Office of Planning, Policy & Program Support
Quality Assurance Administration




2008

Quality Service Reviews

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Contents

1. Introduction

The Child and Family Services Agency (CFSA) is committed to providing quality care to the children and families it serves in the District of Columbia. To enhance case practice and system performance, we have fully instituted a Quality Service Review (QSR) process to gather data and provide feedback about individual child welfare cases and the system as a whole. CFSA began using this best practice in October 2003, in partnership with the Center for the Study of Social Policy (CSSP), to supplement ongoing collection and assessment of quantitative data. The QSR examines case practice, systems, and outcomes for individual children and families to identify strengths and areas that need improvement. Together, quantitative and qualitative data provide a deeper understanding of family dynamics and needs and of service delivery system performance. While the QSR does not include a large enough sample to generalize findings to the entire population of children and youth in the District's child welfare system, it does provide a snapshot of what is working and not working for those in the sample.

Quality Service Reviews are an essential component of CFSA's continuous quality improvement (CQI) approach to sustaining best practices and a high performing service delivery system. CFSA and community partners have developed In-Home and Out-of-Home Practice Models, which outline values and guiding principles in effective practice and service delivery. The practice models offer solid strategies for deepening the quality of case practice. CFSA purposefully aligned tenets of the Practice Models with QSR indicators. Following a series of semi-annual QSRs beginning in 2005, we shifted the process in 2007 to a unit-based review of CFSA cases and an annual review of private agency cases. The unit-based approach increases opportunities for peer networking and for staff to receive coaching in applying the QSR and CFSA Practice Model protocols on the job. In the future, we plan to expand this unit-based approach to private agencies with child welfare case management responsibilities.

The QSR process involves social workers in providing background information on each case in the sample. Pairs of reviewers go through each case record for background information, which allows them to assess how social workers use written assessments and evaluative information in case planning and decision-making. Reviewers interview as many stakeholders as possible, beginning with the social worker and including the child, birth parents, caregivers, guardian *ad litem*, family members, school staff, service providers, and others. Reviewers then rate a series of indicators that assess the status of the child, parent/caregiver, and system. Next, they conduct a debriefing with the social worker and supervisor to share strengths, challenges, and recommended next steps regarding the case. For each case in the sample, reviewers write a narrative or "case story" that highlights effective case practices and areas in need of improvement.

We randomly select cases to include in the QSR. For unit-based QSRs, we chose one case per social worker in a unit, with each unit having two to five social workers. The case review process is the same as for unit-based and larger QSRs, with one notable addition at the unit level. For each case reviewed, QSR specialists developed specific next steps collaboratively with the social worker. Two months after the review, QSR specialists returned to evaluate whether or not social workers implemented these steps and whether they improved the status of the case.

In 2008, CFSA reviewed a total of 62 cases using the QSR process: 35 CFSA cases from nine units using the unit-based process and 27 cases from 10 of the 18 private agencies throughout the year. Reviewers completed over 450 interviews, with an average of seven interviews per case. Trained reviewers from CFSA, CSSP, the Consortium for Child Welfare, CFSA Citizen Review Panel, and experienced consultants from other states came together to conduct the QSRs. Quantitative data, case stories, and identities of individual reviewers appear in the appendices.

Sample

QSR specialists selected the nine units for the unit-based QSRs at random. QSR specialists reviewed 18 cases in the sample in conjunction with the District's Department of Mental Health (DMH) during their annual Dixon Community Service Reviews (CSR) in March 2008. That review looks at children and youth receiving mental health services. The Department of Mental Health selected the sample which included open child welfare cases. We randomly selected all other cases reviewed, whether CFSA or private agency, from the caseload of each social worker in the targeted units or agencies. We reviewed one or two cases from each private agency, with one exception. In one agency, which managed a larger proportion of CFSA cases than the others, we reviewed nine cases.

Table 1: Characteristics of QSR Sample

Case Management Responsibility	CFSA	35	
	Private provider	27	
Length of Time Case Open	0-2 years	26	
	3-5 years	15	
	6-8 years	10	
	9-18 years	11	
Placement Setting	Specialized Foster Home	10	
	Traditional Foster Home	10	
	Kinship Foster Home	9*	
	In-home	4	
	Residential Treatment Facility	1	
	Independent Living Program	4**	
	Pre-adoptive home	11***	
	Group Home	4****	
	Dept of Youth Rehabilitative Services	2	
	Medically Fragile	1	
	Abscondance	1	
	Protective Supervision	5	
Permanency Goal	APPLA	14	
	Adoption	19	
	Guardianship	7	
	Reunification	18	
	In-home	4	
Age/Gender	Age	Male	Female
	0-5	2	10
	6-10	13	3
	11-15	6	7
	16-20	11	10

*Includes one specialized kinship foster home
**Includes two teen mothers in Independent Living Programs
***Includes two kinship homes and five specialized homes
**** Includes one specialized group home

Children and youth involved in these cases ranged in age from one to 20 years. Their cases had been open from three months to 18 years. Average time in care was 4.3 years. Median time in care was 4.8 years. Table 1 provides details about the sample.

QSR Protocol

In the fall of 2004, national experts from Human Systems and Outcomes, Inc. facilitated meetings to tailor a QSR protocol specifically for the District's child welfare system. Representatives from all areas of CFSA, the Healthy Families/Thriving Communities Collaboratives, Consortium for Child Welfare, Foster and Adoptive Parent Advocacy Center (FAPAC), and DC Kids (Children's National Medical Center) participated in the

development process. Since then, CFSA has further refined the protocol to conduct focused QSRs that looked at in-home cases and cases involving teens.

Protocol Structure

The QSR protocol has three sections: **Child Status**, **Parent/Caregiver Status**, and **System Status**. Table 2 lists indicators for each section. For Child Status, reviewers examined the situation of the child within the past 30 days for the indicators shown.

Parent/Caregiver Status has four indicators. Reviewers rate parents only if they have an in-home case or the child's goal is reunification. Caregivers include foster and kinship parents and staff of group homes, independent living programs (ILPs), and residential treatment centers (RTCs).

Table 2: QSR Indicators by Section

Child Status Indicators	
• Safety	• Emotional/behavioral well being
• Stability	• Academic status
• Permanence	• Responsible behavior
• Health/physical well being	• Life skills development
Parent/Caregiver Status Indicators	
• Physical support of the child	• Participation in decisions
• Emotional support of the child	• Progress toward safe case closure
System Status Indicators	
Practice Performance Indicators	Attributes and Conditions of Practice
• Engagement	• Tracking and adjustment
• Coordination and leadership	• Pathway to safe case closure
• Team formation/functioning	• Maintaining family connections
• Assessment and understanding	• Family Court interface
• Case planning process	• Medication management
• Implementation	• Informal family support/connections

The multiple indicators of System Status assess overall child welfare system performance based on a specific practice framework. This framework was the basis for CFSA's original Practice Model and is reflected in even greater detail in the more recent In-Home and Out-of Home Practice Protocols. The system includes all people working with the child and family, such as child welfare staff, school staff, service providers, and legal personnel.

Collectively, these three sets of indicators allow reviewers to thoroughly assess functioning of the child welfare system as represented by the cases reviewed and to identify what is working and areas in need of improvement in serving children and their parents and caregivers.

Protocol Scoring

Reviewers score indicators based on a six-point scale. Table 3 presents the "QSR Interpretive Guide for Child Status" as an example. The scale runs from **1—adverse** status—to **6—optimal** status. After scoring, the protocol provides two options for viewing findings:

- By **zones**—**Improvement**, **Refinement**, or **Maintenance**—or
- By **status**—**Acceptable** or **Unacceptable**.

We used status as the basis for analyzing data from QSRs in 2008. Appendix A provides charts for each indicator according to both zones and status.

The QSR is a qualitative tool, and the review sample is not representative, making it impossible to generalize findings. Findings do offer insights into ways to improve practice, however. Information in the case stories is the primary source for areas we identified as strengths and challenges.

Table 3: Example of QSR Scoring Protocol

QSR Interpretive Guide for Child Status

Zones	*Scoring*	*Status*
MAINTENANCE Status is favorable. Maintain and build on a positive situation.	6 = OPTIMAL Best or most favorable status for this child in this area (taking age and ability into account). Child is doing great! Confidence is high that long-term goals or expectations will be met.	**ACCEPTABLE**
	5 = GOOD Substantially and dependably positive status for the child in this area, with an ongoing positive pattern. This status level is consistent with attainment of goals in this area. Situation is "looking good" and likely to continue.	
REFINEMENT Status is minimal or marginal, possibly unstable. Make efforts to refine situation.	4 = FAIR Status is minimally or temporarily sufficient for child to meet short-term goals in this area. Status is minimally acceptable at this time but may be short term due to changes in circumstances, requiring adjustments soon.	
	3 = MARGINAL Status is marginal/mixed, not quite sufficient to meet the child's short-term objectives now in this area. Not quite enough for the child to be successful. Risks may be uncertain.	**UNACCEPTABLE**
IMPROVEMENT Status is problematic or risky. Act immediately to improve situation.	2 = POOR Status has been and continues to be poor and unacceptable. Child seems to be "stuck" or "lost" and is not improving. Risks may be mild to moderate.	
	1 = ADVERSE Child status in this area is poor and getting worse. Risks of harm, restrictions, exclusion, regression, and/or other adverse outcomes are substantial and increasing.	

DMH CSR and CFSA QSR

In March 2008, CFSA partnered with DC Department of Mental Health (DMH) to conduct their annual Dixon Community Service Review (CSR) of Children and Youth. The *Dixon* Plan requires DMH to measure itself in key performance areas and to "have an ongoing measurement of system performance." DMH uses CSRs to measure District progress toward achieving the target for system performance established in the *Dixon* Plan[1]. DMH uses contracted reviewers, internal staff, and local partners to conduct their CSRs. The QSR Unit and other CFSA QSR-

[1] For more information on the *Dixon* Plan, go to http://dmh.dc.gov/dmh/cwp/view,a,3,q,639222,dmhNav,|31262|.asp

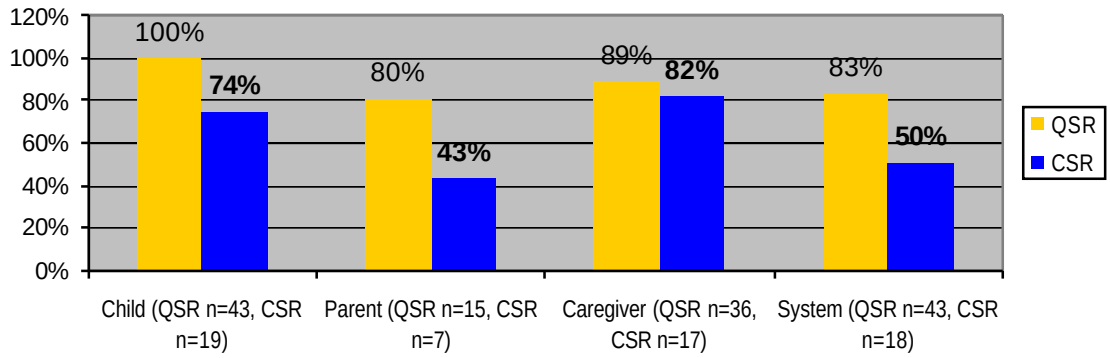
trained staff and reviewers co-reviewed 18 CSR cases, where children and youth had an open child welfare case and concurrently received mental health services through DMH. These cases are included in this year's QSR sample.

The CSR and QSR have some similarities and some significant differences. Both reviews look at a sample of the population receiving services, and both use a review instrument to rate indicators on a six-point scale. When reviewers conducted QSRs of CFSA cases during the CSR, they completed both the QSR and CSR tools. A significant difference between the two reviews is that the CSR has a mental health focus while the QSR focuses on child welfare.

In addition, differences exist between the actual review processes. The CSR is a one-day review, which limits the number of interviews reviewers can conduct, in comparison to the two-day QSR reviews. Interviews are also limited mostly to DMH providers and do not include outside sources normally invited to participate in the QSR, such as attorneys. DMH selected cases and scheduled interviews for the CSR, while CFSA selected cases and scheduled interviews for the QSR.

These disparities in the process are worth noting in light of significant differences in results of the two reviews (Figure A). Caregiver status was similarly high for both QSR and CSR cases. However, disparities in numbers of cases with acceptable child, parent, and system status between the two reviews are quite marked.

Figure A: Acceptable Overall Status

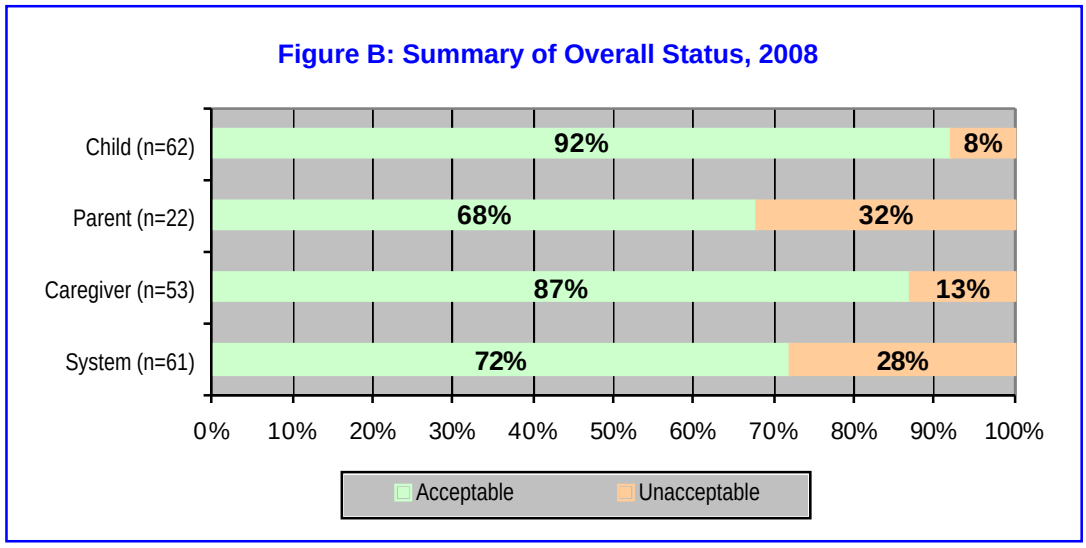


Reasons for the lower rating of the CSR cases is these areas are unclear, and given the small number of cases involved, we are unable to offer a conclusive explanation. It is possible that the DMH cases may have been more complicated or differences in the processes may have contributed to the significant disparities in child, parent, and system status. Because reviewers relied on fewer interviews and did not have information from all relevant parties, they may have rated indicators lower than if they had had a fuller picture of the team's activities, especially regarding the child welfare cases. However, it is also possible that when children and youth are involved in both the child welfare and mental health systems, their multiple service providers may not work as cohesively as do teams from either organization alone.

As the partnership between CFSA and DMH forges ahead, the plan is for CSR reviews to become more similar to the QSR reviews, where the review process is two days and interviews are more diverse.

Summary of 2008 QSR Results

Figure B summarizes overall findings about child, parent, caregiver, and system status for the 62 cases we reviewed in 2008. Charts with data for each indicator appear in Appendix A.



Overall, children's status was rated acceptable in 92% of cases. Highest-rated child status indicator was health and physical well being at 97% acceptable. Stability in the home was the lowest indicator at 65% acceptable. Emotional/behavioral well being in the home was 84% acceptable, indicating that overall, children were doing well behaviorally in their placements. Permanency prospects were rated acceptable in 69% of the cases reviewed.

Parent status was rated for children involved in an in-home case or with a goal of reunification. If parents were involved but the goal was not reunification, reviewers described their participation in the case story but did not rate it quantitatively. Eight children reviewed were living with a parent (one child lived with both parents), three in in-home cases and five under protective supervision. Eighteen others had a goal of reunification. The low number of parents rated makes it difficult to draw conclusions or identify trends. Lack of consistent effort to involve parents, specifically fathers, is a systemic challenge discussed later in this report.

Out of home caregivers of all kinds, including foster parents, kinship parents, and congregate care staff, received high ratings. Details appear in the Strengths section of this report.

System indicators with the highest aggregate ratings included assessment and understanding of the child (acceptable in 77% of cases), engagement of the child (acceptable in 73% of cases), and implementation of services for the child (acceptable 72% of cases). Lowest-rated indicators were

engagement, understanding of and implementation of services for the father (acceptable in 26%, 29%, and 23% of cases respectively). These findings are discussed in more detail in section 2. The pathway to safe case closure system indicator (acceptable 70% of cases) correlates with the pathway to safe case closure indicator for caregiver status (acceptable in 68% of cases) and the permanency prospects child status indicator (acceptable in 69% of cases).

QSR Scores Over Time

While previous QSRs are not completely analogous to the 2008 QSRs, it is still worthwhile to look at trends in overall status. The Fall 2005 QSR (40 cases) was a broad review of cases throughout the agency. In Spring 2006, the QSR Unit reviewed 40 in-home cases, and in Fall 2006, we looked at 25 cases involving teens. In 2007 (76 cases) and 2008 (62 cases), we reviewed CFSA cases with a mix of permanency goals as well as private-agency cases. As Figures C and D show, child status has improved significantly. System status improved, then plateaued. Parent status continued to climb, while caregiver status remained virtually flat from 2007 to 2008.

Figure C: Historical Comparison of Child and System Status

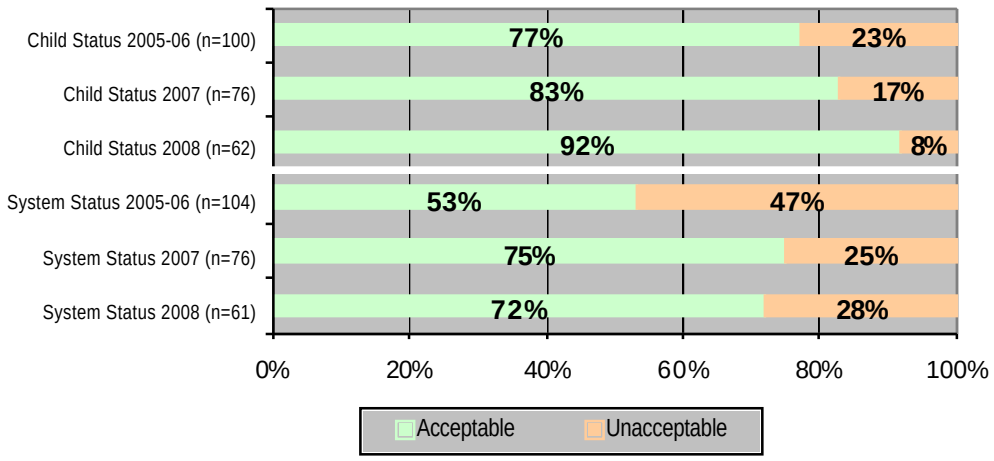
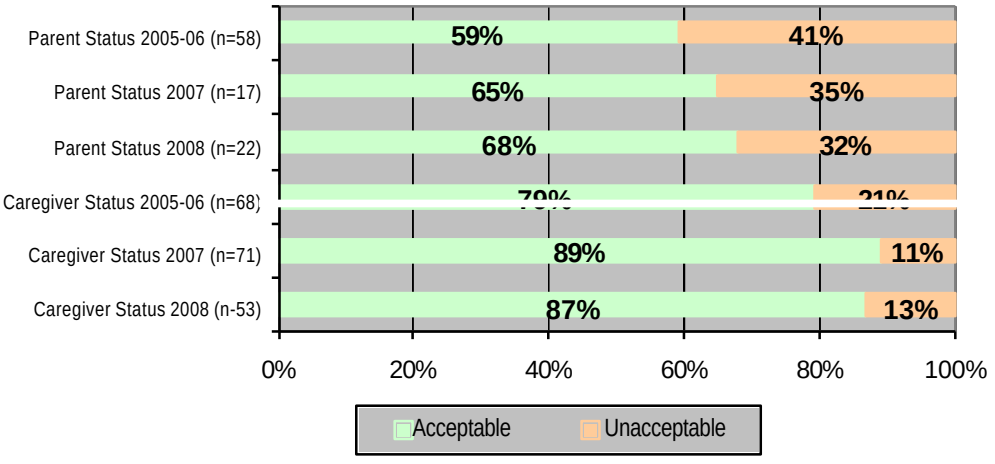


Figure D: Historical Comparison of Parent and Caregiver Status



2. Findings

Quantitative data from the indicators were used to identify areas for deeper analysis. Case story examples generally illustrate specific strengths or challenges. The sections that follow highlight some of these trends. Selected highly-rated indicators are described in more detail in the Strengths section; similarly, a sample of low-rated indicators is described in the Challenges section. Areas identified as strengths were not rated as acceptable in 100% of cases, nor were challenges rated as unacceptable in every case. In fact, *the areas described as challenges were rated acceptable in most cases*, but the percentage of acceptably-rated cases was lower than other indicators. These issues were highlighted because they illustrate specific areas of needed practice change identified in the QSRs.

Strengths

Health/Physical Well Being

Acceptable
97%
Unacceptable
3%

Ratings for this child status indicator continued to increase in 2008. Children were receiving timely and appropriate medical and dental services, yielding a finding of 97% acceptable cases, nearly one hundred percent. This indicator correlates with high ratings for system indicators in the assessment and implementation of services for children. Social workers have a good understanding of children's health needs and are ensuring that children are linked to adequate medical service providers.

This was demonstrated specifically in two cases where each child was considered medically fragile. In Case #4, where the child was residing in a 24-hour medical facility, reviewers reported her medical care as a strength:

> *The focus child's stability at this facility and the care that she receives there are major strengths in this case, especially considering her high level of medical care needs. All parties reported that there have been no concerns related to safety or well-being for this little girl and that the staff is providing quality services to her.*

Likewise in Case #33, the baby became known to the agency after he was admitted to the ICU at Children's Hospital. At the time of the review, he had been at home for five months with his parents under protective supervision:

> *Medically and developmentally, team members consider this child extremely resilient as he has made a remarkable recovery from his extensive injuries. He is considered active and engaging with his parents and others. He receives weekly occupational and physical therapy due to difficulties with fine and gross motor skills development.*

Social workers and caregivers were on target with ensuring that the children's health care needs were being met. The child in Case #9 was reported to be current with medical, vision, and dental

evaluations; furthermore, the child was scheduled for her six-month dental evaluation during the month of the QSR.

Safety of the Child: Home

Acceptable
92%
Unacceptable
8%

Safety is paramount to the wellbeing of children and was rated acceptable in 92% of cases reviewed. Children were safe in their living situation and were residing with reliable and competent caregivers. All known risk to the children's physical safety and others in the child's daily setting seems to be adequately managed by both parents and caregivers.

In Case #18:

> *[T]he focus child has made immense behavioral progress over the past year. Problems reported by previous foster parents have not come up in the current home. The child is not violent towards himself or others, as he had been in the past.*

The youth in Case #36, was placed in a very structured group home, where his safety was no longer of concern to team members, unlike his other placements:

> *Reportedly, the youth seems to be adjusting well and since his placement two months ago; there have been no concerns regarding his safety at home or at school. According to everyone interviewed, the youth is the safest he has been in the past two months.*

There was a situation in Case #29 where the foster parents were successful in maintaining safety in the home for two brothers despite the tendency of the older brother to beat the younger one. To ensure the youth's safety, the foster parents had to make a difficult decision.

> *Even with the safety concern with the older brother, they had requested assistance in enhancing safety and ultimately requested the older youth's removal from the home. They attempt to keep the boys separated and monitored as much as possible.*

Emotional/Behavioral Well Being: Home

Acceptable
84%
Unacceptable
16%

Emotional and behavioral well being were acceptable in 84% of cases reviewed, which was a 5% increase from the 2007 review. Many children had DSM diagnoses and were receiving services to meet their mental health needs. Of the 62 cases reviewed, 26 children/youth were known to DMH, of which 17 were receiving therapy.

Following are examples of children and youth who were doing well in this area.

> *The focus child participates in play therapy and seems to be progressing well. Reportedly, he was very depressed during the period that his mother was not consistent with visitation and he rarely saw her. For the past two months his emotional stability seems to have improved significantly, as he now spends a lot*

of time with his mother. The child has unsupervised weekend visits with his mother, sees her on a regular basis, and enjoys doing special activities with her. (Case #35)

The focus youth has numerous medical conditions, ranging from genetic, to congenital, to contracted. He also has a mental health diagnosis of Conduct Disorder (by history) and is mentally retarded, with an IQ of 64. Overall, the youth has reportedly made progress on his anger management skills since he came to the group home, and he can describe what coping skills he has learned from his therapist, namely to take himself out of a situation that is making him angry. (Case #11

The focus child is residing in a stable and safe placement, and she has an excellent relationship with her foster parent and refers to her as "ma." She attributes her success to her foster mother, indicating "she helped get me stable and this is where I want to be." Prior to moving into her current placement, the focus child had a history of absconding frequently for long periods of time. (Case #56)

Caregivers

Acceptable **89%**
Unacceptable **11%**

Caregivers of all kinds, including kinship parents, foster parents, and congregate caregivers, were doing an excellent job of meeting children's needs. Following are examples of quality support a variety of caregivers were providing to children and youth.

The foster mother was described as being the epitome of a therapeutic foster care placement. She has remained committed to caring for the focus child and his brother. She is able to keep up with necessary appointments, meetings and follow-ups that are needed She has a strong bond and relationship with the focus child and his brother as well as the birth mother. (Case #21)

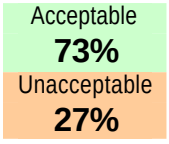
The foster mother is very involved with the focus child and is a strong advocate for the achievement of her goals. The foster mother's advocacy was demonstrated through her tenacity and determination to ensure the focus child graduated from high school. She encouraged the focus child to attend day/night school and closely supported and cheered her through graduation. The focus child gave a special acknowledgement to her foster mother by writing a thank-you letter in the graduation book. (Case #56)

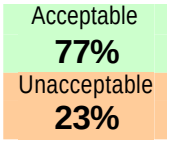
In Case #55, the pre-adoptive family (who was Caucasian) took the necessary steps to ensure that the child remained connected to his African American culture:

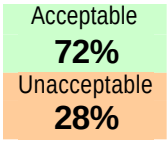
The pre-adoptive mother has made a conscious effort . . . to switch to a church that had more African-American members. His current therapist is Caucasian, and the pre-adoptive mother and some other interviewees felt the focus child could benefit from having an African-American therapist. The pre-adoptive

mother appears to be very observant and has a keen understanding of the focus child's needs and has proven to be resourceful For example, she researched and identified a new therapist on her own.

Engagement, Assessment/Understanding, and Implementation: Child







Engagement, assessment and understanding, and implementation services for the child received some of the highest ratings for system indicators. Social workers and other team members were using formal and informal assessments to identify needs and were implementing appropriate services or making appropriate adjustments to case plans. Many children and youth were connected to and were receiving the appropriate services to address their individual needs in the areas of physical and mental health, education, and mentoring.

Case #11, exemplifies a team that had a clear assessment and understanding of the youth to ensure that his needs were being met and that he was receiving the appropriate services:

The youth has numerous health conditions that are being monitored by the staff at his group home. He sees a number of specialists on a regular basis and takes many medications. He has not had any hospitalizations, and he is reportedly compliant with his medications. The case manager worked diligently to ensure the youth was seen by the numerous appropriate doctors to get new prescriptions for his medications when they began to run out. He was assisted in this challenging endeavor by one of CFSA's nurses. The youth will likely move from the group home to a residence run by Rehabilitative Services when he turns 21. Interviewees were not confident that this youth can take care of his own needs, especially regarding his medication, and live on his own without assistance.

In Case #36:

All parties involve in the youth's case share similar concern that if the youth leaves his current structured setting, he may return to his old habits. The youth has a history of non-compliance and involvement in illegal activities and risky behaviors, which caused him to have a juvenile case. However, since coming to his current placement, he has been demonstrating more responsible behavior. Everyone attributes the youth's good behavior to the type of placement.

Case #50 demonstrated the effectiveness of engaging youth in the case planning process and allowing them to be an integral part of the team:

Engagement of the youth in this case is a strength. The youth is invited to court. She attends all school meetings and meetings with her social worker. She also actively worked with her CBI therapist for three months. She has been asked her thoughts on permanency and reported that while she would like to return to her mother's care, she understands her need to remain with her cousin.

Family Connections

Acceptable **77%**
Unacceptable **23%**

This indicator describes the system's capacity for keeping children and youth in foster care involved with their biological parents, siblings, and extended family. The indicator for maintaining family connections was acceptable in 71% of cases reviewed in 2005-2006, dropped by 9% in the 2007 QSRs, and has increased to one of the highest system indicators for 2008 at 77%. Children and youth have been linked to family members and continue to maintain supportive relationships with them while in care.

This was also noted in adoption cases, where so often, children/youth lose connection with their biological families. The adoptive father in Case #54 understood the value of the youth's birth family and wanted the youth to maintain this connection:

> *The adoptive father sees the value of maintaining family connections for the youth. He has agreed to maintain written contact with the birth parents through a post office box. He has agreed to send pictures and updates about the children. He encourages the youth to have telephone contact with a younger sister who was also adopted. He works with that child's adoptive parent in order to maintain visitation between the children, especially around birthdays and holidays. Additionally, the adoptive father has expressed a willingness to maintain occasional face-to-face contact among the youth, his mother, and the three siblings who reside with her. He will supervise visitation as appropriate.*

In Case #28, where the youth was residing in a group home, the private agency not only ensured that the youth was maintaining connections with her family but also hosted events that would bring families together:

> *The youth has been maintaining regular contact with extended maternal family members and her siblings. Supervised family visits are held on a bi-weekly basis. The youth has infrequent visits with her mother; visits are usually scheduled with the mother once per month. The private agency that manages the youth's case also schedules events that the entire family is invited to participate in (i.e., holiday dinners).*

Another example of positive family connections can be seen in Case #60. This 16-year-old girl is the oldest of five children. She has one younger sister also in foster care, as well as three siblings who have been adopted. It was reported that this young lady was not placed with her siblings for a variety of reasons, including "incompatible behaviors," yet she "continues to have contact with her biological siblings, a connection that appears to be important to her. The foster family is supportive of her contacts with her siblings and other extended family members, which have persisted even though three of her siblings are adopted."

Post Permanency Supports

Acceptable **75%**
Unacceptable **25%**

This indicator describes the degree to which the system is purposefully connecting families and older youth to informal supports that will assist them in maintaining safety, well being, and independence once the child welfare case is closed. Among post-permanency supports are the Collaboratives, mental health service providers,

places of worship, extended family members, food banks, and housing assistance.

This indicator applied to youth has reached age 20 and to in-home cases or cases in which the child is living in what is likely to be a permanent home (i.e., protective supervision or with a guardian or pre-adoptive parent). This indicator was rated for 21 of the 62 cases reviewed. A rating of four or higher was given to 15 (75%) of the cases.

In Case #9, reviewers noted that the caregiver was linked to numerous informal support systems that would extend after permanence to support the child and family:

> *The caregiver appears to have a wealth of informal supports and community connections in her life that support her in parenting the focus child. She expressed that she has a very strong, supportive church family, a good supply of friends, and extended family even though they are mostly out-of-state. She feels that the school and the psychiatrist are also supportive of her and the child.*

In Case #53, the 19-year-old-youth was linked to a number of services both formal and informal:

> *The youth and his twin will likely achieve permanence within a year. He has strong community supports in his church, which will continue to support him once permanence is achieved. . . . The formal supports involved with the youth include a mentor and a tutor, in addition to the CSW and the social worker. Additional formal supports are likely available to him through the University of the District of Columbia where he is in school. This constellation of supports, including his foster parents and church community, has obviously achieved impressive results with the youth. The array of services pulled together for the youth has been successful in supporting him towards the successful outcomes being achieved.*

In Case #54, the social worker ensured that the adoptive parent was aware of and linked to post-permanency supports before closing the case to ensure that the family had the support they need:

> *Post-permanency supports were put into place. The social worker is still working with the family regarding several issues in order to have all items dealt with prior to closing the case. The adoptive parent indicated that he has an extensive support network of friends and family. He is able to identify community resources on his own. He has been made aware of the post-permanency services provided by the agency and the agency's contracted post-permanency program.*

Challenges

Coordination and Leadership

Acceptable	Unacceptable
61%	**39%**

The first steps toward development of a successful team involve the social worker leading the team and communicating with the right people. The Coordination and Leadership indicator assesses the social worker's regularity in communication and coordination and leadership in the decision-making process with all parties,

including the child/youth, birth family, caregivers, and service providers. In addition, it assesses the worker's effective coordination and continuity in assessment, planning, organization, and provision of services to the child and family. In only 61 percent of the cases reviewed, the social worker was achieving this standard at an acceptable level.

Examples of unsatisfactory coordination and leadership can be seen in Cases #48 and #22. In the first case, it was reported that the social worker was assigned the case in November, but went on extended leave in February. She did not return until the end of May. During her absence, no one else took the role of leader. While she appeared to have a relationship with the foster parent, communication and coordination with the rest of the team was very poor. One of the recommendations was, of course, for the social worker to increase communication amongst all the team members through both formal and information discussions [meetings]. In the second case (#22), the social worker, who had been on the case for approximately eight weeks, was the third worker assigned to this case within one year. The new worker had not been able to assert herself as the leader in this case, which allowed for disjointed teaming and case planning. In addition, no one was coordinating or leading the way towards safe case closure.

Another example of poor coordination and leadership can be seen in Case #13, involving a 16-year-old female residing with her maternal aunt in a kinship foster care placement. At the time of the review, the social worker had been on the case for approximately seven weeks and would temporarily be transferring the case to another worker the following week. In addition, the social worker was found to have not fully engaged the family and did not demonstrate a thorough knowledge of the case and its history. There was concern that lack of a steady leader and multiple case transfers would lead to loss of information regarding services and case planning. Most o f the next steps stem from the recommendation of convening a case planning meeting to discuss all areas of this case that need attention and planning. Without a consistent social worker, other team members will need to step up and take responsibility for ensuring various services/needs are met (including visitation with siblings, updated school information, attendance at the next Center of Keys for Life orientation, and obtaining a recent psychological evaluation and follow up on recommendations). In addition, someone (even if it is the temporary social worker or supervisor) will need to lead and coordinate all the different team members. Without a coordinator, important needs could fall through the cracks, leading to poorer outcomes for the youth.

Despite significant evidence of lack of coordination and leadership, we also found examples of quality work. For example, Case #3 highlights a social worker who was the case leader. In fact, two attorneys "complimented her on her clinical skills in terms of making appropriate decisions regarding this family." The focus child in this case is a two-year-old girl who resides in a 24-hour nursing facility. The social worker has been able to maintain contact with all the various team members, including medical professionals, the grandmother, and the birth mother who struggles with mental health and substance abuse issues. Due to the social worker's overall leadership, the case had effective coordination and continued assessment/implementation with the child and other family members.

Team Formation and Functioning

Acceptable	Unacceptable
52%	48%

Team formation and functioning assesses to what degree have the "right people" for the child/family formed a working team that meets, talks, and plans together to achieve the goal of case closure. It measures how well members of the services team collectively function as a united body in planning services and evaluating results. This indicator also measures the level of cohesive and effective teamwork and collaborative problem solving that benefits the child and family. This tenet is a common thread in CFSA's Practice Models aimed at strengthening the quality of case practice. According to CFSA's Case Practice Principles:

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

Data from the 2008 QSR show that only 52% of the cases had acceptable team formation and functioning. This is a change from the aggregate scores in 2007, when 61% of the cases were rated acceptable. A lack of positive teaming can negatively impact relationships, assessment, service delivery, and movement towards safe case closure. One example of this can be seen in Case #37, that of a 5-year-old girl in foster care. Reviewers saw no "real team assembled or operating," which significantly hampered case planning and implementation. Missing team members included the past and current foster parents and representatives from the mother's mental health and substance abuse treatment programs and the child's school and daycare. The current foster mother "was not provided with the children's information packets, did not have medication information, and her work schedule was not fully assessed prior to the placement of the children. This has led to the need for different respite care providers and minimal-to-nonexistent emotional support of the child and her sister."

In this same case, it was also felt that team members were not fully informed about how the case was progressing and could therefore not fully participate in problem solving. For example, there were concerns related to licensing the children's godmother and the focus child's grandmother due to criminal backgrounds. Reportedly, the social worker had "trouble determining the policy regarding Maryland licensing a foster parent with a criminal history, and other CFSA staff were not helpful in providing information to the social worker." This lack of teaming was a real problem as the godmother and other team members believed that the children would be placed with the godmother as soon as her probation ended. In addition, the grandmother, who was an alternative placement for the focus child, was also unaware of any barriers to her becoming licensed for placement.

Among the multiple next steps outlined in this case, it was agreed that the social worker would immediately update all team members by phone or email, especially the godmother and grandmother, of the status and barriers of licensing. A family team meeting was to be held within two weeks and should include a representative from the mother's treatment program to discuss permanency and placement plans should the perspective home not be licensed. The social worker was to meet with the mother within the next two weeks to reiterate the timeframes and outcomes involved in child welfare cases and the necessity for her to make immediate and intense efforts to

remediate issues of concern if she wishes to regain custody of her children. This meeting should be documented in writing. In addition, within 30 days after the QSR review, the social worker would contact the mother's mental health and substance abuse teams to ascertain the mother's status, participation, and progress. These team members should be consistently asked to participate in planning for this case.

In Case #47, reviewers found little evidence of a team: "[N]o one is meeting and talking to address issues that need to be discussed." The current GAL was new and did not have a well-rounded view of the child or his needs. In addition, there had been a succession of social workers involved in the case, and the latest social worker, who had been on the case for two months, was in the process of leaving that agency. Participants reported "the changes in social workers are sometimes disruptive to the case."

Another example (Case #61) found team formation and functioning were considered very poor due to there being "pods of team members who appear to be working against each other in order to accomplish their own agendas." Reviewers also found "clear biases against one another," especially towards the new social worker. Several team members who had been on the case for several years appeared to have an "I know what's best" attitude. Furthermore:

> *Team members expressed hesitancy and anxiety in sharing their real thoughts of the case. Team members give lip service to "working together," but their actions demonstrate otherwise, especially in court. This lack of unity in teaming negatively impacts case planning and implementation for the family, as they cannot agree on services, frequency, visitation, or placement.*

Recommendations for this case included continued attempts by the social worker to engage all team members and her documentation of conversations with team members through summary emails or letters. Social worker was also to continue to attempt to form a more efficient working team through face-to-face meetings and email chains, so that all team members could be kept in the loop regarding the children and the family.

While the system struggles with teaming, there is evidence of quality team formation and functioning occurring in cases. Case #56 is an example of this type of teaming. The focus youth is a 19-year-old young lady with the goal of APPLA who resides in a foster home. It was said that team members had a positive working relationship with the social worker, and everyone worked together to achieve identified goals:

> *Reportedly, the social worker has maintained contact with team members via telephone, and face-to-face meetings occur with the foster parents and focus child. It was evident that this team communicates fluently to obtain goals and ensure successful outcomes for the focus child. Subsequently, the communication, team functioning, and case planning efforts in this case have been beneficial to the success of this case.*

Case Planning Process

Acceptable **61%**
Unacceptable **39%**

CFSA's Practice Protocols incorporate many QSR system performance indicators including case planning. Fundamentals of case planning include assessing the individual strengths and needs of each child, developing comprehensive case plans that build on strengths and meets needs, and adjusting service strategies as the parties make—or fail to make—progress. In addition, planning consists of helping to build a safety net and a stable family infrastructure as the pathway to permanency. Youth and their families should be actively involved in case planning, and case plans should include time-limited, measurable outcomes that, when achieved, will lead to permanence and safe case closure.

Case planning is not merely writing a document but rather implementing a process of actively following a "roadmap for positive change." According to CFSA management reports, there is a 92% success rate for completing written case plans for children and 78% success rate for completing case plans for families, both of which are required agency benchmarks.[2] While that is a very positive step for the system, QSR results showed a disparity between written case plans and actual working case plans. The case planning process, which was rated as acceptable in only 61% of cases, was one of the lower-rated system indicators in the 2008 QSR. In addition, this rating has decreased from 2007's QSR rating of 75% acceptable. This decrease in case planning is evidence that moving beyond quantity to quality development and implementation of case plans continues to challenge the system.

Examples of inadequate overall case planning can be seen in several QSR case stories including Case #27, which tells the story of a 17-year old male, who at the time of the QSR had been in abscondance for over two months. It was thought that he was residing with his birth mother. While this young man's permanency goal was APPLA, it was reported that he had no desire to work towards this goal as he wanted to be reunited with his mother.

In this story, the social worker was unsuccessful in engaging the youth and his family. Reviewers felt that: "Because the youth's goal is APPLA, workers did not see the need to continue to reach out to the mother, and there was no attempt to engage the youth's father. The youth's permanency goal of APPLA is not realistic considering that the youth has such strong desire to be with his mother." The mother reported that she was "tired of the mixed messages she received from workers" and added that "each time a new worker came on board, the rules would change." In addition, the mother did not feel she was part of the case planning process and that plans were "developed without her input." An example of the mixed messages sent to the family was that the team made an agreement with the youth in court that if he attended school regularly, he would be able to spend the Christmas holiday with his mother. The youth complied. However, the day before the youth was to visit his mother's home for the holiday, the social worker denied his visit. The only explanation given was that the holiday period was too long for him to spend with his mother. This incident caused the youth to abscond to his mother's home.

The system implemented case planning in a very different direction for a 17-year-old bent on returning home to his mother. Because the youth was in abscondance, the system was in the process of placing the youth in a different foster home. Reviewers were concerned with this plan

[2] FACES management reports CMT 163 and CMT 164 as of December 31, 2008.

since the current foster mother and birth mother seemed to have established a working relationship: "Instead of relocating the youth, agency could have explored some creative options with the foster mother in regard to overnight visits with the mother to alleviate the abscondance issue." Furthermore, no one seemed to understand the importance of his mother to this youth. It was felt that the workers' failures to involve the mother together with the youth in case planning would continue to affect their ability to move the case towards safe case closure. Next steps included the need for the social worker to coordinate a team meeting (including the birth parents) to address the youth's permanency goal of APPLA and his abscondances.

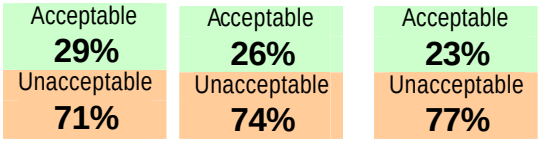
Case #15 demonstrated significant case planning problems, especially around reunification. Reviewers found that "while everyone is on the same page with the children returning to their mother's care, team members were unaware of what other members were planning." There was no evidence that timeframes for reunification were planned or agreed upon. For example, one professional stated, "I think it should be some time in July maybe, but the mother probably thinks it will be the day after she gets a new house. I'm not sure how she would feel about the children not returning until this summer." The mother, on the other hand, was planning for the children to return to her care the day after school ended for the year.

Other planning issues were apparent in this case. Two team members outlined a list of things the mother needed to accomplish before the children returned to her home. These included "additional parenting support and hands-on education around establishing structure, maintaining a clean home, and managing the behaviors of all her children at once." None of these concerns was addressed with the mother or stepfather, nor were they outlined in the treatment or case plans, nor had "any steps been taken to identify the appropriate service to address these needs." Recommended next steps included: convene a full team meeting within 30 days to document a written time frame for reunification with contingency plans should the mother have trouble obtaining her new home; provide the mother with a copy of this written plan; professionals will discuss with the mother their concerns related to her need for additional hands-on parenting skill training and AD/HD education; and assess the need for additional services and complete a plan of action.

Although case planning is a continuing challenge for CFSA, examples of quality case planning were evident. Case #21, that of a 9-year-old boy residing in a therapeutic foster care placement, highlights quality case planning as illustrated by the social worker's communication with all team members, follow through with necessary referrals, and ensuring that the birth mother participated in critical meetings regarding her child. The social worker was found to have been able to "pinpoint specific behaviors and risk factors that must be addressed to move the case towards safe case closure." Reviewers felt that:

> *Critical team members, the social worker, birth mother and foster mother, were able to verbalize a detailed plan that outlines steps toward reunification, including timeframes for increased visitation and specific services to be implemented to support the family, such as family therapy.*

Engagement, Assessment/Understanding, and Implementation: Father



In June 2007, the Children's Bureau in the Administration for Children and Families of the U.S. Department of Health and Human Services conducted CFSA's second Child and Family Services Review (CFSR). Federal reviewers indicated that one of the challenges CFSA faced was engagement of fathers. As a result of the CFSR findings, engagement of fathers became a key areas identified in the District's Program Improvement Plan (PIP). However, the 2008 QSR findings indicated that engaging fathers remains a challenge for social workers. Fathers were alive and had intact rights in 51 of the cases reviewed, but only 14 cases had evidence of father involvement and visits.

Fathers' information was known in five cases, but there was no evidence of CFSA engaging the fathers in the case planning process. In Case #50:

> *The engagement of the birth father is poor, even by his own attorney. The father indicated that he had not been contacted by any child welfare social worker in years, and he had questions related to his daughter's care and well-being. The social worker encouraged the father's attorney to maintain contact with his client, but the child welfare system did not engage him to explain what was happening around the guardianship and answer any questions that could have made him feel comfortable with consenting to the guardianship. This has led to not being able to complete an assessment of the father, even though he has weekly contact with the youth.*

Similarly, there were instances where social workers failed to engage fathers who wanted to become involved with the case. Case #21 demonstrates this problem: "While the birth father has reached out to the social worker to resume visits, she had not responded to him at the time of the review." Likewise in Case #12:

> *The birth father is not being engaged by the system and has not been a party to planning for the youth even though the youth maintains contact with his father. As previously stated, he was able to acknowledge his historical shortcomings in providing for his son, yet he would like to be a support for him. He expressed a desire to participate in planning for the youth and appeared honest about his own time/work limitations in being a member of the team. The agency has not reached out to the father in terms of valuing him as the youth's father and as a connection the youth wishes to maintain.*

When fathers are engaged in the case planning process, it can provide social workers with additional resources for permanency planning and important support for children and youth in care. Case #28 provides an example:

> *In the beginning of the case it was documented that the youth's father had showed interest in the children; however, reviewers only observed two attempts to contact the father, one by phone and the other via mail. Three and half years later, there*

was no evidence to indicate that anyone made attempts to locate the father since those initial efforts. There was also information regarding a paternal aunt, but it was unclear as to what happen regarding her being a potential resource.

In other instances, children and youth were residing with not only their father, but also with extended paternal relatives. In Case #10, the child was residing with her father under protective supervision. The child was residing with her paternal aunt in Case #9, and in another case (#42), the goal was reunification with the father with a concurrent plan of guardianship with paternal aunt. Reviewers noted that in Case #62, the paternal grandfather was identified as a very important person in the child's life, one who maintains regular contact and is seen as an excellent male role model.

Since the CFSR in 2007, the 2008 QSR data have indicated that the agency has not made any significant improvement in working with fathers. The overall system status for fathers was rated 74% unacceptable and 26% acceptable for the 2008 QSR. It seems the lack of effort to involve fathers remains a systemic challenge for the agency, which ultimately can impact the agency's ability to achieve permanence in a timely manner.

3. Permanence and Case Outcomes

Analysis of Pathway to Safe Case Closure

All children served by CFSA deserve a safe, secure, appropriate, and permanent home. The QSR Pathway to Safe Case Closure indicator assesses to what degree is there a clear, achievable case goal, is the team aware of this goal, and is the team making progress to achieve this goal. Of the 62 cases reviewed, there were 18 cases rated in the unacceptable zone and 43 cases rated in the acceptable zone for this indicator. An analysis was conducted to compare the differences between cases rated acceptable and unacceptable for this indictor, specifically, what other indicators were impacted by the Pathway to Safe Case Closure rating.

When comparing cases rated acceptable and unacceptable for Pathway to Safe Case Closure, data show that the lower rated cases also had significantly lower scores in coordination and leadership, team formation and functioning, assessment and understanding of the child, and case planning. Cases #16 and 19 illustrate how a lack of case planning negatively affected permanence. In the first case, an in-home guardianship case, there was no functional team and a new social worker. Team members disagreed with services and the possible need for residential treatment for the 14-year-old youth, who was in a psychiatric hospital at the time of the review. It was noted that "While service providers and family members have met at various points throughout the case, they have not been able to create a case plan that everyone is implementing, nor have they set requirements for case closure." Among the multiple next steps identified for this case, it was important that team members plan for the youth's next placement regardless of where that may be. The team was to work with the caregiver to keep the youth supervised and safe while the decision regarding a residential placement was being made. In addition, the youth was to be engaged to find out what she wanted, what motivated her, and how she could be supported. Additional family members, including the birth father and others living in the home, were to be engaged in the case planning and implementation process to support the youth and caregiver.

In the second case (#19), the birth father was ordered to complete several tasks (including parenting classes and individual and family therapy) before reunification with his 16-year-old daughter. However, he was not fully compliant, choosing to only begin to participate in family therapy because it was a court-ordered requirement for reunification. In this case, it was reported that the father had systematically "kicked out" this 16-year-old and two of her older siblings as they "became teenagers and reportedly developed behavioral problems." One of the siblings also resides in foster care.

For the focus youth, the team had not created a "clear, time-sensitive case plan that will bring them to the permanency goal of reunification." One of the key recommended next steps in this case was for team members to meet with the father to concretely plan for the future and assess whether or not reunification was a realistic goal. If it is not a realistic goal, potential kinship placements were to be identified and explored. As a follow-up, this teenager was reunified with her father during the summer of 2008, but returned to foster care two months later. The father has since refused to have his daughter returned to his care, and her goal changed to APPLA.

In Case #62, the focus youth had been in care since 2001. His permanency goal changed numerous times over seven years and is now adoption by his grandmother. Historically, this same grandmother had gone back and forth regarding guardianship and asked for the child's removal several times. Even now, the reviewers found that "the grandmother has concerns about limitations to her freedom if she were to remain his primary caregiver and has clearly expressed that she is not prepared to keep the child if there are behavioral problems." There was also a lack of teaming and leadership. High social worker turnover was cited as a contributing factor. In fact, at the time of the review, the supervisor was carrying the case. Service providers were left out of case planning. For example, the therapist did not know that there was an anticipated removal from the grandmother's home. Reviewers found "the lack of stable leadership has taken its toll on this case," and there were specific areas that needed immediate coordination (therapy, tutoring, and educational evaluations) by the supervisor and pending social worker.

Multiple next steps were agreed upon in this case, including the supervisor immediately convening a Family Team Meeting for the family to hear alternative options to adoption by the grandmother, stressing that that results of the next court hearing could likely be removal of the child from his grandmother's home into a foster or pre-adoptive home. In addition, visitation with an older paternal uncle will be arranged as he may be a placement option, and visitation between the child and his father, step-mother, and siblings will be facilitated. Family therapy will be initiated for the child and his grandmother.

It appears that challenges in the areas of leadership, teaming, and case planning limit the performance of the entire system. Of the 18 cases rated in the unacceptable zone for permanence, 11 were also rated unacceptable for Overall Performance-System. One case (#5) was rated in the improvement zone for Overall System Status. In this case, the mother had left her one-year-old son with a neighbor for several days without contact. The neighbor became an unwilling caregiver and called CFSA. Since the case was opened, the mother had shown signs of depression, and the family was facing eviction. In speaking with the mother and father, minimal teaming was occurring. Reviewers found that even with the goal of reunification, "The parents do not feel like team members, and it appears as though the social worker tends to be more directive than collaborative when working with this couple." At the time of the review, this case had been open approximately one year, yet the case plan did not have measurable goals and did not cover all areas of concern with this family, especially around addressing the underlying reason why this family became known to the child welfare system.

The QSR recommendations included the social worker speaking with the mother regarding her mental health needs and assisting her in contacting the Department of Mental Health. It was noted that "If she [the mother] has symptoms of depression, the social worker may need to provide a higher level of 'hand-holding' in order to engage the mother in counseling services." In addition to assisting with the eviction issue, the social worker would work cooperatively with the family in developing an extensive case plan with measurable tasks to address the following issues for safe case closure: monthly budgeting, home maintenance, and safety planning around babysitting and child supervision. Specifically, "The social worker will work with the family in order to engage extended family members and local collaterals (paternal and maternal grandparents, the children's two godfathers, and the family's pastor) in creating a higher level of

informal supports to these children and parents. Creating a safety net for child care and emergency financial assistance will greatly benefit this family."

The opposite trend can be seen in cases rated as acceptable for Pathway to Safe Case Closure. Cases appeared to have an increased level of coordination and leadership, team formation and functioning, assessment and understanding of the child, and case planning.

In Case #35, the child had been removed from his mother in the latter part of 2006, and the goal was reunification. Reviewers indicated that "It was clear that there was a functional team and everyone had a clear understanding and a good assessment of the family and what needed to happen in order for the case to reach closure [reunification]." The social worker was seen as the leader, and team members were able to engage the mother effectively. It was also important to work with the child in this case: "The therapist working with the focus child was able to identify concrete progress for the child and maintains contact with the social worker and the maternal grandmother regarding the child's progress." This child was reunified with his mother under protective supervision in the summer of 2008.

Case #49 tells the story of a 9-year-old boy who had been removed from his mother in 2006. Within two months, he was living with a relative under kinship care. After approximately one year, the goal was changed to guardianship. In this case, the social worker has a great assessment and depth of knowledge of the child. The social worker was described as a good leader in the case who maintained consistent communication with the team members, and the current GAL had been assigned to the child since the beginning of the court case. It was found that all team members were "aware of the case plan and next steps toward achieving the permanency goal." Tasks appeared to be completed within a specific time frame, and team members were responsible for their own parts of the plan. Guardianship was achieved in the summer of 2008.

Strong leadership by the social worker and positive teaming can also be seen in Case #55. In this instance, the seven-year-old focus child and his brother had been in their adoptive home for approximately 10 months. The social worker was found to be a "good communicator, responsive, thorough" and "actively working on the case." She was said to have a comprehensive assessment of the focus child's needs. The story indicates "While the case has only been assigned to her for approximately six months, she has been able to move it towards permanency in an expeditious way." In fact, "All team members, including the pre-adoptive mother, are aware of the case plan and next steps toward achieving the permanency goal. Team members all agree that there are no concerns regarding this adoption."

Of the 43 cases rated in the acceptable zone for permanence, 38 were rated as acceptable for Overall Performance-System. An example of a case with an overall system status of optimal is seen in the adoption case of a teenage male and his two brothers. Their adoptions were completed within 11 months of their placement in the adoptive home (Case #54). The social worker and adoptive father were seen as the team leaders and worked together as effective advocates for the youth:

> *The social worker reviewed the written case plan with the youth and his adoptive parent. Team members had a comprehensive and accurate assessment of the*

youth; his history, his current status, and his future needs. Necessary conditions for safe case closure were fully interpreted and understood by the team.

QSR Cases Closed During 2008

Of the 62 cases reviewed, 15 cases were closed as of December 2008. Four in-home stabilization cases were reviewed this year, and three were closed. One of these cases (#16) closed due to two of the children being in residential treatment facilities and the remaining child reaching age 18. Another in-home case (#5) closed even with an unacceptable Pathway to Safe Case Closure rating. The goal was reunification with the mother after she had left one of the children, a one-year-old, with a neighbor for approximately three days. This neighbor became an unwilling caretaker. The social worker identified that the mother had depressive symptoms but had not engaged her around this issue. According to available documentation, the case was closed without addressing the mental health concern or the reason why the case became known to CFSA.

Five protective supervision cases were reviewed this year, and four were closed. One in-home case (#7) closed after the 18-year-old young man and his mother refused to accept any services from the agency. In another case (#8), the little girl was originally reunited while her mother was participating in an in-patient drug treatment program. After completing the program, the family moved into their own apartment. This mother has support in caring for the children from her own mother and the focus child's father.

In Case #10, a male toddler was removed from his mother's care at the end of 2006. He remained in foster care for several months until he was placed with his father under protective supervision in early 2007. The father was described as being "very self sufficient and able to work effectively with all team members." Team members found him "receptive to assistance and support" and compliant with all services. This man completed parenting and anger management classes and filed for custody of the focus child. He was found to have completed all agency requirements, and the child was found to be safe and receiving good care.

Three adoption cases reviewed were closed this year. One illustrates that older teens can be adopted (Case #38). This 17-year-old male and two of his younger siblings were adopted together. This young man was diagnosed as mentally retarded and had other issues. He had resided in this foster family for four years and had had a permanency goal of adoption for the last two years. Reviewers found that one of the positive things about this pre-adoptive home was that "his great-aunt and pre-adoptive mother have collaborated to enable him to have contact with his siblings who live in another foster home." This collaboration and thoughtfulness around maintaining family connections appears to have had a positive outcome for this young man and his adoptive family.

Children in Care for More Than Five Years

All children deserve a safe, secure, appropriate, and permanent home. While celebrating the 15 children in the QSR sample who had their cases closed this year, it is important to recognize that three of those children had been in care for five or more years, the longest being 12 years. This youth (Case #12) was one of two teens in the QSR sample who aged out of the system.

It is also important to recognize that out of 62 cases reviewed, 47 children or youth remain in care. Of those 47 cases, 18 children have been in care for five years or more. Seven children have been in care for 10 years or more.

Children remain in care for various reasons such as behavioral issues, multiple placement disruptions, foster parent challenges, and legal opinions. Among cases reviewed in 2008, five (Cases # 1, #3, #12, #44, and #57) are clear instances in which the system has allowed the foster parent(s) to become a major obstacle to permanence.

In Case #1, the 14-year-old focus child was removed from her mother's care in 1996. She lived in a foster home for four years before returning to her mother under protective supervision, which lasted for approximately two years before she re-entered foster care. She has lived in the same pre-adoptive home for the past four years. Recently, the pre-adoptive mother "decided not to go forward with the adoption. After the pre-adoptive parent stated she did not want to adopt the youth, the youth said she did not want to live in the home anymore." This is the second time the pre-adoptive mother has expressed a desire not to adopt the child. The first time, she rescinded her adoption petition in court. This second time, the child's behavior escalated after the pre-adoptive mother did not follow the team members' plan to therapeutically address suspension of visits between the child and her birth mother. The pre-adoptive mother rejected the offer of in-home supportive services and said that she "did not want to continue with the adoption. At the time of the review, she said the girls did not want to be adopted or live with her anymore, so she did not want to force them to stay." It should be remembered that this is a 14-year-old child who has said that she does not want to be adopted by anyone. Due to her age, she will have consent to any future adoption.

Agreed-upon next steps for this case included: convene a clinical staffing with all team members to create a placement plan for the youth, contract with the caregiver regarding the length of time the youth will be in her home, refer the youth for therapeutic placement, re-refer the youth for adoption recruitment, explore maternal and paternal relatives for possible kinship placements, work with the team regarding how to address birth family visitation, and ensure all service providers are aware of any placement changes so that they can provide continuity of services.

Case #3 involves a 15-year-old girl who had been in care for seven years. Reunification was the goal for three years before changing to adoption. She resided in the same pre-adoptive home since 2004; however the pre-adoptive parents have informed the court that they wish to adopt only the youngest child in the sibling group because "caring for the focus child and her two siblings was overwhelming, even with multiple services already in place." In addition, it was reported that the pre-adoptive mother has "occasionally been resistant in cooperating with social workers when it comes to letting the children participate in foster/pre-adoptive home recruitment

activities, such as adoption meet-and-greet parties." The focus child has told the court that she wants to be adopted only by her current caregivers. She, too, is at an age where she will have to consent to any proposed adoption.

Recommendations for Case #3 included: review report from the adoption family therapist and address concerns regarding permanency prospects at a meeting before returning to court, discuss with the foster parents the importance of continuous cooperation with adoption recruiters, revisit the idea of featuring the child on "Wednesday's Child," make efforts to contact the child's extended family members to serve as possible information supports and/or placement options, continue adoption recruitment through CFSA and other adoption programs, and continue to assess and provide support for the child's feelings regarding adoption by someone other than her current caregivers.

In several cases, other system barriers appear to have prevented children from achieving permanence. In Case #39, the focus youth is an 18-year-old female who entered agency care several months after she was born. At age two, she and her three older sisters were placed with her maternal grandmother in another state. All four children had a goal of adoption for eight years with their grandmother, but two factors got in the way: "Over the years there were multiple barriers in achieving permanency through adoption, one of which was licensing issues, and another was the grandfather not residing in the United States." Because the grandfather refused to come back to the United States for the duration of the adoption process and the grandmother refused to divorce her husband to adopt the children, the adoption could not be finalized. In the end, the grandmother withdrew her adoption petitions for all four girls.

In this same case, the girls continued to reside with their grandmother and their maternal aunt. In 2004, CFSA attempted to close the case and was denied by the court. Reviewers noted: "The GAL filed a motion to change the permanency goal from adoption to APPLA as she opposed closing any of the girls' cases prior to their 21st birthdays because the aunt required financial assistance in order to provide for the girls." APPLA became the current goal in 2004. In the end, this teenager will have spent a little less than 21 years in the child welfare system, while having lived in the same place for nineteen years. In this case the system opted for keeping a child welfare case open until adulthood to address financial concerns of the caregiver rather than opting for a more permanent solution such as adoption or guardianship allowing the youth to reach permanency sooner.

In another case (#59), permanency is stalled for an 8-year-old girl who has been in care for six years. Her permanency goal has been adoption for four years. After a previous pre-adoptive placement disrupted, the child and her two older siblings were placed in their current foster home. This foster family is not interested in becoming an adoptive resource for all three children. While recruitment for the children is active, inquiries have been made only about the focus child. There are behavioral concerns with her two siblings, and "[t]here are issues with the older children questioning if they wish to be adopted at all, and they are at the ages of consent". In addition, the team in this case is "hoping that the foster parents will change their minds." There does not appear to be any urgency to address permanence due to the children being stable in this home. The problem seems to be as follows:

> *The longer the team waits to make a decision regarding permanence for this child, the more her chances of becoming adopted are diminished. Even if the goal was changed to APPLA for all of the children in order for them to remain in their current foster home, there is no certainty that this family will continue to provide for these children until they are twenty-one.*

It is imperative for someone on this child's team to initiate discussion of the difficult topic of permanence for this child—whether she should be adopted alone or continue to hold out for a family to adopt all three children. Decisions need to be made on how to proceed with this case; however, "it appears as if team members are waiting for someone else to make the decision." One of the next steps agreed upon in this case was for the case managing agency to convene a meeting with the GAL, adoption recruiters, therapist, and other parties to initiate the discussion and planning around permanence for the focus child within 60 days.

The safe setting of foster care is an essential need for some abused and neglected children, but the system must continue to address barriers to achieving permanence for children in care. Children in foster care need to have strong advocates for permanence, not just stability. Their social workers, guardians *ad litem,* and judges need to value permanence and believe in the benefits of a forever home. According to CFSA's Case Practice Principles:

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

Without strong advocates to make tough, timely decisions, children do not make progress but rather stagnate in care. This sense of urgency and direct action should be afforded to each child with legal permanence as the goal.

4. Recommendations and Next Steps

Individual Case Recommendations

Each case story includes several recommendations from reviewers for next steps to address issues identified during the review and to move the child to permanence. We have broadly categorized these recommendations to illustrate the areas most frequently identified as in need of improvement. Reviewers suggested a total of 261 next steps, an average of four per case. Table 4 shows all the categories of recommendations and the number of times reviewers suggested a step that fell into each category.

Table 4: Categories of Recommendations

Rank	Category	Frequency
1.	Case planning	27
	Social worker form relationship with family member	27
2.	Permanence	25
3.	Teaming	23
4.	Education	22
5.	Mental health	18
6.	Communicate with service provider	16
	Other	16
7.	Family visits	15
	Independent living skills	15
8.	Refer/participate in services	10
	Work directly with family	10
9.	Health/dental	9
10.	Informal supports	8
	Evaluation	8
11.	Address placement issues	6
12.	Refer to Collaborative	3
13.	Family team meeting	1
	Close case	1
	Financial assistance	1
	Total recommendations	261

The Permanency category included recommendations such as identifying and/or reaching out to family members to be placement/permanency resources for children in care. For Case Planning, recommendations included developing a cooperative case plan with the parents and team members outlining specific measurable tasks to be completed in order to safely close the case. Examples of services in the Refer/Participate in Services category included grief counseling, anger management, substance abuse and mentoring services. In the Other category, specific administrative next steps were identified. For example, communicate with or complete paperwork related to the Interstate Compact on the Placement of Children (ICPC) Unit and follow up on referrals made to the Diligent Search Unit to locate persons on the case, etc. Reviewers also made recommendations for social workers that were categorized as Work Directly with the Family. This was described as assisting clients in creating monthly budgets, developing homemaking skills and improving the quality of visits with children. In the Address Placement Issues category, recommendations were focused on necessary tasks to maintain the current placement, such as contracting with the foster parent to ensure the child's service needs are met, identifying respite options for foster parents and ensuring that licensure requirements are met and/or maintained to avoid disruption.

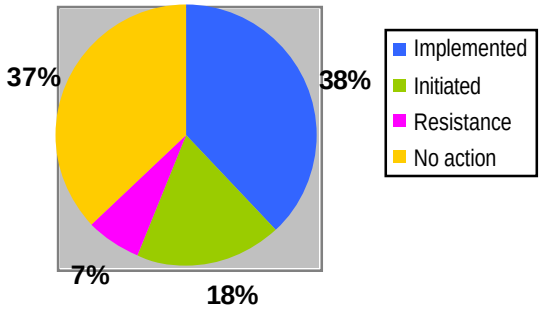
Sixty-Day Follow-up

QSR specialists returned after 60 days to evaluate whether social workers had acted on recommendations. Of the 62 cases reviewed in 2008, QSR specialists were able to conduct a 60-

day follow up on 20 cases, reviewing 111 of the 261 recommendations. They were not able to follow up on 39 cases (20 CFSA/private-agency cases and 19 CSR cases). Three cases had no recommendations or next steps.

Specialists found social workers had implemented or initiated action on 63% (Figure E) of the 111 recommendations. In 7% of cases, social worker had made efforts but encountered resistance from another party in the case. Specialists found no action on 37% of recommended next steps. They shared information from the 60-day follow-up with supervisors and program managers. Information gathered in follow-ups with social workers appears at the end of each unit-based case story (Appendix B).

Figure E: 60-Day Followup on QSR Recommendations



Implementation of recommended next steps often led to progress in cases. One hundred percent of recommendations for financial assistance, collaborative referrals, and addressing placement issues were followed or in progress. Social workers had achieved or initiated nearly 90% of all case planning and permanency recommendations at the time of follow up. Social workers were making efforts to ensure appropriate permanency plans were in place and families were linked to necessary services as per their case plans. Fifteen of the 62 cases reviewed had successfully closed in 2008. In half of these cases (7), children were reunited or were stabilized with their parents. Three children were adopted, two aged out of the system with supportive services in place at the time of the 60-day follow up, two achieved guardianship with relatives, and one was moved to a residential placement to receive needed services.

Summary

Following is a recap of major findings from the 2008 QSRs.

Strengths

- **Children were safe in their homes and out-of-home care settings.**
  Parents and caregivers were adequately managing any risk factors to ensure children's safety. There were no safety issues requiring recommendations or follow up.

- **Children were receiving necessary medical/dental care.**
  Medical and dental services were provided in a timely manner and were appropriate for children's needs. This indicator rated the highest in the Child Status category.

- **Strong caregivers were meeting children's physical and emotional needs.**
  Children with mental health needs were linked to appropriate services and had support from their caregivers.

- **Social workers were engaged with children, leading to good assessment and understanding of their needs and situation.**
  Social workers and team members were using formal and informal assessments to identify children's needs and implement appropriate services.

- **Social workers ensured children in foster care were connected to biological family members.**
  Described as a challenge in 2007, the Family Connections indicator rated as one of the highest system indicators in 2008.

- **Families were being connected to post-permanency supports.**
  Families were linked to Collaboratives, mental health services providers, and other supportive services to assist them in maintaining children's safety and well being once the child welfare case is closed.

Challenges

- **Involving fathers:** The 2006 Federal Child and Family Service Review noted this deficiency. Fathers and paternal relatives continue to be overlooked, resulting in loss of a meaningful connection and possible resources for the child and family.
  - § Social workers should reach out to fathers throughout all stages of a case, regardless of the child's goal, until the court terminates parental rights (unless engaging the father is demonstrably not in a child's best interest).
  - § Social workers should invest time in searching for fathers and paternal family members who can be connections or permanent resources for children in care.
  - § Efforts to engage fathers should include outreach to those who are incarcerated.

- **Team formation and functioning:** Lack of a cohesive and effective team is detrimental to assessment, service delivery and tracking, and movement to safe case closure. Inclusive teams that employ open and ongoing communication yield better outcomes for children.

- **Leadership and coordination in the decision-making process:** In a number of cases, there was no clear leader identified to guide the decision-making process for case planning and implementation of necessary services to move to safe case closure.
  - § Social workers should ensure that all team members are up to date on case activities and contribute to decision-making.
  - § Teams must quickly identify a coordinator to ensure continuity of service delivery and case planning in the absence of a permanent leader (i.e., social worker turnover on a case).

- **Case planning:** While the rate of completed written case plans is high, the development process too often does not fully engage parents, youth, and team members, and a clear pathway to permanence is often missing.
  - § Case plans must not be just written documents but blueprints that guide and stimulate action to achieve children's permanency goals.

- Case plans must include time-limited, measurable tasks with objectives that lead to permanence and safe case closure.
- Team members should agree on case plans and identify each person's role and responsibility in implementation.