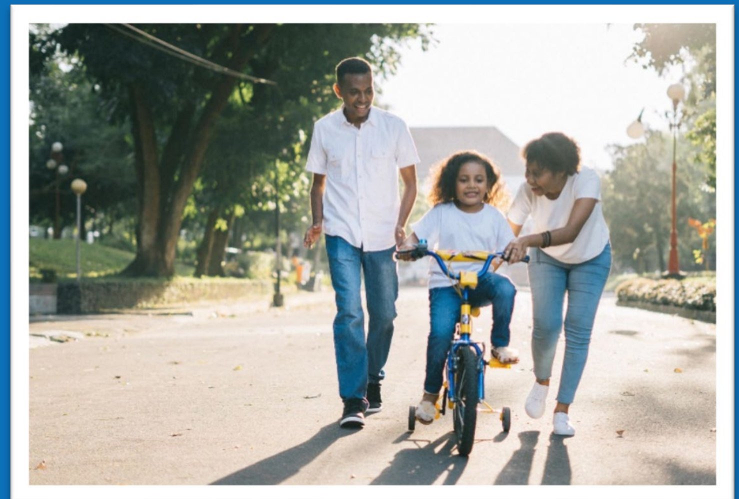
ANNUAL NEEDS ASSESSMENT

A LOOK-BACK AT FISCAL YEAR 2023 ACTIVITIES THAT INFORM PLANNING FOR FISCAL YEAR 2025



District of Columbia Government | Child and Family Services Agency

TABLE OF CONTENTS

1. HISTORICAL PERSPECTIVE 3
2. IN-HOME FAMILY PROFILE/CHARACTERISTICS 13
3. CURRENT IN-HOME PRACTICE 23
4. IN-HOME SERVICE ARRAY 48
5. IN-HOME PROGRAM EVALUATION 56
6. IN-HOME SOCIAL WORKER SUPPORTS AND NEEDS 68
7. CONCLUSION (SUMMARY OF RECOMMENDATIONS) 75
8. RESOURCE DEVELOPMENT PLAN AT-A-GLANCE 78
9. APPENDICES 82

1. HISTORICAL PERSPECTIVE

1.1 HISTORICAL PERSPECTIVE AND EVOLUTION OF IN-HOME PREVENTION EFFORTS

Since fiscal year (FY) 2010, the Child and Family Services Agency **(CFSA or Agency) has experienced a 76 percent decline in its foster care population,** reflecting the Agency's successful efforts toward keeping families together, ensuring child safety, and investing in primary, secondary and tertiary prevention. As a result, CFSA's in-home population has outpaced its foster care population and revealed the nation's capital city as a leader in prevention efforts. The following graph highlights the families served through in-home, foster care, and front porch and front yard.

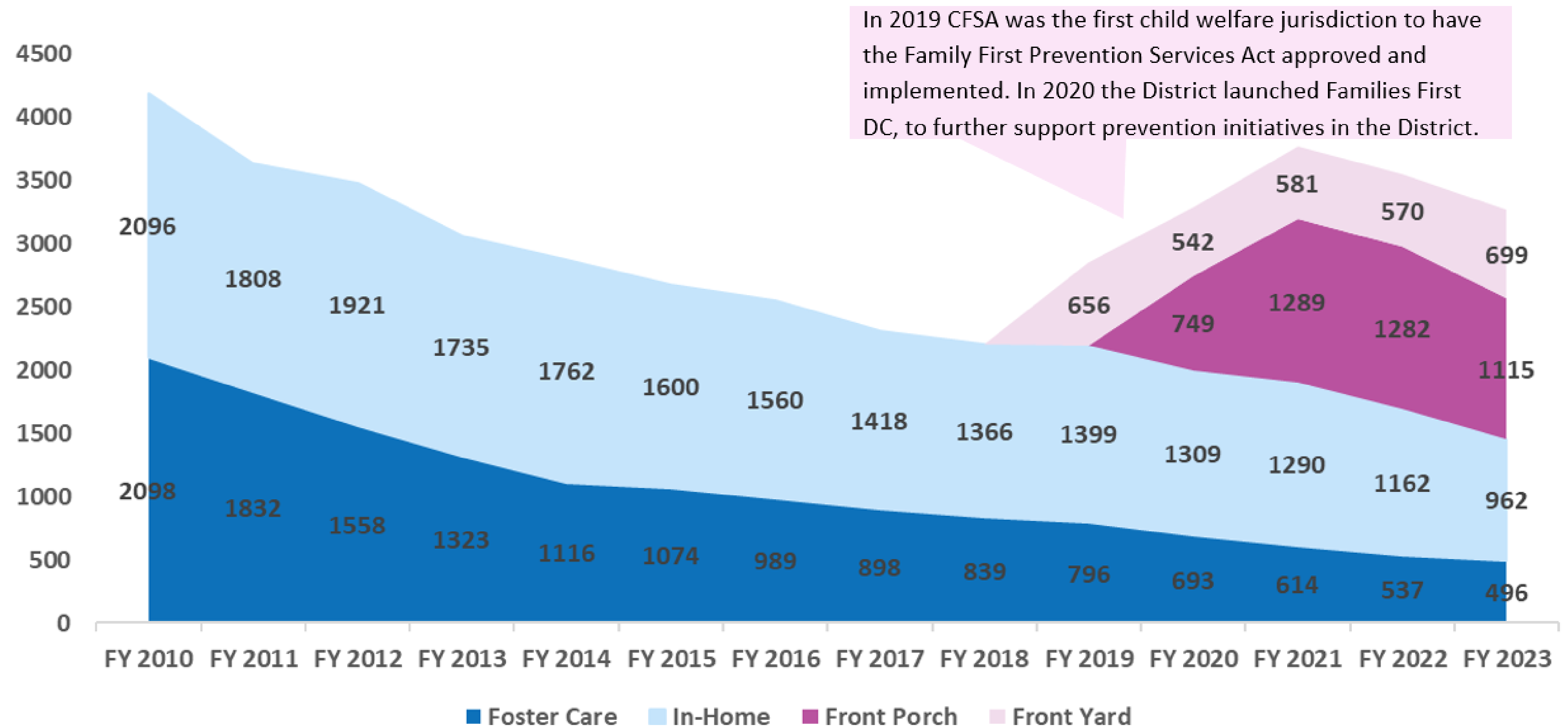


Figure 1 CFSA population, FY2010-FY2023. Source: CMT232 management report, ad hoc query and Efforts to Outcomes (ETO)

Additional prevention efforts over the last 30 years are detailed in the paragraphs below.

From 1993 to 2023…

While there are community-based organizations that exist in neighborhoods across the country, CFSA's unique 30-year partnership with the Healthy Families/Thriving Communities Collaboratives (HFTC) stands apart for its intentional evolution toward primary, secondary, and tertiary preventive services. Multiple service organizations comprise CFSA and the HFTC network, including the five Collaborative sites located in specific Wards of the city where residents have indicated the most need for preventive or ongoing supportive services. In response to those identified needs, the CFSA/HFTC network continues to provide a population-based comprehensive service delivery structure. The network in its entirety includes a dedicated group of professional and residential stakeholders committed to a shared vision of children and families achieving self-sustaining, self-actualizing, and well-being potentials.[1]

From 2007 to 2011…

As a new initiative in 2007, the Partnership for Community-Based Services (PCBS) promoted the CFSA/HFTC shared mission to "improve the long-term safety, permanence, and well-being of children and to strengthen their families." PCBS goals continue to include increased engagement of families, especially fathers and paternal kin, as an essential component of its overall vision, i.e., every child in the District of Columbia lives "in a safe, stable, permanent home, nurtured and supported by healthy families, strong communities, and a coordinated cohesive child welfare system of care." Moreover, the PCBS model continues to encourage timely communication and early identification of risk factors that can be addressed to maintain family stabilization.

As a result of the 2007 PCBS joint effort, CFSA and the HFTC Collaboratives created a new community-based practice model for the provision of in-home services, tailored to increase the protection and strengthening of family systems. By 2008, CFSA had successfully implemented the PCBS in-home model by co-locating CFSA's 10 In-Home Administration Units (supervisors and social workers) at the five HFTC Collaborative sites. Since then, co-located CFSA and Collaborative social workers and staff have continued to team up on cases to provide families with inclusive, culturally competent case management.

In addition to its partnership with the HFTC Collaboratives, CFSA also used its grant-making capacity to expand the array of child abuse and neglect prevention and intervention resources. For example, through a grant agreement with the advocacy and research organization,

---

[1] The terms "child" and "children" refer to clients from birth to age 20 except for specific references to populations of older youth served by the Agency's Older Youth Empowerment Administration.

Prevent Child Abuse America, CFSA developed a 2010 comprehensive city-wide Child Abuse and Neglect Prevention Plan to function as a blueprint for the development of healthier children and stronger families in the District of Columbia.

The District's Interagency Collaboration and Services Integration Committee (ICSIC) provided funding for annual awards totaling up to $1 million.[2] CFSA distributed these awards to community-based programs and agencies that were providing prevention and supportive services or activities focusing on parenting education and support, respite care, and home-based supports for new parents.

In April 2010, CFSA and the HFTC Collaboratives released their Year 1 Implementation Report. This evaluation found that co-location of CFSA staff at the Collaboratives improved CFSA and HFTC social workers' mutual understanding of each organization's functions, missions, and working practices. As a result of these shared systemic insights, CFSA social workers had easier access to families and a greater understanding of family needs, allowing for more effective service delivery. At the same time, the evaluation identified several areas for improvement. These areas included logistical issues, practice protocols, and clarification of roles, responsibilities, and expectations for cooperation among the CFSA and HFTC social workers and family support workers (FSWs).

As of December 31, 2010, CFSA provided in-home services to 2,011 children from 626 families (see below *1.6 A Long-Run View of In-Home Cases*). CFSA's goal was (and continues to be now) the safe maintenance of children with their families rather than placing children in foster care, excepting any situation where there is evidence of imminent risk to a child's safety. CFSA social workers continue to provide in-home services, often in partnership with HFTC social workers and FSWs, as part of the ongoing PCBS model. To this end, the Agency's investment in community-based prevention over the last decade, along with its partnerships with sister health and human services agencies, has reduced the number of children in foster care by over 50 percent, even as the city's population increased.

From 2012 to the present…

In 2012, CFSA developed the Four Pillars Strategic Framework to improve outcomes for children and families at every step of their involvement with the District's child welfare system. Each pillar sits on a values-based foundation, a set of strategies, and a series of specific outcome targets. CFSA's Four Pillars include the Front Door, Temporary Safe Haven, Well-Being, and Exit to Permanency, all as a continuum of service interventions designed to meet families' needs and to prevent child abuse and neglect. For families receiving in-home services, the Front Door pillar focuses on service delivery to prevent children from entering foster care.

---

[2] ICSIC is a 21-member commission established by the Executive Office of the Mayor.

As the Four Pillars Strategic Framework evolved, CFSA recognized the importance of considering the nuanced needs of families inching closer and closer to the Front Door. Accordingly, the Agency extended its prevention efforts outside of the Front Door threshold to the Front Yard and the Front Porch.

- Families in CFSA's Front Yard are not involved with CFSA but may present with potential risk factors for involvement. Primary prevention efforts are designed to ensure children and families in CFSA's Front Yard are supported in their communities.
- Families on CFSA's Front Porch may have engaged with CFSA but have been able to keep their children safely at home (or reunify in cases of separation). These families receive community-based prevention services offered by their neighborhood HFTC Collaboratives.
- Families engaged at CFSA's Front Door have an open case with CFSA. As appropriate to the family's circumstances, the Agency consistently prioritizes keeping families together and working with parents and children in their communities.

1.2 IN-HOME'S EXPERIENCE WITH THE TITLE IV-E WAIVER AND IMPLEMENTING THE FAMILY FIRST PREVENTION SERVICES ACT (FFPSA)

Approximately 10 years ago, CFSA was granted the opportunity to participate in the federal Title IV-E Waiver Demonstration Project (Waiver). Under the Waiver, CFSA was given the flexibility to use federal funds, previously earmarked only for out-of-home (foster) care, in order to test prevention activities for better serving children and families. CFSA renamed these combined Waiver-funded programs and services as the Safe and Stable Families Program.

Prior to the Waiver, CFSA theorized that enhancing services and supports to children and families at various levels of involvement with the child welfare system would result in more children remaining safely and stably in their homes. For those children who were separated for safety concerns, the children would be able to achieve more timely permanence. The Agency had already taken steps to this end, by increasing community-based resources that could meet family needs without entry into the Front Door of the child welfare system. As expected, CFSA experienced an increase in the number of children served in their homes and neighborhoods. To accommodate the ever-increasing in-home population, CFSA maximized Waiver funding to strengthen and expand the existing network of prevention and early intervention programs.

Implemented over a 5-year period, many Waiver-funded programs responded as expected to the anticipated needs of the increasing in-home population. CFSA's continuous quality improvement feedback loops and ongoing evaluation structures also indicated many outcomes

were better for families involved in Waiver-funded programs. Nonetheless, CFSA documented other programs revealing less successful outcomes, including a small set of programs that consistently failed to reach their goal for enrollment numbers.

Based on evaluative evidence and data, the Agency therefore reconsidered the kinds of programs in which families would most likely engage, participate, and complete with demonstrated positive outcomes. With the no-cost extension of the Waiver dated until September 30th, 2019, CFSA continued to implement those evidence-based service interventions that worked best for the District's families and indicated increased well-being, both of children and their parents.

At the end of September 2019, many of CFSA's Waiver-funded programs transitioned to federal funding from the Family First Prevention Services Act (Family First). Even still, Waiver funding remained available for a subset of the families previously served under the Waiver (e.g., pregnant or parenting youth in foster care, collectively referred to as Family First prevention-eligible children, along with other Family First candidates). Enactment of Family First also provided an opportunity for development of a new, in-depth, and holistic population-specific prevention plan.

The plan was not solely driven by the Family First legislation. A cross-sector or government and community members utilized the legislation to build a vision for a comprehensive citywide strategy. CFSA expected the strategy to result in evidence that District families were being strengthened and stabilized. In June 2018, CFSA launched its Family First Prevention Work Group to develop both the strategy and the plan. The subsequent proposal to the Children's Bureau was CFSA's 5-year prevention plan in accordance with Family First, but also the District's own citywide Families First DC initiative.

CFSA's prevention plan builds on the substantial progress made over the past decade to reform DC's child welfare system and to bolster prevention efforts that help reduce child abuse and neglect. The plan reinforces the successes garnered through the implementation of CFSA's Waiver and capitalizes on the critical lessons learned to refine programs and services that better meet the needs of the District's children and families. In particular, the Keeping DC Families Together plan, co-developed and designed with people with lived expertise, remains in close alignment with the Children's Bureau's vision to keep families healthy, together, and strong, while still building upon the primary prevention work emphasized by the Children's Bureau.

1.3 FAMILIES FIRST DC: PRIMARY PREVENTION STRATEGY

PRIMARY, SECONDARY AND TERTIARY PREVENTION

Primary Prevention: Front Yard – Families not known to CFSA
As previously described, families in the Front Yard have no child welfare involvement but nonetheless face challenges that could put them at risk of coming to the Agency's attention. Two primary examples of these Front Yard families include young (under age 25) homeless families with young children, and "grandfamilies" (i.e., grandparents responsible for caring for their children's children). These families may already be connected to one of CFSA's five contracted HFTC Collaboratives. The local Collaborative will often take the lead on connecting these families to other District and community resources to address specific needs such as housing, employment, and mental health.

Secondary & Tertiary Prevention: Front Porch – Families known to CFSA, both with and without an open case
Families on the Front Porch may be receiving secondary or tertiary prevention services. Secondary prevention includes families that have already experienced a Child Protective Services (CPS) investigation or a legacy family assessment (FA) response to a CPS Hotline allegation.[3] The FA Unit often referred families to the Collaboratives to provide family stabilization and other support for their specific needs. Many of these families may still be connected to a Collaborative.

Families on the Front Porch receiving tertiary prevention services have an open in-home case and are working towards case closure. These families may have short-term needs requiring additional community-based support. In such instances, the Collaboratives will provide the identified services and the HFTC social worker will team with the CFSA social worker to support the successful closure of the CFSA case.

---

[3] The FA Unit formerly served families with allegations of abuse or neglect that had safety or risk levels not rising to the level of child separation or the opening of an in-home case. Although CFSA discontinued FA responses in April of 2019 (see "Secondary Prevention" section below), CPS did not forsake the benefits of the FA Unit. Instead, CPS integrated the basic premise of the FA response into the current CPS investigation process by determining when families may still need or benefit from Collaborative services, but without opening a CFSA case.

1.4 A LONG-RUN VIEW OF IN-HOME CASES

1.4.1 Case Count

Over the past 12 years, **the number of families served by the In-Home Administration has declined overall**. As Figure 1 reveals, the number of families who had a case opened with the In-Home Administration peaked in FY 2013 at 843 families. This number declined each year until hitting a low in FY 2016 with 431 families. After a few years of increasing caseloads, the number of families who had an open case dropped in FY 2020; the count has remained relatively stable since then, hovering at or below 500. In FY 2022, the most recent fiscal year for which CFSA has cumulative data, 471 families had an open in-home case.

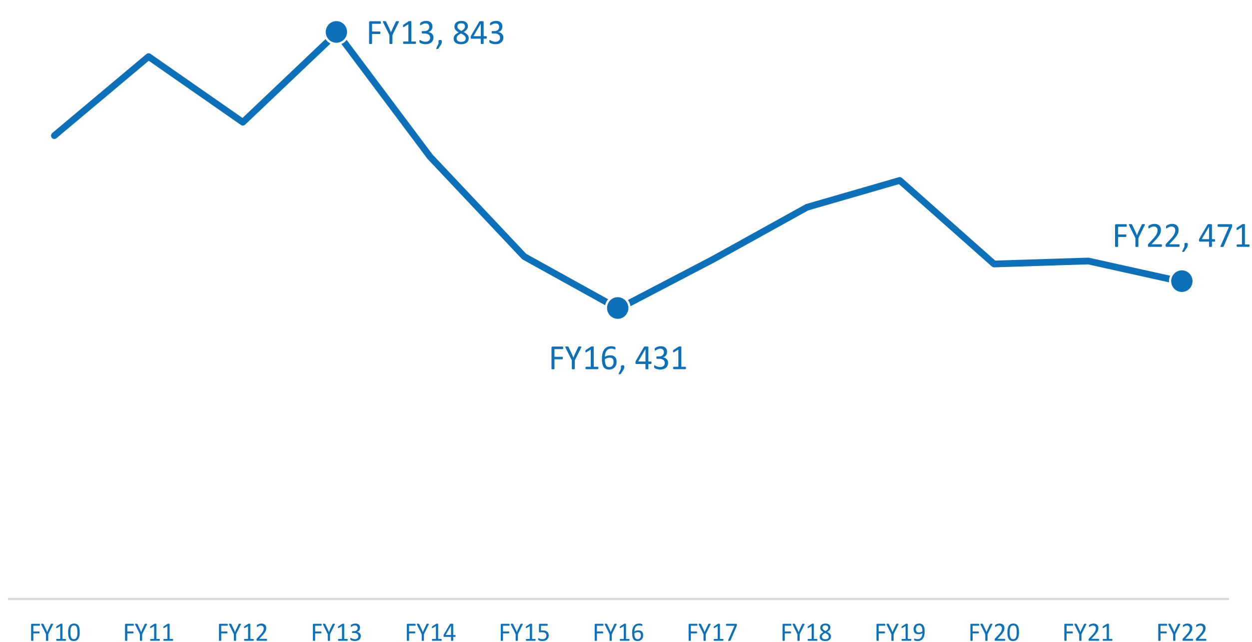


Figure 2 The Number of (Unique) Families with an Open In-Home Case. Source: FACES database (fopsz)

1.4.2 Prior Case History

Each time a family has an in-home case opened, CFSA refers to the case as a "case episode". In the last 5 years, the typical family receiving in-home services did not have a prior in-home case episode when the new case opened. In contrast, from FY 2010 to FY 2018, the typical in-home family more often experienced one prior case episode when the new case opened.

Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Median Prior Episode Count	1	0	1	0	1	1	1	0	1	0	0	0	0

Table 1 Prior In-Home Case Episode Count for In-Home Cases. Source: FACES database (fopsz)

1.4.3 Allegations

When considering the types of allegations leading up to an open in-home case, **neglect has been the primary allegation for approximately 8 of 10 in-home cases**. In FY 2022 in particular, neglect accounted for 80 percent of the open in-home cases, up from a recent low of 73 percent in FY 2016. Also in FY 2016, CPS substantiated relatively more families for abuse. Table 2 lists the primary substantiated allegation that led to an in-home case.

Primary Substantiated Allegation Leading to Opening an In-Home Case					
Fiscal Year	Neglect	Abuse	Sexual Abuse	Sex Trafficking	Suspicious Child Death
2010	77%	21%	2%	0%	0%
2011	79%	19%	2%	0%	0%
2012	78%	20%	2%	0%	0%
2013	78%	19%	3%	0%	0%
2014	73%	23%	3%	0%	0%
2015	78%	19%	3%	0%	0%
2016	73%	24%	3%	0%	0%
2017	75%	22%	2%	0%	1%
2018	77%	20%	3%	1%	0%

Primary Substantiated Allegation Leading to Opening an In-Home Case					
Fiscal Year	Neglect	Abuse	Sexual Abuse	Sex Trafficking	Suspicious Child Death
2019	81%	16%	2%	1%	0%
2020	81%	15%	2%	1%	0%
2021	82%	16%	2%	1%	0%
2022	80%	18%	2%	0%	0%

Table 2 Primary Substantiated Allegation for Opened In-Home Cases from FY 2010 – FY 2022. Source: FACES database (fopsz)

For CPS investigative social workers, CPS policy, training, and protocols (as well as the law) break out the subcategories applicable to the overarching terms "neglect" and "abuse".[4] Educational neglect and medical neglect, for example, are maltreatment subcategories of neglect. When breaking down neglect allegations into more detailed subcategories, the most common substantiated subcategories are educational neglect; inadequate supervision; substance use by a parent, caregiver, or guardian; exposure to domestic violence; and physical abuse.

Table 3 outlines each of these common maltreatment subcategories and provides the percentage of in-home cases that opened in FY 2022 as a result of the listed subcategory substantiations. An investigation can be substantiated for multiple allegations; therefore, these maltreatment subcategories are not mutually exclusive.

Maltreatment Subcategory	Share
Educational Neglect	22%
Inadequate Supervision	22%
Substance use by parent, caregiver, or guardian	21%
Exposure to domestic violence	16%
Physical Abuse	14%

Table 3 Most Common Substantiated Maltreatment Categories for In-Home Cases Opened in FY 2022. Source: FACES database (fopsz)

[4] DC Official Code §16-2301(9)(A)(I-X)

Two additional trends also stand out:

- In FY 2021, 21 percent of the substantiations were for exposure to domestic violence (DV), a 5 percentage-point jump from the 16 percent of DV substantiations seen both in FY 2020 and again in FY 2022.
- Educational neglect dropped in FY 2020 to 17 percent, a 9 percentage-point decrease from 26 percent in FY 2019. In FY 2022, substantiations for educational neglect rose by 5 percentage points to 22 percent.

The COVID-19 pandemic could have played a role in both trends since DC Public Schools were virtual between March 2020 and February 2021, and children were not in-person during the school day, and household members spent more time in the household together during social distancing.

A detailed table of all substantiated maltreatment subcategories can be found in the *Technical Appendix, Section 1-4*.

2. IN-HOME FAMILY PROFILE/CHARACTERISTICS

CFSA conducted a study based on a sample that included a total of 4,327 high-to-intensive risk referrals between October 2020 and March 2023. Of these referrals, 922 (21 percent) were substantiated and led to in-home services while the remaining 3,405 referrals (79 percent) did not receive in-home services. For the purposes of the study, the 3,405 referrals serve as the comparison group. Approximately a third (n=1,133) of all referrals in the comparison group were ultimately substantiated, and around 15 percent (n=499) of all referrals in the comparison group eventually led to a subsequent referral to the Collaboratives. Despite posing a high-to-intensive risk and not being served by In-Home, the majority of referrals (n=2,906) in the comparison group did not result in a Collaborative referral. Among these 2,906 referrals, CFSA eventually substantiated 1,021 referrals.

One of the **key criteria to opening an in-home case is that CPS assesses a risk level of high or intensive** during the CPS investigation. All referrals included in the sample had a risk level assessed by CPS as high or intensive. That is, the sample for analysis consists of families with a higher risk. Defining the sample in this manner aims to create a reasonable comparison group, i.e., families with a low-to-moderate risk. Defining a comparison group is particularly important when assessing outcomes detailed in the Appendix, *Section 5 IN-HOME PROGRAM EVALUATION.* The following sections describe the sample by looking at basic demographics, the allegations of the referrals, and prior Agency involvement for families included in the sample.

2.1 BASIC CHILD/PARENT DEMOGRAPHICS

Race/Ethnicity. Black or African American families were slightly overrepresented among the families receiving in-home services, in contrast to the comparison group. This overrepresentation was observed by 6 percentage points, indicating a slight disparity in the demographic composition of the two groups.

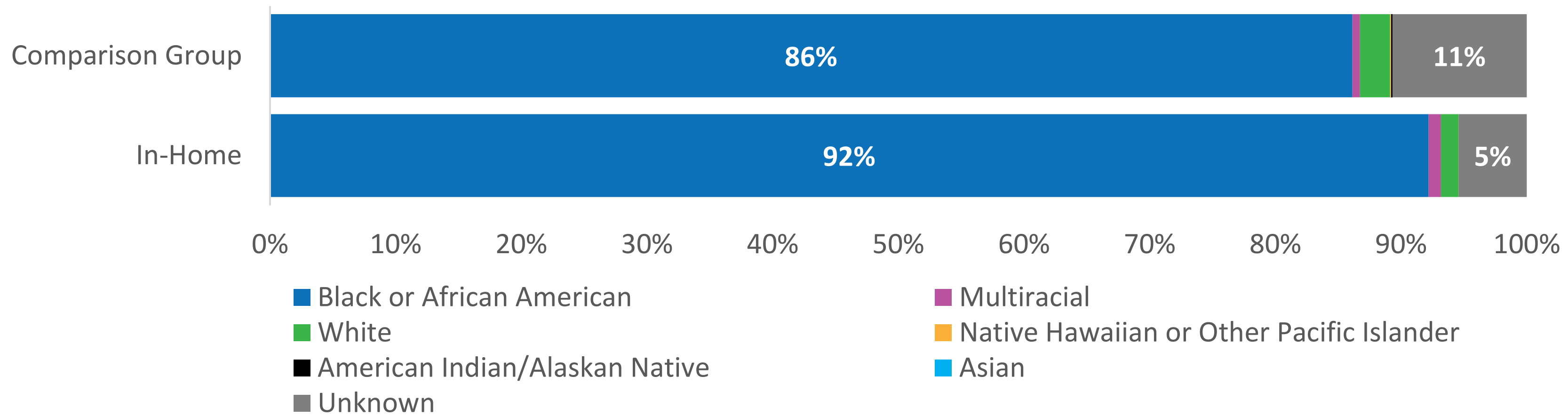


Figure 3 Family Race by Referral. Source: FACES database (fopsz)

Age. CFSA observed that children served by in-home services tended, on average, to be relatively younger than the children in the comparison group. However, there was a significant amount of missing data for the age of children in the in-home services group, which may impact the accuracy and generalizability of the findings for age differences. In contrast, the average age of the caregivers in both the in-home services group and the comparison group was found to be relatively similar.

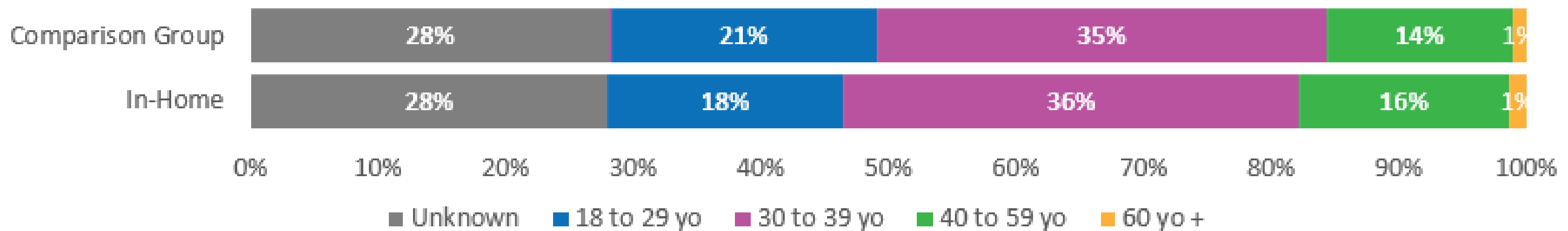


Figure 4 Average Age of Caregiver per Referral. Source: FACES database (fopsz)

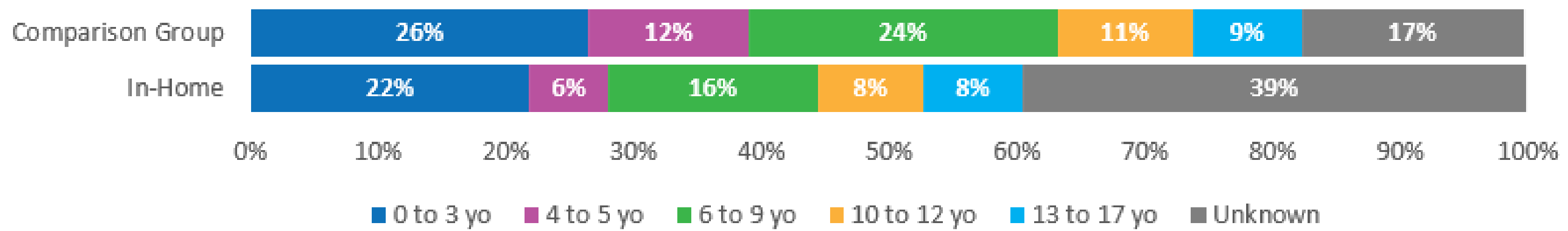


Figure 5 Average Age of Children per Referral. Source: FACES database (fopsz)

Number of children. There was no significant difference in the number of children per family between the in-home group and comparison group.

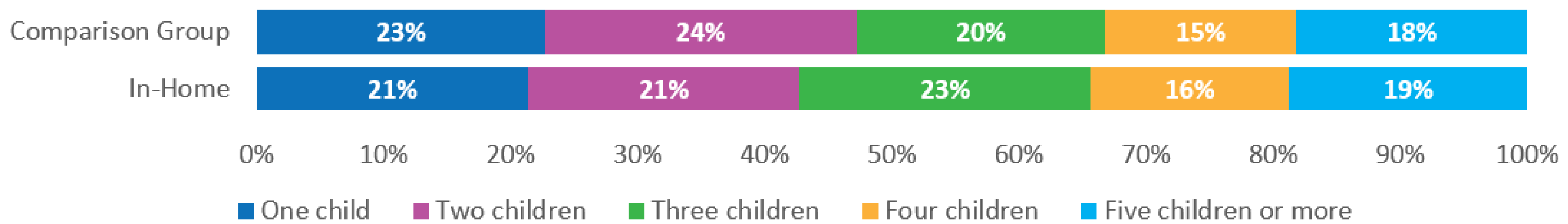


Figure 6 Number of Children per Referral. Source: FACES database (fopsz)

Ward. Ward 7 was slightly overrepresented by 4 percentage points among families receiving in-home services, indicating that Ward 7 families were more likely in need than families from other Wards.

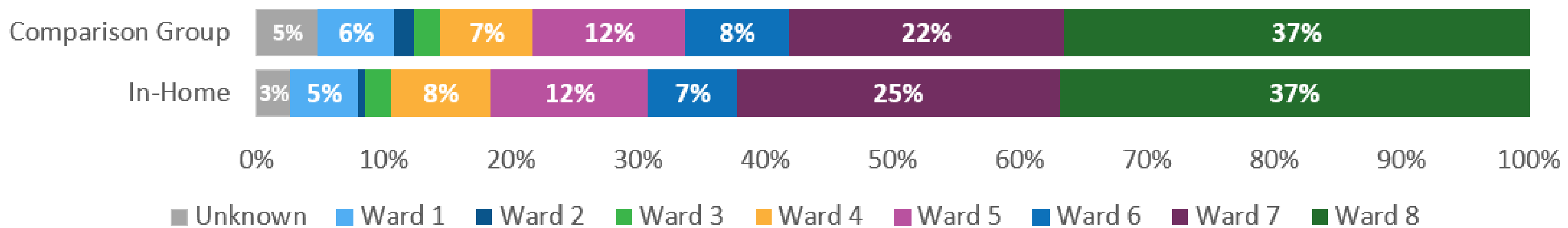


Figure 7 Percent of Referrals by Ward. Source: FACES database (fopsz)

2.2 CHARACTERISTICS OF THE RESULTING IN-HOME CASES

2.2.1 Risk Level

Summary

CPS investigative social workers follow a protocol and a risk assessment tool to determine one of the following levels of risk: low, moderate, high, or intensive. Similarly, once the Agency opens an in-home case, the assigned In-Home Administration social worker also assesses for risk. In-home social workers complete the risk *reassessments* within the first 30 days of case opening and every 90 days thereafter. Overall, 90 percent of referrals in the sample have a risk level of high. The remaining 10 percent are intensive. When an in-home case first opens, the most frequently assessed initial reassessment risk level is high (57 percent). The second ranked risk level is moderate (34 percent).

Analysis

The bulk of referrals in the sample have a risk level of high. Referrals that result in a family receiving in-home services tend to have a higher CPS risk level.

Most Investigations in the Sample Population have a Risk Assessment Level of High

Risk Level	Comparison Group	In-Home	Overall
High	93%	82%	**90%**
Intensive	7%	18%	**10%**

Table 4 Initial CPS Risk Level by Group. Source: FACES database (fopsz)

As Figure 7 demonstrates, low and intensive risk levels are the least common initial risk level from a risk *reassessment,* i.e. the first assessment of risk conducted by the In-Home Administration, and as noted earlier, the most common risk level is high (57 percent) and the second ranked risk level is moderate (34 percent).

Most Initial Risk Assessments are High or Moderate

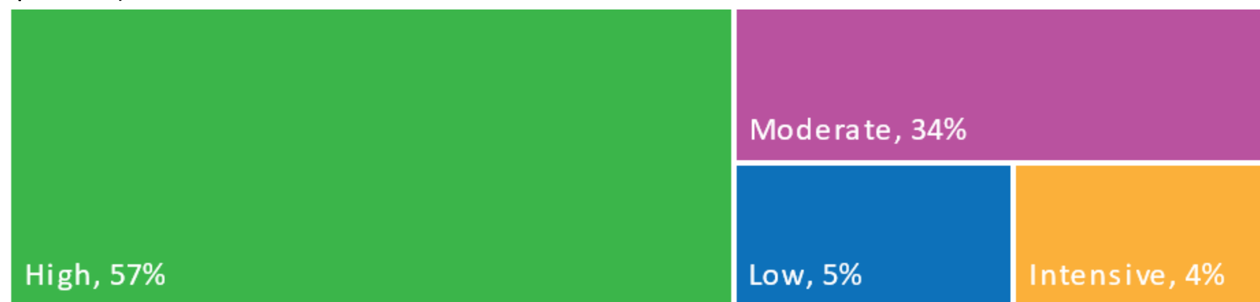


Figure 4 Distribution of Risk Level of the First Risk Reassessment. Source: FACES Management Report CMT402

Section 3.3.2 details the typical trajectory of risk reassessments over the life of a case.

When a family's risk reassessment level is intensive, they receive more services and an increased number of visits during the month. For example, CFSA policy requires families to receive two visits per month. (A family support worker may complete one of the two visits in the place of a social worker). When a family's risk level is intensive, social worker visits to the home increase to at least four visits a month.

2.2.2 Length of time with an In-Home case

The average in-home case lasts 9 months. A full description of the data lives in *Technical Appendix, Section 2-2*.

In general, the In-Home Administration strives to keep cases open only as long as clinically necessary. To better understand the barriers to case closure, the In-Home Administration conducts quarterly reviews of those cases that have been open for more than a year. Barriers might include a new referral or the family's case becoming court involved. The quarterly reviews also include discussions on whether case closure is appropriate, given the case circumstances. In any given month during the period of analysis, the share of families who have a case open for more than a year ranges from 13 to 20 percent of the total cases served by the In-Home Administration. Common barriers to case closure for cases open more than a year include court involvement, relapse on goal progress, or a new Hotline call.

2.3 FAMILIES WITH PRIOR AGENCY INVOLVEMENT

2.3.1 Investigation History

Based on the sample population, families receiving in-home services tended to have more prior CPS involvement on average (3.25 prior investigations) than families in the comparison group (0.45 investigations).

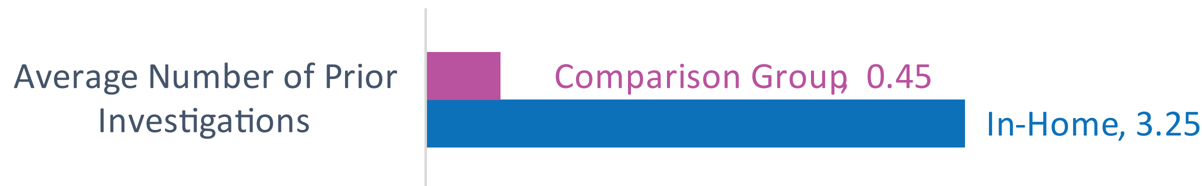


Figure 5 Average number of Prior Investigations by Sample Group. Source: FACES database (fopsz)

2.3.2 Prior In-Home Case Episodes

As noted earlier, each time a family has an in-home case opened, CFSA refers to the case as a "case episode". Most families (57 percent) with an open in-home case have not had a previous case opened. For those families that have had a previous in-home case, a sizable portion (43 percent) had at least one prior case episode but, as shown in Figure 9, some have had more.

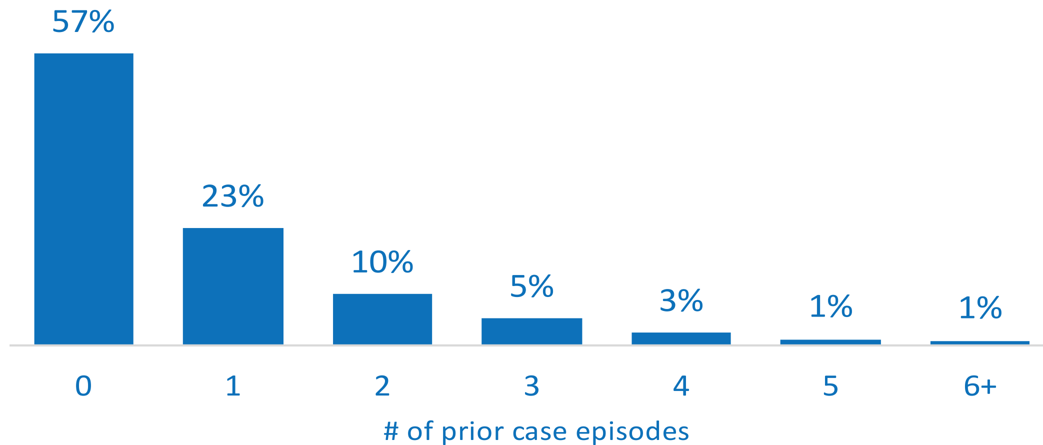


Figure 6 Prior In-Home Case Episode History. Source: FACES database (fopsz)

2.3.3 Multigenerational Child Welfare History

The 4,327 investigations included 8,740 children in the sample study. CFSA identified 70 percent (n=6,080) as victim children.

CFSA identified 3,612 caregivers in the sample. One-third (33 percent, n=1,202) had their own previous history with CFSA as victim children, i.e., prior to the age of 18. Their interaction with CFSA as children included being subjects of investigations, receiving in-home assistance, and being separated from their homes (including placement into foster care).

Of the 1,202 caregivers who were part of a CPS investigation prior to the age of 18, a subset of 493 caregivers (41 percent) were also part of an open in-home case prior to the age of 18. An additional subset of 384 caregivers (32 percent) were separated from their parents and

placed in foster care (some of these parents may have also been part of an open in-home case prior to the age of 18). Additionally, 325 caregivers (27 percent) were victim children exclusively during investigation procedures, i.e., without being involved with further services like foster care or in-home services.

One-third of caregivers had their own previous history with CFSA as victim children.

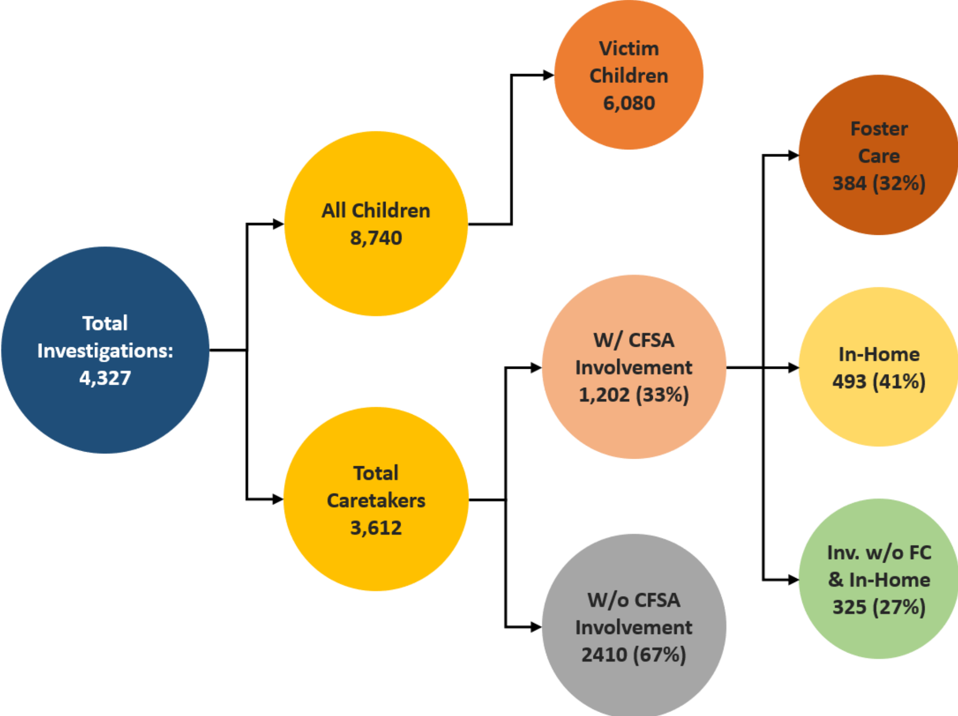


Figure 7 Caregiver Involvement Status in High and Intensive Risk-Level Investigations from FY 2020 – FY 2023-Q2

2.3.4 Separation History

Similarly, families with open in-home cases tended to have experienced more separations of children from the home (0.29 separations) than the families in the comparison group (0.23 separations). While the gap may not seem wide on the surface, the difference between is statistically significant.

Figure 8 Average number of prior separations, by group. Source: FACES database (fopsz)

There are a few limitations to this analysis: 1) since the analysis focuses solely on the caregiver's involvement with the child welfare system prior to reaching the age of 18, the analysts noted that some of these caregivers may have been teen parents prior to turning 18; and 2) CFSA was unable to identify whether these caregivers had child welfare involvement while under the age of 18 in any jurisdictions beyond the District of Columbia. A full description of the data lives in the *Technical Appendix, Section 2-4*.

2.4 CONCURRENT KIN PLANNING[5]

The Agency's Practice Model requires a child's foster care case to consistently move forward toward closure with more than one permanency option (concurrent planning) if reunification is no longer viable. Ideally, concurrent planning for permanency includes relatives who are willing and able to serve as potential placement resources (kinship providers). For families receiving in-home services, CFSA incorporates a similar concurrent kin planning process to identify and engage family relatives who have been or are willing and able to support the family involved with the child welfare system. Ideally, identified relatives help with family stabilization to expedite, as feasible, case closure.

Concurrent kin planning may begin with the Hotline worker if school personnel report educational neglect. The Hotline worker will ask the school reporter if the family has listed emergency family contacts, in which case those contacts may be involved in concurrent kin planning. During the CPS investigation process, the CPS worker explores potential relative supports and continues throughout the life of the In-Home Administration's case. Initially, the CPS investigative social worker gathers information on how a relative has already been or may become a support to the family. After case transfer, the in-home social worker also gathers information and engages relatives, especially to help the family meet their identified case plan goals. Social workers may identify relatives who are willing and able to serve as kinship providers in the event of a family emergency or a need to separate a child from the home due to imminent risk of danger. The social worker documents the concurrent kin plan as part of the case planning process.

[5] CFSA considers kin as both blood relatives and "fictive" kin, i.e., individuals not necessarily related by blood, marriage, or adoption but with a bonded and emotionally significant relationship with the child.

2.4.1 Identification and Engagement of Kin

As described, CFSA prioritizes efforts to identify relatives (i.e., kin) in the early stages of a family's involvement with the Agency. Identification of kin does not mean that the social worker is planning to separate the child from the family home. To the contrary, **kin may help prevent separation**. More often, kin serve as key supports and invaluable stabilization resources for children and families.

- When CPS transfers a case to the In-Home Administration, the assigned social worker is responsible for building on the information gathered during the investigation process. The social worker is further responsible for actively engaging non-custodial parents to secure their involvement with the child. Most applicable to CPS investigations, the Agency's administrative issuance, *Facilitating Child Living Arrangements with Non-Custodial Parents,* outlines the conditions and requirements for expediting a living arrangement with a non-custodial parent, irrespective of whether the non-custodial parent resides within or outside of the District of Columbia. If placement is unnecessary and CFSA opens an in-home case, the In-Home Administration may also facilitate similar living arrangements as needed.
- The Agency strives to engage all parents for identifying and engaging kin. However, there are situations in which parents who have an open in-home case may not want to give permission for a social worker to engage their relatives, either for case planning or as potential placement options in the event of a need to separate a child due to imminent danger. The Agency's administrative issuance, *Engagement of Kin without Parental Consent,* provides guidance on how to engage kin without a parent's consent.

2.4.2 Concurrent Kin Plan (CKP) Development

In-home children are at high-risk of separation if parental behavior impacting child safety and well-being is not changed. Often, supportive engagement of relatives can offset such risks. During the onset and early assessment stage of the in-home case, concurrent kin planning is important work for exploring and hopefully designating other capable adults to provide care for children if the parent is unable to do so, e.g., due to an unforeseen family emergency or a necessary separation of the child from the home.

- Each family completes a CKP, which specifically documents whether there are different caregivers for different children.
- The social worker and family develop the CKP together within the first 30 days of the in-home case opening as part of the case planning process. Accordingly, the social worker and family update the CKP every 90 days in conjunction with the review and updates to the service plans.
- The social worker documents the CKP in a FACES.NET contact note, selecting the purpose as "Concurrent Kin Plan".[6]

[6] FACES.NET is CFSA's current web-based child welfare information system (CWIS). In 2024, CFSA will finalize a transition from FACES.NET to STAAND (Stronger Together Against Abuse and Neglect in DC), a federally mandated platform and comprehensive child welfare information system (CCWIS).

If the social worker is unable to develop the CKP with the family, the social worker documents the attempts to do so. If the family has no or limited supports, the social worker must document team efforts to strengthen the family's support system. These documented efforts are included both in the ongoing case plan and in the sustainability plan, which is developed prior to case closure.

2.4.3 Concurrent Kin Planning and Separation

- As of October 1, 2023, if CPS must separate a child from a family with an open in-home case due to imminent risk, and if the Agency initially places the child in a non-kin home, the assigned social worker partners with the Kinship Family Licensing Unit (KFLU) to continue identification of and engagement with kin within the first 90 days of the placement.
    - If the Agency is unable to identify or locate any kin within the 90 days, the social work team continues to try and identify kin throughout the duration of the children's stay in the non-kin foster home. If kin are identified, the social worker will make concerted efforts to engage the kin either as a potential licensed kinship resource parent or as a lifelong connection.
- When the Agency identifies prospective kin caregivers who are willing and able to consider assuming primary responsibility for a child, the social worker must provide the family with the brochure, Kinship Care: A Guide to Exploring Your Options. This brochure provides information to help the kin family make the most informed decision possible about the crucial role they will be playing as caregivers for their family member. The social worker supplements this information by educating the kin family with additional details on the array of services that may be available to the kin family, either directly from the Agency or from the community.
- When a separation has been initiated by CPS and a kinship family makes the informed decision to become a licensed kinship caregiver, the KFLU worker assesses the identified kin and, if they are a viable resource, initiates the kinship licensure process.

If the prospective kin providers need resources (e.g., furniture, gift cards for food or clothing, or utility payment assistance), the assigned social worker or licensing worker contacts the KFLU program manager to discuss referral options.

3. CURRENT IN-HOME PRACTICE

3.1 INTRODUCTION

In 2023, CFSA's In-Home Administration moved from Entry Services to the Office of In-Home and Out-of-Home Care in order to streamline case management and family support. Currently, CFSA's in-home social workers manage cases (either court-involved or not) that CPS has substantiated for child maltreatment and that have a high or intensive family risk level where the children still remain in the family home. As noted earlier, CFSA continues to co-locate staff at the neighborhood Collaboratives, which allows for more teaming for case management to address the concerns that brought the family to CFSA's attention.

CFSA opens an in-home case when the investigation results in a substantiated finding and a high or intensive risk level indicates that protection of the child's safety does not require separating the child from the caregiver (most often the birth family). However, there are circumstances where social workers from a private agency or CFSA's Out-of-Home Clinical Case Management and Support Administration may also serve children who live with their birth parents. The following two circumstances apply: (1) the child reunified with a parent after spending time in foster care and the foster case is not yet closed; (2) at least one child of a sibling group was separated from the home, due to immediate safety concerns, but CPS determined that the other siblings may remain safely in the home; or (3) children born to parents who have a child in foster care and there is a need for Agency support.

Case management includes but is not limited to scheduling and conducting visits in the home and in the community to assess safety and to provide direct support for increasing parental capacity. In addition, case management helps to reduce risk by making sure appropriate services are available, sharing those resources with a family, and facilitating access to appropriate community connections. Once the risk level has decreased, CFSA may refer families to the Collaborative for step-down services and case closure.

3.2 ALLEGATIONS THAT OPEN IN-HOME CASES

3.2.1 Allegation Types

Summary

- Most investigations involve an allegation of neglect. Families receiving in-home services are more likely to have both an allegation and a substantiation of neglect than the comparison group.

- CPS investigations that result in an in-home case are more likely to involve educational neglect, caregiver substance use, inadequate supervision, and physical abuse than those in the comparison group. Educational neglect has the widest gap between the in-home cases and the comparison group.

Analysis

Typical CPS investigations in the sample included an allegation of neglect. About one-third of the CPS investigations included an allegation of abuse. These observations held true for investigations that led to an in-home case and for those in the comparison group without cases.

Table 5 breaks out investigation allegations for both groups in the sample population.

Most Investigations Involve an Allegation of Neglect

Allegation	Comparison Group	In-Home
Abuse	32% (1100)	34% (314)
Neglect	86% (2919)	90% (832)
Sex Trafficking	2% (71)	1% (10)
Sexual Abuse	7% (231)	6% (57)
Suspicious Child Death	0% (16)	0% (0)

Table 5 Share and Count for each Allegation tied to Sample Population Investigations. Source: FACES database (fopsz) [7]

The allegation types are similar between both groups, e.g., both groups experience similar rates of abuse allegations as well as allegations of sexual abuse and suspicious child deaths, although the latter two allegations are much less common overall. **Families receiving in-home services are more likely to have an allegation of neglect**, i.e., 90 percent in contrast to 86 percent for the comparison group.

When looking at allegations that CPS substantiated during an investigation, **families receiving in-home services are more likely to be substantiated for abuse and neglect**. However, families receiving in-home services are less likely to be substantiated for sex trafficking than the comparison group. The differences for the remaining allegations are not statistically significant. A full description of the data lives in the *Technical Appendix, Section 3-1*.

[7] The table comprises data from FY 2021 through the 2nd quarter (Q2) of FY 2023.

Table 6 shows the 10 most common alleged maltreatment subcategories, both for in-home cases and for the comparison group.

The Most Common Alleged Maltreatment for Both Groups is Substance Use by a Caregiver

Maltreatment Subcategory	Comparison Group	In-Home
Substance use by a parent, caregiver, or guardian	30%	38%
Inadequate supervision	25%	30%
Physical abuse	26%	30%
Educational	13%	24%
Exposure to domestic violence in the home	20%	20%
Caregiver incapacity (due to incarceration, hospitalization, or physical or mental incapacity)	12%	17%
Exposure to unsafe living conditions	13%	15%
Medical neglect	8%	9%
Inadequate food/nutrition	8%	8%
Inadequate clothing or hygiene	8%	8%

Table 6 Share of Investigations with the Top 10 Most Common Alleged Maltreatment Subcategories. Source: FACES database (fopsz)

As noted at the beginning of this section, in-home allegations and substantiated investigations are more likely to involve educational neglect, caregiver substance use, inadequate supervision, and physical abuse. Educational neglect, for example, occurred 11 percentage points more frequently for families receiving in-home services than for the comparison group. See the *Technical Appendix, Section 3-2*A for a full description of the data.

3.3 ASSESSMENT OF FAMILIES

3.3.1 INTRODUCTION – HOW DO WE ASSESS FAMILIES?

An accurate and quality assessment of a family and their needs is critical to the child and family's well-being. Assessments help the whole family's team identify the most appropriate services for the family. Services help the family build upon their strengths as well as help to

identify strategies for overcoming challenges. In-home social workers continually assess safety, risk, and caregiver strengths and challenges. These safety and risk assessments also provide team members with an extensive understanding of the family's current situation, past influencing circumstances, underlying issues, strengths, capabilities, and presenting challenges and concerns.

No single form, tool or event can adequately inform the assessment process. The process is holistic, multi-faceted, and ongoing by nature. Assessments factor in feedback and insight from the family, the social worker, the family support worker (FSW), and service providers.

To ensure an authentic, holistic assessment process, CFSA incorporates an array of informal and formal (i.e., evidence-based) assessment tools. Informal assessments may include clinical observations during a home visit or a simple, casual conversation where the social worker incorporates motivational interviewing and active listening skills.[8] Formal assessments may incorporate the Structured Decision Making® (SDM) tools and the Parent's Evaluation of Developmental Status (PEDS) tool.

The following sections present findings from formal assessments used by the In-Home Administration. Refer to Table 17 in the Appendix to find a more detailed description of these formal assessments.

3.3.2 RISK REASSESSMENT

Summary

Family risk levels measurably decrease on average over the life of a case with the In-Home Administration, as measured by the In-Home Risk Reassessment tool.

About the Risk Reassessment

As noted earlier in this report, within 30 days of receipt of a case, the in-home social worker completes a risk reassessment to determine the level of services needed by the family to maintain safety for the children in the home. In addition, the social worker determines contact

[8] CFSA's Child Welfare Training Academy provides training for social workers and other interested staff in the following six principles of motivational interviewing: (1) expressing empathy, (2) developing discrepancy, (3) avoiding arguments, (4) rolling with resistance, (5) supporting self-efficacy, and (6) assessing confidence. Active listening skills include soliciting input from the family and valuing their opinion, asking open-ended questions as part of the engagement process, showing empathy, and providing choices and support.

guidelines with families and collaterals. Ongoing risk reassessments provide an evaluation of family progress, specifically whether family behaviors and actions have reduced or eradicated the risks identified at case opening.
Supervisors review risk levels with social workers every 90 days in conjunction with updates to the service plan and the Caregiver Strengths and Barriers Assessment. Social workers may also complete risk reassessments when a family's circumstances change, e.g., if a new Hotline report alleges additional abuse or neglect or if a new safety plan is necessary.[9]

Risk Reassessment Analysis

As discussed in the demographics section on Risk Level, Section 2.2.1, one of the primary criteria for opening an in-home case is that the risk assessment conducted during the CPS investigation results in a risk level of high or intensive. The in-home risk *reassessment* is like the CPS risk assessment but asks different questions and targets different risk factors. In general, the initial CPS risk assessment includes greater emphasis on the family's history of risk factors while the in-home reassessment focuses on the caregiver's ability to address identified risk factors (see the *Appendix*, *Section 11.2* for a list of assessment questions). Both the risk assessment and risk reassessment have risk levels of low, moderate, high, and intensive. As shown in Figure 7 in the demographics section, the initial risk reassessment risk level is most commonly high.

Due to the life of an in-home case being on average less than a year, few cases have more than four risk reassessments completed for the caregiver. For all in-home families in the sample population, Figure 12 summarizes distribution of the number of risk reassessments completed for each family's case episode. The reassessments are point-in-time as of July 1, 2023.

---

[9] Safety planning is discussed in detail in Section 3.6.

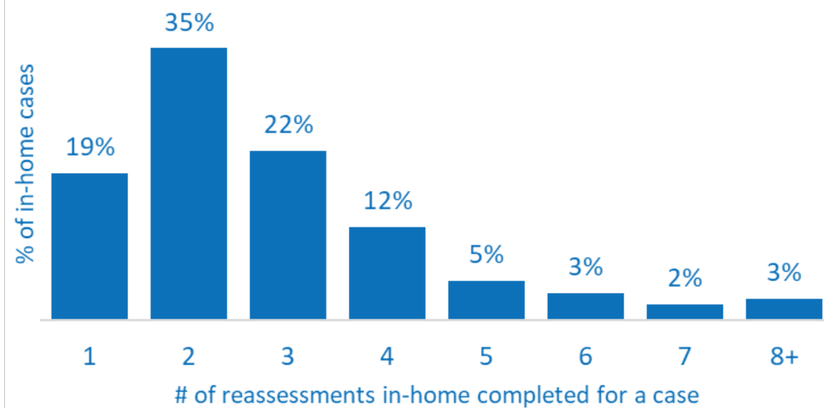


Figure 9 Distribution of Total Risk Reassessments for the Sample Population (Point-in-Time as of 7/1/2023, n=1,134 case episodes)

Aside from the principal goal of family stabilization and case closure, the preliminary goal of the in-home case is to reduce the family's risk of maltreatment. Ideally, the family's risk level decreases over the life of the case, regardless of the risk level when the case began.

Figure 13 considers families in our sample population (as defined in Section 2) who received in-home services and groups them by their initial reassessment risk level. It then tracks whether the risk level decreased, on average, over the life of the case.

On average, families initially reassessed as moderate, high, and intensive all saw a decrease in their risk level. Families in those three categories decreased to the moderate range. In contrast, families who started out as low saw a slight increase in their risk level. But this risk level group merits two caveats: (1) their average risk score remained in the low range and (2) with 40 families initially reassessed with low risk, the subgroup is relatively small.

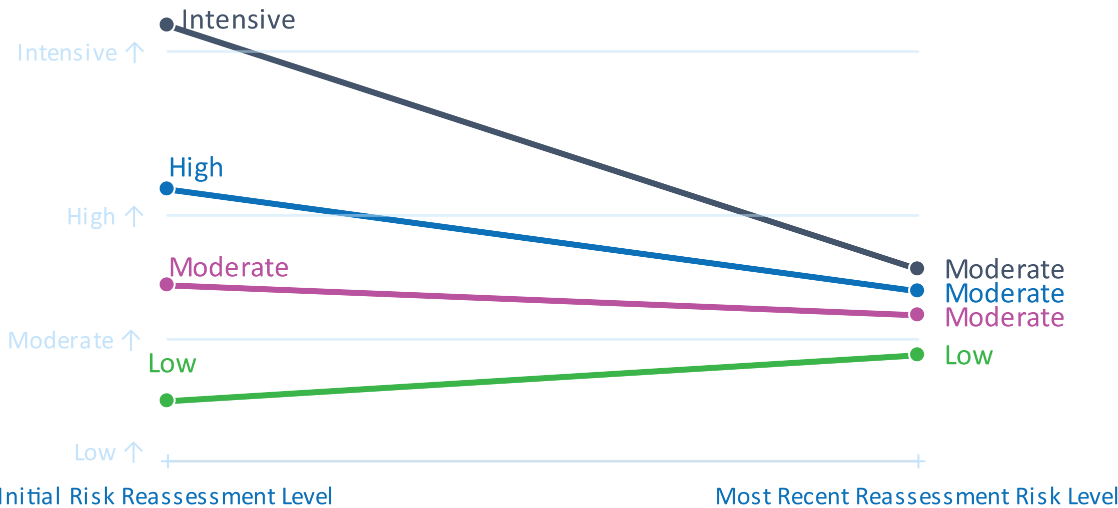


Figure 10 Average Change in the In-Home Reassessment Risk Level, grouped by Initial Reassessment Risk Level (n=740)[10]

3.3.3 Danger and Safety Assessment

Summary

From FY 2021 through FY 2023-Q2, the Danger and Safety Assessments (DAS) resulted in a safety status of "safe" for 88 percent of the time. Seven percent of assessments result in "safe with a plan," which typically results in the creation of a safety plan.

A DAS may flag multiple danger indicators. Among all assessments in which there was at least one danger indicator present, the following were most common indicators of danger:

- History or risk of harm due to lack of (1) supervision, (2) medical or mental health care, or (3) food clothing and shelter: 42 percent.

[10] The analysis does include any family with only one risk reassessment.

  - Drilling down within this indicator, **lack of supervision contributed to the history or risk of serious harm in 33 percent** of all assessments.
- History or risk of **physical harm** by caregiver: **28 percent.**
- Hazardous **living conditions** contributing to the history or risk of harm: **27 percent.**

About the DAS

First and foremost, the household-focused DAS tool assesses the imminent danger of serious harm or maltreatment for each child in the home. All CPS investigations include the DAS as part of a standard assessment process. If the tool indicates a risk of maltreatment, the DAS also navigates whether a safety plan is sufficient to provide protection for the child or whether the Agency must separate the child from the home to ensure the child's safety. If CFSA opens a case with the In-Home Administration, the in-home social worker may also conduct a DAS, if deemed clinically appropriate.

The DAS guides a social worker's decisions regarding the following levels of safety:

- **Safe:** No indicators of danger are present for the child. The child is safe with no concerns.
- **Safe with a plan:** One or more indicators of danger are present but the child can safely remain in the home with the use of a safety plan. The social worker creates a safety plan with the family.
  - Although the child may safely remain in the home, the family in partnership with the social worker must develop a documented concrete safety plan that the family is able and willing to follow. Safety plans specifically address or eradicate any identified indicators of danger without the Agency needing to separate the child from the home.
- **Unsafe:** One or more indicators of danger are present and cannot be controlled through a safety plan for the child.
  - To protect the child, the Agency will separate the child from the home until the family is able to ameliorate or eradicate indicators of danger.
  - Note: If one child is found unsafe, the social worker considers the necessity for a safety plan for all other children in the household.
- **Unable to assess:** A child in the household is not present for the assessment, e.g., the social worker was unable to locate the child, the child was in another jurisdiction outside of the District, or the child is an older youth who is incarcerated.

The DAS Analysis

The most common outcome level from the DAS tool is “safe,” as shown in Figure 14. Note this section considers all DAS tools completed during the period of analysis (FY 2021 through FY 2023-Q2), not just those investigations in the sample population. CFSA analysts reviewed a total of 9,610 completed DAS tools.

Most Danger and Safety Assessments Result in an Outcome of “Safe”

Figure 11 Danger and Safety Assessment Decision Outcomes (FY 2021-FY 2023-Q2 n=9,610 Assessments). Source: Tableau Server — Approved Danger and Safety Assessments

If the outcome is “safe with a plan”, the Agency will develop a safety plan accordingly. One of the key components of the safety plan is to determine *who* needs to take *what* actions in order to keep the child safe. Safety plans are time-bound (typically just over a month). Again, the social worker and caregiver together develop the plan with the social worker explicitly defining the scope of the plan before having the caregiver sign off on it.

CPS completes three quarters of the total number of completed DAS tools and develops an even larger share (85 percent) of the actual safety plans created and signed. In-home social workers complete most of the remaining quarter of the assessments. Other administrations conduct the assessment occasionally.

CPS Completes Three Quarters of the Total Number of DAS Tools Conducted

Administration	Danger and Safety Assessments	Safety Plans	D&S resulting in Safety Plans (%)
CPS	76%	85%	7%
In-Home	23%	15%	4%
CCMS	1%	<1%	3%
Private Agencies	<1%	<1%	5%

Table 7 Danger and Safety Assessments by Administration (FY 2021-FY 2023-Q2 n=9,610 Assessments). Source: Tableau Server — Approved Danger and Safety Assessments

While in-home social workers also develop safety plans once a family has a case with the In-Home Administration, many of the safety plans created for a family with an in-home case start during the active CPS investigation and prior to the in-home case opening. Rather than isolating all safety plans tied to families who either had a safety plan created and ended up with an in-home case or had an in-home case at the time of the safety plan's creation (which is a somewhat complex task), the following analysis opts to break down *all* assessments where the social worker found at least one indicator of present danger.

The most common indicator of danger is serious harm to the child or serious risk of harm due to lack of supervision or resources. These indicators occur in 42 percent of all DAS assessments with at least one indicator present. Some indicators drill down to more specific factors that drive the risk. For example, the sub-indicators of the top indicator are risk of harm due to lack of (1) supervision, (2) medical or mental health care or (3) food, clothing and/or shelter. A lack of supervision contributed to a risk of serious harm in 33 percent of all assessments in which an indicator of danger was present.

As noted, the DAS tool asks a series of questions designed to assess the presence of indicators for danger to the child. Table 8 summarizes how commonly each indicator of danger occurs by considering how often the assessor selects a specific indicator. A single assessment may include more than one indicator of danger.

Lack of Supervision is a Major Indicator Danger

Indicator of Danger	#/%
Child has been seriously harmed or is in imminent danger of being seriously harmed due to lack of:	**209 (42%)**
▪ Supervision	165 (33%)
▪ Medical or mental health care	55 (11%)
▪ Food, clothing and/or shelter	40 (8%)
Child has been seriously physically harmed by caregiver and/or is in imminent danger of being seriously physically harmed by caregiver.	**139 (28%)**
Child is living in conditions that are hazardous AND child has suffered serious harm OR is in imminent danger of serious harm as a result of:	**136 (27%)**
▪ Domestic violence	53 (11%)
▪ Other (specify)	53 (11%)
▪ Physical living conditions of the home	47 (9%)
Child has been sexually harmed and/or is in imminent danger of being sexually harmed by:	**51 (10%)**
▪ Other adult household member	28 (6%)
▪ Caregiver	15 (3%)
▪ Unknown person AND the caregiver or other adult household member cannot be ruled out	10 (2%)
Child has been seriously harmed by others and/or is in imminent danger of being seriously harmed by others AND caregiver is unable or unwilling to protect the child.	**38 (8%)**
Child has been seriously emotionally harmed by caregiver and/or child is in imminent danger of being seriously emotionally harmed by caregiver AND caregiver is unable or unwilling to respond to concerns.	**30 (6%)**
Child is unable to be seen AS A RESULT OF caregiver purposefully hindering the assessment.	**21 (4%)**

Table 8 Share of Each Indicator Among all Danger and Safety Assessments with At Least One Indicator Present (FY 2021-FY 2023-Q2). Source: Tableau Server — Approved Danger and Safety Assessments

3.4 Caregiver Strengths and Barriers Assessment (CSBA)

3.4.1 Summary

The CSBA is an assessment that allows CFSA to track whether an in-home case has built up caregiver capacity. Based on engagement and service provisions, most caregivers, on average, improve on every CSBA domain previously identified as a barrier. However, **the following barriers are the most common and the least likely to change**:

- Substance use
- Mental health
- Daily parenting behavior and routines

Further exploration is needed to determine the barriers to caregivers' improvement in these areas, such as motivation to change, access to adequate services, and engagement and assessment by the social worker. The In-Home Administration strives to keep cases open only as long as it is clinically necessary. Typically, CFSA in-home cases last about 9 months. Given the length of an in-home case, such services will likely need to extend beyond the life of the case.

3.4.2 About the CSBA

When CFSA opens an in-home case, one of the first activities is to complete the CSBA with the parent or caregiver. As the name of the CSBA tool suggests, the intent is to identify the strengths and barriers a caregiver brings to their role as a caregiver. The in-home social worker uses the CSBA to inform what services the caregiver should receive and what goals should be included in the case plan.

The CSBA serves several purposes:

- Provides a collaborative tool and an objective format for the social worker and the parent or caregiver to identify critical needs that the family can address by incorporating one or more proposed interventions and service referrals into the case plan.
- Provides a guide for the social worker, FSW, supervisor, and extended family members to identify and maximize the parent or caregiver's key areas of strengths while simultaneously addressing challenges and barriers.
- Opens opportunities for identification of resources and interventions that can be used to increase the caregiver's protective capacity to maintain child safety.

- Allows for periodic reassessments that permit family members, social workers, FSWs, and supervisors to assess together any changes in family functioning and thus assess the effectiveness of interventions over time and during the case plan service period.

3.4.3 CSBA Analysis

An in-home social worker completes the CSBA tool with the caregiver both at the beginning of a case and every 90 days thereafter. CSBAs do not occur prior to case opening, i.e., during an investigation.

Figure 16 summarizes the most common strengths and barriers identified at the beginning of the in-home cases opened for the 961 caregivers included in this report's sample population. Each category considered in the assessment is called a domain. The social worker determines whether each domain is a strength or a barrier for the caregiver. The assessment works on the following four-point scale:

1. Strength
2. Neither Strength nor Barrier
3. Barrier
4. Contributes to imminent danger of serious physical or emotional harm to the child[11]

[11] If any domain assessment reveals the fourth option, the in-home social worker elevates the case for possible separation of the child from the caregiver.

The most common strengths are having a social support system and physical health. The most common barriers are daily parenting behavior, mental health, and substance use.[12]

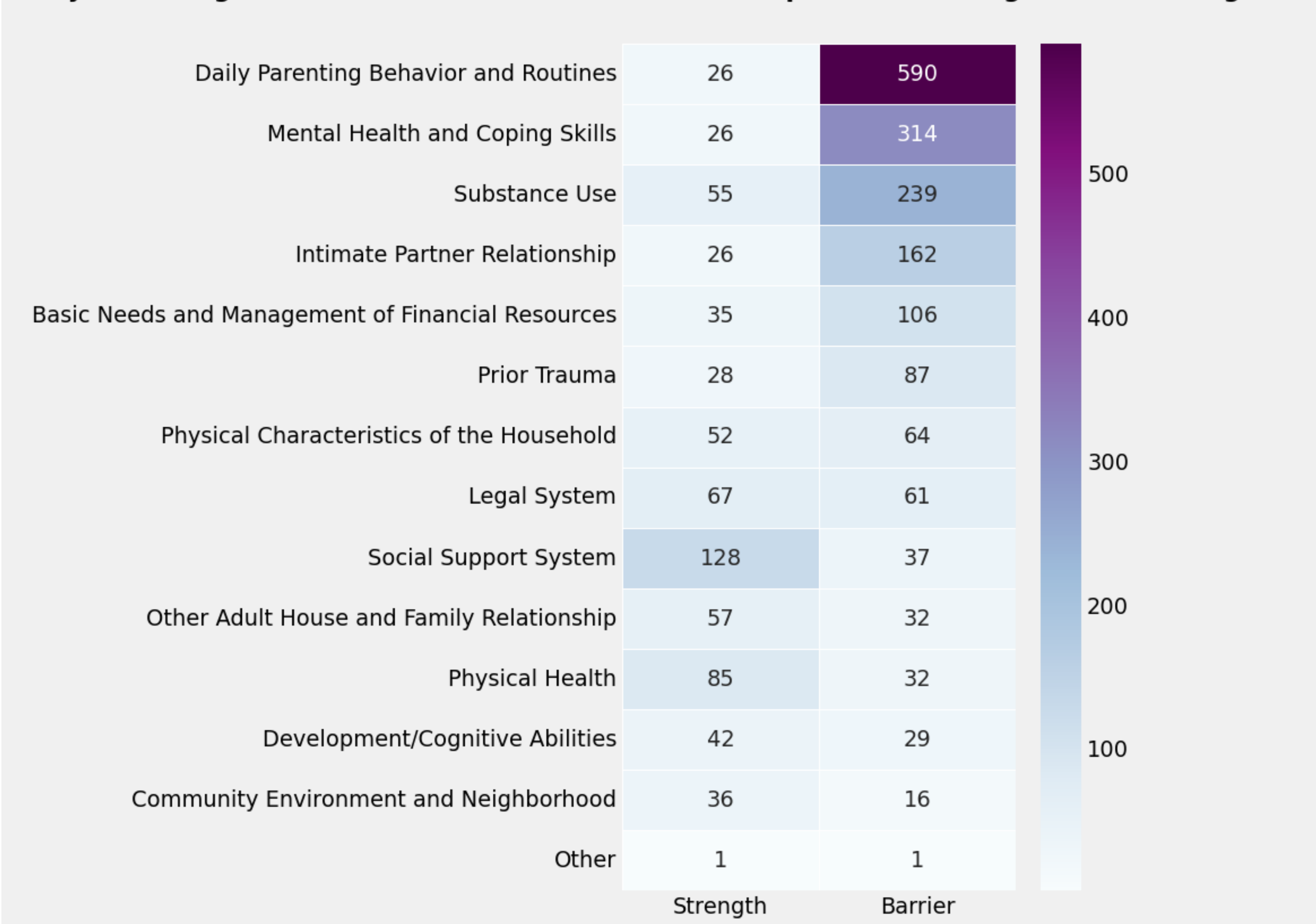


Figure 12 Count of Strengths and Barriers for the In-Home Administration Sample Population. Source: FACES database (fopsz)

[12] Section 4 of this report discusses the existing service array designed to address caregiver barriers.

Since the In-Home Administration's social workers complete CSBAs over the life of the case, it is readily possible to measure whether caregivers improve on domains initially identified as a barrier. Social workers can determine improvement simply by looking at the difference between the initial assessment and the most recently available assessment.

When comparing initial to subsequent results of the CSBA tool, caregivers improve (on average) in every domain previously identified as a barrier. While the CSBA scores improved for all, improvement varied substantially by domain. In the figure below, the higher the score the greater the improvement. For example, the largest improvements happened for relatively uncommon barriers: (1) developmental and cognitive abilities; (2) other adult, house and family relationship; and (3) social support system – all of which increase at least one point on average. Again, the most common barriers – daily parenting behavior, mental health, and substance use – show the smallest improvement, all ranging near a 0.3-point shift on average. Figure 16 summarizes the typical improvement on CSBA barriers.

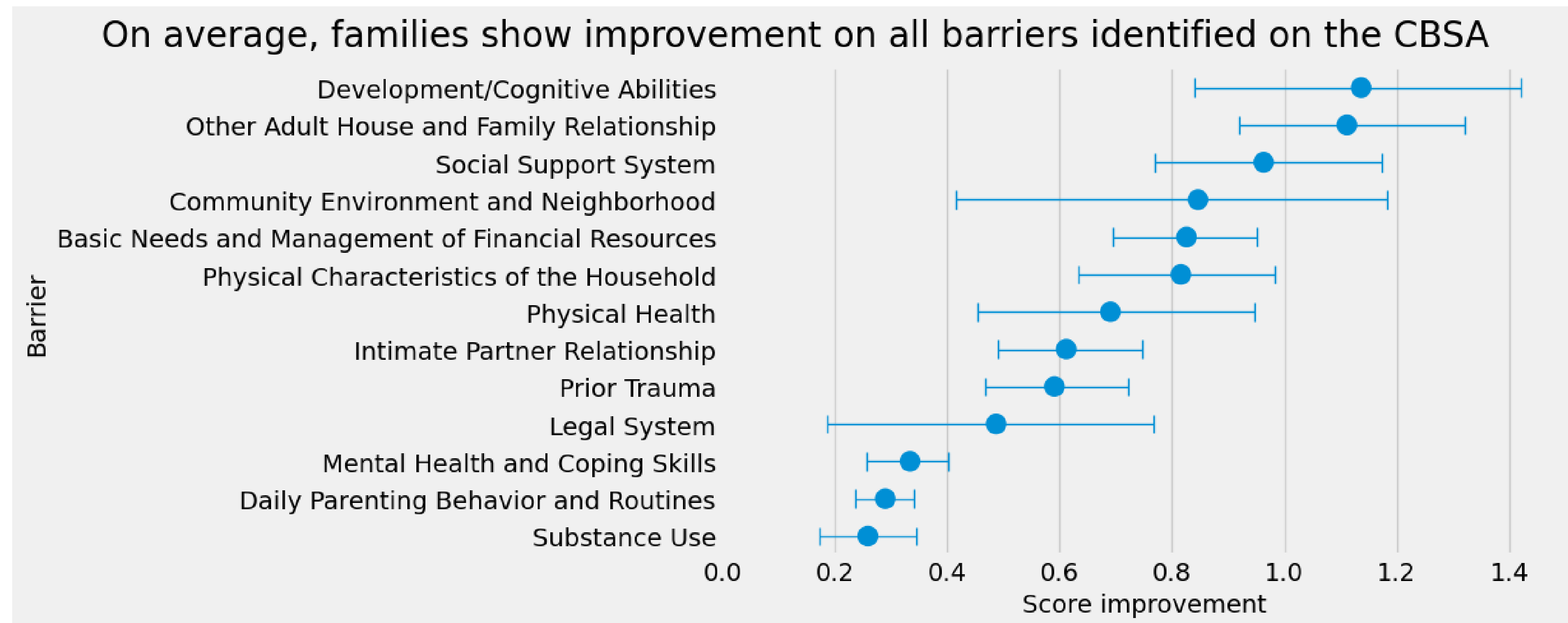


Figure 13 Average Improvement for CSBA Barriers in the Sample Population with 95 Percent Confidence Intervals. Source: FACES database (fopsz)l[13]

[13] Note: The last domain, "Other", is excluded from Figure 16 due to a small sample size.

3.4.4 PROTECTIVE CAPACITIES AND FACTORS

The primary goal for CFSA's in-home social worker is to maintain children safely in their homes. The social workers accomplish this goal by addressing and reducing any evidence of the abuse or neglect that initially led to the family coming to the attention of the Agency. Social workers focus on helping the family to build protective capacities and factors that support the caregivers' safe parenting of their children in their own home.

Protective capacities and protective factors complement one another. However, the focus and scope of each are slightly different. The social worker uses both to assess and serve families. **Protective Capacities** are caregiver characteristics that contribute directly to child safety. A caregiver with these characteristics ensures the safety of his or her child and responds to threats in ways that keep the child safe from harm. Building protective capacities contributes to a reduction in risk. **Protective Factors** are used to assess and strengthen a family's protective capacities, focusing on prevention or focusing on protecting children if child abuse or neglect has already occurred.

Protective capacities have a strong correlation to safety planning and determinations regarding a child's level of safety or lack thereof. For CFSA, the definition of an unsafe child includes the presence of existing or imminent danger to a child as well as the lack of evident parent or caregiver protective capacities that assure a child is protected from danger.

Parents need to demonstrate enhanced protective capacities before a family's case can safely close. Without evidence of protective capacities in place, the probability of reoccurring maltreatment increases. Therefore, the pathway to closure must include a parent or caregiver's demonstration that appropriate responses are consistent even during stressful, threatening, or dangerous circumstances.

3.4.5 PARENT'S EVALUATION OF DEVELOPMENTAL STATUS (PEDS)

The evidence-based PEDS screening tool asks parents to respond to 10 short questions that help the social worker identify whether children from ages 3 to 5 years old are at risk for school problems or possible developmental and behavioral disabilities. The tool assesses the children's language, motor, self-help, and early academic skills, in addition to the children's behavioral, social, emotional, and mental health. The results from the PEDS screening helps the in-home social worker determine whether a parents' concerns might legitimately require service referrals or whether the social worker might best respond to the parents' concerns with clinical advice and reassurance.

Early Stages is a District of Columbia Public School (DCPS) program that provides diagnostic testing for children from ages 2 years and 8 months to 5 years and 10 months. CFSA has an agreement with the DCPS Early Stages program to ensure that children who become

involved with CFSA's In-Home Administration receive a developmental screening within 30 days of their case opening. If warranted, the children receive referrals for a special education evaluation, based on the results of their Early Stages screenings.

3.5 CASE PLANNING

Effective family case planning depends on three elements of social work practice: (1) authentic engagement of the family, (2) subsequent teaming, and (3) comprehensive assessments of the family. Per best practice standards and CFSA policy, case planning incorporates the family-focused, collaborative, and inclusive tenets of all three practice elements.

The family case plan is a living document that should reflect ongoing input from the family and be reviewed and updated throughout the life of the case. Agency policy requires the in-home social worker to actively seek input from the family, beginning with the initial drafting of the case plan and continuing throughout the planning and implementation process until case closure.

A successful family case plan is culturally responsive and affirms every family member's identity. Cultural responsiveness results from effective engagement, which in turn impacts successful assessments. Accordingly, each family case plan incorporates results from a comprehensive assessment of strengths and needs, including presenting issues, ways in which the family has been successful in the past when dealing with presenting issues, and how the family presently addresses challenges to achieving progress. The family case plan also charts an achievable path to family stabilization. The plan therefore outlines family-specific steps for monitoring the family's accomplishment of objectives and goals, and evaluating and re-evaluating the appropriateness of services, and developing helpful and often innovative strategies if the family is not meeting objectives or goals as expected.

In summary, case planning tools incorporate teaming, motivational interviewing skills, engagement, assessments, referrals to appropriate services, a family's informal supports, social worker visits, and monitoring. Essentially, these tools collectively assist in developing family-driven, tailored strategies that strengthen the family's progress toward achievement of case plan goals, ultimately resulting in case closure.

3.6 SAFETY PLANNING

Ensuring child safety is an ongoing process that begins with the CPS investigation and continues through to case closure. At no time does a social worker ever leave a child in unsafe circumstances. When an in-home social worker identifies safety concerns that can be reasonably addressed without separating a child from the home, the social worker will first develop a safety plan with the family. Safety planning, as previously noted, requires a time-limited agreed-upon plan with the lowest possible level of intrusiveness while still assuring a child's safety.

Information collection, safety assessments, safety analyses and safety planning are integral to successful case planning throughout the life of the case. A thorough analysis of the safety components (danger indicators, child vulnerabilities, parental, and child protective capacities, etc.) help the in-home social worker determine if a child is safe or unsafe. This analysis also guides the social worker in the development of tailored safety interventions that help to control identified threats. Interventions should directly link to the family's identified long-term goals for enhancing protective capacities that ultimately lead to safe case closure.

To confirm the need for a safety plan, the in-home social worker uses the Danger and Safety Assessment (DAS) tool to determine if the child is likely to be in imminent danger of serious harm or maltreatment by the parent or caregiver.[14] When clinically appropriate and based on the outcomes of the DAS and the parent's willingness and ability to participate, the social worker develops a formal, written safety plan with the child's parent or caregiver to address immediate safety threats and to allow the child to remain safely in the home without necessitating a court-ordered separation.

3.7 COMMUNITY PAPERING

Community papering is a process to seek court-ordered services and interventions for the family when there are concerns for child safety and the families are non-compliant with a current case plan, or aren't engaged with staff, or have repeat CFSA involvement or substantiations. Through the Community Papering process, the DC Superior Court's Family Court Operations Division (Family Court) may decide to separate the children from the parents or will allow children to remain in the home with a plan of safe care agreed upon and signed by all parties. Prior to submitting a petition with the Family Court, the Office of the Attorney General confirms the legal basis to pursue court intervention.

Court-ordered services might compel parents to enter a substance abuse treatment program, order a parent to desist from harmful behavior (e.g., adhering to a domestic violence protective order), or the Family Court might compel a medical evaluation or treatment to ensure the health of a child. If parents fail to comply with services that are mandated by the Family Court and relevant conditions in the home environment threaten the safety of a child, despite the Agency's reasonable efforts, CFSA might be forced to separate a child from the home and subsequently place the child into out-of-home care for the child's safety and best interests.

[14] Section 3.3.3 provides more detail on the DAS.

3.7.1 Reasons CFSA Refers Families for Community Papering

Community papering is a tool focused on improving family engagement while prioritizing child safety. As described earlier, when an in-home family is non-compliant with their case plan or continues to have conditions that impact safety, CFSA considers the merits and benefits of the Family Court's intervention. Other factors the Agency takes into consideration include a family's history of past removals, prior substantiations, court involvement, number of previous case episodes, and any other extenuating circumstances.

The decision to community paper is a consultative process that includes a collaboration of multidisciplinary professionals discussing a child's circumstances and the efforts made to stabilize the family. There are instances where the Family Court does not agree with the recommendation for a conditional release to the parent, and there are instances, as described above, where CFSA separates a child, whose case is being papered, and places the child in shelter care status which requires placement in foster care. CFSA's In-Home Administration will monitor the cases of conditional release to ensure ongoing safety and mitigation of any risks that brought the family to the Agency's attention. If a separation occurs, the case is transferred to CFSA's Out-of-Home Clinical Case Management and Support (Out-of-Home) Administration or to a private agency partner, depending on the location of the placement.

Educational Neglect was the Leading Concern for Community Papering from FY 2021 - FY 2023-Q1

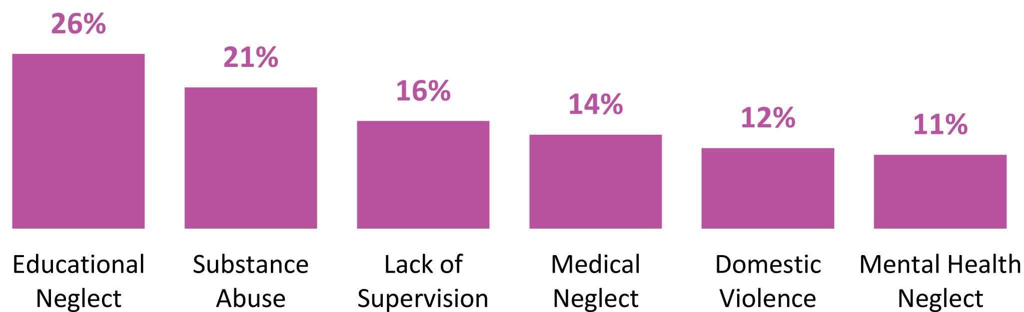


Figure 14 Reasons for Community Papering Recommendations FY 2021 - FY 2023-Q1. Source: manual community papering data

3.7.2 What administrations are community papering referrals coming from?

The In-Home Administration's first strategy is always to work to engage the family in collaborative case planning. When those engagement attempts are unsuccessful or engagement doesn't mitigate further concerns, the next step is to use the community papering process.

Of the 140 children's cases recommended for community papering in FY 2021, CFSA's In-Home Administration recommended 91 (65 percent), while CPS recommended 46 (33 percent) for consultation. CFSA's contracted private agencies recommended the remaining 3 cases (2 percent). Of the 145 children's cases recommended in FY 2022, the In-Home Administration recommended 85 (59 percent) for court involvement, while CPS recommended 45 (31 percent). CFSA's contracted private agencies and CFSA's Out-of-Home Administration recommended the remaining 15 children's cases (10 percent) for court involvement.

As of FY 2023-Q1, the In-Home Administration recommended 4 (18 percent) of 22 children's cases for court involvement while CPS recommended 18 (82 percent). Overall, from FY 2021 through FY 2023-Q1, the In-Home Administration recommended 63 percent of all the children's cases presented for a community papering intervention.

The In-Home Administration Recommended 63 percent of all Children's Cases for Community Papering from FY 2021 – FY 2023-Q1.

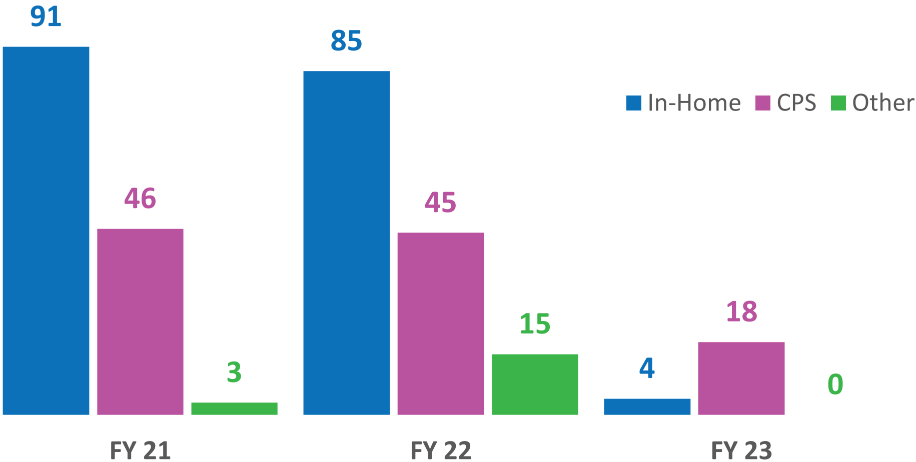


Figure 15 Source of Community Papering Recommendations, FY 2021- FY 2023-Q1. Source: manual community papering data

3.7.3 What are the Outcomes of the Community Papering Recommendations at the Initial Hearing?

In FY 2021, CFSA presented 140 children's cases for court involvement through the community papering process. Of these cases, the Family Court ordered that 33 (24 percent) of the children be separated from their parents or caregivers at the initial hearing and placed in shelter care. The remaining 107 children (76 percent) were conditionally released to their parents and remained in their homes. In FY 2022, CFSA presented 145 children's cases for court involvement. CFSA separated 52 (36 percent) of the 145 children at the initial hearing and placed the children in shelter care. The remaining 93 children (64 percent) were conditionally released to their parents and remained in their homes. As of FY 2023-Q1, CFSA presented 22 children's cases for court involvement. The Agency separated 10 (45 percent) of these children at the initial hearing and subsequently placed the children in shelter care. The remaining 12 children (55 percent) were conditionally released to their parents and remained in their homes.

The Majority of Children Presented for Community Papering are Conditionally Released at the Initial Court Hearing

Fiscal Year	# of children presented for community papering	# of children separated and placed in shelter care at the initial hearing	# of children conditionally released to their caregivers at the initial hearing
FY 2021 (n=140 children)	140	33	107
FY 2022	145	52	93
FY 2023-Q1	22	10	12

Table 9 Children Presented for Community Papering, FY 2021 to FY 2023-Q1. Source: manual community papering data

3.7.4 What are the Outcomes of the Community Papering Recommendations by Program Area?

From FY 2021 through FY 2023-Q1, the In-Home Administration recommended a total of 180 children's cases for community papering. Of the cases, 119 (66 percent) children were conditionally released to their parents or caregivers and remained in their homes. CFSA separated the remaining 61 children (34 percent) from the home and placed the children in shelter care. Over the same time-period, the CPS Administration recommended 109 children's cases for community papering. Of those cases, 82 (75 percent) of the children were conditionally released to their parents or caregivers and remained in their homes. CFSA separated the remaining 27 children (25 percent) from their homes and placed them in shelter care. As noted above, CFSA's Out-of-Home Administration also recommended community papering for children on their caseload. All combined from FY 2021 through FY 2023-Q1, the Out-of-Home Administration recommended 18 children's cases for community papering. Of these cases, 11 (61 percent) of the children were conditionally released to their parents or

caregivers and remained in their homes. CFSA separated 7 (39 percent) of the children from the home and placed them in shelter care. Overall, across the three administrations, 212 children were conditionally released at the initial hearing and 95 children were placed in shelter care.

The Majority of Children Presented for Community Papering are Conditionally Released at the Initial Court Hearing

Outcome at Initial Hearing FY 2021 – FY 2023-Q1	Conditionally Released	Shelter Care
In-Home	119	61
CPS	82	27
Out-of-Home	11	7
Total	**212**	**95**

Outcome at initial hearing FY 2021 – FY 2023-Q1	In-Home	CPS	Out of Home Administration
Conditionally Released	119	82	11
Shelter Care	61	27	7
Total Children by Admin.	**180**	**109**	**18**

Table 10 Community Papering Outcome at Initial Hearing, FY 2021 – FY 2023-Q1. Source: manual community papering data

3.7.5 EARLY ALERTS

The Early Alert meeting is a thoughtful consultation decision-making process focused on placement matching with kin and the elimination of any barriers to kinship licensure. These consultations may happen in a lot of different ways and are often combined with community papering.

As mentioned earlier, identifying relatives (kin) is a high priority for CFSA when a family is involved with the Agency. Relatives serve as an important part of keeping families together as well as an important resource for supporting positive permanency outcomes if there is any risk of separation for a child. With both family stabilization and kinship placement in mind, the Agency's Early Alert process includes a

multidisciplinary team meeting to develop a placement plan that includes kin who can minimize trauma and maximize successful achievement of permanency goals.

Meeting participants examine any proposed activities that may require a waiver for the Agency's director to approve, e.g., a non-safety-related licensing provision for potential kinship caregivers. The emergency licensing process is designed to remove any immediate barrier to a relative safely caring for the child and maintaining the family connection. In addition to examining foster care licensing requirements, meeting participants consider the proposed kinship provider's needs, including supports and services, and culturally competent approaches to complex family dynamics that might affect a kin's ability to care for children.

3.8 NEW REPORTS ON OPEN IN-HOME SERVICES CASES

CPS investigates all screened-in allegations of abuse. If there is a screened-in allegation for an open in-home case, the CPS Hotline supervisor notifies the assigned in-home social worker and supervisor of the new report and CPS assignment.

During the investigation, CPS also notifies the in-home social worker and supervisor if there are any additional neglect allegations, including educational neglect, which may go through the Educational Neglect Triage Unit. If new incidents are reported that specifically relate to the same allegation that opened the original case, CPS forwards the referral to the In-Home Administration and may close the neglect referral. Depending on the new allegations, the Hotline team may link the referral to the open investigation and determine whether the report requires a child welfare response.[15]

Based on the risk assessment, investigation findings, and the CPS disposition, the CPS and in-home social workers and supervisors discuss recommendations and plans for the continued work with the family. When the investigation leads to an additional substantiated finding on the open in-home case, assessments completed by the CPS and In-Home Administration teams play a critical role in determining what strategies or interventions could ameliorate or prevent further child abuse and neglect. Community papering is one intervention that may be considered.

[15] CFSA's Hotline RED Team functions in a consultative decision-making capacity for the review, evaluation, and direction of case practice as needed.

3.8.1 IN-HOME'S RESPONSE TO NEW NEGLECT ALLEGATIONS

In May 2022, CFSA's Office of Entry Services implemented the "In-Home's Response to New Neglect Allegations" process to address an influx of Hotline referrals during CPS staff shortages. This process allows CPS to forward a referral on a family with an open in-home case to the In-Home Administration team for a response; CPS then closes the accepted neglect referral. In some cases, the Hotline may screen out the referral but will still forward the referral to the assigned In-Home Administration manager for a response. Note: The screen-out decision of a neglect referral can be reversed if approved by the In-Home administrator or designee. Otherwise, the In-Home Administration team will contact the family within 1 business day to inform the family of the new report.

After receiving a new neglect report, the team will gather as much information as possible about the allegation details in order to address any nuanced or misunderstood circumstances of the family's current status. Information gathering includes a thorough review of records and documented interviews of family, collaterals, providers, and other sources. Interviews with the alleged maltreaters and all victim children occur within 5 days of the referral. The assigned social worker also completes the SDM Danger and Safety Assessment (DAS), documenting the DAS outcome in a FACES.NET contact note, referencing the referral number, and outlining any recommended next steps. If the team is unable to contact the family or gather pertinent information related to the referral, the social worker elevates the concerns to the assigned supervisor and program manager.

Any other allegation type, e.g., abuse, is screened-in according to protocol. Referrals for positive toxicology of a newborn and neglect referrals that require an immediate response (e.g., "Child Left Alone") are also screened in for an investigation by a CPS social worker.

3.9 SUBSTANTIATIONS AFTER 6 MONTHS OF COLLABORATIVE SERVICES

During FY 2020 and FY 2021, families engaged either with the in-home teaming services or with step-down services all demonstrated a higher likelihood of being re-referred to CFSA and undergoing a new substantiation process within 6 months after the closure of their Collaborative case, compared to the entire population of CFSA-involved families receiving Collaborative services. Also during FY 2020 and FY 2021, the percentage of new referrals for families receiving teaming services increased from 11 percent to 14 percent. For all families receiving Collaborative services either during or after their involvement with CFSA, the percentage increased from 7 percent to 8 percent over the same timeframe.

Percentage of All Families Served by Collaboratives with New Substantiations within 6 months of Case Closure		
Year of Case Closure	**In-Home**	**All CFSA**
FY 2020	11% (5 of 45 Collaborative Case Closures)	7% (13 of 200 Collaborative Case Closures)
FY 2021	14% (8 of 56 Collaborative Case Closures)	8% (30 out of 379 Collaborative Case Closures)

The heightened risk of experiencing repeat referrals and substantiations might be ascribed to three potential factors. First, regardless of whether they receive Collaborative services, families that receive in-home services might already have a higher likelihood of being brought again to CFSA's attention. Second, the effectiveness of the Collaboratives in averting repeat CFSA referrals and substantiations may be comparatively lower when dealing with families who have previously been engaged with in-home services. Third, it is plausible that a combination of these two explanations contributes to the observed trend. Lastly, when comparing percentages or proportions, consideration of sample size is crucial for accurate analysis. The larger the sample size, the more reliable and stable the percentage estimate tends to be. Conversely, smaller sample sizes are prone to greater variability and, therefore, less reliable estimates. This may imply greater variability in the In-Home Administration sample than in the CFSA-wide sample.

4. IN-HOME SERVICE ARRAY

4.1 COLLABORATIVE SERVICE REQUESTS: STEP-DOWN VS. TEAMING

Families with an open in-home case may receive services both from CFSA and from their local HFTC Collaborative. As described earlier, CFSA and Collaborative social workers will team together to ensure that all services meet the needs of the family. When in-home families begin to fulfill case plan goals, the in-home social worker may "step-down" the level of services in preparation for case closure. More often than not, the family's neighborhood HFTC Collaborative will take over all step-down services for the family. Alternatively, CFSA provides in-home teaming services with the Collaboratives before case closure. To better understand the service needs of both populations, CFSA examined and compared service referrals for 126 families experiencing either in-home step-down or in-home teaming services.

Results indicated distinct and yet also overlapping patterns of priorities. For example, both groups shared a primary emphasis on housing-related needs with "Housing and/or Housing Supports" ranking as the most requested service for both. However, families experiencing a step-down tended also to require services catering to family and child supports, evidenced by the high demand for "Childcare," "Children's Education," and "Parenting Support." In contrast, families experiencing in-home teaming placed a higher emphasis on individual financial stability and self-sufficiency, indicated by their need for services such as "Financial Management" and "Rental Assistance."

While both groups had needs for employment services, mental health services, and concrete supports like food and clothing, their differing service requests highlighted the varying degrees of familial versus personal needs in their sought-after supports. Table 11 outlines the priority service needs based on the number of families from each group.

In-Home Step-Down: Services Requested (Number of Requests)	In-Home Teaming: Services Requested (Number of Requests)
Housing and/or Housing Supports (29)	Housing and/or Housing Supports (16)
Employment (23)	Parenting Support (12)
Eligibility/Benefits (19)	Eligibility/Benefits (8)
Parenting Support (18)	Employment (8)
Mental Health (Adult) (15)	Mental Health (Adult) (6)

In-Home Step-Down: Services Requested (Number of Requests)	In-Home Teaming: Services Requested (Number of Requests)
Childcare (11)	Financial Management (4)
Food (9)	Food (4)
Children's Education (8)	Rental Assistance (4)
Clothing (8)	Clothing (3)
Financial Management (8)	Furniture (3)

Table 11 Top 10 Collaborative Services Most Requested for In-Home Families (Step-Down and Teaming) October 2022 – June 2023. Source: Efforts to Outcomes (ETO).

4.2 FAMILY PEER COACHING PROGRAM

The Family Peer Coaching Program is an evidenced-based multi-family trauma intervention that focuses on families with an open CFSA in-home case. The program specifically works with birth parents who feel isolated, overwhelmed, and reluctant or frightened to address their histories of significant trauma and behavioral health issues. When the family peer coaches are able to engage birth parents to address their fears, sense of isolation, etc., evidence indicates that more children remain safely in their homes. Further, engagement with peer coaches directly reduces many risk factors that might lead to separation.

When social workers refer a birth parent to the program, the provider (Community Connections) assigns a family peer coach to the parent. Trained by the Department of Behavioral Health, family peer coaches provide outreach to CFSA-involved families, connect parents to resources, organize and facilitate peer groups and multi-family groups and activities, link families to community and professional services, and provide support and coaching.

4.3 COMMUNITY-BASED NURSES

CFSA assigns registered nurses to the In-Home Administration to provide in-home and community health services and other health supports to families with infants and children. The assigned nurse meets with the parent or caregiver prior to assessing the identified child’s growth, development, and medical needs, which can range from outdated immunizations to an acute or chronic health condition. The nurse then assists the family with appropriate medical services. The nurse also develops, implements, evaluates, and revises a plan of care to ensure

appropriate treatment. This plan includes a review of medications and treatments authorized by the family's regular health care provider. As needed, nurses connect families to additional community resources or District agencies while monitoring any follow-up health care needs. In addition to monitoring and tracking the effectiveness and appropriateness of the health-related services, the assigned nurse works closely with the in-home social worker to assess the safety and well-being of children.

4.4 OFFICE OF WELL-BEING (OWB) SERVICES

CFSA may connect a family to a handful of services provided by the Agency's OWB. These services fall into three general categories:

- Substance Use Disorder (SUD)
- Domestic Violence Support
- Mental Health Support

The first category, SUD services, includes several service types: an adult SUD assessment, a youth SUD assessment, a Project Connect referral, and an eligibility referral for Family Treatment Court (FTC).[16] Adult SUD assessments represent the bulk (71 percent, n=1132/1596) of all SUD referrals made during the core period of analysis, FY 2021 through FY 2023-Q2.

There was one primary limitation for reporting OWB service referrals during the period of analysis. Social workers made referrals on a set of standalone QuickBase applications that were separate from the primary database of record, FACES.NET. The referrals therefore lack sufficient information to readily link the records back to FACES.NET data, e.g., the identification number for a referral or case. As a result of insufficient data, there are built-in limits to the amount of detail CFSA can report on OWB service referrals.

Another limitation involves the analysis of SUD referrals entered into the QuickBase application. Many SUD referrals for in-home families occur during the CPS investigation and prior to the case opening. In those situations, the referral was attributed solely to CPS in QuickBase. When the Agency sought to break down the number of referrals by administration, the QuickBase data would fail to include the total number of in-home families who had received a SUD referral outside of the CPS entry. At present, the CPS administration represents 63 percent of all SUD referrals on the SUD QuickBase application.

---

[16] Family Treatment Court is a court-supervised substance use treatment program that provides access to services and protects children, reunites families when safe to do so, and expedites permanency. Project Connect is a voluntary, intensive, home-based clinical and case management service designed to keep children safe by helping substance-affected caregivers pursue and maintain a lifestyle of recovery.

With those two limitations being noted, Table 12 shows a count of SUD referrals broken out by administration and referral type. Note that the In-Home Administration is the largest requester of Project Connect services.

Adult SUD assessments are the most common type of SUD referral.

SUD Referral Type	CPS	CCMS	In-Home	Private Agencies	OYE	Unknown	Total
Adult SUD Assessment	908	80	85	54	2	3	1132
FTC Eligible	7	118	11	43	2	12	193
Youth SUD Assessment	83	31	10	15	5	1	145
Project Connect	1	21	97	7			126
Grand Total	**999**	**250**	**203**	**119**	**9**	**16**	**1596**

Table 12 OWB Substance Use Disorder Service Referrals by Service Type and Administration, FY 2021 – FY 2023-Q2. Source: OWB SUDS QuickBase app

Domestic violence (DV) support receives substantially fewer service referrals, in part due to resource constraints. CFSA dedicates one full-time employee to DV services. Table 13 shows a count of DV referrals broken out by administration. As in Table 12, Table 13 uses the administration provided on QuickBase to break down the data.

The In-Home Administration is the Largest Requester of DV Services within the Agency

Administration	Domestic Violence Support Referrals
In-Home	23
CPS	14
Private Agency	13
CCMS	10
Unknown	7
Other	6
OYE	1
Total	**74**

Table 13 OWB Domestic Violence Support Service Referrals by Administration, FY 2021-FY2023Q2. Source: OWB Other Supportive Services QuickBase app

Technically, children involved in an in-home case are also eligible for OWB's in-house, short-term mental health services. **However, OWB necessarily prioritizes delivery of mental health services to children recently placed in foster care. Based on the available data, nine children receiving in-home services also received OWB mental health services.** (Source: CFSA Mental Health Tracking).

4.5 SERVICES TO PREVENT FAMILY SEPARATION

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

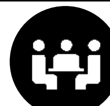
Case Management
Case management is a process that plans, seeks, advocates for, and monitors the services provided by different social services or health care organizations.

Emergency Family Flexible Funds[17]
Upon request by a social worker, the Collaborative should provide funds within 36 hours to address needs that can prevent disruption. Such needs may include rental assistance, transportation, utilities, food, housing search, or temporary placement. CFSA also provides direct assistance through gift cards for transportation, clothing, furniture, and food.

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

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

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



Parent Cafés through DC Children's Trust Fund
Trained facilitators guide support group meetings for biological families to share experiences and to support other parents who may be new to the child welfare system.

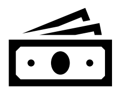
[17] As footnoted under *Section 5*, *In-Home Services and Quality Service Reviews*, Flex Funds are appropriated by DC Council and provide emergency financial assistance to families receiving CFSA and HFTC Collaborative services.

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

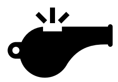
Community and Other District Agency Supports: Mental Health & Substance Use
CFSA utilizes the Department of Behavioral Health's city-wide provider agencies for children and adults in need of mental and behavioral health services and substance use services. CFSA also contracts with the Collaboratives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

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

Substance Use Services
Project Connect works with families who are affected by parental substance abuse and are involved in the child welfare system.



Financial Assistance
The grandparent and close relative caregiver subsidies provide monthly financial assistance to help you care for the child related to and living with their relatives.



Family Peer Coaches
CFSA utilizes Family Peer Coaches to connect parents to resources, organize and facilitate peer-to-peer groups and multi-family groups and activities, and provide support and coaching to these families.

Neighborhood Legal Services
CFSA utilizes Neighborhood Legal Services to allow families to receive free legal advice regarding various issues, including child custody and guardianship.

4.6 SOCIAL WORKER SURVEYS AND FEEDBACK ON IN-HOME SERVICE ARRAY

From July 24 to August 3, 2023, CFSA conducted an online, exploratory survey of 56 in-home social workers, family support workers, supervisors, and managers to better understand what barriers they encounter as they work to address families' needs. Survey questions focused on social workers' experiences with referrals of services, interventions and supports, collaboration and teaming, and delays in services. The survey was intentionally designed to allow participants to skip questions to encourage maximum responses. Analysts received

a total of 27 surveys, but these respondents did not necessarily answer every question. In addition to the surveys, analysts reviewed feedback results from four different focus groups. The groups were held from August 4 to August 10, 2023 and included a total of 32 participants. Two of the focus groups included 16 social workers, one focus group included 7 supervisory social workers and program managers, and the last focus group included 9 family support workers. Despite the low number of survey responses received, feedback garnered from the focus groups was consistent with the results of the surveys. Analysts noted little variation across the different roles.

4.6.1 Services, Interventions, and Supports Utilized

Survey respondents received a list of services and resources frequently referred by social workers for families with in-home cases. Survey questions asked respondents to identify the three most effective services for stabilizing families and keeping them intact.

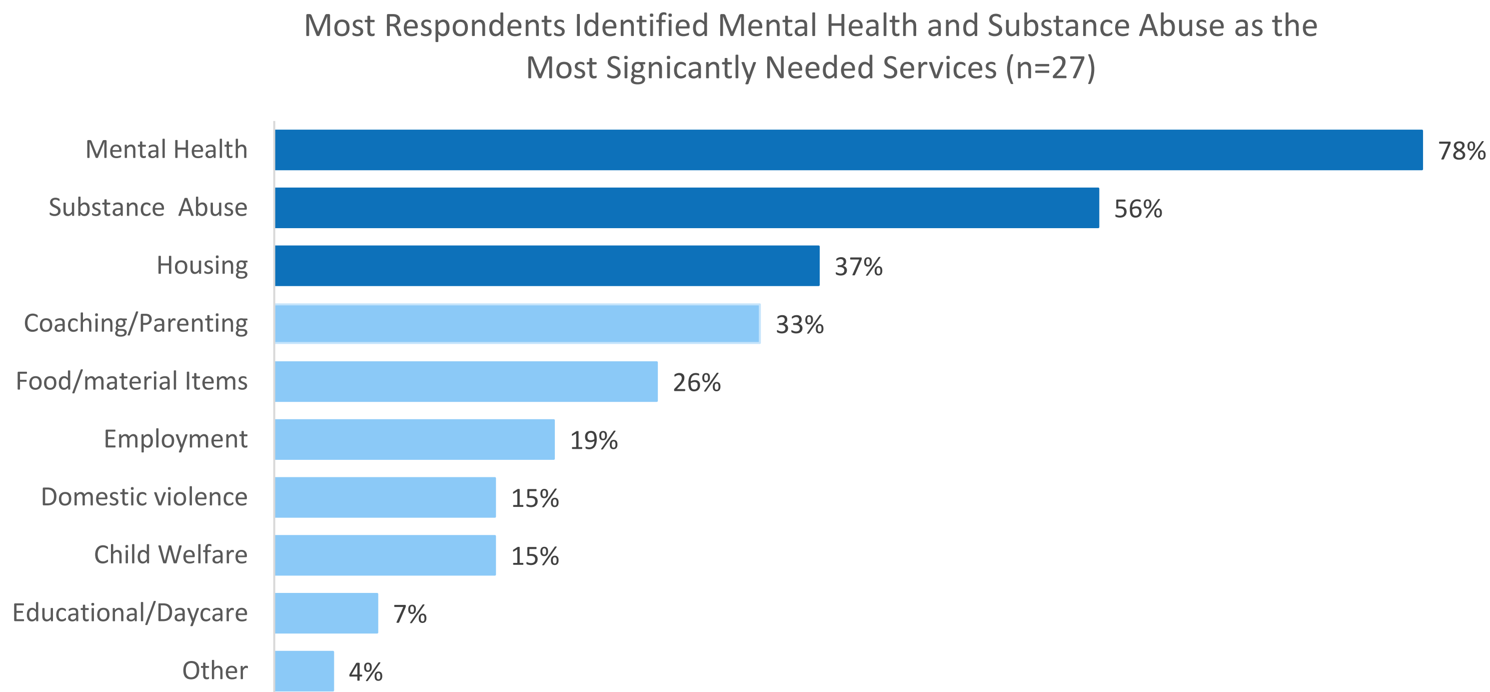


Figure 16 Survey Responses: Most Effective Resources

4.6.2 Delays in Service Delivery

Survey respondents identified wait lists for services as a major impediment to families progressing toward stabilization and case closure. One hundred percent (n=27) of the respondents agreed that families have been "somewhat frequently" (63 percent) or "very frequently" (37 percent) impacted by having to wait weeks or months for services to begin. Focus group participants elaborated, stating that wait lists often mean cases will stay open longer. They described cases "in limbo" or with progress "stopped" while the family waited, especially in cases in which the services were intended to address major issues, e.g., mental health, substance use, and housing concerns. Such long waits prevent families from immediately focusing on important areas of change to foster stability. **Respondents most often identified mental health (56 percent) and housing services (81 percent) as having frequent and long waiting lists for services** (see Table 14 below for more information).

Figure 17 Survey Responses: Delays in Services

Service/Resource	Identified by Staff	
	Significant Need/Resource	Frequent Waitlists
Mental Health	78%	56%
Substance Abuse	56%	19%
Housing	37%	81%
Employment	19%	33%

Table 14 Survey Responses: Identified family service need and waitlists

5. IN-HOME PROGRAM EVALUATION

5.1 DOES AN IN-HOME CASE LEAD TO POSITIVE OUTCOMES FOR FAMILIES?

When a family receives in-home services, **the likelihood of family separation decreases by 15 percent** within a year of the CPS investigation that initiated the family's involvement, all else being equal. In this case, "all else being equal" accounts for the effect of confounding factors like family demographics, prior Agency involvement, and the nature of the allegations of the CPS investigation that led to the in-home case opening. To account for these factors, an evaluation implements a propensity score matching (PSM) model. This methodology is detailed in the Appendix, *Section 9.3 EVALUATION METHODOLOGY: PROPENSITY SCORE MATCHING.*

The evidence gathered for the above data suggests that in-home services overall play a demonstrable, positive role in keeping DC families together, particularly for high-risk families. Even a new investigation can be a positive tool for exploring deeper issues that did not initially surface at the onset of the in-home case.

Conversely, **the likelihood of a new investigation increases by 10 percent** within a year of the CPS investigation for families engaged in in-home services.

Regarding the lower rate of separations and yet a higher rate of subsequent investigations, one explanation could be that the subsequent investigation simply extends the life of the in-home case rather than separating the child. When a new referral comes in, the in-home team makes a clinical assessment based on the facts of the investigation. It is possible that the case management team will pursue a clinically appropriate escalation to the case, e.g., implementing a safety plan or pursuing community papering through the Family Court, both of which fall short of separation.

For an example designed to illustrate the concept of propensity score matching, refer to the Appendix, *Section 9.4 A VIGNETTE: ILLUSTRATING A MATCH WITH A PROPENSITY SCORE MATCHING (PSM) MODEL.*

5.2 QUALITY SERVICE REVIEWS (QSR)

The QSR is a case-based review of frontline practice for organizational learning and development. These reviews are a form of real-time rapid assessment that help the Agency strengthen what is working well in practice and improve what is not working so well. Through a continuous quality improvement feedback loop, the QSR process is purposed to improve outcomes for children and families being served by the District's child welfare system.

From February through May 2023, the QSR Unit reviewed 57 randomly selected in-home families for purposes of the QSR process. The assigned QSR specialists gathered information through interviews with birth parents, children, extended family members, social workers, and service providers. Additionally, the specialists examined FACES.NET investigation summaries, court reports, contact notes, and other supporting documents. After completing all in-home reviews, the QSR Unit presented their case findings to In-Home Administration managers, highlighting the strengths, challenges, and themes for the in-home families reviewed.

5.2.1 Methodology

Over the course of 2 days, two partnering QSR specialists review and rate each case based on a QSR Protocol that uses a Likert-type scale ranging from 1-to-6. In its simplest form, the QSR Protocol distinguishes ratings from 1-to-3 as unacceptable practice and ratings from 4-to-6 as acceptable practice.[18] To determine acceptable ratings, the assigned specialists consider a series of indicators from two QSR protocol domains, *Child and Family Status* and *System Performance*. Each specialist must rely upon the detailed parameters outlined in the QSR Protocol prior to determining indicator acceptability for each domain. To verify scoring accuracy and interrater reliability, the QSR specialists partner with CFSA data analysts through an established quality assurance process.

5.2.2 Data Limitations

Certain limitations are implicit when interpreting the QSR results, e.g., the QSR process only looks at system performance and the status of children and families for a defined period of time. For the *Child and Family Status* domain, the specialists are rating multiple indicators related to safety, stability, and daily functioning over the past 30 days. On the *System Performance* side, the specialists are rating multiple indicators related to engagement, assessment, and case planning over the past 90 days.

To inform ratings, the QSR specialists seek to interview all birth parents. However, efforts are sometimes unsuccessful for a variety of reasons. Some birth parents are reticent to be interviewed, or despite the Agency's concerted efforts to explain the benefits of sharing their personal experiences via the QSR process, birth parents may feel the Agency has enough personal information. Resultantly, findings that are reported reflect only the responses of those birth parents who are willing to participate in the review.

[18] Unacceptable practice at the 1-3 level is defined by inconsistencies that fail to meet the family's identified needs, either for services or the path to case closure or both; practice at the 4 level requires refinement, i.e., the practice is only minimally meeting the identified needs, even if acceptably so. At the 5-6 maintenance level, practice is consistent and dependably addressing all identified family needs.

5.2.3 Overview of Substantiated Allegations for the 57 Cases Reviewed in 2023

QSR data outlined in Figure 21 reinforce data previously reported in this year's Needs Assessment, i.e., educational neglect is the primary substantiated allegation for open in-home cases, followed by substance use impacting caregiving and inadequate supervision. Note: Cases may have more than one substantiation for the current in-home case.

Allegations for Cases Reviewed in FY 2023

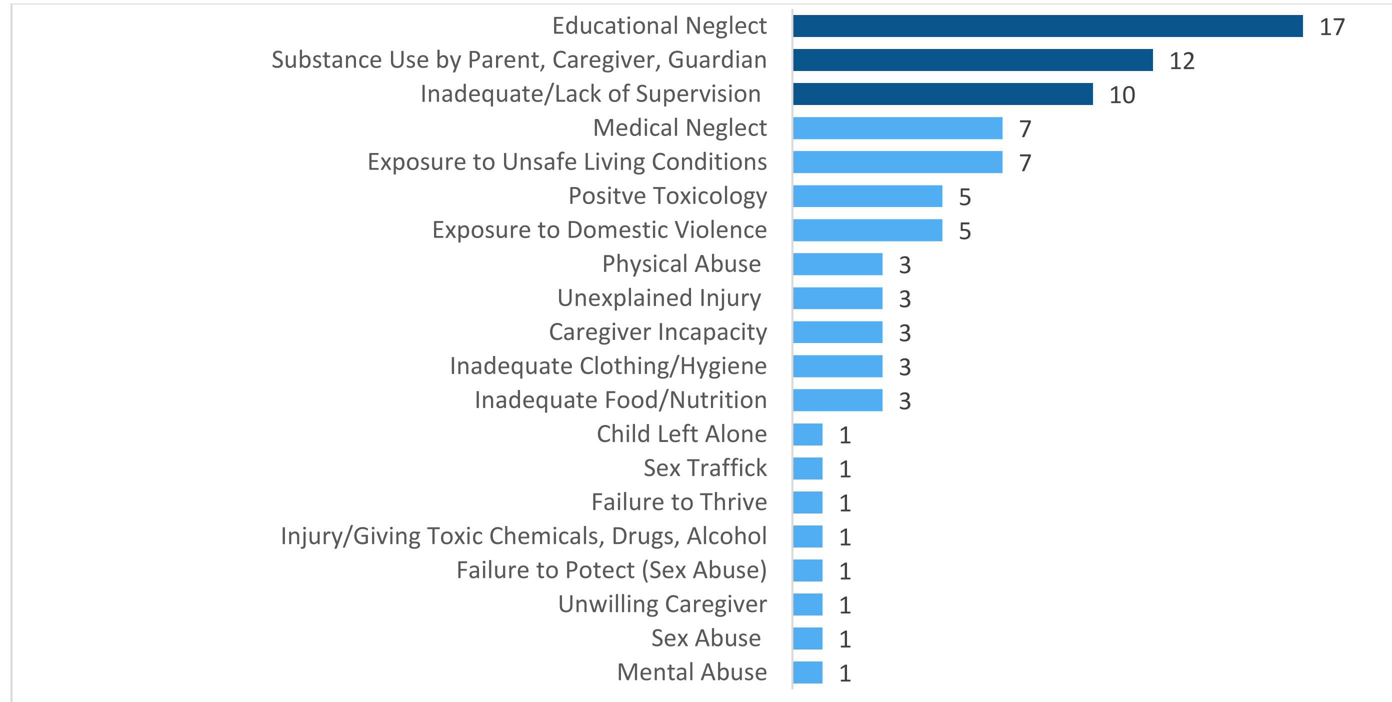


Figure 18 QSR Results for In-home Substantiated Allegations. Source: QSR Quickbase app

5.2.4 CFSA History of Closed In-Home Cases Reopened within 6 months and/or 2 years

Of the 57 cases reviewed, there were 52 families with a prior history within 3 years of CFSA involvement, i.e., CPS investigations or opened cases. There were 14 families with recent history, i.e., the family's case *reopened within 6 months and/or within 2 years.* One family's history overlapped by having a case reopened within 2 years and then reopening the case again within 6 months. Eight families had a case reopened within 6 months, while six families had a case reopened within 2 years. Four out of six families with reopened cases within 6 months had similar substantiated allegations to the original allegations. Six out of eight families with reopened cases within 2 years also had

similar substantiated allegations. **For the 14 families** combined, **the most common reasons for a case reopening** were **inadequate supervision, educational neglect, unsafe living conditions, domestic violence, and medical neglect.**[19]

Figure 19 In-home families with prior CFSA history. Source: QSR QuickBase app

When examining a family's past history of maltreatment allegations, QSR specialists may also consider any involvement of the parents as child victims. This "big picture" holistic view of the family helps the specialists provide a comprehensive landscape during debriefings with the social workers and during case presentations. Identified trends serve to inform risk assessments and the selection of tailored intervention strategies, both of which contribute to greater support of the family to keep children safe and reduce the risk of repeat maltreatment.

5.2.5 Characteristics of the Families Reviewed

QSR data identify distinguishing family characteristics and family histories that contribute to the risk and safety factors for children and, by extension, the family's level of need for services or intervention. Of the 57 in-home families interviewed, 52 (91 percent) had prior history with CFSA, i.e., CPS investigations or opened cases. Of these 52 parents, 14 (27 percent) experienced CFSA involvement as child victims.

The most common family characteristics were mental illness (68 percent), substance use (67 percent), and domestic violence (44 percent). Some families experienced one, two or all three of these characteristics.

[19] Caregiver incapacity may include, for example, hospitalization for physical or mental health issues, residential substance use treatment, or arrest and subsequent incarceration.

Families Struggled with Mental Health, Substance Abuse and Domestic Violence

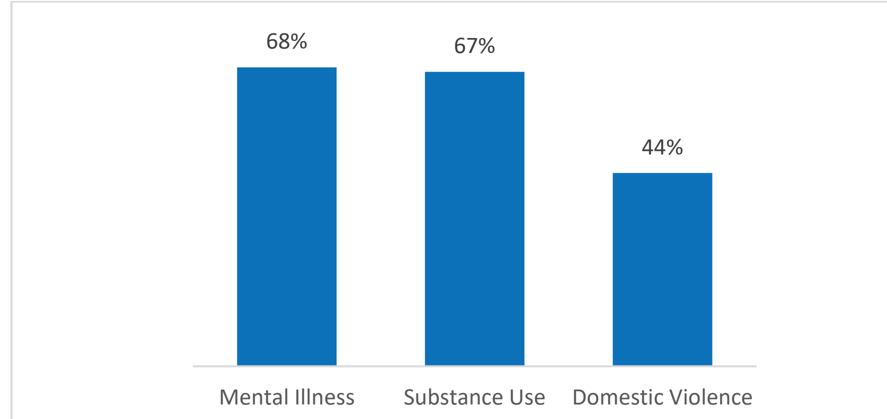


Figure 20 Most Common Family Characteristics. Source: QSR QuickBase app

The most frequently identified needs for the 57 families included trauma-informed mental health services, substance use treatment, and domestic violence services. QSR specialists noted that when these needs were unmet, the resulting challenges also impacted children's school attendance and medical care.

Specialists further identified the following additional characteristics:

- High School Graduate – 18 parents (32 percent)
- Employment – 14 parents (25 percent)
- Child Education Challenges – 14 families (25 percent)
- Child Chronic Medical Concerns – 12 families (21 percent)

For most families, there were multiple characteristics that contributed to their circumstances. These families presented with clustered challenges that led to the multiple complicating factors that informed the rating outcomes of those cases.

5.3 FAMILY HOUSING BARRIERS

QSR findings indicated that 18 families (32 percent) experienced difficulties with housing availability, affordability, and appropriate living conditions. As described below, many in-home families are confronted with housing conditions over which they have little direct control. These types of challenges added to the complexity and management of those family's cases.

5.3.1 Substandard Living Conditions Experienced by In-Home Families

- Displacement/Uninhabitable Living Conditions
- Insufficient Plumbing (bathtub used as toilet)
- Gaping Holes in Ceilings/Walls/Floors
- Rodent/Insect Infestation
- Inoperable Kitchen Appliances
- Rent/Utility Arrears
- Inoperable Utilities (heat, electricity, water)
- Leaking Raw Sewage
- Foul Odor such as "Decomposing Rodents"

5.3.2 Intervention Opportunities for In-Home Families

- Floor Fully Covered by Trash, Debris, Clothing (Intervention: Home Organization)
- Risk of Eviction (Intervention: Flexible Funds for Back Rent, Employment Services)[20]

5.4 WHAT SERVICES, INTERVENTIONS, AND SUPPORTS DOES CFSA PROVIDE?

Specialists noted a combination of strategies, supports, and services did assist families and children with achieving improved safety and family stabilization. For nine families, systemic programs such as Project Connect helped coordinate services to address the families' multiple needs.[21] Table 15 below outlines a list of community providers and services identified by QSR specialists as being offered to the families reviewed. These common supports and services may have been useful for the child and parent to improve family functioning and increase family stability.

[20] Appropriated by DC Council, the Flex Funds Program provides emergency financial assistance to families receiving CFSA and HFTC Collaborative services. Flex Funds may assist with housing supports, utility payments, food, etc.

[21] Noted previously, Project Connect is a best-practice model from Rhode Island that provides families with intensive services to help re-establish family relationships. CFSA has made Project Connect a centerpiece of the drive to expand community-based services.

5.4.1 Families Identified Needs, the Supports They Received, and the Providers Utilized.

Identified Needs	Supports & Services Supports Implemented	Providers
Housing Instability	Emergency Shelter, Rapid Re-Housing	S.O.M.E. (So Others Might Eat), Humanity in Transition, Department of Disability Services (residential program), Community Connections, Brooks Shelter, Career Navigators, Community of Hope, Red Cross, Crime Victims Compensation Program
Domestic Violence	Domestic Violence Counseling, Social Worker as Interventionist for Immediate Support	CFSA's Office of Well-Being, Crime Victims Compensation Program
Mental Health	Department of Behavioral Health, Core Service Agency, Mobile Crisis Unit	Family Wellness Center, Paving the Way, Life Enhancement Services, Community Connections, Trinity Square, Husband Therapeutics, Preventive Measures, Goshen Healthcare, MBI, Hillcrest Children and Family Center, Community Wellness Ventures, Anchor Mental Health, Kinara Health Care Services, Umbrella Therapeutic Services, NYA Health Services
Substance Use	Project Connect, Addiction Prevention & Recovery Administration, Outpatient Services	Community Connections, Court Services & Offender Supervision Agency (CSOSA)
Children Medical Concerns	Community Nurse	CFSA Healthy Horizons Assessment Center, Health Services for Children with Special Needs
Parenting Incapacity	Homemaker Services, Parenting Coaching and Classes, Fatherhood Programs	Georgetown Parenting Program, HFTC Collaboratives (Fatherhood Programs), New Heights Teen Parenting Program
Education	Educational Supports (Individualized Educational Plans, Individual Family Service Plans) Home Hospitalization Program (Online Learning), Social-Emotional Learning Groups	Educational Attorney (Advocated for IEP services to be provided) DC Office of the State Superintendent of Education (OSSE)
Financial	Food, Gift Cards, Baby Supplies, Transportation, Reactivation of Benefits, Employment	Collaborative, Community of Hope, Red Cross Capital Area Food Banks
Other	Supportive Services for the Deaf	Deaf Reach

Table 15 Services provided by Community providers to address the needs identified for the families reviewed. Source: QSR QuickBase app

QSR findings indicated that multiple services facilitated well-being improvement for 50 (89 percent) of the focus children reviewed, including improvements to behavior, physical health, and education status. Further, social workers' assessments of children's needs were timely and accurate, resulting in referrals to supports and services that were in alignment with the children's identified needs. For example,

QSR specialists identified 12 children diagnosed with chronic health concerns. QSR findings indicated that the health status of those children improved through the assignment of the community nurse and through collaborations between CFSA or contracted social workers and pediatricians. Additionally, these children's parents actively engaged in the service delivery process and received education on the specific medical needs of their children, increasing overall positive outcomes.

Likewise, the QSR findings indicated that 96 percent of participating mothers and 100 percent of the participating fathers received appropriate supports and services to address their identified needs. These parents were key partners in identifying their service needs and reported the selected services to be accessible, solution-focused, and beneficial. For some parents, parenting classes were very helpful for increasing caregiving capacity, i.e., increasing parental understanding of adequate supervision and the importance of ensuring a child's regular school attendance.

5.5 BUILDING UP THE PROTECTIVE CAPACITY OF PARENTS

Data gathered from the QSR *Child and Family Status* indicator *Voice and Choice* revealed successful Agency intervention for improving caregiver capacity. *Voice and Choice* measures the level of involvement that a parent has in shaping the decisions made about their children and family. When social workers actively and successfully engage parents, the parents have a sense of personal ownership in the case plan and in the decision-making process, which is a best practice standard for child welfare. The family change process ultimately belongs to the family. For the *Voice and Choice* rating, QSR specialists interviewed a total of 44 mothers and 24 fathers out of the 57 families reviewed. Note: QSR specialists do not rate this indicator if they are unable to interview the parent.

5.5.1 To What Degree do Parents Feel Satisfied with the Services Provided by the Agency?

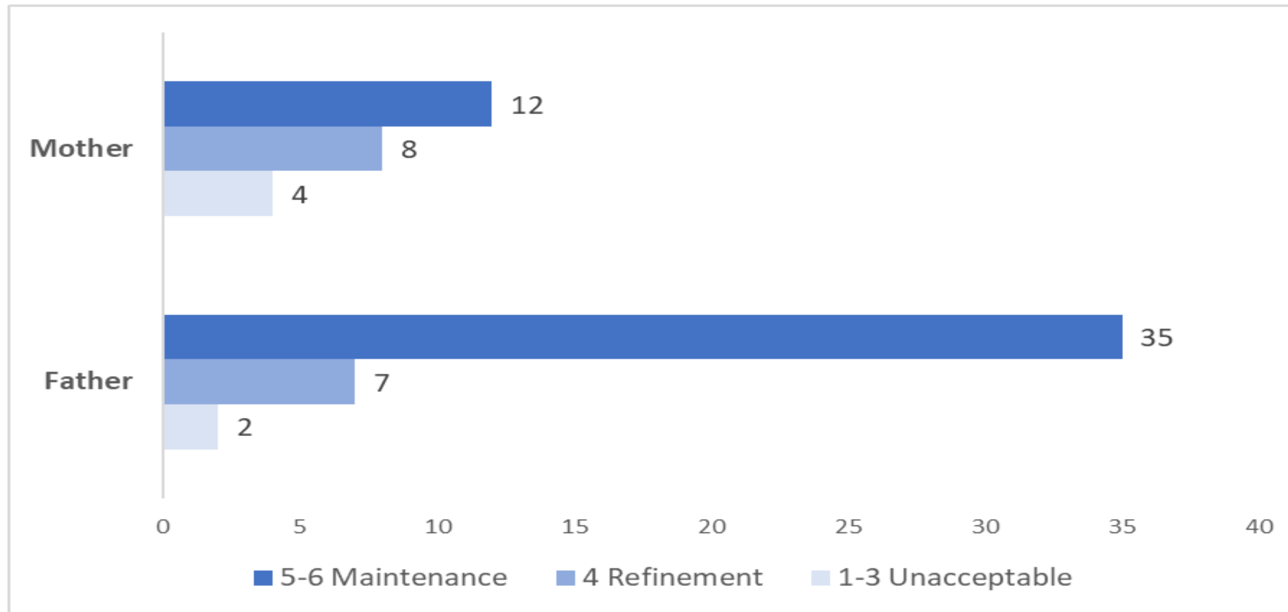


Figure 21 Parents' Voice and Choice. Source: QSR QuickBase app

QSR specialists rated the *Voice and Choice* indicator in the maintenance zone (4-6) for 35 (61 percent) of the mothers and 12 (21 percent) of the fathers. These maintenance ratings indicate that the parents had a central and directive role in case planning, and provided a voice that shaped the decisions made on behalf of their family. In order to determine if the parents' involvement with the Agency resulted in better outcomes for their families, QSR specialists relied on data from the parents' progress toward achieving case plan goals.

In 14 (25 percent) of the 57 cases reviewed, there was clear evidence that families were demonstrating improvement as a result of the Agency's involvement. Parents were taking the initiative to change their family's circumstances through their engagement and participation in case planning as well as services. Feedback from parents also indicated that they were satisfied with the assistance received from the Agency, which they considered beneficial to them. Some measurable outcomes were the improvement in children's school attendance, increased safety for families dealing with domestic violence, and parents improving their parenting capacity through participation in mental health and substance use treatment. The other 43 (75 percent) cases were at different stages of progress at the time of the review.

5.6 STRENGTHS AND CHALLENGES FOR PARENTS BASED ON FY 2023 QSR FINDINGS

Strengths	Challenges
▪ Forty parents were willing to identify a family member for Concurrent Kin Planning. ▪ Ten parents were co-parenting to ensure their children were appropriately supervised and attending school. ▪ Seven mothers and seven fathers were employed at the time of the review. ▪ Six parents (including one father) partnered with schools to improve educational outcomes for their children. ▪ One stepfather took on the role of protective capacity (i.e., providing supervision to the child) in the home.	▪ Thirty-eight parents had a history of or struggled with current substance abuse. ▪ Twenty-five parents had current or historical issues with domestic violence. ▪ Eighteen families experienced housing hardships. ▪ Seventeen families had a limited number of informal support, i.e., no extended family. ▪ One father's re-entry into the community following incarceration impacted his overall involvement with his children, including co-parenting with the mother. ▪ One mother reported feeling overwhelmed and unsupported while parenting multiple children and experiencing housing instability.

Table 16 Strengths and Challenges from the Cases Reviewed. Source: QSR QuickBase app

Family challenges naturally impact case progress, despite Agency efforts. A significant lack of progress in some cases was due to the lack of parent engagement in services, while in other cases progress was slow based on case complexity and challenges. For example, some parents were challenged with cognitive disabilities and severe mental health issues that impacted case progress.

Of the total 57 cases, 34 (60 percent) were opened for less than 6 months at the time of the review, i.e., the cases were still at the beginning phase of practice. For these cases, progress may not be evident until sufficient time passes for the family to trust the system and for authentic family engagement to occur.

5.6.1 Three Cases with Positive Outcomes after Agency Involvement

(Family A) The team was aware of the mother's lack of informal supports, her mental health illness, her child welfare history, and her experience with domestic violence (DV). The mother's mental health provider, along with the Agency social worker, provided ongoing counseling to the mother to improve her self-esteem and to help her understand the impact of DV on her children's well-being. This counseling effectively supported the mother toward feeling empowered and toward recognizing the many things she could do independently to protect herself and her children.

(Family B) CFSA's planning strategies focused on providing the mother with tangible skills that would improve her parenting capacity and increase her ability to fully address her infant child's needs. Planning also included preparing the family for the transition away from Agency involvement. Feeding her infant was a challenge the Agency helped address. The mother and social worker created a written feeding regimen that included directions for making infant formula. The mother kept the regimen visible in the kitchen to help her remember until the routine became familiar. Team members also educated the mother on the dangers of co-sleeping. This education included the mother watching a video on the dangerous impacts of unsafe sleeping arrangements. As a result of these supports and services, the mother felt empowered and demonstrated her readiness to appropriately care for her child.

(Family C) The mother completed parenting classes and received peer coaching services. The team provided the mother with education regarding the importance of maintaining a clean and safe home environment for her family. As a result of successful engagement, the mother demonstrated good progress by consistently taking the trash out and cleaning the bathrooms more regularly. The mother also cleaned the walls and repainted the children's room. By agreement, the landlord completed monthly apartment checks to ensure and support the mother's commitment to maintaining an acceptable living environment.

5.7 SUMMARY OF FINDINGS

QSR findings indicated that the majority (91 percent) of the 57 families involved in the review process had prior CFSA involvement with similar maltreatment allegations. Findings indicated multiple complicating factors for why these families continued to come to the Agency's attention. As noted earlier, the majority of the parents' personal (and unresolved) issues tended to impact their children's education as well as medical needs.

Although only a quarter of cases (24 percent) demonstrated good progress, that progress also highlighted the strong clinical skills of social workers, e.g., successful engagement of parents, strategic service implementation, consistent monitoring, and ongoing completion of safety and risk assessments throughout the life of a case. These clinical skills, combined with the parents' dedicated efforts, effectively addressed that 24 percent of families' needs and resulted in improved outcomes.

Additional evidence indicated that a lack of progress for the remaining 76 percent of cases was due to the lack of parent engagement in services. Historically, QSR reviews have shown that parents' active participation and engagement in services, and their ambivalence to work with the Agency, remain a challenge for the In-Home Administration. Despite training in evidence-based skills (such as motivational interviewing, which encourages and supports families in resolving their issues), social workers continued to face multiple challenges for

achieving positive outcomes.[22] Again, challenges for the social work team and the families included complicating factors such as unresolved (or insufficiently addressed) family histories of trauma, substance use, mental illness, cognitive challenges, and parenting capacity with multiple children.

5.7.1 Areas of Need

The QSR identified several areas of need, including mental health treatment, inter-agency communication, family engagement, and chronic housing issues. Regarding mental health, families experienced delays in service provision due to various mental health providers not having available therapists to provide individual therapy for children and parents. While the District's network includes multiple providers to choose from, staffing issues have been an ongoing challenge that contributes to the delay in service delivery. Often the Agency relies on its contracted partnerships with the neighborhood HFTC Collaboratives to supplement service delivery but there are circumstances where the Collaborative case is closed due to the family's lack of engagement.

There were 18 families (32 percent) dealing with housing instability due to a series of issues. Some of these issues included the home's poor environmental conditions, rodent infestation, and inoperable utilities. This systemic housing issue continues to challenge the In-Home Administration's efforts to support families with housing concerns. In addition to the chronic lack of affordable housing in the District, there are significant delays in the receipt of housing vouchers, or there are systemic barriers within agencies that provide housing support for District residents. In one case, the family lost an opportunity to move into an apartment because of a delay with the assignment of the housing inspector, which was reportedly caused by a backlog within the District's Housing Authority. As a result, the family was also at risk of potentially losing a second available housing option. For all these areas of need, CFSA faces challenges that are out of the Agency's control.

[22] As noted earlier under section 3.3.1, CFSA's Child Welfare Training Academy provides training for social workers and other interested staff in the following six principles of motivational interviewing: (1) expressing empathy, (2) developing discrepancy, (3) avoiding arguments, (4) rolling with resistance, (5) supporting self-efficacy, and (6) assessing confidence.

6. IN-HOME SOCIAL WORKER SUPPORTS AND NEEDS

6.1 SERVICES AVAILABLE TO SUPPORT SOCIAL WORKERS

The work of an in-home social worker can be very challenging when making decisions that have a significant impact on the safety and well-being of children. As such, supervisors and managers ensure that consultative supports are available to social workers:

- Providing direction on complicated cases.
- Improving worker engagement and assessment skills.
- Increasing access to supports and services for families.
- Supporting worker wellness and well-being.

6.1.1 In-Home Clinical Consultations (IHCC) and Multi-Administration Clinical Staffings (MACS)

In-Home Clinical Consultations (IHCC) and Multi-Administration Clinical Staffings (MACS) are two teaming forums available to in-home social workers with complicated cases. IHCC participants include in-home program managers, the in-home administrator, and possibly the assigned in-home assistant attorney general. Consultations are not meant to replace supervisory decision-making or existing clinical processes. However, the IHCC approach does offer the social worker a safe and supportive space to review and analyze in-home cases that require additional guidance and further clinical insight. Consultations are available every Tuesday for 2 hours.

While IHCC meetings address specific complications, the MACS meeting is a multidisciplinary team approach used to assess in-home cases that have been stagnant or show little progressive improvement. MACS meetings provide case-specific direction and support, particularly when there are issues related to mental illness, substance abuse, and domestic violence. When two or more of these problems are co-occurring in a case, the combined efforts of multidisciplinary professionals and perspectives can assist in addressing critical systemic issues facing the In-Home Administration's efforts. Accordingly, MACS participants include representation from the Office of Well-Being (substance use specialist, domestic violence specialist, community nurses, and mental health therapists), CFSA's Commercial Sexual Exploitation Committee, Placement Unit, Diligent Search Unit, Quality Service Review Unit, and the Office of the Attorney General. Although the MACS meeting primarily includes internal CFSA partners, key external partners may include the Collaboratives and representation from CFSA's contracted private agency partners (Latin American Youth Center and the National Center for Children and Families). If the case involves an active CPS investigation or neglect court case, the referring In-Home Administration team may include CPS representatives. The In-Home Administration may also invite other internal CFSA partners according to their involvement with the identified case. The MACS team is available every third Thursday of the month for 2 hours.

6.1.2 Crisis Support

Another resource available to in-home social workers is crisis support offered by CFSA's Office of Well-Being (OWB). OWB offers support Monday through Friday from 9:30AM to 7:30PM. Support can occur in real time under various circumstances. For example, a social worker may encounter a dysregulated child or youth and contact the OWB support line in the moment to speak with a therapist who can provide supportive tips and coaching to de-escalate and help manage the crisis. If similar support is needed on the weekend or after hours, the Child and Adolescent Mobile Psychiatric Service (ChAMPS) is available 24 hours a day, 7 days a week. Managed by Catholic Charities DC, ChAMPS is a District-wide free resource for District residents.

6.1.3 Assistant Attorney General

The Office of the Attorney General (OAG) assigns a dedicated assistant attorney general (AAG) to work solely with CFSA's In-Home Administration. As an additional in-home social worker support, the AAG can answer a social worker's legal questions and help to address relevant legal issues that come up in a social worker's day-to-day work. The AAG may also analyze the legal sufficiency of evidence for in-home cases and provide next steps to strengthen cases for court involvement and safe case closure. The following AAG duties support the In-Home Administration:

- Meeting with social workers and their supervisors to discuss the legal sufficiency of moving a case forward towards community papering, or alternatively to in-home case closure.
- Providing in-home social workers with court orders, court documents, and the status of cases; court orders may include civil protection orders, temporary protection orders, and other orders related to child custody determinations, criminal cases, and domestic violence cases.
- Meeting with social workers and their supervisors to determine whether a pre-petition custody order (PPCO) is necessary. When needed, the AAG will review and file the affidavit and the proposed PPCO.[23]
- Acting as liaison with other OAG divisions and District agencies and CFSA.
- Participating in the IHCC and MACS meetings.
- Facilitating routine training on the law to keep social workers current with legal trends.

---

[23] When a CPS investigative social worker is unable to locate a child suspected to be in immediate danger or the social worker has established reasonable grounds to believe that the child is otherwise endangered (including an illness or injury) such that a separation is necessary, CPS will request assistance from the AAG to file a pre-petition custody order that will provide CFSA with the legal right to immediately separate the child once located.

6.1.4 Lyssn Motivational Interviewing Training

CFSA uses motivational interviewing (MI) as an evidence-based case management approach in working with families. As a complement to the Child Welfare Training Academy's training (CWTA), CFSA provides In-Home social workers, family support workers, and supervisors access to Lyssn, an artificial intelligence (AI) platform that accurately assesses the use of evidence-based practices, including MI. While CWTA's initial MI training serves as the bedrock for essential MI skills, Lyssn takes the learning experience a step further by providing a flexible and continuous opportunity for workers to hone and apply these skills. With Lyssn, individuals can practice their MI skills on their own terms – choosing where and when they want to engage in training exercises, all year round. This flexibility allows for ongoing skill development, ensuring that social workers and other staff can progressively improve their proficiency in MI at a pace that suits their schedule and learning preferences.

Lyssn provides the opportunity to enhance MI skills through five MI skills modules. These modules focus on the following skills:

- Ambivalence and Listening Statements
- Existing Motivation and Exploring Questions
- Identifying Change Talk and Lifting Language
- Refraining from Anti-MI Approaches
- Identifying Strengths

The In-Home Administration has been utilizing the platform for at least 9 months. As of September 29, 2023, 48 workers and 10 supervisors had access to Lyssn. All supervisors and 44 of all 48 workers (92 percent) had completed the training. Most designated in-home staff (55 percent) were able to use the appropriate MI skills in 75 percent or more of their interactions in Lyssn. The resource is available for any of the social workers to utilize at any time.

6.1.5 Primary and Secondary Traumatic Stress (PSTS) Supports

Primary traumatic stress happens from direct experience or observation of a disturbing or distressing event or learning about it afterwards. Secondary traumatic stress can happen when working with someone who has been traumatized by a disturbing or distressing event. Both direct and indirect exposure can also remind an employee of difficult experiences from their own history and personal life, which can in turn exacerbate memories of prior traumatic stress and bring it back to the forefront of daily living. As such, CFSA has a PSTS Committee with members who have worked to develop a policy and an array of supports to address the pervasive PSTS experienced by employees in any

system confronting chronic events of child abuse, neglect, and fatalities. CFSA provides the following supports for all staff, including in-home social workers:

- **External 1:1 support.** Through INOVA, the District's Employee Assistance Program (EAP), staff can engage with a therapeutic service provider. Staff can also use their private insurance for this support.
- **Internal 1:1 support.** With the support and referral of a supervisor or the CWTA administrator, staff can access 1:1 therapeutic support through CFSA's dedicated resource, the Onyx Therapy Group.
- **Group support.** CWTA offers group support sessions; Onyx Group also offers group support.
- **Wellness program.** CFSA has a multi-faceted wellness program managed by the Agency's Human Resources Administration. The program features resources and activities to support stress reduction, prevent health risks, and to promote self-care. Activities include meditation, yoga, dietary health, psychological safety, and other wellness activities. In addition, the Agency promotes staff self-care during "Meeting-Free Wednesdays" when staff have access to wellness activities between 11:30 AM and 1:30 PM.
- **Training.** CWTA provides all-staff training on the signs and symptoms of PSTS, ways to mitigate these symptoms, and strategies for addressing PSTS.

6.2 COLLABORATION AND TEAMING WITH PARTNERS

Survey respondents' top internal communication barriers included cumbersome referral processes that take too long (28 percent) and the lack of information regarding currently available services (28 percent). Focus group participants stated that utilizing the newly launched STAAND system for making referrals is confusing and cannot be accessed by everyone.[24] Staff stated that they often didn't know who the point of contact was for some specific referral submissions, and that multiple calls or emails to other staff were sometimes needed to identify the right contact. Participants in each of the four focus groups said that the referral process would be much easier, and families served more effectively and faster, if there were more in-house resources that staff could access directly. Specifically, participants frequently cited the Project Connect program (under the Agency's Office of Well-Being) as a model for provision of in-house referrals for services to address domestic violence, coaching and parenting instruction, or employment assistance.

Social workers and family support workers stated that they typically learn about Agency services and referral processes through asking their peers or supervisors for information on a case-by-case basis. Focus group participants agreed that they too experience confusion over what

[24] In 2024, CFSA will finalize a transition from the current child welfare information system, FACES.NET to STAAND (Stronger Together Against Abuse and Neglect in DC), a federally mandated platform and comprehensive child welfare information system.

resources are currently available to their families or what services other staff at the Agency can offer. Social workers in particular pointed out that some services through CFSA, e.g., both tutoring and mentoring services are available only to families with children in foster care, but not for in-home families.

To assist with this process, CFSA's Office of Thriving Families has launched a Service Navigator model with designated points of contacts to assist social workers with identifying appropriate service needs for families and with making and tracking referrals to partner agencies (DC Housing Authority, Department of Human Services, Department of Behavioral Health, Collaboratives, and other community-based organizations). The Agency plans to embed this model in STAAND and to expand the Service Navigator model to other program areas. However, based on feedback from the social worker survey, most social workers are currently unaware of the Service Navigator as a resource.

Slow government response and lack of interagency coordination were top barriers for social workers and family support workers

Figure 22 Survey Responses: Barriers to Collaboration with Partner Agencies

By far the most frequently identified barrier to working with partner service agencies was the perception that the agencies were unresponsive or very slow to respond to requests and communication from CFSA staff. This concern is compounded by families who do not

have a reliable phone, internet, or transportation, which leads to confusing or frequently missed communications, delays in confirming appointments and transportation, and fostering a family's mistrust of the social worker and the Agency. Social workers specifically stated that unresponsive agencies can negatively influence the relationship between CFSA and their families, e.g., parents awaiting referrals for services may blame the social workers for not following through or for impeding families from progress toward case closure when, in fact, the circumstances are out of the social worker's control.

Multiple focus group participants shared that families on their caseload frequently complain that they also experience slow or no responses from outside agencies and providers. Social workers further cited high staff turnover at many provider agencies, e.g., new employees continuously must learn new systems and procedures and these learning-curve factors may contribute to lack of engagement or disconnects with clients. Other barriers included communications with outside collaborations, i.e., social workers and family support workers were not always aware of non-CFSA services received by the families on their caseload. For example, a family may already be engaged in a newly referred service, or the family is already awaiting a service. These situations are particularly common at the onset of case assignment. Staff reported that some families also don't know the name of their providers or why they are receiving a certain service. Social workers most often mentioned District agencies such as the Department of Behavioral Health (DBH), Department of Human Services (DHS), and the DC Housing Authority (DCHA) as the entities that are the most difficult to collaborate with due to their unresponsiveness to CFSA and families in general, their bureaucracies and confusing procedures, and repetitive paperwork. Staff generally agreed that collaborations with DC schools (both public and charter), and the HFTC Collaboratives were generally seamless, although some schools were admittedly better than others at providing information and access to children. Participants explained that schools and the HFTC Collaboratives were much more aware of CFSA's roles and protocols, leading frequently to good rapport with familiar social workers, and usually much more accommodating when approached for collaboration.

Concerning referrals for services both internally and externally, staff stated that they needed a one-stop directory for identifying providers for specific services, referral processes, provider locations, and other vital information. Staff stated that having such a directory, if updated regularly, would save considerable time navigating services for the family. Several staff mentioned that a comprehensive online service directory was previously an accessible resource for staff from the In-Home Administration. This resource is currently not available and, according to feedback, was significantly underutilized when it was available.

The Agency recently launched a new platform called Unite Us, which has similar functions for identifying available resources and tracking referrals with participating community-based organizations. The platform will also be part of the Service Navigation model. A centralized

mailbox will be set up for social workers and supervisors to send questions and requests regarding service needs. The Service Navigators in Thriving Families will then redirect the questions to the right points of contact and submit referrals through Unite Us. As this is a new initiative, the Agency is planning a communication campaign to make social workers aware of this added resource.

Respondents indicated they needed a one-stop directory for identifying providers for specific service referrals

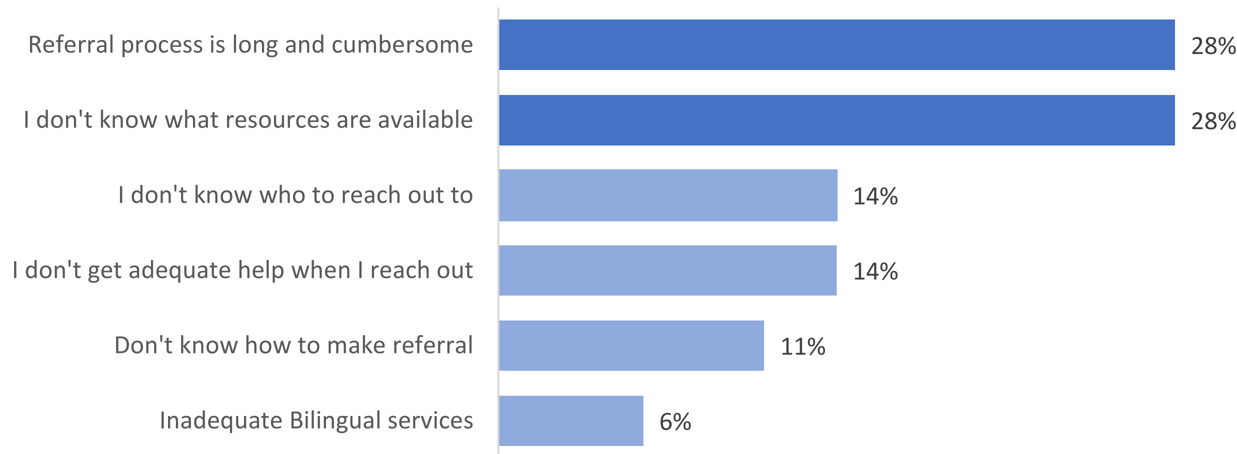


Figure 23 Survey Responses: Barriers to Collaboration within CFSA

7. CONCLUSION (SUMMARY OF RECOMMENDATIONS)

Overarching findings reinforce the Agency's need to address four areas of practice. As noted in the Executive Summary, these four areas include (1) the improvement of interagency coordination and collaboration, (2) an increase in the engagement of families, (3) maximization of housing supports, and (4) deepening research and evaluation of existing or new services and resources. For purposes of the actual development of resources in FY 2025, CFSA leadership will focus on the first three areas and incorporate the following strategies into the Agency's Resource Development Plan.

Interagency Coordination and Collaboration

At present, social workers report the need for a readily accessible and updated compendium of existing services. In response, CFSA's senior leadership intends to explore a comprehensive tool for service navigation (Unite Us/Find Help). To promote the tool's use and access, CFSA's Office of Public Information will keep staff informed of updates in conjunction with leadership's support for quality service delivery to families. In addition, the In-Home Administration along with the Office of Well-Being (OWB) and the Office of Thriving Families (OTF) will convene on a quarterly basis to discuss and address lingering systemic barriers to service access and coordination. The In-Home Administration's administrator will facilitate the meeting and invite the Deputy Director of the Office of In-Home and Out-of-Home Care as needed.

Social workers and staff also requested tangible methods to facilitate teaming across DC Government agencies, e.g., tracking the status of services per agency and ensuring regular communication among service providers. In response, designated CFSA staff will inventory and adjust, as needed, any existing memoranda of agreements that address improved data sharing among agencies. The inventory will examine how CFSA and other agencies currently share data, and whether or not the shared data are used or needed. The inventory will further prioritize data sharing among those agencies that most often interface with CFSA, e.g., DBH and DHS, along with DCHA. Lastly, CFSA leadership is committed to establishing an interagency coordinator and possibly a taskforce to address the systemic barriers identified during the quarterly meetings between the In-Home Administration, OWB and OTF. CFSA anticipates that these responses, along with implementation of the Service Navigator, will increase access to data on service progress and reduce redundancy or duplication of service requests.

The most frequently identified interagency service need was high quality trauma-informed mental health services. In particular, social workers and families noted delays in the assignment of therapists due to staff shortages among mental health service providers. Leadership has since revealed that DBH is moving to a new care model by April 2024. CFSA anticipates that the new DBH model will streamline both the

referral process and the delivery of quality services to families. Moreover, the Agency intends to develop concerted partnerships between CFSA and school-based mental health services to ensure that children have expedited access to services.

Lastly, a key leadership response is the development of regularly scheduled director-to-director discussions wherein CFSA benefits from consistent advocacy at the highest level of leadership. Such advocacy will reinforce the crucial nature of interagency responsiveness to CFSA requests for services that the Agency cannot provide on its own but are essential for the Agency to sustain its commitment to serving the District's child welfare population.

Engagement of Families

Leadership reiterated the use of motivational interviewing (MI) as an evidence-based approach for engagement. As described in the Executive Summary, leadership also reinforced the use of the MI quality assurance and quality improvement functionalities of the training platform. These training tools may positively impact the outcomes of family engagement with services, solely because of Agency engagement with the family. Similarly, MI might also improve a family's willingness to provide names and contact information for extended family members who may potentially serve during concurrent kinship planning. Along with MI, leadership is also considering development of a management report that tracks concurrent kin plans at the case level.

Maximization of Housing Supports

The most frequently identified housing challenge focused on substantial delays in families receiving housing vouchers, as well as delays in housing improvements for the Housing Choice Voucher Program housing. In response to this need, OTF intends to develop a housing component for both pre-service and in-service training. OTF expects that such training will reinforce staff knowledge of the housing voucher system and strengthen social workers' capacity to ensure that planning strategies for housing account for processes outside of CFSA's control.

Social workers also indicated challenges with DCHA responsiveness to CFSA in general, atop confusing procedures, and repetitive paperwork. Leadership responses and recommendations include the same director-to-director discussions to reinforce DCHA responsiveness to CFSA, engaging the DCHA liaison to help address housing conditions, and OTF's recommendation for training on the Service Navigator tool, e.g., when housing is a barrier to family preservation.

Research and Evaluation of Existing Services and Supports

For FY 2025, CFSA's Performance Accountability and Quality Improvement Administration (PAQIA) intends to deepen its analyses of existing services and supports that families rely upon for preservation and stabilization.[25] PAQIA will therefore reactivate use of the updated artificial intelligence version of NVivo, an application that has provided CFSA's Office of Planning, Policy, and Program Support with excellent data outcomes for previous Needs Assessments.[26] Coding qualitative data from surveys, interviews, feedback forums, and Quality Service Review narratives, the NVivo application can pull narrative from case reviews, identify trends and themes for the usefulness or challenges with identified services, and provide a comprehensive data set for evaluation.

PAQIA will focus on referral data from families at both the Front Porch and the Front Door, including service referrals to the Healthy Families/Thriving Communities Collaboratives. To reinforce the research and evaluation process, PAQIA will also develop a tailored continuous quality improvement (CQI) strategy in partnership with CFSA's CQI team, OTF, and CFSA's Office of Program Outcomes (under the Office of the Director). OFT will drive the evaluations and Program Outcomes, will clean up the data, and complete final analyses.

In summary, CFSA's determination to protect children and to preserve families is ongoing. To this end, the Needs Assessment and the associated Resource Development Plan are key components of the Agency's dedicated service to the District of Columbia.

---

[25] PAQIA functions under the direction of CFSA's Office of Planning, Policy, and Program Support.

[26] Per the website of NVivo's developer, Lumivero, NVivo has been a pioneer, leading the charge in integrating technology to enhance qualitative research. Our journey into harnessing the potential of Artificial Intelligence (AI) began in 2015, and we haven't looked back since. From auto-coding themes to sentiment analysis and using existing coding patterns, we've been at the forefront of making qualitative research smarter and more efficient. And in 2018, we introduced NVivo transcription, further cementing our commitment to innovation. https://lumivero.com/resources/blog/revolutionizing-text-data-analysis-with-ai-autocoding-with-nvivo/

8. RESOURCE DEVELOPMENT PLAN AT-A-GLANCE

IMPROVE INTERAGENCY COORDINATION AND COLLABORATION

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
Social workers should not be responsible for an encyclopedic knowledge of CFSA's service array. Social work teams require basic knowledge of existing resources available to families they serve.	▪ Implement the comprehensive Service Navigator model, including communications to impacted staff in FY 2024 to centralize efforts to engage specific service needs. Unite Us/Find Help will be critical tools for Service Navigation staff and will support social workers' insights and updates on a regular basis for progress to support their families' needs. ▪ Meet quarterly with internal program areas with the Office of Wellbeing (OWB) and the Office of Thriving families (OTF) to discuss systemic barriers with service access and coordination. ▪ OWB will coordinate with the Office of Public Information (OPI) to market the service navigator model and the available services.
Tangible supports are needed to facilitate teaming across agencies, including tracking of involved agencies, status of services, and ensuring regular communication among service providers (priorities: DBH, DHS, and DCHA).	▪ Complete inventory of data-sharing agreements to identify gaps and modify or create memoranda of agreements (MOAs) to address gaps. ▪ Address how the information being shared is or is not used or, and if other details or processes need to be put in place for the data sharing MOAs with the priority agencies referenced via DC Cross Connect (DBH and DHS) and a separate DCHA MOA. ▪ Establish interagency coordinator or taskforce to address systemic barriers ▪ Discuss with DBH, and the DCHA if the Service Navigators will have access to view data about progress in the future to reduce the redundancy of requests received regularly about cases. This effort is already underway for DCHA.
Consistent Agency-wide publication of available (and especially new) services is necessary.	▪ Recommend OPI communication campaign in concert with OWB and OTF to ensure consistent information for social workers to engage with Service Navigator.
Referral processes need streamlining.	▪ Address the referral process through the Service Navigator model to support the social workers' access to services for the family. ▪ Ensure OTF takes the lead with inter-agency coordination to streamline referral processes and access relevant updates in near-real time. ▪ Ensure STAAND plays a critical role for internal programs being able to streamline and simplify use of referral processes, including use of the Service Navigator model to request supports and view efforts. ▪ Align technology and business processes through Service Navigator model for overall success.

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
All-staff awareness of existing interagency liaisons is necessary.	▪ Convene quarterly All Staff Meetings with interagency liaisons (DBH, DCHR, etc.) to share information and identify gaps and strategies. ▪ Share information with staff who benefit from utilizing interagency liaisons.
From the QSR results: The most frequently identified needs for the 57 families included trauma-informed mental health services, substance use treatment, and domestic violence services. QSR specialists noted that when these needs were unmet, the resulting challenges also impacted children's school attendance and medical care. There are delays in mental health service provision due to the DBH core service agency therapist availability. There is a chronic lack of affordable housing and significant delays in the receipt of housing vouchers and addressing housing conditions.	▪ Discuss with DBH regarding available therapist resources. ▪ Inform staff of DBH's new care model (estimated to be implemented by April 2024 - "Managed Care Organization (MCO) carve-in"). ▪ Assist CFSA's understanding for how the MCO carve-in will impact referrals and families getting connected and staying connected to quality services in a streamlined way. ▪ Develop intentional connection with school based mental health services. ▪ Continue to engage the DCHA to address significant delays in receipt of housing vouchers and housing conditions (where DCHA has jurisdiction). ▪ Create training about housing services as part of pre-service and in-service training to learn more about common issues individuals and families face when trying to rent in the DC housing market. OTF training will discuss responsible government agencies, government and community-based provider advocates, and information about when to connect with a Housing Service Navigator. Additional resources will be required, and have been requested, through the FY 2025 budget presentation with OTF; OFT specifically requested a dedicated Housing Service Navigator position to support youth applicants who are preparing to exit care, or who require housing support after exiting care. ▪ Implement director-to-director discussions and level reinforcement of interagency responsiveness to CFSA requests and inquiries with sister agencies. ▪ Provide Flex Funds to the Collaboratives to meet the needs of CFSA involved families. More discussion throughout this report around the In Home Administration's use of Flex Funds is needed and subsequent Resource Development Plan recommendations about an increase (if needed) to Flex Funds to support in-home cases.

INCREASE ENGAGEMENT OF FAMILIES

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
CFSA needs to increase a family's engagement with, participation in, and completion of services. There were situations where the Collaborative closed cases due to the family's lack of engagement. In some of these situations, the Collaborative did not provide	▪ Promote consistent use of quality assurance and quality improvement functionalities of the Lyssn Motivational Interviewing platform. ▪ Clarify Collaboratives responsibilities for not having to follow up on their closed cases. Depending on the case-type, Collaboratives are not required, nor should they be required to follow up with CFSA after a case has been closed at the Agency unless it is to report a

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
notification of closure to the Agency, preventing timely CFSA intervention to ensure that those children were safe, and that the family was sufficiently stable to prevent repeat maltreatment.	new concern. More practice guidance may be needed to determine when to refer to a Collaborative and accurate expectations of a Collaborative's role as a community-based provider for closed cases. If we are talking about teaming cases, this is something that OTF can work with the Collaboratives to address poor teaming communication. More information is needed about the specific concern to recommend practice changes.
CFSA needs to improve the effectiveness of services engagement with families.	▪ Promote use of family evaluations and survey feedback per service. ▪ Promote and increase use of MI training and consistent use/passing scores on Lyssn.
CFSA needs to increase the utilization of concurrent kin plans.	▪ Develop a FACES.NET management report that tracks concurrent kin plans at the case level.

MAXIMIZE HOUSING SUPPORTS FOR FAMILIES

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
The top in-home step-down and teaming service request was for housing and housing supports.	▪ Promote use of the newly developed OTF's Community Engage and Connect Unit (CECU) for In-Home step-down cases.
Social workers most often mentioned District of Columbia Housing Authority as one of the entities most difficult to collaborate with due to unresponsiveness to CFSA and families in general, bureaucracies and confusing procedures, and repetitive paperwork.	▪ Increase teaming with Mayor's Services Liaison Office for court involved families (MSLO's scope). ▪ Recommend Service Navigator model to streamline what is asked of DCHA and other partner agencies. ▪ Engage the Housing Authority to address housing conditions ▪ Continue OFT training of in-home social workers on when to engage a Service Navigator if housing is a barrier to family preservation. In-Home has historically been a low utilizer of both the Rapid Housing Assistance Program and Family Unification Program Vouchers but understand this is a pervasive issue for this population. ▪ Implement consistent director-to-director discussions, and level reinforcement of interagency responsiveness to CFSA requests and inquiries with sister agencies.
Delays in housing services impeded family stability and case closure. Thirty-seven percent of social workers reported housing as a significant need/resource. They identified housing services (81 percent) as having frequent and long waiting lists for services.	▪ Engage DCHA to address housing conditions. ▪ Implement consistent director-to-director discussions, and level reinforcement of interagency responsiveness to CFSA requests and inquiries with sister agencies.
QSR findings indicated that 18 families (32 percent) experienced difficulties with housing availability,	▪ Engage DCHA to address housing conditions.

Summary of Needs to be Considered	Recommended Resources and Proposed Practice Strategies
affordability, and appropriate living conditions. Many in-home families are confronted with housing conditions over which they have little direct control.	▪ Implement consistent director-to-director discussions, and level reinforcement of interagency responsiveness to CFSA requests and inquiries with sister agencies.
In FY 2024, OWB and OTF will begin using the Service Navigation model to ensure social work teams receive assistance in connecting to services offered by integrating service navigation through OWB and OTF staff. Service navigation will assist social work teams by providing information and assisting in the submission of referrals to OWB services. In addition, service navigation will assist social work teams in connecting to external services within the District and surrounding counties. The implementation of service navigation and enhanced care coordination will begin to assist social work teams and families in ensuring connection to services is actualized and engage in opportunities to coordinate care and team through existing case review opportunities with social workers/supervisors.	▪ Utilize existing staff as Service Navigators. ▪ Implement an OPI promotional campaign as part of an Agency-wide shift/retraining effort on how the Service Navigator model will work and who across the Agency should be contacted for Service Navigator support before full STAAND implementation (which will ideally automate many of these functions).

9. APPENDICES

9.1 ASSESSMENT TOOLS AT A GLANCE

Circumstance	Purpose	Decisions
SDM® Caregiver Strengths and Barriers Assessment (CSBA)		
▪ Within the first 30 days of a case being opened and every 90 days thereafter	▪ Assessment of caregiver's functioning over time, including progress or the need to address challenges ▪ To help guide goals and services in the family service plan	▪ Determination of safe case closure ▪ What priority strengths and barriers should be included and addressed in the family service plan
SDM® Risk Reassessment		
▪ High or Intensive level of care at onset until assessed otherwise ▪ Within the first 30 days of a case being opened ▪ New allegation or substantiation ▪ Updated a minimum of every 90 days within 30 days prior to case closure	▪ Likelihood that a child may be abused or maltreated in the future ▪ Frequency of visits ▪ Determine intensity, extent, and duration of case management services for In-Home Administration cases	▪ If case remains open, determines level of service (Intensive, High, Moderate, or Low), including contact guidelines ▪ Whether or not to close a case ▪ Need for referral to the neighborhood Collaborative ▪ May override as needed
SDM® Danger and Safety Assessment		
▪ Within the first 30 days of a case being opened ▪ Whenever the safety situation changes ▪ When recommending case closure ▪ Following a Hotline report alleging abuse or neglect that requires a CPS response on an open case	▪ Determination of any immediate threat or danger of harm to the child ▪ Assessment of the need for immediate interventions	▪ Whether the child may remain in the home with no intervention ▪ Whether the child may remain in the home with a safety plan in place (*developed in partnership between social worker and parents or caregivers, signed by all)* ▪ Whether the Agency separates the child from the home to ensure the child's safety
Parent's Evaluation of Developmental Status (PEDS)		

Circumstance	Purpose	Decisions
▪ At the time of initial case opening ▪ Within the first 30 days of case assignment	▪ For each child in the household aged 3 to 5 years to receive an early intervention screening ▪ For social workers to submit a referral to the Strong Start Program	▪ Whether further developmental evaluation is needed ▪ Whether the child needs additional supports and services

Table 17 Common Formal In-Home Assessment Tools

9.2 RISK ASSESSMENT AND REASSESSMENT QUESTIONS

9.2.1 CPS Risk Assessment

Current Investigation and CPS History

1. Current Report is for
    a. Neglect
    b. Abuse
    c. Both
2. Prior investigations
    a. No
    b. Yes

    2a. Prior neglect
    a. None
    b. One
    c. Two
    d. Three or more

    2b. Prior abuse
    a. None
    b. One
    c. Two or more
3. Household has previously received services (court or non-court involved)
    a. No
    b. Yes

4. Number of children involved in the current child abuse/neglect incident.
    a. One, two, or three
    b. Four or more

Children in the Household

5. Prior injury to any child resulting from child abuse/neglect
    a. No
    b. Yes
6. Age of youngest child in the home
    c. 2 or older
    d. Under 2
7. Characteristics of children in the household (check all that apply)
    e. Medically fragile/failure to thrive
    f. Positive toxicology screen at birth
    g. Physical disability
    h. Developmental disability
    i. Delinquency history
    j. Mental health/behavior problems
    k. None of the above

Caregiver Characteristics

8. Primary 's assessment of incident (check all that apply)
    a. Blames child
    b. Justifies maltreatment of the child
    c. None of the above
9. Primary caregiver provides physical care consistent with each child's needs
    a. No
    b. Yes
10. Primary caregiver's characteristics (check all that apply)
    a. Provides insufficient emotional/psychological support
    b. Employs excessive/inappropriate discipline
    c. Domineering caregiver

d. None of the above

11. Primary caregiver has a past or current mental health problem
    a. No
    b. Yes (check all that apply)
        i. During the last 12 months
        ii. Prior to the last 12 months
12. Primary caregiver has past or current alcohol or drug problem (check all that apply)
    a. No
    b. Alcohol (check all that apply)
        i. During the last 12 months
        ii. Prior to the last 12 months
    c. Drugs (check all that apply)
        i. During the last 12 months
        ii. Prior to the last 12 months
13. Secondary caregiver has past or current alcohol or drug problem (check all that apply)
    a. No secondary caregiver
    b. No
    c. Yes
        i. Alcohol
            1. During the last 12 months
            2. Prior to the last 12 months
        ii. Drugs
            1. During the last 12 months
        iii. Prior to the last 12 months
14. Primary caregiver has a history of abuse or neglect as a child
    a. No
    b. Yes

Household

15. Two or more incidents of domestic violence in the household in the past year
    a. No
    b. Yes

16. Housing (check all that apply)
    a. Current housing is physically unsafe
    b. Homeless at time investigation began
    c. Family has housing that is physically safe

9.2.2 In-Home Risk Reassessment

CPS History

1. Number of prior investigations
   a. None
   b. One
   c. Two or more
2. Household has previously received services (court or non-court involved)
   a. No
   b. Yes
3. Primary caregiver has a history of abuse or neglect as a child
   a. No
   b. Yes
4. Characteristics of children in household
   a. One or more children in household are developmentally or physically disabled
   b. One or more children in household are medically fragile or diagnosed with failure to thrive
   c. No child in household exhibits characteristics listed above

Current assessment period

5. New investigation of abuse or neglect since the initial Risk Assessment or last Reassessment
   a. No
   b. Yes
6. Caregiver has not addressed alcohol or drug abuse problem since last assessment/reassessment
   a. No history of alcohol or drug abuse problem
   b. No current alcohol or drug abuse problem; no intervention needed
   c. Yes, alcohol or drug abuse problem; problem is being addressed
   d. Yes, alcohol or drug abuse problem; problem is not being addressed

7. Problems with adult relationships
    a. No problems observed
    b. Yes, harmful/tumultuous relationships with adults
    c. Yes, domestic violence
8. Primary caregiver provides physical care consistent with child needs
    a. No
    b. Yes
9. Caregiver's progress with case plan (check one, based on the caregiver demonstrating the least progress)
    a. Demonstrates behaviors consistent with all case plan objectives; has successfully met or is pursuing all case plan objectives
    b. Demonstrating some improved behavior; participating in some case plan goals; this includes waitlisted service
    c. No improvement in behavior; fails to participate or has minimal/sporadic participation

9.3 EVALUATION METHODOLOGY: PROPENSITY SCORE MATCHING

9.3.1 A Primer

To address the question “Does a case with the In-Home Administration result in better outcomes for families?”, CFSA uses a quasi-experimental statistical method called propensity score matching (PSM). PSM estimates the effect of a treatment – in this case services received by In-Home – has on an outcome by matching those who received the treatment with those who did not based on how similar they are on other confounding factors, say prior removal history or number of children in the family. The intent is to proxy random assignment that one would achieve in a randomized control trial, which requires conducting an experiment, with retrospective observational data available through an administrative database, like FACES.NET, when such experimentation is either impractical or unethical. By establishing a balanced matching procedure, analysts can reduce bias from the confounding factors and are better able to estimate the causal impact the treatment has on an outcome.

9.3.2 Population

CFSA considered all families with a CPS investigation and the following qualifications:

- The CPS investigation started in FY 2021 or the first half of FY 2022.
- The CPS risk assessment resulted in a High or Intensive risk level.

The first criterion narrows the timeframe compared to the sample population analyzed in this report. The constraint is to allow sufficient time to track the outcomes a year after the investigation began. The second criterion conforms with the sample population and is highlighted for emphasis. One of the key requirements for a CPS investigation to result in an in-home case is a High or Intensive risk level.

9.3.3 Treatment Measure

The CFSA analysis split the population into two groups: (1) the treatment group, i.e., those families that had an open in-home case due to the investigation; and (2) the control group, i.e., those families for which the CPS investigation did not subsequently result in an open in-home case.

9.3.4 Outcome Measures

Many outcomes that CFSA may be interested in strengthening, say parental resilience or attachment, are hard to measure. However, the Agency can measure the following significant events:

1. Did the family experience a subsequent **investigation** within a year of the initial investigation?
2. If so, was the investigation **substantiated**?
3. Did the family experience a subsequent **separation** within a year of the investigation?

The start date for all outcome measures is the investigation start date.

9.3.5 Confounding Factors

The PSM procedure (detailed below) considers a host of factors when determining “similarity” during the matching procedure. The following matching covariates are included in the process:

- Family demographics: family race, family Ward of residency, number of children in the case
- CFSA involvement: the number of previous investigations and the number of previous separations of a child from the family
- Investigation details: the allegations (and the more detailed maltreatment categories) of the investigation including the Hotline decision, the response priority, the outcome of the Danger and Safety Assessment, the identified risk levels, and the disposition (substantiated, inconclusive, or unfounded)[27]

[27] The CFSA Investigation Procedural Operations Manual (IPOM) outlines the process for disposition decisions (pp 136-138). The IPOM can be accessed here: https://cfsa.dc.gov/publication/investigations-pom-pdf

A full list of matching covariates, which are used synonymously with confounding factors in this report, including their balance statistics, are reported in the *Technical Appendix, Section 9-1*

9.3.6 Unit of Analysis

The unit of analysis is referral/investigation. Analysts chose referral, instead of family or household, as the unit of analysis since the outcome variables are timeline driven, i.e., defined by the investigation start date, which has a clearly defined timeline relationship relative to the outcome events of interest. Further, each investigation is an event that may result in a different outcome for the family.

Note: If CPS investigated a family multiple times through the period of analysis, analysts could potentially match a family with themselves. However, the risk of this self-matching happening has been lowered since the matching procedure accounts not just for family demographics, but also prior history and the allegations and maltreatment categories of each investigation.

9.3.7 The Procedure

The PSM procedure estimated the average marginal effect of In-Home Administration services as a treatment on the likelihood of (1) a referral, (2) a substantiated referral, and (3) a separation within a year of the originating investigation by accounting for confounding effects of the matching covariates. The unit of analysis is by referral. The procedure includes the following three steps:

1. Estimate the probability of receiving treatment based on the matching covariates.
2. Estimate the probability of the outcome based on the treatment usings weights captured in step 1.
3. Find the marginal effect (risk difference) of the treatment found in step 2 to estimate the average treatment effect on the treated (ATT).

Analysts conducted the data processing for the following steps in R, a statistical programming language.[28]

Step 1: Selecting the Matching Method

Analysts tested the following matching procedures to estimate the probability of receiving treatment based on the covariates.

1. 1:1 nearest neighbor with replacement using a logistic regression
2. Full matching using a logistic regression
3. Full matching using a logistic regression and a caliper of 0.2 standard deviations

[28] https://www.r-project.org/about.html

Balance statistics for methods 1-3 are in the *Technical Appendix, Section 9-1*. Methods 1-3 yielded adequate balance.[29] For all three methods, standardized mean differences for the covariates were below 0.1 after matching, except for two covariates. The imbalanced covariates are (1) the total number of previous investigations the family had and (2) the total number of previous separations the family has experienced. Since these covariates are imbalanced and are likely to be prognostically important variables, the two covariates are included in the outcome estimation regression in step 2 as terms interacted with the treatment variable to account for the imbalance.

Analysts reported the estimated marginal effects of treatment using both methods 1 and 2 in the subsequent step. Methods 2 and 3 achieved an approximately similar balance. Further, no units dropped because of the caliper in method 3. Given this similarity, analysts proceeded with method 2 and dropped method 3 before proceeding to step 2.

For method 2, full matching uses all treated and all control units, so no units were discarded by the matching. For method 1, 998 units matched out of the 3179 given in the original sample.

Step 2: Fitting Models for the Outcome Variables

Analysts fitted a set of logistic regression models for each of the three outcome measures. Each set considered the combination of the matching method, method 1 versus method 2, and whether the model included the interaction terms for the imbalanced covariates. This yielded four models per outcome measure for a total of twelve models across the three outcome measures. For all models, weights come from the matching method. Table 18 summarizes the variation between models.

Outcome Measure	Matching Method	Include Interaction Terms of Imbalanced Covariates?
Separation	Method 1	Yes
	Method 1	No
	Method 2	Yes
	Method 2	No
Referral	Method 1	Yes

[29] Balance statistics for Methods 1-3 are in the *Technical Appendix, Section 9-1*.

Outcome Measure	Matching Method	Include Interaction Terms of Imbalanced Covariates?
	Method 1	No
	Method 2	Yes
	Method 2	No
Substantiation	Method 1	Yes
	Method 1	No
	Method 2	Yes
	Method 2	No

Table 18 Fitted outcome model variation summary

Step 3: Calculating the Marginal Effect to Estimate ATT

For each model fitted in step 2, analysts used the comparisons function in the marginal effects package to perform g-computation in the matched sample to estimate the ATT. For models using matching method 2 (full matching), analysts used a cluster-robust variance to estimate standard error with matching stratum membership, i.e., membership in a subclass, as the clustering variable. For models using matching method 1 (1:1 nearest neighbor), analysts used robust variance to estimate standard error.

Findings

Analysts found a statistically significant difference for subsequent separations. This finding was robust across all models. Analysts controlled for the imbalanced covariates by including them as terms interacted with the treatment variable. The marginal effects were consistent when analysts used the nearest neighbor matching. Analysts reported the findings for all outcome measures in the *Technical Appendix, Section 9-3*.

Analysts also found a statistically significant difference for subsequent referrals. This finding was also robust across all models. Once we controlled for the imbalanced covariates by including them as terms interacted with the treatment variable, the point estimate stayed the same. The marginal effects were consistent when analysts used the nearest neighbor matching. Analysts reported the findings for all outcome measures in the *Technical Appendix, Section 9-3*.

Analysts did not conclude that there was a statistically significant difference between treatment and control groups for subsequent substantiations. Of the four models reported, only one model did not use the interaction terms. Given the imbalance for the covariates included in the interaction terms, analysts did not reject the null hypothesis.

In summary, the analysts took this evidence to support the inference stated at the beginning of the section that families participating in in-home services would likely experience a 15 percent reduced probability of separation within a year of the initial CPS involvement, all else being equal, and that families receiving in-home services were 10 percent more likely to experience a subsequent investigation.

9.4 A VIGNETTE: ILLUSTRATING A MATCH WITH A PROPENSITY SCORE MATCHING (PSM) MODEL

To illustrate the concept of a PSM model, this section highlights a single match composed of two families. One of the families is part of a treatment group and the other is part of a control group. CFSA matched the two families together by one of the PSM procedures. Table 19 shows the how the matched families compare.

Note that this vignette is presented only for the purpose of illustration. A single match neither constitutes an adequate substitute for analyzing the full population nor for comparing the results of several matching models. Rather, the vignette is intended to build intuition for how the matching procedure plays out. Not all matching variables are included here, e.g., the details of the maltreatment categories. This decision is in part for concision and in part to limit the amount of personally identifiable information published.

Variable	Family 1 (Treatment Group)	Family 2 (Control Group)
Treatment		
Did the investigation result in an in-home case?	Yes	No
Investigation Details		
Response Priority	Within 24 hours	Within 24 hours
Risk Level	High	High
Investigation Disposition	Substantiated	Substantiated
Allegations	Abuse, Neglect	Abuse, Neglect
Substantiated Allegations	Neglect	Neglect

Variable	Family 1 (Treatment Group)	Family 2 (Control Group)
Danger and Safety Assessment Decision	Safe	Safe
Family Demographics		
Number of children in the family	3	2
Ward	Ward 8	Ward 8
Family Race	Black or African American	Black or African American
CFSA Involvement		
Total Number of Investigations	4	3
All time child separation count	2	2
Outcome Variables		
Referral within a year	No	Yes
Substantiated within a year	No	Yes
Separation within a year	No	Yes

Table 19 A comparison vignette selected to illustrate propensity score matching