbia. CWTA offers pre-service and in-service training that works to keep resource parents prepared to effectively carry out their role as trauma-informed caregivers.

Crisis Management. The Mobile Crisis Stabilization and Support (MCSS) contract will end on September 30, 2020. See Resource Parent Support Workers description below.

Healthy Horizons: Medical Support. CFSA has nurse care managers assigned to children in foster care with medical needs according to the referrals submitted by social workers. Social workers can submit a nurse referral at any time throughout the life of a case including at point of case closure.

Health Horizons: Clinic support. CFSA provides initial health screenings for children entering foster care or for children who change foster care placements. Provide screening and referrals for COVID 19 testing and provides immunizations in certain circumstances.

Office of the Ombudsman. CFSA established an internal Office of the Ombudsman in order to ensure that the public has a point of contact within CFSA to communicate concerns directly to the Agency. The Ombudsman is responsible for responding to, investigating and resolving concerns, complaints, inquiries, and suggestions from CFSA constituents.

Older Youth Enrichment Bootcamp. CFSA's Office of Youth Empowerment operates the Enrichment Bootcamp, a day program to serve youth in foster care from grade 6 (age 12) to youth who have reached age 20 and are temporarily unable to attend school due to suspension, placement disruption, or a school enrollment change.

Resource Parent Support Workers. Resource parent support workers (RPSW) are available to provide weekly support to resource parents and to help them navigate systems within CFSA and to troubleshoot youth placement issues or concerns.

- **Resource Parent as Coaching Support.** RPSW are now trained in a family centered parent coaching model to provide parenting coaching techniques.
- **Resource Parents as Crisis Suppor**t. RPSW will be trained in a crisis response model to quickly facilitate crisis interventions. This service is moving to an in-

house model from a contractor. Two RPSW's will be providing crisis intervention support after business hours.

Resource Parent Support Line. The Resource Parent Support Line is a phone line for resource parents to call when issues in the home have escalated and the parents need assistance in resolving them. The Support Line is available Monday-Friday from 5:00pm-1:00am and Saturday, Sunday and holidays from 9:00am-1:00am.

School Transportation. The DC Child and Family Services Agency (CFSA) has a transportation model for school transports in limited circumstances. In partnership with the DC Department of For-Hire Vehicles (formerly the DC Taxicab Commission), the transportation plan enhances the current educational supports of children in care. This service reduces the time spent on transport for our children who have long commuting times to and from school. Additionally, in FY 2020, CFSA added a new contract with VOW Transportation LLC to provide vans for group transportation for children.

Conclusion and Needs to be Considered

CFSA has responded to needs raised by resource parents such as respite care, parenting approaches and techniques to mitigate or lessen the need for a crisis intervention response and support them in caring for and treating the most challenging children. To address the needs, CFSA has modified its parent support program, now called the BOND; provided a training course to staff designed to make the best use of parent coaching techniques and interventions; and will train resource parent support workers in a crisis intervention model all in effort to support and partner with resource parents.

SECTION 3: WELL-BEING

CFSA's Office of Well Being (OWB) provides clinical supports and a service array that aligns with the health, wellness, educational, and other needs of children and families involved in the District's child welfare system.

Services to Support Well-Being

What is the profile of students in care?

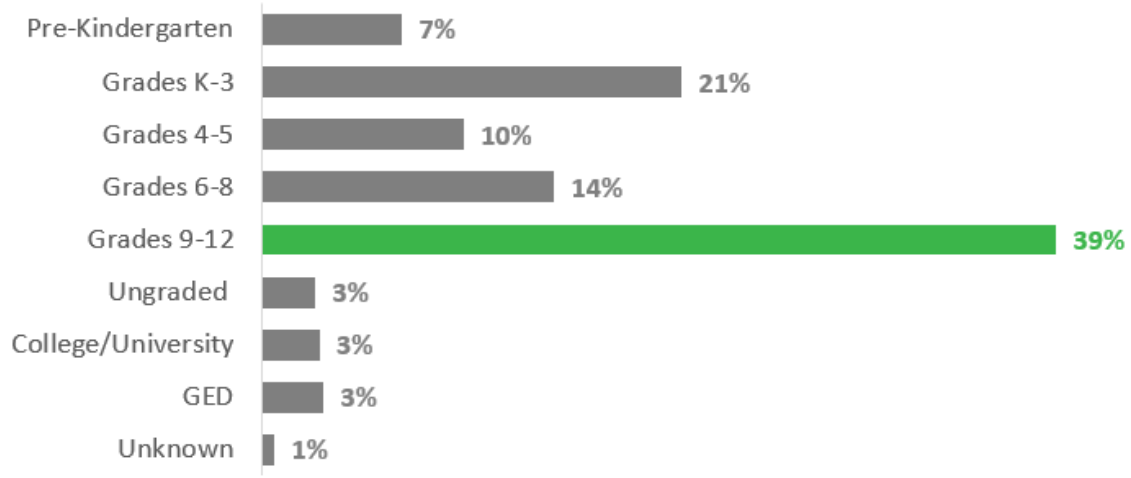
Of the 494 school-aged children in care, 59 percent are enrolled in a traditional public school. Twenty-one percent are enrolled in a public charter school. Students enrolled in a non-public school account for nine percent of children currently in care. Six percent of students in care are enrolled in a GED program, college/university, or other education program. Other enrollment types include a residential treatment program (5 percent) and private school (<1 percent).

The majority of children in care were enrolled in a traditional public school for the 2019-2020 school year.

Educational Provider	# of Children	% of Children
Traditional Public School	292	59%
Charter Public School	102	21%
Private School	1	0%
Non-Public School	44	9%
Residential Treatment Center	24	5%
College/University	14	3%
GED or Other	17	3%
Total	**494**	**100%**

Source: Office of Well Being manual tracking

39 percent of all school-aged children in care were enrolled in Grades 9-12.



Source: Office of Well Being manual tracking

What tutoring and mentoring services are available to help students?

The Agency has contracts to provide tutoring and mentoring to children on an as needed basis.

Tutoring

CFSA uses the "A Plus Success" in-home tutoring program to provide tutors to children in foster care. Students between the ages of 5 and 20 years old must meet the following criteria to be eligible to receive tutoring services:

- Must be in CFSA custody or have an open court case
- Must have an identified academic need:
  - Need for support in a particular class/course (demonstrated by low grades in the course)
  - Need for general remediation in reading or math (demonstrated by being below grade level)
  - Need for support with test preparation (GED, SAT, etc.)
- Must not have access to other forms of tutoring support in their school or community

A student's length of service is based on a variety of factors including demonstrated need, case status, and prior utilization of service. Tutoring services always cease upon case closure, but they may be discontinued from service earlier if:

- a student's tutoring goal is met (i.e., they pass the class they needed help with, took the test they were receiving tutoring help in preparation for);
- they no longer have academic need (i.e., their grades improve);
- data shows they are not utilizing the service (i.e., 3 or more missed scheduled sessions without justification); or
- the student/family requests to terminate service.

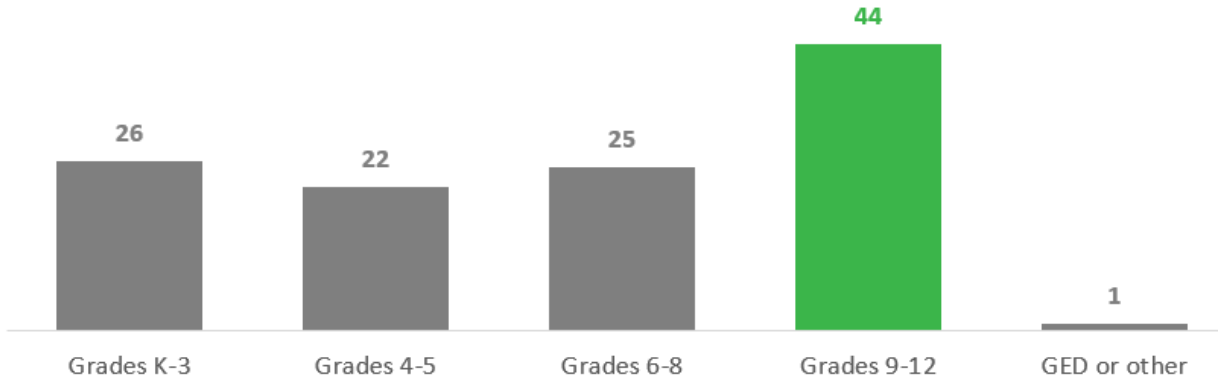
How many children participated in tutoring?

This fiscal year, the tutoring program had a capacity to serve up to 90 youth at any one time. **As of May 31, 2020, a total of 118 students received tutoring services during FY 2020.** Students referred for tutoring services should receive their first tutoring session within 30 days of the referral. **Ninety-four percent of students (n=111) received their first tutoring session within 30 days of referral.** Of the seven students who did not receive their first session within 30 days, four students were delayed because a Spanish-speaking tutor was not available, one referral for tutoring services was lost, and two other referrals were put on hold while we were waiting for additional information to complete the referral.

With the onset of social distancing protocols in March 2020, A Plus shifted its in-home tutoring model to one-on-one virtual tutoring sessions for all children who received tutoring assistance and

wanted to continue services in that manner. This shift allowed the Agency to continue services to approximately 90 students through the end of the 2019-2020 academic year. Services were reduced to 50 students in June 2020 and July 2020 when interest in tutoring typically decreases. The OWB Education Team has received positive feedback from social workers, students, and resource families on the quality of A Plus tutors and services.

Most of the students who received tutoring services were in Grades 9-12.



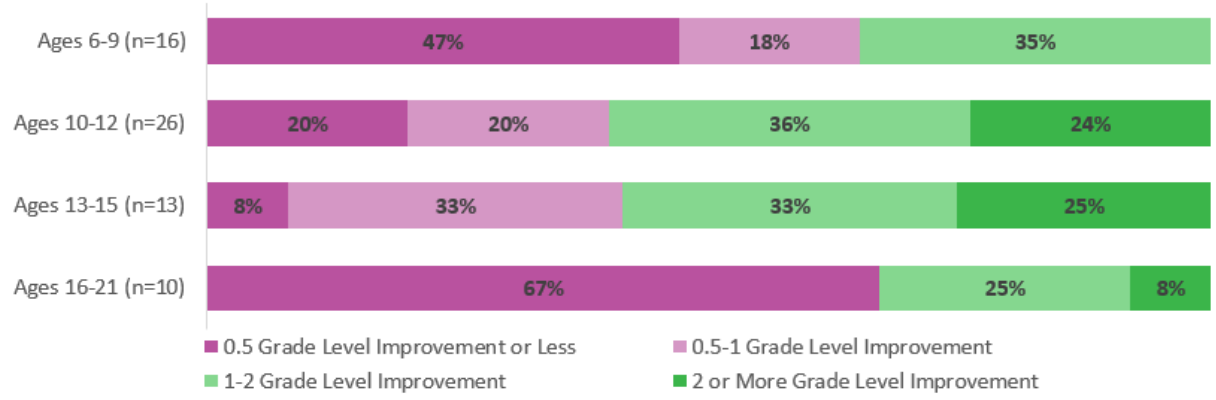
Source: Office of Well Being Manual Tracking

How has student participation in tutoring services impacted academic performance in reading and math during FY 2019?

A total of 206 students received tutoring services during FY 2019; of which 65 students received tutoring services for at least one year as of December 2019 and had pre- and post-assessment data for comparison. Assessment data from the 2018-2019 school year shows that **most students who received tutoring services for a year or more increased their performance in reading and math by one-half grade level or more**. **The largest gains in both subjects were demonstrated by students aged 10-12 years old.** Data from the 2019-2020 school year was not available as of the writing of this report.[37]

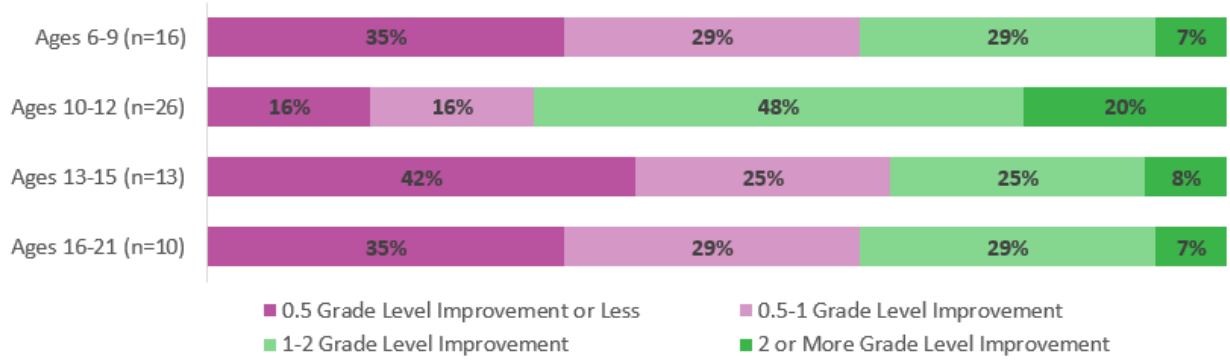
[37] Assessment data is typically reported in the October following the conclusion of the school year. For example, the assessment data for the 2018-2019 school year was reported in October 2019. Data from the 2019-2020 school year may be available in October 2020; however, it is unclear how educational data reports from local school districts will be affected due to the COVID-19 pandemic.

60 percent of children ages 10-12 who received at least one year of tutoring support demonstrated at least one year of grade level improvement in reading.



Source: Office of Well Being manual tracking

68 percent of children ages 10-12 who received at least one year of tutoring support demonstrated at least one year of grade level improvement in math.



Source: Office of Well Being manual data

Conclusion and Needs to be Considered

Contracting with service providers who are proficient in understanding and working with families of color, immigrants and speaking the primary languages of these families would strengthen the service array for families involved in the foster care system.

The Office of Well Being identified the following needs that should be addressed to improve service delivery for FY 2021:

- There is a need to increase access to tutors with English as a Second Language (ESL) training and/or the ability to tutor students in their native language. Most students (94 percent) referred for tutoring services had their first session within 30 days of the referral, meeting the program's timeframe goal. For the 6 percent of students who did not receive tutoring services within the timeframe, 57 percent of the delay was due to not having a Spanish-speaking tutor available.

- Based on the assessment data from the 2018-2019 school year, **there is a need to improve academic performance outcomes in reading and math for children ages 6-9 and youth ages 16-21.** The largest gains in both subjects were demonstrated by students aged 10-12 years old.
- There is a need for tutors for youth ages 16-21 that are closer in age to the youth who receive services, as the majority of children who received tutoring services were in grades 9-12.

Mentoring

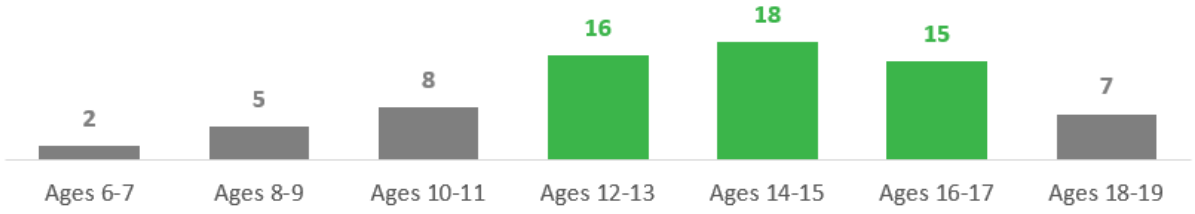
CFSA contracts with BEST Kids, Inc., a DC-based non-profit that provides mentoring support to children in foster care. The program encourages children to discover their unique skills and abilities, develop a positive sense of self, learn teamwork and group social skills, and become productive members of society.

All mentoring clients must be at least 6 years old, committed to CFSA, and the social worker must believe that mentoring would benefit the youth. To refer a client for mentoring services, a social worker completes a referral packet on behalf of the youth and submits the information to the OWB program specialist. Upon receipt, the program specialist sends the packet to BEST Kids for processing. BEST Kids follows up with the social worker to schedule an intake for the youth. Children are matched with mentors from BEST Kids as soon as mentors become available.

How many children participated in mentoring?

The BEST Kids contract capacity is to serve up to 125 children at any given time during the year; CFSA sent BEST Kids, 47 referrals in FY 2018, 51 referrals in FY 2019, and 16 referrals in FY 2020 (as of June 30). These referrals can rollover year to year. As of June 30, 2020, 71 children between the ages of 6 and 19 years old were referred to BEST Kids for mentoring services in FY 2020.

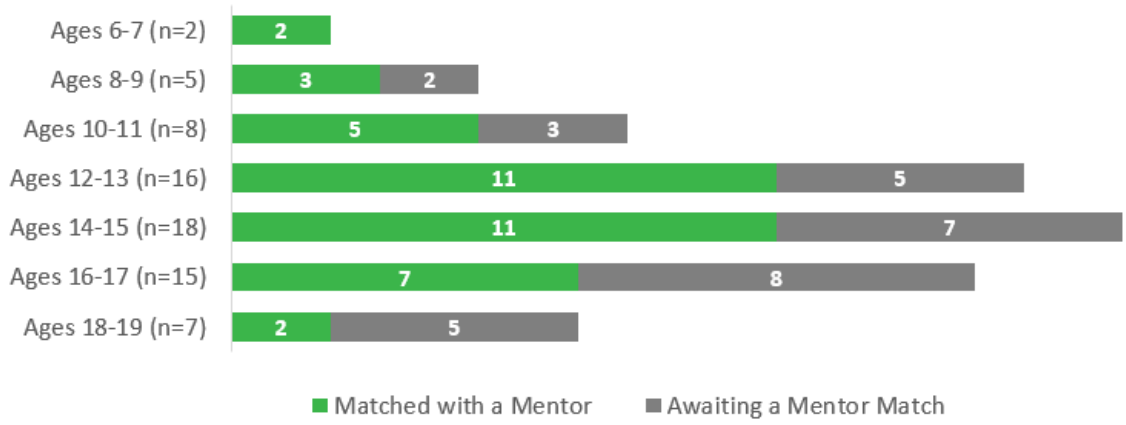
Most of the children who were referred for mentoring services were between the ages of 12 and 17 years old.



Source: Office of Well Being manual tracking

As of June 30, 2020, only **41 of these children (58 percent) received individual mentoring and the remaining 30 children (42 percent) were waiting to be matched to a mentor**.[38] Of the 30 children waiting for a mentoring match, 66 percent (n=20) were youth between the ages of 14 and 19 years old. The children have been waiting for a mentor match for at least 50 days; however, they have had the opportunity to engage in monthly group activities as they await their mentor match. These children were not matched because BEST Kids was unable to recruit enough mentors to serve the children who needed services. Mentor-mentee matching may have been complicated by COVID-19; however, mentor recruitment has been a challenge for BEST Kids prior to the pandemic.

66 percent of the 30 children waiting for a mentor match were between the ages of 14 and 19 years old.



Source: Office of Well Being manual data

Conclusion and Needs to be Considered

While 71 children between the ages of 6 and 19 years old were referred to BEST Kids for mentoring services, 42 percent of children who were referred were waiting to be matched to a mentor, of which 17 were teens. BEST Kids is in the process of updating their recruitment strategy and has hired a new staff person to manage the recruitment strategy moving forward. Based on the difficulty with BEST Kids' recruitment to find mentors for older youth, CFSA needs to consider supplemental approaches to accommodate youth still in need of matches, particularly mentors for older youth and children who reside in Maryland.

Home Visiting

How many parenting teens in foster care participated in home visiting services?

In 2019, CFSA and DC Health partnered for the first time to offer a home visiting program using federal Community-Based Child Abuse Prevention (CBCAP) funds for a grant to Mary's Center to operate the program. Launched in December 2019, the program is targeted specifically to CFSA's

[38] OWB has received referrals for mentoring services during the COVID-19 pandemic but at a slower pace than earlier in the fiscal year. The number of new mentor-mentee matches made by BEST Kids were: FY18 - 50, FY19 - 34, FY20 (as of 6/30) - 23.

pregnant and parenting youth in care, with surplus slots open to teen parents with an open in-home case. The home visiting program uses the Parents as Teachers (PAT) evidence-based model due to its more expansive eligibility requirements than other evidence-based models and it has a curriculum specifically designed for teen parents.

Sixteen of the 27 pregnant and parenting teens in foster care participated in formal home visiting services as of FY 2020 Q2.

Home Visiting Provider	Utilization
Mary's Center: Parents as Teachers (PAT)	6
The Mary Elizabeth House: Effective Black Parenting	10
Other MIECVH program[39]	0
Not eligible	1
Declined	10
TOTAL	**27**

Source: OYE monthly report

In addition to the home visiting programs offered, pregnant and parenting youth have access to other CFSA services including the Safe Sleep Program, Nurse Care Managers, and OYE services such as the Youth Villages LifeSet Program, Making Money Grow, educational specialists, and case management. Other community-based services include:

- Teen Alliance for Prepared Parenting (TAPP): a community service initiative within the division of Women's and Infants' Services at MedStar Washington Hospital Center. The program addresses the high rate of teen pregnancy in the nation's capital, providing reproductive, obstetrical and sexual health services. TAPP is a comprehensive program that provides a unique mix of clinical and psychosocial services, to help young parents avoid unintended subsequent pregnancy during adolescence; continue and complete their education; master life management skills and improve the future for their children.
- Healthy Generations Program: a "teen-tot" program at Children's National Medical Center that provides medical care, family planning, case management, social work and mental health for young parents and their children.

Conclusion and Needs to be Considered

CFSA's OYE staff have positive feedback about the quality of the PAT home visiting service yet they question the need to maintain the current capacity of 30 in FY 2022 for the young mothers in care. Pregnant and parenting teens with children from birth through kindergarten are eligible to participate in PAT but a requirement of this program is that participation be voluntary. One young

[39] DC Health oversees several home visiting programs in the District funded by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

mother had a child in kindergarten and was not eligible. Other reasons for non-participation in PAT include: the declining number of teen parents in care (26 as of August 2020), The Mary Elizabeth House utilizes the Effective Black Parenting home visiting model, and the availability of other home visiting programs and related services in the District. Additionally, some youth do not believe they need assistance with parenting and decline the home visiting services. They utilize their informal networks, doctors, and daycare providers for assistance with parenting needs.

What are services offered to youth involved with sex-trafficking?

CFSA utilizes HOPE Court which is a unique multi-disciplinary voluntary program launched in February 2018 under the direction and authority of the D.C. Superior Court. The main goal of this program is to ensure youth victims of commercial sexual exploitation are protected from arrest for charges related to their exploitation, as well as ensuring at-risk children are identified and referred by law enforcement to child protective services. What makes HOPE Court unique is the support participants receive from an anti-trafficking service provider that brings a trauma-informed and a youth-led approach to the program. These providers directly support youth in setting goals, achieving their potential, and removing barriers to a safe, free and productive life.

HOPE Court partners with Fair Girls to provide sex-trafficking intervention services to non-CFSA community youth. FAIR Girls provides intervention and holistic care to survivors of human trafficking who identify as girls or young women. Services include services or referrals for crisis counseling, mental health and substance abuse services, housing assistance or educational/vocational supports. Since not all youth participate in HOPE Court as it is voluntary, CFSA separately contracts with Fair Girls.

Additionally, CFSA contracts with Courtney's House to provide services to survivors of child sex trafficking and children at risk of being sex trafficked. The organization serves girls, boys and transgender survivors. Courtney's House provides 24-hour crisis intervention services through its Survivor Hotline. Through its website, Courtney's House offers tips for parents, guardians, caregivers and children on what to look for and how to prevent sex trafficking.

Provider	Capacity	FY20 Referrals	FY20 Utilization (at any point in time)
HOPE Court	NA	-	14
Fair Girls	30	37	16
Courtney's House	25	23	36

Source: OWB CSEC Manual Tracker

Conclusion and Needs to be Considered

There are technically no capacity, waitlist or budget needs identified for HOPE Court, all youth who are referred to HOPE Court will eventually go through the Court process. HOPE Court clients and staff receive supports through the Children's Justice Act grant to enhance the program and services to youth if needed.

Courtney's House has maintained full capacity of 25 youth in FY 2019 and FY 2020. Utilization in FY 2019 was 30 youth and 36 in FY 2020 (22 from FY 2019 and 14 from FY 2020). Funding was insufficient to recruit and sustain staff as well as support increased demand for services, mental health needs and outreach. The Courtney's House contract will be increased to support capacity for 35 youth in FY 2021.

The Fair Girls contract is a prevention-based grant that began in April 2020 with a capacity to serve 30 youth. Utilization since April is 16 youth served of the 37 referred through CPS, MPD or another community provider. There are no budget needs for Fair Girls at this time. Youth may not engage in services for a variety of reasons including a lack of parental support for the youth to remain engaged with this provider.

Substance Abuse Supports: Project Connect

Project Connect, launched in-house in October 2019[40], **is a parenting-in-recovery model** utilized by CFSA **to provide intensive home-based services to families dealing with substance use issues**. The model is built on five key tenets:

- All families have strengths.
- The family drives the partnership.
- The work is done within the context of relationships.
- Individual needs are addressed in the context of the family and their community.
- Services are flexible and culturally relevant.

Project Connect provides services such as **case coordination; substance abuse assessment and monitoring; relapse prevention; advocacy; parent education; nursing services; and linkages to other services** deemed appropriate for the family. The Project Connect team includes three resource development specialists, a parent educator, and a registered nurse; participating families are referred to treatment and community providers who can provide additional targeted services. **Up to 30 families may participate in Project Connect at a time** (8-10 families per worker). Team members visit families at their homes, in the community or contact by phone an average of two times per week to provide services; the length of service and number of contacts per week are

[40] Prior to November 2019, the Project Connect program were contracted and offered at Collaborative sites through contracts with Progressive Life and Catholic Charities.

based on each family's need. As a result of the COVID-19 pandemic, team members continue to engage with families through phone calls and virtual visits.

How many eligible families agreed to participate in the Project Connect intervention?

From October 2019 to June 2020, 39 families were referred to the Project Connect program. **CFSA's In-Home Unit accounted for most (46 percent) of the Project Connect referrals**, with others coming from the CFSA Permanency Unit (38 percent) and the National Center for Children and Families (NCCF)[41] (15 percent). The 39 participating families had a total of 79 children, with an average age of 7 years and an age range of birth to 17 years. Most children (53 percent) were living with their parents/caregivers at the time of the Project Connect referral, with 22 percent living in kinship placements, 20 percent living in traditional foster homes, and 3 percent placed in long-term medical facilities.

What is the current capacity of the Project Connect program? Are there enough staff for the number of families who need services?

The Project Connect program is at capacity (30 families) and has been at capacity since January 2020. The program receives 5-6 referrals per month. If space is not available, families may have to wait 30-60 days from their referral date before they can begin services. An additional resource development specialist would allow families to access the service immediately upon referral.

How many families complete the required assessments for participation?

The Project Connect model requires the completion of the Risk Inventory for **Substance-Affected Families (SARI)** and the **North Carolina Family Assessment Scale (NCFAS)**. The SARI is an assessment tool developed by Project Connect to assess parents' substance use risk in seven domains: commitment to recovery, patterns of substance abuse, impact of parents' substance abuse on their ability to care for their children, their neighborhood environment, social supports, and self-efficacy. The NCFAS is an assessment tool designed to examine family functioning in five domains: the family environment, parental capabilities, family interactions, family safety, and child well-being. CFSA procedures require administration of the Pre-SARI assessment within 60 days of the start of Project Connect services and the Pre-NCFAS within 90 days of the start of services; both assessments are completed again at the close of the Project Connect case (Post-SARI and Post-NCFAS).

For the 39 families being reviewed, **34 families (87 percent) completed the Pre-SARI and 33 families (85 percent) completed the Pre-NCFAS upon starting services.** For all cases in which the

[41] NCCF is the contracted Maryland family-based foster care provider for DC children in foster care.

Pre-SARI and Pre-NCFAS were not completed, the client either had their Project Connect case closed before reaching the 90-day mark or was part of an active case which had not yet met the 90-day mark. Of the 15 Project Connect cases that had "Case Closed" status at the time of the analysis, 100 percent indicated that the **Post-SARI and the Post-NCFAS were completed.** Manual data from the assessments is available for review. The Resource Development Specialists, who complete the assessments, meet with the social work teams to inform case planning activities. Pre- and post-assessment data were not available for analysis as of the writing of this report; the results of the paper-based assessments are not available in Quick Base or FACES. During FY 2020, OWB worked to develop a contract with an outside provider to score the NCFAS assessments via an online platform; however, the contract was not finalized prior to the COVID-19 emergency.

How many families began treatment?

Twenty-four of the 39 parents/caregivers (63 percent) were assessed by a substance use assessor through DBH's Assessment and Referral Center (ARC) to be appropriate for a recommendation to receive substance use treatment other than Project Connect support services.[42] **Of the 24 that received recommendations, 22 (92 percent) entered treatment with a substance abuse disorder (SUD) provider, Narcotics Anonymous (NA), or Alcoholics Anonymous (AA).** At the conclusion of the review, eight of the participants who entered treatment (36 percent) had completed treatment. An additional eight participants (36 percent) were still participating in treatment and six (27 percent) had their Project Connect case closed without completing treatment.[43]

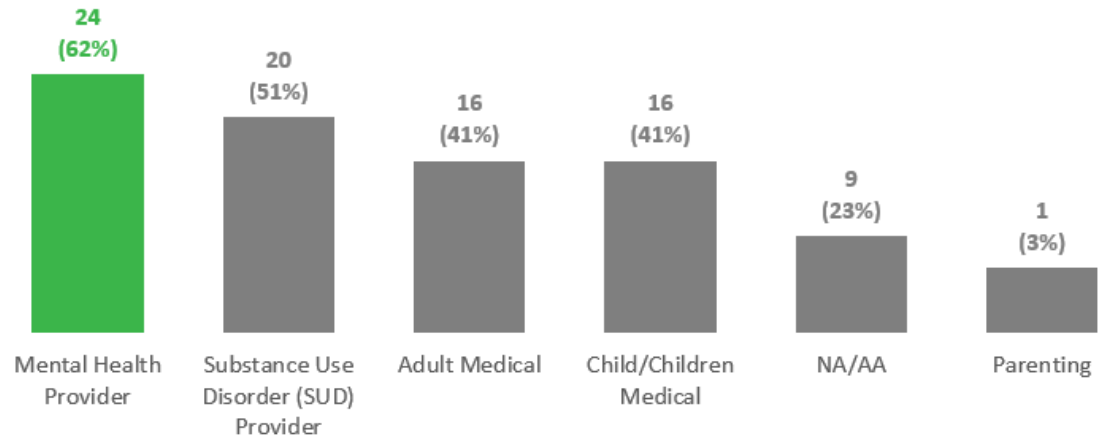
To which services are participating families linked?

The Performance and Quality Improvement Administration (PAQIA) reviewed the Project Connect database for indications that clients with active Project Connect cases were linked to other needed services, as well as the closed cases.

[42] Project Connect data in Quick Base provided general treatment modalities such as "outpatient" or "intensive inpatient", etc.

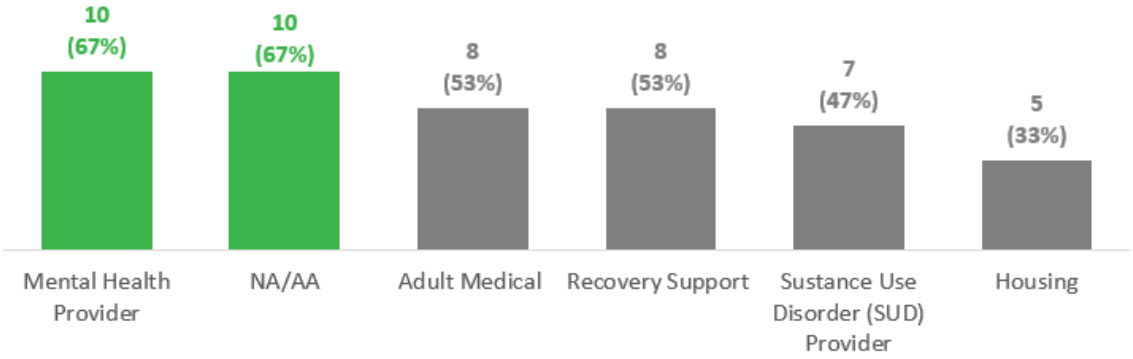
[43] While the Project Connect database did not record reasons for clients who did not complete treatment from outside providers, Project Connect staff report that since COVID restrictions have been in effect, many substance abuse treatment providers are limiting the number of new clients they can accommodate, creating a barrier to starting services. In addition, families experienced difficulties connecting with providers via telehealth and online conferencing platforms.

The most frequently referred service during family participation in Project Connect was mental health. (N=39)



Source: Office of Well Being manual data

Most families whose cases closed were linked to mental health and substance abuse recovery services. (N=15)



Source: Office of Well Being manual data

Conclusion and Needs to be Considered

In FY 2020, there were 39 families referred to the Project Connect program. CFSA's In-Home Unit accounted for most (46 percent) of the Project Connect referrals, followed by the Permanency Unit (38 percent) and National Center for Children and Families (NCCF) (15 percent). Between 85-87 percent of families completed the necessary assessments before starting services. Of the cases that were closed during this review period, 100 percent of the post assessments were completed for the 15 families.

Sixty-three percent of the families were assessed by DBH's Assessment and Referral Center (ARC). ARC recommended that the parents/caregivers receive substance abuse treatment beyond the Project Connect support services. Ninety-two percent of these parents/caregivers entered treatment, but only 36 percent completed treatment. The most frequently referred service during family participation in Project Connect was for mental health. After case closure, most families

were referred to community-based mental health and substance abuse recovery services to support their continued progress. Due to HIPAA protections, CFSA is not privy to case treatment information for clients served by DBH or another mental health provider unless the client provides consent.

There is a need to increase capacity by hiring an additional resource development specialist to allow families to access services immediately upon referral. Project Connect program has been at capacity (30 families) since January 2020. When space is not available, families must wait 30-60 days from their referral date before they can begin services.

There is a need to have pre and post family assessment data available for future evaluation. At the writing of this report, pre and post assessment data were unavailable for analysis. It would be beneficial to have these data to gain a fuller picture of parental substance use risk and family functioning. OWB has worked to develop a contract with an outside provider to score the NCFAS assessments via an online platform.

Mental Health Redesign

CFSA's Office of Well Being implemented a mental health redesign in October 2018 to improve positive outcomes for clients and families within the DC child welfare system. The strategic redesign had a goal of ensuring timely and accessible services and involved centralizing mental health assessments, in-house direct therapy at CFSA, and medication management for applicable CFSA clients. The positive outcomes sought by this redesign include, but are not limited to, reduced wait time for services, increased placement stability, reunification, family engagement, and decreased disruptions. The therapy services are office based; however, during the time of COVID-19 pandemic, therapists are providing tele-health services only.

The OWB therapeutic staff work to address the short-term mental health needs of children and parents (typically 3-6 months, but up to twelve months if appropriate), unless more intensive services are required through a community-based service agency or long-term mental health interventions (beyond 6 months) are necessary. All of the therapeutic interventions are trauma-informed therapies to address various mental health issues. The OWB therapeutic staff is trained in the following modalities to address the various forms of trauma impact:

- Trauma Systems Therapy (TST)
- Family Therapy
- Child Centered Play Therapy
- Grief and Loss Therapy
- Cognitive Behavioral Therapy (CBT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Traditional Integrative Approach

The services were originally implemented for children entering or re-entering foster care (and their parents as necessary) who aren't receiving therapy or other mental health interventions through a DBH-contracted Core Service Agency (CSA). During the first year of implementation, OWB set the age range of eligible clients at 3-years-old and up. Due to the challenges associated with providing clinical therapeutic services to children 3 to 4 years old, OWB decided as of October 2019 to change the age criteria to 5-years-old and up. In addition, in October 2019, the eligibility requirements were expanded to include children and families already in foster care and for a smaller number of in-home families.

The Office of Well Being began their mental health redesign originally with a clinical supervisor, and three therapists in FY 2019. The administration added a psychiatric nurse practitioner and an additional therapist who both came on board during FY 2020. With the full complement of staff in place, the PAQIA and OWB teams are developing a CQI process to collect and analyze the data necessary to evaluate the entire mental health redesign effort.

In-house therapists have been office-based only since inception of the program. They do not provide home or community-based services. During the time of COVID, in-house therapists are providing tele-health services only. Upon agency clearance, office-based services will resume."

This initial report focuses on the available data related to the implementation process during FY 2019 through FY 2020 Q2 (October 2018 - March 2020).[44] **During this time period there were a total of 189 children and 14 parents who received a full mental health evaluation**. As of March 2020, there were 37 active clients receiving therapeutic services. This includes two children from an open in-home case, 27 children from the foster care population, and eight parents receiving in-house mental health services.

The limitations of the available data are described on page 23 at the end of this section and are referenced throughout this section. Once there is consistent data collection, there will be further evaluation regarding the impact of CFSA in-house mental health services on placement stability and permanency. This report will focus on the available quantitative data for:

- # of clients referred by referral source
- # of clients who received a full evaluation
- # of clients recommended for treatment
- # of clients who received at least one therapy appointment
- # of days between evaluation and first therapy session

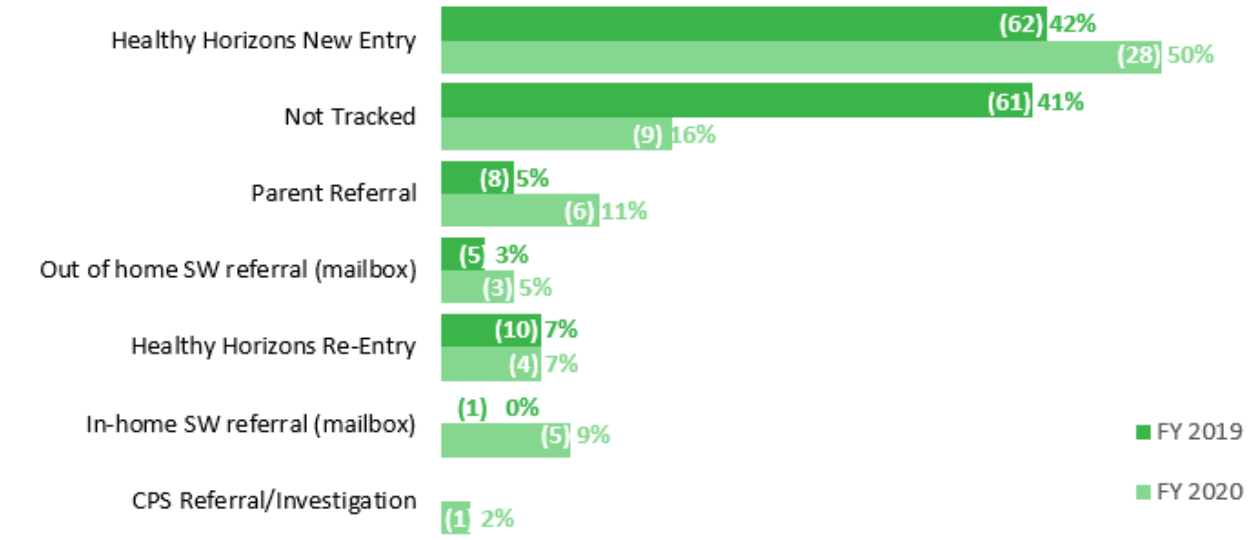
[44] The OWB team began the mental health redesign data tracking within Microsoft Excel in FY 2019 and transitioned to Quick Base in FY 2020. The Quick Base data migration improved how and what data was captured, but there remain some data elements that weren't consistently captured during this time period.

- # of clients who completed/exited therapy by discharge reason
- # of clients by age group

For the children referred for an in-house mental health evaluation, what was the referral source?

When the Mental Health Redesign was first implemented, CFSA's Healthy Horizons clinic would refer new entries and re-entries for mental health evaluations after they came through the clinic for their pre-placement screening. After the eligibility requirements were expanded to include children already in foster care and with in-home cases, those administrations began making referrals for evaluations as well. The parents who desire services may self-refer for a mental health evaluation and may also be referred through the assigned social worker. **There was a total of 147 clients referred for a mental health evaluation in FY 2019, and 56 clients referred through Q2 in FY 2020**. Out of the total 147 clients in FY 2019, 59 percent (86) of clients had the referral source or administration documented. In FY 2020, the referral source was documented for 84 percent of clients (47 out of 56). **The clients who were referred through the Office of Well Being's Healthy Horizons clinic as new entries or re-entries into foster care were the primary source of clients for mental health evaluations**. Initial foster care entries accounted for 42 percent of all referrals in FY 2019 and 50 percent of all referrals in FY 2020. It is important to note that in FY 2019, referral source was not tracked for 41 percent of clients. Due to this data quality issue, OWB made documenting the referral source mandatory in FY 2020, and the consistency of data entry for referral source has greatly improved since then.

An average of 46 percent of referrals for therapy were new entries from Healthy Horizons.



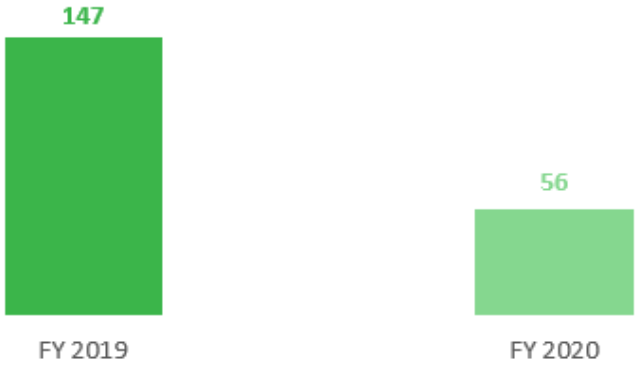
Source: Office of Well Being manual data

How many children received a full evaluation?

All 203 clients who were referred received a full mental health evaluation in both fiscal years. There were 147 clients who received a mental health evaluation in FY 2019, of those clients eight

(five percent) were parents. There were 56 clients who received a mental health evaluation through the 2nd quarter FY 2020, of those six (11 percent) were parents.

100 percent of referred clients had a full mental health evaluation in both fiscal years.



Source: Office of Well Being Manual data

What methodologies/instruments were used as part of the mental health evaluation?

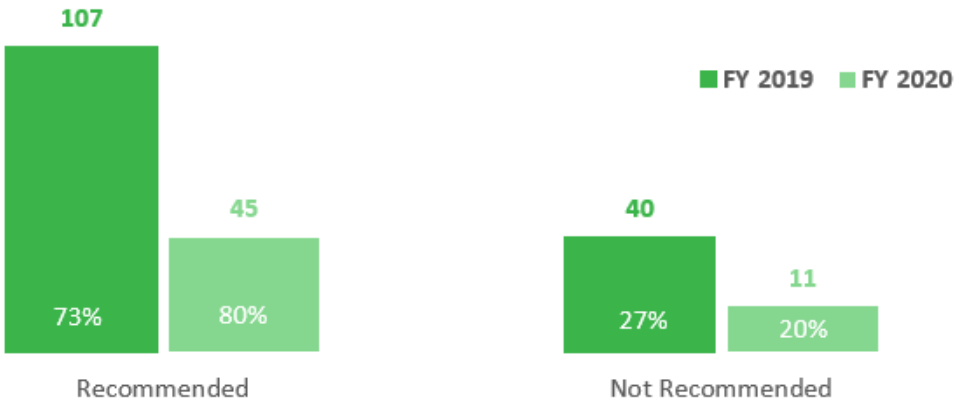
Various instruments are used to accompany the evaluation, based on the client's age and presenting issues. These instruments include:

- Pediatric Symptom Checklist-17 (PSC-17)
- Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)
- Patient Health Questionnaire (PHQ-9) Modified
- Zung Self-Rating Anxiety Scale
- Zung Depression Scale
- Vanderbilt Diagnostic Rating Scale
- Global Appraisal of Individual Needs – Short Screener (GAINS-SS)

Of those evaluated, how many children were identified for on-site mental health treatment?

A treatment recommendation for mental health therapeutic services for clients is based on client need and could be for in-house therapy through OWB or through an outside agency for those clients who present with clinical needs outside of current scope of the in-house therapists. Whether the mental health evaluation led to a recommendation for therapy was consistently documented across both fiscal years. **Seventy-three percent (107/147) of the applicable clients referred in FY 2019 were recommended for therapy. So far in FY 2020, 80 percent (45/56) of clients were referred and recommended for therapy**.

An average of 77 percent of clients were recommended for therapy across FY 2019 and FY 2020 through Q2.



Source: Office of Well Being manual data

Of the 40 children who were not recommended for in-house therapy in FY 2019:

- Fifteen (38 percent) were not recommended to receive therapy because the youth were stable at the time of the evaluation or the youth was already connected to a CSA.
- Twelve had documented reason why therapy was not recommended.
- Five were not recommended for therapy due to developmental delays of the client.
- Four clients were referred directly to a CSA (for a higher level of therapeutic service).
- Four children were not recommended to receive therapy due to distance, the youth refusing, or a higher level of care needed. A higher level of services could be a specialized therapy recommendation that may not be offered through OWB.

Of the 11 children who were not recommended for therapy in FY 2020:

- Seven (64 percent) were not recommended to receive therapy because the youth were stable at the time of evaluation
- Three were referred directly to a CSA (for a higher level of therapeutic service).
- One had no documented reason why therapy was not recommended.
- None of the children in FY 2020 were referred to a PRTF.

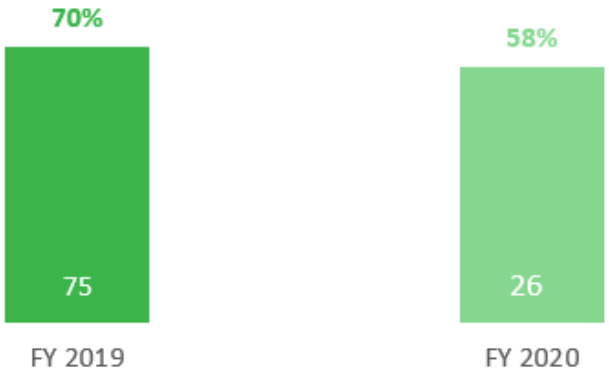
How many children received in-house mental health treatment?

Seventy percent of clients (75/107) who were recommended for therapy by OWB therapeutic staff, received at least one therapy appointment in FY 2019.[45] In FY 2020 through Q2, 58 percent of clients (26/45) recommended for therapy went on to have a therapy session. Therapy is

[45] This was an area identified for improved data collection. The initial therapy session was included in the database; however, the additional sessions were not regularly recorded in the database, and therefore this report only focuses on the initial session.

recommended as a result of a clinical assessment, which determines that the client is experiencing symptoms that are causing psychological distress or challenges in everyday functioning.

An average of 64 percent of recommended clients had a therapy visit.



Source: Office of Well Being manual data

The most frequent reason for therapy not occurring after a therapy recommendation in FY 2019 were categorized as administrative discharges. Administrative discharges occur when there are circumstances that prevent a client from fully engaging in therapeutic services consistently or because the client is best served in another capacity outside of OWB. They are used for any client who doesn't receive recommended therapy services from an in-house OWB clinician and/or who ends therapy services as a result of anything other than completion of their treatment plans and goals. Administrative discharges are differentiated by whether the client was discharge for engagement related reasons vs. non-engagement related administrative discharge reasons.

Of the 107 clients that were recommended for therapy in FY 2019, there were 44 (55 percent) clients who were subsequently administratively discharged. Of the 44 clients who were administratively discharged, 31 never attended a therapy session. The remaining 13 clients, including two parents, attended at least one therapy session before being administratively discharged for various discharge reasons. There was one child where therapy was recommended, but an initial therapy session did not occur, and they were not administratively discharged.

Of the 45 clients that were recommended for therapy between FY 2020 Q1-Q2, there were 26 (58 percent) clients who were administratively discharged. Of the 26 administratively discharged clients in FY 2020, 19 never attended a therapy session. The remaining seven clients, including two parents, attended a therapy session before their administrative discharge.

Why would an administrative discharge be used for a child referred to a CSA?

During the mental health evaluation, the evaluator may determine that the client is recommended for therapy but would be better served by a CSA. In this instance, the recommendation regarding

treatment would be recorded as a "yes" but since the client will not be receiving services in-house they are administratively discharged.

The top two reasons for administrative discharge for the clients recommended for therapy over both fiscal years were that the client verbally refused or declined therapy, or the client didn't engage in therapy after agreeing to engage. The table below details the reasons why a client would be discharged for administrative reasons.

Administrative Discharge Reason	Administrative Discharge Definition	# of Clients in FY19	# of Clients in FY20
Engagement Related Discharge		**29**	**13**
Refused/Declined services[46]	Client refused services prior to engaging in therapy or during the time engaged in therapy	14	7
Missed 3+ Sessions	Client missed 3 scheduled sessions consecutively	4	2
Never engaged in therapy[47]	Client did not engage in therapy after MH evaluation conducted	11	4
Hospitalization[48]	Youth enters hospitalization while receiving therapy	0	0
Non-Engagement Related Discharge		**15**	**13**
Referred to CSA	Client is referred to a CSA at MH evaluation	6	7
Previously linked to CSA	During MH eval we receive information that client is already linked to a CSA – clinician checks in with DBH co-located staff to assist in continuity of care	2	2
Higher level of service required	Client needs higher level of service that is determined during MH evaluation	1	2
Geographical Location	Geographical location inhibits ability to attend therapy at CFSA	2	1
Residential	Client enters residential treatment when attempting to schedule therapy at any time during service implementation	2	0
SW Cancelled or Rescheduled	SW cancelled or rescheduled therapy – client's situation may have changed and cannot attend therapy at CFSA	1	0

[46] "Refused/declined" verbally said that they will not engage in services.

[47] "Never engaged in therapy" are those clients who receive a MH eval, but the client never responds to requests to schedule treatment

[48] Youth may be discharged following a medical hospitalization or acute psychiatric hospitalization, per recommendation for continued treatment from the inpatient facility, and recommendation of the therapist, therapist supervisor, and social work team regarding the best clinical path for the child following hospitalization.

Administrative Discharge Reason	Administrative Discharge Definition	# of Clients in FY19	# of Clients in FY20
Engaged in school-based services	Youth is connected to school-based services when MH evaluation is complete and recommendation to continue these services is made	1	0
Runaway	Client who ran away when attempting to schedule therapy at any time during service implementation	0	1
No consent	Client did not consent to therapy	0	0
Transportation	Client has transportation issues in attending therapy at CFSA	0	0
Total		**44**	**26**

Source: Office of Well Being manual data

What was the length of time between the evaluation and initiation of treatment?

A major goal of the mental health redesign is the implementation of timely evaluations and the initiation of therapy (when recommended). A shorter time span between the entry or re-entry into foster care and engagement of family members in targeted therapeutic services has the possibility to improve outcomes. Removing children from their homes and placing them into foster care is a trauma and increases the risk of decreased functioning on several levels: socio-emotional, behavioral, and cognitive. Because of these risks, targeted mental health supports for the child and family are recommended.

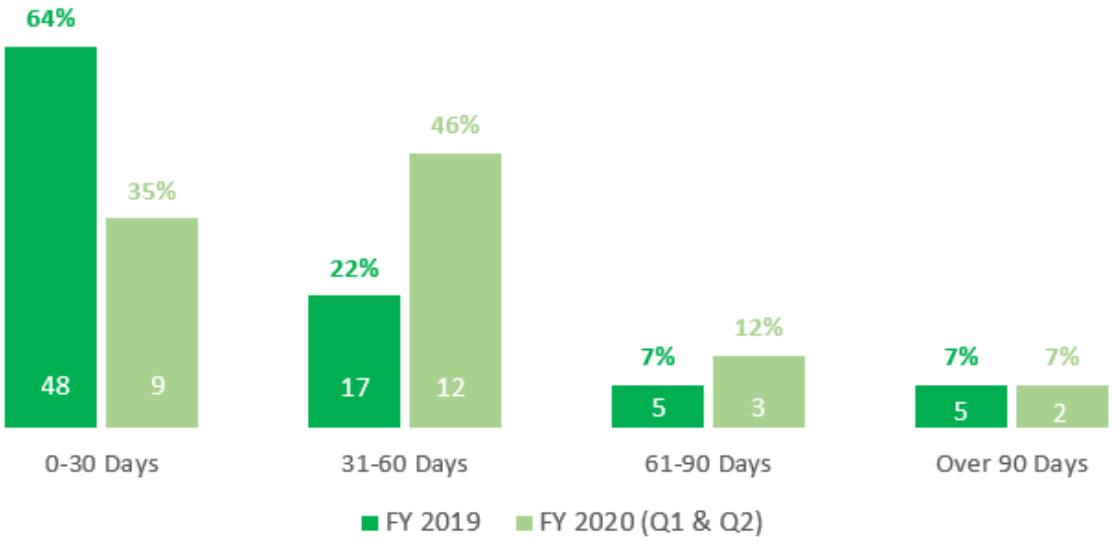
Prompt engagement of mental health supports can help improve a child's outcomes. The Office of Well Being has set a goal of implementing therapy for those clients recommended within 60 days of the mental health evaluation. The administration has been successful in initiating most of the first therapy visits within 60 days of evaluation. Of the 75 clients in FY 2019 that engaged in therapy, there were 65 clients (87 percent) who had a therapy visit within 60 days of evaluation. In actuality, the majority of clients who received mental health services in FY 2019 were seen within 30 days of evaluation (64 percent).

In FY 2020 through Q2, of the 26 clients that engaged in therapy, there were 21 clients (81 percent) that started therapy within 60 days. There were 9 clients (35 percent) who were seen within 30 days by the end of the 2nd quarter FY 2020 – a decrease from 64 percent in FY 2019. This decrease was due to a shift in how mental health evaluations were conducted. In FY 2019, OWB's four mental health therapists conducted the mental health evaluations while the Agency secured a Psychiatric Mental Health Nurse Practitioner. In FY 2020, the mental health team added a Psychiatric Mental Health Nurse Practitioner who is primarily responsible for conducting all

evaluations. As a result, the role was streamlined from 4 staff members conducting evaluations to 1 staff member.

The primary barrier to engaging and connecting clients to services within 60 days in FY 2019 and FY 2020 is scheduling challenges. In addition, some youth were in abscondence when treatment was recommended, which resulted in a longer period of time to connect them to services. It is important to note that 33 percent of the clients recommended for therapy over FY 2019 and FY 2020 through Q2 did not engage with in-house therapy and were ultimately administratively discharged for various reasons (see table above). These clients were excluded in the timeframe of engagement for therapeutic timeliness.

The majority of engaged clients recommended for therapy were seen within 60 days.



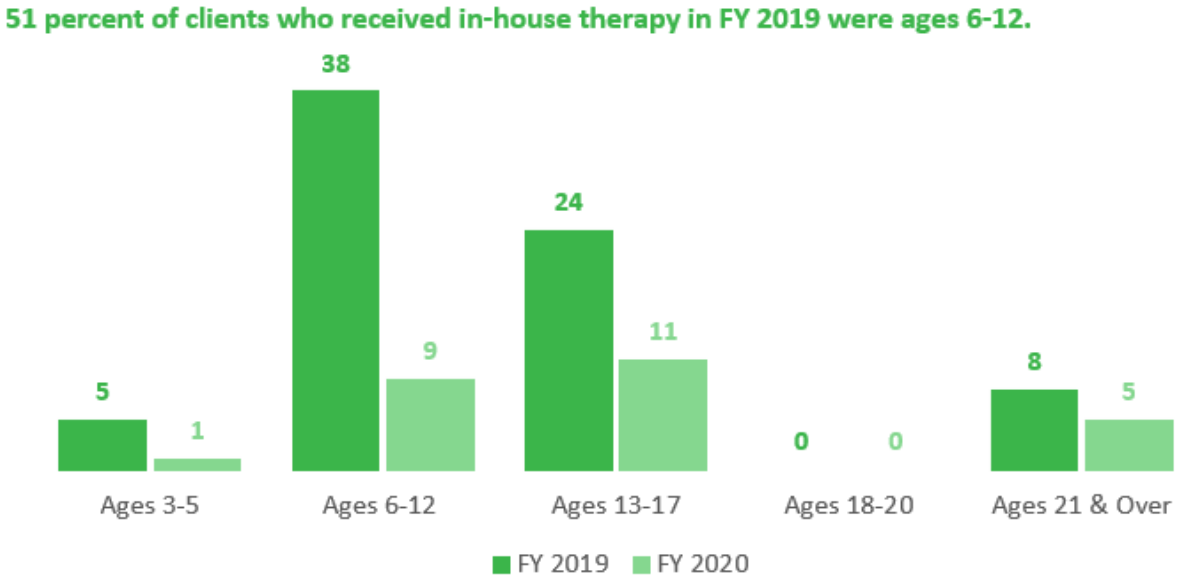
Source: Office of Well Being manual data

What were the ages of children receiving in-house therapy?

Over the course of FY 2019, 51 percent (n=38) of the 75 clients engaged in therapy were between the ages of 6-12. By the end of the FY 2020 Q2 review period, there were nine out of 26 children (35 percent) between the ages of 6-12 engaged in therapy. Over both fiscal years, 45 percent of the children recommended for therapy were in the 6-12 age group and all but six children were age 6 or older.

During the first half of FY 2020 (n=26), the largest age group in therapy was children ages 13-17 at 42 percent (n=11). The 3-5 age group only represents six percent (n=6) of all clients that received therapy. Since the eligible population for OWB therapy changed from children ages 3 and up in FY 2019 to ages 5 and up in FY 2020, this finding was expected. In-house therapy through the Office of Well Being can be offered to clients, including parents, over the age of three. Thus far, most of

the clients have been children, with 14 parents engaging in therapy services, representing 14 percent out of the 101 total clients over FY 2019 and FY 2020 through Q2.



Source: Office of Well Being manual data

As of the end of FY 2020 Quarter 2, how many clients had been discharged from therapy?

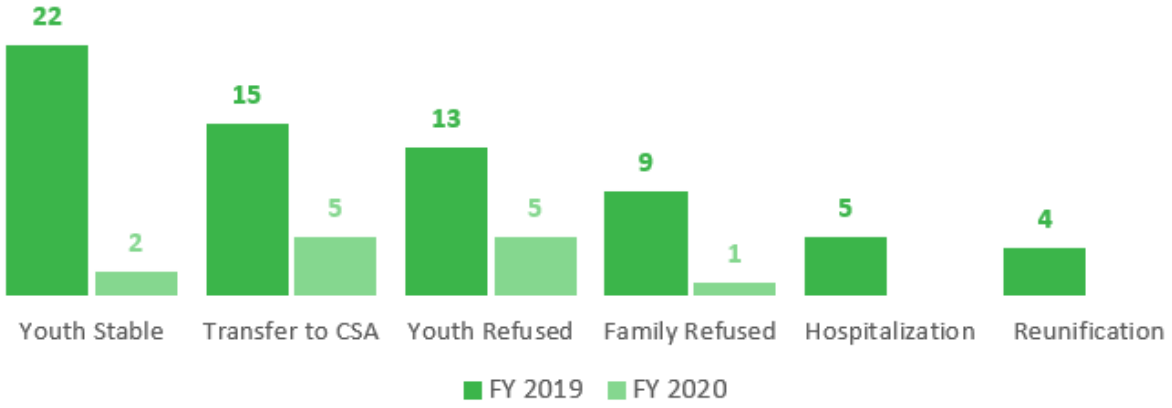
Ninety-one percent (n=68) of the 75 clients who had at least one therapy visit during FY 2019 have been discharged from CFSA therapeutic services for the following documented completion reasons.[49] The youth attaining a level of stability was the highest reason for discharge at 32 percent (n=22). **The progress components considered for children discharged as stable are:**

- Clients have met or addressed at least half of their treatment plan goals, with plans for continuing to address goals.
- Clients have developed coping skills and adequality demonstrated an ability to utilize them and their support system in an appropriate way.
- Clients have demonstrated a sustained period of reduction of referring symptoms, which can and should be evidenced by client self-report, family, social worker, school report, etc.

Fifteen clients (22 percent) were transferred to long term mental health treatment through a CSA, such as MBI Services, in FY 2019. In FY 2020 Q1-Q2, 13 of the 26 clients (50 percent) who engaged in a therapy visit were discharged. A transfer to a CSA for continued therapeutic services and a youth refusing therapy were the top two reasons for discharge in FY 2020.

[49] This was an area identified for improved data collection. The initial therapy session was included in the database; however, the additional sessions were not regularly recorded in the database, and therefore this report only focuses on the initial session.

32 percent of the youth discharged from therapy in FY 2019 for positive stability.



Source: Office of Well Being manual data

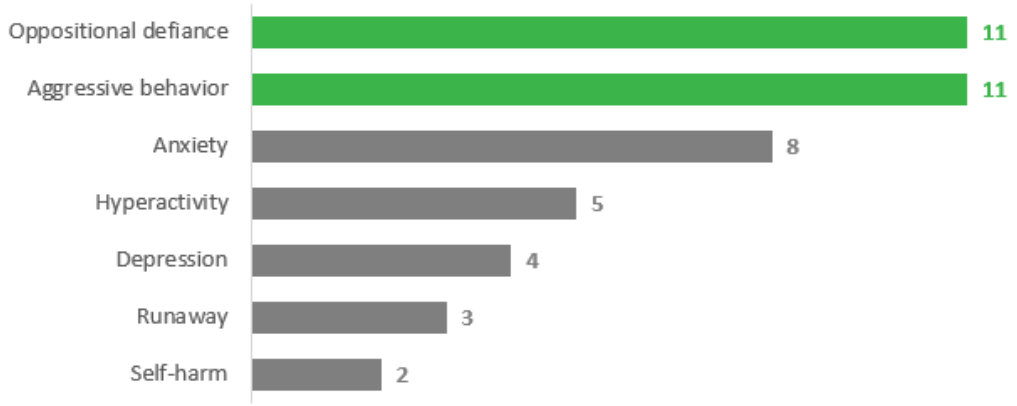
Qualitative Analysis: Children Who Completed CFSA Mental Health Services During FY 2020

A qualitative analysis was conducted using a subset of children who received mental health services through the Office of Well Being. The purpose of the qualitative study was to examine the characteristics of children who completed mental health services, including their pre-service behaviors, mental health diagnoses, recommended treatment modalities, discharge reasons, and any placement disruptions that occurred while receiving treatment. The qualitative study included 30 children who received at least one therapy session with an OWB clinician and completed mental health services between October 1, 2019 and March 31, 2020. Twenty-eight of the children in the sample (93 percent) were in the foster care system when they began therapy: 20 children were living in a foster home, three children were living in a group home, and five children were placed with kin. Two children (seven percent) had an open in-home case when they started treatment.

What behavior(s) were exhibited by the children who received a mental health screening?

Forty-seven percent of children (n=14) who completed mental health services during the review period exhibited behavioral symptoms prior to or during their mental health evaluation. Behaviorally, the clients were referred for services for a variety of reasons including oppositional defiance, aggressive behavior, anxiety, hyperactivity, depression, runs away, and self-harm.

Oppositional defiance and aggressive behavior were the most common behavioral issues seen in clients who received a mental health evaluation (n=30).

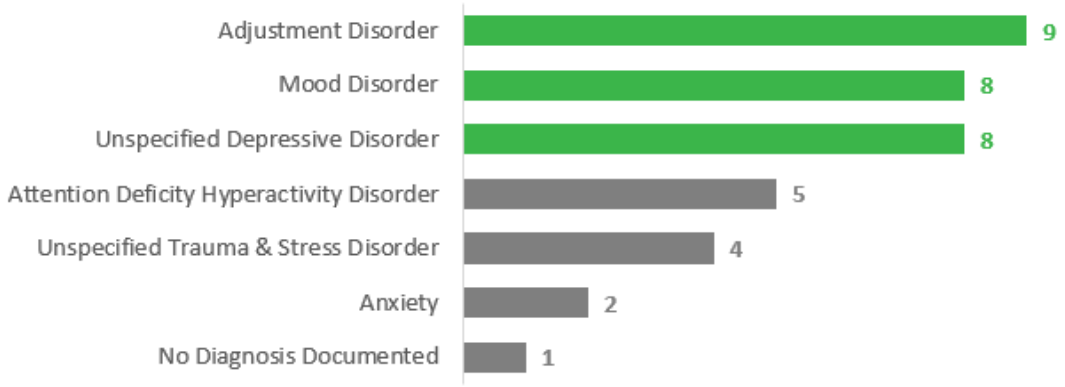


Source: Office of Well Being manual data

What are the kinds and frequency of mental health diagnoses occurring for children in foster care?

The majority of children (97 percent) received official diagnoses after completion of their mental health evaluation; diagnoses included Adjustment Disorder, Mood Disorder, Unspecified Depressive Disorder, Attention Deficit Hyperactivity Disorder, Unspecified Trauma & Stress Disorder, and Anxiety.[50]

Adjustment, mood, and unspecified depressive disorder were the most prevalent diagnoses for children completing mental health services during the review period (n=30).



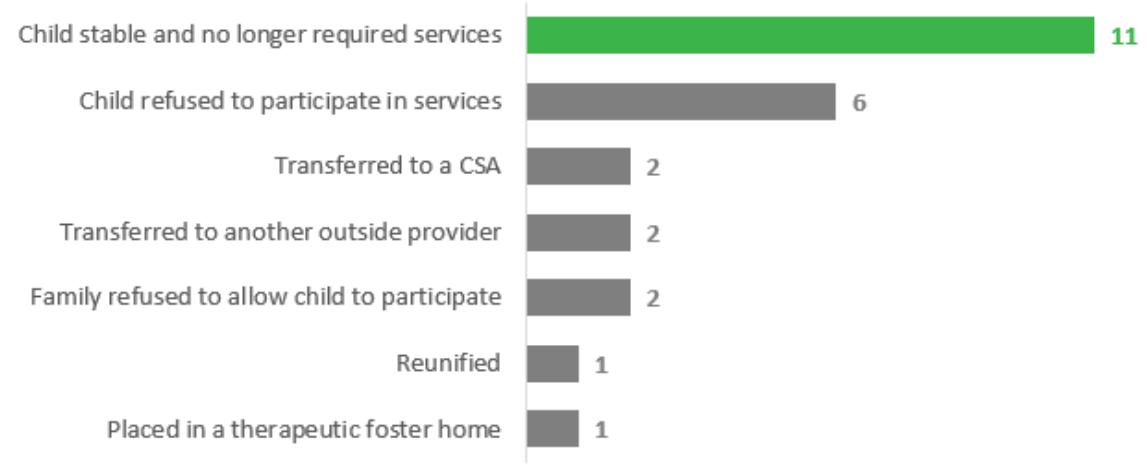
Source: Office of Well Being manual data

[50] Only 29 of the 30 clients had a documented diagnosis in Quick Base as of the writing of this report. Clients may have received one or more diagnoses after their mental health evaluation.

What were the discharge reasons for children completing mental health services during the review period?

Of the 30 children who were discharged after receiving at least one session, 37 percent were discharged from mental health services because they were deemed stable and no longer required services (n=11). Six children (20 percent) refused to participate in services. Five children (17 percent) were transferred to a CSA and two children (seven percent) were referred to an outside provider. Two families (seven percent) refused to allow their child to participate in services. Two children (seven percent) were discharged due to hospitalization. One child (three percent) was discharged due to placement in a therapeutic foster home in another jurisdiction. One child (three percent) was discharged from mental health services due to reunification.

The most prevalent discharge reason was that the child was deemed stable and no longer required services.



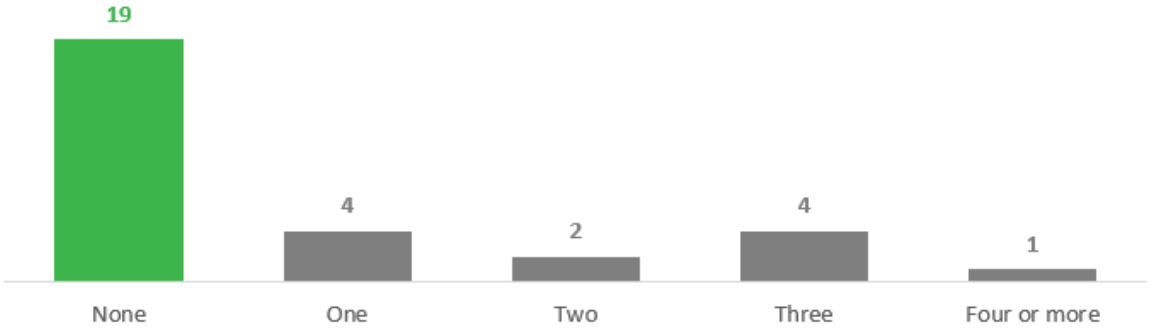
Source: Office of Well Being manual data

Did children who participated in CFSA mental health services experience placement disruptions during their treatment period?

Sixty-three percent of participating children (n=19) did not experience a placement disruption during their treatment period. Of the 11 children who experienced disruptions, four children (36 percent) had one disruption, two children (18 percent) had two disruptions, four children (36 percent) had three disruptions, and one child (9 percent) had four or more disruptions. Reasons for placement disruptions included abscondence/running away, the provider requested a placement change of placement, the youth required a different level of care, the placement could not meet the child's behavioral treatment needs, and the placement was temporarily unable to care for the child.[51]

[51] A more comprehensive qualitative study, to begin in FY 2021 Q1, will examine the impact of participation in mental health services at CFSA on placement stability.

Six out of every ten children who received at least one session during the review period did not experience a placement disruption (n=30).



Source: Office of Well Being manual data

Conclusion and Needs to be Considered

Overall, the mental health redesign has been successful in meeting the short-term therapeutic needs of children in care. Most children receiving mental health services were in foster care at the time of their initial therapy session. Since the program's inception in FY 2019, all children who were referred for mental health services received a full mental health evaluation. The redesign has also shown effectiveness in having children complete their first session in a timely manner (86 percent in FY 2019 and 81 percent in FY 2020). From the smaller qualitative study, we learned that oppositional defiance and aggressive behavior were the most prevalent behaviors exhibited by children referred for treatment. Adjustment disorder, mood disorder, and depression were the most-common diagnoses following the mental health evaluation. Most children who completed treatment were discharged because services were no longer needed, and the majority of children who completed treatment did not experience a placement disruption while receiving mental health services.

OWB has identified the following service delivery improvements for children who have been recommended for mental health services. The needs include:

- **Streamline screening processes**. Improve screening process efficiency to allow children to receive evaluations sooner and, in turn, receive their first therapy session in a timelier manner. The mental health evaluation are now scheduled at the same time as the comprehensive physical evaluation. This reduces the number of appointments needed to get the youth into therapy services, if needed.
- **Hire additional FTEs to provide therapeutic services to all children who are recommended for treatment.** The mental health program is currently at capacity (30 children assigned to three therapists) and has a history of being over capacity. A fourth mental health therapist was hired in March 2020 to support capacity.
- **Strengthen engagement.** Identify strategies to lessen refusal by youth to engage in therapy.

Given that this is the first review of the mental health redesign, lessons were learned to potentially improve the practice of documenting all contacts with clients referred for mental health services. The needs for improved client record keeping and data collection are as follows:

- **Utilize and maintain electronic patient file system in order to retrieve patient data electronically.** Additional information related to client experiences – such as treatment plans, session notes, and total number of sessions attended by a client – is currently maintained outside of the Quick Base system in paper format.
- **Continue collaboration between PAQIA and OWB to improve the evaluation process.** PAQIA's Quality Assurance team will be in ongoing discussions with OWB regarding the re-creation of survey tools prior to the next review to ensure that the questions relate directly to the outcomes sought for analysis; the use of clinical language is consistent; and, clarity with OWB practices and processes.

A more comprehensive review will be conducted in FY 2021 to examine the effects of the mental health redesign on placement stability, family engagement, and decreased disruptions.

Mental Health Redesign Evaluation Data Limitations

While completing the evaluation, the following limitations were identified that will be addressed moving forward.

- **Missing data**: Occasionally data points were inconsistently entered or missing impacting the analysis recorded in Quick Base, the system of record for the Mental Health Redesign FY 2020 data. FY 2019 missing data points include after the mental health evaluation, whether in-house therapy or referral to an outside provider is recommended, the modality of therapy, and the reason for the recommendation. By having this information, OWB would gain a fuller picture of the mental health needs of the children and families that are completing the mental health evaluations, and how in-house mental health services complements and enhances the mental health services available in the community.
- **Definitions for referrals:** There needs to be further clarity regarding the definitions for being referred to a Core Service Agency (CSA) versus referred to a higher level of service (defined as being referred to a PRTF or for therapeutic services needed to address a child's cognitive delays). Currently they are very similar and appear to be used interchangeably. This lack of clarity and consistency leads to some confusion with the evaluation findings.
- **Definitions of administrative discharges:** They are not fully mutually exclusive and are not consistently used. For example, a child may not be recommended for mental health services because a higher level of service is required; this determination is made during the mental health evaluation. It is not clear why some children are not recommended for treatment immediately following the mental health evaluation due to being referred to a higher level of service and some children are administratively discharged for the same reason.
- **Documentation outside of Quick Base:** Treatment plans, Discharge Summaries and Mental Health Evaluations are currently maintained outside of the Quick Base system in paper format, which limited the amount of data that was available for the qualitative OWB analyses. It is recommended that a HIPPA-compliant electronic patient file system be

utilized to maintain and access patient data electronically. Online access to client data will make it easier for therapists and evaluators to access needed data from any location.

Longer Term Contracted Mental Health Therapy

CFSA recognized that longer term therapeutic services might be necessary after the shorter-term in-house therapy service ends. In alignment with the reason for bringing mental health services in house (receiving timely therapeutic services), in November 2019, CFSA contracted with a mental health provider, MBI Health Services, LLC (MBI) to provide out-patient therapeutic services for children, youth, parents and caregivers involved with CFSA. Clients who need longer term services are referred to MBI.

How many children and caregivers did MBI serve?

MBI has the capacity to serve 150 children and 75 parent caregivers. In FY 2019 – FY 2020 Q2, 13 clients received services. The low number of referrals is believed to be as a result of program areas not being aware of available services.

Conclusion and Needs to be Considered

The MBI contract has more capacity to utilize. There is a need to increase awareness of this resource and the contract should be maintained at current levels to accommodate referrals after outreach. In addition, the impact of the COVID-19 pandemic increases the need for mental health support. The capacity to utilization ratio should be assessed at the midpoint and end of FY 2021.

SECTION 4: EXIT TO PERMANENCE

In the District, most children who leave foster care are reunified with their parents. When a child is unable to return home and the goal changes to either adoption or guardianship, a permanency resource must be identified. Typically, a resource has been identified when the goal changes to guardianship. Ideally, an adoptive resource has been identified when the goal changes to adoption. However, if there is no adoptive resource, child-specific recruitment is initiated. As a last resort, if older youth must exit foster care without reunification, adoption or guardianship, then their team supports them as they actively prepare for adulthood with lifelong connections. This section will focus on CFSA's permanency cohorts, adoption-specific recruitment, and services for youth aging out of foster care.

PERMANENCY DATA FOR CHILDREN IN FOSTER CARE

Permanency Measures

By the end of FY 2019, 420 children (out of 1,207 children served in the fiscal year) had exited foster care. This represents a total of 425 exits since a few children had multiple entries and exits in the same fiscal year. Of these 425 exits, 228 exited to reunification (54 percent), 100 exited to adoption (24 percent) and 40 exited to legal guardianship (9 percent). In total, 368 of the 425 exits **(87 percent) were to positive permanency**. At the end of FY 2020 Q3, 232[52] children (out of 1,010 children served in FY 2020 through Q3) had exited foster care. This includes a total of 232 exits, and of these 232 exits, 94 exited to reunification (41 percent), 74 exited to adoption (32 percent), and 34 exited to legal guardianship (15 percent). In total, 202 of the 232 **(87 percent) of the total exits were to positive permanency**.

What is the rate of exits to permanency for children in foster care?

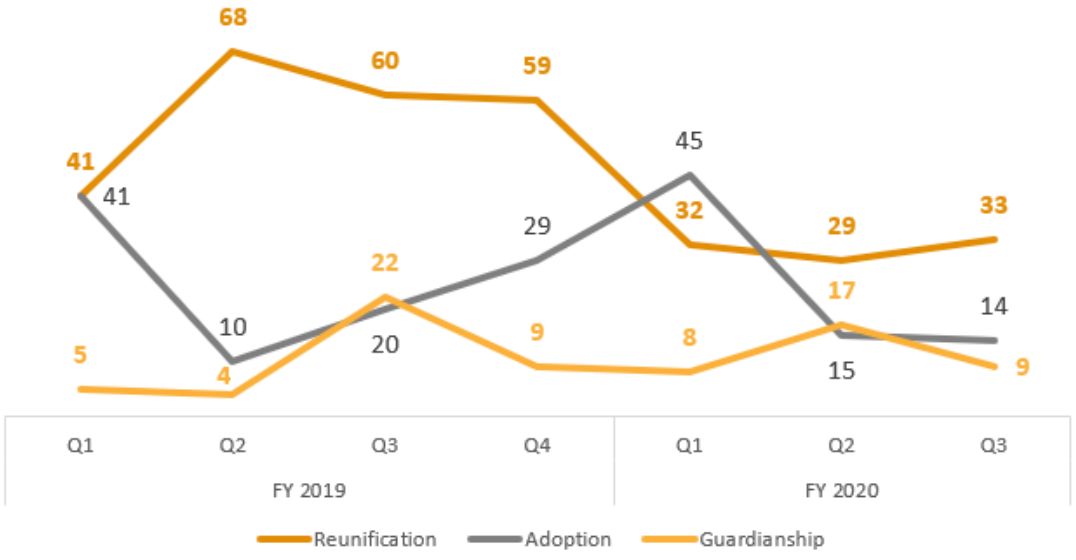
The rate of children who exit to permanency was further examined by quarter. The graph below shows that the number of exits to reunification decreased in the first three quarters of FY 2020 compared to FY 2019. Further analysis of this trend through the end of Q4 and beyond will be

[52] Due to the COVID-19 pandemic, children who are turning 21 during the pandemic have the option to elect to stay in foster care until up to 90 days past the end of the pandemic, per DC Council legislation passed in April 2020. Due to the small number of clients this impacts, and the unknown duration of the pandemic, major changes to FACES were not made and children are still automatically end-dated from their placement and home removal (and therefore show up as exits) on their 21st birthday. CMT367 was manually manipulated to correctly reflect the exits. As of the end of FY 2020 Q3, after the beginning of the pandemic five children did exit foster care on their 21st birthday and are included amongst the exits. Nine children elected to stay in foster care at this time and have been removed from the total number of exits.

done using the Permanency Tracker and other tools.[53] The number of exits to adoption does demonstrate a seasonal effect, with the highest number of exits to adoption in both years occurring in Q1. This is expected because a higher number of adoptions are scheduled to finalize on Adoption Day which occurs annually during Q1 in November. The number of exits to guardianship is typically lower than both reunification and adoption, however both FY 2019 and FY 2020 through Q3 had one quarter where more children exited to guardianship than adoption (in FY 2019 Q3, there were 22 exits to guardianship and in FY 2020 Q2 there were 17 exits to guardianship).

When comparing FY 2019 (Q1-Q3) to FY 2020 (Q1-Q3), overall exits are down 26 percent. Of positive note, children exiting to guardianship increased by 10 percent (34 children exited to guardianship in FY 2020 Q1-Q3 compared to 31 children in FY 2019 Q1-Q3), and children exiting to adoption increased by 4 percent (74 children exited to adoption in FY 2020 Q1-Q3 and 71 children exited to adoption in FY 2019 Q1-Q3). Reunifications decreased 44 percent, with 94 children exiting to reunification in FY 2020 through Q3 compared to 169 children during the same time period in FY. 2019. **Despite the COVID-19 related court delays, CFSA has still exited 71 children to permanency from March 13 to June 30, 2020.**

While the number of reunifications decreased in FY 2020, adoptions and guardianships have increased.



Source: FACES management report CMT367

[53] In FY 2020, CFSA launched a Permanency Tracker which is a single source of up-to-date, accessible information on the status of any child on key milestones on his or her path to permanency, and on progress to permanency across children.

The proportion of children exiting to reunification decreased in FY 2020 Q1-Q3

Type of Positive Permanency Exit	FY19 # of Exits	% of Total Exits	FY20 Q3 # of Exits	% of Exits
Reunification	228	62%	94	47%
Adoption	100	27%	74	37%
Guardianship	40	11%	34	17%
Grand Total	368	--	202	--

Source: FACES management report CMT367

CFSA began utilizing the Permanency Tracker in FY 2020 to promote closer tracking on an aggregate level of the progress of children in care towards positive permanency. The MicroStrategy dashboard was developed after analysis identified a total of 74 case milestones from removal to reunification, adoption, and guardianship, of which only 23 percent are accessible in FACES. The remaining 77 percent of the milestones are manual data held across eight different program areas. The MicroStrategy dashboard allows CFSA to add the manual data onto what it is in FACES, allowing for a comprehensive view.

The Permanency Tracker is used as a management tool to assess progress towards permanency, and to assist in identifying cases experiencing barriers to permanency where further refinement of a plan to address the barrier may be required. The Permanency Tracker was designed and created as an iterative tool that is responsive to practice needs, and CFSA will continue to assess how it can be best used to promote achieving positive permanency for youth in care.

How are we moving more children to permanency using LaShawn cohort data?

Agency progress towards achieving permanency for youth in foster care can be measured in different ways. The analysis above utilizes an exit cohort approach and focused on the raw number of exits to foster care in FY 2019 and exits so far in the first three quarters of FY 2020, and the percent increase and decrease for exits to reunification, guardianship and adoption for the first three quarters in each fiscal year. CFSA also measures agency progress toward achieving permanency for youth in foster care through exit standards in the LaShawn v. Bowser Exit and Sustainability Plan (ESP).[54] The data below reflect how permanency is measured in the ESP and includes the third quarter through June 30, 2020.

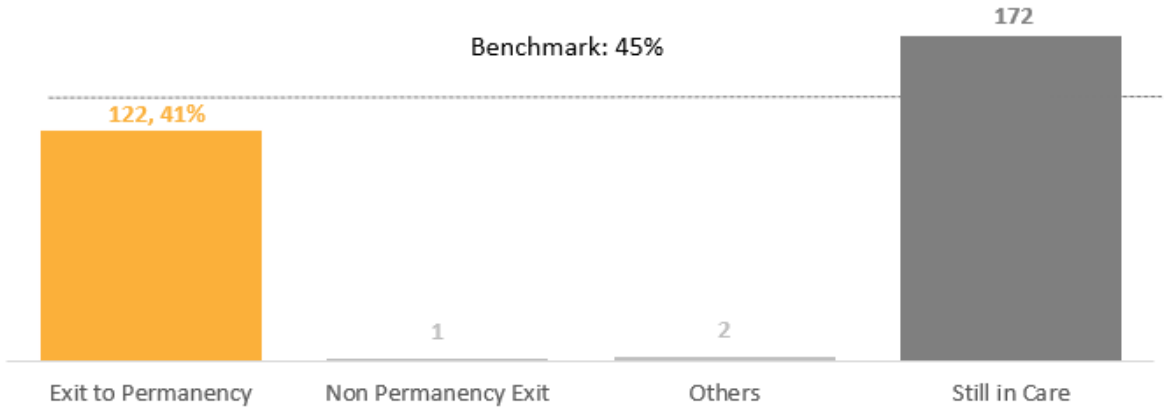
Currently, CFSA tracks permanency (reunification, guardianship, and adoption) for three distinct cohorts of children:

[54] https://cfsa.dc.gov/publication/lashawn-exit-sustainability-plan

- **Cohort 1:** 45% of children who have entered foster care during FY 2019 will exit to permanency within 12 months (by September 30th, 2020), Note: this is an entry cohort approach
- **Cohort 2:** 45% of children who have been in foster care 12-24 months (as of September 30th) will exit to permanency within 12 months (by September 30, 2020)
- **Cohort 3**: 40% of children who have been in foster care for 25 months or more (as of September 30th will have exited to permanency within 12 months (by September 30, 2020) or before their 21st birthday, whichever is earlier

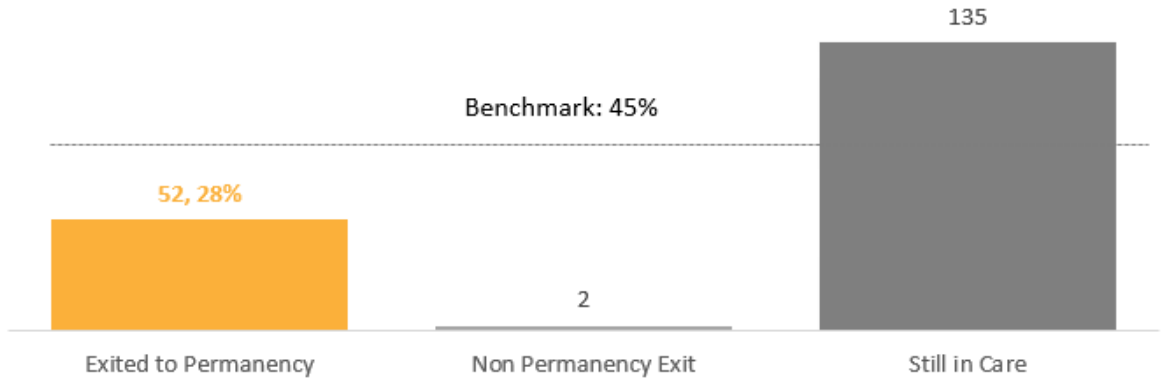
CFSA is on track to meet cohort 1 and could come close to meeting cohort 2 for children achieving permanency by September 30, 2020. This conclusion is based on current permanency numbers and projections based on case reviews.

As of June 30, 2020, only 12 more positive permanency exits are needed to achieve the 45% benchmark for cohort 1 by September 30, 2020.



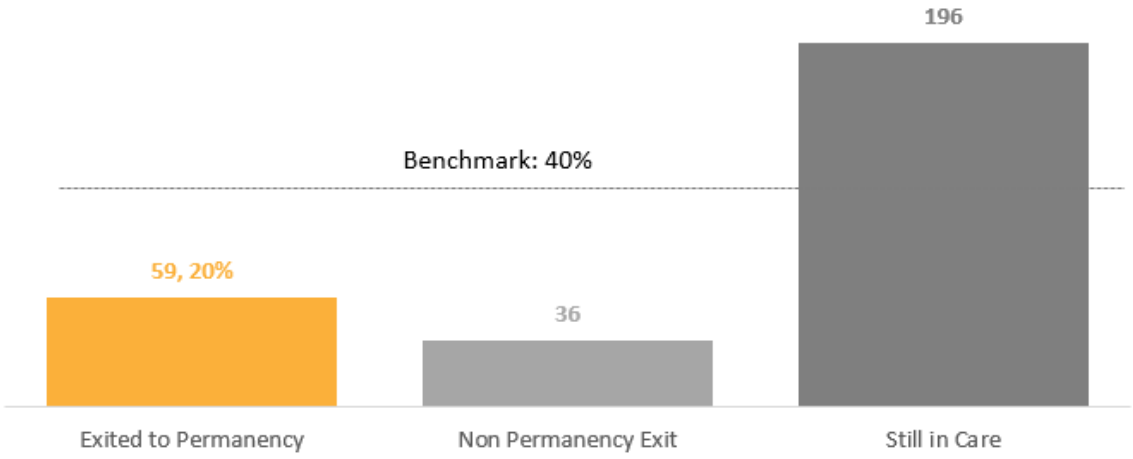
Source: FACES Management Report CMT384

As of June 30, 2020, 33 more positive permanency exits needed to meet the 45% benchmark for cohort 2 by September 30, 2020.



Source: FACES Management Report CMT385

As of June 30, 2020, 57 positive permanency exits needed to meet the 40% benchmark for cohort 3 by September 30, 2020.



Source: FACES Management Report CMT385

Conclusion and Needs to be Considered

Permanency can be measured in different ways which involve different methods to look at the population, and therefore lead to different conclusions. The three ways permanency is measured include:

- **Point-in-time:** looking at data as of a specific date for children in foster care
- **Exit cohort:** measures only the children who have left foster care
- **Entry cohorts:** includes all children who have entered foster care and follows them for the duration of their stay in foster care

Entry cohort is the best and most comprehensive method to measure permanency because it looks at the experiences of all the children who entered care at the same time over a specified duration of time. In comparison, point-in-time results and exit cohorts only include those children who are in foster care or who are exiting foster care and therefore misses important portions of the whole population. CFSA is working to build the necessary technology infrastructure in order to have real-time monitoring of permanency for all goals using an entry cohort framework.

Currently, the LaShawn Entry Cohort 1 is an entry cohort, however it only follows youth for the first fiscal year after they enter care. Cohorts 2 and 3 take a point-in-time look at which children in the foster care population had been in care for a specific duration of time as of the end of the fiscal year and examines who exits over the next fiscal year. This is not an entry cohort approach. The following summary will provide information about the different approaches that CFSA uses now to measure permanency.

CFSA will continue the work to change measurement of permanency to entry cohorts to understand the full experiences of child outcomes as it relates to permanency, placement stability,

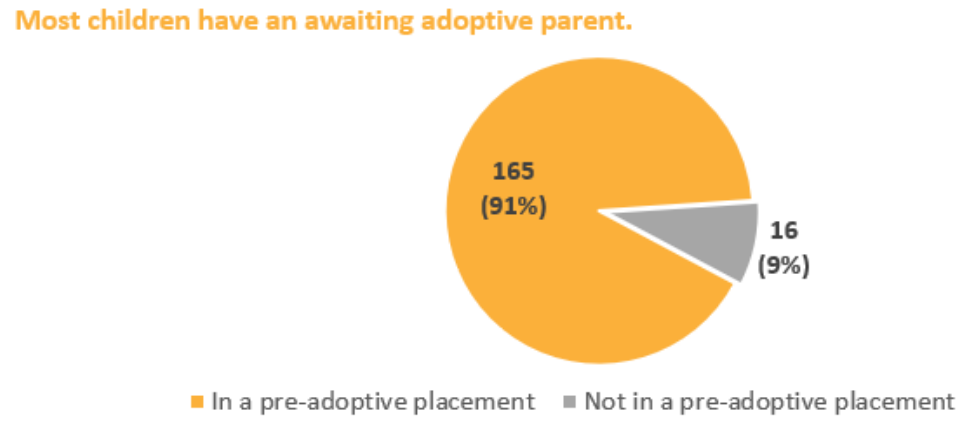
and how long children are staying in foster care. CFSA will use that data to compare against national data.

Children Needing Child-Specific Adoption Resources

How many children with a goal of adoption have an identified adoptive resource?

When CFSA recruits adoptive families for children with no identified adoptive resource, the recruitment team does not close out adoption-specific recruitment efforts until either (1) a petition is filed, and the child is placed in the pre-adoptive home or (2) the child's goal changes to guardianship or reunification. Since FY 2018, even if the Agency has a letter of intent, cases will remain open until a petition file date.

In June 2020, there were 181 children with the goal of adoption; 165 were in a pre-adoptive home and 16 were still in active recruitment status.[55] Of those 16 children, seven had no identified pre-adoptive resource and nine had an identified pre-adoptive resource but no petition filed yet. Once the petition is filed, the child is considered placed in a pre-adoptive home.



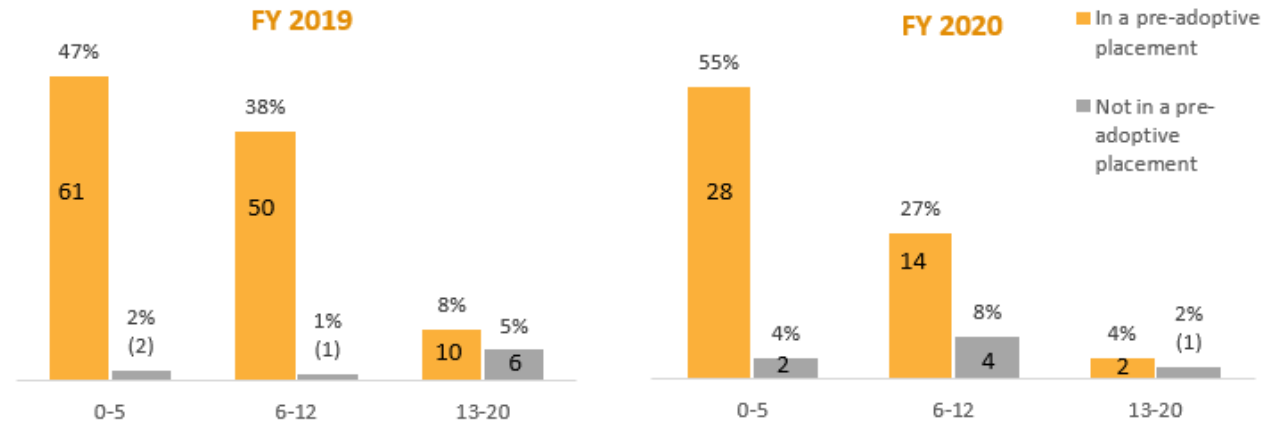
Source: Adoption Recruitment Manual Data Tracking

More children ages 0-12 are placed in a pre-adoptive home. In FY 2019, forty-seven percent of the children in a pre-adoptive home were ages birth to 5 years old. Thirty-eight percent were ages 6 to 12 and eight percent were ages 13 to 20 years old. Of those children with a goal of adoption in FY 2019, waiting to be placed in an adoptive home, two percent were ages birth to 5 years old, one percent was ages 6 to 12 years old, and five percent were ages 13 to 20 years old. In FY 2020, fifty-five percent of the children in a pre-adoptive home were ages birth to 5 years old. Twenty-seven percent were ages 6 to 12 and four percent were ages 13 to 20 years old. Of those children with a goal of adoption in FY 2020, waiting to be placed in an adoptive home, four percent were

[55] Five children were removed from the universe: three children had a permanency goal changed to guardianship, one child returned to their mother for protective custody and there was one child fatality.

ages birth to 5 years old, eight percent were ages 6 to 12 years old, and two percent were ages 13 to 20 years old.

Most children, across all age groups, with a goal of adoption, have an adoptive resource.



Source: ADP072 and Adoption Recruitment Manual Data Tracking

What are the characteristics of children for child-specific adoption?

As of June 30, 2020, 75% of children with a goal of adoption who are not in a pre-adoptive home have either behavioral needs or have medically-fragile as a characteristic.

Characteristic	# of Children	% of Children
Behavioral Needs[56]	N=9 out of 16	56%
Medically Fragile	N=3 out of 16	19%
Total	**N=12 out of 16**	**75%**

Source: Adoption Recruitment manual database

For the remaining four children, three have an identified adoption resource; however, the identified resource is currently under study for completion of licensure and placement. The fourth child had a recent disruption in their adoptive placement.

Resources used to match children with the goal of adoption include:

- **Licensed Resource Families:** Making presentations to licensed resource parents who have expressed an interest in adoption and working with current resource parents to serve as pre-adoptive resources once a child's goal changes to adoption.

[56] Behavioral needs include having a DSM-V Axis I diagnosis that includes behavioral problems as one of the primary symptoms of the disorder, diagnosis on the Autism spectrum, children residing in a psychiatric residential treatment facility, youth with identified CSEC involvement, in abscondence, and/or multiple placement disruptions due to behavior issues.

- **Kinship Resources:** Conducting case mining and diligent searches to identify kin and other adults in the child's life (e.g., teachers, coaches, mentors) who may be an adoptive resource.
- **Website Promotion:** CFSA uses several platforms to recruit prospective resource parents including: AdoptUSKids.org, www.adoptionstogether.org/heart-gallery and CFSA Fosterdckids.org. More than 50 percent of prospective resource parents have been recruited from the Fosterdckids.org platform.

Referral Source	Fiscal Year	# Expressed Interest	# Submitted Application	# Became Licensed
AdoptUSkids.org	FY19	23	3	1
	FY20	12	1	1
	Total	**35**	**4**	**2**
Fosterdckids.org	FY19	297	52	22
	FY20	270	40	13
	Total	**567**	**92**	**35**
Adoptions Together	FY19	6	0	0
	FY20	1	0	0
	Total	**7**	**0**	**0**

Source: Recruitment Unit Quickbase data

- **Presentation to Private Adoption Organizations:** CFSA works with private organizations, particularly those with a focus on older youth, to look for a match.
- **Matching Events:** Metropolitan Washington Council of Governments[57]. One matching event was held in November 2019 with providers from the District, Maryland and Virginia.
- **Family Match Night:** CFSA hosts monthly events (now virtual) to present six to eight children who need a forever family. The night is themed (e.g., teens, children who are medically fragile or are diagnosed on the Autism spectrum, sibling groups).
- **Reverse Searches**: Reverse searches allow CFSA to search a national database through AdoptUSKids.org and gather home studies of families who are interested in being matched with children with specific characteristics such as LGBTQ, special needs, medically fragile, and children on the Autism spectrum. This has been a valuable tool for matching teenagers and children with special needs. As of March 2020, case mining and diligent reverse searches have resulted in recruiters locating viable resources for two teens and a sibling group of three.
- **Resource Family Working Group:** CFSA recently joined the Resource Family Working Group, which is a cohort of more than 15 states and counties working to increase the

[57] Metropolitan Washington Council of Governments. https://www.mwcog.org/

efficiency and effectiveness of foster parent licensing, recruitment, and placement processes across the nation. For child-specific adoption, CFSA participates in virtual matching events with other jurisdictions and share resources.

- **Partnerships:** CFSA partners with various DC and Maryland medical providers and hospitals to profile medically fragile children for potential adoptive resources: CFSA's Recruitment staff has facilitated "Lunch and Learn" activities with Kaiser Permanente, United Health, and the Black Nurses Association. CFSA also included a child-specific spotlight in its monthly newsletter, Fostering Connections, which is distributed to resource parents. Implemented in FY 2020, as of March 2020 one nurse is currently in the home study process to provide permanency for a toddler identified as medically fragile.

When matching children to a pre-adoptive home, the matching process includes a matching conference, background conference, and transition plan. Due to the COVID-19 pandemic and limitations on in-person meetings, the conferences required for the matching process are held virtually via Microsoft Teams and WebEx online conferencing platforms.

- **Matching Conference:** When CFSA identifies a potential adoption match for a child, the home study and matching tools are collected for review. A team of professionals (the social worker, supervisor, recruitment team, and guardian *ad litem)* reviews both documents. If the information presented seems to indicate a good match, the adoption recruiter schedules a background conference to gather additional information. In 2019, CFSA completed matching staffings for 22 of 111 children. The remaining 89 children had already achieved permanency.
- **Background Conference:** The background conference assembles the child's entire team: the social worker, clinical and legal professionals, recruitment worker, current resource parent, and prospective adoptive family (along with their support). The team presents as much child information as possible, including placement history, education, mental health, medical, recreational interests, social background, legal status, etc. After the conference, the prospective adoptive parent and the team have two days to decide if they want to move forward. If both agree to move forward, a transition plan is created. Since COVID-19, the matching and background conferences have gone virtual. The Agency held 11 background conferences in 2019. The 11 children represent the number of background conferences held and the number of children that received a matching conference. However, some of the children required multiple matching meetings due to the team declining families they deemed would not be a good match for the children. For example, there were three matching conferences held for one child until a family was selected for whom to facilitate a background conference. The outcome resulted in a teen male transitioning from a residential treatment facility to a pre-adoptive resource.
- **Transition Plan:** A written agreement between the prospective adoptive parent, CFSA, and the current provider outlines the schedule of supervised visits to final placement.

Conclusion and Needs to be Considered

CFSA has most of its children in a pre-adoptive resource and a small number of children need a child specific recruitment plan for an adoptive parent. As of the end of FY 2020 Q2, the 12 children

without an identified pre-adoptive resource had either behavioral needs or were diagnosed as medically-fragile.

What is the rate of disruptions from guardianship and adoption?

In FY 2019, 13 cases experienced a guardianship disruption, and two cases experienced an adoption disruption. In FY 2020 as of March 31, 2020, no cases experienced a guardianship disruption and no cases experienced an adoption disruption.

Most post-permanence disruptions occur from guardianship.

Disruption Outcome	Guardianship		Adoption	
	FY19	FY20 Q2	FY19	FY20 Q2
Child absconded	0	0	2	0
Guardianship/adoption terminated	13	0	0	0
Totals	**13**	**0**	**2**	**0**

Source: Disruption Manual Data Tracking

CFSA provides services to support adoptive and guardianship parents.

- **Permanency Specialty Unit Pre- and Post-Adoption Support.** Five social workers comprise the CFSA Permanency Specialty Unit (PSU) to provide both pre- and post-adoption support for families. PSU social workers assess the family's needs, refer the family to appropriate services, and provide support and crisis counseling services to help prevent disruptions during the family's transition into adoption.
- FamilyWorks Together (formerly known as the Post Permanency Family Center) and the Center for Adoption Support and Education (CASE). CFSA contracts with two non-profits to provide support. More information on these programs can be found in the following Exits to Adoption and Guardianship section of this document.
- **Guardianship and Adoption Subsidies.** To ease the potential financial challenges that may come with welcoming a new child or sibling group into the home, CFSA provides adoption and guardianship subsidies, including coverage of certain non-recurring adoption or guardianship costs as specific needs arise.

Conclusion and Needs to be Considered

More disruptions occur on guardianship cases than adoption cases. A further analysis to identify the precipitating reasons for the disruptions and the length of time to the disruptions should be done to determine needs. A revised tracking tool needs to be developed for better analysis to understand precipitating factors for disruptions.

What are the goals of older youth?

As of March 31, 2020, there were 263 youth ages 15 and older in foster care with the following goals:

Age	Reunification	Adoption	Guardianship	APPLA	No Goal	Total
15	24	7	8	3		42
16	17	9	19	2		47
17	18	3	16	2		39
18	6	7	18	16		47
19	3	4	17	22	2	48
20	1		2	37		40
Total	**69**	**30**	**80**	**82**	**2**	**263**

Source: FACES management report CMT366

Services for for OLDER YOUTH AND Youth aging out of foster care

CFSA provides several specialized services to support youth who are aging out of foster care. This includes an evidence-based practice for disengaged youth, aftercare up to 23 years old, and housing supports. OYE provides direct case management and concurrent permanency and transition planning services to older youth in foster care (ages 15-20). OYE works to achieve permanence for these older youth while at the same time providing life skills training, vocational and educational support, transitional assistance, and encouraging informal but committed relationships with safe, caring adults willing to act in a mentoring or parental capacity following a youth's exit from foster care. As a last resort, if older youth must exit foster care without reunification, adoption or guardianship, then youth's team supports them as they actively prepare for adulthood with lifelong connections.

OYE Enrichment Bootcamp: This is a day program to serve CFSA youth in foster care who are temporarily unable to attend school due to suspension, placement disruption, or a school enrollment change. Youth in the program keep up with school assignments and receive academic support. In FY 2019, OYE received 80 referrals for the OYE Enrichment Bootcamp. Of these referrals, 14 percent were due to school enrollment or disruption, 25 percent were due to placement disruption or new removals and 61 percent were due to school suspensions. Youth with previous referrals accounted for 59 percent of the total number of referrals.

CFSA Match Savings Program/Making Money Grow: Offers youth (ages 15-20) the opportunity to participate in a matched savings and financial literacy program where every dollar saved is matched by Capital Area Asset Builders (CAAB). The matched funds are capped at $1,000 per year and youth can transition out of care

	with up to $12,000 to purchase a vehicle or to pay for housing, education, or entrepreneurial endeavors. CFSA's capacity allows for meeting the needs of 100 participants at any given time. About 112 youth utilized this service in FY19 and 122 in FY20.
	**College Tours**: Group, community based, and individual tours of target colleges/ universities. Youth are exposed to college life and academics to determine best fit for post-secondary education. Five youth went on college tours in FY19 and tours were cancelled in FY20 due to the pandemic.
	**College and Career Preparation**: Exposure to post-secondary educational options and high demand employment fields. There were 167 youth who utilized this service in FY19 and 117 in FY20.
	**Career preparation**: Support youth in preparation for vocational training, internships, or employment. Thirty-two youth utilized this service in FY19 and FY20.
	**College Connect 4 Success**: An academic and professional development workshop for all youth attending college. The purpose of this workshop is to provide students an opportunity to dialogue directly with a variety of college representatives (i.e. academic advisors, financial aid representatives, TRIO program counselors, etc.) and receive guidance and information aimed at empowering students to be successful academically. Eight youth utilized this service in FY19 and 4 in FY20.
	**Youth Recognition Ceremony**: Annual ceremony that recognizes education and vocational accomplishments. There were 131 youth who utilized this recognition in FY19 and OYE held a virtual recognition in FY20 (75 were recognized).[58]
	**JUMP (Juvenile Mentoring Program)**: Mentoring for young men who are experiencing difficulties in the communities to receive guidance and support. Seven youth utilized this service in FY19 and 10 in FY20.
	**Youth Council**: An introduction for youth currently in care to join with other peers in order to vocalize the experience, needs and concerns of youth in the foster care system. Youth will participate in community activities, and educational workshops while developing life-skills. The Council was established in February 2020 and 25 youth are currently involved.
	**Youth Villages LifeSet:** Peer to Peer-Opportunity for youth to meet up for the purpose of engaging in therapeutic activities that can enhance positive coping skills and creativity. Between April 2019 and March 31, 2020, the YVLifeSet program has served 54 youth.

[58] Recognized means the youth was acknowledged for receiving an award in an area of accomplishment in their education or vocation.

Evidence-based Practice for Disengaged Youth – Youth Villages Model

In April 2019, through a partnership with Youth Villages[59] CFSA launched the YVLifeSet Program. Using evidence-based practices, YVLifeSet replaced the Career Pathways Unit as OYE's vocational and life skills service delivery model. The YVLifeSet Unit focuses on providing one-on-one intense supports to youth to assist them in achieving their individual defined goals. YVLifeSet specialists meet with participants at least once a week and are readily available to help the youth. The goal is to have highly individualized services in the youth's natural environment, including the home, place of employment, and community. The unit consists of one supervisor and four specialists.

The program has key program indicators, tracking positive outcomes monthly in the following areas: Education, Employment, Reduction in legal involvement, length of time in the program, housing stability, and staff caseload. Participants also work on developing positive coping and healthy emotional regulation skills. Review of data also show an average program participation rate of 31 youth, an average caseload of eight, and an average length of stay in the program of 214 days. The YVLifeSet unit has a capacity to serve 32 youth at a given time. Youth typically participate in the program for 6-12 months, based on their needs. Between April 2019 and March 31, 2020, the YVLifeSet program has served 54 youth.

Measure	FY19: 10 discharged youth	FY20: 33 discharged youth
Education advancement	75%	88%
Obtained employment	23%	37%
Reduction in legal involvement	92%	100%
Length of time in program	100 days on average	240 days on average
Housing stability upon discharge	100%	87%
Staff caseloads	6 youth per staff on average	7.5 youth per staff on average

Source: OYE manual data

Conclusion and Needs to be Considered

In October 2019, Youth Villages (YV) conducted a six-month review of CFSA's YVLifeSet program, measuring several different benchmarks to determine overall fidelity. Youth Villages found that within CFSA, the YVLifeSet program has maintained high fidelity to the evidenced-based model. Voluntary youth surveys show that youth feel heard, respected and productive as participants in the program. Youth have also reported feeling that strong rapport with their assigned specialist,

[59] Founded in 1986, Youth Villages is a non-profit organization that has become one of the country's largest and most innovative providers of children's mental and behavioral health services. Serving over 27,000 youth across 16 states in 2018, Youth Villages works to find solutions using proven treatment models that strengthen the child's family and support systems and dramatically improve their long-term success.

paired with the weekly sessions, helps them progress through their goals and work through any struggles confronted. There is no waitlist and the program meets the identified need.

What aftercare services are available to youth?

On October 1, 2019, CFSA ended its contract with the vendor providing aftercare services for youth exiting foster care and began in-house aftercare program run by the Office of Youth Empowerment (OYE). When CFSA's in-house aftercare program was launched on October 1, 2019, all 49 youth, both active and inactive, who had been eligible for services through the prior vendor transitioned to CFSA for services.

The in-house program connects youth exiting the foster care to an OYE resource development specialist (RDS) who helps the youth create an individualized transition plan for accessing community supports and services that can support the youth's transition from foster care into adulthood. There are two full-time aftercare specialists that have an average caseload of 30 – 35. Youth are eligible for aftercare services up to age 23 and if they exit foster care at 21, reside within 25 miles of DC at the time of exit, and agree to services. Youth are ineligible for services if they are connected to housing and case management supports through the Department on Disability Services, the Department of Behavioral Health, or a transitional housing program. Youth are also ineligible if they have run away, are incarcerated, or reside more than 25 miles outside of DC at time of transition. However, if circumstances change before their 23rd birthday, they will again be eligible for services.

The OYE RDS determines a youth's eligibility for aftercare services during a transition planning meeting called the 21 JumpStart review. This process, which is initiated six months before the youth's 21st birthday, includes assigning an aftercare specialist to the youth to welcome and guide the youth throughout the program. The aftercare program provides both individual support and group opportunities that offer connections to the following supports:

- Housing Assistance
- Medical and Mental Health Support
- Education and Vocational Training Preparation
- Employment Assistance
- Budget and Financial Management
- Life Skills Development
- Guidance for Accessing Public Services and Benefits
- Transportation Stipends
- Limited Emergency Support

The 21 JumpStart reviews are not linked to YV LifeSet. The reviews are a quality assurance meeting to ensure realistic transition planning is occurring and there are no identified barriers to a successful transition. These meetings only occur once; however, youth transition planning meetings (YTP's) occur on a time basis. If the youth is connected with the YV LifeSet program, the specialist is invited to the 21 JumpStart reviews as well as to YTP meetings to assist with goal accomplishment.

What is the aftercare participation for youth who have emancipated from foster care?

In FY 2020 Q1 and Q2, CFSA referred 12 youth to the in-house aftercare program prior to the youth aging out of care. As of July 2020, OYE documented a total of 63 youth enrolled and 25 transitioned youth actively participating in the OYE in-house aftercare program. While there is no wait list, the numbers are increasing. "Active participation" includes meeting monthly (at a minimum) with the assigned RDS, and intentionally engaging in youth-driven discussions regarding service needs for housing, education, employment, finance, parenting, medical health, and mental health.[60] Regular email and telephone contact regarding the Youth Aftercare program is done to try to engage youth that are not participating in the program. Youth remain eligible for the program up to age 23.

Of the 24 youth who participated in the aftercare program in September 2020, youth had the following status:

- **Housing:** 14 youth had permanent housing, three had temporary housing and five had unstable housing
- **Employment:** 10 youth had full-time employment, six had part-time and five were unemployed
- **Education/Vocational Programs:** three are enrolled, seven have completed

What housing resources are available for youth who have aged out of the child welfare system?

Housing is an important resource for youth who age out of foster care. CFSA provides a variety of resources to housing needs for youth.

- **Rapid Housing Assistance Program (RHAP).** RHAP provides funding to support eligible youth through age 23. To be eligible, youth must be employed or have consistent income that would allow you to live in the housing of their choice. Rapid Housing assistance is also available to youth attending college full time who have at least a 2.0 grade point average. Assistance is also available to youth attending college part-time and residing off campus.

[60] Active participation is defined as contact with the assigned specialist at least twice a month to provide a specific support/service. Barriers usually related to youth not wanting to engage in services until they feel they have an immediate dire need.

Nighty-five percent of youth (n=20) who applied were approved for rapid housing in FY20 compared to 50 percent (n=3) of youth approved in FY19.

- **Family Unification Program (FUP) Vouchers.** FUP was initiated in FY20. With access to specially allocated federal housing vouchers for CFSA families in need of housing assistance, CFSA partners with the DC Housing Authority to administer the FUP vouchers. The FUP operates as a conventional federal voucher program and gives priority to families with children under the age of 8 years and provides long term rental assistance to prevent entry into foster care, to facilitate reunification, and to support emancipating youth. The FUP vouchers also provide semi-permanent housing to youth who are aging out from foster care and are between the ages of 18-24 and classified as homeless. The vouchers do not exceed 36 months. In FY20, one youth applied for and was approved for a FUP.
- **Wayne Place Project.** Wayne Place is an innovative model established through CFSA's partnership with the DBH. The project prevents homelessness by supporting the housing needs of young men and women ages 18-24. Residents receive educational and job support, money management, and other life skills. In FY19, Wayne Place served 56 youth and 30 youth were served in FY20. There are currently 10 vacancies.

Conclusion and Needs to be Considered

CFSA has a process to determine a youth's eligibility for aftercare services during a transition planning meeting called the 21 JumpStart review and a process to begin building the relationship between the specialist and youth if aftercare support is needed prior to the youth aging out of foster care. The Aftercare program does not have a waiting list.