ANNUAL NEEDS ASSESSMENT

A LOOK-BACK AT FISCAL YEAR 2022 ACTIVITIES THAT INFORM PLANNING FOR FISCAL YEAR 2024

District of Columbia Government | Child and Family Services Agency

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I. HISTORICAL PERSPECTIVE

Foster care is intended to provide a temporary stable and caring environment for the child while the parents address the reasons for involvement with the child welfare system.[1] CFSA initially partners with the family to identify relatives who are able and willing to become a kinship caregiver for the child, maintaining family connections in a familiar home environment. Only when relatives are not available does CFSA then seek to identify a non-relative but welcoming family-based foster home. To a much lesser extent, CFSA may place older youth in congregate care facilities.

The Agency continues to partner with the family to establish a permanency goal and documents the goal in each child's case plan. The preferred permanency goal for children is reunification with their family of origin as quickly but as safely as possible. When safe reunification is not possible, CFSA explores adoption or legal guardianship, either through the kinship caregiver or through a safe, loving, and permanent home with a non-relative caregiver. For eligible youth aged 16 years and older, CFSA's director may approve a goal of Another Planned Permanent Living Arrangement (APPLA).[2]

In this year's *Needs Assessment and Resource Development Plan,* CFSA will focus specifically on placement stability. As an agency, CFSA believes that placing children in the most appropriate placement upon entering care promotes placement stability and ultimately enhances timely permanency for children and their families, biological, kin, and foster parents. A stable placement cannot be achieved, however, without an adequate, diversified placement array suited to meet the needs of the children we serve, in conjunction with, the necessary services and supports required for the children, families, placement providers and child welfare professionals the agency interacts with.

This analysis starts by explaining how CFSA has operationalized a definition for placement stability, and an examination of other definitions of placement stability used nationally. It continues with a historical perspective of population changes, racial and economic disparity and other factors that impact the availability of foster care placements in the District of Columbia, as well as an examination of the types of placements and placement supports provided by the Agency over the past 10 years. Following the historical perspective are quantitative and qualitative analyses examining the Agency's current placement array, placement supports, and placement needs. In some instances, there are limitations to the analyses or additional analyses that need to be completed, due to the Agency's plans to complete these analyses in FY 2023. Current and proposed resources to address children's needs are detailed throughout the body of the report and summarized in the conclusion.

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[1] The terms "child" and "children" refer to clients from birth to age 20. The term "youth" is used in context for children ages 14 and older, e.g., youth served by CFSA's Office of Youth Empowerment.

[2] APPLA goals are reserved for youth when all other permanency options are exhausted, and when the youth has an established life-long connection with an adult who is able to assist the youth with developing and enhancing his or her independent living skills. For more information, please refer to CFSA's policy: Establishing the Goal of APPLA, https://cfsa.dc.gov/publication/program-establishing-goal-appla

HOW TO USE THIS DOCUMENT

Each subsection begins with a summary of the need and presents proposed strategies and resources. This is followed by a narrative description and analysis that supports the summary of need.

FOCUS ON PLACEMENT STABILITY

CFSA's primary focus is on the prevention of placement through providing community supports, or when necessary, to the In-Home Administration when there has been a substantiation and the family has a high or intensive risk level for services. When the Agency must separate a child from the home, the safety, behaviors, and needs of the family and of the separated child are necessarily complex enough to warrant the separation. Consequently, meeting those needs is also more complex, particularly in the development of a robust and comprehensive placement array. These complex challenges directly impact placement stability (see Section 3: Placement Stability Through the Lens of Quality Services Reviews).

Both federal and internal case reviews examine placement stability in terms of limited placement changes for the child in foster care. Changes that do occur should be in the best interests of the child and consistent supporting their overall well-being with the goal of the child returning home. Within this context, CFSA defines placement stability as any placement that provides an established, consistent, secure, and nurturing home environment with minimal placement moves. For purposes of this year's *Needs Assessment*, the focus is on placement disruptions, not planned placement moves that further a child's path to returning home. CFSA strives to make a child's first placement be the best placement.

For this year's *Needs Assessment* and *Resource Development Plan* report, CFSA is focusing data analysis on the children served from October 1, 2020 through March 31, 2022.[3] Included in the analysis of placements within this time frame are three cohorts based on a child's length of stay:

- Children in care at least 8 days and up to 12 months
- Children in care 12 months to 23 months
- Children in care 24 months or longer

[3] The historical perspective includes information through FY 2022 Quarter 3

For the first two cohorts, analysts examined the total number of a child's placements since entering foster care. For the third cohort, analysts examined the total number of a child's placements within the last 12 months. For each cohort, the analysts compared **children who experienced two or fewer placements** to the children **who experienced three or more placements**.

CFSA'S PUBLIC PERFORMANCE MEASURES FOR PLACEMENT STABILITY

As part of CFSA's exit from the *LaShawn v. Bowser* lawsuit, CFSA updated the public performance measurement framework for FY 2023. Starting with data representing performance at the end of FY 2023, CFSA will be examining placement stability from two different perspectives:

- **Placement Stability for Children Entering Care:** This measure uses entry cohort methodology and groups children by the year they were separated from their parents. This will also be accompanied by a step-up, step-down analysis that will look at what the second placement was for those children who did experience a placement change-for example did they go from a resource parent home to a kinship home. At this time, the agency is collecting baseline data and no performance targets are set. This measure uses the Chapin Hall Foster Care Data Archive,4 looking at the percentage of youth entering care who did not have a change in placement during the first 0-3 months in care, 4-6 months in care, 7-9 months in care and 10-12 months in care.
- **Placement Stability for Children in Care:** This point in time analysis includes two groups: a) Among children in care as of the first day of the fiscal year, how many had 1, 2 or 3+ placements. This will also be disaggregated by the child's length of stay in care (0-3 months, 4-6 months, 7-9 months, 10-12 months, 13-15 months, 16-18 months, 19-23 months, and 24+ months) and b) Among children who enter care during the fiscal year, the number of children with 1, 2 or 3+ placements broken down by duration of time in care: 0-3 months, 4-6 months, 7-9 months, or 10-12 months. Placement stability is defined as children with two or fewer placements and a qualitative evaluation will be complete for those youth who had placement instability (three or more placements) to provide additional information regarding what led to the placement changes.

[4] https://fcda.chapinhall.org/

In addition to the above parameters for placement stability, CFSA acknowledges the following national definitions of placement stability:

1. Child and Family Services Reviews (CFSR) Statewide Data Indicator[5]

The technical definition for this per the federal register is, "Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?". The **national standard is "4.44**[6] **moves per 1,000 days in care."**[7]

2. Child Welfare Outcomes Report

The federal Administration on Children, Youth and Families publishes the *Child Welfare Outcomes Report*, an annual report to Congress required by the Adoption and Safe Families Act. The most recent report (2018)[8] defines placement stability (Outcome 6) as having had **"two or fewer placement settings in a single foster care episode."** The report has national performance (for 2018) for placement stability for three cohorts:

- For children in care less than 12 months (6.1a), the median performance across all states was **83.5 percent** (i.e., 83.4 percent of children had two or fewer placement settings during their episode)
- For children in care between 12 and 24 months (6.1b), the median performance across all states **65.8 percent**
- For children in care at least 24 months (6.1c), the median performance across all states **41.1 percent**

Note: Each of the above federal cohorts includes planned positive moves as well as placement disruptions.

3. Annie E. Casey

In its Child Welfare Leader's Desk Guide, Annie E. Casey suggests defining placement stability as the **"% of children in care for 2 or more years who had 2 or fewer placements"**. Using AFCARS data from 2012, they report that median national performance for this measure was **31 percent**.

[5] https://www.federalregister.gov/documents/2015/05/13/2015-11515/statewide-data-indicators-and-national-standards-for-child-and-family-services-reviews

[6] The average placement stability for children across 48 states in the U.S based on AFCARS data for FY14; data from AL, CO, NC, and PR were not used due to data quality problems.

[7] 1,000 days equates to 2.8 years.

[8] *Child Welfare Outcomes 2018 Report to Congress (hhs.gov)

CHANGING DEMOGRAPHICS IN THE DISTRICT OF COLUMBIA

HISTORICAL PERSPECTIVE

CFSA recruits, supports, and celebrates resource parents and their vital importance to a child's safety, well-being, and positive permanency. This section provides a retrospective of demographics and supports and services between 2010 and 2020 during the Agency's ongoing progress to reduce the number of children in foster care. Over the 2010-2020 decade, the Agency has carefully differentiated between those situations where a family may require intensive interventions but not separation of a child, and those family circumstances where separation of a child must occur based on imminent risk and safety concerns. As a result, CFSA's current cohort of children has presented with heightened clinical needs when entering foster care. CFSA has therefore intensified its efforts over the past decade to secure a diverse community of qualified and appropriate caregivers who have the skill sets to provide care for a variety of children and youth.

OVERALL POPULATION GROWTH

Between 2010 and 2020, the population of the District of Columbia grew from 601,723 to 689,545. This increase of almost 15 percent[9] nearly doubled the national growth rate of just over 7 percent.[10] All eight of the District's Wards experienced some level of growth, with the highest rates being found in Ward 6 at 42 percent and Ward 5 at 20 percent.[11]

ETHNICITY AND RACE

In 2010, the District's 54,749 Hispanic or Latino residents accounted for 9 percent of the population. By 2020, this population increased to 77,652, and accounted for 11 percent of the District's population.[12]

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[9] All data here is rounded.

[10] United States Census Bureau data available at data.census.gov, last accessed July 2022.

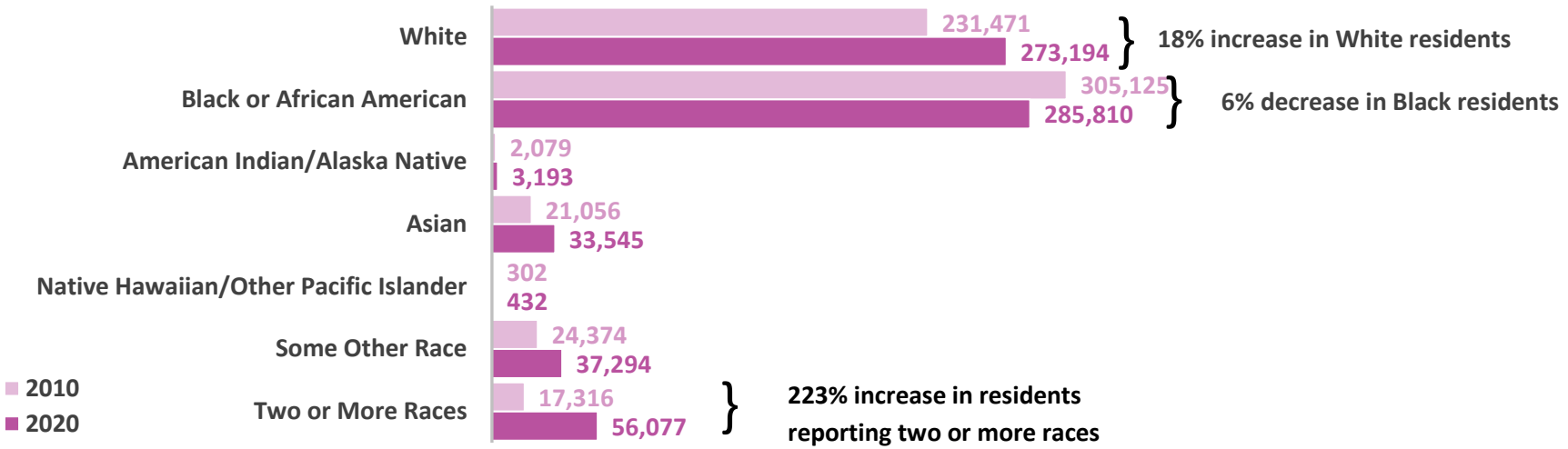
[11] District of Columbia Office of Planning data available at planning.dc.gov, last accessed July 2022. All ward-level data in this report was obtained prior to the DC Council's final approval of Advisory Neighborhood Committee Redistricting Legislation on June 7, 2022. Notable changes to the District's ward structure will include extension of Ward 7 into three neighborhoods west of the Anacostia River (formerly Ward 6); and extension of Ward 8 north of the Anacostia River to include a portion of the Navy Yard District (formerly Ward 6). A map of the District's new ward structure is available at the Office of Planning Demographic Data Hub.

[12] data.census.gov.

The majority of District residents not identifying as Hispanic or Latino continue to be White or Black; however, the District is becoming more diverse. In 2010, Black and White residents accounted for 89 percent of the non-Hispanic population. In 2020, they accounted for 81 percent. While Black residents continue to account for more residents than any other race, they no longer comprise the majority of the District's population. In 2010, Blacks accounted for 51 percent, and in 2020, their numbers dropped to 41 percent. Notably during this period, the proportion of White residents grew from 38 percent to 40 percent, and individuals of two or more races grew from 3 percent to 8 percent.[13]

The District's population of White residents grew by 18 percent between 2010 and 2020, while the population of Black or African American residents decreased by 6 percent. In going from 12,858 to 42,459, the number of individuals of two or more races more than tripled.

Figure 1 Population Changes, by Race 2010 through 2020



Source: data.census.gov

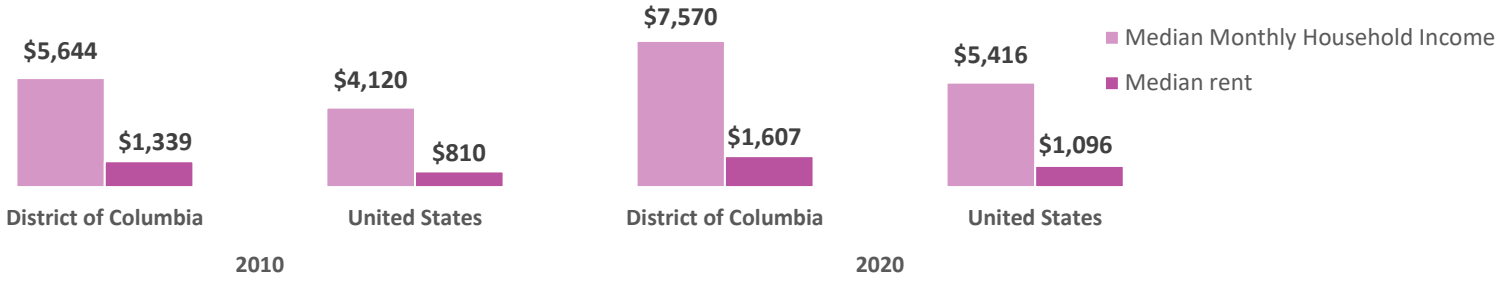
[13] The following graphs represent populations that identify solely as the listed race (with the exception of the category "Two or More Races"). The graphs exclude individuals who identify as both the listed race and as Hispanic.

HOUSING AND INCOME IN THE DISTRICT OF COLUMBIA

In 2020, there were 350,364 total housing units with 37,916 vacancies in the District of Columbia. This 11 percent vacancy rate was just over the 10 percent national average. At the time, the District's home ownership rate was 43 percent, compared to the nationwide rate of 64 percent.[14] The majority of occupied housing units in the District had between one and three bedrooms. One-bedroom homes accounted for 30 percent of housing units while two-or-three-bedroom homes combined to account for 47 percent. Approximately 46 percent of the District's housing units were located in complexes with 10 or more apartments, 17 percent were located in complexes with fewer than 10 apartments, and 37 percent of housing units were single-family dwellings. [15] Not only is majority of the District's housing located in multi-unit complexes, but the average apartment size is getting smaller. From 2010 to 2019, the average size of a newly built rental in an apartment building decreased by almost 90 square feet to 737 square feet, which was the third smallest among large metropolitan areas in the nation.[16]

Housing costs have increased with population growth. Between 2010 and 2020 the median gross monthly rent in the District increased from $1,339 to $1,607 (20 percent). Nationwide, it increased from $810 to $1,096 (35 percent). The median annual household income in the District increased between 2010 and 2020, from $67,731 to $90,842 (34 percent). Nationwide, it increased from $49,445 to $64,994 (31 percent). The District's poverty rate decreased between 2010 and 2020, from 19 percent to 16 percent, and nationwide it decreased from 19 percent to 13 percent.[17]

Figure 2 Monthly Income Compared to Monthly Rent



Source: deptofnumbers.com; fred.stlouisfed.org

[14] data.census.gov

[15] data.census.gov

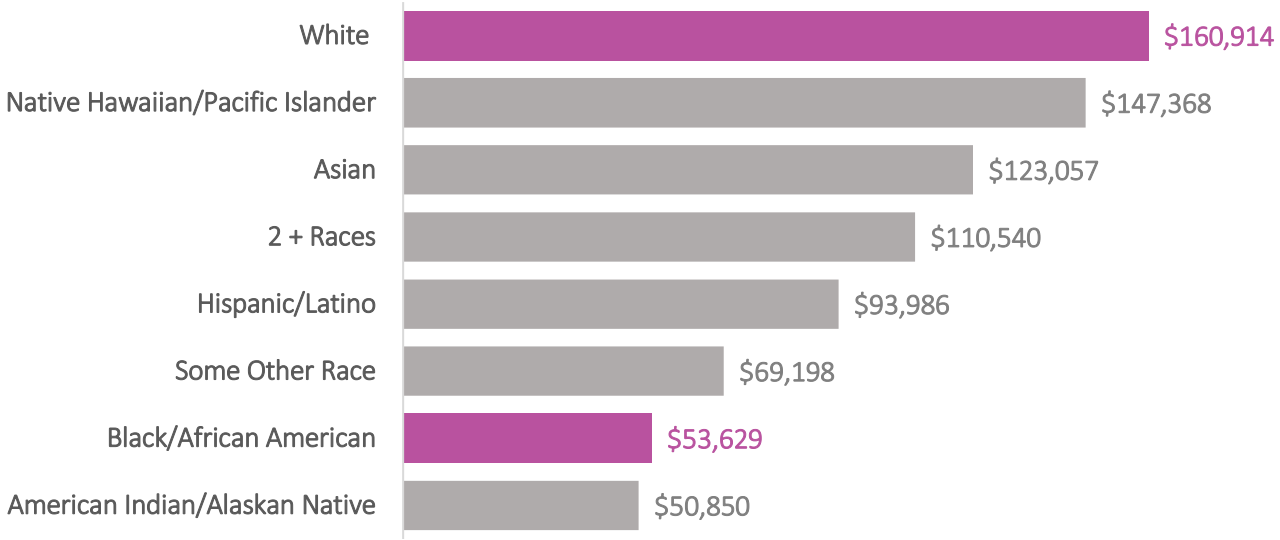
[16] StorageCafe housing data available at storagecafe.com last accessed September 2022.

[17] Washington DC Department of Numbers data available at deptofnumbers.com last accessed July 2022. Fred (national) economic data available at fred.stlouisfed.org last accessed July 2022.

RACIAL AND ECONOMIC DISPARITIES WITHIN THE DISTRICT OF COLUMBIA

While the District of Columbia has, overall, demonstrated encouraging trends in terms of income and poverty, there remains a significant discrepancy in financial well-being based on race and geography. As of March 2022, the average income of White households was $161,221, which is more than twice the $74,728 average for Black households. The median income of White households was $160,914, which is over three times the $53,629 median for Black households.[18]

Figure 3 District of Columbia Median Household Income by Ethnicity and Race



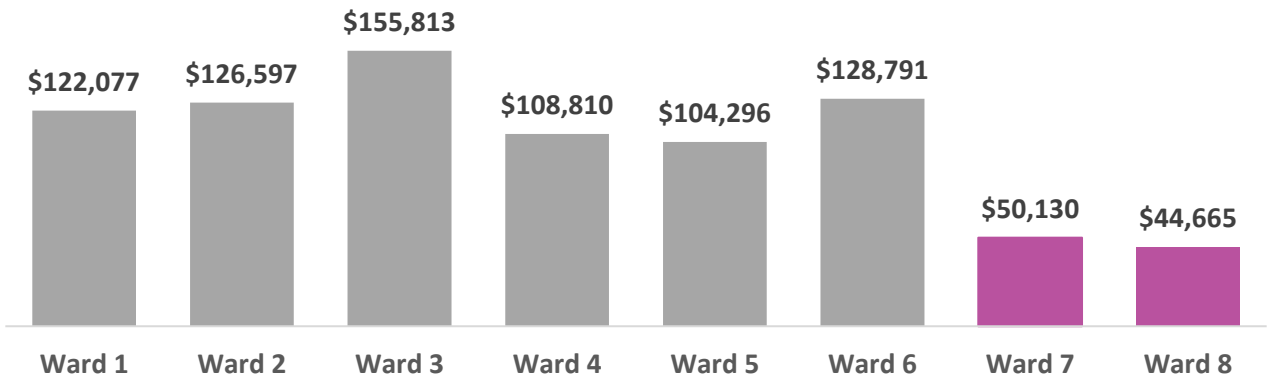
Source: dchealthmatters.org

The District of Columbia's eight geographic regions ("Wards") provide further evidence of racial and economic disparity. Most notably, Ward 7, which is 92 percent Black, has a median household income of $50,130, and Ward 8, which is also 92 percent Black, has a median of $44,665. These figures are significantly below the District median of $102,806. In starkest contrast, Ward 3, which is 81 percent White and 5 percent Black, has a median household income of $155,813. Moreover, 22 percent of Ward 7 families and 23 percent of Ward 8 families are living in poverty, which is double the District's overall rate of 11 percent. The disparities are more extreme when compared to Ward 3's rate of 2 percent. Additionally, 15

[18] DC demographic and economic data available at dchealthmatters.org, last accessed July 2022.

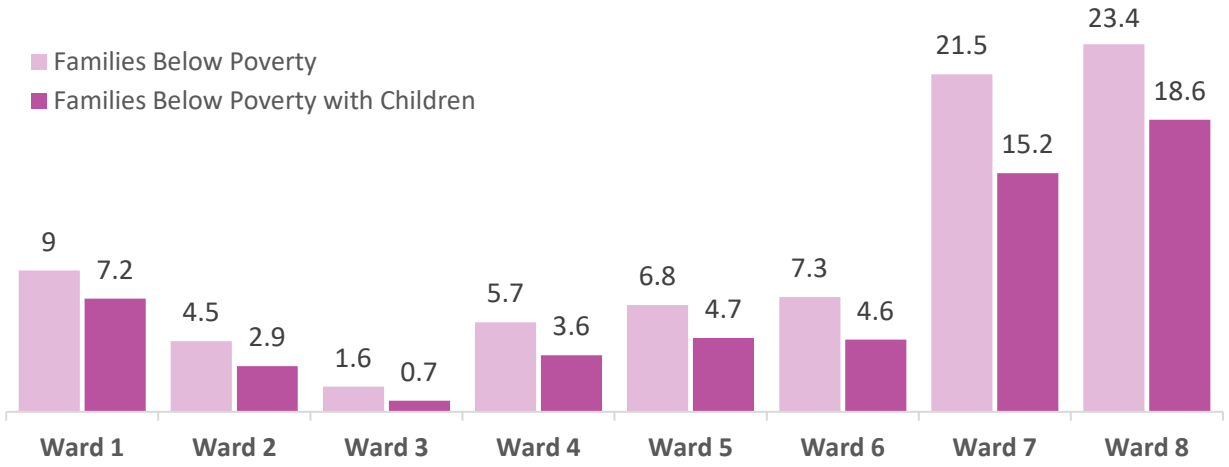
percent of Ward 7 families with children and 19 percent of Ward 8 families with children are living in poverty compared to the District rate of 8 percent and the Ward 3 rate of 1 percent.

Figure 4 District of Columbia Median Household Income by Ward



Source: dchealthmatters.org

Figure 5 Poverty Rates by Ward



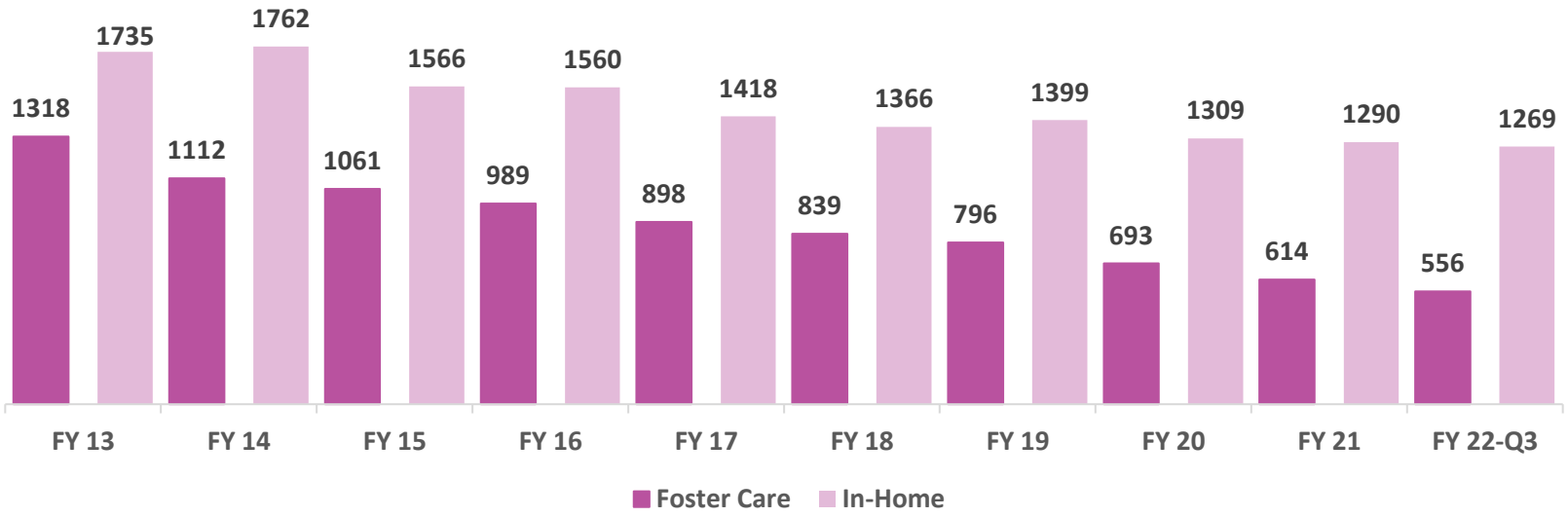
Source: dchealthmatters.org

The Foster Care Population in the District of Columbia

OVERVIEW

The steady and significant decline in the District of Columbia's foster care population has continued during the past 10 years, going from 1,318 at the end of FY 2013 to 556 as of the end of FY 2022-Q3. Additionally, during this time, the District has continued to see a greater share of in-home cases to foster care cases.[19]

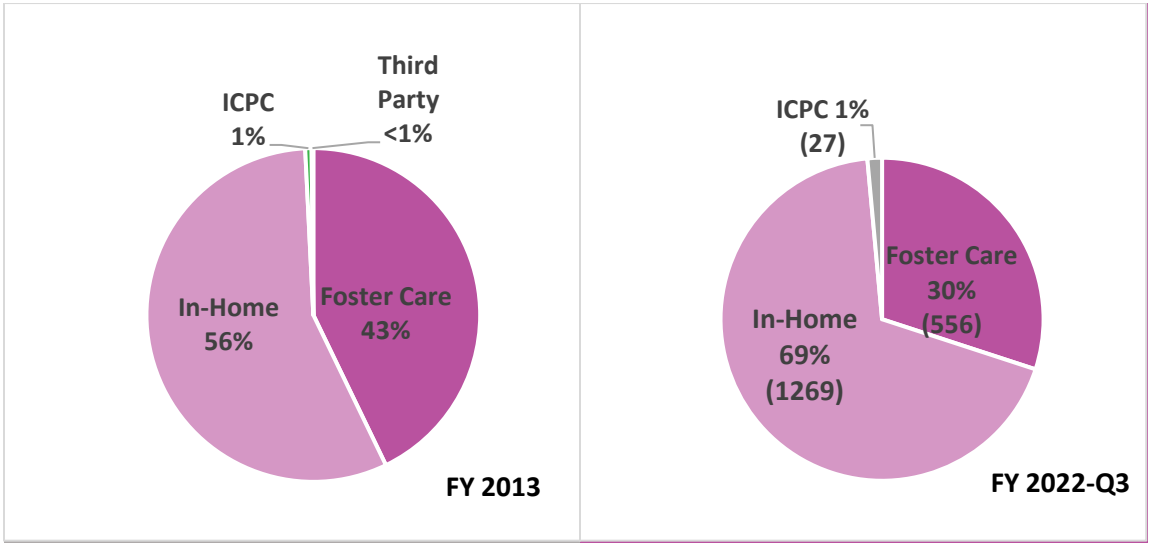
Figure 6 Children Served in Foster Care and In-Home, FY 2013 to FY 2022-Q3



Source: CFSA Management Report CMT 232, pull dates October 15, 2013 to July 15, 2022

[19] The population of children receiving in-home services includes children served both by CFSA and its private agency partners, as well as children remaining in the home while siblings are served in out-of-home placement.

Figure 7 Ratio of Children Served in Foster Care and In-Home, FY 2013 and FY 2022-Q3[20]



Source: CMT 232

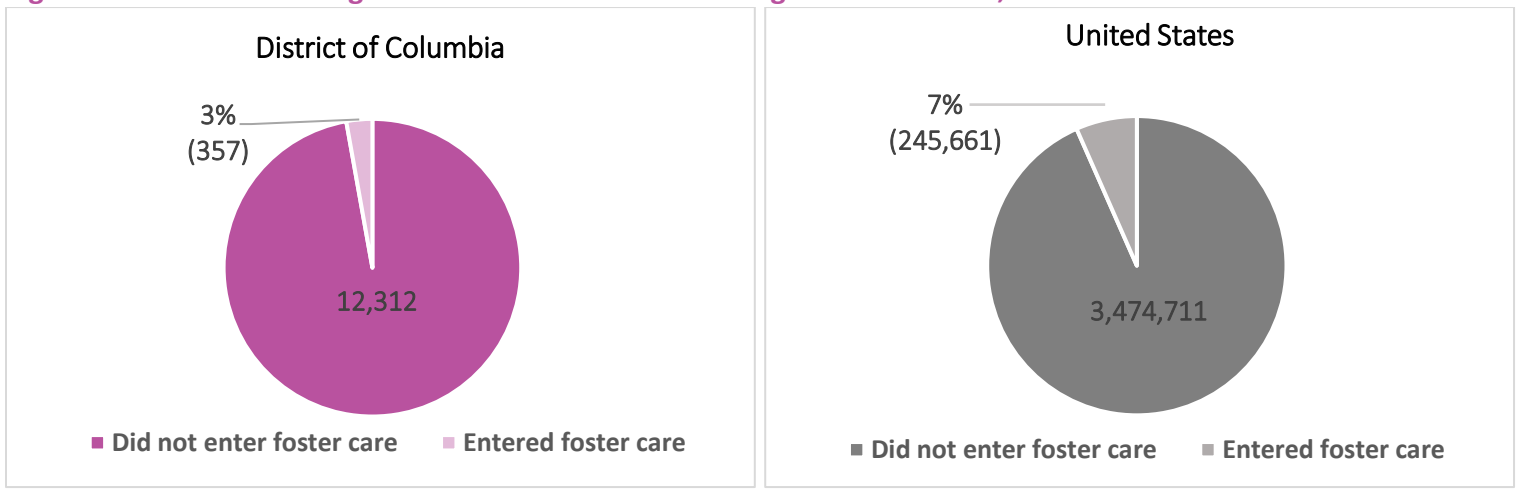
In addition to experiencing a decline in its general foster care population, the District has also seen a decline in the rate of foster care entries, both overall and in relation to national levels. In 2013, the foster care entry rate for children in the District of Columbia was 4 entries for every 1,000 children in the population, while the national rate was 3 entries per 1,000. By 2020, the District's rate had dropped by half to 2 entries per 1,000 children, while the national rate remained at 3 entries per 1,000.[21] Additionally, the District's proportion of investigations that resulted in a foster care case had been comparatively small. In 2019, Child Protective Service investigated 12,312 cases of children in the District. Of those cases investigated, 3 percent (n=357) entered foster care. This entry rate of 29 foster care entries for every 1,000 investigations is well below the national average of 71 entries for every 1,000 investigations.[22]

[20] The Interstate Compact on the Placement of Children (ICPC) is a uniform law that affords children in CFSA custody who are placed out of the District the same agency protections and benefits as those placed within the District. The ICPC allows children placed out-of-state to return to their "home state" in the event that the out-of-state placement proves not to be in their best interest or if the need for out-of-state services ceases.

[21] Kids Count data on District of Columbia and national foster care entry rates available at datacenter.kidscount.org, retrieved August 2022.

[22] Casey Family Programs data available at casey.org, retrieved July 2022.

Figure 8 D.C. Investigation outcomes vs. U.S. Investigation Outcomes, 2019



Source: Casey.org

PREVENTION EFFORTS

As the foster care population continues to decrease relative to the in-home population, the overall number of CFSA-involved families has also substantially decreased. From FY 2013 to FY 2022-Q3, the total number of children involved in an open case of any kind decreased by 40 percent, from 3,053 to 1,817. CFSA's along with community members, community organizations, advocates and other District Government agencies are working to shift from being a child welfare to a child and family well-being system.[23] The ultimate result is for families to receive support within their community without formal intervention from the child welfare agency. As a result, many District families that would have previously experienced child welfare involvement will receive community services prior to coming to the attention of the child welfare system.

CFSA has historically relied on such community-based organizations as the Healthy Families/Thriving Communities Collaboratives to serve families in their neighborhoods and communities of origin. Each of the five Collaboratives serve one or more of the District's eight Wards, as applicable, and

[23] CFSA's most recent approach to an optimal prevention and family preservation framework is based on the nationwide Thriving Families, Safer Children (TFSC) initiative, funded by the U.S. Children's Bureau, Casey Family Programs, and Prevent Child Abuse America. As one of 22 jurisdictions participating in round two of TFSC implementation, the District is emphasizing that while CFSA is the District's cabinet-level child welfare agency, CFSA is not the District's *child welfare system*. In a child and family well-being system, CFSA's involvement is only one option to be exercised after a family's safe and sustainable engagement of community resources has been unable to address the family's intensive or clinical needs.

provide family preservation services to assist with housing, employment, education, mental health, domestic violence, substance use, and public benefits. Additionally, when the Federal government passed the Family First Prevention Services Act of 2018, the District of Columbia was the first jurisdiction in the nation to receive approval for a prevention-focused family strengthening program at the local level. Launched in 2019, Families First DC included the funding of 10 Family Success Centers located in neighborhoods where families experience disproportionate levels of child welfare involvement. In FY 2022, an 11th Family Success Center opened in Ward 5, a Ward experiencing similar social and economic trends as those in Wards 7 and 8. Through a place-based approach, the Family Success Centers facilitate access to government and community resources tailored to meet families' needs, to mitigate the effects of trauma, and to increase protective factors for sustainable independence from welfare involvement.

DEMOGRAPHIC TRENDS

Although prevention and family preservation efforts have played a major role in reducing the foster care population, the District's changing racial landscape must also be acknowledged. As noted earlier, the population of White residents grew by 16 percent between 2010 and 2020, while the population of Black or African American residents decreased by 5 percent. As of the end of the third quarter of FY 2022, **Black or African American children accounted for 78 percent of the foster care population and White children accounted for approximately one percent**.[24] Whether persistent disproportionality is based on discriminatory reporting habits, income inequalities, community level disparities, or other forms of racism, the District's systemic inequities continue to manifest in its child welfare population. As a child welfare agency, CFSA does not have full control over the underlying causes of disproportionality. Notwithstanding, the Agency has initiated grassroots efforts to mitigate the impact of child welfare involvement on the disproportionate population served. These efforts include the Agency's recent establishment of the Development and Equity Administration, which focuses on infusing diversity, equity, belonging and inclusiveness at CFSA and through the *Thriving Families, Safer Children* efforts.[25] Mandated reporter trainings include individuals across the District, e.g., educators, health professionals, and others. The Agency's efforts will be ongoing for the addition of diversity, equity, inclusion, and belonging (DEIB) priorities in trainings, as well as DEIB considerations in all aspects of services, supports and best practice standards. In addition, the Agency has advocated for legislative changes, particularly a tiered response for the expungement of an individual's name in the Child Protective Register as a lifelong barrier to certain employment opportunities.

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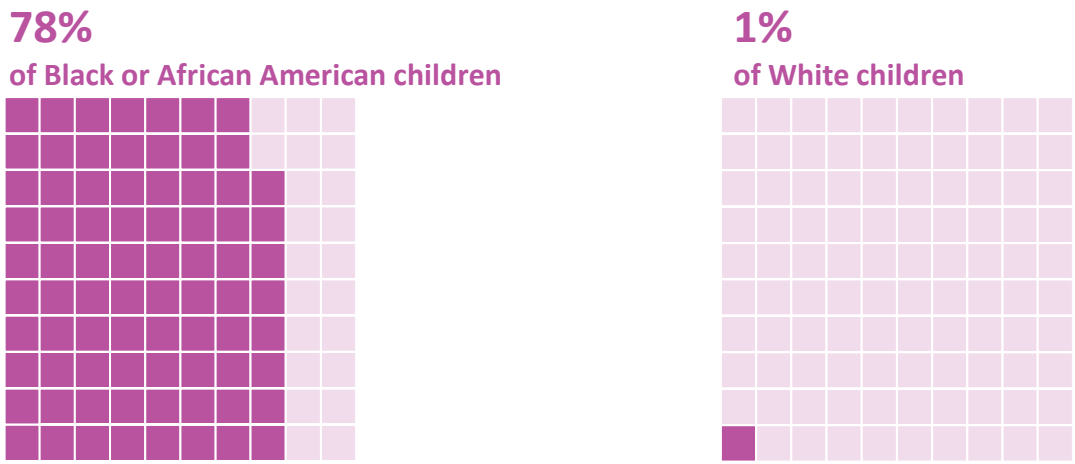
[24] CFSA population data available on the CFSA Public Dashboard last accessed September 2022. Hispanic children accounted for 16 percent of the foster care population and there was no race data recorded for the remaining 5 percent.

[25] *Thriving Families, Safer Children* is a new initiative promoted by the federal Administration for Children and Families, the Annie E. Casey Foundation, and Casey Families' Programs, and Prevent Child Abuse America. For CFSA, *Thriving Families, Safer Children* is a philosophical and practical shift from a child welfare system to a child well-being system, which emphasizes the meaningful inclusion of all community partners and people with lived experience in the co-design.

Figure 9 Race comparison of the foster care population, FY 2022-Q3



Source: CFSA Public Dashboard as of September 2022

ECONOMIC TRENDS

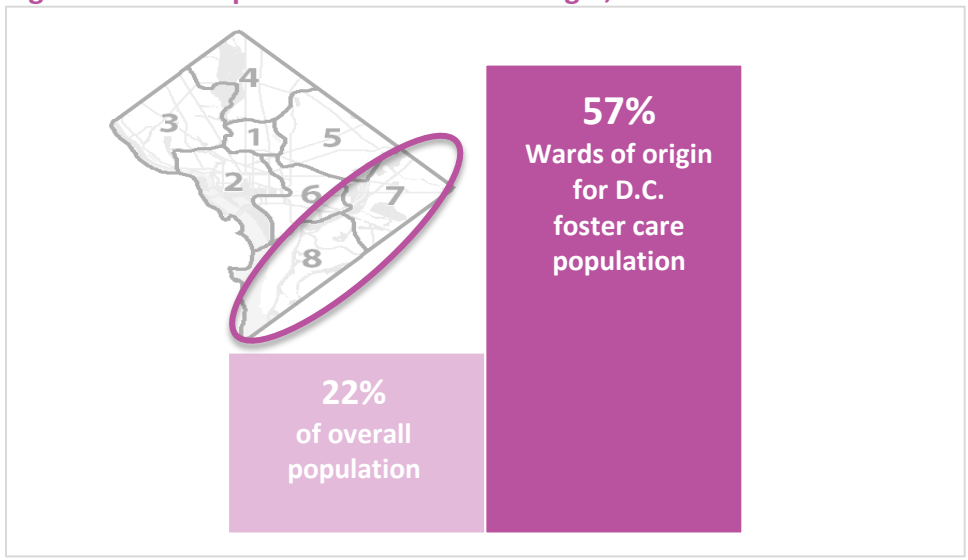
As noted earlier, the median household income increased by 34 percent between 2010 and 2020 while the poverty rate decreased from 19 percent to 13 percent. Although such overall positive trends suggest a decrease in some of the systemic factors that can result in child welfare involvement, the District's overall progress obscures the economic disparity that persists among its various Wards. Disparity in income provides another systemic basis for disproportionality in the District's child welfare system, whether that disparity is poverty impacting adverse childhood experiences, exposing a family to aggravating circumstances in the community, reducing a parent's protective capacity, or limiting a parent's ability to conceal the evidence of child neglect or maltreatment.

Research shows that children living in poverty are significantly more likely to be reported to the child welfare system and are overrepresented in foster care.[26] As noted earlier, Wards 7 and 8 include families with significantly lower incomes, higher poverty rates, and higher child poverty rates than the District average. In March 2022, Wards 7 and 8 combined to account for 22 percent of the District's overall population but were the Wards of origin for 57 percent of the District's foster care population. Ward 5 was also disproportionately represented, accounting for 13 percent of the

[26] Rostad WL, Ports KA, Tang S, Klevens J., Reducing the Number of Children Entering Foster Care: Effects of State Earned Income Tax Credits. Child Maltreat. 2020. Link

District's population and 19 percent of the foster care population. While the median annual household income for Ward 5 ($104, 296) is above the District's overall median household income ($102,806), there are significant discrepancies within Ward 5. In 2018, the median household income by neighborhood ranged from approximately $21,150 to $127,336 and as of March 2022, the median income of White residents of Ward 5 ($179,284) was over two and a half times the median income of Black residents ($69,873).[27]

Figure 10 Population and Ward of Origin, March 2022



Source: CFSA Public Dashboard

[27] Ward 5 neighborhood information part of the report Mapping Gentrification in Washington D.C., available at storymaps.arcgis.com; Ward 5 income data, by race, available at dchealthmatters.org.

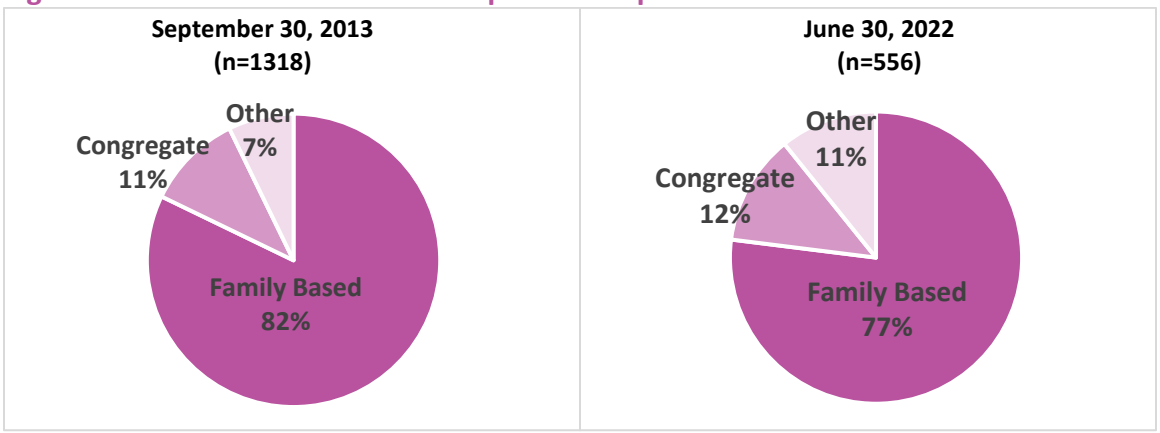
THE FOSTER CARE PLACEMENT ARRAY

PLACEMENT SETTINGS

For every month in calendar year 2021, CFSA consistently maintained a surplus of 23 to 35 percent of licensed non-kin foster and congregate care beds (see Appendix A for the number of homes and facilities, beds and total children placed in each setting), relative to the needs of the District's foster care population. In addition to the placement surplus, CFSA and its contracted partners continued to revise and re-establish the diversity of the placement array to reflect the changing and unique circumstances, characteristics, behaviors, and needs of the children in care. Within that diversity, CFSA continues to prioritize the least restrictive environment possible as the most appropriate placement for the majority of children.

Between FY 2013 and FY 2022, the portion of CFSA placements that are in family-based homes (e.g., kinship and foster care) declined from 82 percent to 77 percent. During this time, congregate care placements (e.g., group homes and residential treatment facilities) increased slightly from 11 percent to 12 percent, and "Other" placement categories (e.g., hospitalizations, incarceration, and abscondence) increased from 7 percent to 10 percent. Despite the slight proportional changes, the number of children in foster care has significantly declined across all placement categories.[28]

Figure 11 CFSA Out-of-Home Population September 2013 vs June 2022



Source: CMT 232

[28] Unless otherwise indicated, all graphs represent children committed to the District of Columbia's foster care system, regardless of the geographic location of their placement. For example, many children and homes included in these counts are located in Maryland and are receiving case management support through CFSA's contracted partner, the National Center for Children and Families.

KINSHIP CARE

Placement with relatives has remained the Agency's preferred strategy for promoting stability, well-being, and positive permanency for children who are separated from their family. To ensure children can be placed with relatives amid the urgent circumstances that typically accompany separation, CFSA employs dedicated units of diligent search investigators, family team meeting facilitators, and kinship licensing social workers and support workers to locate, identify and vet suitable relatives. These teams work alongside social workers from the CPS and Clinical Case Management and Support Administrations during the process of locating kin immediately upon a child's entry into care.

Through a border agreement with the state of Maryland, CFSA may also provide temporary emergency licensure to kinship providers living in Maryland. The screening process includes criminal and child protective registry background checks of all household members and a clinical home assessment in accordance with District of Columbia and Maryland regulations.

TRADITIONAL FAMILY-BASED FOSTER CARE

When kinship placement is not viable, CFSA and its partners next seek to place children and youth in traditional, family-based foster care homes. CFSA and its partner agencies' foster parents are licensed, trained, and supported in accordance with the jurisdiction's regulations, national standards, and best practices.

Historically, CFSA has provided direct case management service to children in foster care while assigning a portion of its cases to family-based foster care providers. In early 2018, CFSA launched the *Temporary Safe Haven Redesign* and transitioned from seven contracted family-based foster care providers to a system where CFSA serves as the primary traditional foster care agency for children placed in the District. CFSA contracts out for Spanish-speaking families in the District (Latin American Youth Center) as well as contracting out for unaccompanied minors (Lutheran Social Services). For traditional foster homes in Maryland CFSA contracts with the National Center for Children and Families (NCCF). NCCF serves as the primary case management service provider for children placed in Maryland.

SPECIALIZED FAMILY-BASED FOSTER CARE

While some of the programs have changed over the past 10 years, the District continues to contract with various subsets of resource parents to provide specialized care for children and youth with urgent needs, developmental delays, intellectual disabilities, behavioral challenges, and

medical conditions, as well as those who identify across the LGBTQIA+ spectrum, speak Spanish as their first language, or arrived in the region as unaccompanied refugee minors.[29]

- ***Short-term Placement*** – Prior to the development of emergency kinship licensing protocols in 2015, CFSA had placed children, when necessary, in interval resource homes for stays of 3 to 72 hours. These short-term placements allowed sufficient time for CFSA to complete federally and locally required background checks of kinship providers. Until FY 2018, CFSA's Stability and Respite (STAR) program provided short-term foster care placement in a family setting.
    - In 2019, CFSA established the placement option of SOAR homes (Stabilization, Observation, Assessment, and Respite) with professional resource parents specifically trained in trauma-informed caregiving (described below). SOAR homes provide temporary care for up to 90 days. These homes are particularly appropriate for children who need an array of comprehensive assessments prior to the Agency being able to appropriately identify the best placement match for the children's exact needs. As of June 30, 2022, there were two SOAR resource parents providing a total of four beds. Three children were residing in a SOAR home.
- ***Intensive foster care –*** In 2019, CFSA contracted with the Maryland-based private agency, Children's Choice, to provide 36 beds as part of an intensive family-based foster care program. The homes have since served children of all ages in need of a family-based setting but experiencing (or likely to experience) placement instability. Either risk or history of placement instability may have been based on such factors as a history of physical or verbal aggression, step-down from a diagnostic or psychiatric residential treatment facility, or current mental health diagnoses. Children's Choice did not renew their contract at the end of 2021. In July 2022, the Agency awarded a contract to PSI Family Services who won the solicitation, for 40 beds. PSI is scheduled to accept placements in September 2022.
- ***Pregnant and Parenting Youth (PPY) Foster Parents –*** CFSA has always prioritized placement of its PPY population with relatives first, then in traditional foster homes, and lastly, in an independent living program. In 2018, the Agency developed a program of professional resource parents who contract directly with CFSA and subsequently receive special training to care for pregnant and parenting youth. As of June 30, 2022, the PPY program included two resource parents and four beds, all of which are occupied by two parenting teens and their children.
- ***Professional Resource Parents –*** In 2021, CFSA expanded its placement array to include trauma-informed professional parents (TIPPs), who, like PPY and SOAR foster parents, are compensated to provide specialized foster care. Based on the unique needs of children with adverse childhood and traumatic experiences, CFSA requires that no TIPP works more than 20 hours per week outside of the home, allowing for

[29] The family-based array also includes the category "pre-adoptive" placements in which substitute caregivers have either filed an adoption petition or have submitted a letter of intent to adopt. This category can include traditional or specialized foster parents, as well as kinship providers who have received foster care licensure, are no longer working with the Agency's Kinship Unit, and are caring for a child with the goal of adoption.

dedicated time to the care of the children and youth in these homes. TIPPs care for children ages eight and up, who have experienced significant trauma and have presented specific mental or behavioral health concerns that have impeded success in a traditional foster care setting. As of June 30, 2022, there were four TIPPs providing a total of eight beds. At this time, CFSA is interviewing and planning to contract for five additional TIPPs with a total capacity of 10 additional beds. In addition to a TIPP home currently located in Maryland, NCCF operates another professional parent program. NCCF selects its own professional foster parents (PFPs) based on the PFP's demonstration of exceptional commitment to supporting children and youth with the most severe behaviors. PFPs provide emergency placement, assessment, advocacy, and support toward positive permanency. As of August 2022, there are five PFP homes providing a total of 12 beds.

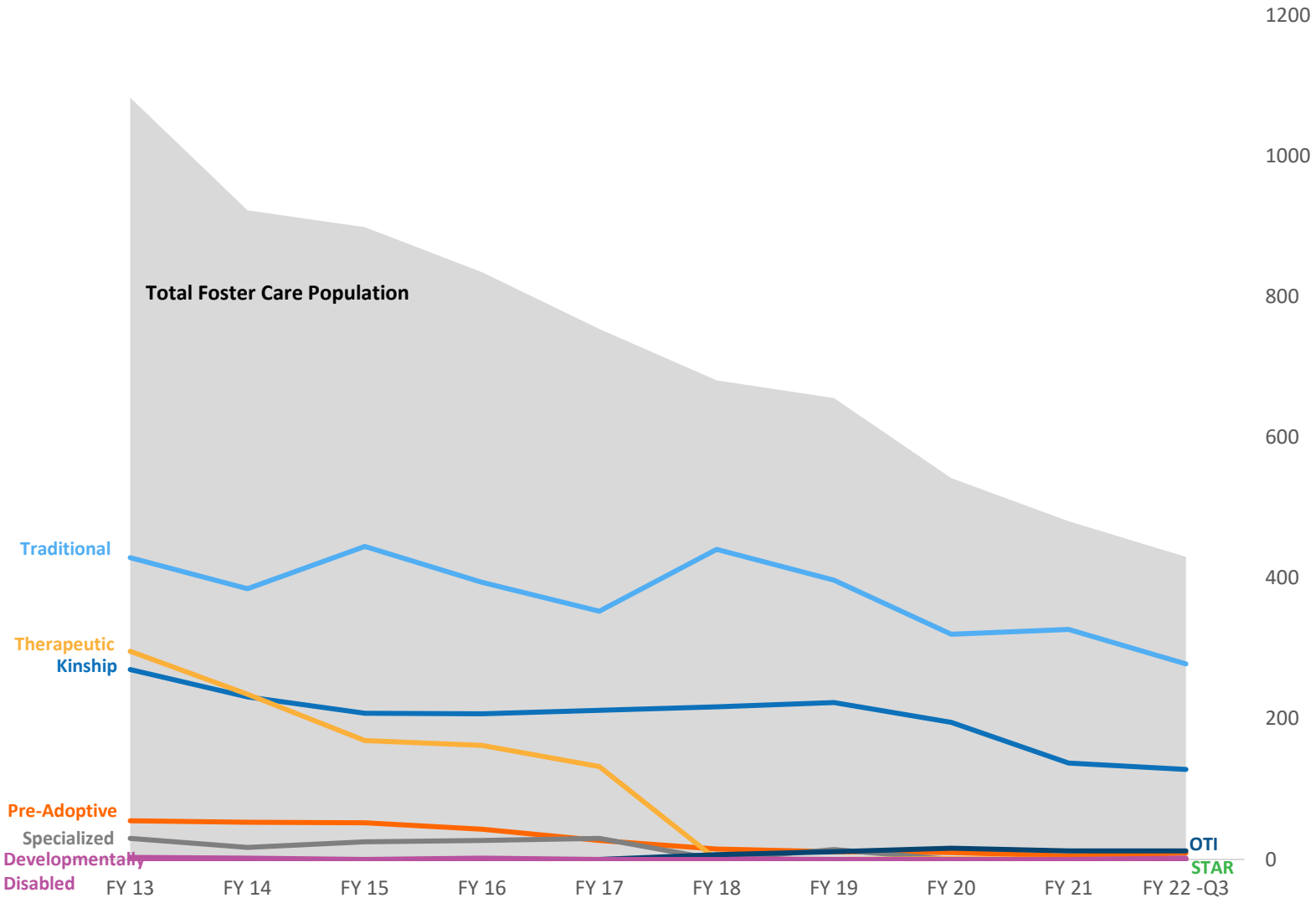
- ***Specialized Opportunities for Youth (SOY) –*** In 2017, CFSA developed the SOY program to match specially trained CFSA foster parents with youth who have had challenges in a traditional family-based setting due to behavioral or mental health needs. Aged 13 to 20, SOY youth require parents who are skilled in working with teens and young adults and can support them in learning required independent living skills. As of June 30, 2022, there were eight SOY homes with 19 beds, providing placement for 13 youth.
- ***LGBTQIA+*** – Over the past 10 years, CFSA has continued to ensure that the placement array reflects the community. Compared to each of the 50 states, the District maintains the highest percentage of individuals that identify as LGBTQIA+.[30] In addition to targeted recruitment efforts, described later, the Agency periodically surveys its resource parent pool to identify LGBTQIA+ friendly homes, offering training on understanding and working with LGBTQIA+ youth. In March 2022, 43 percent of CFSA's resource parents identified as LGBTQIA+ or LGBTQIA+-friendly based on an internal resource parent demographic report.
- ***Hispanic Children and Youth –*** Over the past 5 years, Hispanic children have accounted for 15 to 17 percent of the District's foster care population. Currently, 28 percent of this group speaks Spanish as a primary language. CFSA recognizes the importance of placing these children with families who share their language and cultural identity. The Latin American Youth Center (LAYC) elected to end its contract for 10 Spanish-speaking foster homes on September 30, 2022. Of the six children placed in LAYC homes, two will achieve permanency prior to the contract end date, and the other four will remain in their current foster homes. CFSA plans to replace the LAYC contract with another provider who can provide case management services as well as licensed homes in which the parents are Spanish speaking; this contract will be competitively bid through OCP process.
- ***Unaccompanied Refugee Minors*** – Lutheran Social Services of the National Capital Area (LSSNCA) provides foster homes in the District and in Maryland for youth who fled war and persecution and arrived in the United States without parents or guardians. LSSNCA specially trains its

[30] Gallup Daily tracking data for 2013 available in gallup.com and Williams Institute, UCLA tracking data available at williamsinstitute.law.ucla.edu last accessed July 2022.

resource parents to care for this population and provides youth with case management and supportive services. As of May 31, 2022, there were 16 LSSNCA resource homes providing a total of 26 beds. In 2021, there were 18 youth placed through the program.

As part of the *Temporary Safe Haven Redesign*, CFSA discontinued the targeted recruitment of family-based therapeutic foster care providers. Instead, the Agency enhanced the training and support models for traditional foster parents. As a result, the Agency has an array of traditional foster parents who are equipped to provide intensive and thoughtful care for children with behavioral needs whose behaviors do not rise to a level that requires a specialized environment. In cases where a child is experiencing severe developmental, medical, or behavioral challenges, and the resource parent requires additional support, the assigned social worker can apply for a Determination of Intensive Needs and Supports (DINS) on behalf of the child. If approved, the resource parent will receive a higher daily foster care payment. By 2019, the Agency began placing children with particularly challenging behavioral needs in intensive foster care homes. Due to the reclassification, traditional foster homes, although decreasing from 429 to 278 between FY 2013 and FY 2022-Q3, went from 40 percent of the overall family-based population to 65 percent during the same period. The proportional increase in kinship placements from 25 percent to 30 percent of all children placed in family-based settings during this period is likely attributable to an abundance of new kinship support initiatives (described later); moreover, this growth rate is kept in check by the fact that exits to positive permanency from kinship homes regularly outpace exits from other types of foster care.

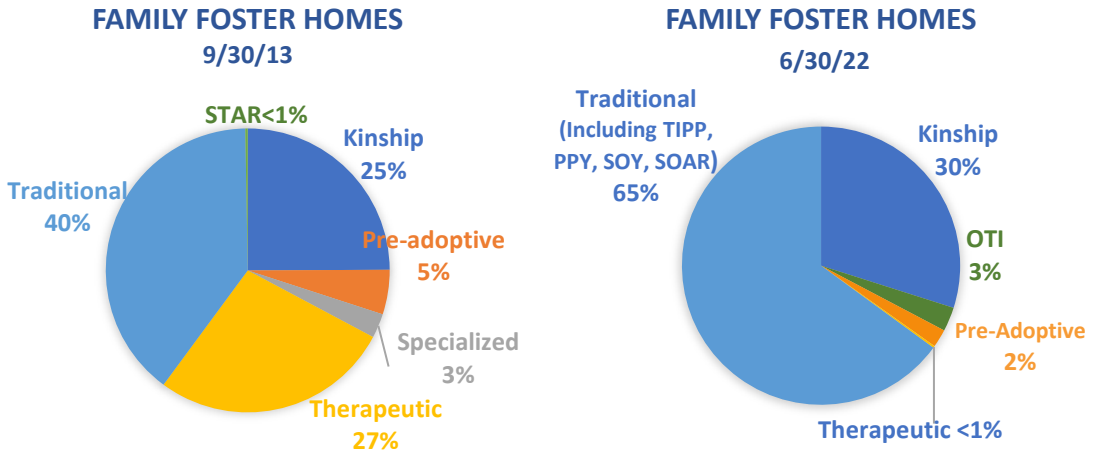
Figure 12 Family-Based Foster Care Population, by Placement Type[31]



Source: CMT 232

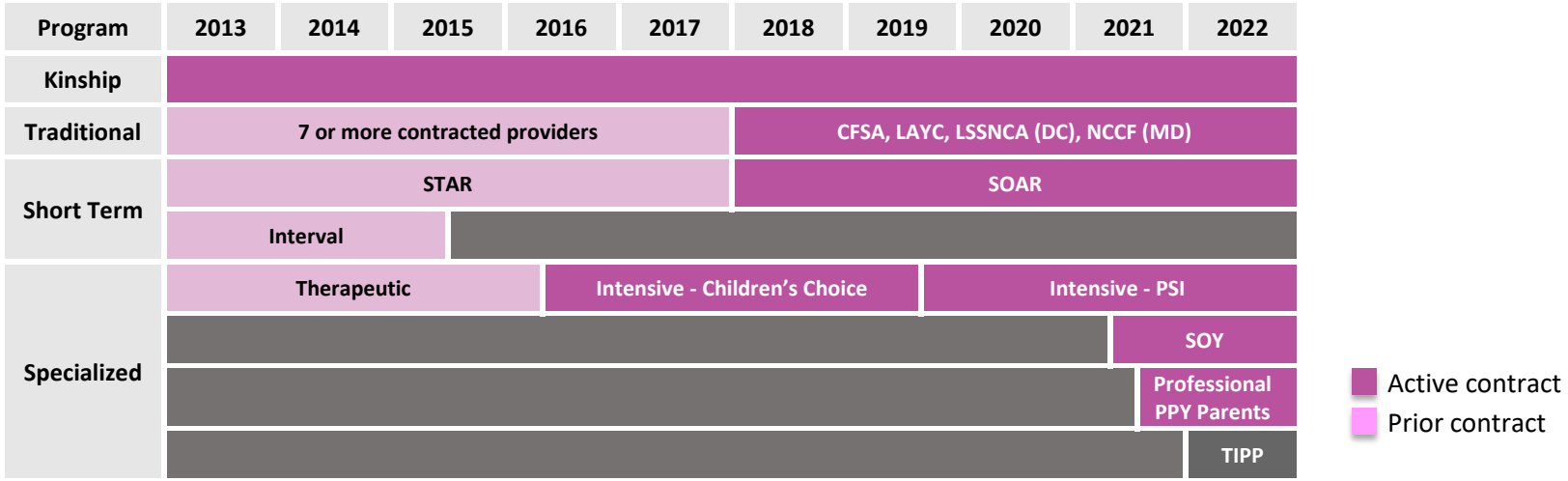
[31] In figure 12, OTI stands for out-of-town inquiry. The OTI is a request by another state to place a child in the District of Columbia, per the Interstate Compact on the Placement of Children (ICPC). The request may be to place the child with a parent, relative, guardian, or foster home. See footnote 20 for more information on ICPC.

Figure 13 Family Foster Homes 2013 vs 2022



Source: CMT 232

Figure 14 Family-Based Foster Care Program Timeline



Source: CFSA Annual Progress and Services Reports FY 2014 – FY 2023; Manually tracked data from CFSA's Contracts Monitoring Division

Congregate Care

CFSA considers placement in a congregate care setting under three general circumstances: (1) when a youth's medical or behavioral needs prevent placement in a family-based environment, (2) when a youth frequently disrupts from family foster care placements, or (3) when other individual characteristics suggest that a youth will achieve more stability and success in a group setting. Staffed 24 hours a day, seven days a week, congregate care facilities include staff members who monitor, advise, and support residents. Staff also provide transportation and facilitate group meetings and activities. As of June 30, 2022, CFSA had placed 12 percent (n=68) of the District's total out-of-home youth in the following congregate care environments.

- ***Emergency Placement*** – Emergency placements are designed to last for a period of 30 days or less, during which time the social worker will assess the child; determine the needs of the child, family, and caregiver; and decide on the appropriateness of continued out-of-home placement. Historically, CFSA has provided emergency placements for children at risk of imminent danger or abandonment, prior to the completion of a full caregiver assessment and home evaluation. CFSA's resource for emergency placements since FY 2016 has been Sasha Bruce Youthwork (SBY), a community organization described in the Congregate Care section for older youth. SBY accepts youth ages 12 – 17 for emergency placements.
- ***Short-term Placement*** In July 2022, the Agency solicited bids for a Bridge program which would provide eight beds for youth between the ages of 12 and 17. The Agency has not yet identified the new program vendor but will require the program to support youth who are in immediate danger or at risk of safety, as well as youth with varying degrees of emotional and behavioral problems caused by the traumatic circumstances of abuse and neglect, recent separation from the home, multiple placements, or other traumatic experiences. Intended as an alternative to overnight Agency stays or placement in a youth shelter, the program will normally provide placement for up to 30 days, which may be increased to 60 days for those with complex needs who require additional assessments over time. CFSA anticipates the new Bridge program's contract award to be signed by January 2023.
- ***Care for Survivors of (or those at risk for) Sex Exploitation and Trafficking*** - CFSA may refer females to Youth for Tomorrow (YFT) when there is suspicion or evidence of sexual exploitation and trafficking. YFT accepts females ages 12 to 19. The program offers specialized therapeutic and recovery services in a safe and secure residential setting. In addition, CFSA works with Courtney's House, a community-based drop-in center that provides trafficking survivors with a safe housing environment, support groups, workshops, and other therapeutic activities.
- ***Traditional Congregate Care*** – Over the past 10 years, CFSA has continued to contract with traditional congregate care providers to provide beds for youth, aged 13 to 21, in various Wards of the District. For older youth who may likely exit the child welfare system at age 21, congregate care programs provide planning for and support to the youth's transition to self-sustaining adulthood. These programs are

designed to provide youth with a set of viable life skills before their exit from foster care. CFSA currently relies on the following four contracted congregate care programs: (1) God's Anointed Now Generation (GANG) provides 12 beds for male youth in Wards 4 and 5; Boys Town of Washington provides 24 beds in two houses in Ward 5, one house for males and one house for females; [32] Maximum Quest (Caitlin's Place) provides six beds in Ward 4 for female youth; and Umbrella provides six beds in Ward 7 for males.

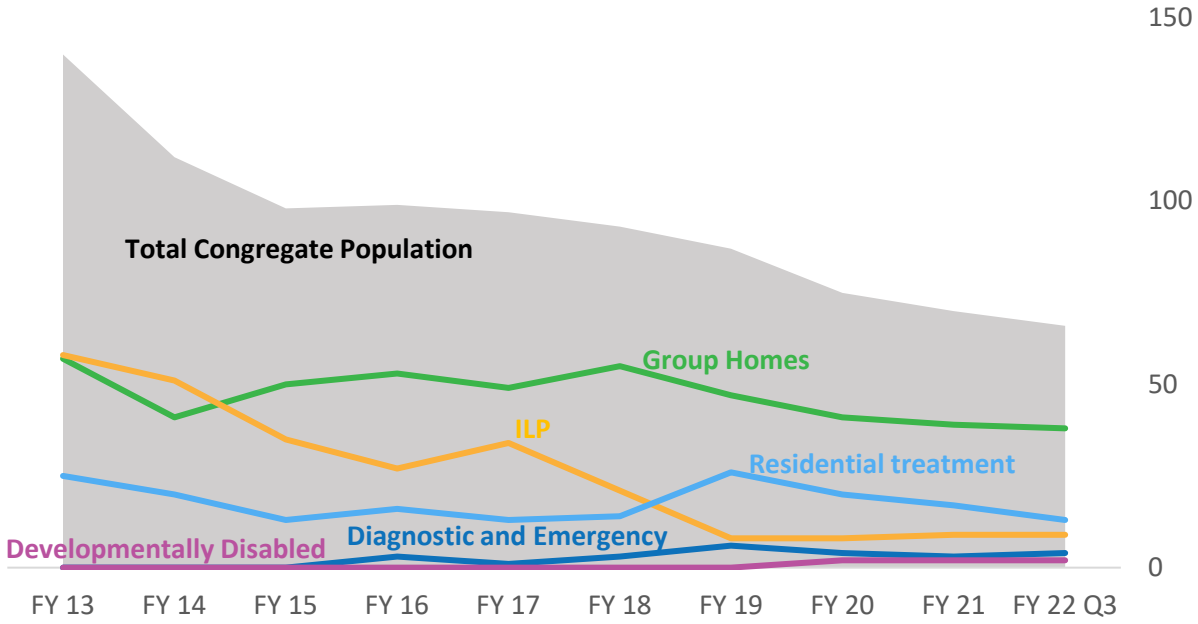
- ***Therapeutic Congregate Care*** – CFSA continues to contract with therapeutic groups homes for youth with behaviors that call for specially trained staff and specialized programing in a congregate setting. Most recently, CFSA had placed males and females in two homes in Baltimore through the behavioral health provider, the Children's Guild, which had a capacity of six beds. However, the Children's Guild closed its facilities in December 2021. At present, CFSA is contracting with Youth for Tomorrow (YFT), which can accommodate two females in its facility in Virginia. Since the Children's Guild closure, CFSA has been working with OCP to solicit a new provider that can provide eight beds for males and females (ages 13 to 21). The Agency expects to award a contract in November 2022, and for the program to be operational in the first quarter of FY 2023.
- ***Group Homes for Youth diagnosed as Intellectually Disabled and Developmentally Delayed (ID/DD)*** –Through a contract with a local therapeutic network, Innovative Life Solutions, CFSA has procured five group home beds for males who are diagnosed as intellectually disabled or developmentally delayed. In addition, CFSA has contracted with Community Services for Autistic Adults and Children (CSAAC) for group home placement of male and female youth who are diagnosed on the autism spectrum and require 24-hour care and support.
- ***Residential Treatment Facility (RTF)*** – When a youth's diagnoses and high-risk behaviors warrant sustained monitoring and treatment from behavioral health professionals, CFSA has traditionally relied upon RTFs located as near as possible to the District whenever possible.[33] In 2021, CFSA contracted with Catholic Charities to provide up to four slots for children ages 8-12 for treatment in the St. Vincent's Villa Residential Treatment Center in Baltimore, Maryland. Services include a full scope of treatment interventions to support youth who are experiencing emotional and behavioral problems and cannot be served in a less restrictive setting. Youth who enter this program have a history of severe trauma, abuse and neglect, and disrupted attachments. CFSA is currently partnering with other District agencies to develop a PRTF with a 30-bed capacity located within 50 miles of the District.[34] CFSA's partners in this endeavor include the Department of

[32] Due to recent changes to Boys Town's program model, CFSA will not be renewing the placement contract, which will end on September 30, 2022. CFSA is currently soliciting bids for a new provider and has developed transition plans for all youth currently placed in the Boys Town facilities.
[33] The District's Department of Behavioral Health provides CFSA with a list of DBH-contracted Medicaid-approved PRTFs that CFSA may explore for placement, based on the youth's eligibility and the PTRF's admission criteria. When a non-Medicaid reimbursable PTRF admits a youth, CFSA funds pay for the youth's care.
[34] St. Vincent's location is approximately 56 miles away from CFSA headquarters.

Behavioral Health (DBH), the Department of Youth Rehabilitative Services (DYRS), and the Office of the State Superintendent of Education (OSSE). The proposed 30-bed facility will be available to youth served by any of the partnering agencies: CFSA, DBH, DYRS, and OSSE.

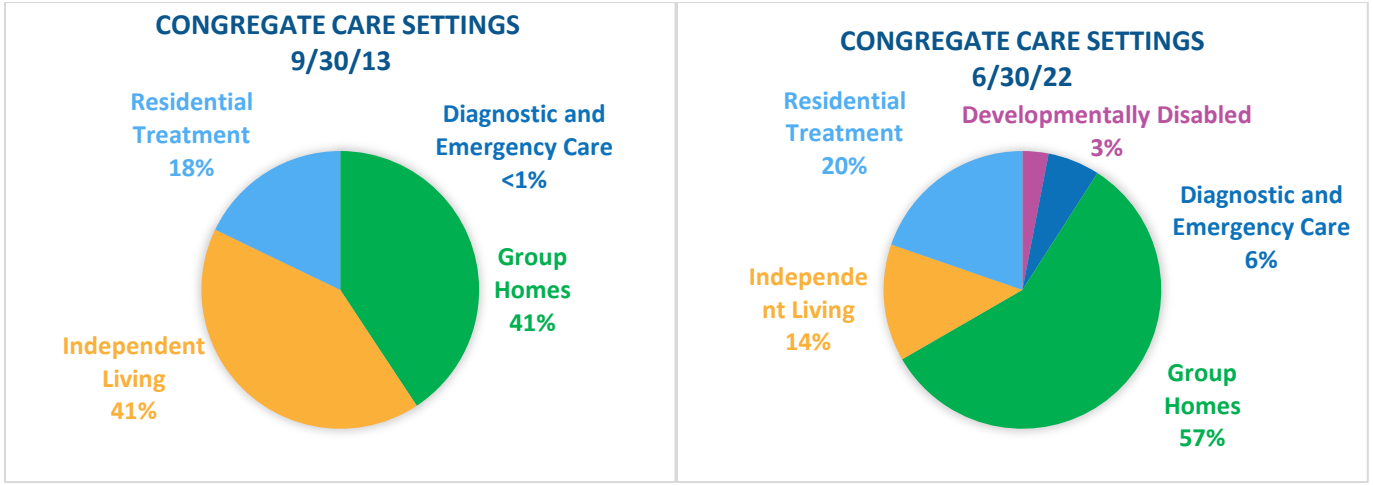
- ***Pregnant and Parenting Youth (PPY)*** – While CFSA places many pregnant and parenting youth with relatives or professional foster parents (described above), some teen mothers and their children are more suited to independent living programs (ILP). The PPY ILPs offer individual apartments, as well as staff to provide supervision and parent education, transportation, and childcare. Due to the declining population of teen parents in foster care, CFSA discontinued a contract with one of its two providers in 2016. The Agency now only places PPY in the one contracted program, The Mary Elizabeth House, which is located in Ward 7 and has capacity for 12 parenting youth and their children.
- When looking across congregate care placements, independent living programs represented 41 percent of all congregate care placements in FY 2013 and 13 percent in FY 2022-Q3. Although the number of youth with traditional group home placements decreased overall from 57 to 38 youth, the proportion rose from 41 percent to 56 percent of all children placed in congregate care settings.

Figure 15 Congregate Care Population, by Placement Type



Source: CMT 232

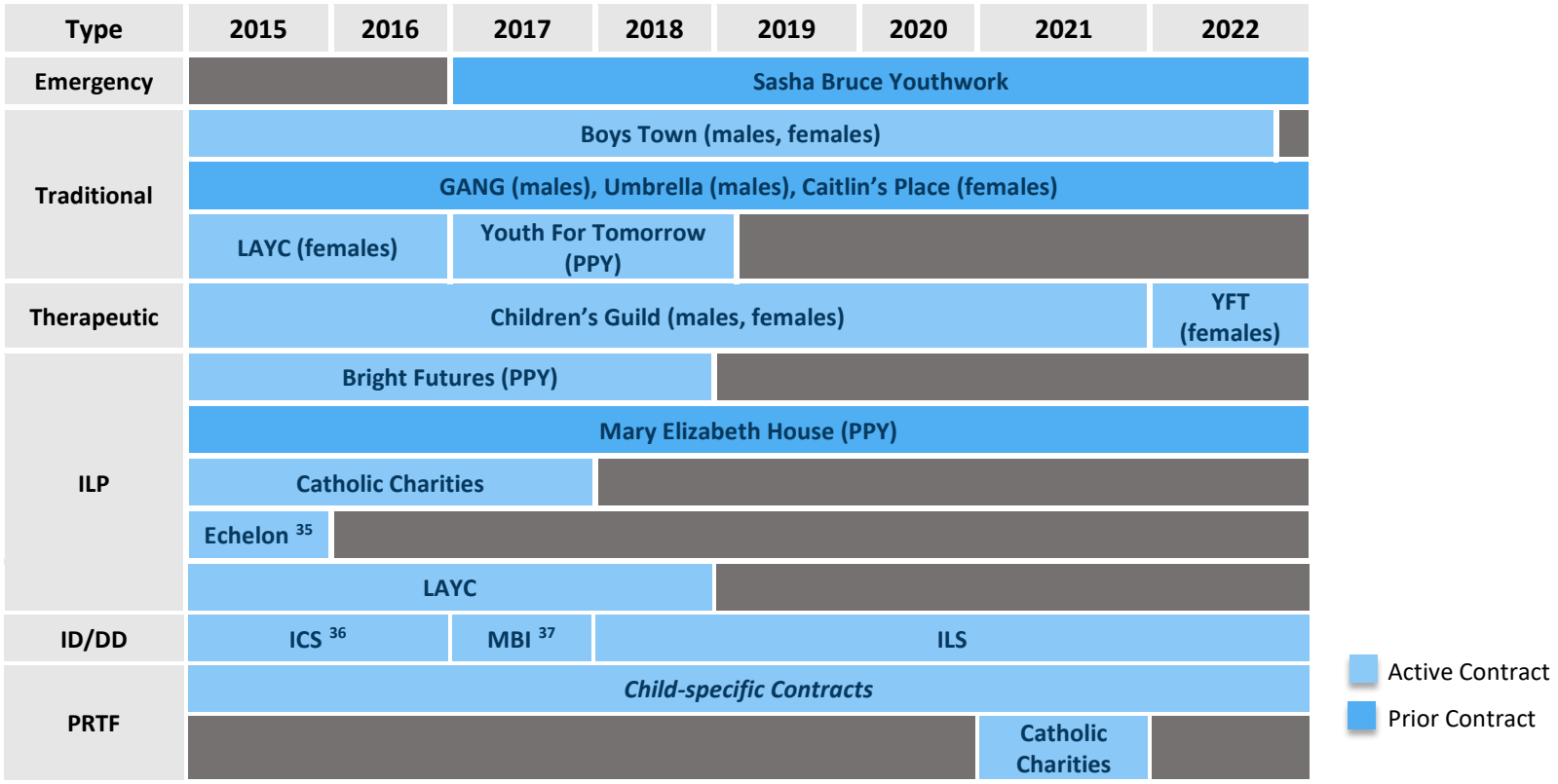
Figure 16 Congregate Care Settings in 2013 vs 2022



Source: CMT 232

As noted above, there has been a significant reduction in the number of congregate care providers, even though the types of congregate care programs have remained relatively consistent, except for a decrease in independent living programs, over the past 10 years. The number of contracts naturally decreased as demand for beds declined proportional to the decrease in the older youth foster care population, and CFSA's increased dedication to youth placement with kinship caregivers and family-based resource parents. With fewer contracts, CFSA has greater latitude in selecting providers that can provide for the specific needs of older youth, while also providing more exact monitoring of the providers' best practice standards. Between 2014 and 2017, Agency leadership conducted in-person visits to congregate care facilities to assess conditions and determine performance-based criteria for contract renewal. To quantify performance and identify priority placements, the Contracts Monitoring Division created a Congregate Care Scorecard that assesses a provider's ability to promote youth safety, health, well-being, and progress toward permanency. In response to feedback from providers who indicated that certain performance measures were not quantifiable or were not based on contractual obligations, the Agency modified the Congregate Care Scorecard in 2018, and has begun enhancing contract language around performance standards in such areas as staff training and retention, as well as youth safety, well-being, transition planning, and program satisfaction.

Figure 17 Congregate Foster Care Program Timeline



Source: CFSA Annual Progress and Services Reports FY 2014 – FY 2023; Manually tracked data from CFSA's Contracts Monitoring Division

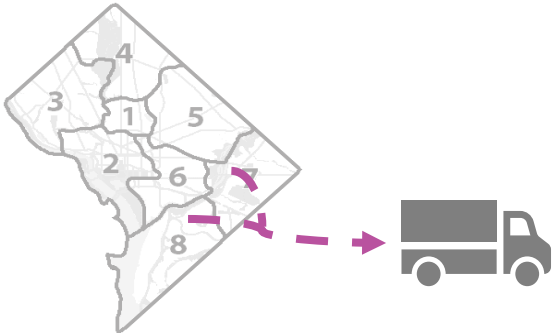
Placement with Siblings

Regardless of placement setting, CFSA has always prioritized the placement of siblings together in the same foster home. Several types of circumstances impact the success of the Agency's efforts: (1) family dynamics, including large sibling sets and child on child abuse between siblings requiring separation; (2) clinical issues, such as acute medical or behavioral health needs; and (3) limitations with the placement array. Specifically, many kinship and foster parents do not have the physical space in their homes to accommodate more than one or two children. There are inherent

[35] Echelon Community Services, Inc. provided residential units in Wards 7 and 8.
[36] Integrated Community Services provided placements in Ward 4.
[37] MBI Health Services, LLC's placements were available at the District's border (Ward 8) in Temple Hills, Maryland.

restrictions imposed by the District's housing landscape. According to the 2020 census, only 13 percent of homes in the District and only 7 percent of the homes in Wards 7 and 8 had four or more bedrooms compared to the national average of 23 percent. Additionally, in 2019, a DC Housing Survey Report found that over one third of low-income, large households in the District face a bedroom shortage. The survey also found that Black residents are over three times more likely than White residents to have last moved due to an inability to pay a bank or landlord; 20 percent of Black residents in Wards 7 and Ward 8 believe they will need to move within 3 years due to an inability to pay housing costs.[38] This impacts the pool of kinship providers, as well as traditional foster parents who can provide placements close to the children's birth family, community, and school. Despite the District's housing limitations, the percentage of children placed with at least one sibling decreased only slightly between FY 2013 and FY 2022, from 66 to 64 percent.

Figure 18 DC Housing Survey, 2019

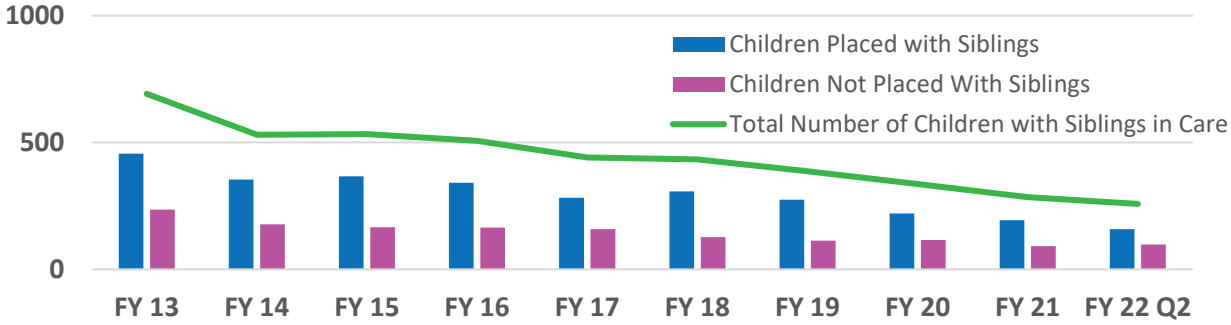


Black residents over 3Xs more likely to move than White residents due to inability to pay housing costs.

20% of Black residents will need to move within 3 years due to an inability to afford housing costs.

Source: DC Housing Survey Report, 2019

Figure 19 Children Placed with Siblings in Foster Care, FY 2013 - FY 2022-Q2



Source: CFSA Management Report PLC 003, pull dates October 15, 2013 to July 15, 2022

[38] Office of the Deputy Mayor for Planning and Economic Development's DC Housing Survey Report.

Resource Parent Recruitment

CFSA has always employed a comprehensive approach to promoting the benefits and importance of caring for children in the District's foster care system, particularly through the successes of the Agency's dedicated team of resource parent recruitment specialists, but also through CFSA's Office of Public Information. The Agency uses a variety of electronic and print media as part of its general recruitment efforts, including environmental scans, advertisements, social media campaigns, referral incentives, and orientations. CFSA also partners with numerous community and faith-based organizations to give presentations and connect directly with prospective resource parents.

Between October 2020 and February 2021, the Agency launched the resource parent recruitment and retention campaign called REACH (Recruit, Educate, Advocate, Collaborate, and Help). Developed in collaboration with experts from the Annie E. Casey foundation, REACH's primary objective is to build and strengthen CFSA's recruitment and retention process, and to secure the licensing and retention of additional resource homes. To ensure a continued focus on this effort, CFSA created a REACH recruitment specialist position dedicated to leading and coordinating the comprehensive REACH strategy. The Agency currently conducts targeted outreach to identify suitable resource parents for the following foster care subpopulations:

- ***Children from birth to age 5*** – Over the past 5 years, the Agency has reached out to over 100 community partners to highlight the needs of young children in foster care and to provide an overview of the supportive resources that are available to foster parents. Collaborations have included information sessions, presentations from resource parents currently caring for young children, and website announcements.
- ***Youth aged 12 and above*** – In partnership with the Agency's Youth Advisory Board, the recruitment team has facilitated matching events, created social media postings, and produced individual video profiles to leverage the power of the youth voice in explaining the rewards of caring for this population.[39] Additionally, CFSA provides current resource parents with a $500 incentive for referring new resource parents to care for teenagers.
- ***Children with special medical and intellectual needs*** – The Agency works with local medical care providers to highlight recruitment of resource parents for child diagnosed as medically fragile children. The virtual information sessions provide details on children's needs and requirements. Additionally, the Agency works with the current resource parent community to add child-specific information to newsletters and to facilitate presentations where firsthand experiences are shared.

[39] CFSA's Youth Advisory Board comprises older youth, ages 17 to 21, meeting regularly to advise the program area managers and deputy director about how the Agency can do more to address issues and meet the needs of youth. Members receive leadership training and other growth opportunities in return for their involvement and input that help to improve the foster care experience for all youth in care.

- ***Pregnant and Parenting Youth (PPY) –*** In FY 2021, CFSA presented information to current resource parents and community partners that serve the PPY population, including WIC administrators, healthcare practitioners, faith-based organizations, and other parenting support groups.[40] Additionally, recruiters highlighted PPY in a 2021 virtual conference held by the local LGBTQIA+ non-profit advocacy organization, Rainbow Families.
- ***Hispanic and Latino youth*** – CFSA has partnered with community organizations and the Mayor's Office of Latino Affairs to spotlight recruitment of Hispanic and Latino resource families. Recruitment efforts have included a variety of print and electronic media to promote and facilitate learning outreach opportunities. Most recently, the Agency placed recruitment ads on city bus stop shelters in the District's predominantly Hispanic and Latino neighborhoods.
- ***LGBTQIA+ youth*** – CFSA partners with several local organizations and advocacy groups to host events, post recruitment information online, and disseminate collateral material in order to identify LGBTQIA+-friendly families. The recruitment team also participated in a Community Block Party held by the District of Columbia Mayor's Office for Lesbian, Gay, Bisexual, Transgender, and Questioning Affairs.
- ***Commercial Sexual Exploitation of Children (CSEC) Youth –*** To identify suitable resource parents for this vulnerable population, CFSA hosts quarterly CSEC information sessions, highlights available supports in the community partner newsletters, and conducts presentations at events held by fellow District agencies, community organizations, and faith-based organizations. CFSA has also worked with technical advisors to create and post professional resource parent recruitment advertisements on Google and Facebook.

THE FOSTER CARE EXPERIENCE

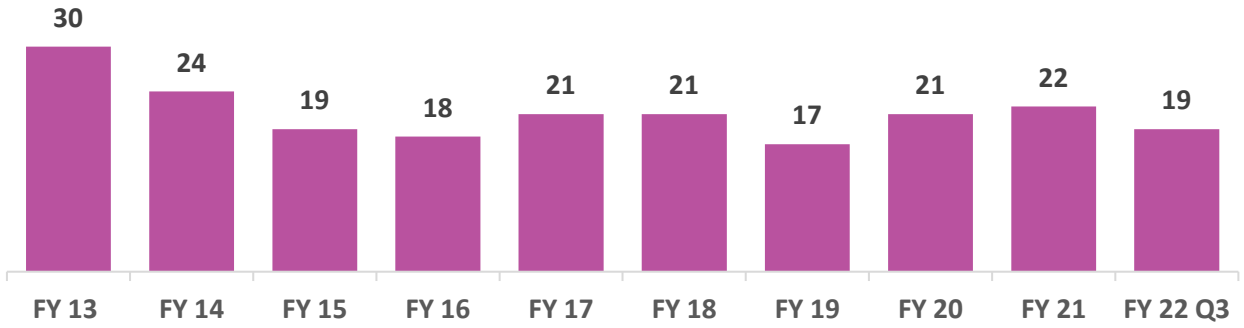
LENGTH OF TIME IN FOSTER CARE

As noted earlier, CFSA's continuing emphasis on prevention and family preservation has led to a substantial reduction in the foster care population. As a result, families with children who pass through the "Front Door" to foster care are displaying elevated risk factors related to a child's safety and well-being, as well as heightened service needs in such areas as substance use, behavioral health, domestic violence, and effective parenting. For those who do enter foster care, CFSA continues to focus on returning children home to their parents (when appropriate) or achieving a permanent home through adoption, guardianship, or legal custody (preferably each with a family member). The Agency has seen definitive successes over the past 9 years to reduce children's time in foster care, i.e., **the median length of time in care for children that had exited care**

[40] DC Health provides vouchers for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

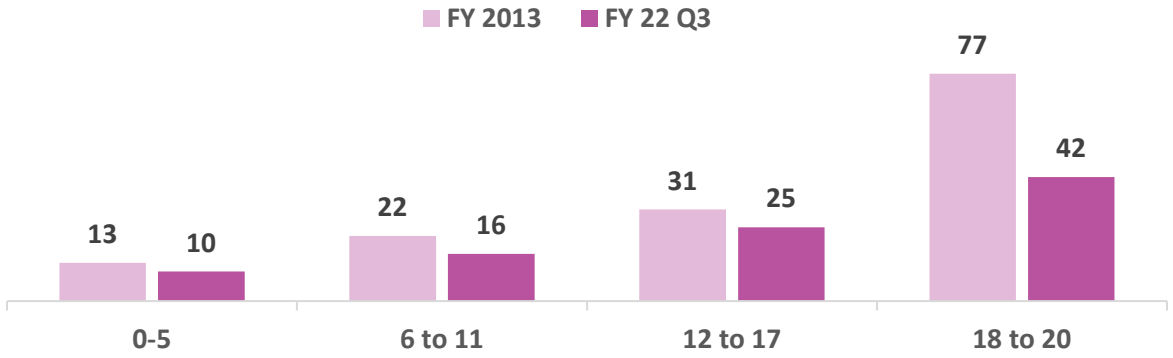
declined from 30 months at the end of FY 2013 to 19 months at the end of FY 2022-Q3. Most notably, youth over the age of 18 experienced a decline of 35 months, and youth ages 12 to 17 experienced a decline of 14 months.

Figure 20 Median Length of Stay in Foster Care



Source: CFSA Management Report CMT 366, pull dates October 15, 2013 to July 15, 2022

Figure 21 Median Length of Stay in Foster Care, by Age



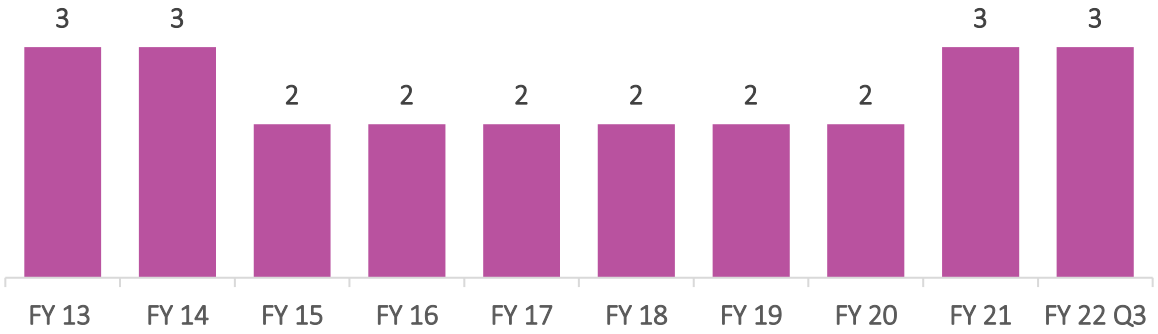
Source: CMT 366

NUMBER OF FOSTER CARE PLACEMENTS

CFSA regularly tracks the number of times a child or youth changes placements during their time in foster care prior to achieving the permanency goal identified in the case plan. Some reasons for placement changes are positive, including a youth's release from a residential treatment facility,

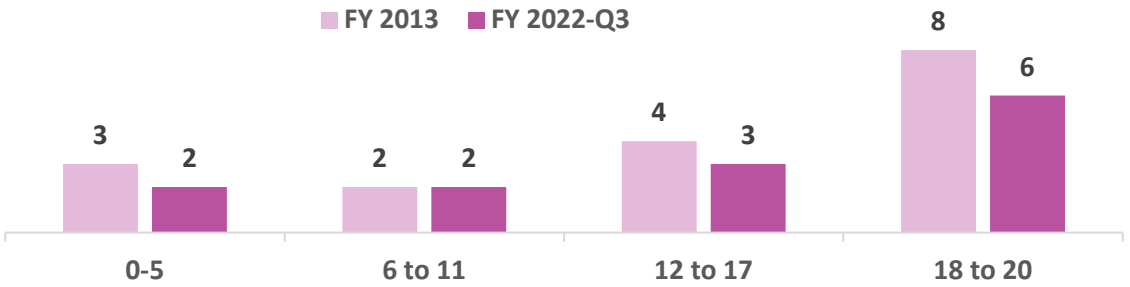
the licensing of a kinship caregiver, or the identification of a pre-adoptive resource home. By contrast, placement disruptions (described in the following section) are typically associated with challenges within the resource home or congregate care setting that cannot be overcome through clinical or other interventions. Placement disruptions may also be caused by procedural circumstances, such as the ending of a placement provider's contract. Since 2013, the median number of placement changes for all children in foster care has ranged from two to the current level of three. When broken down by age, the most significant change was found among youth ages 18-to- 20 years old. For this age group, the median number of placements decreased from eight to six.

Figure 22 Median Number of Placements while in Foster Care, FY 2013 - FY 2022-Q3



Source: CMT 366

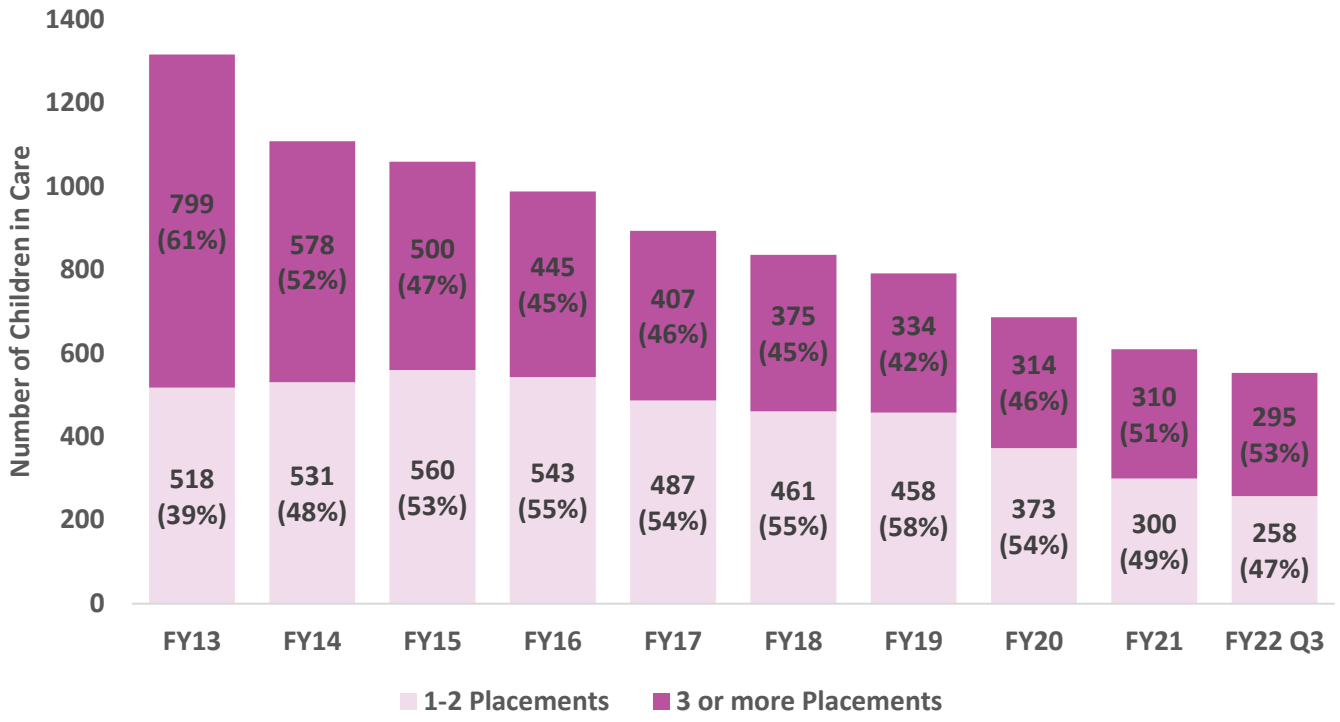
Figure 23 Median Number of Placements while in Foster Care, by Age



Source: CMT 366

While the overall number of children who experienced three or more placement changes has decreased commensurately with the overall decrease in foster care population since 2013, the proportion of children with three or more placements has been increasing since FY 2020 after decreasing for several years. In FY 2013, 61 percent of children (n=799) in care as of the end of the fiscal year had experienced three or more placements. This proportion declined in each consecutive fiscal year to a low of 42 percent of children as of the end of FY 2019. However, it has increased each year since then and as of FY 2022-Q3, 53 percent of children (n=295) in care had experienced three or more placements. This is still a decrease from the high of 61 percent at the end of FY 2013.

Figure 24 Children with Three or More Placements, FY 2013 to FY 2022-Q3



Source: CFSA Management Report CMT366, pull dates October 15, 2013 to July 15, 2022

SUPPORTS AND INTERVENTIONS TO PROMOTE PLACEMENT STABILITY

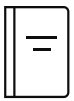
In addition to monitoring overall data pertaining to placement changes, CFSA specifically tracks, and works to reduce, the number of disruptions as well as the proportion of children and youth who experience disruptions in foster care. As part of these efforts, CFSA and its collaborative partners continuously explore, implement, evaluate, and enhance a wide variety of strategies to support foster parents, including information sharing, practical supports, activities to motivate resource parents, advocacy, community supports, and general services provided by CFSA.

INFORMATIONAL SUPPORTS

Placement Passport – The Placement Passport is an essential tool for helping resource parents to understand the characteristics and needs of the child being placed in their home. It contains copies of the child's birth certificate, Social Security card, Medicaid card, court orders, and medical history, as well as important contact information and protocols for responding to such situations as medical or mental health emergencies.

Placement Transition Information Exchange (PTIE) – To support the "warm handoff" of a child into a new foster home, resource development specialists from the Placement Administration utilize the PTIE, a formatted conversational guide, which is based on information the social worker has provided about the child. The PTIE is shared with the resource parent support worker as well as the assigned social worker to ensure that the agency personnel have shared language and understanding when engaging the child and parent.

Online Support for Resource Parents – In 2015, CFSA introduced an electronic application that allowed resource parents to use their mobile devices to remain connected to helpful information, people, and services. The app included quick links to the child's social worker and support resources, child summary information, foster parent licensing and household information, the child's Medicaid card and medical information, and court information such as hearing dates. Due to limited utilization, CFSA discontinued the app in 2019, and currently encourages the use of a dedicated webpage for resource parents www.fosterdckids.org. The password protected dedicated webpage for licensed resource parents includes links to training courses, tip sheets, newsletters, and other informational materials, as well as contact information for advocates and professionals who can offer customized individual support.



Resource Parent Handbook – In 2018, CFSA developed and published the *Resource Parent Handbook*, an accessible and comprehensive guide to foster care resources, rights, responsibilities, and best practices. A notable example is an entire chapter dedicated to the Reasonable and Prudent Parenting (RPP) standard. RPP is a framework in which resource parents are empowered

and encouraged to make parenting decisions based on the same values as a biological parent. Those decisions promote a normalized experience for the children in their care, as opposed to decisions that are governed by authorization or liability considerations. The Resource Parent Handbook is a "living document" that CFSA regularly revises to ensure that information is current and relevant to the needs to the resource parent population.

Newsletters – CFSA publishes the monthly Fostering Connections Newsletter to celebrate particular resource parents, profile specific children in need of a forever home, share relevant articles, announce upcoming activities, and respond to feedback received from the resource parent community.

Online Community Resource Directory (for kinship caregivers only) **–** As part of District's federally-funded Kinship Navigator program, CFSA developed an Online Community Resource Directory that became operational at the start of FY 2020. Currently accessed by CFSA's Kinship Unit specialists, the directory includes tools and resources that address the particular needs of kinship caregivers. Using the directory, specialists can search for services and resources by location and service type before forwarding the information to clients via text messaging or email.

Statement of Rights and Responsibilities **–** In 2016, CFSA partnered with foster parent advocates, attorneys, community providers and other stakeholders to develop a statement of rights and responsibilities for foster parents. Currently available online and in booklet form, the document explains foster parents' rights to fair treatment, timely information, support from the case management team, training, timely payment for services, and clear channels for elevating concerns and complaints.

Training – CFSA's Child Welfare Training Academy (CWTA) had previously utilized the Trauma-Informed Partnering for Safety and Permanence – Model Approach to Partnerships in Parenting (TIPPS-MAPP) for pre-service foster parent training. After conducting extensive outreach among new and experienced resource parents, the Agency adopted the New Generation PRIDE Model in 2020. The New Generation PRIDE model teaches knowledge and skills in five essential competency categories: (1) protecting and nurturing children; (2) meeting children's developmental needs and addressing developmental delays; (3) supporting relationships between children and their families; (4) connecting children to safe, nurturing relationships intended to last a lifetime; and (5) working as a member of a professional team. For kinship provider pre-service training, the Agency offers Caring for Our Own, a 10-class program designed to help kinship caregivers work in partnership with the children, the birth parents, and the case management team. The program also includes information on trauma and the current federal guidelines for kinship care. CWTA further offers prospective and current resource parents free on-line training via a contract with FosterParentCollege.com, which provides interactive

multimedia training courses on many relevant topics. NCCF resource parents receive additional training through the Triple P Parenting Program, a multi-level system of support to prevent and treat social, emotional, and behavioral problems in children by enhancing parent knowledge, skills, and confidence. NCCF provides ongoing training and develops individualized training plans for resource parents caring for children with varying characteristics and needs. Topics include LGBTQIA+, sex trafficking, disabilities, mental health disorders, substance use, violent behavior, and pregnant or parenting youth.

Shared Parenting – Encouraged and facilitated by CFSA's Kinship and Placement Administration, Shared Parenting refers to the ongoing, active, supportive relationship between birth and resource parents.

PRACTICAL SUPPORTS

Support Workers, Coaches, and Specialists – CFSA assigns a resource parent support worker (RPSW) to each resource parent to provide information, support, and advocacy. Among other things, the RPSW facilitates access to resource parent training and provides information about the child, case details, and available services; serves as a point of contact for communication and remediation of concerns; works with the social worker to initiate team meetings to resolve matters that may impact placement stability and resource parent retention; and assists the resource parent with the navigation of relevant systems (e.g., CFSA, school, childcare, court, and medical systems). Each RPSW receives a minimum of 30 annual hours of continuing education that helps keep the RPSW abreast of relevant social, cultural, and child welfare trends. The Agency is also requiring trauma-informed trainings for RPSWs to reinforce the TIPP Unit's expansion. In Maryland, NCCF assigns seasoned employees to serve as foster parent coaches to support new resource parents, and to assist resources homes with children and youth who have experienced frequent placement disruptions, or upon request by resource parents who demonstrate a particular need. Foster parent coaches apply a strength-based approach when providing one-on-one support, helping foster parents to better understand and more efficiently work with the children in their care. When children present with particularly challenging behaviors, NCCF assigns behavioral specialists, who are specially trained employees who typically visit with the child two to three times per week. Behavior specialists develop a behavior modification plan to address the behaviors that the foster parent has identified as untenable and as having negative impact on household members.

Respite – CFSA defines respite as a supportive service designed to provide resource parents, guardians, and children with a period of temporary, short-term, planned, or unplanned relief from the ongoing care arrangement. Respite services are purposed to reduce

the possibility of crisis and disruption of the placement. Respite care is agency-arranged (CFSA or private), and provided by licensed, approved respite care resources, and should be for less than 30 days.

Resource Parent Support Networks (Hubs) – Until 2020, CFSA had implemented the Mockingbird and Family Connections support constellation models based on the concept of extended family. Within these frameworks, "cluster leads" welcomed resource parents into a community-based network that provided support, continuous learning, coaching, mentoring, socializing, and respite care. Under the Mockingbird and Family Connections models, hub parents were required to be available 24 hours a day, 7 days a week to provide respite. In March 2020, CFSA ended both the Mockingbird and Family Connections programs in favor of developing its own equitable and sustainable parent support program. The Bridge, Organize, Nurture and Develop (BOND) program currently serves as CFSA's "hub" model for resource parent engagement, networking, peer support, and respite care. CFSA assigns resource families to a BOND "squad" of 8-12 peer resource parents. Each squad has an assigned BOND leader, who is an experienced and committed resource parent who provides or arranges for peer support, coordinates special activities, and provides or arranges for respite care. The BOND leader has one bed available for respite stays for families within their squad. When the bed is unavailable, the BOND leader arranges for respite within the squad, or coordinates with the leader of another squad, if necessary. NCCF launched its own comparable BOND program in October 2021. See Appendix B for information on resource parent satisfaction with the BOND Program.

Mobile Crisis and Stabilization Services – Until 2019, CFSA had referred families to Catholic Charities DC to provide mobile crisis stabilization services, including the Child and Adolescent Mobile Psychiatric Service (ChAMPS) for families and children experiencing an emotional or mental health crisis. Due to underutilization, as well as the need to improve the continuity of service delivery, CFSA discontinued the practice of referring families to ChAMPS. However, Catholic Charities DC still provides ChAMPS services District-wide through a contract with the Department of Behavioral Health.

In-House Crisis and Stabilization Services - In 2020, CFSA brought mobile crisis and stabilization services in-house under the Resource Parent Support Unit. To support the transition, CFSA provided RPSWs with additional training on parent coaching and also created the REACH Resource Parent Support Line, which is staffed after normal business hours by two dedicated RPSWs. Available on weekdays between 5:00 pm and 1:00 am, and on weekends and holidays between 9:00 am and 1:00 am, these crisis intervention services provide an additional layer of support to address escalating behaviors presented by children and youth placed in CFSA resource homes. For children placed in Maryland, NCCF utilizes a Call Center that receives and dispatches all emergency calls after hours to their trauma specialist who contacts the individual directly to offer support and an emergency response.

Kinship Caregiver Support Line – Since 2019, CFSA has administered a dedicated toll-free *Kinship Caregiver Warmline*. Staffed by members of the Kinship Support Unit during business hours, the line provides an opportunity for real-time facilitation or mediation of conflicts or issues that are occurring in the kinship caregiver's home. The Warmline further serves as a mechanism for promptly linking kinship caregivers to nearby community-based resources. For messages left after-hours, the Kinship Unit responds by the next business day.

Placement Stability Incentives – CFSA offers a financial incentive to licensed resource parents ($1,100 for CFSA and $1,500 for NCCF) who demonstrate the ability to contribute to positive outcomes for children in their care, e.g., by maintaining a safe and stable placement and by working toward timely permanency. To qualify, a resource parent must maintain placement stability for a child or youth in the home for 12 consecutive months from the date of placement. While scheduled to continue until the end of FY 2022, the Agency is currently evaluating the efficacy of a fiscal incentive and exploring alternative approaches.

Transportation – Resource parents typically arrange for or provide school transportation for children in their care. However, CFSA provides time-limited transportation assistance when all alternative means of transportation supports have been deemed unavailable. Additionally, the child's case management team can coordinate with the resource parent for the social worker or family support worker to provide transportation to medical, court, and other appointments as needed.

Childcare – Resource parents can apply for a subsidy for a pre-determined rate that CFSA will pay to defray the cost of a licensed childcare provider. The subsidy rates vary depending on the age of the child and the location and type of facility. If the rate offered does not cover the full cost of child-care, the resource family makes up the difference. Additionally, resource parents in the District can obtain a voucher, through the Department of Human Services or the Office of the State Superintendent of Education, to cover the cost of childcare at participating centers. For infants that require vaccinations before entering childcare centers, CFSA contracts with PSI Family Services for emergency childcare in the resource parent's home. For children placed in Maryland, CFSA issues payment directly to childcare providers.

MOTIVATIONAL SUPPORTS

Networking, Wellness, and Celebration – To promote peer networking and to reinforce the District's appreciation of its valuable resource parent community, CFSA conducts regular events, including celebratory lunches, river cruises, game-nights, awards

ceremonies, and seasonal gatherings. Although organized through the Kinship and Placement Administrations, CFSA utilizes surveys and committee meetings to solicit resource parent input regarding the timing, venue, and theme of these events. Since 2020, CFSA has also provided funding and resources to BOND lead families so that they can arrange similar events among their BOND squads. For kinship caregivers, the Agency has held seasonal Family Enrichment Events, which provide opportunities to connect with Agency staff and fellow kinship families, play games, enjoy meals, and receive gifts. The CFSA Permanency Unit also held an outdoor 2022 Summer Carnival for resource parents and families. NCCF's Recruitment and Retention Unit similarly celebrates its resource parent community on a monthly basis, including such recent events as the Paint & Sip, Mindfulness and Caribbean Dance, Family Fun Day, Holiday Party, and Foster Parent Appreciation Banquet.

ADVOCACY AND COMMUNITY SUPPORTS

DC Foster and Adoptive Parent Advocacy Center (FAPAC) – Founded in 2000, FAPAC is a local nonprofit organization that seeks to strengthen, support, and empower foster, adoptive, and kinship parents to serve as advocates for the needs of children in their care. Under the direction of a board comprising mostly current and former foster parents, FAPAC activities include advocacy in stakeholder meetings, resource parent training, the facilitation of peer support activities, and the dissemination of informational resources.

DC Metropolitan Foster and Adoptive Parent Association (DCMFAPA) – In addition to providing support for birth parents, DCMFAPA works to increase awareness of the role of foster, adoptive and kinship parents. DCMFAPA also collaborates with government and community organizations to strengthen foster and adoptive care systems. Resource parent services provided DCMFAPA include peer mentoring, training, seminars, and loss, grief and healing services for foster families that have suffered the loss of a foster child or parent.

Foster Parent Advisory Board (NCCF - Maryland) – Each member of NCCF's Foster Parent Advisory Board is a foster parent who is responsible for reaching out on a monthly basis to an assigned group of foster parents to check in and to obtain feedback. The Board then meets with NCCF staff to share the feedback, which typically involves support needs and administrative issues.

Parent Forums –Until the spring of 2022, the Parent Action Committee (PAC) served as a primary vehicle for discussing resource parent-related topics. Members from CFSA's Resource Parent Support Unit, Child Welfare Training Academy, Out-of-Home Administration, and the Office of the Ombudsman met monthly with advocates from FAPAC and DCMFAPA to discuss performance measures, policy and practice changes, strategies for obtaining feedback, and participant insights. Historically a forum for resource

parents, PAC expanded in 2021 to include all parents: birth, kinship, and pre-adoptive parents. Despite Agency outreach efforts, there was low birth and kinship parent participation, which therefore restrained PAC's intention to represent the parent experience. In the spring of 2022, CFSA discontinued PAC, but with an information-sharing campaign that ensured all resource parents were aware of their opportunities to collaborate with peers and to engage CFSA staff, management, and leadership. Current opportunities include monthly Feedback and Fellowship meetings where resource parents can provide feedback and recommendations to program leadership, as well as monthly meetings among BOND squads and among the various professional foster parent groups described earlier. NCCF's Recruitment and Retention Team also facilitates monthly Foster Parent Support Groups, which are open to all resource parents, and typically attended by social workers and relevant professional consultants. Recent topics discussed at these groups include How to Listen Empathetically, Fostering LGBTQIA+ Youth, Fostering through the Holidays, Self-Care, Abscondence, Expectations of Kinship Care, Human Trafficking, Healthy Boundaries, and Mental Health and Trauma in Adolescents.

Kinship Program Advisory Committee (KinPAC) – Since October 2019, KinPAC has been conducting quarterly virtual meetings. Facilitated by the Kinship Outreach and Support supervisor, meeting participants commonly include kinship caregivers, resource parent advocates, attorneys, Kinship Unit staff, Community Resources Administration staff and, at times, various other community-based organizations, District government agencies, and CFSA personnel. Committee meetings provide an opportunity to facilitate presentations and exchange feedback on relevant topics. Recent topics for discussion have included Grandparent and Close Relative Caregiver legislation, parenting skills instruction, educational enrichment, Kinship Navigator platform enhancements, family enrichment events, and support group activities.

GENERAL AGENCY SUPPORTS THAT BENEFIT RESOURCE PARENTS AND THE CHILDREN IN THEIR CARE

Case Management – In the course of visiting a child in a kinship or foster home, the social worker engages with the caregiver regarding recent observations and additional support needs. Visitation also provides an opportunity for the social worker to ensure children are current in their routine medical and dental appointments, participating in services, and achieving academic goals. The social worker is also responsible for engaging the resource parent, encouraging the resource parent's "voice and choice" in how the child's needs are met on a daily basis. Social workers must complete ongoing assessments of the entire family's needs. Sometimes those needs are practical, e.g., transportation to a service or court hearing. Both social workers and family support workers assist in providing for concrete needs.

Placement Stabilization – Prior to 2021, whenever a placement disrupted, CFSA convened Placement Disruption Staffings that were facilitated by a CFSA out-of-home resource development specialist. As appropriate, attendees included the child, family members, current and former caregivers, and the guardian *ad litem* (GAL). These staffings, which occurred within 30 days of the placement disruption, provided an opportunity to assess the child's medical, social, behavior, educational and dental needs to determine the additional evaluations, services, and supports required to prevent future placement disruptions. In 2021, the Agency transitioned to a more proactive approach: the Placement Stabilization Staffing (PSS). Usually facilitated by an RPSW, the PSS involves similar parties and discussion points as the previous protocol. However, the PSS is a proactive effort focusing on the child being able to maintain the current placement. The PSS specifically addresses any potential issues that may lead to disruption.[41] Per Agency policy, the PSS must occur under the following circumstances: (1) within 10 business days of a child's initial entry into care, (2) within 5 business days for a child who has moved twice in the first 12 months of care, (3) for a child who remains in a placement pending a referral for a higher level of care, and (4) for a child who is discharged from a hospital, PTRF, or correctional facility. In Maryland, NCCF conducts Placement Stability Meetings (PSMs) when a placement disrupts. The PSM occurs when a resource parent requests an end to the placement, or in order to address challenges that may lead to a disruption. PSMs provide an opportunity to identify factors that led to disruption, reassess the needs of the child or youth, and to identify the necessary actions, resources, and services needed for placement stability.

Child Assessments – All children in care receive initial and periodic functional assessments. The case management team shares the assessment results with resource parents to help provide additional insight into a child's characteristics, behaviors, and needs. Over the past 10 years, CFSA has continued to administer the empirically-based tools, Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) for all children and youth in foster care.

Healthy Horizons Assessment Center (HHAC) – HHAC is staffed weekdays during regular business hours with on-call hours for evenings and weekends. Staff include licensed nurse practitioners and certified medical assistants contracted through CFSA's Health Services Administration. Serving as the Agency's medical intake center, HHAC also serves as a health information resource for resource parents and children in their care. For children with special medical needs, agency nurses conduct placement visits to ensure the resource parents are educated in requisite information to ensure the child's well-being, to help ensure children are up to date with medical appointments, and to assist when necessary to obtain medical documentation. Additionally, since 2019, HHAC

[41] The RPSW is typically the preferred facilitator, based on greater firsthand knowledge of the resource provider. However, Agency policy also permits facilitation by resource development specialists or Agency leads as necessary.

nurse practitioners have been administering immunizations to all children in the event they are not up to date in compliance with the current Centers for Disease Control immunization schedule.

Mental Health Redesign – CFSA's Office of Well-Being implemented a mental health redesign in October 2018 to centralize mental health assessments, thereby increasing timely and accessible services. The redesign included implementation of in-house trauma-informed therapy at CFSA, and medication management for applicable CFSA children. The in-house mental health unit is staffed by four behavioral health therapists, a behavioral health clinical supervisor, and a psychiatric nurse practitioner. Originally offered solely to children entering or re-entering foster care, services were extended in 2019 to include all children in foster care over the age of 5. The positive outcomes sought by the redesign include, but are not limited to, reduced wait times for services, increased placement stability, expedited reunification, increased family engagement, and decreased placement disruptions.

Education – Reflective of evolving educational practices in the District, CFSA's education units have evolved over time as new tools and support strategies are identified but at CFSA and through OSSE, DCPS and the DC Charters. In 2018, CFSA developed a new model of educational support services to maximize the use of the education specialist staff and to produce better educational outcomes for youth in foster care. Education specialists from the Office of Youth Empowerment (OYE) and the Office of Well-Being (OWB) provide three tiers of services: (1) direct services and intensive supports throughout the school year for youth at-educational-risk [specialists use an evidence-based student engagement model called Check & Connect as well as other interventions]; (2) consultative support on individual cases, as needed, from a specialist assigned to each supervisor and their social work unit; and (3) educational performance incentives and rewards for youth and the resource family to assist with prioritization of education and postsecondary planning. Youth attending college are assigned educational specialists that provide support and assistance with college registration, obtaining financial support and to troubleshoot issues as they arise throughout the semesters.

Older Youth Services– In addition to educational supports, OYE helps older youth obtain job readiness, financial management, and other life skills. For those 18 and older, OYE specialists place particular emphasis on transition planning.

- While OYE has always provided some level of job readiness, particularly for those youth who were not interested in post-secondary education, the programming has changed over the past 10 years. In 2013, OYE created a unit called "Career Pathways" in which a team of specialists assessed youth, helped them identify professional goals, connected them with vocational training programs, and monitored their progress in employment positions and government-subsidized internships. In 2019, CFSA contracted with the non-profit organization Youth Villages (YV) to implement the YVLifeSet program, which focused on providing one-on-one intensive support to assist youth in achieving their individual goals. When the Youth Villages contract

ended in FY 2021, OYE continued to internally implement the program model, which is now called LifeSet DC. LifeSet DC helps youth to re-engage in school, soft skills, and career supports.

- CFSA has used federal funding to promote and reward financial literacy among older youth in care. Until 2017, the Agency had partnered with Bank on DC to provide the Establishing Savings Creating Revenue Obtaining Wealth (ESCROW) program, a multi-faceted education and training program featuring an online financial literacy course, financial education seminars, account enrollment, financial mentoring, peer learning, and matched savings. Since 2017, CFSA has provided youth with the opportunity to participate in the financial literacy program, as well as a matched savings program where every dollar saved, up to $1,000 per year, is matched by Capital Area Asset Builders (CAAB). Matched funds can be accessed to purchase a vehicle or to pay for housing, education, or entrepreneurial endeavors.
- CFSA internship program funded with CHAFFEE dollars
- Co-located staff at the District's Department of Employment Services

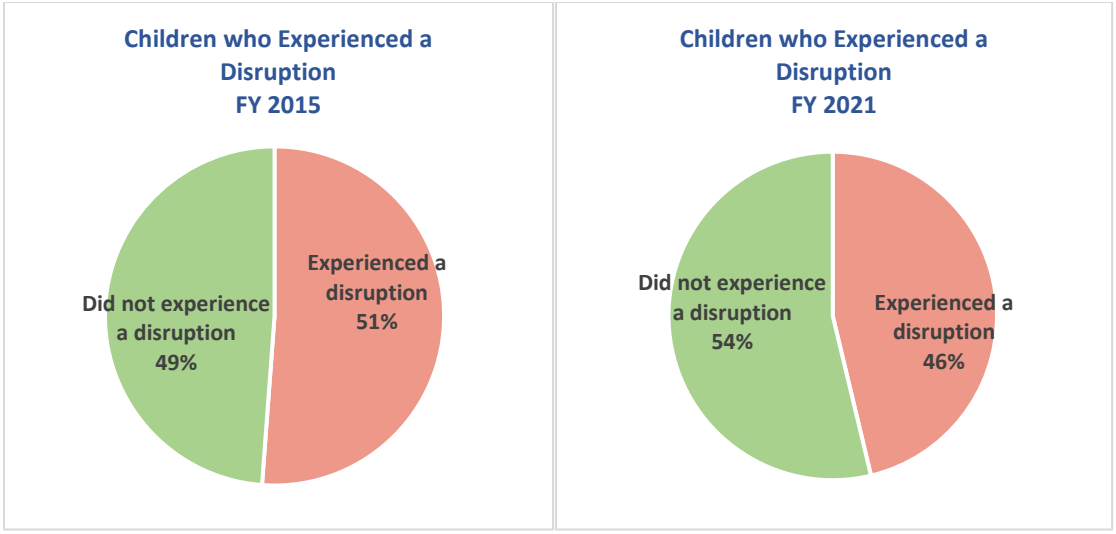
Ombudsman – CFSA's Office of the Ombudsman serves as an impartial liaison for constituents (i.e., children, youth, birth parents, foster parents, kinship caregivers, guardians, adoptive parents, mandated reporters, concerned citizens, and contractors) who are seeking internal Agency resolutions to issues. The ombudsman reviews concerns and prepares recommendations and responses when necessary. The ombudsman may utilize alternative dispute resolution and facilitate meetings to identify recommendations and resolve concerns in adherence with local and federal laws, DC Municipal Regulations, and Agency policies and procedures.

THE IMPACT OF FOSTER CARE INTERVENTIONS AND SUPPORTS

As noted earlier, a significantly reduced foster care population has resulted in a greater proportion of children with heightened support needs, which can impact the number of placement disruptions that a child or youth experiences.[42] However, the total number of placement disruptions experienced by children who were in foster care as of the end of FY 2015 decreased by 75 percent by the end of FY 2022-Q3, going from 1,817 to 456. Additionally, at the end of FY 2015, there were 543 children in care who had experienced at least one disruption, and this number not only declined by 80 percent to 109 at the end of FY 2022-Q2, but the proportion of children with disruptions relative to the overall foster care population also declined during this period.

[42] Placement disruption data requires extensive validation, which has significantly increased in recent fiscal years. Data listed here from prior to FY 2020 may not have the same level of reliability as data from FY 2020 on.

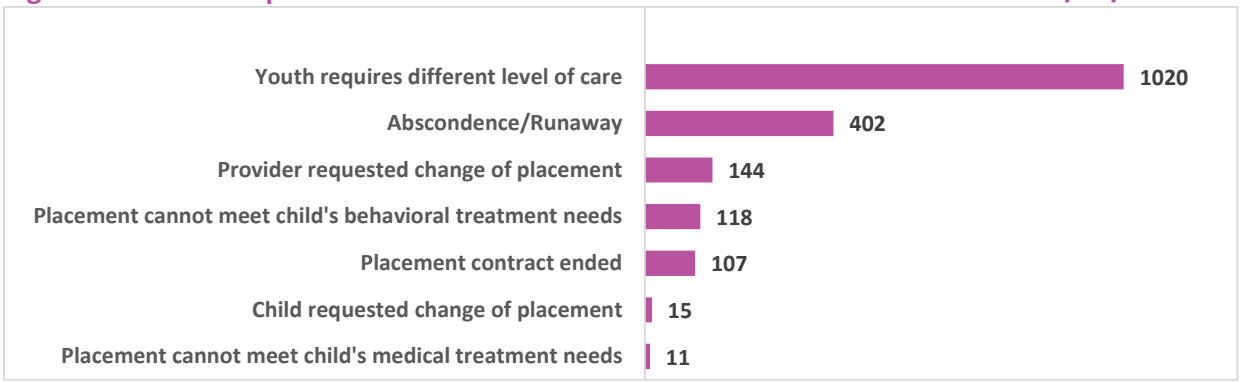
Figure 25 Children who experienced a disruption in FY 2015 vs FY 2022



Source: CMT 407 pull dates October 1, 2015 and October 1, 2021

In general, the most commonly reported reason for a placement disruption relates to the youth's needs and behaviors. Among youth in care at the end of FY 2015, a majority (56 percent, n=1020) of placement disruption reasons were reported as "Youth requires a different level of care."

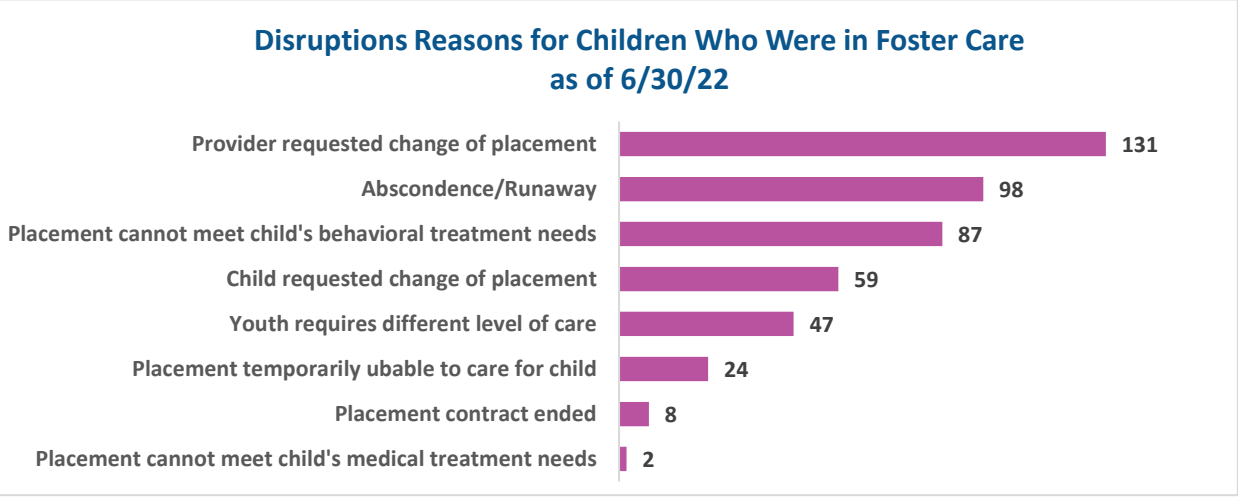
Figure 26 Disruptions Reasons for Children Who Were in Foster Care as of 9/30/15



Source: CMT 407 pull date October 1, 2015

Over the ensuing reporting periods, CFSA data analysts determined that the category "Youth requires a different level of care" was too broad, as it could include a myriad of factors, many of which overlapped with other categories. For this reason, CFSA's data team has taken an increasingly deliberate approach to categorizing placement disruptions. By FY 2022-Q3, the overall number of disruptions attributable to a youth's needs remained high, but the count for the specific category "Youth requires a different level of care" dropped dramatically from 1,020 to 47 and accounted for only 10 percent of all disruptions. Concurrent with this decrease was a proportional (but not numerical) increase in more specific reasons, such as "Placement cannot meet child's behavioral needs," "Provider requested a change of placement" and "Child requested a change of placement."

Figure 27 Disruptions Reasons for Children Who Were in Foster Care as of 6/30/22



Source: CMT 407 pull date July 1, 2022

With more specific data coding, the Agency is becoming better able to identify the kind of trends that can ensure interventions are geared toward the right issues and the right parties. A recent example can be found in the FY 2022-Q3 data. Cases in which a provider either requested a change of placement or reported an inability to meet the child's behavioral needs accounted for 218 (48 percent) of all disruptions. This type of finding inspires a reassessment of the foster care placement array and, in particular, the Agency's recent expansion of professional foster parent programs that include compensation, specialized training, limitations on outside employment, and the contractual reinforcement of heightened foster parent responsibilities.

As of June 30, 2022, there were 556 children who met the threshold for out-of-home placement in a District that had historically maintained a foster care population of well over 2,000. A higher threshold means that relative to before families of children entering foster care are confronting greater challenges, and the children themselves are presenting with heightened clinical needs. CFSA focus continues to be building and maintaining a diverse placement array that is characterized by cultural competence, clinical expertise, and impassioned caregiving. To this end, CFSA remains committed to recruiting, training, and supporting resource parents to effectively carry out their critically important role of meeting the unique needs of each child in the District's foster care system.

II. PLACEMENT STABILTY: A DEEPER LOOK

PLACEMENT STABILITY BY COHORT

Objective: to increase placement stablity, for older youth in particular

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Females aged 13 to 17 years old represented the highest number of placement changes (three or more).	• CFSA will further consider the specific behaviors of the youth in this age category to determine their unique needs during foster care placement, and to provide services or interventions to prevent compromises for their placement stability • Utilize the therapeutic group home when available and the Bridge program should help to stabilize this population • Utilize the TIPP foster homes to support this population • Target this population for credible messengers and other community mentorship opportunities • Provide training for resource parents on stages of development, normal teenage behavior that is exaggerated by the trauma they have experienced, to decrease parents asking for their removal based on their behaviors
Females aged 18 years or older was the largest population of children in foster care for 24 months or longer and in each placement change type.	• Conduct the Agency's first qualitative analysis for children and older youth with three or more placements to begin during fall 2022. • Utilize the therapeutic group home that when available and the Bridge program should help to stabilize this population • Utilize the TIPP foster homes to support this population

Are there demographic differences between children with placement stability (defined as two or fewer placements) and children with placement instability (defined as three or more placements)?

This demographic analysis for placement stability consists of children in foster care for longer than 8 days during FY 2021 and the first two quarters of FY 2022 (October 2021-March 2022). During this timeframe, 989 distinct children entered and re-entered foster care, according to data pulled by

CFSA's Office of Agency Performance.[43] The data analysis focused on three cohorts, providing a comparison of children with two placements or fewer and children with three placements or higher. Additionally, Agency Performance analyzed the following characteristics as part of the evaluation of initial versus re-entry into foster care: duration of time in care, age, sex, and race. The analysis of these data is included in this report. In the fall of 2022, CFSA will be conducting a qualitative analysis that looks deeper at children with three or more placements, and this analysis will be published in the Four Pillars Public Performance Report for FY 2022.

Children were placed into three cohorts for this analysis. The first cohort consisted of children who had been in foster care for at least 8 days but not longer than 12 months. The second cohort consists of children who had been in foster care for at least 12 months but not longer than 24 months. The placement analysis for these cohorts looked at the total number of placements from the date when the child first entered foster care to the end of FY 2022 Q2, or the date when they exited foster care if prior to end of FY 2022 Q2. The third cohort comprised children in foster care for 24 months or longer. That placement analysis looked at the total number of placements within the last 12 months. Between the three cohorts, 51 percent (n=509) of the children were in care for 24 months or longer. 25 percent of the children were in care for 12 months but not longer than 23 months. 24 percent of the children were in care for eight days but not longer than 12 months. [44]

Figure 28 Children in Foster Care, by Length of Stay

Length of Stay	Count of Children	%
8 Days < 12 months	236	24%
12 months < 24 months	248	25%
24 months or longer	509	51%

Source: Ad Hoc FACES data pull, as of March 31, 2022

Summary of Needs to Consider

In the cohorts of children in foster care for at least **8 days but less than 12 months and children in foster for 12 months but less than 24 months, youth aged 13 to 17 years old represented the highest number of placement changes (three or more). The majority were female.** According to

[43]Agency Performance pulled data to evaluate placement stability for children with multiple placements. Four children had duplicative placement representation throughout the analysis. One child experienced two re-entries into foster care during this timeframe, while three children experienced one initial entry and one re-entry during the timeframe.

[44] These subgroups are using the multiple placement cohorts used under the *LaShawn* vs. Bowser lawsuit.

Erikson's stages of development, the 13 to 17-year-old age category is centered around identity and role confusion. This developmental stage has been deemed the age of the "identity crisis" because the youth are overwhelmed by expectations, responsibilities, and establishing their individuality.[45] CFSA intends to further consider the specific behaviors of the youth in this age category to determine their unique needs during foster care placement, and to provide services or interventions to prevent compromises for their placement stability.

In the subgroup of children in foster care for 24 months or longer, young adults aged 18 years or older was the largest population in this subgroup and in each placement change type. Again, **more of these youth were female than male.** Similar to the 13 to 17-year-old age bracket, CFSA intends to conduct further analysis into the needs of young adults aged 18 and older in foster care, particularly in consideration that the median duration of time in foster care for this subgroup was just over 3 years (38 months). A focused analysis for the 18 and over age group will help CFSA to determine the reasons for placement changes and whether those changes met the needs of the youth. In addition, CFSA intends to examine what has been working well within the foster care system as a whole and where further resources or supports could be developed and implemented to protect placement stability for older youth. Additional details are given regarding these findings below.

One strategy to accomplish this goal is a survey of service providers that will help categorize findings and improve the definitions of stability and instability. Such an analysis would better define deeper needs and more effective improvements to the placement and service array. The Agency's first qualitative analysis for children and older youth with three or more placements is planned to begin during fall 2022.

One limitation of these analyses was continuance of categories used during the *LaShawn* lawsuit, i.e., the placement stability of children in care for 24 months or more only looked at their last 12 months of placement history. CFSA is implementing new placement subcategories that will look at the number of placements by duration of time in care, as well as the number of placements from the start date of a child or youth entering foster care. Another limitation is the number of missing values for race and ethnicity. To offset this limitation, the Agency is reinforcing early and ongoing training for data entry into the child welfare system database. When entering information for children, training will review the importance of staff appropriately capturing a child or youth's demographic information to decrease the number of indicators not entered for categories such as race and ethnicity to ensure that data outcomes are not impacted nor change the scope of the analysis.

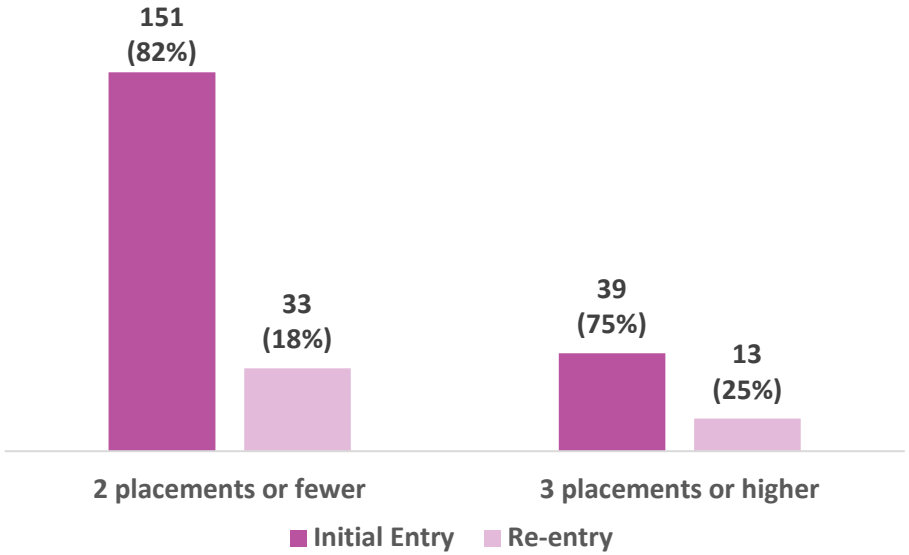
[45] Retrieved from https://www.webmd.com/children/what-to-know-eriksons-8-stages-development

8 DAYS < 12 MONTHS (N=236)

Most children in foster care for at least 8 days but not longer than 12 months had two or fewer placements within this timeframe and can be categorized as having placement stability (78 percent, n=184). Children with three or more placements experienced what is categorized as placement instability, equaling 22 percent (n=52).

For children in this cohort with two or fewer placements, 82 percent (n=151) were in foster care for the first time, while 18 percent (n=33) were in a foster care placement after re-entering foster care. For children with three or more placements, 75 percent (n=39) were in foster care for the first time while 25 percent (n=13) were in a foster care placement after re-entering foster care.

Figure 29 Entries for Children in Foster Care 8 days < 12 months



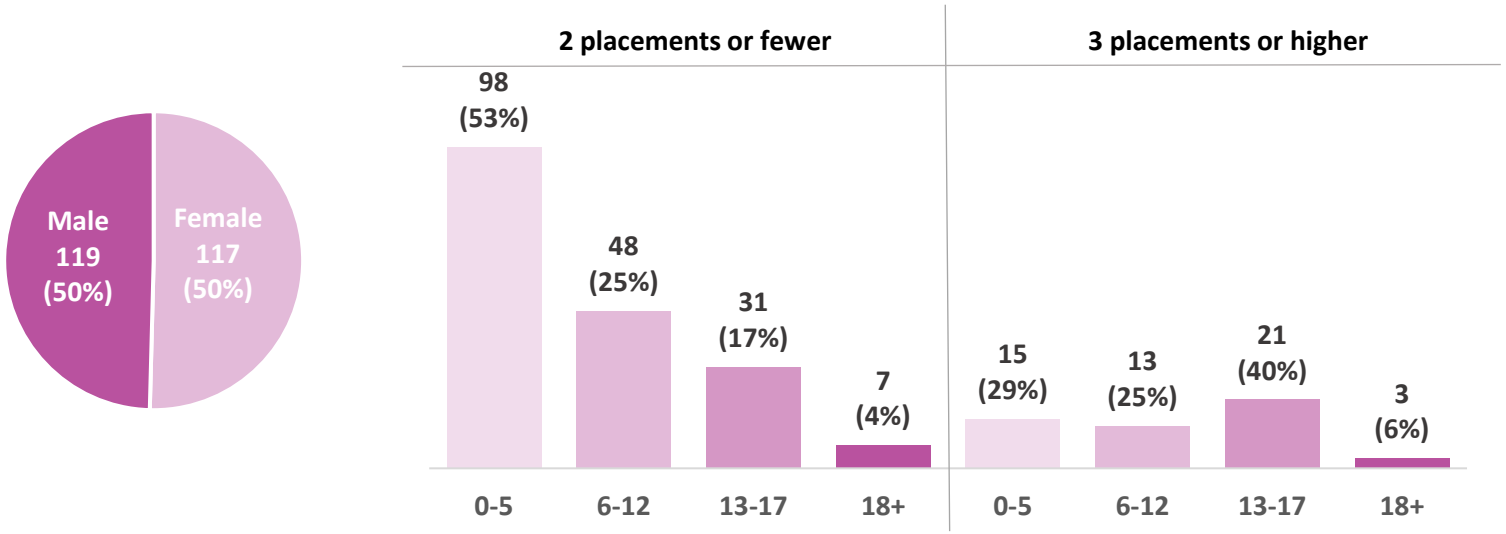
Source: Ad Hoc FACES data pull, as of March 31, 2022

Five months was the overall median duration of time in foster care for this cohort. Children with two or fewer placements had a median duration of 2 months in foster care. Children with three or more placements had a median duration of 7 months in foster care.

Age

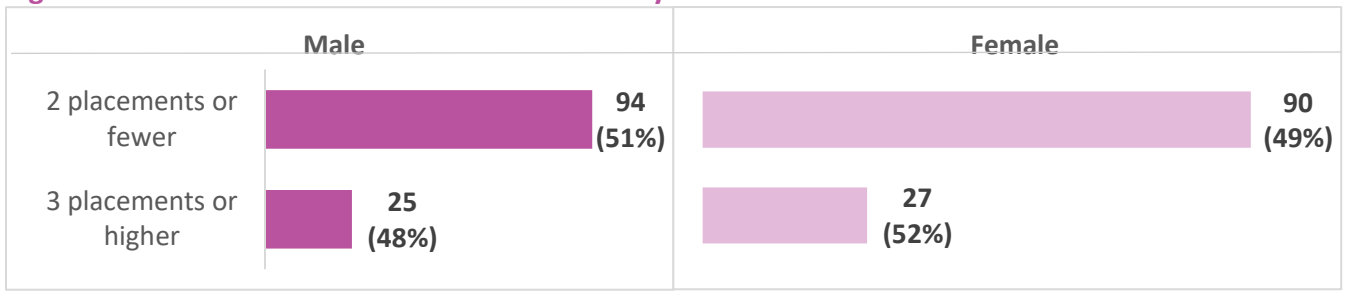
Most children in the sample were age birth to 5 years old and had experienced two or fewer placements while in foster care. Youth aged 13 to 17 had the highest number of placements for the subgroup with three or more placements. Youth aged 18 and older in this cohort were the smallest population served.

Figure 30 Age of Children in Foster Care 8 days < 12 months



Source: Ad Hoc FACES data pull, as of March 31, 2022

Figure 31 Sex of Children in Foster Care 8 days < 12 months



Source: Ad Hoc FACES data pull, as of March 31, 2022

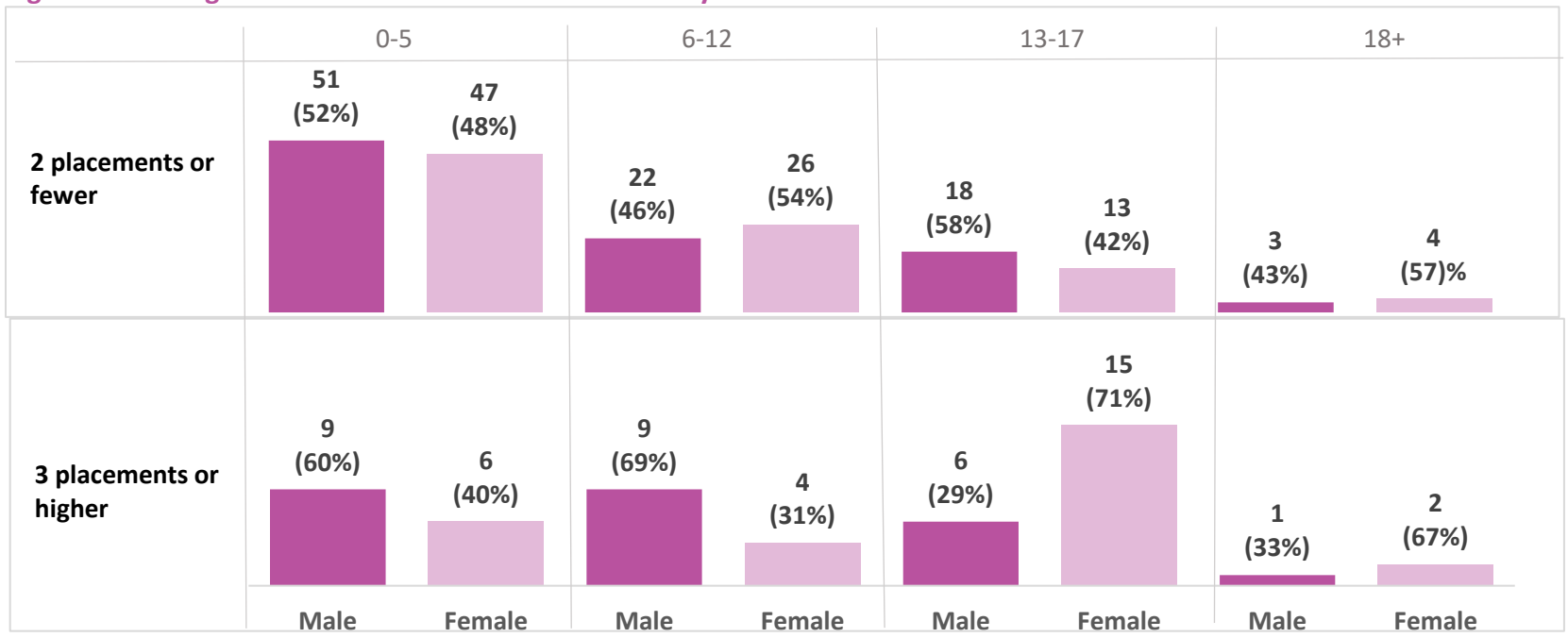
Age & Sex

There were slightly more male children (119) than female children (117) overall in this group. For children with two or fewer placements, 49 percent (n=90) were female, and 51 percent (n=94) were male. For children with three or more placements, 52 percent (n=27) were female while 48 percent (n=25) were male. More females had three or more placements than males.

More male children (52 percent, n=51) aged birth to 5 experienced placement stability (two placements or fewer) compared to their female counterparts (48 percent, n=47) for the same age group. For children aged 6 to 12 years old, there were more females (54 percent, n=26) with placement stability compared to males (46 percent, n=22).

For youth aged 13 to 17 years old who had three or more placements, 71 percent (n=15) were female compared to 29 percent (n=6) of the male youth.

Figure 32 Age & Sex of Children in Foster Care 8 days < 12 months



Source: Ad Hoc FACES data pull, as of March 31, 2022

Race and Ethnicity

African American children represented the racial majority (77 percent, n=141) for the subgroup with two placements or less, followed by Hispanic children (14 percent, n=26). However, limitations occurred for this category due to no race data (9 percent, n=16) or ethnicity data (22 percent, n=40) entered into the child welfare information system.

Figure 33 Race and Ethnicity of Children in Foster Care 8 days < 12 months

Ethnicity	Race	2 placements or fewer		3 placements or more	
		#	%	#	%
Hispanic/Latinx	Black or African American	13	7%	3	6%
	No Race Data Recorded	8	4%	1	2%
	White	2	1%		
	Unable to Determine	2	1%		
Hispanic Total		**25**	**13%**	**4**	**8%**
Non-Hispanic/Latinx	Black or African American	120	65%	40	77%
	No Race Data Recorded	2	1%		
	Native Hawaiian or Other Pacific Islander	1	1%		
Non-Hispanic Total		**123**	**67%**	**40**	**77%**
Unknown/ Unable to Determine	Black or African American	24	13%	7	13%
	No Race Data Recorded	12	7%	1	2%
Unknown/Unable to Determine Total		**36**	**20%**	**8**	**15%**
Grand Total		**184**	**100%**	**52**	**100%**

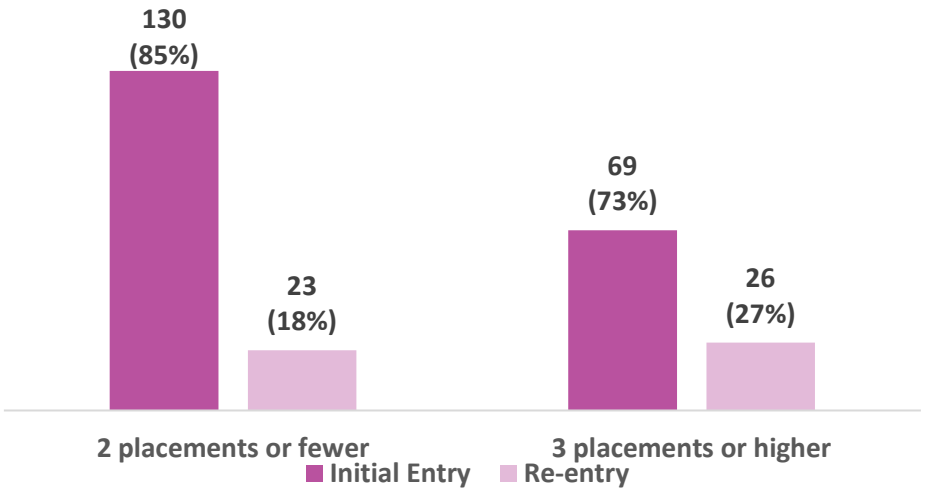
Source: Ad Hoc FACES data pull, as of March 31, 2022

12 Months < 24 months (n=248)

Most children (62 percent, n=153) in foster care for 12 months but no longer than 24 months had two or fewer placements, while 38 percent (n= 95) had three or more placements. Therefore, more than 6 out of 10 children in this cohort continued to meet the definition for placement stability. These children, who had been in foster care for a longer period of time, did have a higher portion of children meeting the definition for placement instability.

Most of the children in this cohort experienced foster care for the first time. For children with two or fewer placements, 85 percent (n=130) experienced foster care for the first and 15 percent (n=23) were in a foster care placement after re-entering foster care. For children with three or more placement in this cohort, 73 percent (n=69) were experiencing foster care for the first time while 27 percent (n=26) were in a foster care placement after re-entering foster care.

Figure 34 Entries for Children in Foster Care 12 months < 24 months



Source: Ad Hoc FACES data pull, as of March 31, 2022

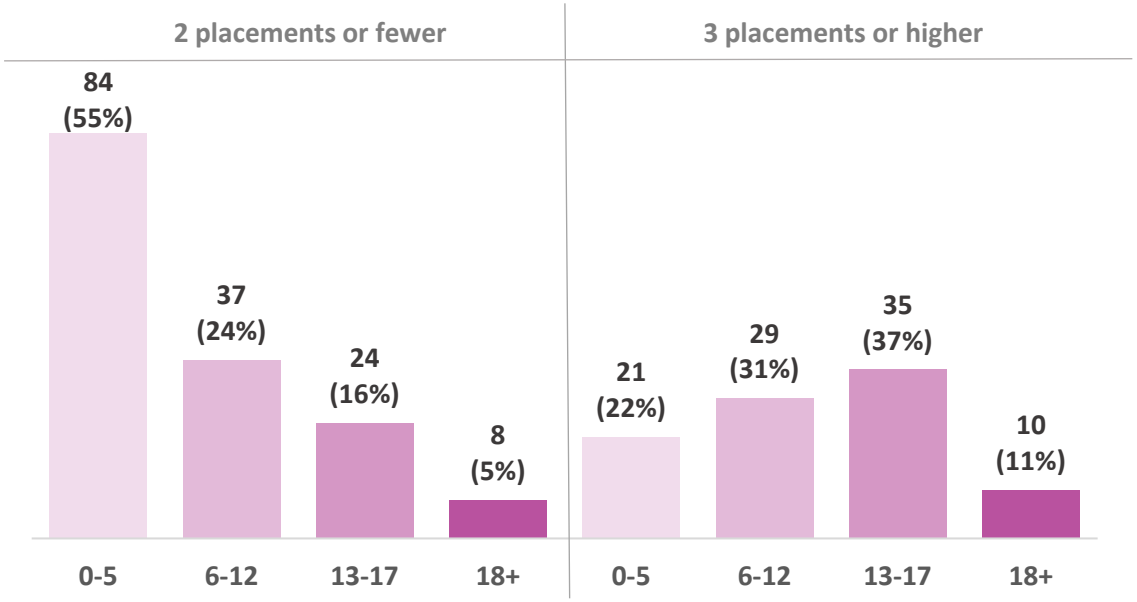
The median duration of time in foster care for children in this cohort was seventeen months. Seventeen months was also the median duration of time in foster care for children with two or fewer placements and children with three or more placements in this cohort. It should be noted that 46 percent (n= 114) of children in this cohort exited care prior to March 31, 2022.

Age

Most children in this cohort with two or fewer placements were birth to five years old (55 percent, n = 84). Additionally, 24 percent of children (n=37) with two or fewer placements were children aged six through twelve years old; children thirteen through seventeen years old experienced two or fewer placements at 16 percent (n=24); and children eighteen years old and older experienced two or fewer placements at 5 percent (n = 8).

Among children in this cohort with three or more placements, the highest proportion was children thirteen years old through seventeen years old at 37 percent (n = 35). Children eighteen years old and older with three or more placements in this cohort had the lowest number of placement changes at 11 percent (n = 10). Additional age groups for children with three or placements is represented in the graphic below.

Figure 35 Age of Children in Foster Care 12 months < 24 months

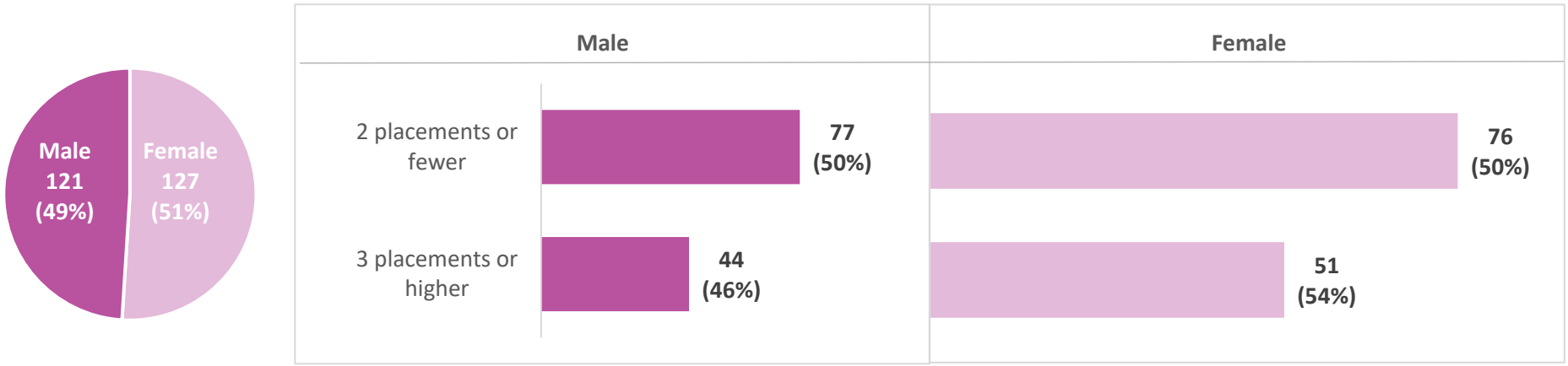


Source: Ad Hoc FACES data pull, as of March 31, 2022

Sex

More female children were represented in this cohort overall at 51 percent (n=127) and males represented at 49 percent (n = 121) with only a slight difference. For children with two or more placements, there was an even split at 50 percent for both male (n = 77) and female (n =76). For children with three or more placements, 54 percent were female (n = 51) and 46 percent were male (n = 44).

Figure 36 Sex of Children in Foster Care 12 months < 24 months



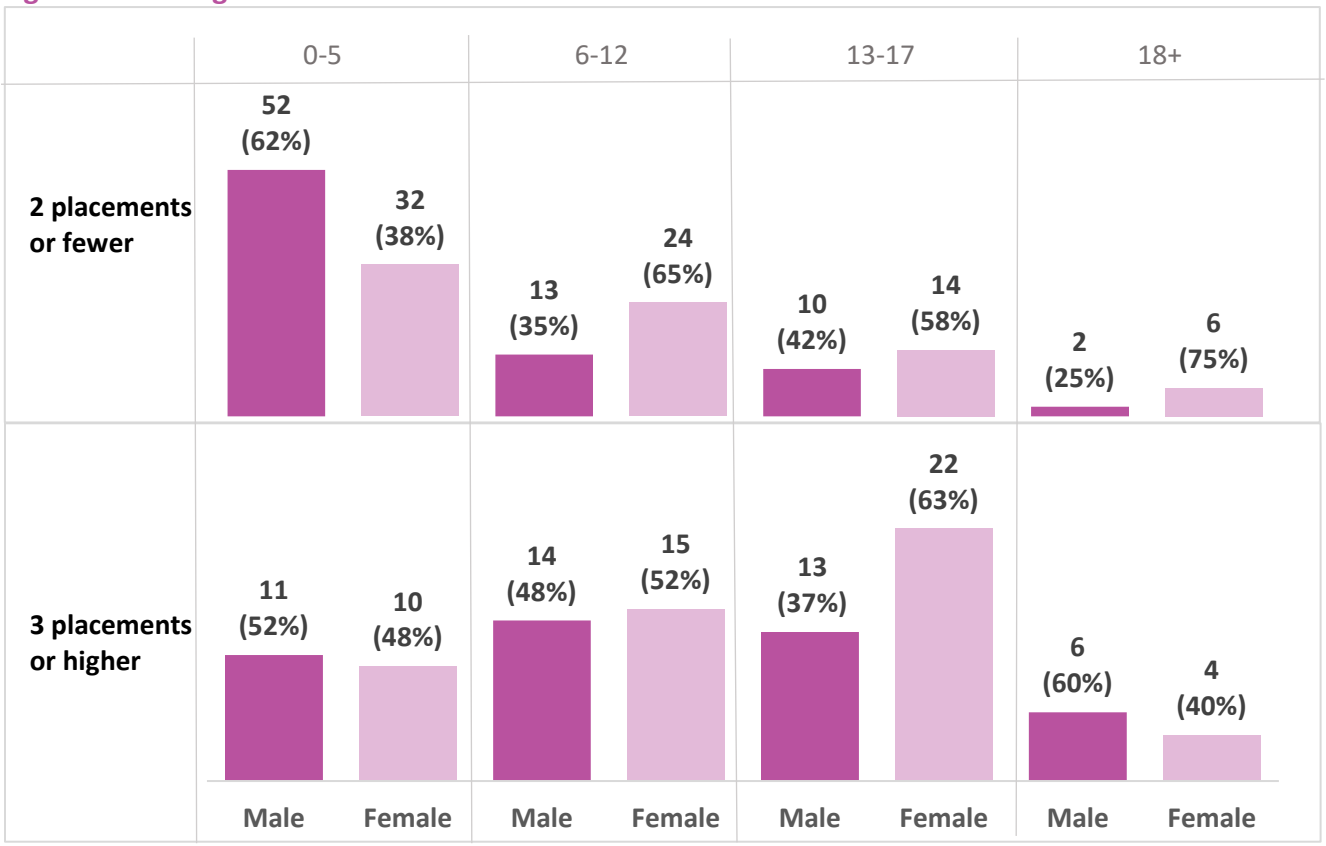
Source: Ad Hoc FACES data pull, as of March 31, 2022

Age and Sex

More male children (34 percent, n=52) aged birth to 5 experienced placement stability (two placements or fewer) compared to their female counterparts (21 percent, n=32) for the same age group. For the additional age groups, more female children experienced placement stability than male in each age group.

For youth aged 13 to 17 years old who had three or more placements, 63 percent (n=22) were female compared to 37 percent (n=13) of the male youth. This age group represented the highest number of placements for children with three or more placements.

Figure 37 Age and Sex of Children in Foster Care 12 months < 24 months



Source: Ad Hoc FACES data pull, as of March 31, 2022

Race/Ethnicity

African American children represented the racial majority (81 percent, n=200) for this cohort followed by Hispanic children. No recorded data was the third category for race for children no matter their number of placements. Additional data concerning race/ethnicity is captured in the next graphic.

Figure 38 Race & Ethnicity of Children in Foster Care 12 months < 24 months

Ethnicity	Race	2 placements or fewer		3 placements or more	
		#	%	#	%
Hispanic/Latinx	Hispanic	11	7%	9	9%
	No Race Data Recorded	4	3%	5	5%
	White	3	2%	1	1%
	Unable to Determine/Unknown	1	1%		
Hispanic Total		**19**	**13%**	**15**	**15%**
Non-Hispanic/Latinx	Black or African American	119	78%	61	64%
	White			3	3%
Non-Hispanic Total		**119**	**78%**	**64**	**67%**
Unknown/ Unable to Determine	Black or African American	9	6%	12	13%
	No Race Data Recorded	5	3%	4	4%
	White	1	1%		
Unknown/Unable to Determine Total		**15**	**10%**	**16**	**17%**
Grand Total		**153**	**101%**	**95**	**99%**

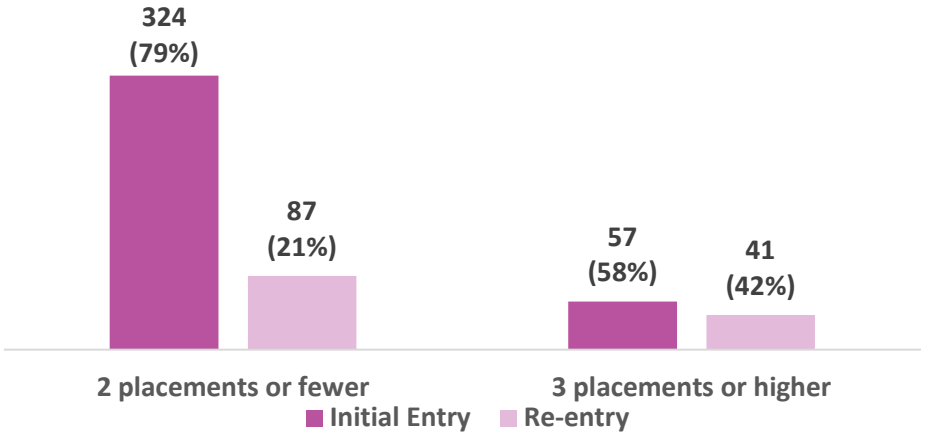
Source: Ad Hoc FACES data pull, as of March 31, 2022

24 MONTHS OR LONGER (n=509)

Of the total 509 children in foster care for 24 months or longer, most children have had two or fewer placements (81 percent) in the last 12 months. The remaining 19 percent of children had three or more placements in the last twelve months.

Seventy-nine percent (n=324) of children in this cohort experienced foster care for the first time and had two or fewer placements. Twenty-one percent (n=87) were in a foster care placement after re-entering foster care. For children with three or more placements, 58 percent (n=57) were in foster care for the first time, while 42 percent (n=41) were in a foster care placement after re-entering foster care.

Figure 39 Entries for Children in Foster Care 24 months or longer



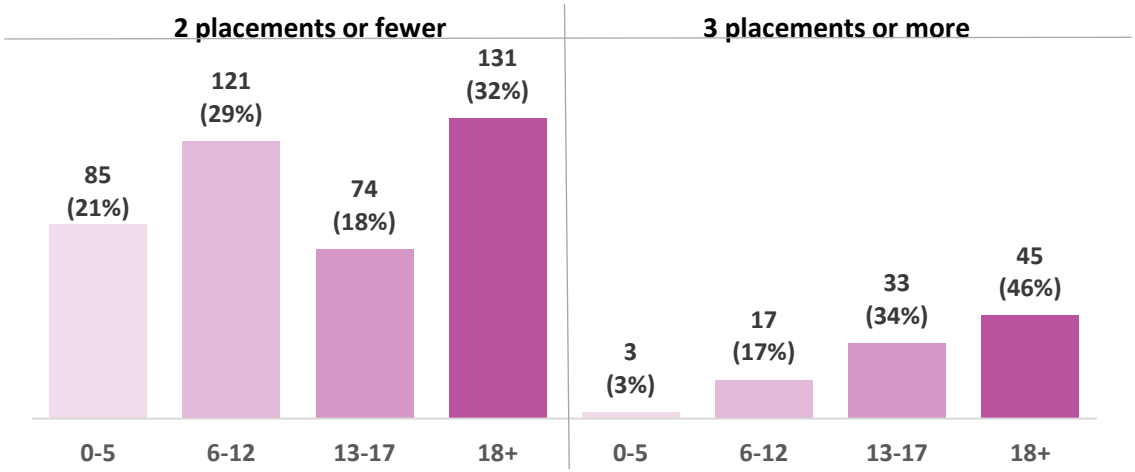
Source: Ad Hoc FACES data pull, as of March 31, 2022

The overall median duration was 39 months in foster care for this subgroup. Children with two or fewer placements were in foster care for a duration of 38 months. Children with three or more placements were in foster care for about 43 months.

Age

Most of the children in this subgroup were youth aged 18 years or older, followed by children ages 6 through 12 years old (Figure X). For children with three or more placements, the ages increase with the number of youths in this subgroup. This increase represents the placement difficulties and instability that often occur as children get older and remain in the foster care system.

Figure 40 Age of Children in Foster Care 24 months or longer

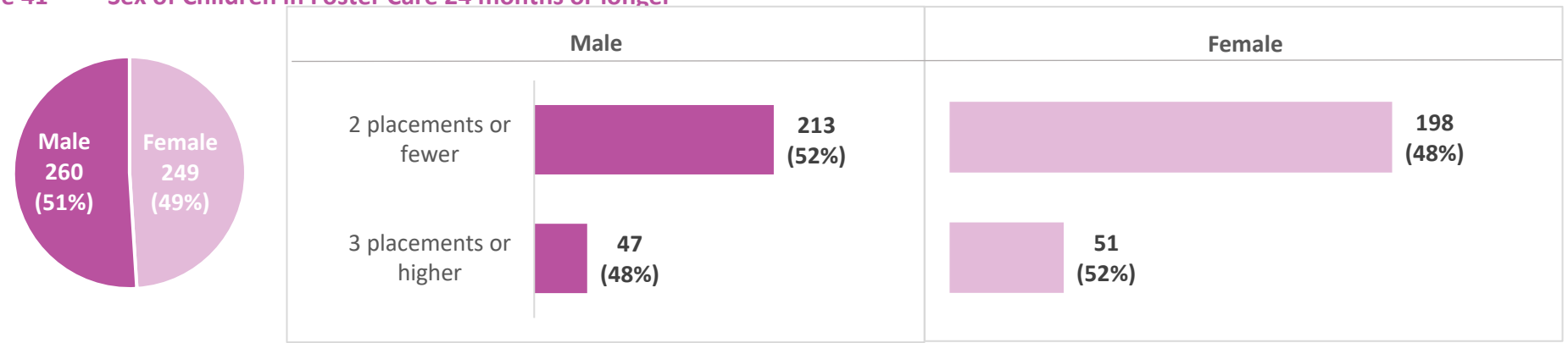


Source: Ad Hoc FACES data pull, as of March 31, 2022

Sex

There were slightly more male children (51 percent, n=260) than female (49 percent, n=249) for children in foster care 24 months or longer (Figure 41). For children with two or fewer placements, 48 percent (n=198) were female, and 52 percent (n=213) were male. For children with three or more placements, 52 percent (n=51) were female, and 48 percent (n=47) were male. More females had three or more placements which was the same in the children in foster care for less than twenty-four months subgroup.

Figure 41 Sex of Children in Foster Care 24 months or longer

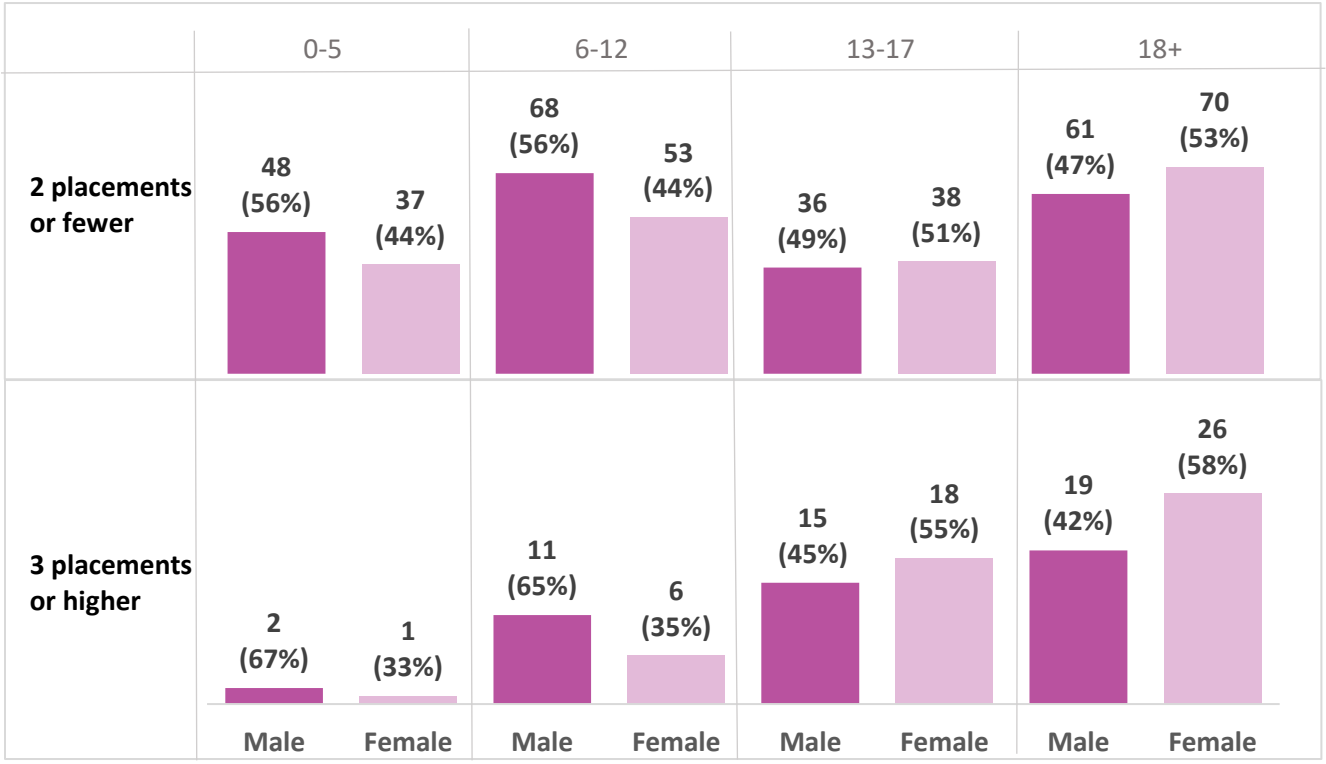


Source: Ad Hoc FACES data pull, as of March 31, 2022

Age & Sex

An analysis of age and sex together (Figure X) indicated comparable amounts of males and females across age groups for children with two placements or fewer. For ages birth to 5, there were slightly more male children (56 percent, n=48) than female children (44 percent, n=37), and a comparable ratio for ages 6 to 12: 56 percent male (n=68) and 44 percent female (n=53). Conversely, there were slightly more female children ages 13 to 17 (51 percent, n=38) compared to male children (49 percent, n=36). For ages 18 and above, there were also more females (53 percent, n=70) compared to males (47 percent, n=61). Slightly more female children aged 13 to 17 (55 percent, n=18) with three placements or more were counted compared to their male counterparts (45 percent, n=15). Among the 18+ age group with three placements or more, there were also more females (58 percent, n=26) compared to males (42 percent, n=19).

Figure 42 Age & Sex of Children in Foster 24 months or longer



Source: Ad Hoc FACES data pull, as of March 31, 2022

Race and Ethnicity

For the subgroup of children in foster care for 24 months or longer, African American children continued to represent the largest racial group (76 percent, n=314), followed by Hispanic children (17 percent, n=70). This breakdown is comparable to the overall analysis and current census of foster care children in the District.

Figure 43 Race and Ethnicity for Children in Care 24+ Months

Ethnicity	Race	2 placements or fewer		3 placements or more	
		#	%	#	%
Hispanic/Latinx	Black or African American	45	11%	6	6%
	No Race Data Recorded	15	4%	4	4%
	Native Hawaiian or Other Pacific Islander	1	0%		
	White	7	2%	2	2%
	American Indian/Alaskan Native	1	0%		
	Unable to Determine/Unknown	2	0%		
Hispanic Total		**71**	**17%**	**12**	**12%**
Non-Hispanic/Latinx	Black or African American	314	76%	80	82%
	No Race Data Recorded	2	0%	1	1%
	Asian	4	1%		
Non-Hispanic Total		**320**	**77%**	**81**	**83%**
Unknown/ Unable to Determine	Black or African American	12	3%	5	5%
	No Race Data Recorded	8	2%		
Unknown/Unable to Determine Total		**20**	**5%**	**5**	**5%**
Grand Total		**411**	**99%**	**98**	**100%**

Source: Ad Hoc FACES data pull, as of March 31, 2022

KINSHIP PLACEMENT

Objective: to increase, streamline and strengthen kinship placements

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Due to the accelerated placement timeline, kin caregivers face challenges being prepared to accept a child in their home.	• CFSA maintain and ensure Agency assistance with childcare is known to all staff and relayed to kinship providers • CFSA provide additional support to kin parents during the first 30 days of placement by way of providing metro cards, use of family support workers and assist in identifying informal supports to appointments, visits, and school • CFSA improve warm hand-offs to the National Center for Children and Families (NCCF) for kinship placements in Maryland
The Code of Maryland Regulations (COMAR) licensure requirements are more restrictive than the regulations in the District. CFSA must seek waivers to some COMAR provisions (e.g., use of bunkbeds and allowing cribs in the provider's bedroom), and if unsuccessful, this limits the pool of kin placements.	• CFSA Director previously had talked with his Maryland counterpart to determine if an agreement can be reached to waive certain non-safety related licensing requirements and minor child protective involvement of caregivers or others in the household. However, this is not viable due to COMAR.
Management Report CMT 232 which is used to track kinship placements, is a point-in-time measure that reflects the total number and percentage of kinship placements compared to the total population of children in foster care and is limited in its usefulness.	• CFSA will use Management Report CMT 367 as the primary tool to examine engagement and efforts to place children with relatives within 30 days, to highlight expedited placements, to focus on specific barriers, and to identify areas of successful support from across the Agency

CFSA has a Kinship Licensing Unit dedicated solely to licensing prospective kin providers in DC, and/or to facilitating licensing for providers in Maryland per the border agreement. However, some common hurdles in the kinship licensing process exist that are not prevalent with traditional placements due to the accelerated timeline for placement. For example, the traditional foster caregiver has already received training and licensure prior to placement while with "kin first placements" this typically happens in reverse order – placement first, training and licensure second. There are resulting challenges based on the lack of up-front preparation, including expediting the eligibility check (background and medical clearances) and assessing living quarters for the child, and getting the necessary resources for the children in place as soon as possible (e.g., furniture, childcare or school enrollment, transportation, accessible mental health services, and afterschool activities).

In addition, for placements with kin in Maryland, CFSA must adhere to the Code of Maryland Regulations (COMAR) licensure requirements, some of which are more restrictive than the regulations in the District. CFSA must seek waivers to some COMAR provisions (e.g., use of bunkbeds and allowing cribs in the provider's bedroom), and if unsuccessful, this limits the pool of kin placements. While CFSA will attempt to obtain waivers, those waivers are not always approved.

An additional consideration for increasing and supporting kinship placements is modification of the current tracking method. Prior to FY 2022, the Agency tracked kinship placements solely using Management Report CMT 232, a point-in-time measure that reflected the total number and percentage of kinship placements compared to the total population of children in foster care. As of FY 2022, this tracking transitioned to gathering data on kinship placements within the first 30 days of a child entering foster care, using Management Report CMT 367 as the primary tool. The transition from CMT 232's data and CMT 367's data has allowed CFSA to examine engagement and efforts to place children with relatives within 30 days, to highlight expedited placements, to focus on specific barriers, and to identify areas of successful support from across the Agency.

CONTINUED PRACTICES FOR KINSHIP CAREGIVERS

CFSA will continue to provide resources such as daycare vouchers for kinship providers, which will help maintain placement stability.

The Kinship Unit will continue promotion of the Kinship Caregiver Warm Line for kinship caregivers to address any needs for resources or services, thus facilitating placement stability. The support line is available Monday through Friday from 8:15am to 4:45pm at (866) FAM-KIN1 or (866) 326-5461.

The Kinship Licensing Unit, the Office of Entry Services, and the Family Team Meeting Unit will continue and strengthen collaborative efforts to identify the most suitable potential kinship providers during the investigation process and, whenever possible, prior to a child coming into foster care.

CFSA will continue to utilize and promote the Kinship Navigator Program to enhance accessibility of services available to kinship caregivers.

How Do Kinship Placements Impact Placement Stability?

Placing children first with a kinship caregiver, whenever appropriate, increases the child's placement stability, primarily due to a child's existing comfort level with extended family members. Research shows that children living with relatives are more likely to experience placement stability than living in non-kinship homes.[46] The bond with relatives or fictive kin provides a sense of connection that generally does not exist when placing children in the care of traditional resource parents whom the child generally does not know. The data below suggests that children in CFSA's care between 2021 and 2022, who were placed with a relative caregiver while in foster care (even when kin placement happened later), were stable with most of the population staying in their placements between 7-15 months.

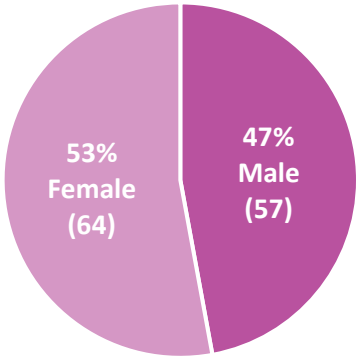
From FY 2021-Q1 to FY 2022-Q2, CFSA served a total of 1,030 children in foster care. During this reporting period, there were a total of 468 children who exited foster care. Of that total, as of March 31, 2022, 36 percent (n=168) exited foster care from a kinship placement. Of those exits, 99 percent (166) exited to positive permanency, including 54 percent (n=91) to adoption, 26 percent (n=43) to reunification, and 19 percent (n=32) to guardianship.

Regarding placement stability for the 168 children who exited foster care from a kinship placement, the majority, 78 percent (n=131), experienced two or fewer placements. Their median length of stay was 15 months. Kin placements were identified upon entry or re-entry into care for 54 percent (n=71) of those children. Eight percent (n=14) of the exits involved children who were placed with a relative on their third placement, where they remained in the stable environment until case closure. For those 14 children, the median length of stay was 14 months. CFSA placed 13 percent (n=23) of the children with a relative in the fourth or subsequent placement. The median length of stay for those 23 children was 15 months.

Fifty-five percent (n=562) of the 1,030 children were in care with 22 percent (n=121) placed with a kinship caregiver. Sixty-three percent (n=76) of the kinship placement sample had no more than two placements with a median length of stay in kin placement being 7 months. Eighteen percent (n=22) were not placed with their relative until their third placement change. However, those same placements experienced stability in the placement with a median length of stay of 9 months. Of the remaining 19 percent (n=23), the Agency was unable to place the children with a kinship caregiver until the child's fourth or even subsequent placement. Following the trend of placement stability with kin, those later placements still had a median length of stay of 7 months.

[46] https://www.childwelfare.gov/topics/permanency/relatives/impact/

Figure 44 Sex of Youth in Kin Placements

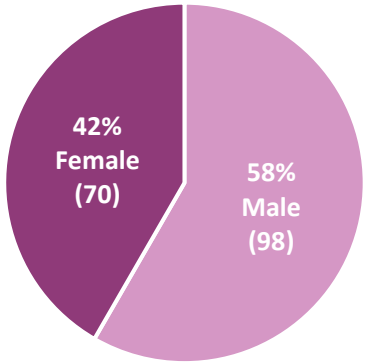


Source: FACES Management Report CMT 366

Figure 45 Age of Youth in Kin Placements

Age Range	Count
Birth - 5	58 (48%)
6 - 12	33 (27%)
13 - 17	21 (17%)
18+	9 (7%)
Total:	**121**

Figure 46 Sex of Youth who Exited Kin Placement



Source: FACES Management Report CMT 367

Figure 47 Age of Youth who Exited Kin Placement

Age Range	Count
Birth - 5	72 (43%)
6 - 12	59 (35%)
13 - 17	27 (16%)
18+	10 (6%)
Total:	**168**

What factors contribute to delaying or denying kin placement?

Often prospective kinship providers express a willingness to become caregivers to ensure the safety of their relatives' children who have been separated from the home. When families are receiving in-home services there are also efforts made through concurrent kinship planning to identify relatives as caregivers in the event of a separation. The *Fostering Connections to Success and Increasing Adoptions Act of 2008* includes two very important provisions specific to licensing relative foster homes. First, the legislation codifies earlier guidance that states may waive non-safety-related licensing standards on a case-by-case basis. The purpose of this waiver is to eliminate barriers to placing children with relatives, either in a temporarily licensed home or in a permanently licensed home. These standards may include requirements such as mandatory square footage and minimum numbers of bedrooms or bathrooms per person. While CFSA utilizes these licensing waivers whenever possible, not all kinship caregivers can meet the licensing requirements even with a waiver.[47] When kinship placements are emergency placements, CFSA makes every effort to ensure a streamlined temporary emergency licensing process. Due to the imminent need for the placement, there is little time to prepare, which means one or more of the following issues may arise, either causing ineligibility or delaying the temporary licensing process for prospective providers:

- **Lack of sufficient income** to ensure foster rates are supplementary and not primary sources of income [prevents licensing]
- **Lack of space** [prevents licensing]
- **Background clearance issues** [prevents or delays licensing]
- **Unique work hours** [delays licensing]
- **Transportation challenges** [delays licensing]
- **Apprehension regarding government involvement** [prevents or delays licensing]
- **Birth parents' behavior and interfamilial tensions** [prevents or delays licensing]
- **Kinship caregiver's mental health evaluation** [prevents or delays licensing]
- **Children diagnosed with severe medical conditions**, requiring equipment and specialized care [prevents or delays licensing]

For all of the above examples, prospective kinship providers may be willing to foster but struggle with the licensing requirements. A primary example is a **lack of sufficient income**. Sufficient income means that one's income can cover all their living expenses. When this is the case, others

[47] https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/fosteringconnections/

in their support system may help them make up financial losses by assisting in covering bills on their behalf. Also, when the kinship caregiver's name is not on a lease, it requires additional research to prove their housing and financial stability. The prospective kinship provider may be reluctant to involve other parties for fear of causing housing instability for themselves.

CFSA may have willing prospective caregivers, but housing in the District is often a serious challenge. The prospective caregiver may **lack the proper space** to meet requirements outlined for the District or for Maryland.[48] An example might be a couple residing in an efficiency apartment where the couple is willing, but the space is insufficient for additional beds, and privacy becomes an issue. Other instances include homes where a caregiver has two biological children in an extra bedroom with two beds and the caregiver is already on a couch, but the placement requires space for a crib. If the two beds could be converted into one bunkbed, the room space could have allowed for adding a crib. However, Maryland state regulations do not permit bunkbeds.

At times other household members in the prospective kinship caregiver's home may be unwilling to comply with or pass requisite **background clearances** (i.e., Child Protection Register clearance as well as FBI and National Crime Information Center criminal records' check).[49] The household members may feel they are not a part of the case and should not be held responsible for their past convictions resulting in the home being unable to obtain a license.

Licensing for willing and able kinship caregivers may be stalled because of the prospective caregiver's **current work schedule.** The place of employment may lack flexibility which prohibits changes to their work hours, preventing the relatives to become providers. Some providers work retail or evening shifts and may have a limited support system. CFSA will attempt to provide extended supports, like aftercare, but these supports may not be sufficient, depending on the type of employment.

CFSA makes every effort to maintain a child in its familiar school placement. Sometimes, a prospective kinship caregiver lives enough distance away that **transportation challenges** might impact a providers' capacity to ensure timely attendance, especially if they are relying on public transportation that requires transfers from buses to subway stops. When there are multiple children of varying ages to be placed, all attending

[48] For the District of Columbia, kinship caregivers must be eligible based on Title 29, Chapter 60 of the DC Municipal Regulations (DCMR) (https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/foster_home.pdf); for the state of Maryland, relatives must comply with the Code of Maryland Regulations (COMAR) (https://dhs.maryland.gov/documents/Licensing-and-Monitoring/Laws%20and%20Regulations/pfc.pdf).

[49] Per DCMR Title 29, Ch. 60 § 6008, individuals 18 years or older must not have convictions of child abuse (including sexual abuse) or neglect, spousal abuse, fraud, drug convictions, homicide, etc. Per § 6009, individuals must not have a record in the Child Protection Register, the database for substantiated and inconclusive abuse and neglect allegations.

different schools, transportation for an elementary school student presents a challenge to the middle school student, etc. CFSA can provide transportation supports, however it could take a few days after the child is first placed in the kinship placements for these transportation services to be put in place.

Prospective kinship caregivers may be **apprehensive or mistrusting of the government** and refuse to be subjected to the various steps to become a licensed provider. If they have previously cared for the child through an informal process, including a safety plan without court involvement, the relatives may view kinship licensing as unnecessary and intrusive. Often overwhelmed, the relatives may decide not to move forward, or they may become unresponsive midway through the initial licensing process.

With regard to the **parents' behavior**, the circumstances that brought the family to CFSA's attention usually includes the parents' complex trauma histories as well as the children's histories. The children's trauma necessarily includes the separation itself along with their parents being substantiated for neglect or abuse. However, the separation is also a trauma for the parents. Beneath that separation is generally a long history of trauma, and often substance use addictions. Sometimes family members sever ties with the parent. There may be sibling rivalries even before a sibling welcomes nieces and nephews into the home. The parent may feel emotions such as anger for the situation. There are multiple justifiable reasons parents do not accept the kinship caregiving depending on family dynamics. For example, if family history includes aggressions, the prospective kinship caregiver may decline the placement.

Licensing regulations require all resource parents to be physically and mentally capable of the caregiving responsibility. Prospective kinship caregivers must disclose any physical and behavioral health challenges, along with any therapeutic interventions to address the challenges, and any medications. Gathering the **behavioral health** evaluation documentation may take time, delaying or preventing licensure depending on the results. Once CFSA receives the documentation, there may be a need to follow up on the findings. For example, there might be an instance when a past behavioral health provider documented the caregiver never being officially discharged from treatment. In addition, some physical ailments may affect licensure, such as an inability to walk long periods and bare the weight of carrying an infant, or conditions like diabetes with medication that may cause drowsiness. The Agency could work with the circumstances and determine whether the kinship placement can be delayed, versus denied, if the Agency assists with a referral for services.

Lastly, sometimes children are born with **severe medical conditions** that require feeding tubes, heart machines, even full-time nursing care, but the children do not require a full-time hospital setting. The kinship caregiver realizes that even with full-time nursing or home aide support, a child diagnosed as medically fragile is a daunting task that may require several pieces of special equipment, including a hospital bed, and possibly a separate room with sufficient space for the equipment. All age-appropriate family members should be educated to some level on the care of the

child. With all that responsibility, there are still times when the proposed kinship caregiver willingly cares for such a child. There are often times when the kinship caregiving, for whatever reason, is not an option.

What are the factors that cause a kinship placement to disrupt?

In addition to research that supports the Agency's kinship placement practice, CFSA's direct experience supports the Agency's kinship practice which has demonstrated increased stability and improved outcomes experienced by children with kinship caregivers. However, CFSA has also experienced kinship placement disruptions. From FY 2021-Q1 to FY 2022-Q2, 22 percent (n=27) of the total 121 kinship placements experienced disruptions. Thirty percent (n=8) of the 27 disruptions were due to the kinship provider becoming overwhelmed or no longer willing to allow the child to remain in the home for other reasons. Twenty-six percent (n=7) disrupted due to a youth's physical and verbal acts of aggression towards the kinship provider, or simply a youth's refusal to follow house rules. Nineteen percent (n=5) disrupted due to family and sibling conflict within the home. For the remaining seven children, 11 percent (n=3) of the placements disrupted due to medical concerns and another 11 percent (n=3) disrupted due to incompletion of the licensing regulations. Three percent (n=1) disrupted when the teenager transitioned to a teen parent home.

With these and other data, plus kinship caregiver feedback, the Agency regularly re-examines engagement, assessments (caregivers and the children in the home), and clinical determinations for what types of supports and services need to be tailored, both in general and for any given kinship provider. This re-assessment process occurs through ongoing data analysis, case reviews, and clinical discussions between social workers, their supervisors, and their program managers.

Figure 48 Reasons for Kinship Placement Disruptions, FY 2021 to FY 2022-Q2

Kin Disruption Reasons	Count	Percentage
Unwilling/Overwhelmed	8	30%
Behavioral/Physical and Verbal Aggression	7	26%
Family Conflict within the Home	5	19%
Medical/Behavioral Concerns	3	11%
Kin Did Not Complete Licensing Requirements	3	11%
Transition to Teen Parent Program	1	3%
Total:	**27**	**100%**

Source: FACES Management Report PLC 257 (qualitative review)

What are the barriers to Maryland placements and how can CFSA address them to facilitate kinship placements as a first placement?

Barriers to Placing with Kin First in Maryland

The most cumbersome Maryland placement barrier is the Agency's inability to be granted waivers through Maryland's licensing process. Often during phone screenings and home assessments to issue a Maryland temporary license, CFSA encounters spacing issues, especially with sibling groups where bunkbeds (against COMAR regulations) would alleviate the issue. Maryland's rules prevent infants older than 6 months from sleeping in the kinship caregiver's bedroom, even in a crib. Maryland's licensing also prevents a waiver to CPS history, even when a case occurred over 10 years ago. This barrier is specifically problematic when the provider has demonstrated growth, reflection, and stability over those 10 years, or when the substantiation occurred even after the provider took steps to mitigate the circumstances around the allegation (e.g., addressing domestic violence).

Due to challenges with securing mental health services upon separation, neither CFSA nor its contracted Maryland placing agency, the National Center for Children and Families (NCCF) consistently and in a timely fashion ensure prompt and tailored services to address a child with behavioral challenges. Inherently, the process of securing mental health services involves multiple steps to include: a mental health evaluation to determine if services are needed, and if services are recommended, agreeing on a consistent schedule for treatment, assigning a responsible party for transporting the child, and then initiating services. Throughout the time it takes to complete these steps, the child may be exhibiting behavioral symptoms of their mental health condition and/or trauma experienced, which can impact the stability of the placement. Stable service provision should include one dependable provider and ongoing maintenance of the child's basic behavioral and emotional well-being (which may include medication management, supportive services, after-school intervention programs, and summer programming). Kinship caregiver feedback has also included concerns over CFSA and NCCF's ability to assist with families with quick access to daycare, which also has multiple steps for identifying convenient and affordable locations, in addition to confirming which of the locations have available slots.

Recommendations to Increase Kin First in MD

In the past, CFSA has tried to advocate with Maryland's child welfare officials for CFSA or the Maryland provider agency to grant waivers for challenges related to spacing issues (where safety is determined not to be at risk), and waivers for minor CPS history that can allow placement of children with family. However, Maryland's COMAR requirements do not allow for this waiver.

Continue the assignment of a dedicated CFSA staff member who is familiar with and can locate suitable and quality daycare in the provider's area to ensure the child's enrollment. The Agency staff member would assist with the enrollment process, including daycare vouchers and facilitation of

any appointments needed to ensure medical compliance, and submission of completed medical forms. When the Kinship Unit learns about the immediate need for daycare, they would share the information with the OWB daycare specialist to begin identifying an appropriate provider.

How can the Agency encourage more kinship placements sooner?

As with the recommendation of daycare assistance for potential providers in Maryland, the same is true for providers identified within the District's boundaries. By offering vouchers, locating daycare centers, and continuing to facilitate necessary medical appointments, providers may become much more likely to pursue kinship licensing. Furthermore, the Agency can encourage earlier kinship placements through early engagement, specifically during the investigation process and during initial family team meetings. To that end, the agency has implemented more efficient tools to track the success of Diligent Search efforts to locate kin. For any family receiving in-home services, engagement within the family's support network is a key resource in the event that the family is unable to remain stable and a separation occurs. Both circumstances are opportunities for the Agency to identify and engage immediate and extended relatives, including fictive kin. Early engagement with a family's relatives also allows the social work team to enter the names of family members as collaterals in the child welfare information database, allowing for any additional staff to identify and reach out to the relatives as needed, including for an initial informal placement vetting process.

The children themselves are a critical source of information when trying to identify close relatives or fictive kin supports whom the children trust, visit, and have an existing bonded relationship. When applicable, early and consistent engagement with the non-resident parent is also a critical practice standard. Even if the non-resident parent is not involved, the parent's relatives should be explored and engaged. If the non-resident parent's full name is known, the assigned social worker can request a diligent search to help identify family members. Once identified, the social worker can initiate engagement, including invitations to family team meetings. Generally, the non-resident parent is a father but there are also cases whether the non-resident parent is the mother.

Fundamental to the recruitment and support of kinship caregivers, the Kinship Unit hosts information sessions and webinars to reiterate the positive importance of kinship placements when children and youth have to be separated from their families of origin. In this regard, the Kinship Unit can help strengthen case-carrying social worker's skills with assessing relatives to ensure that CFSA and private agency social workers are well-versed in licensing expectations and requirements. While working with families, social workers should always feel comfortable asking a Kinship Unit staff member to speak directly with potential kinship caregivers, even if only briefly to assist them in making an informed decision.

III. PLACEMENT STABILITY THROUGH THE LENS OF QUALITY SERVICES REVIEWS

PLACEMENT STABILITY

Objective: to increase placement stablity, for older youth in particular

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Resource parents lacked the ability to manage children and older youth with behavioral challenges (e.g., inflexibility). This need is reflective in kinship care disruptions where 26% (second highest reason for disruptions) were due to behavioral, physical and verbal aggression.	Training for resource parents on stages of development, normal teenage behavior that is exaggerated by the trauma they have experienced, to decrease parents asking for their removal based on their behaviors
Resource parents are not consistently active team members.	• Resource parent support workers at CFSA and Parent Coaches at NCCF should make themselves active team members alongside the resource parents to elevate their voices. Placement managers will work with the BOND squad leads to enhance their support of resource parents who are feeling disconnected or left out of the team
Social worker turnover made it difficult to address placement instability.	CFSA hired a recruiter to hire social workers
Placement instability in general is more common among youth over the age of 13 than for younger children in foster care. For example, older youth struggle with symptomatic reactions to their own complex trauma history. Six out of ten youth children experienced placement instability were girls. Among these girls, they were older youth (between the ages of 14-17 years old) and one 17-year-old was a parent. Females aged 13 to 17 years old represented the highest number of placement changes (three or more).	• CFSA intends to further consider the specific behaviors of the youth in this age category to determine their unique needs during foster care placement, and to provide services or interventions to prevent compromises for their placement stability. • Training for resource parents on stages of development, normal teenage behavior that is exaggerated by the trauma they have experienced, to decrease parents asking for their removal based on their behaviors. CFSA social workers, resource parent support workers and OYE staff, in partnership with GALs, will explore and connect youth to mentorship and other prosocial activities, such as sports, music etc. DC CASA and

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
*From the cohort analysis in the placement stability by cohort which supports the findings of the QSR.	DC FYI are long term partners of the agency who will also provide support and notification of new city programming.
Females aged 18 years or older was the largest population of children in foster care for 24 months or longer and in each placement change type. *From the cohort analysis in the placement stability by cohort	Conduct the Agency's first qualitative analysis for children and older youth with three or more placements to begin during fall 2022.

What do the Quality Service Review (QSR) findings tell us about Placement Stability?

CFSA uses the nationally recognized QSR process to assess CFSA's practice standards and service delivery to clients of the District's child welfare system. The QSR process is a critical continuous quality improvement strategy (CQI) for CFSA and its partners to assess those practice standards, regardless of a child's goal, foster care placement, or receipt of in-home services. In CY 2021, CFSA reviewed a total of 80 out-of-home cases. To examine each case, the QSR specialists used a Likert scale to rate practice: 1-3 ratings are "unacceptable" and require improvement, 4 ratings are "acceptable" but required practice refinement, and 5-6 ratings are "acceptable" and only require maintenance of excellent practice. Ratings shared in this report are based on multiple indicators from two domains: *Child and Family Status* and *System Practice Performance* indicators.

Summary of Needs to be Considered

QSR findings continue to highlight trends that impact placement instability. The QSR reviews identified the following three main trends:

- **Behavioral Challenges:** Resource parents lacked the ability to manage children and older youth with behavioral challenges. Team efforts to stabilize the placement were offset by a youth's criminal history, ongoing high-risk behaviors, and incarceration.
- **Parenting Style:** Resource parents demonstrated inflexibility when parenting older youth.
- **Teaming:** Teams were not including resource parents as team members. Team inconsistency had a negative impact on planning for the youth stability. Social worker turnover appeared to contribute to the team's capacity to authentically address the placement instability.

Placement instability in general is more common among youth over the age of 13 than for younger children in foster care. For example, older youth struggle with symptomatic reactions to their own complex trauma history. A youth's own behaviors may include physical altercations, criminal history, risky sexual behaviors, and substance use. Prior to placement, assessment and understanding of resource parents' caregiving capacities must include a

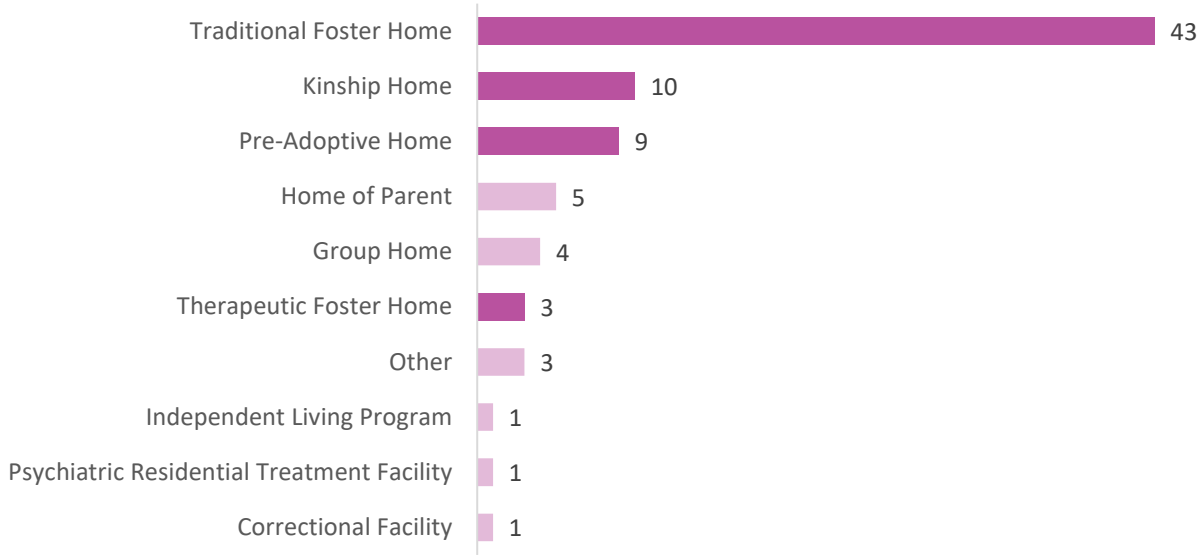
resource parent's preparedness to embark upon intensive trauma-informed caregiving. In most cases with placement instability, the resource parents' needs are not well understood.

Successfully stable placements more often include caregivers who are flexible and focused on a child or youth's strengths, and actively advocating for the needs of the child or youth in their home. If a team is not proactively engaging with the resource parent, issues of flexibility and preparedness cannot be sufficiently addressed to ensure stability.

Placement Settings for Cases Reviewed in CY 2021

Of the 80 children reviewed, 81 percent (n=65) were residing in a family-based foster care setting (traditional foster home, kinship home, pre-adoptive home, or therapeutic foster home). Of these family-based placements, 15 percent (n=10) were living with kinship caregivers.

Figure 49 The majority of Children Evaluated in the CY 2021 QSR Findings Resided in Family-Based Foster Care Settings

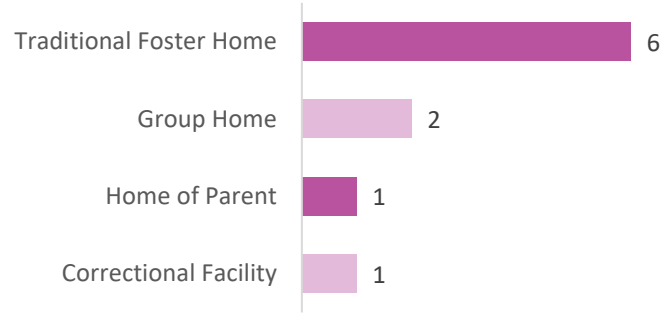


Source: Quality Services Review Data

For this report, the most relevant Child and Family Status indicator is ***Stability*** indicator, which measures the degree to which a child is experiencing stability in the home, school, community, and other environments (e.g., weekend visits at a grandparent's home).[50] QSR reviewers examine whether the child's daily settings (home or placement) regular routines, and relationships are protected from the risks of disruption; whether the stability of these daily settings, routines, and relationships have been consistent over the past 12 months; and whether the Agency is addressing known risks in order to achieve stability and reduce the probability of any future disruptions, specifically the child's projected stability for the next 6 months. Of the 80 out-of-home children's cases reviewed in CY 2021, **88 percent (n=70) received an acceptable rating for placement stability. Reviewers rated 12 percent (n=10) as unacceptable for placement stability.**

What are the characterisitics of and barriers faced when children and youth experience placement instability (n=10)?

Figure 50 Most Children (7 out of 10) with Unacceptable Ratings for Placement Stability Resided in a Family-Based Setting

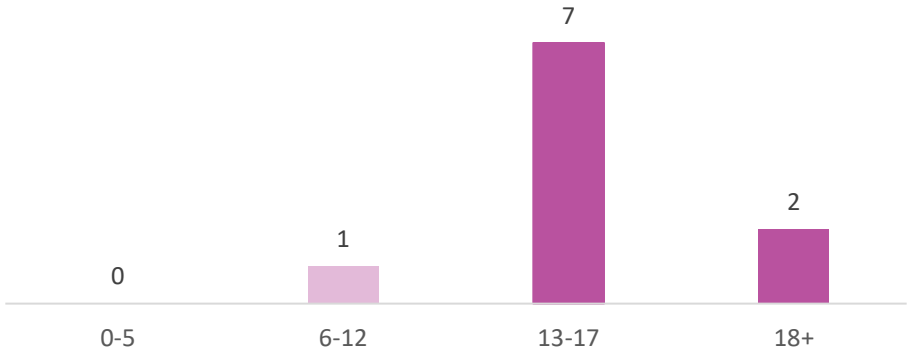


Source: Quality Services Review Data

Of the ten children who experienced placement instability, the majority (n=7) were older youth aged 13 to 17, followed by two young adults (18 and older). The youngest child experiencing placement instability was 6 years old.

[50] For listings of children in "home of parent," a child in foster care may be living in the home of a birth parent under protective supervision until the Agency closes the foster case.

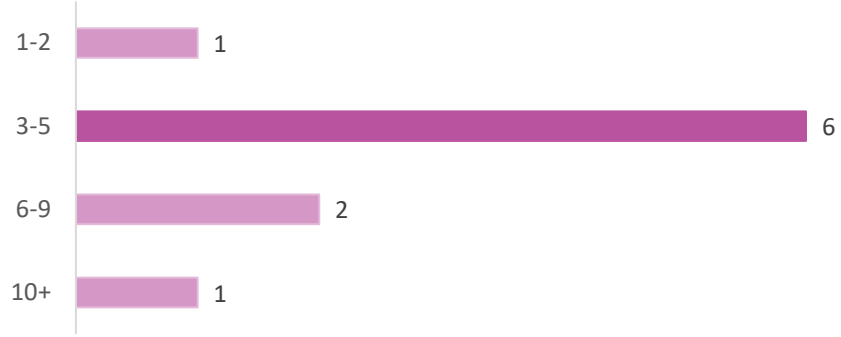
Figure 51 Most Youth (9 out of 10) experiencing placement instability were older youth and young adults



Source: Quality Services Review Data

Collectively, more than half (n=6) of the 10 children and youth experienced three-to-five placements, including the 6-year-old (Figure 45). Two older youth experienced six-to-nine placements, followed by one older youth who experienced more than 10 placements and one youth experiencing one-to-two placements within the 12-month period. Six out of ten youth children experienced placement instability were girls. Among these girls, they were older youth (between the ages of 14-17 years old) and one 17-year-old was a parent.

Figure 52 Sixty percent of Youth with Placement Instability had 3-to-5 Placements within the Past 12 Months



Source: Quality Services Review Data

Despite these placement changes and instability, there is **strength in practice: 70 percent (n=7) of these children were able to remain in the same school setting.**

What are the mental health implications for children who experience placement instability?

Among the 10 children with unacceptable ratings for placement stability, half (n=5) were receiving behavioral health interventions. Of these five, three received an acceptable rating for behavioral health intervention, and two received an inadequate rating for behavioral health services. For the *Behavioral Risk* indicator, half of the 10 children and youth received acceptable ratings and half received unacceptable ratings. Ratings for the *Emotional Functioning* indicator were slightly different: six children and youth received unacceptable ratings and four received acceptable ratings.

Figure 53 Mental Health Characteristics of Youth who Experience Placement Instability

Characteristics	# of Youth	# Acceptable Ratings	# Unacceptable Ratings
Behavioral Health Intervention	5	3	2
Behavioral Risk	10	5	5
Emotional Functioning	10	4	6

Source: Quality Services Review Data

One of the youth receiving unacceptable ratings for behavioral health interventions was not consistently receiving therapy. When the youth did participate in therapy, the intervention was not reported to be addressing the youth's trauma, aggressive behavior, and difficulties with peer and family relationships. The youth was not learning adequate coping skills to improve behavior and meet treatment goals. There were also limited options in the choice of treatment modalities (i.e., the majority of options were limited to talk therapy). Traditional talk therapy did not prove effective for addressing the youth's complex traumas and emotional dysregulation. As a result, the youth's acting-out behaviors persisted, which ultimately and negatively impacted placement stability.

The second youth continually refused to engage in behavioral health treatment, which resulted in challenges for consistent intervention. **The lack of youth participation in behavioral health interventions contributed to ongoing risky behavior and poor emotional functioning, which directly impacted placement stability.**

Engagement, Assessment and Support and Services for Youth

Despite unacceptable ratings for placement stability, there was **good social work team engagement with 8 of the 10 children and youth in the sample**. The team was able to successfully develop organic assessments that guided the intervention strategies for addressing safety, permanence, and wellbeing.

For the two youths with poor engagement ratings, there was one marginal assessment rating and one poor implementation of appropriate supports to address identified needs. Three of the youth who were not involved with behavioral health interventions were engaged in risky behaviors and had poor emotional functioning, both of which impacted their placement stability. Findings also indicated that there was limited engagement of one youth that contributed to a poor assessment that resulted in a lack of appropriate supports and services to address the placement instability. The one 6-year-old child experienced three placements in 8 months due to the behavior and behavioral health needs of a sibling who shared the placement. The Agency usually prioritizes sibling placements but in this case the sibling's behavior impacted placement for the child whose case CFSA was reviewing.

Cases with Unacceptable Stability and Behavioral Health Interventions

Forty-eight percent (n=38) of the 80 out-of-home cases included children who were receiving behavioral health services. Of the children receiving behavioral health services, 13 percent (n=5) of cases rated for instability of placement, all five received acceptable ratings for delivery of appropriate services. There were five main categories of diagnostic disorders: (1) post-traumatic stress, (2) unspecified bipolar and related, (3) attention deficit hyperactivity, (4) unspecified trauma and stress-related, and (5) conduct. Eighty-four percent (n=32) had acceptable placement stability.

IV. WHAT DO RESOURCE PARENTS SAY ABOUT PLACEMENT STABILITY?

PLACEMENT STABILITY

Objective: to increase support for resource parents

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Improve communication of resource parents with their BOND squad regularly and effectively	• Administrator and Program Manager will join monthly meetings with BOND Squad leads and their support workers to facilitate and model effective communication and information gathering
Increase respite BOND opportunities	• Continue to utilize DC127 respite options

Both the Kinship and Placement Administrations surveyed 64 resource parents in February 2022. The survey included questions about experiences of placement stability supports. Of the 64 resource parents who responded, 79 percent are traditional, 9 percent are kinship and 12 percent are specialized including SOY, SOAR, and Professional Foster Parents. The survey items shown in Table X below represent areas that have an impact on placement stability: interaction with **CFSA Staff**, information regarding **the placement process**, and the **BOND program & respite**. See Appendix B for the number of respondents to each question and per response.

In summary, resource parents generally agree that appropriate placements are more complicated with unplanned or emergency placements (61 percent agreed or strongly agreed that CFSA effectively identified placements in emergency situations) versus planned placements (77 percent agreed or strongly agreed that CFSA effectively identified placements in non-emergency situations). A little under half of the resource parents (46 percent) agreed or strongly agreed children were placed with them according to their preferences. The same proportion of resource parents (46 percent) agreed or strongly agreed that the placement team provides resource parents with enough information to determine whether they are equipped to provide placement for a specific child and whether they can meet that child's needs.

Resource parents understand the role of the placement specialist and the resource parent support worker (95 percent and 92 percent agreed or strongly agreed, respectively) and believe the recruitment team, placement specialist, and resource parent supports worker regularly connect with the resource parents (69 percent agreed or strongly agreed). Overall, resource parents believe their resource parent support workers are easy to contact (89 percent agreed or strongly agreed), support them (83 percent agree or strongly agree), and help resolve issues (81 percent agree or strongly agree) that directly impact positively on placement stability.

While most resource parents agreed or strongly agreed (73 percent) that their BOND lead helps them obtain resolution for the issues they raise, and that they felt comfortable reaching out to their BOND lead for support (75 percent agreed or strongly agreed), slightly less than half of respondents reported that their BOND lead communicates with their BOND squad regularly and effectively (46 percent agreed or strongly agreed). Just over half of the resource parents (55 percent) agreed or strongly agreed that they understood how respite care is coordinated within their BOND squad, and just under half of resource parents (48 percent) agreed or strongly agreed that it was easy for them to obtain response when they needed it. Slightly more resource parents (62 percent) agreed or strongly agreed that the Agency's BOND program provides enough respite to meet their needs. A limitation of this survey data was the lower number of responses for BOND and respite questions than other questions. Of the 64 resource parents, 38 respondents answered the question about whether they were in a BOND squad. Of the 38 respondents, 21 parents were in a BOND squad (55 percent) and 17 were not (45%). While approximately 40 total respondents (range of 36 to 42) answered each of the questions regarding working with CFSA staff and the placement process, fewer than 20 respondents answered the questions regarding the BOND program and respite (range of 16 to 18).

Figure 54 Resource Parent Survey Results

Topic	Questions	% Strongly Agree	% Agree	% Neither Agree nor Disagree	% Disagree	% Strongly Disagree	Total Agree or Strongly Agree
Staff	I understand the role of the CFSA Placement Specialist.	31%	64%	0%	0%	5%	**95%**
	I understand the role of the CFSA resource parent support worker (RPSW).	49%	43%	0%	8%	0%	**92%**
	My RPSW demonstrates an understanding of the role.	50%	39%	0%	11%	0%	**89%**
	CFSA's recruitment team, in partnership with resource parent support workers, regularly connect with resource parents.	31%	38%	0%	21%	10%	**69%**
	It is easy for me to contact my RPSW.	57%	32%	0%	11%	0%	**89%**
	My RPSW reaches out to me at a frequency that is appropriate for my needs and the needs of the child(ren) in my care.	49%	41%	0%	11%	0%	**90%**
	I feel comfortable asking questions, making requests, and expressing concerns to my RPSW.	58%	26%	0%	13%	3%	**84%**
	My RPSW resolves the issues that I raise.	43%	38%	0%	14%	5%	**81%**

Topic	Questions	% Strongly Agree	% Agree	% Neither Agree nor Disagree	% Disagree	% Strongly Disagree	Total Agree or Strongly Agree
	My RPSW works with me, as needed, to provide support and mentorship to ensure placement stability.	51%	32%	0%	16%	0%	**83%**
Placement Process	In emergency situations, CFSA's Placement team effectively identifies placements for children.	23%	38%	0%	15%	8%	**61%**
	In non-emergency situations, CFSA's Placement team effectively identifies placements for children.	23%	54%	0%	0%	5%	**77%**
	CFSA's Placement team places children according to resource parent preferences.	10%	36%	0%	44%	10%	**46%**
	CFSA's Placement team provides resource parents with enough information to determine whether they are equipped to provide placement for a specific child and whether they can meet that child's needs.	13%	33%	0%	33%	21%	**46%**
BOND & Respite	My BOND lead communicates with my BOND Squad regularly and effectively.	28%	17%	0%	56%	0%	**45%**
	I feel comfortable reaching out to my BOND Lead for support.	45%	28%	0%	28%	0%	**73%**
	My BOND Lead helps me obtain resolution for the issues that I raise.	31%	44%	25%	25%	0%	**75%**
	I understand how respite care is coordinated within my BOND Squad.	33%	22%	0%	45%	0%	**55%**
	The Agency’s BOND program provides enough respite to meet my needs.	31%	31%	0%	25%	13%	**62%**
	It is easy for me to obtain respite when I need it.	18%	30%	0%	41%	12%	**48%**

V. SPECIALIZED PLACEMENT ARRAY TO ADDRESS PLACEMENT STABILITY

Objective: to increase specialized placement types to meet children with increased challenges and needs

CFSA has addressed placement stability over time through creating or contracting for family-based homes that will support various and diverse needs and challenges experienced by many children in foster care when kinship care providers are not available. In FY 2022, CFSA continued efforts toward placement stability by recruiting and contracting with resource parents who have the specialized skills, abilities and supports to provide a healing environment for children. Further, CFSA procured specialized congregate care providers to address as necessary the unique needs of children living in group home settings.

Several providers (e.g., PSI Inc., professional resource parents, and Spanish-speaking providers) have either recently come on board in September 2022 or are currently in the procurement process. **CFSA's expects that recent placement array interventions will help support placement stability.**

Summary of Specialized Needs to be Considered for Specialized Placements	Recommended Resources and Proposed Practice Strategies (see chart below)
• Children aged 12-17 experiencing varying degrees of emotional and behavioral symptoms due to the trauma of abuse and neglect, recent removal (separation), or multiple placements • Youth who have experienced multiple moves.	• Implement the short-term assessment and diagnostic placement called the Bridge Program (6 beds) • Continue the short-term SOAR professional resource parent program to assess the most appropriate placement (4 beds)
• Children and youth with significant challenges, multiple placements, and trauma history who need intensive-trauma informed placements with resource parents trained to provide this intensive support. • Youth with multiple placements, significant behavior challenges, and trauma history for planned placements	• Continue the PSI intensive resource parent program (36 beds) • Continue the Trauma Informed Professional Resource Program (TIPP) and add additional TIPP resource parents (10 beds) • Continue the Special Opportunities for Youth program for planned placements (15 beds)
Children, youth and parents who speak Spanish	• Implement the provider once contract begins (10 beds)
Youth who are pregnant and parenting in a family like setting who need additional support around parenting	Continue the family-based Pregnant and Parenting professional resource parents (5)
Youth who live in congregate care with significant challenges and specialized need who need specialized, healing environment	• Continue the therapeutic based congregate care programs (40 beds)

Summary of Specialized Needs to be Considered for Specialized Placements	Recommended Resources and Proposed Practice Strategies (see chart below)
Youth who need crisis support	• Continue the Youth for Tomorrow congregate care program (3 beds)
Youth who are autistic	• Continue the therapeutic based congregate care programs (4 beds)
Youth who are teen parents and need a group home environment with specific supports and services	• Continue the Mary Elizabeth Teen Parenting Program (12 beds)

This chart shows the diverse placement array. Analyses to determine the resource needs and subsequent adjustments to the array is underway for FY 2024.

Type		Contract	Focus	# Parents or # Homes	#Beds
FY 2023 Non-specialized Traditional Placement Array					
Kinship Family Based	CFSA Kinship Resource Parent Homes	No	Family-based resource parent homes who are kin		100
	NCCF Kinship Resource Parent Homes	Yes	Family-based resource parent homes who are kin		75
Traditional Family Based	CFSA Resource Parents Homes	No	Family-based resource parent homes for youth without specialized needs		110
	Maryland Resource Parent Homes NCCF	Yes Family-based provider	Family-based resource parent homes for youth without specialized needs		109
Congregate	Umbrella Therapeutic Services	Yes	Congregate care for youth without specialized needs		6
	God's Anointed New Generation (G.A.N.G.)	Yes	Congregate care for youth without specialized needs		12
	Maximum Quest	Yes	Congregate care for youth without specialized needs		14
FY 2023 Specialized Placement Array					
Short-term	Assessment and Diagnostic Center Bridge Program	Yes Congregate care	Short-term placement option for children aged 12-17 experiencing varying degrees of emotional and behavioral symptoms due to the trauma of abuse and neglect, recent removal (separation), or multiple placements		6
	Stabilization SOAR	Yes Individual resource parents	Youth who have experienced multiple moves. Allows time to assess the most appropriate placement	2	4
	Emergency Placement Sasha Bruce	Yes Congregate care	Emergency placement for youth aged 12-17 at risk of imminent danger or abandonment, prior to the completion of a full caregiver assessment and home evaluation		4

Type		Contract	Focus	# Parents or # Homes	#Beds
			Use on a limited basis and the Bridger Program and the SOAR professional resource parents will be the first choice.		
Family-based	Provider for Spanish speaking children, youth and parents TBD (in procurement process)	Yes Family-based provider	Hispanic and Latino (Spanish speaking) children and youth		10
	Lutheran Social Services	Yes Family-based provider	Youth who are unaccompanied refugee minors	16	30
Family-based Intensive	Trauma Informed Professional Resource Parents	Yes Individual resource parents	Youth with multiple placements, significant behavior challenges, and trauma history	5	10
	Pregnant and Parenting Youth Professional Resource Parents	Yes Individual resource parents	Youth with infants/children in a family like setting who need additional support around parenting	2	5
	PSI, Inc	Yes Family-based provider	Youth with multiple placements, significant behavior challenges, and trauma history		36
	Special Opportunities for Youth (SOY)	No CFSA resource parents	Planned placements for youth with multiple placements, significant behavior challenges, and trauma history		15
Congregate Care Therapeutic	Innovative Life Solutions (ILS)	Yes	Serves with severe and persistent mental health diagnosis		5
	Community Services for Autistic Adults and Children (CSAAC)	Yes	Serves children and adults with autism		4
	Youth for Tomorrow	Yes	Serves males and females who need crisis support and are not ready for traditional settings		3
Congregate Care Teen Parent	The Mary Elizabeth House Teen parent program	Yes	Services teen parents and children		12

VI. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF): PLACEMENT MOVES POST DISCHARGE

DISHARGE TO APPROPRIATE STEP-DOWN

Objective: to decrease moves post dishcarge

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Providers where the child disrupted post discharge may have had unrelated reasons for the request or been ill-equipped to handle the child's post-discharge mental and behavioral health struggles. Specific to those types of struggles, 11 percent (n=3) of the reasons were based on the child needing a different type or level of placement support	• Therapeutic based step-down placements are online or coming online in FY 2023 • Ensure the youth's community treatment team and natural supports are involved in the process of entering and exiting PRTF • Use treatment planning and visitation to assist youth with transition back to the community following treatment. • Continue collaboration with the Department of Behavioral Health to stand up a PRFT within 50 miles of the District.

CFSA only places a youth in a PRTF after a clinical determination that the youth requires an intensive therapeutic intervention in a restrictive environment to assist the youth to self-regulate, address trauma, and to understand how safe and stable behaviors will serve the youth when re-entering the community. In order for youth to enter PRTF, the assigned social worker makes a clinical judgement that PRTF may be beneficial and submits a referral to the CFSA Internal PRTF Review Committee. If PRTF is approved, the youth's packet is forwarded to various residential programs that are designed to meet the clinical needs of the youth. Upon entering PRTF, a detailed discharge plan is established that will meet the treatment needs of the youth. Youth do not generally remain in PRTFs longer than the amount of time required to meet their treatment goals, which is planned on an individualized basis depending on the needs of the child.

What ages and where did CFSA initially place children post discharge?

During the span of the review period from FY 2021 to FY 2022-Q2, there were 24 youth in PRTF placements. Of these 24 youth, the PRTF had not yet discharged 21 percent (n=5) as of FY 2022-Q2. For the remaining youth, the PRTF discharged 79 percent (n=19) after a 6-month median length of stay. The majority of the 19 children were older youth between the ages of 16 and 18 (47 percent, n=9). Forty-two percent (n=8) were between the ages of 13 and 15, while 11 percent (n=2) were between 10 and 12 years old.

What is PRTF discharge planning?

Discharge often requires extensive follow-up support for the youth to remain safe and stable in the community. CFSA considers every initial placement post discharge to be a planned placement. As such, it is critical that the team establishes a detailed discharge plan for meeting the youth's needs. Discharge planning begins immediately upon a youth's acceptance into a PRTF and continues throughout treatment.
At the point at which a youth attains 60 days of substantial therapeutic progress, including adherence to the PRTF's programming rules and expectations, the social work team partners with the PRTF clinical team to begin the process of returning the youth back to the community within the next 120 days.

Per the processes established by CFSA's Placement Administration and the Office of Well-Being (OWB), the following processes are included in discharge planning meetings:

- Identifying a family-based placement for the youth[51]
- Identifying an appropriate educational placement and ensuring enrollment prior to discharge
- Linking the youth (and family, if applicable) to the appropriate mental health supports, including medication management, and to the extent possible, ensuring that linkage is arranged prior to discharge
- Linking the youth (and family, if applicable) to any other services that may be indicated (e.g., mentoring or tutoring)

As part of the discharge planning process, CFSA relies on the following three potential placement categories, defined by the Agency's Placement Administration:

- Resource home providers committed to the placement at the time of the youth's entry into the PRTF
- Resource home providers that need to be identified for the youth during discharge planning
- Gradual step-down programs such as a therapeutic group home

[51] When applicable, a youth may return to the same placement, which requires a "bed hold" for the youth. If the youth does not return to the same placement, the Placement Administration may still hold a bed for the youth in a new family-based placement.

Once a PRTF discharges a youth, relevant parties work to ensure that the process of community reintegration is seamless for the youth, including (as noted above) any relevant supports and services that will support the youth's ongoing stability and safety. Upon placement, the social work team continues to support the youth through visits, service advocacy, ongoing assessments, and ongoing case management.

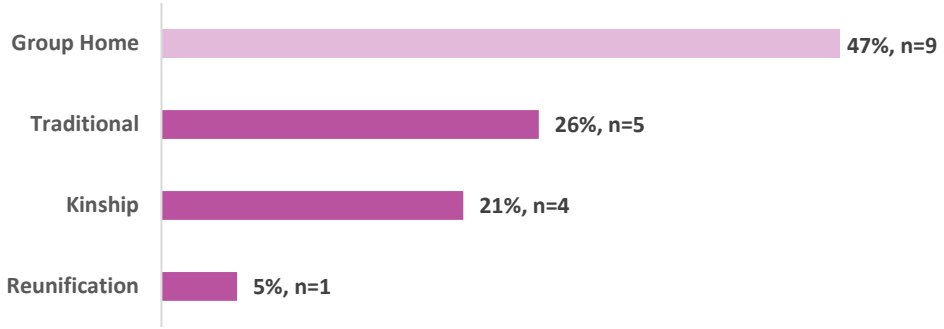
The social worker team also arranges a post-discharge team meeting with two specific objectives in mind: (1) to ensure all recommended services are in place, and (2) to mitigate any barriers and address any challenges that may present themselves in the days immediately following the discharge. Though the exact timing of the post-discharge meeting varies based on case circumstances, the meeting is usually held as soon as possible. Participants include the age-appropriate youth, representation from OWB, the case management team, mental health providers, family members (as appropriate), and any other relevant supports.

Figure 55 Age at the Time of Discharge

Source: PRTF Census FACES Management Report PLC 257

The Agency placed 47 percent (n=9) of children in a group home, 26 percent (n=5) in a traditional foster home, and 21 percent (n=4) in a kinship foster home. One child reunified with their family of origin.

Figure 56 Family-Based Placements Post PRTF Discharge



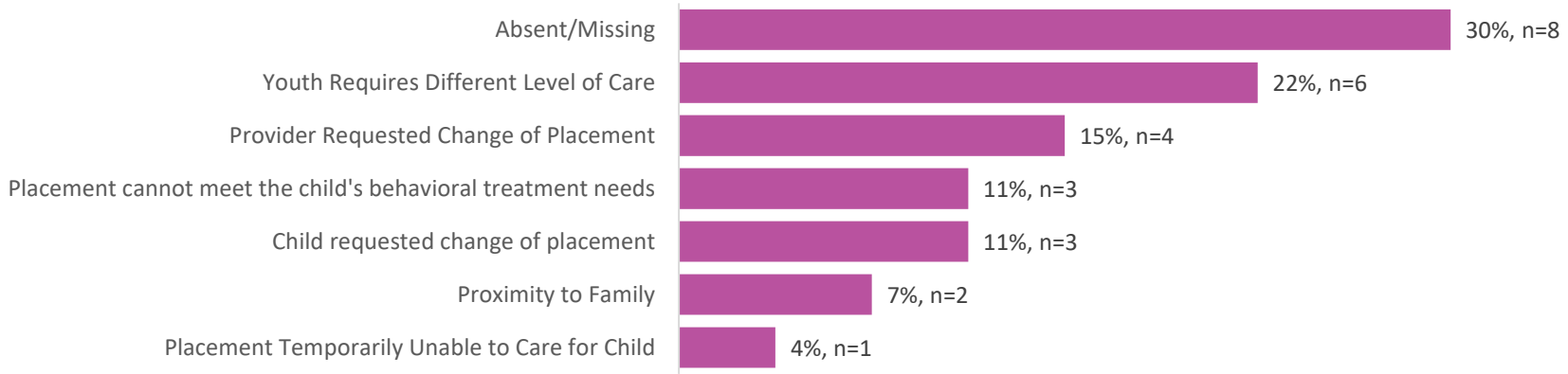
Source: PRTF Census FACES Management Report PLC 257

What are the reasons for placement moves post discharge?

CFSA data entry includes a total number of placement disruptions per child. Due to individual children often having more than one reason for a move, the total number of exit reasons exceeds the number of children involved. For example, as a reason for the documented disruption, youth running away from their placement accounted for 30 percent (n=8) after a PRTF discharge. However, within the tally of eight runaway episodes, one youth accounted for 75 percent (n=six) of total. In general, older youth are more likely to run away from a placement, either returning home to parents or other relatives, or sometimes "couch-surfing". Of those youth who exited PRTF, Twenty-two percent (n=6) of the reasons for a placement move included youth in need of a different level of care, which may have been an increased level or a stepped-down level. For 15 percent (n=4) of the exit reasons, the provider requested the change in placement. Those providers may have had unrelated reasons for the request or perhaps been ill-equipped to handle the child's post-discharge mental and behavioral health struggles. Specific to those types of struggles, 11 percent (n=3) of the reasons were based on the child needing a different type or level of placement support. Another 11 percent (n=3) of the reasons for the placement moves related to the child's request. Seven percent (n=2) of the reasons included the Agency placing a child closer to family members. Finally, one reason for a placement move was based on the placement provider being temporarily unable to care for the child.

To equip providers and caregivers to handle the complex needs and behaviors of youth in PRTF, training is offered by CFSA on managing the behavioral health needs of youth. In addition, it is important for providers to be involved in the treatment process while youth are at PRTF such that they are equipped with therapeutic interventions that will assist them when youth return to their communities. CFSA will also refer youth to Core Services Agencies for therapy, crisis intervention, and medication management in preparation for the return to their communities.

Figure 57 FY 2021 - FY 2022-Q2 Placement Exit Reasons Post PRTF Discharge



Source: PRTF Census FACES Management Report PLC 257

Despite all concerted efforts to ensure placement stability after a PRTF discharge, there are always unanticipated circumstances that result either in another planned placement move or an unplanned placement disruption. Of the 19 youth who were discharged from a PRTF, 74 percent (n=14) had two or fewer placement moves during the review period post discharge. Eleven percent (n=2) had between three to five moves, while 16 percent (n=3) had six or more placement moves.

Figure 58 FY 2021 – FY 2022-Q2 Number of Disruptions Post Discharge

Source: PRTF Census FACES Management Report PLC 257

VII. MENTAL AND BEHAVIORAL HEALTH FOR CHILDREN IN CARE

THERAPEUTIC SUPPORTS

Objective: to provide mental health supports

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Availability of evening appointments. It can be difficult for the resource (or birth) parents to bring children to the Agency for daytime appointments. The OWB therapists attempt to meet as many clients as possible during the evening hours and to be as flexible as possible to accommodate resource parent and child schedules.	• Extending evening hours to 8pm for all therapists at least 2 days per week • Hiring a therapist to conduct in-home therapy
Failure to engage with children and resource parents recommended for services. Once a child is recommended for treatment, the OWB therapists contact the resource parent to schedule treatment. However, despite this outreach, some children never start services because of appointment availability, limited or no response from resource parents, or due to older youth refusing to engage in services. Improved information sharing.	• Coordinating with resource parent support workers at the onset of referral. • Providing a one-pager on the healthcare/mental health next steps for resource parents to accompany the youth at placement • Coordinating with SW/SSW when youth refuse to conduct a team meeting
Transportation to appointments. Transportation has been noted as an issue with receiving services at the Agency. The location of the resource or birth parent and child, as well as the family's access to reliable transportation, can impact a child's ability to receive services on a regular basis.	• Hire a therapist to conduct in-home therapy • Utilize available transportation options to ensure children and youth get to appointments (i.e., cab service) • Educate resource parents on the important role they play in making therapy valuable and productive and establish times they can transport AND participate/communicate with therapists
Availability of alternative therapy modalities. Although the therapeutic team is able to provide various modalities of trauma-informed therapy, families have expressed interest in alternative forms of therapy such as art therapy, music therapy, play therapy, or animal-assisted therapy.	• Continued utilization of specialized services through OWB budget • Outreach development of a resource book to assist in locating offerings of specialized community based service alternatives for youth

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
	• Ensure that mental health supports in the schools are being accessed
Increase resource parent skills to better address the mental and behavioral health needs of children	• Offer the same training through the Child Welfare Training Academy for resource parents that the Trauma Informed Parenting Professional Foster Parent receive

CFSA's Office of Well-Being (OWB) provides clinical supports and a service array that aligns with the behavioral and mental health, comprehensive wellness, educational, and other needs of children and families involved in the District's child welfare system. In 2018, OWB implemented a **mental health redesign** with two primary goals in mind: **(1) to ensure timely and accessible mental health services for children and families, and (2) to centralize the following in-house services: mental health assessments, direct therapy (including various therapeutic modalities listed below), and medication management for applicable CFSA clients**. The anticipated, positive outcomes include an increase in successful family engagement, the reduction in wait times for services, an increase in participation in services, an increase in placement stability (decreased placement disruptions), and an increase in positive reunification data. An overview of the anticipated outcomes from the Agency's in-house mental health services will be included in the Mental Health Evaluation Report, expected to be published in the spring of FY 2023. For purposes of the current *Needs Assessment*, this section focuses specifically on the mental and behavioral health services and supports provided to children and families.

Summary of needs: What additional services and supports are needed to best support the needs of children in care?

The OWB therapeutic team recommends the following supports to improve mental health outcomes for children and youth in foster care:

- **Improved information sharing** between social workers and therapeutic staff, as well as between DBH providers and CFSA clinicians and social workers in regard to the status of children who receive services in the community.
- **Increased social worker communication with resource parents after the mental and behavioral health evaluation**. Feedback from in-house therapists indicates that some resource parents may be unsure of their role in ensuring the child's mental and behavioral health needs are met. Other resource parents are do not understand how best to support the child when the child does receive treatment or how to implement home-based interventions. Sometimes resource parents do not recognize the necessity for regularly scheduled appointments, which may result in adjustments to treatment plans for a child needing on-site treatment.
- **Additional and ongoing training for resource parents to better address the mental and behavioral health needs of children in their care**, including training on de-escalation, giving children emotional space, safety planning, and mental or behavioral health first aid.

- **Required and ongoing training for clinical staff** to adequately address the trauma and mental health challenges of those children who experience high placement instability**.**

What mental and behavioral health services are currently available for children in care?

The OWB in-house therapeutic staff provide short-term (typically up to 12 months) mental and behavioral health interventions to address the needs of children and parents. When a child or family requires more intensive services, or long-term mental and behavioral health interventions (i.e., beyond 12 months), OWB will submit a referral either to a CFSA-contracted or a Department of Behavioral Health (DBH)-contracted community-based service agency. All therapeutic interventions are trauma-informed to address various behavioral health issues. In particular, OWB therapeutic staff are trained in the following modalities to address 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

In addition to providing short-term mental and behavioral health services, OWB therapeutic staff provide emergency therapeutic services to children in crisis, usually as a result of a social worker's request. The assigned social worker utilizes OWB's Crisis Line for support with crises occurring at the Agency or in the community. The Crisis Line is open between the hours of 9:30am and 7pm daily. Social workers may also bring children directly to the Agency for on-site crisis support.

OWB in-house therapeutic services were originally implemented for children entering or re-entering foster care, specifically those children who were not receiving therapeutic or behavioral health interventions through a DBH-contracted core service agency (CSA). Services were also available to birth parents as necessary. During the first year of implementation of the in-house services, OWB set the age range of eligible children from 3 years old and up. However, in October 2019, OWB changed the age criteria for children from age 5 and up, due to the challenges associated with providing clinical therapeutic services to the younger children. OWB concurrently expanded the eligibility requirements to include children and

families already in foster care (versus entering or re-entering) as well as including a smaller number of families receiving services through CFSA's In-Home Administration.

OWB's therapeutic team includes a clinical supervisor, four licensed therapists, and a licensed psychiatric nurse practitioner. The in-house therapists have been solely office-based since inception of the program. They do not provide home or community-based services. During the COVID-19 pandemic, in-house therapists only provided tele-health services. Although office-based services resumed in July 2021, tele-health services are still available as needed. Total capacity allows for 72 clients to receive in-house behavioral health services. During FY 2021, OWB therapeutic team served 49 total clients. As of FY 2022-Q2, therapeutic staff have served 43 total clients.

Additional Services by Outside Providers

For children and families who may need longer-term services, CFSA has contracted with the mental and behavioral health provider, MBI Health Services LLC (MBI), to provide out-patient therapeutic services for children, birth parents, and substitute caregivers. MBI addresses ongoing therapy needs that have outgrown the short-term treatment model provided through OWB. MBI will support any overflow of referrals if OWB caseloads become full, including therapy referrals for birth and resource parents. MBI also provides two specialized therapeutic modalities -- Dialectical Behavior Therapy (DBT) and Eye Movement Desensitization and Reprocessing Therapy (EMDR). Both these modalities increase CFSA's ability to ensure that children, birth parents, and substitute caregivers receive treatment for more complex clinical needs. MBI has the capacity to serve 150 children and 75 parents or caregivers. During FY 2021, MBI served 12 clients referred by CFSA; during FY 2022 through Q2, MBI served 8 clients.

What are the barriers to accessing mental and behavioral health services for foster care population?

The OWB therapeutic team identified the following barriers to accessing mental and behavioral health services for children and youth in foster care:

- **Availability of evening appointments**. It can be difficult for the resource (or birth) parents to bring children to the Agency for daytime appointments. The OWB therapists attempt to meet as many clients as possible during the evening hours and to be as flexible as possible to accommodate resource parent and child schedules.
- **Failure to engage with children and resource parents recommended for services**. Once a child is recommended for treatment, the OWB therapists contact the resource parent to schedule treatment. However, despite this outreach, some children never start services because of appointment availability, limited or no response from resource parents, or due to older youth refusing to engage in services.

- **Transportation to appointments**. Transportation has been noted as an issue with receiving services at the Agency. The location of the resource or birth parent and child, as well as the family's access to reliable transportation, can impact a child's ability to receive services on a regular basis.
- **Availability of alternative therapy modalities.** Although the therapeutic team is able to provide various modalities of trauma-informed therapy, families have expressed interest in alternative forms of therapy such as art therapy, music therapy, play therapy, or animal-assisted therapy.

Is there adequate capacity of mental and behavioral health services (both within OWB services and services available in the community) to meet the mental and behavioral health needs for children entering care?

Upon entry into foster care, social workers complete a Child and Adolescent Functional Assessment Scale (CAFAS®) tool for all children ages 5 and up.[52] As part of their initial case plan, children are assessed within 30 days of their entry into care.[53] In addition to the CAFAS® tool completed by social workers, OWB assesses children who enter care ages five and up to determine whether a connection to mental and behavioral health services is warranted. Assessments begin with an analysis of the number of children with documented levels of impairment[54] in the following four scales related to mental and behavioral health: (1) mood and emotions, (2) thinking, (3) self-harmful behavior, and (4) behavior toward others. The analysis then compares that number with the confirmed number of children receiving mental health services in the community or the children referred for in-house OWB services. The findings assist the Agency in the evaluation of adequate capacity for meeting the needs of children entering care, either through the Office of Well Being or within the community. CFSA has shored up in-house therapy capacity and caseload forecasting by linking children to community partners or verifying service with partners if therapy is recommended through the community where necessary. Through this effort, OWB therapists have a manageable caseload and capacity for children entering care.

[52] Functional Assessment Systems developed the CAFAS® tool in 1989. Social workers administer the tool for children in kindergarten through high school graduation. CAFAS assesses a child's functioning across life subscales.

[53] In FY 2021, a data analysis of CAFAS findings identified 128 children with no behavioral impairments. In FY 2022, the analysis identified 47 children with no impairments.

[54] The CAFAS tool examines how a child's behavior and symptoms impact their day-to-day functioning and describe this as the child's level of impairment. Levels of impairment range from 0 (minimal or no impairment) to 30 (severe impairment or incapacitation), in increments of 10. The level of impairment can be used for multiple purposes, such as criteria to consider in determining intensity of services needed, an outcome measure (pre/post), assessment of strengths and weaknesses for setting treatment goals, and common language for treatment, collaboration, and supervision sessions, among other reasons.

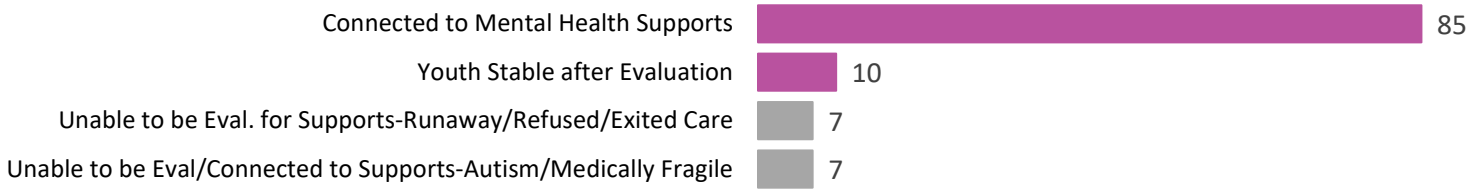
How many children entered care with a CAFAS finding of impairment documented mood and emotions, thinking and communication, and behavior toward others?

The CAFAS tool is a clinician-rated tool that measures eight life domains: (1) school and work, (2) home, (3) community, (4) behavior toward others, (5) mood and emotions, (6) self-harmful behavior, (7) substance use, and (8) thinking and communication. As noted, this year's *Needs Assessment* focuses on findings specifically for the foster care population and results from the four domains related to mood and emotions, thinking, self-harmful behavior, and behavior toward others. Analysts used these results to compare the alignment of CAFAS with the OWB findings for mental and behavioral health needs of children entering or re-entering foster care between FY 2021 and FY 2022-Q2. The sample included a total of 109 children, 82 percent (n=85) of whom entered care in FY 2021 with assessed impairment on the four CAFAS domains and 18 percent (n=24) with assessed impairment who entered as of March 31, 2022. **Fifty percent (n=54) of the 109 children who entered care with assessed impairment were between the ages of 13-17.** Forty-five percent (n=49) were between the ages of 6-12, while the remaining 5 percent (n=6) were 5 years old.

How many children who entered care with a level of impairment noted on the CAFAS scale for mood and emotions, thinking, and behavior toward others were connected to mental and behavioral health services (either in-house or from a community-based provider)?

Seventy-eight percent (n=85) of the 109 children were connected to mental and behavioral services either within CFSA, through a community-based provider, or school-based services. Nine percent of the children (n=10) were not connected to services after the evaluation and assessment were completed and did not recommend participation in mental health treatment. Six percent (n=7) of the children had a medical or developmental diagnosis that prevented an evaluation. The remaining 6 percent (n=7) of the child population received a CAFAS assessment but were not connected to services for the following reasons: (1) two refused to participate in the evaluation, (2) three ran away from their placement, and (3) two children had exited care at the time of evaluation.

Figure 59 Most children who entered care with a CAFAS level of impairment were assessed to determine if mental health services were warranted



Source: Office of Well Being

Of the 85 youth who received an evaluation that resulted in them being connected to mental health supports, 99 percent (n=84) began receiving services. Sixty-one youth (72 percent) were connected to a core service agency (CSA), 17 (20 percent) began receiving services through CFSA's in-house mental health clinic, and six (7 percent) were connected to mental health services at school. The last youth did not start receiving services due to running away from her placement.

In conclusion, a comparison of the CAFAS assessment results and the outcomes of OWB's evaluation of needs after entry into care demonstrates the Agency's **adequate capacity to deliver services or refer to other providers if necessary**. The instances where children were not connected to services was largely due to circumstances outside of the Agency's control.

What additional services and supports are needed to best support the needs of children in care?

The OWB therapeutic team recommends the following supports to improve mental health outcomes for children and youth in foster care:

- **Improved information sharing** between social workers and therapeutic staff, as well as between DBH providers and CFSA clinicians and social workers in regard to the status of children who receive services in the community.
- **Increased social worker communication with resource parents after the mental and behavioral health evaluation**. Feedback from in-house therapists indicates that some resource parents may be unsure of their role in ensuring the child's mental and behavioral health needs are met. Other resource parents are do not understand how best to support the child when the child does receive treatment or how to implement home-based interventions. Sometimes resource parents do not recognize the necessity for regularly scheduled appointments, which may result in adjustments to treatment plans for a child needing on-site treatment.
- **Additional and ongoing training for resource parents to better address the mental and behavioral health needs of children in their care**, including training on de-escalation, giving children emotional space, safety planning, and mental or behavioral health first aid.
- **Required and ongoing training for clinical staff** to adequately address the trauma and mental health challenges of those children who experience high placement instability**.**
- **Targeted efforts with the Contracts Monitoring Division to obtain information on children placed with partnering agencies.**
- **The addition of a program specialist for the OWB therapeutic team** to assist with coordination and follow-up regarding the status of children in care.

VIII. RESOURCE DEVELOPMENT PLAN AT-A-GLANCE

PLACEMENT STABILITY BY COHORT

Objective: to increase placement stablity, for older youth in particular

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Resource parents lacked the ability to manage children and older youth with behavioral challenges (e.g., inflexibility). This need is reflective in kinship care disruptions where 26% (second highest reason for disruptions) were due to behavioral, physical and verbal aggression.	• Training for resource parents on stages of development, normal teenage behavior that is exaggerated by the trauma they have experienced, to decrease parents asking for their removal based on their behaviors
Resource parents are not consistently active team members.	• Resource parent support workers at CFSA and Parent Coaches at NCCF should make themselves active team members alongside the resource parents to elevate their voices. • Placement managers will work with the BOND squad leads to enhance their support of resource parents who are feeling disconnected or left out of the team
Social worker turnover made it difficult to address placement instability.	CFSA hired a recruiter to hire social workers
Placement instability in general is more common among youth over the age of 13 than for younger children in foster care. For example, older youth struggle with symptomatic reactions to their own complex trauma history. Six out of ten youth children experienced placement instability were girls. Among these girls, they were older youth (between the ages of 14-17 years old) and one 17-year-old was a parent. Females aged 13 to 17 years old represented the highest number of placement changes (three or more).	• CFSA intends to further consider the specific behaviors of the youth in this age category to determine their unique needs during foster care placement, and to provide services or interventions to prevent compromises for their placement stability. • Training for resource parents on stages of development, normal teenage behavior that is exaggerated by the trauma they have experienced, to decrease parents asking for their removal based on their behaviors. • CFSA social workers, resource parent support workers and OYE staff, in partnership with GALs, will explore and connect youth to mentorship and other prosocial activities, such as sports, music etc.

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
*From the cohort analysis in the placement stability by cohort which supports the findings of the QSR.	DC CASA and DC FYI are long term partners of the agency who will also provide support and notification of new city programming.
Females aged 18 years or older was the largest population of children in foster care for 24 months or longer and in each placement change type. *From the cohort analysis in the placement stability by cohort	• Conduct the Agency's first qualitative analysis for children and older youth with three or more placements to begin during fall 2022.

KINSHIP PLACEMENT

Objective: to increase, streamline and strengthen kinship placements

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Due to the accelerated placement timeline, kin caregivers face challenges being prepared to accept a child in their home.	• CFSA maintain and ensure Agency assistance with childcare is known to all staff and relayed to kinship providers • CFSA provide additional support to kin parents during the first 30 days of placement by way of providing metro cards, use of family support workers and assist in identifying informal supports to appointments, visits, and school • CFSA improve warm hand-offs to the National Center for Children and Families (NCCF) for kinship placements in Maryland
The Code of Maryland Regulations (COMAR) licensure requirements are more restrictive than the regulations in the District. CFSA must seek waivers to some COMAR provisions (e.g., use of bunkbeds and allowing cribs in the provider's bedroom), and if unsuccessful, this limits the pool of kin placements.	• CFSA Director previously had talked with his Maryland counterpart to determine if an agreement can be reached to waive certain non-safety related licensing requirements and minor child protective involvement of caregivers or others in the household. However, this is not viable due to COMAR.
Management Report CMT 232 which is used to track kinship placements, is a point-in-time measure that reflects the total number and percentage of kinship placements compared to the total population of children in foster care and is limited in its usefulness.	• CFSA will use Management Report CMT 367 as the primary tool to examine engagement and efforts to place children with relatives within 30 days, to highlight expedited placements, to focus on specific barriers, and to identify areas of successful support from across the Agency

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Due to the accelerated placement timeline, kin caregivers face challenges being prepared to accept a child in their home.	• CFSA maintain and ensure Agency assistance with childcare is known to all staff and relayed to kinship providers • CFSA provide additional support to kin parents during the first 30 days of placement by way of providing metro cards, use of family support workers and assist in identifying informal supports to appointments, visits, and school • CFSA improve warm hand-offs to the National Center for Children and Families (NCCF) for kinship placements in Maryland
The Code of Maryland Regulations (COMAR) licensure requirements are more restrictive than the regulations in the District. CFSA must seek waivers to some COMAR provisions (e.g., use of bunkbeds and allowing cribs in the provider's bedroom), and if unsuccessful, this limits the pool of kin placements.	• CFSA Director talks with his Maryland counterpart to determine if an agreement can be reached to waive certain non-safety related licensing requirements and minor child protective involvement of caregivers or others in the household
Management Report CMT 232 which is used to track kinship placements, is a point-in-time measure that reflects the total number and percentage of kinship placements compared to the total population of children in foster care, and is limited in its usefulness.	• CFSA will use Management Report CMT 367 as the primary tool to examine engagement and efforts to place children with relatives within 30 days, to highlight expedited placements, to focus on specific barriers, and to identify areas of successful support from across the Agency

PLACEMENT STABILITY

Objective: to increase support for resource parents

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Improve communication of resource parents with their BOND squad regularly and effectively	• Administrator and Program Manager will join monthly meetings with BOND Squad leads and their support workers to facilitate and model effective communication and information gathering
Increase respite BOND opportunities	• Continue to utilize DC127 respite options

DISHARGE TO APPROPRIATE STEP-DOWN

Objective: to decrease moves post dishcarge

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Providers where the child disrupted post discharge may have had unrelated reasons for the request or been ill-equipped to handle the child's post-discharge mental and behavioral health struggles. Specific to those types of struggles, 11 percent (n=3) of the reasons were based on the child needing a different type or level of placement support	• Therapeutic based step-down placements are online or coming online in FY 2023 • Ensure the youth's community treatment team and natural supports are involved in the process of entering and exiting PRTF • Use treatment planning and visitation to assist youth with transition back to the community following treatment. • Continue collaboration with the Department of Behavioral Health to stand up a PRFT within 50 miles of the District.

THERAPEUTIC SUPPORTS

Objective: to provide mental health supports

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Availability of evening appointments. It can be difficult for the resource (or birth) parents to bring children to the Agency for daytime appointments. The OWB therapists attempt to meet as many clients as possible during the evening hours and to be as flexible as possible to accommodate resource parent and child schedules.	• Extending evening hours to 8pm for all therapists at least 2 days per week • Hiring a therapist to conduct in-home therapy
Failure to engage with children and resource parents recommended for services. Once a child is recommended for treatment, the OWB therapists contact the resource parent to schedule treatment. However, despite this outreach, some children never start services because of appointment availability, limited or no response from resource parents, or due to older youth refusing to engage in services.	• Coordinating with resource parent support workers at the onset of referral. • Providing a one-pager on the healthcare/mental health next steps for resource parents to accompany the youth at placement • Coordinating with SW/SSW when youth refuse to conduct a team meeting
Transportation to appointments. Transportation has been noted as an issue with receiving services at the Agency. The location of the resource or birth parent and child, as well as the family's access to reliable transportation, can impact a child's ability to receive services on a regular basis.	• Hire a therapist to conduct in-home therapy • Utilize available transportation options to ensure children and youth get to appointments (i.e., cab service) • Educate resource parents on the important role they play in making therapy valuable and productive and establish times they can transport AND participate/communicate with therapists

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Availability of alternative therapy modalities. Although the therapeutic team is able to provide various modalities of trauma-informed therapy, families have expressed interest in alternative forms of therapy such as art therapy, music therapy, play therapy, or animal-assisted therapy.	• Continued utilization of specialized services through OWB budget • Outreach development of a resource book to assist in locating offerings of specialized community-based service alternatives for youth • Ensure that mental health supports in the schools are being accessed
Increase resource parent skills to better address the mental and behavioral health needs of children	• Offer the same training through the Child Welfare Training Academy for resource parents that the Trauma Informed Parenting Professional Foster Parent receive

SPECIALIZED PLACEMENT ARRAY

Objective: To increase specialized placement types to meet children with increased challenges and needs

Summary of Specialized Needs to be Considered for specialized placements	Recommended Resources and Proposed Practice Strategies (see chart below)
• Children aged 12-17 experiencing varying degrees of emotional and behavioral symptoms due to the trauma of abuse and neglect, recent removal (separation), or multiple placements • Youth who have experienced multiple moves.	• Implement the short-term assessment and diagnostic placement called the Bridge Program (6 beds) • Continue the short-term SOAR professional resource parent program to assess the most appropriate placement (4 beds)
• Children and youth with significant challenges, multiple placements, and trauma history who need intensive-trauma informed placements with resource parents trained to provide this intensive support. • Youth with multiple placements, significant behavior challenges, and trauma history for planned placements	• Continue the PSI intensive resource parent program (36 beds) • Continue the Trauma Informed Professional Resource Program (TIPP) and add additional TIPP resource parents (10 beds) • Continue the Special Opportunities for Youth program for planned placements (15 beds)
Children, youth and parents who speak Spanish	• Implement the provider once contract begins (10 beds)
Youth who are pregnant and parenting in a family like setting who need additional support around parenting	Continue the family-based Pregnant and Parenting professional resource parents (5)
Youth who live in congregate care with significant challenges and specialized need who need specialized, healing environment	• Continue the therapeutic based congregate care programs (40 beds)

Summary of Specialized Needs to be Considered for specialized placements	Recommended Resources and Proposed Practice Strategies (see chart below)
Youth who need crisis support	• Continue the Youth for Tomorrow congregate care program (3 beds)
Youth who are autistic	Continue the therapeutic based congregate care programs (4 beds)
Youth who are teen parents and need a group home environment with specific supports and services	Continue the Mary Elizabeth Teen Parenting Program (12 beds)

This chart shows the diverse placement array. Analyses to determine the resource needs and subsequent adjustments to the array is underway for FY 2024.

Type		Contract	Focus	# Parents or # Homes	#Beds
FY 2023 Non-specialized Traditional Placement Array					
Kinship Family Based	CFSA Kinship Resource Parent Homes	No	Family-based resource parent homes who are kin		100
	NCCF Kinship Resource Parent Homes	Yes	Family-based resource parent homes who are kin		75
Traditional Family Based	CFSA Resource Parents Homes	No	Family-based resource parent homes for youth without specialized needs		110
	Maryland Resource Parent Homes NCCF	Yes Family-based provider	Family-based resource parent homes for youth without specialized needs		109
Congregate	Umbrella Therapeutic Services	Yes	Congregate care for youth without specialized needs		6
	God's Anointed New Generation (G.A.N.G.)	Yes	Congregate care for youth without specialized needs		12
	Maximum Quest	Yes	Congregate care for youth without specialized needs		14
FY 2023 Specialized Placement Array					
Short-term	Assessment and Diagnostic Center Bridge Program	Yes Congregate care	Short-term placement option for children aged 12-17 experiencing varying degrees of emotional and behavioral symptoms due to the trauma of abuse and neglect, recent removal (separation), or multiple placements		6

Type		Contract	Focus	# Parents or # Homes	#Beds
	Stabilization SOAR	Yes Individual resource parents	Youth who have experienced multiple moves. Allows time to assess the most appropriate placement	2	4
	Emergency Placement Sasha Bruce	Yes Congregate care	Emergency placement for youth aged 12-17 at risk of imminent danger or abandonment, prior to the completion of a full caregiver assessment and home evaluation Use on a limited basis and the Bridger Program and the SOAR professional resource parents will be the first choice.		4
Family-based	Provider for Spanish speaking children, youth and parents TBD (in procurement process)	Yes Family-based provider	Hispanic and Latino (Spanish speaking) children and youth		10
	Lutheran Social Services	Yes Family-based provider	Youth who are unaccompanied refugee minors	16	30
Family-based Intensive	Trauma Informed Professional Resource Parents	Yes Individual resource parents	Youth with multiple placements, significant behavior challenges, and trauma history	5	10
	Pregnant and Parenting Youth Professional Resource Parents	Yes Individual resource parents	Youth with infants/children in a family like setting who need additional support around parenting	2	5
	PSI, Inc	Yes Family-based provider	Youth with multiple placements, significant behavior challenges, and trauma history		36
	Special Opportunities for Youth (SOY)	No CFSA resource parents	Planned placements for youth with multiple placements, significant behavior challenges, and trauma history		15
Congregate Care Therapeutic	Innovative Life Solutions (ILS)	Yes	Serves with severe and persistent mental health diagnosis		5
	Community Services for Autistic Adults and Children (CSAAC)	Yes	Serves children and adults with autism		4
	Youth for Tomorrow	Yes	Serves males and females who need crisis support and are not ready for traditional settings		3
Congregate Care Teen Parent	The Mary Elizabeth House Teen parent program	Yes	Services teen parents and children		12

IX. APPENDICES

APPENDIX A: HISTORICAL PERSPECTIVE

EXCESS BED CAPACITY

Available Foster Homes and Congregate Homes as of last day of the month

Reporting Period	Foster Care Settings	Total Homes	Total Bed Capacity	# of Children in Foster Care (as of last day of the month)	Unused Beds # (%)
Jan-21	Family Based (not including Kinship)	355	639	346	**229 (32%)**
	Congregate Providers	11	84	51	
	Other Settings*	N/A	N/A	97	
	Total	**366**	**723**	**494**	
Feb-21	Family Based (not including Kinship)	307	554	353	**149 (23%)**
	Congregate Providers	11	84	51	
	Other Settings*	N/A	N/A	85	
	Total	**318**	**638**	**489**	
Mar-21	Family Based (not including Kinship)	350	625	343	**222 (31%)**
	Congregate Providers	11	84	55	
	Other Settings*	N/A	N/A	89	
	Total	**361**	**709**	**487**	
Apr-21	Family Based (not including Kinship)	347	618	334	**224 (32%)**
	Congregate Providers	11	84	54	
	Other Settings*	N/A	N/A	90	
	Total	**358**	**702**	**478**	
May-21	Family Based (not including Kinship)	335	591	335	**197 (29%)**
	Congregate Providers	11	84	53	
	Other Settings*	N/A	N/A	90	
	Total	**346**	**675**	**478**	
Jun-21	Family Based (not including Kinship)	343	612	337	**222 (32%)**
	Congregate Providers	11	84	49	

Reporting Period	Foster Care Settings	Total Homes	Total Bed Capacity	# of Children in Foster Care (as of last day of the month)	Unused Beds # (%)
	Other Settings*	N/A	N/A	88	
	Total	**354**	**696**	**474**	
Jul-21	Family Based (not including Kinship)	354	636	333	**253 (35%)**
	Congregate Providers	12	83	50	
	Other Settings*	N/A	N/A	83	
	Total	**366**	**719**	**466**	
Aug-21	Family Based (not including Kinship)	346	623	334	**243 (34%)**
	Congregate Providers	12	83	47	
	Other Settings*	N/A	N/A	82	
	Total	**358**	**706**	**463**	
Sep-21	Family Based (not including Kinship)	339	594	344	**200 (30%)**
	Congregate Providers	12	83	53	
	Other Settings*	N/A	N/A	80	
	Total	**351**	**677**	**477**	
Oct-21	Family Based (not including Kinship)	330	587	341	**206 (30%)**
	Congregate Providers	12	91	53	
	Other Settings*	N/A	N/A	78	
	Total	**342**	**678**	**472**	
Nov-21	Family Based (not including Kinship)	325	578	338	**196 (29%)**
	Congregate Providers	12	91	57	
	Other Settings*	N/A	N/A	78	
	Total	**337**	**669**	**473**	
Dec-21	Family Based (not including Kinship)	305	536	327	**157 (25%)**
	Congregate Providers	12	91	55	
	Other Settings*	N/A	N/A	88	
	Total	**317**	**627**	**470**	

Note: Placed in kinship homes are not included in the above table or calculation.

Kinship Foster Care Settings			
Reporting Period	**Total Homes**	**Total Bed Capacity**	**# of Children in Foster Care Census as of last day of the month**
Jan-21	167	240	169
Feb-21	147	210	161
Mar-21	155	221	161
Apr-21	153	221	158
May-21	150	215	151
Jun-21	151	212	149
Jul-21	148	216	152
Aug-21	144	204	148
Sep-21	135	193	137
Oct-21	140	199	134
Nov-21	139	192	134
Dec-21	140	194	134

Other Settings*	**Total Children**											
	Jan-21	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**
Residential Treatment	21	18	19	19	19	19	20	18	17	17	17	16
COVID-19 Placement/Under 21 (Non-Paid)	5	0	1	0	0	1	0	0	0	0	3	4
Abscondence	31	30	26	32	30	28	29	26	22	21	20	31
College/Vocational	2	2	2	2	1	0	0	2	4	4	3	1
Correctional Facility	11	7	9	8	8	9	8	10	8	7	6	9
Developmentally Disabled	2	3	3	3	3	3	2	2	4	3	4	3
Hospitals	7	7	5	4	5	4	5	5	7	4	5	6
Juvenile Foster Care (Non-Paid)	1	1	1	0	0	0	0	0	0	0	0	0
Not in Legal Placement	17	17	23	22	24	24	19	19	18	22	20	18
Total	**97**	**85**	**89**	**90**	**90**	**88**	**83**	**82**	**80**	**78**	**78**	**88**

*Other Settings includes residential treatment, children who are placed due to COVID-19 situation, missing, absent or abducted, college and vocational placements, correction facilities, children in placements paid for by Medicaid such as setting for children with severe developmental disabilities and hospital placements, and children who are not in a legal placement.

Source: PRD141 report run on the 1st of the following month is used to calculate for 'Total Homes' and 'Total Beds Capacity' counts as of the last day of the reporting month. CMT232 report run on the 15th of the following month is used to get the totals for '# of Children in FC census' as of the last day of the reporting month.

APPENDIX B: FULL RESOURCE PARENT SUPPORT WORKER SURVEY RESULTS

Resource Parent Survey Highlights for the Needs Assessment on Placement Stability

CFSA surveyed 64 resource parents in February 2022, which included questions about experiences of placement stability supports. Of the 64 resource parents who responded, 79 percent are traditional, 9 percent are kinship and 12 percent are specialized including SOY, SOAR, and Professional.

The survey items below represent areas that have an impact on placement stability.

CFSA's recruitment team, in partnership with resource parent support workers, regularly connect with resource parents.

Answer Choices	Responses	Respondents
Strongly agree	31%	13
Agree	38%	16
Neither agree nor disagree	0%	0
Disagree	21%	9
Strongly Disagree	10%	4
Total Respondents		42

I understand the role of the CFSA Placement Specialist.

Answer Choices	Responses	Respondents
Strongly agree	31%	12
Agree	64%	25

Neither agree nor disagree	0%	0
Disagree	0%	0
Strongly Disagree	5%	2
Total Respondents		39

In emergency situations, CFSA's Placement team effectively identifies placements for children.

Answer Choices	Responses	Respondents
Strongly agree	23%	9
Agree	38%	15
Neither agree nor disagree	0%	0
Disagree	15%	6
Strongly Disagree	8%	3
Unsure	15%	6
Total Respondents		39

In non-emergency situations, CFSA's Placement team effectively identifies placements for children.

Answer Choices	Responses	Respondents
Strongly agree	23%	9
Agree	54%	21
Neither agree nor disagree	0%	0
Disagree	0%	0
Strongly Disagree	5%	2
Unsure	18%	7
Total Respondents		39

CFSA's Placement team places children according to resource parent preferences.

Answer Choices	Responses	Respondents
Strongly agree	10%	4
Agree	36%	14

Neither agree nor disagree	0%	0
Disagree	44%	17
Strongly Disagree	10%	4
Unsure	0%	0
Total Respondents		39

CFSA's Placement team provides resource parents with enough information to determine whether they are equipped to provide placement for a specific child and whether they can meet that child's needs.

Answer Choices	Responses	Respondents
Strongly agree	13%	5
Agree	33%	13
Disagree	33%	13
Strongly Disagree	21%	8
Total Respondents		39

I understand the role of the CFSA resource parent support worker (RPSW).

Answer Choices	Responses	Respondents
Strongly agree	49%	18
Agree	43%	16
Neither agree nor disagree	0%	0
Disagree	8%	3
Strongly Disagree	0%	0
Total Respondents		37

My RPSW demonstrates an understanding of his/her role.

Answer Choices	Responses	Respondents
Strongly agree	50%	18
Agree	39%	14
Neither agree nor disagree	0%	0

Disagree	11%	4
Strongly Disagree	0%	0
Total Respondents		36

It is easy for me to contact my RPSW.

Answer Choices	Responses	Respondents
Strongly agree	57%	21
Agree	32%	12
Neither agree nor disagree	0%	0
Disagree	11%	4
Strongly Disagree	0%	0
Total Respondents		37

My RPSW reaches out to me at a frequency that is appropriate for my needs and the needs of the child(ren) in my care.

Answer Choices	Responses	Respondents
Strongly agree	49%	18
Agree	41%	15
Neither agree nor disagree	0%	0
Disagree	11%	4
Strongly Disagree	0%	0
Total Respondents		37

I feel comfortable asking questions, making requests, and expressing concerns to my RPSW.

Answer Choices	Responses	Respondents
Strongly agree	58%	22
Agree	26%	10
Neither agree nor disagree	0%	0
Disagree	13%	5
Strongly Disagree	3%	1

Total Respondents		38

My RPSW resolves the issues that I raise.

Answer Choices	Responses	Respondents
Strongly agree	43%	16
Agree	38%	14
Neither agree nor disagree	0%	0
Disagree	14%	5
Strongly Disagree	5%	2
Total Respondents		37

My RPSW works with me, as needed, to provide support and mentorship to ensure placement stability.

Answer Choices	Responses	Respondents
Strongly agree	51%	19
Agree	32%	12
Neither agree nor disagree	0%	0
Disagree	16%	6
Strongly Disagree	0%	0
Total Respondents		37

My BOND lead communicates with my BOND Squad regularly and effectively. (38 respondents are in a BOND squad and 17 respondents are not)

Answer Choices	Responses	Respondents
Strongly agree	28%	5
Agree	17%	3
Neither agree nor disagree	0%	0
Disagree	56%	10
Strongly Disagree	0%	0
Total Respondents		18

I feel comfortable reaching out to my BOND Lead for support.

Answer Choices	Responses	Respondents
Strongly agree	45%	8
Agree	28%	5
Neither agree nor disagree	0%	0
Disagree	28%	5
Strongly Disagree	0%	0
Total Respondents		18

I understand how respite care is coordinated within my BOND Squad.

Answer Choices	Responses	Respondents
Strongly agree	33%	6
Agree	22%	4
Neither agree nor disagree	0%	0
Disagree	45%	8
Strongly Disagree	0%	0
Total Respondents		18

The Agency/BOND program provides enough respite to meet my needs.

Answer Choices	Responses	Respondents
Strongly agree	31%	5
Agree	31%	5
Neither agree nor disagree	0%	0
Disagree	25%	4
Strongly Disagree	13%	2
Total Respondents		16

It is easy for me to obtain respite when I need it.

Answer Choices	Responses	Respondents
Strongly agree	18%	3
Agree	29%	5
Neither agree nor disagree	0%	0
Disagree	41%	7
Strongly Disagree	12%	2
Total Respondents		17

My BOND Lead helps me obtain resolution for the issues that I raise.

Answer Choices	Responses	Respondents
Strongly agree	31%	5
Agree	44%	7
Neither agree nor disagree	0%	0
Disagree	25%	4
Strongly Disagree	0%	0
Total Respondents		16

APPENDIX C: TYPE OF IMPAIRMENT NOTED ON INITIAL CAFAS TOOL

CAFAS Domain	# of children FY 2021	# of children FY 2022 Q1-Q2	Total
Moods & Emotions	77	19	96
Self-Harmful Behavior	17	2	19
Behavior Toward Others	54	14	68
Thinking	9	0	9
Unique Number of Children	**85**	**24**	**109**