

**DRAFT**



**CITY OF PHILADELPHIA  
DEPARTMENT OF HUMAN SERVICES**

.....  
**FIRST JUDICIAL DISTRICT OF PENNSYLVANIA  
COURT OF COMMON PLEAS**

**FAMILY DIVISION/JUVENILE BRANCH**  
.....

**CHILDREN AND YOUTH  
NEEDS-BASED PLAN AND BUDGET  
For  
FISCAL YEAR 2015-2016**

**IMPLEMENTATION PLAN AND BUDGET  
For  
FISCAL YEAR 2014-2015**

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**JULY 21, 2014**

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- Attachment A:** Initial Design and Implementation Report.....
- Attachment B:** County Improvement Plan
- Attachment C:** Shared Case Responsibility Reminder Memorandum

# **PLANNING NARRATIVE**

## Section 2: NBPB Development

### 2-1: Executive Summary

- ❑ Submit an executive summary highlighting the major priorities, challenges, and successes identified by the county since its most recent NBPB submission. The summary should include any widespread trends or staffing challenges which affect the county child welfare and juvenile justice service delivery, particularly those which impact all outcome indicators. Juvenile Justice summary should provide an overview of Juvenile Justice System Enhancement Strategy (JJES) efforts, including any general data or trends related to Youth Level of Service (YLS) domains and risk levels.
  - County may attach any County Improvement Plan (CIP) for detail and reference attachment.
  - JPO Executive Summary components can be discussed under separate heading at the discretion of the county.
  - CWDP counties need only provide responses not captured in their Initial Design and Implementation Report Update (IDIR-U).
  - Counties interested in becoming Child Welfare Demonstration Project (CWDP) counties for FY 2015-16 should express their interest in this section. NOTE- Prospective counties will need to complete the questions in the CWDP Prospective County Information Appendix at the end of the Narrative Template.

FY15 is a critical year for the City of Department of Human Services. During this year, DHS will fully implement the Improving Outcomes for Children system-wide transformation. During FY 15, Community Umbrella Agencies 6, 7, 8, 9 and 10 will begin to accept cases. The full transition will be completed by the Spring of 2015. The Department remains focused to the four goals of IOC:

- More children and youth maintained safely in their own homes and communities.
- More children and youth achieve timely reunification or other permanence.
- Decrease use of congregate care.
- Improved child, youth, and family functioning.

To assist in achieving these outcomes, during FY 15 DHS expects to roll out three evidence based programs: Functional Family Therapy (FFT), Parent Child Interaction Therapy (PCIT) and Positive Parenting Program (PPP). Working in conjunction with the Community Umbrella Agencies (CUA) and Community Behavioral Health (CBH), these services will be offered to eligible children, youth, and families.

Requests for Increases in Funding:

In the FY 15 budget, DHS is requesting additional funding in the following areas:

- Changes to the Child Protective Services Law (CPSL): Due to amendments to CPSL that will expand the definition of child abuse and perpetrator, DHS expects to see an increase in both reports and prevention referrals. This increase will require additional staff in our hotline and investigation sections. Additionally, DHS is requesting increased funding for attorneys and legal assistants to assist with implementing amendments to the CPSL which require attorney sign off on Child Protective Services Reports and information sharing with Domestic Relations Court.
- Truancy and School Climate: DHS is requesting an increase in funding for several prevention programs to be implemented in the Philadelphia School District schools. These

programs are designed to reduce school violence, reduce truancy and promote healthy families. DHS also plans to expand the services offered by the Education Support Center by deploying education liaisons to the schools to assist breaking down education barriers and connecting families to appropriate social services.

- **Permanency:** Due to decline in permanency numbers and a prevalence of data indicating that lengths of stay are getting longer, DHS is requesting additional funding for new attorneys for the City of Philadelphia Law Department. These attorneys will play a crucial role in working with the social work teams to achieve timely reunification or other permanency.

See IDIR-U, Attachment A.

See County Improvement Plan (CIP), Attachment B.

### **Juvenile Justice Services**

Philadelphia has completed Phase One of its implementation of the Juvenile Justice Systems Enhancement Strategy (JJSES) and is actively working on Phases II and III. By September 2013, all probation officers, supervisors, and administrators had benefitted from two major training initiatives: Evidence Based Practice 101 and Family Involvement. In September 2013, Family Court Judges participated in Evidence Based Practices training on applying research evidence to judicial practices, focusing on which practices best bring about long term changed behavior.

With the cornerstones of JJSES philosophy in place, the Youth Level of Service/Case Management Inventory (YLS) policy and procedure went into effect Department-wide in November 2013. The YLS instrument is used in assessing risk, need, and responsivity factors of youth in an effort to match appropriate services and formulate a case plan. During FY 2013-2014, the Department conducted 1,610 YLS assessments. With the YLS as a foundation, a committee has been convened to expand on Graduated Responses via a matrix of services and case plan. The committee in conjunction with a consultant is currently developing the reward and sanction matrix. Developing a structured response system will promote consistency among staff, provide structured decision making and improve desired outcomes.

The Juvenile Probation Department, through an expanded DHS contract with It Takes a Village, Inc., is embarking on the use of Family Group Decision Making (FGDM) for youth transitioning back from residential placement. The first cohort of youth for whom this service will be used includes youth being discharged from St. Gabriel's Hall, Vision Quest Lee Prep, and Glen Mills Schools. In September 2014, Residential Service Unit Probation Officers will receive a one day overview of FGDM followed by a two day skill builder. FGDM will assist in building natural support systems through family and community for high risk youth and bring together all agencies involved with a family to follow one plan.

In November 2013, Philadelphia opened two Evening Reporting Centers (ERCs) as additional alternatives to secure detention. The purpose of the ERCs is to prevent re-arrest and ensure appearance in court. Both ERCs are currently operating close to their capacity of 20 youth each, with one of the programs serving only males, and the other program serving males and females separately with gender-specific programming. Though still in their infancy stage, the ERCs are showing tremendous promise with all of the participating youth having made required Court appearances and only a minute percentage having been re-arrested during the course of their participation. Inspired by the success of the programs, which have been well received by the judiciary, the youth, families, and many of the Department's stakeholders, Philadelphia now

looks to create two new community based centers as alternatives to placement, borrowing heavily from the ERC model. In the new centers, youth will be committed for periods of approximately 6 months, rather than a 30 day commitment which occurs with the ERC model. During the period of commitment, the youth would receive high quality and evidence-based programming, supervision during the evening hours (when such youth are otherwise potentially positioned to re-offend), and an array of positive youth development opportunities. The Department projects the opening of these centers to take place by September 2014, coinciding with the start of the new school year.

Philadelphia recognizes that few resources exist for female youth in its juvenile justice system and is forming a collaborative of stakeholders to identify specific gaps and the resources to address them. The Department remains committed to use community-based resources where possible. However, DHS also recognizes that the response to issues like human trafficking of girls involved in the DHS system may call for an expansion of residential programs to remove these uniquely vulnerable girls from the community and from access by the individuals who jeopardize their safety. To that end, both residential and community based resources are being considered, all of which will have heavy emphasis on trauma based services.

GPS monitoring facilitates the Court supervision of 200 – 225 youth daily in lieu of secure detention. For the first quarter of 2014, 226 youth were successfully discharged from GPS monitoring. The use of GPS monitoring allows the Court to remain consistent with the Balanced and Restorative Justice (BARJ) principles of youth accountability and community protection.

In 2013 – 2014, with Juvenile Justice stakeholder support, including the Department of Human Services, Juvenile Probation has continued the implementation of the Juvenile Detention Alternatives Initiative (JDAI). Through participation in local and statewide JDAI efforts, Philadelphia Juvenile Probation adopted the standardized Pennsylvania Detention Risk Assessment Instrument (PaDRAI) in August 2013. Though the secure detention census remains well below the legal capacity of 184 at the Philadelphia Juvenile Justice Services Center (PJJSC), use of the PaDRAI provides an objective risk screening tool to guide detention decisions and ensure that only those youth who pose threats to public safety are held in secure detention. The PaDRAI is now built into the Juvenile Case Management System (JCMS) and guides all detention decisions which ensures objective, fair and consistent decision making practices.

Participation in JDAI has also resulted in the Probation Department:

- Enhancing data capacity by increasing data reports available through JCMS.
- Addressing disproportionate minority contact by collaborating with the Department of Human Services and the Philadelphia Police Department in the formation of a School Police Diversion program. This program is intended to divert such youth to intensive delinquency prevention programs and services and prevent the unnecessary arrests of youth with certain school based offenses.

Since becoming a JDAI site in 2012, Philadelphia has completed all JDAI developmental milestones, including:

- Completing the quantitative Detention Utilization Study and the qualitative System Assessment.
- Participating in the Fundamentals of JDAI Training in August, 2012.

- Conducting a Model Site Visit to Cook County, IL in December, 2012.
- Participating in the Reducing Racial and Ethnic Disparities Training in September, 2013.
- Attending annual JDAI Inter-Site Conferences, and hosting the 2014 JDAI Inter-Site Conference in Philadelphia.

Finally, consistent with the requirements of the Prison Rape Elimination Act (PREA), the Philadelphia Juvenile Justice Services Center (PJJSC) is preparing for the first of its annual audits. Having benefited from the assistance offered through the National PREA Resource Center, our PREA policies and procedures are currently being reviewed by the Law Department. Once approved, policies and procedures will be communicated to all staff, volunteers, and contracted providers by way of series of substantive trainings. The Department is in the process of contracting with a certified auditor and anticipate that the audit will occur sometime prior to the conclusion of the year, in advance of the detention center's next audit by the Bureau of Human Services Licensing.

## 2-2. Child Welfare Demonstration Project

Counties interested in joining the Child Welfare Demonstration Project for FY 2015-16 must answer the following questions:

Not applicable. Philadelphia is already an existing CWDP county.

### Section 1: Family Engagement

- Describe the county's current use of Family Engagement strategies.
- Provide an estimate of clients/families that will receive Family Engagement services during the first year of the county's demonstration project.
- Provide a plan, including needed resources, for implementing Family Engagement strategies as part of the CWDP.

### Section 2: Assessment

- Describe the county's current use of the FAST/CANS/Ages and Stages assessment tools.
- Provide an estimate of clients/families that will receive each type of assessment during the first year of the county's demonstration project.
- Provide a plan, including needed resources, for implementing Assessment strategies as part of the CWDP.

### Section 3: Other issues related to CWDP Readiness

- Describe the proposed county process for using assessment data and other county resources for making the second year Intervention decisions.

- ❑ Provide an analysis, including needed resources, of the following organizational and system capacity issues related to implementation:
  - Leadership support;
  - Staff characteristics (e.g. number of staff, roles in the component, qualifications)
  - Availability of technical and financial resources to implement the CWDP;
  - Availability and quality of linkages to and support from community organizations;
  - Available training and technical assistance resource capacity.
  
- ❑ Comment on any current processes or elements of county functioning that require attention in order to align with the demonstration components to ensure success.
  
- ❑ Comment on any implementation supports (e.g. infrastructure enhancements, policy changes) that need to be developed to align with the demonstration project components.
  
- ❑ Identify any anticipated barriers to executing any of the program components and any potential strategies for addressing those barriers.

### 2.3a&b. Collaboration Efforts and Data Collection Details

- ❑ Summarize activities related to active engagement of staff, consumers, communities and stakeholders. Identify any challenges to collaboration and efforts toward improvement.
- ➡ CWDP counties may attach Implementation Team membership or CWDP Advisory Team (or similarly named stakeholder group) list to meet this section requirement.

#### Child Welfare Demonstration Project (CWDP) Implementation Team:

\* Denotes Philadelphia COB Board Member; # denotes Ex-Officio COB Board Member

Ali, Kimberly	Operations Director, Ongoing Services
Ambrose, Anne Marie <sup>#</sup>	Commissioner
Anuszkiewicz, Brittany	Stoneleigh Foundation Program Officer
Asad, Khalid	Senior Advisor to the Commissioner
Ash, Barbara	Chief Deputy City Solicitor, Child Welfare Unit, Law Department
Beilenson, John	IOC Communications Consultant
Bottalla, Paul	Policy and Planning Director
Cervone, Frank	Support Center for Child Advocates
Clapier, Brian	Performance, Management and Accountability (PMA) Director
Dougherty, Kevin	Family Court Administrative Judge
Edmonds, David M.	DHS Family and Community Services Center Administrator
Erney, Joan	Community Behavioral Health CEO
Evans, Arthur C., PhD <sup>#</sup>	DBH/IDS Commissioner
Farlow, Timene	Deputy Commissioner
Garrett Harley, Vanessa	Deputy Commissioner
Gomez, Kathy	Community Legal Services
Grasela, Katherine	Family Court Chief of Child and Youth/Dependency Operations
Gutterman, Fran	Casey Family Programs
Hanns, Chanell	Chief of Staff, Finance
Harvey, Tyrone A. Jr	DHS Teaming Director
Jackson, Erica	Philadelphia School District
Jones, Alfreda	District Council 47
Kretsge, Susan	Philadelphia Health Department Chief of Staff
Lynch, Karyn	Philadelphia School District Chief of Student Services
Mauro, Linda <sup>*</sup>	Temple University School of Social Work
Mayo, Pamela	Community Member, former DHS Operations Director
Olshan, Marlene	Intervention Development Director
Powers, Aubrey C.	DHS PMA Administrator
Robinson, Doug	Deputy Commissioner
Shamsid-Deen Hampton, Raheemah	DPW Regional Director, Southeast Regional Office
Shapiro, Jessica	Chief of Staff, Commissioner
Taylor, Alicia	Public Relations and Communications
Tolbert, Lee	Community Activist

Williams, Gary Operations Director, Front End Services  
Williams, Joan Community Activist  
Zukoski, Margaret PA Council of Children, Youth and Families  
Associate Director

## Philadelphia COB Board Members:

Cherna, Marc Director, DHS – Allegheny County  
Christian, Cindy W., MD Chair, Child Abuse and Neglect Prevention,  
Children’s Hospital of Philadelphia; Associate  
Professor of Pediatrics at University of  
Pennsylvania School of Medicine  
Davidson, Howard, JD Director, ABA Center on Children and the Law  
Goode, W.Wilson Sr, Reverend, National Director, Amachi  
PhD  
Lloyd, Todd Child Welfare Policy Director, Pennsylvania  
Partnerships for Children  
Noonan, Kathleen G., JD PolicyLab at Children’s Hospital of Philadelphia  
Sanders, David, PhD Casey Family Programs and Chair, Philadelphia  
COB  
Silver, Judith. PhD Children’s Hospital of Philadelphia  
Stevens, Phyllis -  
Sullivan, Ameera Temple University Student  
Tracy, Carol Executive Director, Women’s Law Project  
Walker, Maria J. Project Manager, Freedom Rings Partnership  
Williams, Tracey Member, The Achieving Reunification Center  
Yanoff, Shelly -

**PUBLIC HEARING**

The Public Hearing is scheduled to be held on Thursday, July 31, 2014 at Temple University Center City (TUCC), 1515 Market Street, Room 222 at 5:00 p.m.

- Identify data sources used in service level, needs assessment and plan development.

Resource	Data Collected	Date of Data
US Census Bureau, American Community Survey	Population, Poverty statistics, Age Distributions	2014
FACTS Data Warehouse	General Indicators: Ongoing Services, JPO Services, Placement Data, Aging Out	July, 2014
FACTS Data Warehouse	Investigations, Days of Care, Placement Data	July, 2014
Court Unit Database	Fostering Connections questions (Aging Out)	July, 2014
FACTS Data Warehouse	Fostering Connections questions (Aging Out)	July, 2014
Cognos 8 Re-entry report	Re-entry Bench Mark	July, 2014
FACTS Data Warehouse	Entries/Exits and Congregate Care Benchmarks	July, 2014
FACTS Data Warehouse	0 to 5 non-permanency	July, 2014
FACTS Data Warehouse	Shared Case Responsibility FY 14	July, 2014
Horby Zeller Data Package	Population Flow	July, 2014

#### 2.4 Program and Resource Implications

Do not address each initiative in Section 2.4; please address any resource needs related to initiatives by identifying and addressing within the AJDUSTMENT TO EXPENDITURE request.

#### 2-4o. Unallowable Costs - Legal Representation Costs for Juveniles in Delinquent Proceedings and Parents in Dependency Proceedings

- Submit any amount expended by the county government in FY 2013-14 for Legal Representation Costs for Juveniles in Delinquent Proceedings

Response will be submitted with final narrative.

- Submit any amounts expended by the county government in FY 2013-14 for Legal Representation Costs for Parents in Dependency Proceedings.

Response will be submitted with final narrative.

### Section 3: General Indicators

#### 3-1: County Information/Background

- Describe the population and poverty population trends for the county, noting any increases or decreases, and the impacts the county expects these changes to have on needs and services. Include the data source.

#### **County Data**

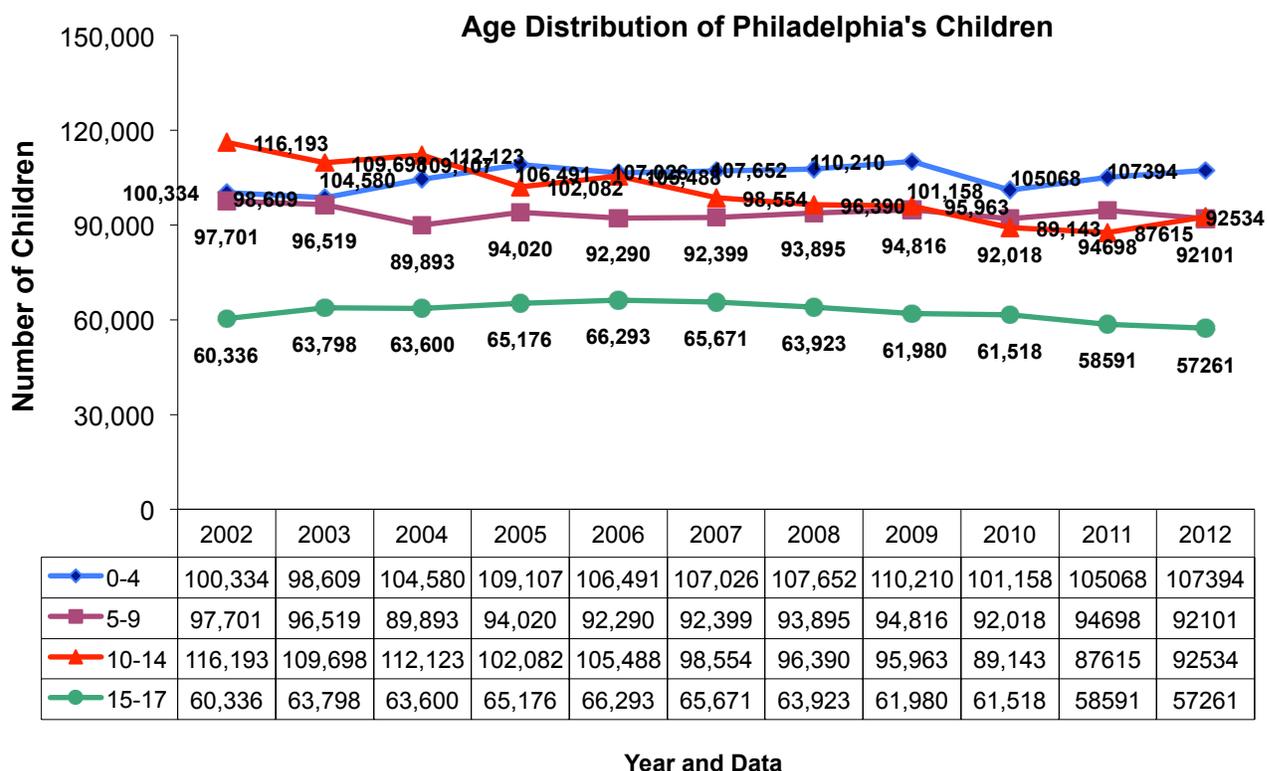
- **Population Trends**

Philadelphia's population, after almost a decade of relative stability, increased by approximately 6% in 2009 and appears to have stabilized at this slightly higher population. The 2012 population is within 310 of the 2009 population. The total number of children and youth (aged 17 and under) remained relatively constant between 2004 and 2006, declined by 1.8% between 2006 and 2007, declined again by 5% between 2009 and 2010. Because of this decrease, the percentage of the population under 17 declined to less than 23% in 2010, where it remains in 2012.

<b>Table 1:</b>	<b>Number and Percentage of Total Population and Children 17 and under with Poverty Status</b>		
Year	Total Population	Population 17 and under	Percentage of population 17 and under
2002	1,436,694	374,564	26.1%
2003	1,423,538	368,624	25.9%
2004	1,414,245	370,196	26.2%
2005	1,406,415	370,385	26.3%
2006	1,448,394	370,562	25.6%
2007	1,449,634	363,650	25.1%
2008	1,447,395	361,860	25.0%
2009	1,547,297	362,879	23.5%
2010	1,526,006	343,837	22.5%
2011	1,536,471	345,972	22.5%
2012	1,547,607	349,290	22.6%
Data Source: Census Bureau, American Community Survey 2000-2012			

• **Age Distribution**

Dividing Philadelphia's children and youth into four age cohorts indicates the relative trends of each. The 0-4 age group continues an increase that began in 2011. The 5-9 age group has been reduced somewhat, to a level below that of 2006. The 10-14 age group increased in size after declines in 2010 and 2011. The 15-17 age group continues a steady decline that began in 2007.



• **Poverty Trends**

A nationally recognized method of measuring poverty is use of the federal poverty line calculation. This is defined as a yearly income of \$15,130 for two people, \$19,090 for three people, \$23,050 for four people and \$27,010 for five people. The poverty line is used to determine eligibility for a number of federal programs (See the 2012 HHS Poverty Guidelines).

In Philadelphia, 26.2% of the population fell below the federal poverty line in 2012, a small decrease from 2011. Of this group, 31.3% were children and youth, almost the same proportion as in 2011. Among all children and youth in Philadelphia, 36.3% are living in poverty, a much higher percentage than among the overall city population, despite the 3% decrease from 2011.

<b>Table 2 : Estimated Total Philadelphia population and estimated total population 17 and under</b>					
Year	Number of Population with Poverty Status	Percentage of Total Population	Population 17 and under in Poverty Status	Children in Poverty as a Total Population with Poverty Status	Children in Poverty as a Percentage of Total Child population
2002	302,560	21.1%	110,948	36.7%	29.6%
2003	315,042	22.1%	102,981	32.7%	27.9%
2004	351,305	24.8%	130,240	37.1%	35.2%
2005	343,547	24.4%	129,639	37.7%	35.0%
2006	363,547	25.1%	128,332	35.3%	34.6%
2007	333,142	23.0%	124,149	37.3%	34.1%
2008	336,272	23.2%	112,331	33.4%	31.0%
2009	359,141	24.2%	123,784	34.5%	34.2%
2010	407,444	26.7%	125,157	30.7%	36.4%
2011	436,358	28.4%	135,967	31.2%	39.3%
2012	405,689	26.2%	126,944	31.3%	36.3%

Data Source: Census Bureau, American Community Survey 2000-2012

- Identify issues that surfaced through the annual licensing inspection and/or the Quality Service Review (QSR). Discuss any necessary changes to county services. Discuss progress on any action items that resulted from the most recent QSR.

See County Improvement Plan (CIP) Attachment B.

In developing the County Improvement Plan, the sponsor team reviewed the results from the state lead Quality Service Review (QSR) as well as the results from the Department's local QSR reviews. Through this process the team found consistencies in both areas of strength (e.g. safety of children and youth, physical health, culturally appropriate services) and areas for continued improvement (e.g. teaming, assessment and planning).

The focus indicators are:

Outcome # 1: Teaming

This overarching outcome supports the family team's ability to achieve unity of effort and commonality of purpose.

Outcome # 2: Assessment and Understanding

This overarching outcome supports understanding the core story, underlying issues, needs and strengths of the child/youth family

Outcome # 3: Planning

This overarching outcome supports a planning process that is fully individualized and relevant to child/youth and family needs.

See CIP, Section IV. Findings for specific QSR findings and description of how the Workplan is aligned with the Child Welfare Demonstration Project logic model and IOC goals and objectives.

- **Juvenile Justice Services**

There were two issues which surfaced during the annual DPW licensing inspection of the Philadelphia Juvenile Justice Services Center (PJJSC), conducted by the Bureau of Human Services Licensing (BHSL). Specifically, it was noted that a staff member whose instructor certificate for CPR had expired had delivered training to other staff. In addition, emergency telephone numbers which should have been posted on the staff desk in the common areas on two of our living units were not so posted.

DHS responded to these citations by: presenting the staff person's current instructor certification (which was valid until 2016) and ensuring that it was now included in his personnel file, and immediately posting the required emergency telephone numbers in the required areas on the two living units identified. As a result of these responses and their acceptance by BHSL, the PJJSC received its full license, valid for the period of April 13, 2014 until April 13, 2015.

- Round One, Two and Three counties of the Continuous Quality Improvement (CQI) efforts should identify areas of focus as a result of the QSR that are identified as an area needing improvement in the County Implementation Plan (CIP). The plan can be referenced in detail where appropriate in the outcome sections of the NBPB submission.

See CIP Attachment B, Section III – Priority Outcomes and Section IV - Findings.

- Address any projected changes in service delivery from the previous FY to the Implementation Plan, including changes to the NBPB proposal from last year. Identify the basis for change in service delivery and projected impact.

See CIP Attachment B, Section IV – Findings, “Connecting the Work Plan with the Identified Outcomes” and Philadelphia’s Work Plan.

- Address any service needs projected for juvenile justice. If Youth Level of Service (YLS) domains/risk levels link to specific service needs, describe the services in context of the YLS domains.

See Executive Summary.

- Counties who did not spend all of their Act 148 allocation in FY 2013-14 should describe the practice and fiscal drivers that impacted the county’s level of resource need and address any projections as to continued under-spending in FY 2014-15.

Response will be submitted with final narrative.

- ❑ Address whether CCYA has a written protocol or memorandum of understanding with Juvenile Probation concerning Shared Case Responsibility (SCR) cases (including dual adjudication cases). If there have been amendments/updates to the SCR protocol since last year's NBPB submission, attach a copy of the most current version and refer to attachment for detail. If your county did not submit your MOU with last year's NBPB submission, it must be attached with this submission.

A revised policy was issued on 12/12/11, and was attached to the FY 2014-2015 Needs Based Plan and Budget Submission. A Memorandum was issued 8/20/13 reminding staff of roles and responsibilities regarding visitation, Joint Assessment Meetings, and case closure requirements. See SCR Reminder Memorandum, Attachment C.

- ❑ In addition, please provide caseload data related to SCR cases.

<b>Shared Case Responsibility Fiscal Year 2014</b>			
	<b>Business Practice Shared Case</b>	<b>Court Shared Case</b>	<b>Total Cases</b>
Initiated	79	343	422
Ended	11	244	255

Data Source: DHS warehouse on 7/15/2014

Total Served from 7/1/2013 to 6/30/2014 n=937

Children starting as Business Practice who became Court Order are counted in Court Shared Case

- ❑ Which agency performs case management responsibilities when handling SCR cases?

Please refer to SCR policy, attached to the FY 2014-2015 Needs Based Plan and Budget Submission, and SCR Reminder Memorandum, Attachment C.

- ❑ To comply with the Child and Family Services Improvement and Innovation Act of 2011, counties should review their data about the length of time children (under age five) being served spend without a permanent family. If warranted, the county should develop a county-specific plan to reduce the time to permanency for children in this age group. The county-specific plan should include distinct strategies to reduce time to permanency, such as strategic decision-making, family engagement practices, family finding, quality visitation practices, concurrent planning and prompt use of SWAN direct services, including child profile, family profile, child specific recruitment, child preparation, placement, finalization and post-permanency services. All counties should request sufficient funds to implement their county-specific plan to move children under age five more quickly to a permanent home.

The data regarding length of time children under five spend without a permanent family was reviewed. It was determined that current programs and strategies related to IOC

and the Child Welfare Demonstration Project will adequately address need for permanency in this age group.

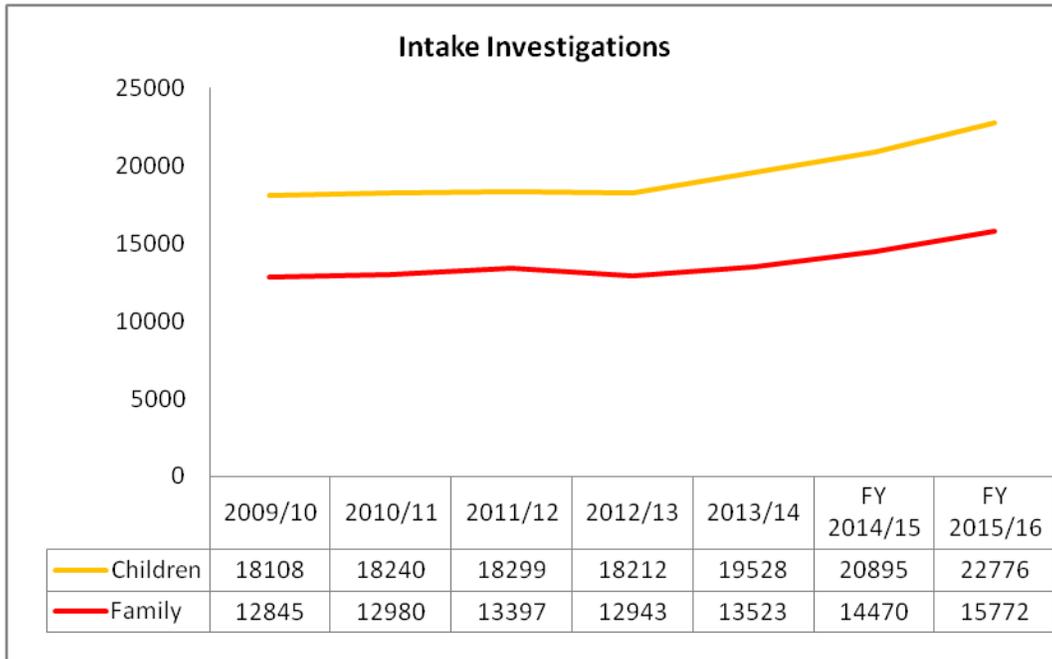
- ❑ Address any other changes or important trends.

Response will be submitted with final narrative.

- CWDP counties are exempt from this section if the information is captured in their IDIR-U. Completion of this section is optional and should cover only areas that the county believes are not adequately addressed in their IDIR-U.
- Prospective CWDP counties may reference responses to the CWDP Prospective County Information (Section 2.2).
- Counties should attach any current County Improvement Plan (CIP) and refer to attachment for detail.

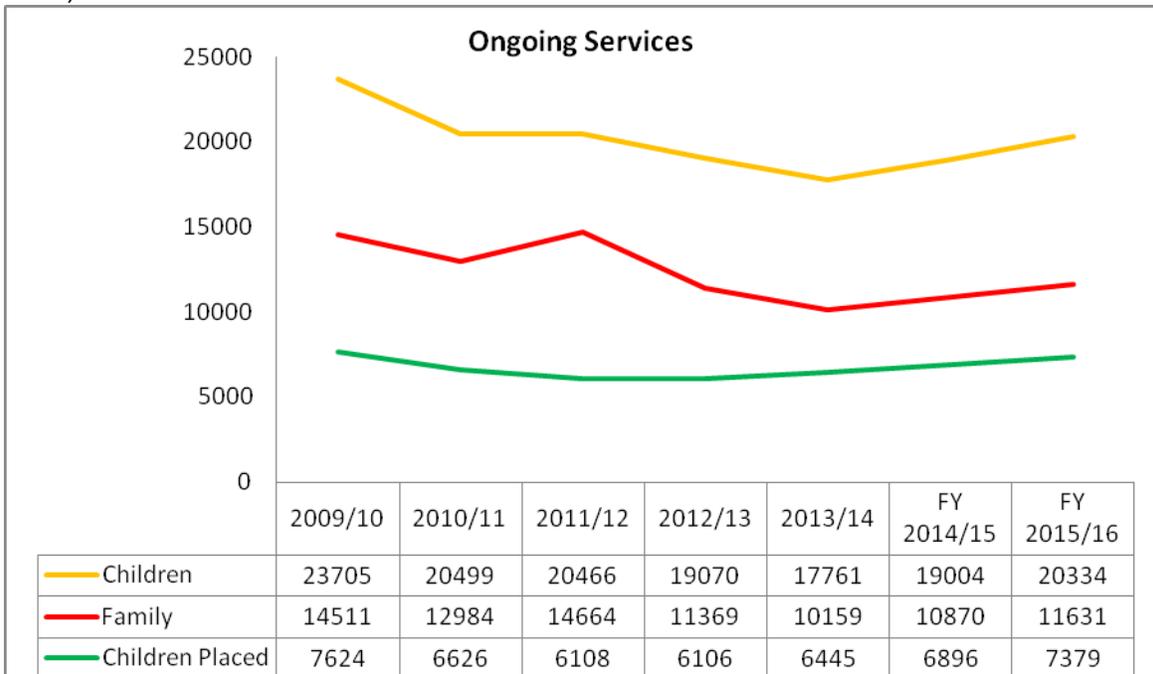
**3-2a. Intake Investigations**

(Chart 1)



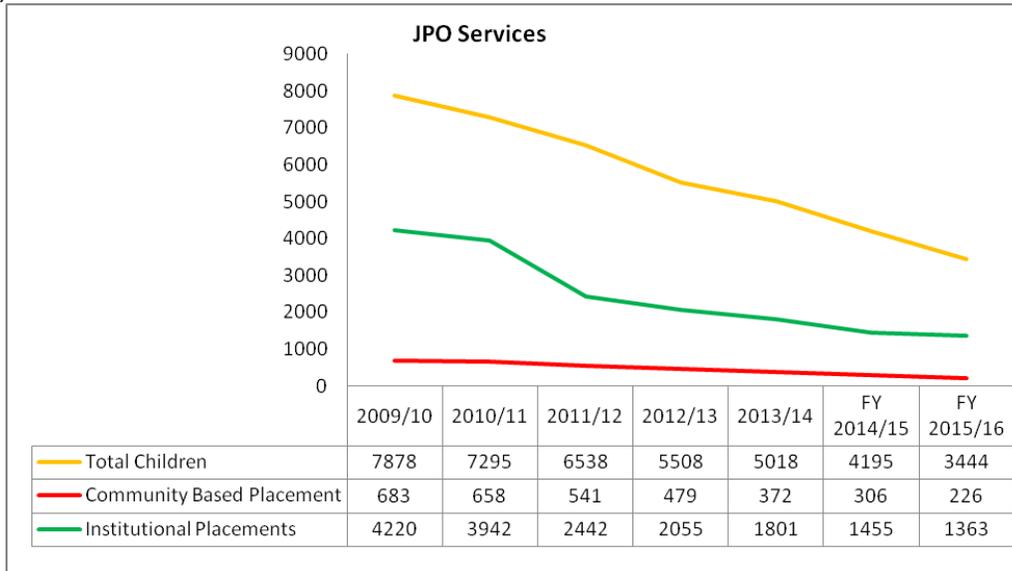
**3-2a. Ongoing Services**

(Chart 2).



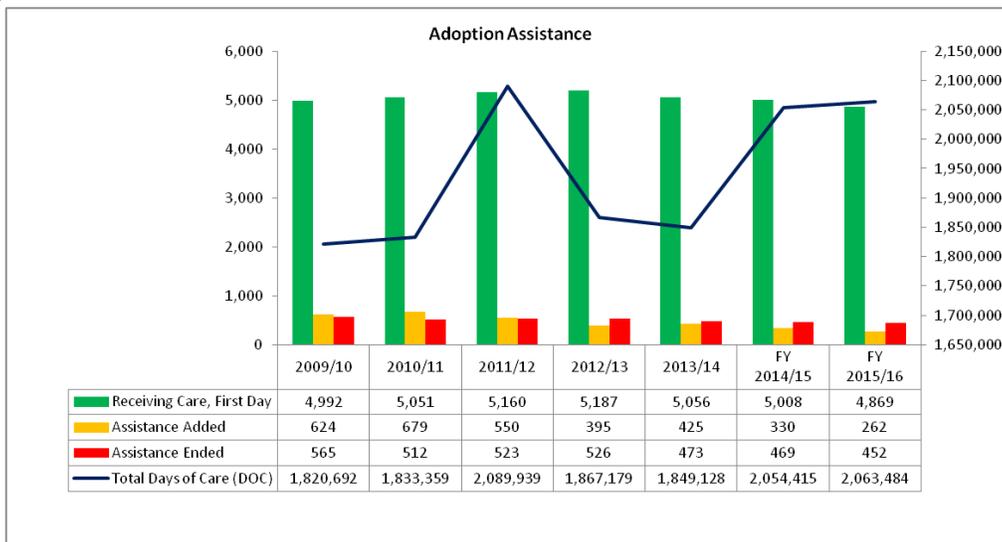
**3-2a. JPO Services**

(Chart 3)



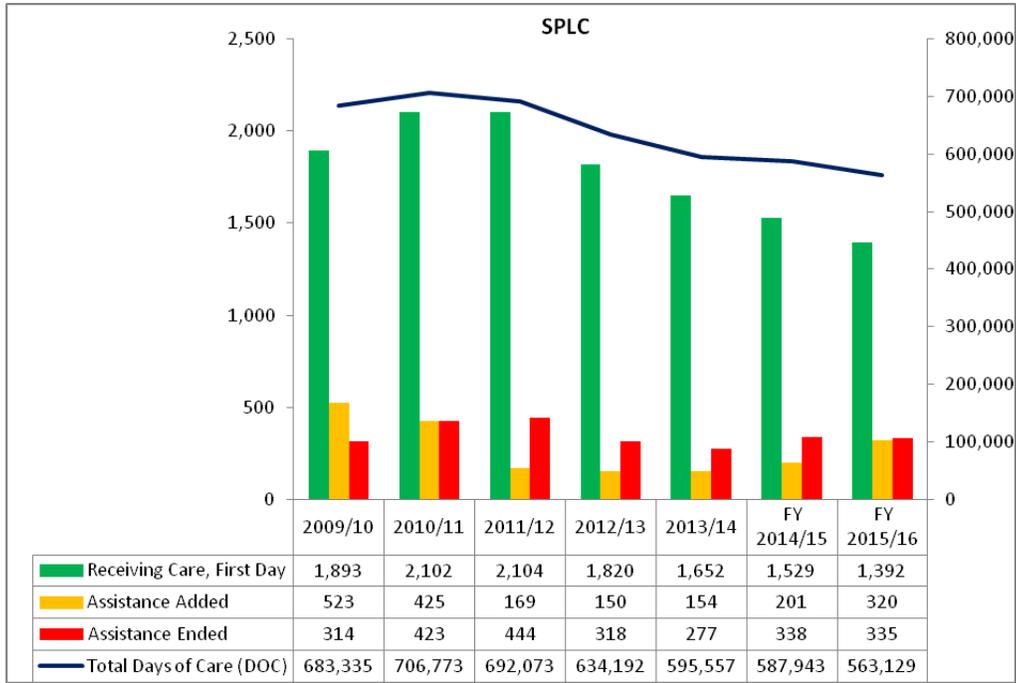
**3-2b. Adoption Assistance**

(Chart 4)



**3-2c. Subsidized Permanent Legal Custody (SPLC)**

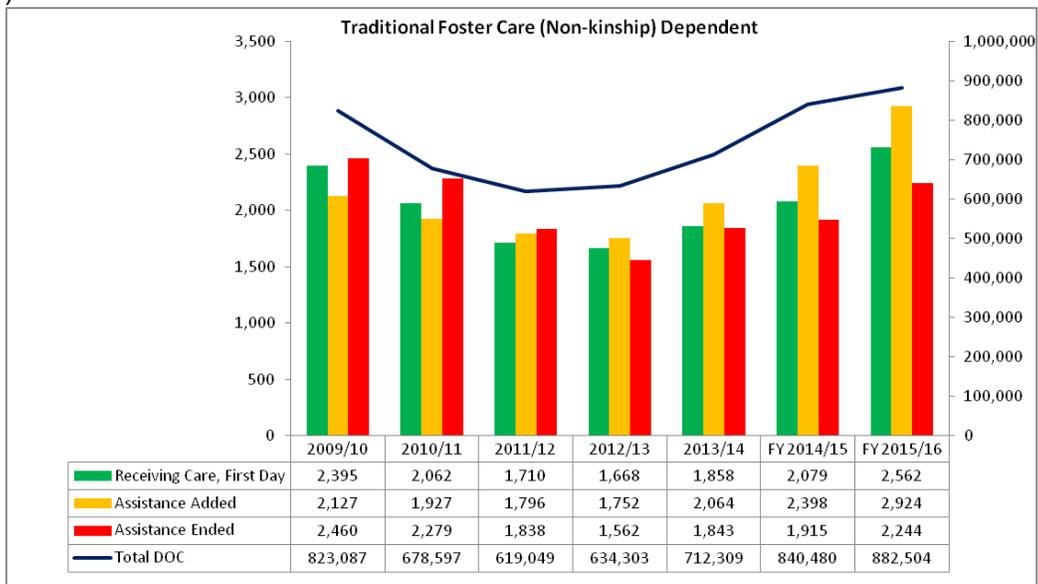
(Chart 5)



**3-2d. Out-of-Home Placements: County Selected Indicator**

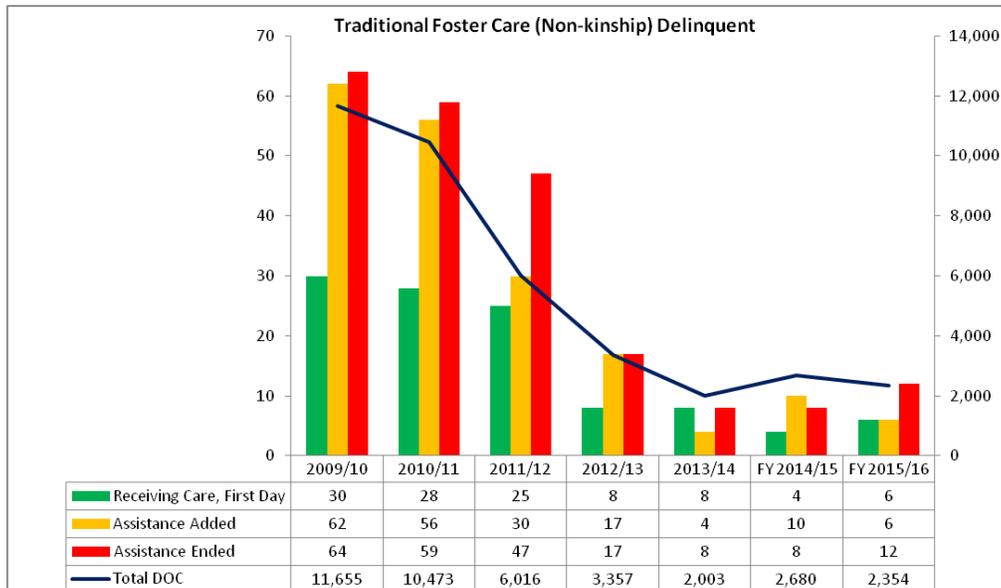
Charts related to out-of-home placements where trends are highlighted (Charts 6-22).

(Chart 6)



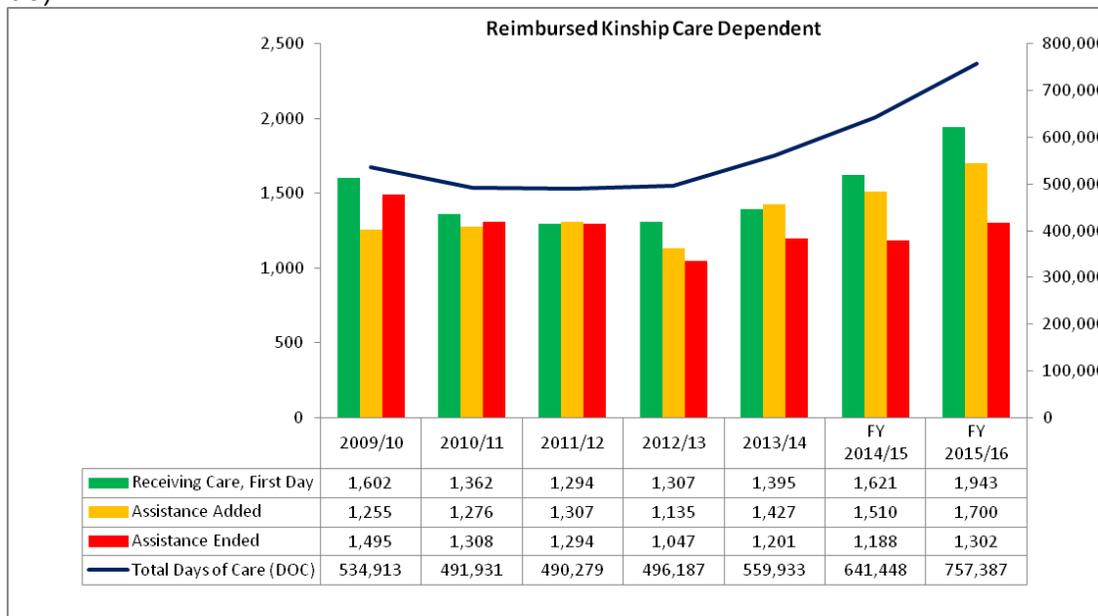
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 7)



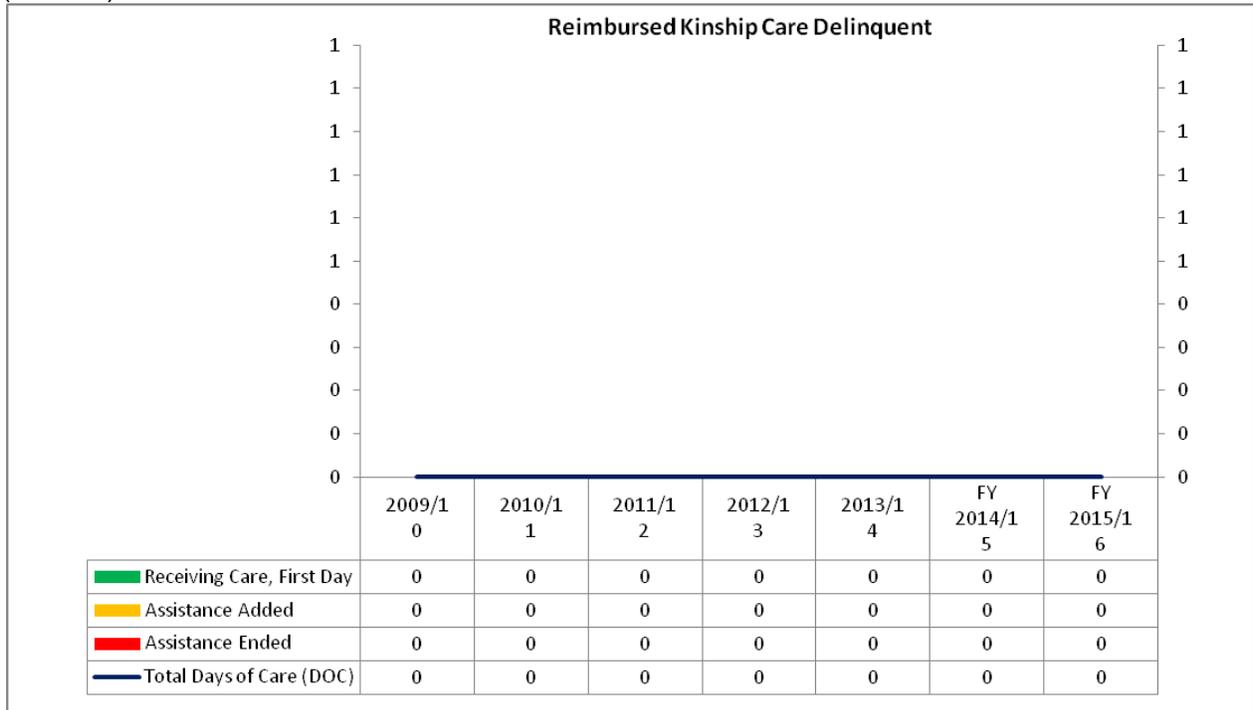
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 8)



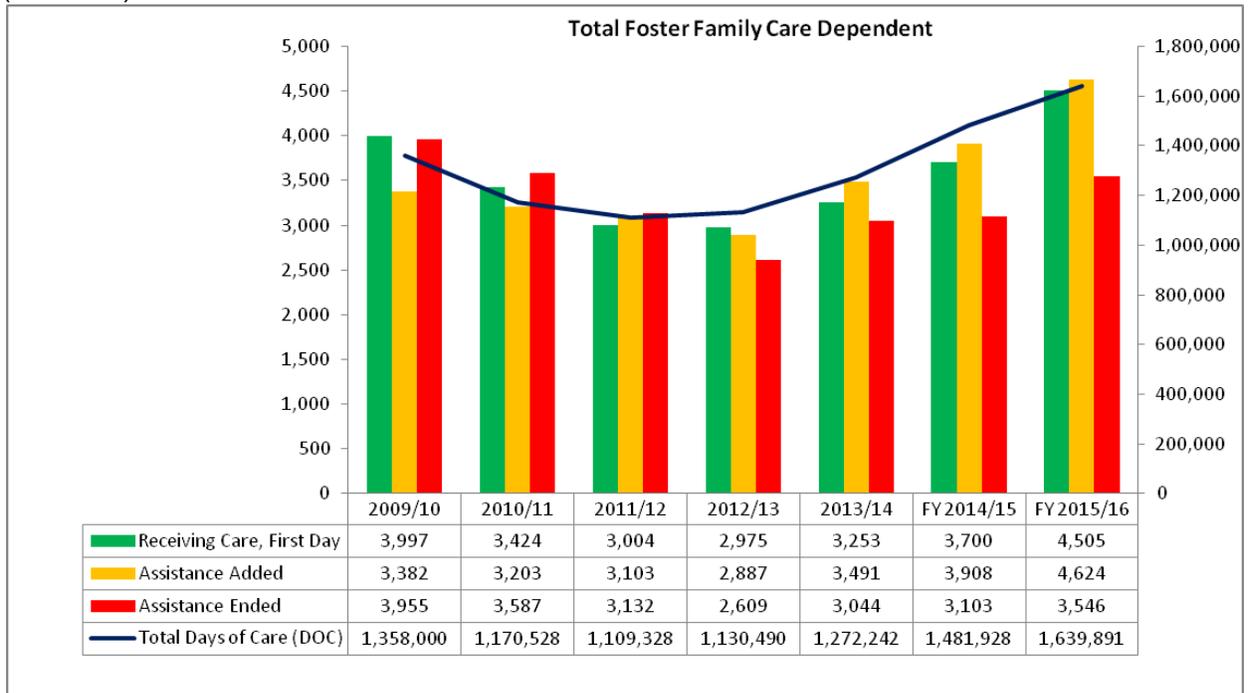
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 9)



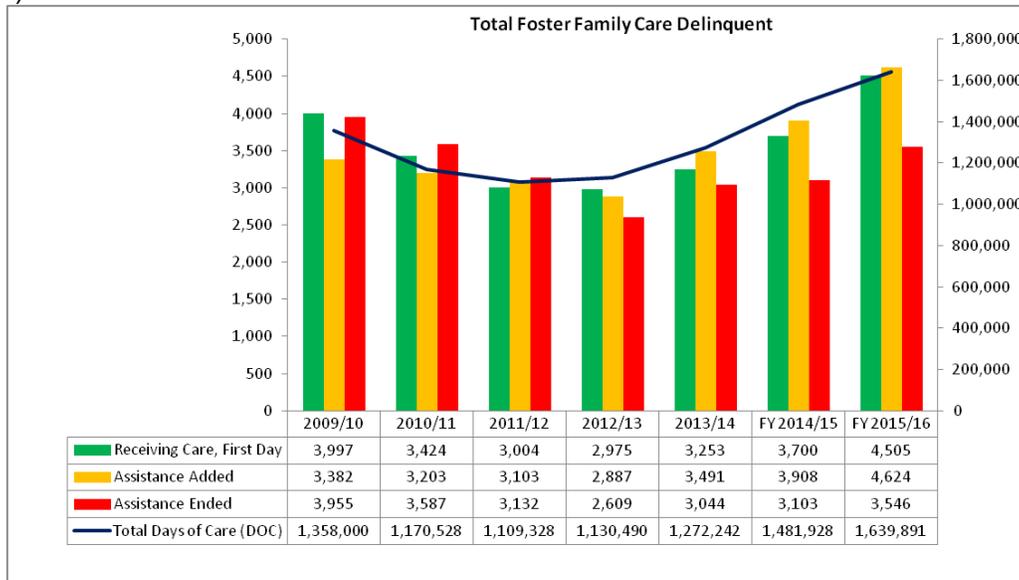
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 10)



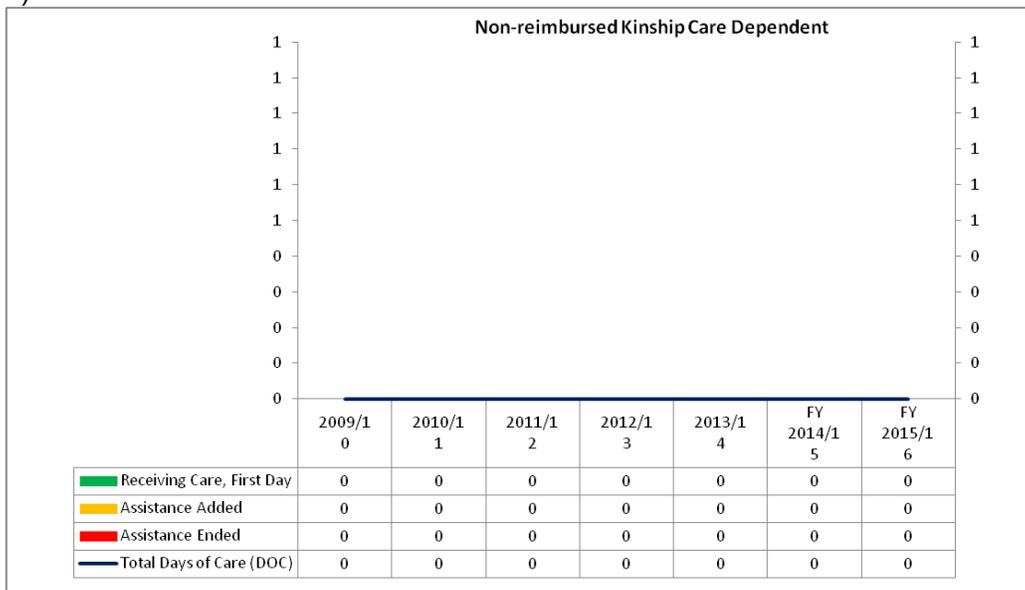
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 11)



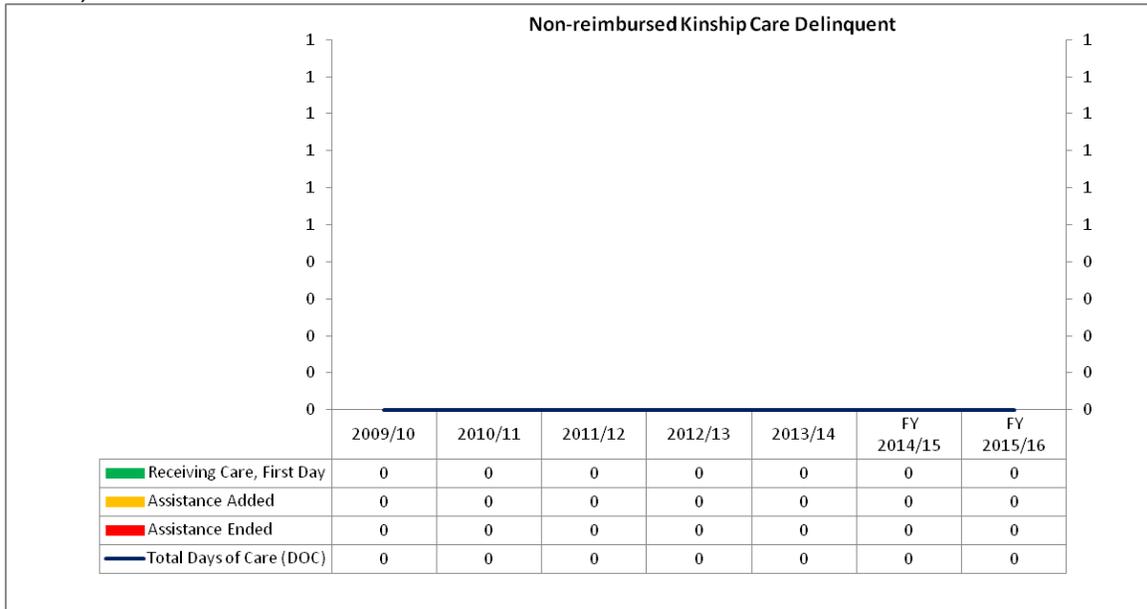
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 12)



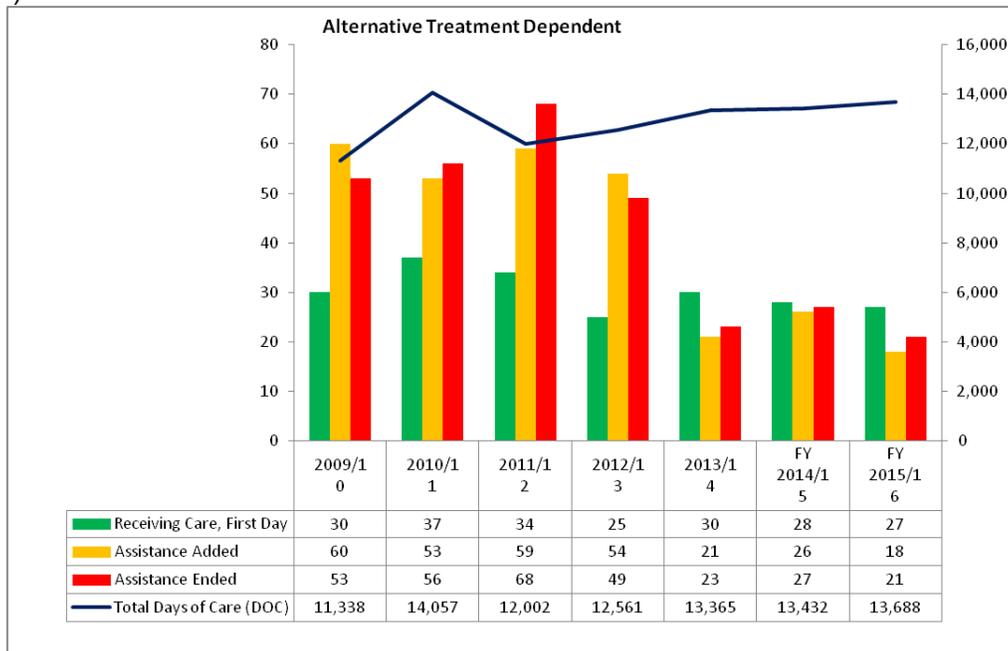
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 13)



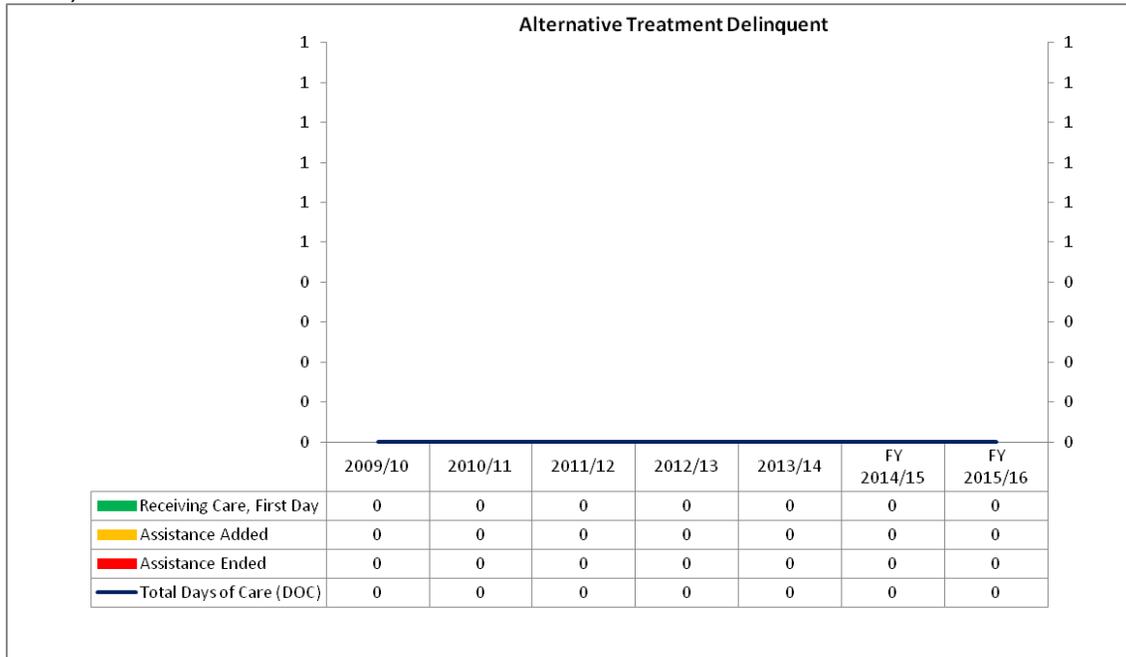
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 14)



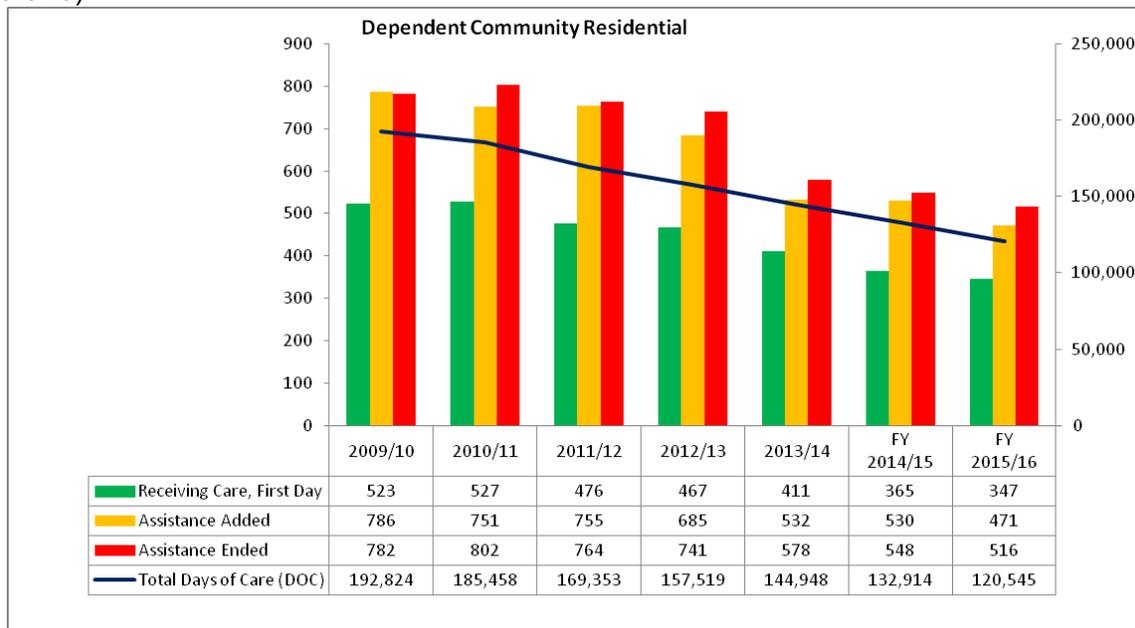
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 15)



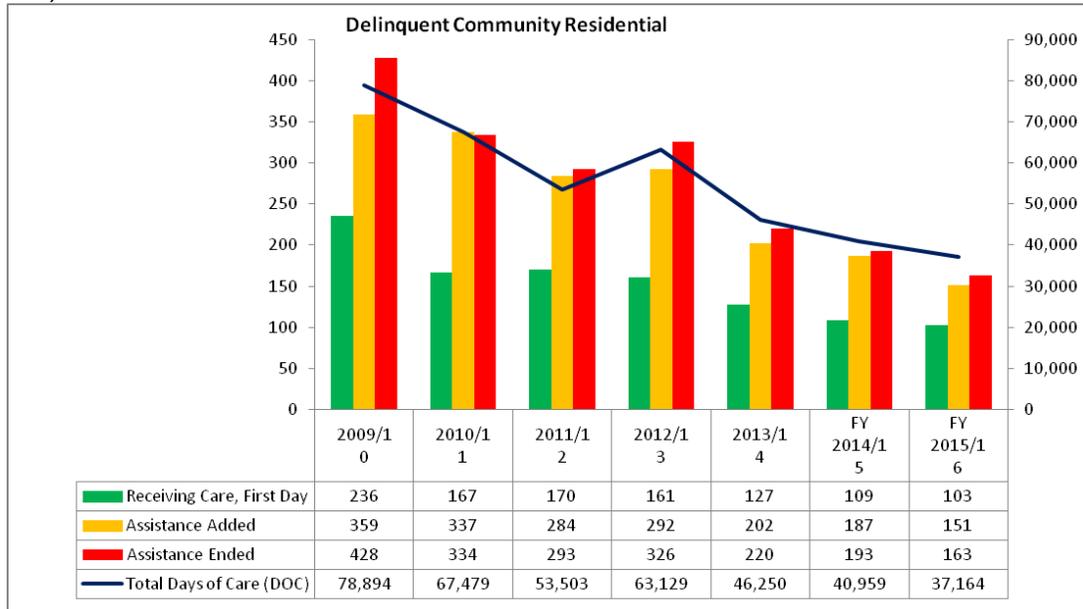
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 16)



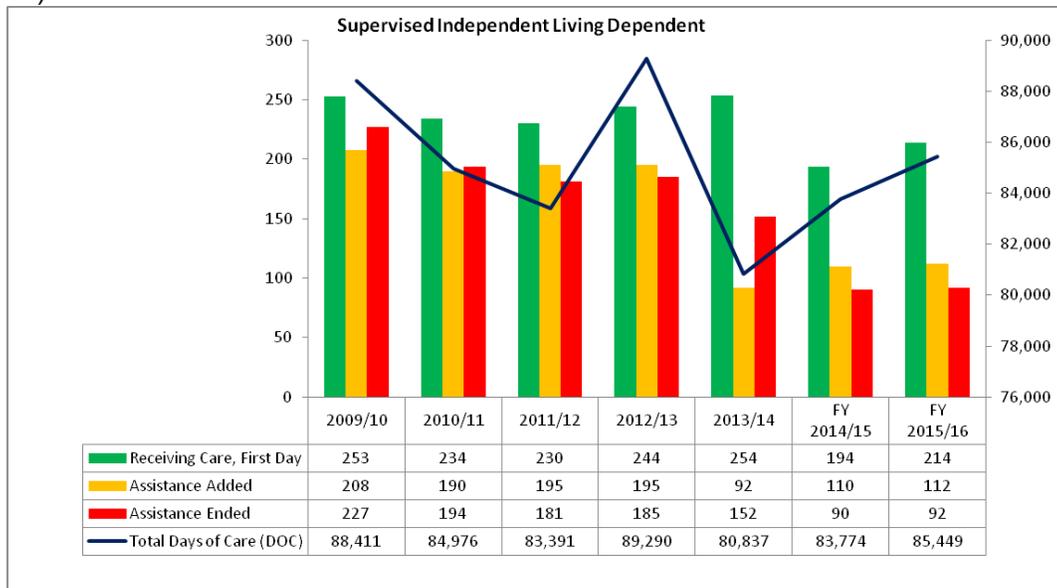
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 17)



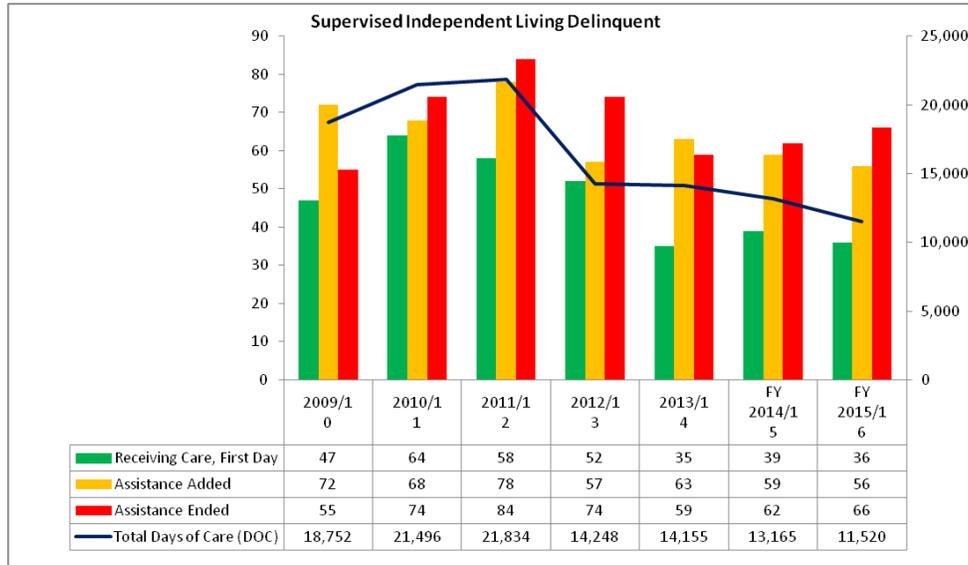
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 18)



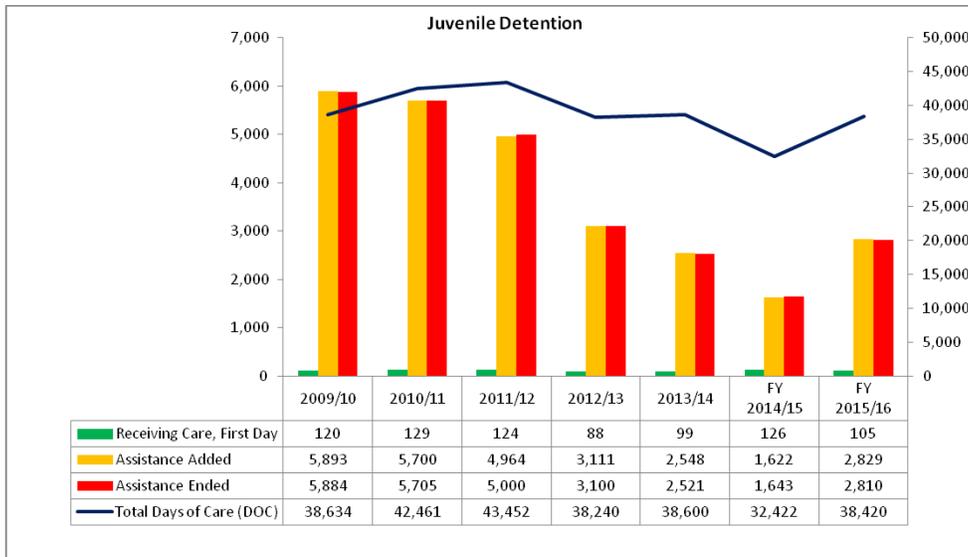
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 19)



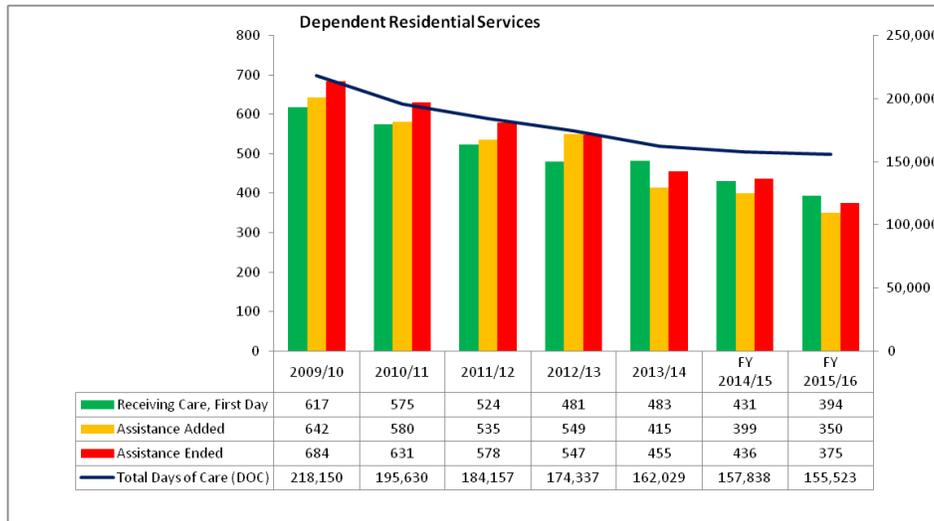
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 20)



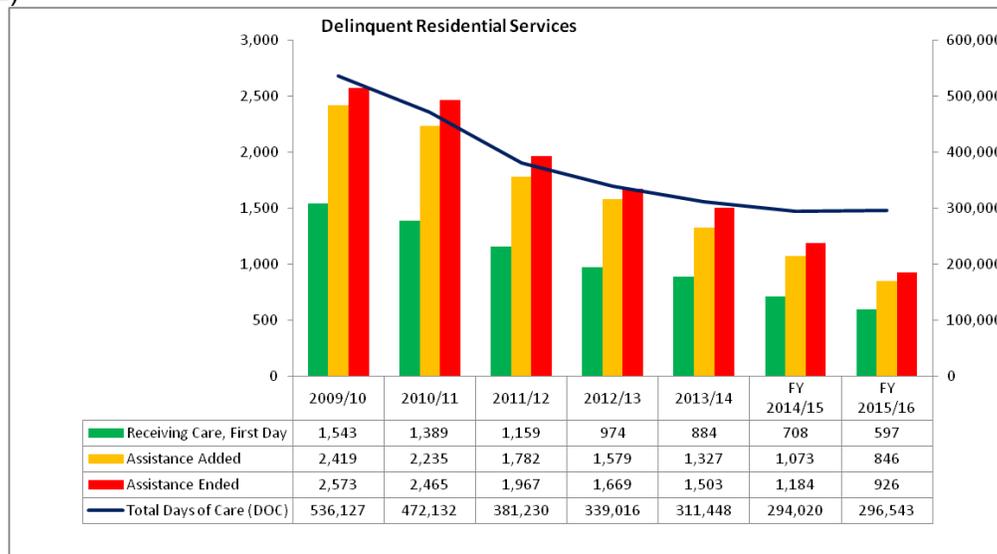
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 21)



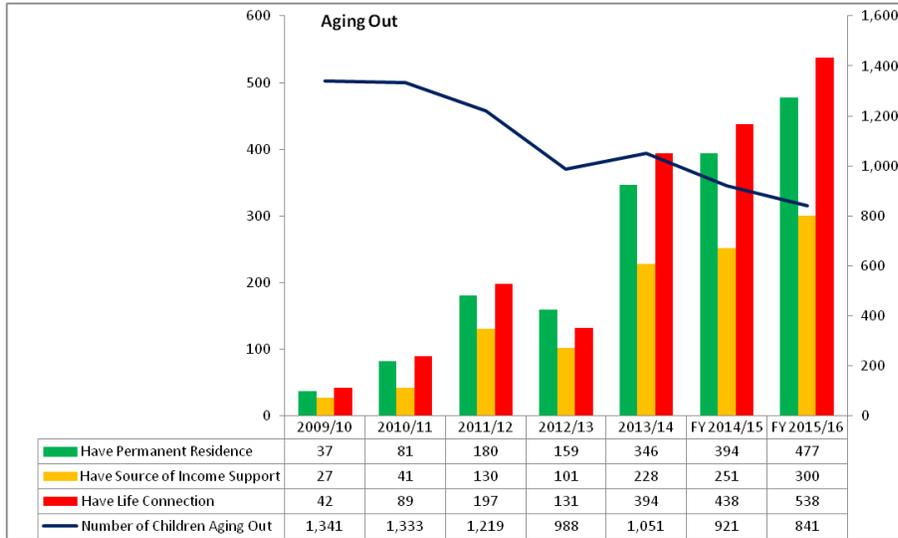
**3-2d. Out-of-Home Placements: County Selected Indicator**

Charts related to out-of-home placements where trends are highlighted (Charts 6-22).  
(Chart 22)



**3-2e. Aging Out**

Aging Out Chart  
(Chart 23)



**3-2f. General Indicators**

Insert the complete table from the *General Indicators* tab. **No narrative** is required in this section.

3-2: General Indicators								
"Type in BLUE boxes only"								
County Number: <input type="text"/>			Class			#N/A		
#N/A								
<input type="button" value="Copy Part 1 for Narrative insertion"/>			<input type="button" value="Copy Part 2 for Narrative insertion"/>			<input type="button" value="Copy Part 3 for Narrative insertion"/>		
<input type="button" value="Print"/>								
3-2a. Service Trends								
Indicator	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	Projected		2009-14
						FY 2014/15	FY 2015/16	% Change
<b>Intake Investigations</b>								
Children	18108	18240	18299	18212	19528	20895	22776	7.8%
Family	12845	12980	13397	12943	13523	14470	15772	5.3%
<b>Ongoing Services</b>								
Children	23705	20499	20466	19070	17761	19004	20334	-25.1%
Family	14511	12984	14664	11369	10159	10870	11631	-30.0%
Children Placed	7624	6626	6108	6106	6445	6896	7379	-15.5%
<b>JPO Services</b>								
Total Children	7878	7295	6538	5508	5018	4195	3444	-36.3%
Community Based Placement	683	658	541	479	372	306	226	-45.5%
Institutional Placements	4220	3942	2442	2055	1801	1455	1363	-57.3%
3-2b. Adoption Assistance								
Indicator	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	Projected		2009-14
						FY 2014/15	FY 2015/16	% Change
<b>Adoption Assistance</b>								
Receiving Care, First Day	4,992	5,051	5,160	5,187	5,056	5,008	4,869	1.3%
Assistance Added	624	679	550	395	425	330	262	-31.9%
Assistance Ended	565	512	523	526	473	469	452	-16.3%
Total Days of Care (DOC)	1,820,692	1,833,359	2,089,939	1,867,179	1,849,128	2,054,415	2,063,484	1.6%
3-2c. SPLC								
Indicator	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	Projected		2009-14
						FY 2014/15	FY 2015/16	% Change
<b>Subsidized Permanent Legal Custodianship</b>								
Receiving Care, First Day	1,893	2,102	2,104	1,820	1,652	1,529	1,392	-12.7%
Assistance Added	523	425	169	150	154	201	320	-70.6%
Assistance Ended	314	423	444	318	277	338	335	-11.8%
Total Days of Care (DOC)	683,335	706,773	692,073	634,192	595,557	587,943	563,129	-12.8%

3-2d. Placement Data								
Indicator	FY	FY	FY	FY	FY	Projected		2009-14 % Change
	2009/10	2010/11	2011/12	2012/13	2013/14	FY 2014/15	FY 2015/16	
<b>Traditional Foster Care (non-kinship) - Dependent</b>								
Receiving Care, First Day	2,395	2,062	1,710	1,668	1,858	2,079	2,562	-22.4%
Assistance Added	2,127	1,927	1,796	1,752	2,064	2,398	2,924	-3.0%
Assistance Ended	2,460	2,279	1,838	1,562	1,843	1,915	2,244	-25.1%
Total DOC	823,087	678,597	619,049	634,303	712,309	840,480	882,504	-13.5%
<b>Traditional Foster Care (non-kinship) - Delinquent</b>								
Receiving Care, First Day	30	28	25	8	8	4	6	-73.3%
Assistance Added	62	56	30	17	4	10	6	-93.5%
Assistance Ended	64	59	47	17	8	8	12	-87.5%
Total DOC	11,655	10,473	6,016	3,357	2,003	2,680	2,354	-82.8%
<b>Reimbursed Kinship Care - Dependent</b>								
Receiving Care, First Day	1,602	1,362	1,294	1,307	1,395	1,621	1,943	-12.9%
Assistance Added	1,255	1,276	1,307	1,135	1,427	1,510	1,700	13.7%
Assistance Ended	1,495	1,308	1,294	1,047	1,201	1,188	1,302	-19.7%
Total Days of Care (DOC)	534,913	491,931	490,279	496,187	559,933	641,448	757,387	4.7%
<b>Reimbursed Kinship Care - Delinquent</b>								
Receiving Care, First Day	0	0	0	0	0	0	0	0.0%
Assistance Added	0	0	0	0	0	0	0	0.0%
Assistance Ended	0	0	0	0	0	0	0	0.0%
Total Days of Care (DOC)	0	0	0	0	0	0	0	0.0%
<b>Foster Family Care - Dependent</b>								
Receiving Care, First Day	3,997	3,424	3,004	2,975	3,253	3,700	4,505	-18.6%
Assistance Added	3,382	3,203	3,103	2,887	3,491	3,908	4,624	3.2%
Assistance Ended	3,955	3,587	3,132	2,609	3,044	3,103	3,546	-23.0%
Total Days of Care (DOC)	1,358,000	1,170,528	1,109,328	1,130,490	1,272,242	1,481,928	1,639,891	-6.3%
<b>Foster Family Care - Delinquent (Total of 2 above)</b>								
Receiving Care, First Day	30	28	25	8	8	4	6	-73.3%
Assistance Added	62	56	30	17	4	10	6	-93.5%
Assistance Ended	64	59	47	17	8	8	12	-87.5%
Total Days of Care (DOC)	11,655	10,473	6,016	3,357	2,003	2,680	2,354	-82.8%
<b>Non-reimbursed Kinship Care - Dependent</b>								
Receiving Care, First Day	0	0	0	0	0	0	0	0.0%
Assistance Added	0	0	0	0	0	0	0	0.0%
Assistance Ended	0	0	0	0	0	0	0	0.0%
Total Days of Care (DOC)	0	0	0	0	0	0	0	0.0%
<b>Non-reimbursed Kinship Care - Delinquent</b>								
Receiving Care, First Day	0	0	0	0	0	0	0	0.0%
Assistance Added	0	0	0	0	0	0	0	0.0%
Assistance Ended	0	0	0	0	0	0	0	0.0%
Total Days of Care (DOC)	0	0	0	0	0	0	0	0.0%
<b>Alternative Treatment Dependent</b>								
Receiving Care, First Day	30	37	34	25	30	28	27	0.0%
Assistance Added	60	53	59	54	21	26	18	-65.0%
Assistance Ended	53	56	68	49	23	27	21	-56.6%
Total Days of Care (DOC)	11,338	14,057	12,002	12,561	13,365	13,432	13,688	17.9%
<b>Alternative Treatment Delinquent</b>								
Receiving Care, First Day	0	0	0	0	0	0	0	0.0%
Assistance Added	0	0	0	0	0	0	0	0.0%
Assistance Ended	0	0	0	0	0	0	0	0.0%

<b>Dependent Community Residential</b>								
Receiving Care, First Day	523	527	476	467	411	365	347	-21.4%
Assistance Added	786	751	755	685	532	530	471	-32.3%
Assistance Ended	782	802	764	741	578	548	516	-26.1%
Total Days of Care (DOC)	192,824	185,458	169,353	157,519	144,948	132,914	120,545	-24.8%
<b>Delinquent Community Residential</b>								
Receiving Care, First Day	236	167	170	161	127	109	103	-46.2%
Assistance Added	359	337	284	292	202	187	151	-43.7%
Assistance Ended	428	334	293	326	220	193	163	-48.6%
Total Days of Care (DOC)	78,894	67,479	53,503	63,129	46,250	40,959	37,164	-41.4%
<b>Supervised Independent Living Dependent</b>								
Receiving Care, First Day	253	234	230	244	254	194	214	0.4%
Assistance Added	208	190	195	195	92	110	112	-55.8%
Assistance Ended	227	194	181	185	152	90	92	-33.0%
Total Days of Care (DOC)	88,411	84,976	83,391	89,290	80,837	83,774	85,449	-8.6%
<b>Supervised Independent Living Delinquent</b>								
Receiving Care, First Day	47	64	58	52	35	39	36	-25.5%
Assistance Added	72	68	78	57	63	59	56	-12.5%
Assistance Ended	55	74	84	74	59	62	66	7.3%
Total Days of Care (DOC)	18,752	21,496	21,834	14,248	14,155	13,165	11,520	-24.5%
<b>Juvenile Detention</b>								
Receiving Care, First Day	120	129	124	88	99	126	105	-17.5%
Assistance Added	5,893	5,700	4,964	3,111	2,548	1,622	2,829	-56.8%
Assistance Ended	5,884	5,705	5,000	3,100	2,521	1,643	2,810	-57.2%
Total Days of Care (DOC)	38,634	42,461	43,452	38,240	38,600	32,422	38,420	-0.1%
<b>Dependent Residential Services</b>								
Receiving Care, First Day	617	575	524	481	483	431	394	-21.7%
Assistance Added	642	580	535	549	415	399	350	-35.4%
Assistance Ended	684	631	578	547	455	436	375	-33.5%
Total Days of Care (DOC)	218,150	195,630	184,157	174,337	162,029	157,838	155,523	-25.7%
<b>Delinquent Residential Services</b>								
Receiving Care, First Day	1,543	1,389	1,159	974	884	708	597	-42.7%
Assistance Added	2,419	2,235	1,782	1,579	1,327	1,073	846	-45.1%
Assistance Ended	2,573	2,465	1,967	1,669	1,503	1,184	926	-41.6%
Total Days of Care (DOC)	536,127	472,132	381,230	339,016	311,448	294,020	296,543	-41.9%
<b>3-2e. Aging Out Data</b>								
<b>Indicator</b>	<b>FY 2009/10</b>	<b>FY 2010/11</b>	<b>FY 2011/12</b>	<b>FY 2012/13</b>	<b>FY 2013/14</b>	<b>Projected</b>		<b>2009-14</b>
						<b>FY 2014/15</b>	<b>FY 2015/16</b>	<b>% Change</b>
<b>Aging Out</b>								
Number of Children Aging Out	1,341	1,333	1,219	988	1,051	921	841	-21.6%
Have Permanent Residence	37	81	180	159	346	394	477	835.1%
Have Source of Income Support	27	41	130	101	228	251	300	744.4%
Have Life Connection	42	89	197	131	394	438	538	838.1%

**3-2g. through 3-2i. Charts**

Insert up to three additional charts that capture the usage and impact of prevention, diversion and/or differential response activities. Each chart should be pasted on a separate page.

**Family and Community Support Center**

The Family and Community Support Center (formerly, Prevention Services Division) offers services to children, youth, and families in need of support but not in imminent risk of danger or exhibiting safety threats.

Services are developed and maintained to divert families from mandated services in the CYD and JJS divisions or to insure that families remain stable after receiving mandated services.

Services seek to maintain family stability and well-being, reduce risks factors for families, increase community support networks and linkages, and increase a family's ability to address its own needs.

Programs keep at-risk youth engaged in meaningful pursuits that encourage team building, self respect and esteem, educational success, anger management, and diverse social and recreational activities.

Community building of cohesiveness, mutual support, pride, and a sense of belonging are at the forefront of programs that encourage families and individuals to actively participate in the vitality, growth, and the sustainability of their communities.

Children, youth, and families served are reflected in the charts below:

DEPARTMENT OF HUMAN SERVICES													
REFERRALS BY REGION MONTHLY													
	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
<b>FY 2014</b>													
Adoptions	2	0	0	0	0	0	0	0	0	0	0	2	4
CAPTA	30	10	10	10	12	12	6	2	3	10	6	10	121
CBPS	3	7	4	1	1	3	4	1	2	1	6	3	36
Focused Services	1	1	1	2	0	1	0	1	0	0	0	1	8
IARS	31	59	84	67	59	52	49	36	44	42	38	34	595
Intake	189	217	150	177	155	172	178	138	158	162	185	188	2,069
JJS	9	6	16	11	16	15	8	7	7	11	5	29	140
OS1	3	2	3	3	1	2	3	2	1	3	3	4	30
OS2	2	0	4	3	1	0	0	1	0	4	1	0	16
OS3	5	3	2	1	1	7	6	0	2	0	0	2	29
Other	0	9	6	5	0	2	3	9	4	0	26	40	104
Prevention Service Un	0	0	0	1	1	1	0	0	1	1	1	2	8
SDP (1st - 3rd Truancy	0	0	0	0	0	0	0	3	0	0	0	0	3
Sex Abuse Speciality	21	7	8	16	17	25	11	6	12	11	17	12	163
Youth Aid Panel	7	7	12	3	3	6	12	5	2	4	10	2	73
<b>Total</b>	<b>303</b>	<b>328</b>	<b>300</b>	<b>300</b>	<b>267</b>	<b>298</b>	<b>280</b>	<b>211</b>	<b>236</b>	<b>249</b>	<b>298</b>	<b>329</b>	<b>3,399</b>

DEPARTMENT OF HUMAN SERVICES													
REASONS FOR REFERRALS													
FY 2014													
	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
After-School Programs/ Camps (OST)	174	113	131	146	82	63	105	96	61	74	140	158	1,343
Basic Needs (food, clothing, daycare, welfare, etc)	267	219	235	315	264	245	256	217	184	160	179	194	2,735
Behavioral Health (Substance abuse MH/MR referral to DBH)	144	100	147	197	159	198	197	172	195	136	148	147	1,940
CAPTA	70	25	14	20	19	21	16	8	12	21	12	43	281
Community support & Outreach	261	174	227	253	262	256	244	237	210	184	233	208	2,749
Delinquency& Violence	11	9	19	9	7	13	12	8	8	7	31	35	169
Domestic Violence	9	26	15	23	17	32	33	17	11	17	29	17	246
Educational Reengagement Center (age 16-21)	30	16	24	32	18	20	23	19	20	17	28	7	254
Family Empowerment Services(FES)	438	473	442	475	429	468	377	388	388	408	498	486	5,270
Intensive Prevention Services	59	39	72	89	104	73	69	64	103	79	111	124	986
Parent Education & Support	246	155	241	237	237	241	201	194	197	162	180	144	2,435
Specialized Supportive Services (Kinship caregivers, Respite/Crisis Care)	11	6	15	90	43	15	11	9	14	8	11	2	235
Youth Aid Panel	7	10	16	8	9	10	12	7	11	5	17	2	114
Youth Development programs/ Recreation	156	93	126	146	114	110	126	82	80	119	155	120	1,427
<b>Total</b>	<b>1,863</b>	<b>1,458</b>	<b>1,724</b>	<b>2,040</b>	<b>1,764</b>	<b>1,765</b>	<b>1,682</b>	<b>1,518</b>	<b>1,494</b>	<b>1,397</b>	<b>1,772</b>	<b>1,687</b>	<b>20,184</b>

**Chart Analysis for 3-2a. through 3-2i.**

- Discuss any highlighted child welfare and juvenile justice service trends and describe factors contributing to the trends in the previous charts.

**Projections and Unduplicated Counts**

Over the last several years DHS has worked to project trends using two very different techniques, using the exact number from the previous year and using a strict scientific logarithm. The first method essentially communicated that service usage was anticipated to plateau and the second did not take into account the dynamic nature of the work of child welfare. In order to refine the precision of the projections, last year DHS took both numeric trends as well as internal and external factors into account. From DHS' perspective this adapted process has worked well. As a result both numeric trends as well as internal and external factors were again taken into consideration when making this year's projections.

**Service Trends**

Beginning in the second half of 12/13 through the entirety of 13/14 DHS experienced an increase in the number of reports received by the Hotline. Due to pending legislation as well as continued anticipated challenges for Philadelphia families due to poverty issues and a decrease of available supports from other system partners (e.g. School District), DHS is projecting that the number of reports during 13/14 to continue to increase.

Regarding ongoing dependent services, DHS is in the process of implementing an array of initiatives that DHS believes will have a direct effect on service utilization. Work with the Child Welfare Demonstration Project, Congregate Care Rightsizing, and Family Team Conferencing will have a direct impact on decreasing the number of bed days used for dependent congregate care placements. Since many youth who leave congregate care will step down to lower level placements, the Department is projecting an increase for family foster care. With the increased number of reports to the Hotline, DHS is also projecting that the number of children, youth, and families receiving ongoing services, including the overall number of children and youth in overall dependent placement, to increase.

The Department anticipates the number of youth in need of SIL services to slightly increase. This increase is anticipated due to the continued implementation of Act 91.

DHS is also anticipating that the number of youth who age out of the system will decrease. The four identified IOC outcomes are directly aimed at achieving permanency for the older youth population. Strategies such as the Congregate Care Rightsizing and Family Team Conferencing will support the achievement of these outcomes. Additionally, with youth who do age out of the system, DHS is projecting increases in the number of these youth having a permanent residence, having a source of income, and having a life connection. These increases will occur due to a focused effort on long term planning through the teaming and single case plan processes.

- Discuss any important trends that may not be highlighted.

Response will be submitted with final narrative.

- Is the overall trend in the number of dependent children being served or in care in the county different than that in the state as a whole? In counties of the same class?

Philadelphia's decreasing population trend from Federal Fiscal Year (FFY) 2008 to 2013 was consistent with the surrounding counties and the state. Beginning in January 2013, Philadelphia began to experience an increase in its placement population which has continued. The proportion of youth in the 13-to-17 age group each comprised approximately 29% of the served placement population. Moreover, the percentage of youth served who were as least 18 years old represents 12% of the placement population.

Currently, Philadelphia has the highest rate of deep poverty of the most populous cities in the country. As a result 37% of the children and youth in Philadelphia are residing in poverty. This factor also contributes to an increase in our service needs.

- Please describe what demographic factors, if any, have contributed to changes in the number of dependent and SCR children being served or in care.

As reported in the Philadelphia Inquirer, March 20, 2013, from an examination of the 2009 through 2011 three-year estimate of the U.S. Census American Community Survey by the Inquirer and Temple University sociologist David Elesh, Philadelphia has the highest deep poverty rate of any of the nation's 10 most populous cities, at 28.4%. Surrounding counties have a rate of 3.6 %. People in deep poverty have incomes below half of the poverty line and are more likely to stay in poverty, never finding a way out. At highest risk within this group are children and youth. Children and youth in poverty and deep poverty do poorly in school, have poor living conditions, and have possible higher risk of abuse and neglect. As reported in the Philadelphia, July 13, 2014, Philadelphia has a reported rate of 37% of children and youth in poverty. DHS believes that these factors contribute to an increase of dependent children and youth and SCR children and youth being served and in care.

- Please describe what changes in agency priorities or programs, if any, have contributed to changes in the number of dependent and SCR children served or in care and/or the rate at which children are discharged from care.

#### Improving Outcomes for Children

In December 2013, the Department of Human Services (DHS) entered year two of the implementation of Improving Outcomes for Children (IOC) initiative. This new approach to service delivery focuses on the neighborhoods where children, youth, and families live. Within IOC, case management services for children and youth involved with the child welfare system are delivered by community-based providers known as Community Umbrella Agencies (CUAs), while DHS maintains responsibility for the Hotline and Investigations functions, monitoring and, oversight, and quality assurance.

#### Child Welfare Demonstration Project (CWDP or Demonstration Project)

The Philadelphia Department of Human Services was accepted as a participating county in Pennsylvania's Child Welfare Demonstration Project. The approach used in IOC is critical to the design of the Child Welfare Demonstration Project. Given the magnitude of the system

change involved in the implementation of IOC, DHS will align th implementation of the Evidence-Based Practices (EBPs) which are components of the Demonstration Project with IOC goals and objectives. Consequently, EBPs will be developed and delivered through the CUAs and through the provider network contracted by Philadelphia's Community Behavioral Health Department (CBH) to deliver behavioral health services and ensure comprehensive coverage for the DHS population.

In year one of the Demonstration Project, as part of the Department's ongoing IOC system change, DHS and the CUAs engaged child welfare clients, particularly those involved in congregate care, in a series of Family Group Decision Making (FGDM) and Family Team Conferencing (FTC) meetings to support safety, permanency and well-being. At the same time, DHS worked toward the implementation of the FAST and CANS tools as a means to assess the needs of our client population and point the way to evidence-based practices that can serve those needs. Development of these tools in DHS' Electronic Case Management System (ECMS) and training CUA staff to conduct these assessments was completed in the fall of 2013.

Preliminary analyses revealed that at least 32% of DHS-involved children and youth are in need of higher level services than are currently available. Furthermore, it is clear the Department's other assessment strategies – Quality Service Reviews (QSR), ChildStat, and routine case file reviews - that trauma-informed services are a necessity for the many children, youth and families in our population, particularly with regard to parent-child relationships and family functioning as they support functioning. Consequently, DHS has been able to work with the CUAs to select three interventions that fit the age range and diverse needs of our general population.

- Parent-Child Interaction Therapy (PCIT) is an evidence-based behavioral health intervention that focuses on improving the caregiver-child relationship, increasing positive parenting strategies, and increasing children's positive behaviors while simultaneously decreasing negative child behaviors. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child.

In Philadelphia, Child-Adult Relationship Enhancement (CARE) is being offered in conjunction with PCIT as part of a separate project conducted by the Children's Hospital of Philadelphia (CHOP). CARE is a field-initiated group training program for adults interacting with children in a variety of settings. Although we may potentially expand this program based on the research, we are not including it in this Demonstration Project.

- Positive Parenting Program (Triple P) is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise to keep kids safely in their communities (IOC Goal 1). Because it is not a one-size-fits-all model, it can be cost efficient and effective as families only receive the services they need for a time period suitable for them.
- Functional Family Therapy (FFT) is an intensive, short-term family therapy model targeting at-risk youth ages 10-18 with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses. FFT has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts. The FFT model is organized around phases of

treatment that emphasize engaging and enhancing the motivation of the youth and family, facilitating change within the family, and generalization of changes.

These three interventions align best with all of IOC outcomes, provide the most comprehensive coverage for all eventualities, and complement an already robust set of services available in the city of Philadelphia. See the detailed descriptions of these interventions on pages 9-18 in the IDIR-U, Attachment A.

#### Rightsizing Congregate Care

Reducing overreliance on group homes and institutions is key to the success of Improving Outcomes for Children. Congregate Care Rightsizing (CCR) ensures that congregate care placements are appropriate and treatment focused. The goal is to identify youth who could be better served in a family setting, and provide an opportunity to serve children and youth in their own homes and communities when possible.

Philadelphia has a higher rate of children in Congregate Care than other jurisdictions of similar size. The national average is 14% and decreasing. Research suggests that children and youth in Congregate Care are at a greater risk of physical, emotional, behavioral, and social issues. These children and youth will lack emotional attachments with adults that they need in order to be successful. To improve outcomes for children and youth who have been placed in group homes, institutions, SILs and shelters, the Department of Human Services (DHS) has implemented CCR.

There are four processes under CCR to improve these outcomes and reduce its use: the Commissioner's Approval Process, the Expedited Permanency Meetings, Emergency Shelter Rightsizing, and clear CUA Guidelines for the use of this level of care.

As of July 1, 2012, 24% of the dependent placement population in Philadelphia was placed in congregate care settings. On October 31, 2012, Commissioner Ambrose instituted the Commissioner Approval Process which required the Commissioner's office to approve all congregate care placements. The Commissioner or designee personally reviews each referral submitted to the CRU when a youth has been recommended to enter a Congregate Care setting. Since the inception of the process, the Commissioner's office has reviewed 1808 referrals.

As of June 2014, the number of children and youth in congregate care has decreased to 17%. DHS has made it a goal to be below the national average and strive to reduce the number of youth in congregate care to 13%.

The Expedited Permanency Meetings (EPMs) is a one-time, structured and facilitated meeting for the purpose of identifying and safely transitioning youth out of congregate care to a family-like setting or achieve the goal of permanence. An EPM addresses those youth who have been in care for over four months and less than two years. During the month of June 2013, DHS hired and trained DHS staff in Expedited Permanency Meetings. As of July 2014, there have been 166 youth selected to take part in the EPM process. To date, 70 children have transitioned to a family like setting from congregate care placements, with the majority of the youth returning home to their parents/guardians with appropriate supportive in-home services to ensure stability. In the upcoming months, it is anticipated that the parameters for EPMs will expand allowing more youth to be eligible for this goal-specific teaming process.

In addition to the Commissioner Approval Process and the EPMs, DHS is taking steps to reduce its use of Emergency Shelter services and reduce the length of time youth remain in Emergency Shelter when kin or resource homes are not immediately available. DHS had nine emergency shelters in May 2013. DHS has discontinued contracts with four shelters. DHS is currently utilizing 4 shelters for youth between the ages of 14-18, and one shelter that is only used for youths 18 years of age or older. New CRU afterhours emergency placement protocol has been implemented to streamline the placement process to ensure that the afterhours emergency placements are monitored. The Performance Management and Accountability (PMA) Division produces monthly data to track shelter utilization.

Finally, in terms of the IOC rollout, the CUA Guidelines require all congregate care placements to be approved by the CUA Director. The CUA Case Manager and Supervisor must specifically document progress being made to move the youth to a lower level of care or adjustments to the plan if the reason for the youth's placement in congregate care are not being ameliorated. Continued placement in the congregate care setting must be reauthorized by the CUA Director every three months. Specific guidelines around the use of Emergency Shelter and limitations on length of stay are currently in development.

#### Shared Case Responsibility (SCR)

Shared Case Responsibility provides an opportunity to provide a wider array of services to youth who are under probation supervision and have child welfare, or dependency issues. SCR ensures that appropriate services are provided to address all identified needs. All staff trainings for SCR within DHS have been completed and the numbers of SCR or dependent cases received in DHS are expected to increase while the numbers of delinquent cases are expected to decrease due to SCR and reintegration services on the juvenile side.

#### Front-End Workflow Streamlining

To more effectively deal with increasing numbers of reports, and to more efficiently transfer families who are accepted for service to the Community Umbrella Agencies, the Department is working with a consultant to streamline Front-End practices. In the first phase, a workgroup consisting of staff from Hotline, Intake, Special Investigations and Policy and Planning, was formed to identify and examine the workflow from the point a referral is made to DHS until the point an Accepted for Service family is transferred to a CUA for ongoing case management services. Additional phases of the work will involve reviewing practices for duplication of efforts and other inefficiencies. By streamlining these practice, families will be able to more quickly receive the services needed to enhance their protective capacities so that children and youth can remain in their homes or have permanency.

#### Family Empowerment Services

This in-home service combines the services formerly known as Alternative Response Service (ARS) and Pre-Alternative Response Service (Pre-ARS) into one service. Family Empowerment Services is a program for families with no identified safety threats, and while they are in need of services, do not warrant formal Child Protection Services. This program allows families to benefit from services within their own community.

- Are there any demographic shifts which impact the proportions of dependent and SCR children in care (for example, are younger children making up a larger proportion of admissions than in years past)?

When comparing July 2012 to July 2014, the percentages the placement population who are youth (i.e. ages 13-15, 16-17, 18-21) in care have slight decreases while the percentages of children in placement are showing slight increases.

- How has the county adjusted staff ratios and/or resource allocations (both financial and staffing, including vacancies, hiring, turnover, etc.) in response to a change in the dependent and SCR foster care population? Is the county's current resource allocation appropriate to address projected needs?

Implementation of IOC continues with seven CUAs receiving cases for ongoing case management services as of July 21, 2014. The first five CUAs receive cases for all in-home and placement services. As of July 15, the first five CUAs are providing services to 1,363 current, active cases. CUAs 6 and 7 will be receiving in-home and placement. As a result, on May 26, 2014, DHS officially phased out its Ongoing Service Region (OSR) 2. Some of the staff from OSR 2 have transferred into the new IOC related positions; the remaining staff have been moved to OSR 1 and 3 to fill vacancies left by staff from those regions who also transitioned to IOC positions.

As IOC has been implemented, DHS realized that CUA staff and DHS Practice Coaches would benefit from having experienced, supervisory level DHS staff to provide guidance and technical assistance around practice related issues. Learning Specialist positions were created within DHS University to supervise the Practice Coaches and to provide additional guidance to the CUAs. The positions were open to DHS Social Work Supervisors to apply. These redeployments, in addition to loss of staff through retirement, promotions, and other lateral moves has resulted in significant CYD staff attrition.

#### **IOC Initiative Reinvestment Strategies:**

As DHS implements IOC, there are key services that are necessary components for supporting families, children, and youth served to achieve permanency, enhance parenting capacities, empower families, and facilitate stabilization of the family unit. Some evidenced based practices that will be implemented in IOC are also components of the Child Welfare Demonstration Project (CWDP).

##### **Parent Child Interaction Therapy (PCIT)**

This is an evidence-based practice that is also a component of the CWDP. Please see response under the question regarding changes in agency programs and priorities for more detail.

##### **Positive Parenting Program (Triple P)**

This is an evidence-based practice that is also a component of the CWDP. Please see response under the question regarding changes in agency programs and priorities for more detail.

##### **Functional Family Therapy (FFT)**

This is an evidence-based practice that is also a component of the CWDP. Please see response under the question regarding changes in agency programs and priorities for more detail.

**Visitation Coaching:**

Visitation Coaching (VC) helps parents to take charge of their family's visits and plan specifically how they will meet their child or youth's needs.

**Strengthening Families Model Training:**

This research-based, evidence-informed approach to practice is central to the community-based emphasis of IOC and uses community programs to enhance protective factors for children and families. This training is for both CUA and appropriate DHS staff.

**Parent Advocate and Youth Advocates:**

These positions serve on an as needed basis to support the overall operations of the CUA.

**In-Home Services Enhancements:**

Concrete goods and Aftercare funding:

Resources for concrete goods and aftercare funding have been included in the CUA budgets.

**Placement Service Enhancements:**

Resource Home Coordinators:

This is specific to the CUA being able to build a pool of resource parents within their subcontractors who live in the CUA area, who view reunification as the preferred permanency option, and who view themselves as mentors for the reunification resource both during and following placement services. In addition, these efforts focus on developing creative strategies to outreach and identify resource parents willing to open their homes to the more challenging population of older youth, minor mothers and their babies, and youth with delinquent behaviors who may also be appropriate candidates for foster care.

Life Skills Coaching:

This position provides life skills coaching, supports, instruction, and modeling for youth and caregivers who are accepted for services with a CUA.

Well-being Specialist:

This position is meant to provide structure to ensure that children and youth have their medical and behavioral health visits completed and whenever possible that a Medical Home is established for each child or youth to ensure consistent and comprehensive care and follow up.

Aftercare Worker:

As a part of the CUA Support Team, Aftercare Workers provide supportive services to families who have recently had a child or youth achieve permanency from any level of placement through reunification, family stabilization, or PLC. Aftercare workers also provide supportive services for children, youth, and families who have achieved safe case closure following in-home services.

Parent Cafes:

Strengthening families within their communities is the core of what IOC strives to accomplish. Parent Cafes allow parents and other support members to gather in a

comfortable, culturally embracing location to form partnerships and allow for discussions on what families in their communities need to support children and youth from entering out-of-home care and what is needed to reach timely permanency plan if out-of-home care is necessary. Parent Cafes provide a forum for conversations around topics that give caregivers the tools to strengthen their parenting capacities and understand the warning signs that could lead to abuse and neglect.

Parent Cafes provide ongoing training and support for “Parent Hosts” so they continue to grow as leaders of their own families and community. Outreach with community groups and systems that serve children, youth and families helps to maintain a consistent and strong support base.

This work is being managed by the Strengthening Families staff at each CUA and lead by staff at the Achieving Reunification Center.

#### Ancillary Services:

Providing support when needed is essential to caregivers and can be the deciding factor in whether or not a caregiver makes a decision to care for children in need while a parent works towards reunification. Understanding how important it is to identify kin to care for children and youth DHS would like the CUA to be able to secure services such as homemaker care to help clean a home and services to help make minor repairs which can help an identified kin bring their home into compliance and open their home to a child or youth who already has an established relationship with the identified kin. Funds could also be used for informal respite such as using a babysitter to allow a parent to attend educational workshops, training programs or even just take a couple of hours as a break when they feel it's needed. By providing these kinds of creative resources to kin, DHS recognizes that many families will be able to benefit from having peace of mind knowing their children are being cared for by someone they are familiar with which will hopefully allow the parent to concentrate more on achieving reunification. DHS funds these positions at the CUA. One “Outcomes Specialist” worker is funded at each CUA for each 50 families.

#### Legal Support:

In an effort to increase permanency and ensure safety and well-being for children involved with the Philadelphia Department of Human Services, the Law Department's Child Welfare Unit (CWU) supports the transition to and implementation of IOC. See response below regarding Legal Support Requirements.

### **Non-IOC Reinvestment Strategies:**

#### **Education Support Center**

Since the Fall of 2009, the Department of Human Services' Education Support Center (ESC) has successfully maintained its principle goal of improving the educational stability, continuity, and well-being of children and youth involved with DHS, including those that are dependent, delinquent, receiving intensive, safety-focused, in-home and placement services, and those receiving prevention services.

The ESC is staffed with Education Stability Liaisons to identify and remove educational barriers for system-involved children and youth. They work closely with existing DHS Social

Work Service teams, CUA Case Management teams, CUA Community Liaisons, Provider Social Work teams, school counselors, and school social work staff to ensure a successful academic experience for children and youth who have challenges around academic performance, attendance and behavior.

As of FY2014, the ESC has adopted the following goals that will undergird the overarching focus of the Center's support delivery:

- Advance Successful Educational Outcomes for DHS Older Youth through exposure to and coordination of afterschool and summer learning experiences.
- Promote Successful Post-Secondary Transitions and Enrichment opportunities for DHS older youth by 10%.
- Ensure Successful Educational Outcomes for DHS children, ages three - five years, by increasing enrollment and/or attendance in quality Early Childhood Education programs by 10% through tactical cross-system coordination and alleviation of barriers to program access.
- Support Successful Educational Outcomes for DHS children, birth to five years, who qualify for Early Intervention services through tactical cross-system collaboration, augmentation of DHS referrals by 10%, and alleviation of barriers to service coordination.

The Education Support Center made several notable funding recommendations for the FY2014/15 Needs Based Budget and has outlined several successful planning and implementation efforts that have occurred in relation to our past recommendations. ESC has utilized multiple strategies to successfully build program capacity, enhance system partnerships and sustain service delivery by way of the following:

#### ESC Support Enhancements

- By strategically co-locating in specified schools within CUA/School District catchments, ESC has increased support for families who are at risk of initial or further system involvement, as well as those who are currently system involved. ESC works with the School District of Philadelphia and Community Umbrella Agencies to support academic success for DHS youth and social and educational continuity and well-being initiatives within CUA service areas.
- ESC maintains collaboration efforts with the School District of Philadelphia by supporting its Re-Engagement Center and Student Transition Center initiatives. These efforts offer alternative school options for obtaining a high school diploma and an expeditious school assignment to DHS youth and to overage and under-credited youth at risk of neglect and abuse.
- ESC most recently expanded its collaborative efforts to include focus on Early Childhood Education/ Early Intervention. The ESC has built cross-system collaboration with Elwyn, Childlink, Department of Behavioral Health & Intellectual Disability Services and the School District of Philadelphia to increase access and streamline coordination of services for DHS children to ECE and EI services. This expansion will increase School District programming support, as well as the early learning program work of providers across Philadelphia County. Efforts extend to revising DHS policy regarding referrals once ASQ assessments are completed.
- ESC is expanding its staff complement from 19 to a total of 45 within FY2015. Expansion will encompass the following:

- 20 DHS Education Liaisons. Two (2) DHS Education Liaisons will be assigned per CUA catchment, co-locating within SDP schools to troubleshoot educational barriers for children and youth K-12<sup>th</sup> grade and also act as the point of contact for their respective CUA, school cluster and CBH staffing within the CUA catchment area for DHS youth.
- Ten DHS Early Childhood/Early Intervention Education Liaisons. One Education Liaison will be assigned per CUA catchment area to troubleshoot educational and service barriers and assure linkages for children birth to six years old to access and receive early intervention and early childhood education.
- Five DHS Education Liaisons dedicated to older youth for Post Secondary Transitions and Academic Enrichment. One Education Liaison will be assigned per two CUA catchment areas to troubleshoot and assist in successful academic transitions for older DHS youth, Act 91 youth, and offer supports to former DHS youth who seek assistance.

ESC has increased and extended its education stability training, support, and incentive capacity to Community Umbrella Agency staff members and is actively working with DHS' Performance Management and Accountability Division to plan data system integration within DHS to encourage improved agency practice and more reliable data reporting on education, and overall well-being outcomes for children and youth ages 0-21 years.

ESC Liaisons have received Strengthening Families Professional Development Training, as well as Being Trauma Informed (BTI) training via DHS' TEECH grant in order to improve their effectiveness in day to day support measures.

ESC has also instituted an Emergency Education Fund to alleviate financial barriers to education. The funding source covers costs such as graduation fees, school uniforms, college tuition balances, academic credit recovery and book fees for DHS involved youth after all other financial resources have been exhausted.

#### **Collaboration and Partnerships:**

Ongoing Project U-Turn Committee Membership & Participation. The Committee facilitates the activities around Philadelphia's campaign to resolve the dropout crisis through a collective impact approach.

- ESC provides guidance, strategic direction and oversight for the high school credential work of the Philadelphia Council for College & Career Success.
- Is involved in the development of a multiyear work plan to guide the PUT investments and advocacy.
- Reviews and recommends program allocations related to the School District of Philadelphia's alternative school programs and models targeting disengaged students and those who left school without completing high school or their respective program of study (vocational / degree / etc.)
- Contributes content knowledge and advises fellow committee members in the Center's areas of expertise, including participation in sub-committees and ad hoc committees where needed.

ESC has newly created partnerships with City-wide stakeholders: Summer Search, The Franklin Institute, Springboard Collaborative and Settlement Music School. The purpose of these partnerships is to ensure that children and youth in out-of-home care whose educational assessments reveal inadequate skills in reading, writing, and/or math receive in-school and out-of-school-time supports. These supports are evidence-based interventions

with ongoing reviews intended to improve their knowledge, academic skill sets and overall social and emotional well-being.

Recently teamed with CCIS, Childspace CDI, DVAEYC, the Mayor's Office of Education, MetroKids and Opportunities Exchange to develop a plan to increase access to quality childcare and early learning programs throughout the City of Philadelphia. The effort has since led to a shared interest in having Great Philly Schools host a web-based mechanism that will give dependent teen parents, system involved families, kin and resource parents and the greater Philadelphia community more streamlined access to quality care and programming throughout the City.

The City of Philadelphia, the School District of Philadelphia and Policy Lab at The Children's Hospital of Philadelphia released a report on the educational outcomes of public school students involved with DHS. The report— *Supporting the Needs of Students Involved with the Child Welfare and Juvenile Justice System in the School District of Philadelphia*—examines the challenges faced by dependent and/or delinquent students and highlights opportunities to align resources to better meet their needs. The ESC worked to provide valuable feedback and input throughout their research process and also collaborated with The School District of Philadelphia and the Mayor's Office of Education to devise an action plan to increase the educational successes of youth served by DHS. One such action was to expand Education Support Center staffing capacity and co-locate Liaisons within District schools that through research and analysis, proved to have a higher number youth with system involvement or an overall community population that was at greatest risk of involvement.

### **Legal Support Requirements**

New Child Welfare legislation, a clarification of parents' and guardians' due process rights with respect to Safety Plans, managing the transition to Improving Outcomes for Children, and an increased emphasis on permanency has led to a need for additional legal staff.

#### **I. Changes in Child Welfare Law**

Solicitor Review of Indicated CPS reports.

Effective 12/31/14, Solicitors must perform a substantive review of CPS reports that DHS intends to indicate, including an assessment of legal sufficiency, as a final step before the report can be submitted to ChildLine. The City of Philadelphia Law Department will create a special unit within the Child Welfare Unit to:

- Perform the review of indicated CPS reports, which are expected to increase due to the expansion of who must report child abuse and the definition of abuse itself. This review is expected to be labor and time intensive, entailing review of DHS documents and other documents and evidence that may need to be requested. The current staff of attorneys spend the majority of their time in Dependent Court and cannot take on this additional responsibility created by the changes in the law without compromising some of their other functions, particularly timely reunification or other permanence.
- Handle fair hearings before the DPW Bureau of Hearings and Appeals (BHA) when indicated perpetrators of child abuse appeal the finding by DHS. Creating a special unit for review of indicated CPS reports allows the same attorney who reviewed DHS' indication of a report to defend the decision before BHA. It improves efficiency and increases the probability of success to have an attorney who is already knowledgeable of the facts and legal issues represent DHS rather than have another attorney have to become knowledgeable of the details of the investigation. A legal assistant will also be

needed to work with the special unit to help prepare documents for hearing, subpoena witnesses, etc. because changes in the Law will shorten the time frame between the date of the appeal request and the actual appeal.

- Complete all redaction/case file request assignments presented to the CWU. The attorneys in the special unit will spend less time in court than other attorneys and are better able to focus their time on these redaction of case file requests. The volume of redaction and case file requests is great and has inadvertently caused a barrier to permanency because it detracts from the amount of time that the CWU attorneys assigned to Dependency Court have to work on achieving reunification or other permanency for these cases. By centering this responsibility in a special unit, the CWU attorneys assigned to represent DHS in Dependency Court will be better able to concentrate on achieving. Furthermore, many of the requests for DHS files are related to BHA appeals of indicated reports and it is most efficient for the same attorney who reviewed the indicated report, and who may be litigating an appeal, to complete the work related to a request for the file.

In order to meet this new requirement of the Law, the Child Welfare Unit (CWU) requires five 5 additional attorneys and one legal assistant.

Exchange of DHS information with Domestic Relations (DR) Court. The changes in the Child Welfare Law also include a new requirement that Domestic Relations Judges must request any CPS, GPS, or both information DHS has regarding the family in cases involving children (e.g. custody cases, divorce cases involving children, etc.). The DR Judges when provided with this information will likely request further information from DHS. We expect a high volume of requests from DR court, based on the significant number of requests currently handled by our Chief Deputy Solicitor before passage of the new law, and anticipate that many of the cases will have had previous or current DHS involvement. A Senior City Solicitor who has experience dealing with many Judges is necessary to ensure that DHS is properly represented in what will likely be voluminous interactions with DR Court. A Senior City Solicitor will act, in effect, as a liaison with DR Court Judges and a Legal Assistant will assist in preparing reports for Judges who make requests for further information.

In order to meet this requirement of the Law, the CWU requires one Senior City Solicitor and one Legal Assistant.

Expanded Definition of Child Abuse and Mandated Reporters. The changes in the Child Welfare Law, as stated above, include an expansion of the definition of abuse and who must report it. This change will result in more Dependency petitions filed by the CWU which will significantly increase work flow. Delays in the filing of petitions can cause safety issues for children and youth and ultimately delay permanency because permanency time frames do not begin until a formal petition is filed with the Court. A Divisional Deputy is needed to supervise and manage the increased workflow based on changes in the Child Welfare Law. The Divisional Deputy will also serve as an Officer Manager who will focus on staffing Dependency Court to most effectively meet the requirements of the changes in the Law.

To meet the expanded work flow, one Divisional Deputy City Solicitor, one Legal Assistant Supervisor, one Legal Assistant, one Support Staff are required.

## II. Safety Plan Hearings.

Recent Federal case law holds that parents and guardians have a due process right to have DHS Safety Plans requiring that a child be separated from a parent or guardian reviewed. DHS has been working with the Honorable Kevin M. Dougherty to establish a forum at Family Court for Safety Plans to be reviewed by a Master. A dedicated Deputy City Solicitor who is skilled at Court representation with very little preparation is needed to adequately represent DHS at the review hearings as there will be little time to prepare these cases for Court. Furthermore, a Legal Assistant will be needed to write and file the petitions that will trigger the review hearings in Family Court.

One Deputy City Solicitor and one Legal Assistant are required for the CWU to prepare for and staff these forthcoming Safety Plan Review hearings.

### III. Permanency/Improving Outcomes for Children.

DHS is in the midst of transitioning to its Improving Outcomes for Children (IOC) initiative which involves Community Umbrella Agencies performing all case management services for DHS involved children and youth. When the transition is complete, it is anticipated that all CWU Dependency attorneys will handle CUA cases. However, during the period that DHS continues to run a dual system, additional staff are needed for purposes of Court preparation. In particular, the LSI Legal Assistants will work with the CUAs and CWU staff to make sure that all documentation (birth certificates, death certificates, searches for parents etc) is generated in a timely fashion so that permanencies such as Adoption and Permanent Legal Custodianship are not delayed. A Senior Solicitor will work with the current Divisional Deputy City Solicitor who is managing the transition to IOC to handle the increasing workload as the roll-out of the CUAs continues to occur.

One Senior Attorney, two LSI Legal Assistants, one Support Staff are required to ensure timely permanency during the transitional period.

#### **ACT 80**

DHS has been implementing the requirements of Act 80 which extends PLC and adoption subsidies to age 21 for youth who enter those arrangements at age 13 or older. Letters were developed to send out to identified caregivers for youth eligible for the extension and additional, clerical staff were hired to process the requests for subsidies and follow-up with families regarding documentation.

#### **Act 91**

Since Act 91 became effective, DHS developed a protocol to assist young adults who are seeking resumption of Court jurisdiction. With the continued implementation of IOC, some of these young adults reside within CUA districts and will receive housing and other services through the CUA. Because the situations leading to resumption of jurisdiction does not fall within the process that normally triggers Family Team Conferencing and transfer of a case to the CUA, the protocol had to be revised to this into account.

Based on initial tracking, data suggest that within a relatively short time after discharge, these youth become homeless or face imminent homelessness often accompanied by the lack the social capital and skills to find employment to remedy their circumstances. The needs of these youth span the spectrum from a simple acquisition of necessary life documents (birth certificate, SSI and insurance card etc.) to incorporation within required systems based on identified needs (OVR, DPA, OMR, CBH, etc.). To meet this need, the

Department will hire an additional Re-entry Liaison. The current Re-Entry Coordinator is responsible for interviewing and assessing young people who are requesting re-entry into DHS care. The Coordinator is responsible for assessing eligibility and following through with the youth to Court. This individual works very closely with the attorney to ensure proper representation of the case and facts to determine if resumption will occur. The person also mentors and supports the youth through the court hearing and until case is assigned to case manager. However, because the Coordinator spends so much time in Court, an additional individual is needed to concentrate on the service side of re-entry, creating a service base, working on transition planning and tracking these young adults for health care reasons.

**National Youth in Transition Database (NYTD) Coordinator:**

In order to meet the challenge of tracking youth and getting them to participate in the follow-up NYTD surveys, the Department is proposing to create a new position, the NYTD Coordinator. This person is responsible for compiling the list of eligible youth who will be the subjects of the NYTD report. The NYTD Coordinator needs to have excellent communication skills to gather information from all sources including social workers, providers and youth. This individual also needs to be able to effectively outreach to youth who may be transient or in other systems to enable us to capture outcomes. The Coordinator is also responsible for communications with providers, child welfare workers and Department of Public Welfare to ensure accuracy and timeliness of report.

**JJS Evening Reporting Centers (ERC):**

JJS Evening Reporting Centers have proven to be a cost effective means of diverting youth from secure detention and subsequent residential placements through constructive engagement, high quality supervision, and educational supports in the evenings, a time when delinquent activities are more likely to occur.

In November, 2013, Philadelphia opened two Evening Reporting Centers (ERCs) as additional alternatives to secure detention. The purpose of the ERC's is to prevent re-arrest and ensure appearance in court. The ERCs are both currently operating close to their capacity of 20 youth each, with one of the programs servicing only males, and the other program servicing males and females separately with gender-specific programming.

Inspired by the success of the ERCs, Philadelphia now looks to create two new community-based centers as an alternative to placement, borrowing heavily from the ERC model. Rather than a 30 day commitment to these programs, as occurs with the ERC model, the Department envisions that youth will be committed to the centers for periods of approximately 6 months. During this time, youth would receive high quality and evidence-based programming, supervision during the evening hours, and an array of positive youth development opportunities. It is projected that the opening of these centers to take place by September, 2014, coinciding with the start of the new school year.

**Gender Responsive Group Homes:**

Philadelphia recognizes that few resources exist for female youth in its juvenile justice system and is forming a collaborative of stakeholders to identify specific gaps and the resources to address them. The Department remains committed to use community-based resources where possible. However, DHS also recognizes that the response to issues like human trafficking of girls involved in the DHS system may call for an expansion of residential programs to remove these uniquely vulnerable girls from the community and from access by the individuals who jeopardize their safety. To that end, both residential and

community based resources are being considered, all of which will have heavy emphasis on trauma based services.

**GPS Monitoring:**

As an alternative to secure detention, GPS monitoring facilitates the Court supervision of 200 – 225 youth daily. For the first quarter of 2014, 226 youth were successfully discharged from GPS monitoring . The use of GPS monitoring allows the Court to remain consistent with the Balanced and Restorative Justice (BARJ) principles of youth accountability and community protection.

**Family Group Decision Making for Delinquent Youth:**

The Juvenile Probation Department, by way of an expanded DHS contract with It Takes a Village, Inc., is embarking on the use of Family Group Decision Making (FGDM) for youth transitioning back from JJS residential placement. In September 2014, Residential Service Unit Probation Officers will receive a one day overview of FGDM followed by a two day skill builder. FGDM will assist in building natural support systems through family and community for high risk youth and bring together all agencies involved with a family to follow one plan.

**Prison Rape Elimination Act (PREA):**

Consistent with the requirements of the Prison Rape Elimination Act (PREA), enacted by congress to address the problem of sexual abuse of individuals in the custody of all public and private institutions that house adults or juvenile offenders, the Philadelphia Juvenile Justice Services Center (PJJSC) is preparing for the first of its annual audits. The Law Department is currently reviewing the Department's PREA policies and procedures. Once they are approved, they will be communicated to all staff, volunteers and contracted providers by way of series of substantive trainings. The Department is in the process of contracting with a certified auditor and anticipate that our audit will occur sometime prior to the conclusion of the year.

**MOM Program:**

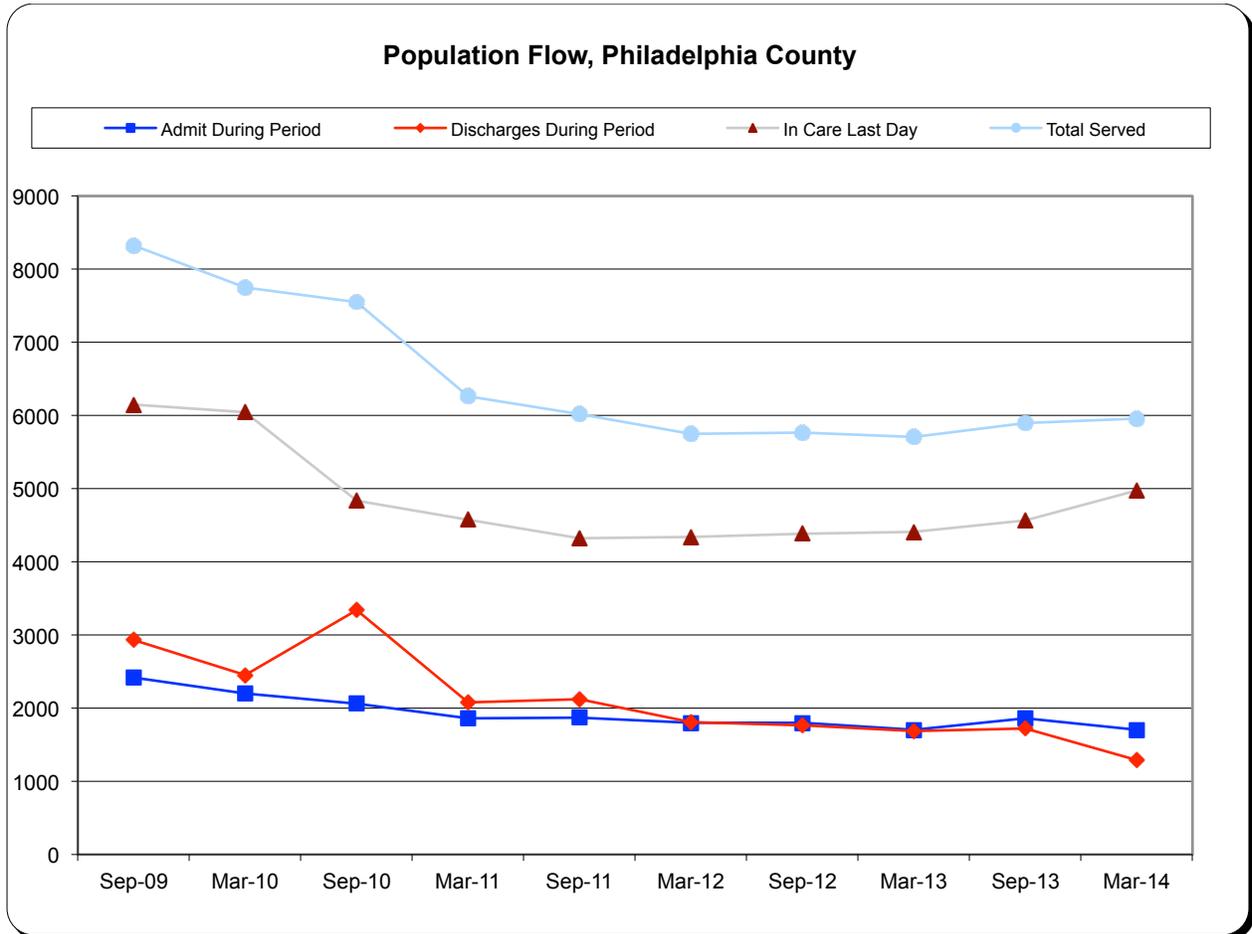
By the close of fiscal year 2014, the MOM program had enrolled over 1,200 participants through its work in five zip codes in North Philadelphia. In the three years of program existence, participants have received 5,500 home visits and more than 8,000 phone calls to discuss their children's health, early childhood education, child development, and Early Intervention Services. Participant retention rates remain extremely high for a home visiting program, running at approximately 70%.

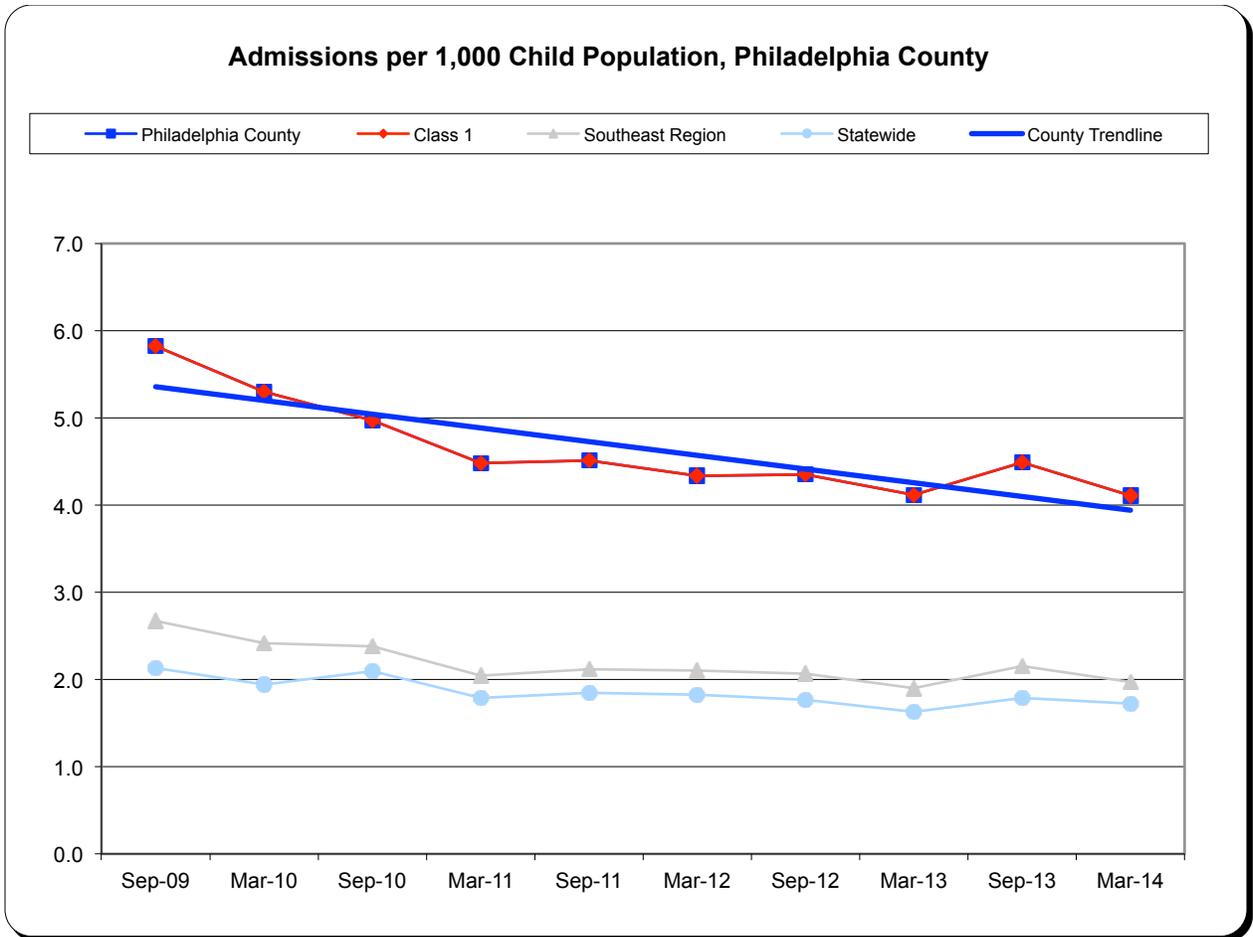
At 18 and 36 months, every child in the MOM program is screened for development delays using the Ages and Stages Questionnaire. To date, about one-third of those screened tested outside normal limits and mothers have been referred to the Early Intervention system for follow-up. These families receive enhanced outreach to assist in navigating the Early Intervention system.

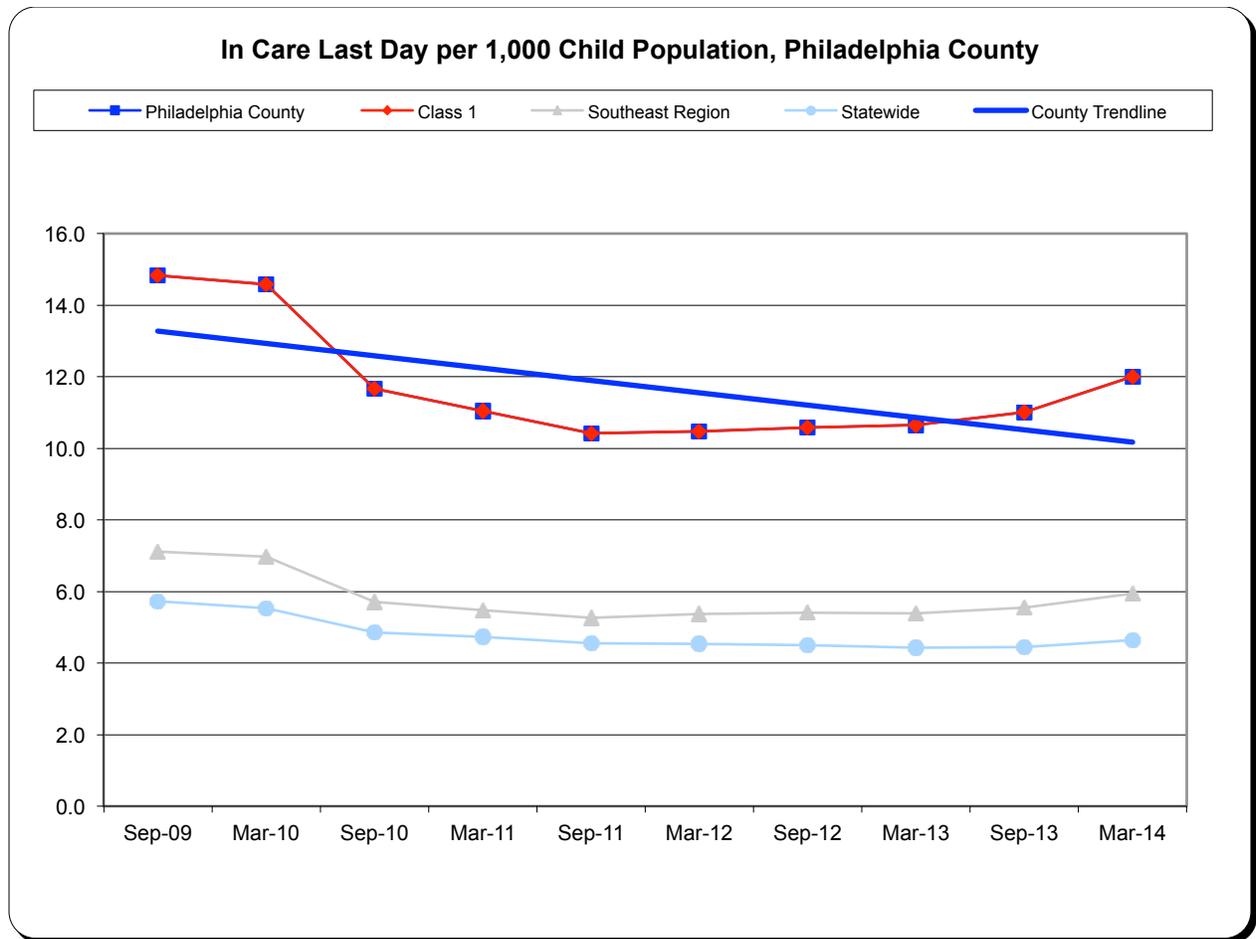
**3-4 Benchmark and Strategies**

Counties must select a minimum of three Outcome Indicator charts that are relevant to their identified Benchmarks and Strategies as previously submitted in their Needs Based Plan and Submissions.

- CWDP counties and prospective CWDP counties must select Outcome Indicators that are reflective of targeted outcomes of their Demonstration Project design.







Despite work on correcting coding errors in AFCARS data, the rates provided in the Hornby Zeller data package continue to differ from data produced by the DHS Data Warehouse. To maintain consistency in reporting out progress on the Benchmarks, the Department will use only the data obtained from the DHS Data Warehouse.

For each benchmark chosen the county must answer the following questions:

- CWDP counties, current and prospective, are exempt from this section as the information is captured in IDIR-U or workplan. Completion of this section is optional and should cover only areas that the county believes are not adequately addressed in their IDIR.
- Counties should attach any current CIP and refer to attachment for detail.

## BENCHMARK # 1: Re-entry into care within 12 months

- What is the current level of performance for this indicator? Provide analysis of historical trends of the current and past five fiscal years. Identify data sources used.

Re-entry rate for Children Discharged during Fiscal Year					
FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
16%	18%	17%	19%	20%	22%

- Identify a measurable target for improvement and timeframes for evidence.

Response will be submitted with final narrative.

- Address the following county practices that contribute to the current level of functioning and/or would need to be enhanced toward improved outcomes.
  - Family Engagement Efforts
  - Use of SAMP in Critical Decision Making
  - Process for Placement Decisions, including Placement Settings
    - Use of Kin, Least Restrictive Setting, Sibling Placements
  - Quality Assessments
  - Individualized Services
  - Continuous Case Status Review
  - Case Planning for Successful Transition/Closure
  - Teaming
  - Shared Case Responsibility

The attached Initial Design and Implementation Report (IDIR) provides a comprehensive explanation of how the Improving Outcomes for Children (IOC) initiative will achieve the selected Benchmark Outcomes by utilizing key practices of family engagement, trauma-informed assessment, and intervention. (For an overview, see section I of the IDIR, pages 1-7.)

- Briefly identify a plan by which strategies towards improvement that were identified in FY 2012-13 and implemented in FY 2013-14 and projected resources needed for continued implementation and sustainment of strategies for FY 2014-15 and FY 2015-16.

The attached County Improvement Plan (CIP) incorporates a work plan that complements the Child Welfare Demonstration Project (CWDP) and the Improving Outcomes for Children (IOC) initiative. The work plan details strategies that the Department of Human Services is in the process of implementing to achieve the identified outcomes related to Teaming, Assessment, and Planning. (See section titled "Philadelphia's Work Plan of the CIP", pages 4-17.)

## BENCHMARK # 2: Entries into Out of Home Care as compared to Exits from Care

- ❑ What is the current level of performance for this indicator? Provide analysis of historical trends of the current and past five fiscal years. Identify data sources used.

Entries and exits are counted more than once. Exits only include permanency discharges. Re-entries could be from other non-permanency discharge reasons. This data is not a direct correlation with the placement population.

Entries into care have declined steadily over the past five fiscal years. Exits have also declined over the past five fiscal years. With continued implementation of IOC, and use of the practices identified under the Child Welfare Demonstration Project, the Department's goal will be to improve timely, safe reunification or other permanency.

Entries into Care and Exits to Permanency by Fiscal Year\*

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Entries	3088	3020	2814	2599	2757	2690
Exits	2261	2331	2195	1667	1342	1268

\* Entries and exits are counted more than once. Exits only include permanency discharges. Re-entries could be from other non-permanency discharge reasons. This data is not a direct correlation with the placement population.

- ❑ Identify a measurable target for improvement and timeframes for evidence.

Response will be submitted with final narrative.

- ❑ Address the following county practices that contribute to the current level of functioning and/or would need to be enhanced toward improved outcomes.
  - Family Engagement Efforts
  - Use of SAMP in Critical Decision Making
  - Process for Placement Decisions, including Placement Settings
    - Use of Kin, Least Restrictive Setting, Sibling Placements
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### BENCHMARK # 3: Least Restrictive Placement Settings

- ❑ What is the current level of performance for this indicator? Provide analysis of historical trends of the current and past five fiscal years. Identify data sources used.

Of the 4,601 youth in DHS' care on the last day of FY 2014, 8% (348) were in group home care and 9% (431) were in institutional care (DHS FACTS Warehouse, July 11, 2014).

#### Children in Congregate Care on the Last Day of the Fiscal Year by Percent of Total Placement Population

	6/20/2009		6/30/2010		6/30/2011		6/30/2012		6/30/2013		6/30/2014	
GH	530	10%	514	11%	461	11%	458	11%	387	9%	348	8%
IN	658	12%	606	13%	556	13%	518	13%	485	11%	431	9%
Congregate Care	1188	22%	1120	24%	1017	24%	976	24%	872	20%	779	17%

- ❑ Identify a measurable target for improvement and timeframes for evidence.

Response will be submitted with final narrative.

- ❑ Address the following county practices that contribute to the current level of functioning and/or would need to be enhanced toward improved outcomes.
  - Family Engagement Efforts
  - Use of SAMP in Critical Decision Making
  - Process for Placement Decisions, including Placement Settings
    - Use of Kin, Least Restrictive Setting, Sibling Placements
  - Quality Assessments
  - Individualized Services
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- ❑ Briefly identify a plan by which strategies towards improvement that were identified in FY 2012-13 and implemented in FY 2013-14 and projected resources needed for continued implementation and sustainment of strategies for FY 2014-15 and FY 2015-16.

The attached County Improvement Plan (CIP) incorporates a work plan that complements the Child Welfare Demonstration Project (CWDP) and the Improving Outcomes for Children (IOC) initiative. The work plan details strategies that the Department of Human Services is in the process of implementing to achieve the identified outcomes related to Teaming, Assessment, and Planning. (See section titled “Philadelphia’s Work Plan of the CIP”, pages 4-17.)

## Section 4: Administration

### 4-1a. Employee Benefit Detail

- ❑ Submit a detailed description of the county’s employee benefit package for FY 2013-14. Include a description of each benefit included in the package and the methodology for calculating benefit costs.

Response will be submitted with final narrative.

### 4-1b. Organizational Changes

- ❑ Note any changes to the county’s organizational chart.

Anticipated Expansions/Changes Services

#### **CYD**

- ESC is expanding its staff complement from 19 to a total of 45 within FY2015. Expansion will encompass the following:
  - Twenty DHS Education Liaisons. Two DHS Education Liaisons will be assigned per CUA catchment, co-locating within SDP schools to troubleshoot educational barriers for children and youth K-12th grade. DHS staff will act as the point of contact for their respective CUA, school cluster and CBH within the CUA catchment area for DHS involved youths.
  - DHS Early Childhood/Early Intervention Education Liaisons. One Education Liaison will be assigned per CUA catchment area to troubleshoot educational/service barriers and assure linkages for children birth to six years old to access and receive early intervention and early childhood education.
  - Five DHS Education Liaisons dedicated to older youth for Post Secondary Transitions & Academic Enrichment. One Education Liaison will be assigned per two CUA catchment areas to troubleshoot and assist in successful academic transitions for older DHS youth, and Act 91 youth, and offer supports to former DHS youth who seek assistance.
- Due to amendments to CPSL that will expand the definition of child abuse and perpetrator, DHS expects to see an increase in both reports and prevention referrals.

This increase will require additional staff in Hotline and Investigation sections as well as an increase in the legal staff (see description later in document).

- Ongoing Service Region I has been dissolved in conjunction with continued IOC Implementation. Some staff have transitioned to internal IOC positions, others to vacancies in the remaining OSRs. The Director now leads the case transitioning efforts to the CUAs.

### **Finance**

The Financial Monitoring Unit (FMU) is a new unit to be implemented in FY15 within the Finance Division. There is no request for new positions. The positions have been allocated from the department's complement of existing positions. The purpose of the FMU is to provide fiscal monitoring and oversight of the Community Umbrella Agency (CUA) contracts and related entities to ensure the funds provided are being expended in a manner that is in compliance with applicable Federal, State, and/or City laws, rules, and regulations. This FMU will work with existing DHS monitoring units and associated staffs to ensure CUAs are programmatically sound (as related to fiscal matters).

### **Division of Performance Management and Accountability (PMA)**

#### Quality Visitation Review

The Quality Visitation review occurs monthly and utilizes interviews with family members to ensure that what is documented in the case record is consistent with the family's experience. Previous to FY14/15 QVR was provided by a contracted provider and focused on the quality of the In-Home Protective Services (IHPS). Beginning in the summer of 2014 QVR will be provided by DHS staff and will focus on the work of the operating CUAs. During the summer of 2014 PMA will be hiring one supervisor and three SWSMs to provide this service for CUAs 1-7. In December 2014 PMA will be hiring two additional SWSMs and will provide this service for the ten operating CUAs. This QVR unit (five SWSMs and one Supervisor) will report to the Director of Quality Improvement in PMA.

#### **4-1c. Staff Evaluations**

- Describe the method for measuring and evaluating the **effectiveness** of staff provided services. Do NOT describe the standard individual performance evaluations.

The CYD Investigation Administrators and Quality Improvement Team review approximately 100 to 200 safety assessments and investigation processes each month. The information collected in these reviews is presented to the chain of command and provides a data source regarding specific work products for decisions in evaluating performance. The findings from these reviews are also presented during quarterly ChildStat meetings.

The Quality Improvement Team also has conducted Quality Visitation Review (QVR) for up to 30 cases each month through June 2014. This process used an outside contractor to visit with families for the purpose of visitation verification as well as to ensure that what was documented in the case record was consistent with the family's experience. Beginning July 2014 this process is being conducted by DHS PMA staff and will focus on the work of the CUA agencies.

The Quality Service Review process occurs bi-monthly and uses extensive interviews with family members and stakeholders to measure if the child, family, and system are achieving the desired outcomes. Each QSR uses a stratified sample from across the CUAs to focus on a specific population. QSR occur in Philadelphia six times a year and each QSR reviews 12 cases.

The Family Team Conferencing report is published on a monthly basis. This report documents the number of conferences that occurred, the timeliness of conferences and participation at the family team conferences.

The DHS Outcomes report is published quarterly and focuses on the achievement of the four identified IOC Outcomes. Under each outcome are a handful of outcome measures. The four identified IOC Outcomes include: More children and youth maintained safely in their own homes and communities, more children and youth achieving timely reunification and other permanence, a reduction in the use of congregate care, and overall improved child, youth, and family functioning.

#### 4-1d. Contract Monitoring & Evaluation

- Note the employee/unit which oversees county contracts. Describe the evaluation process to determine the **effectiveness** of provider services. Do NOT describe the process by which provider submissions are reviewed in relation to state and federal funding.

The Provider Relations and Evaluation of Programs (PREP) section organizationally exists in the PMA Division. This section evaluates and monitors programs to ensure that providers are meeting their contractual obligations by adhering to program performance standards that are derived from law, regulation and DHS policy. The major focus of annual evaluations is the services provided by an agency. Thus, an agency that provides in-home, congregate care, and family foster care services receives three evaluations based on standards specific to the service being provided. The service standards address case management, safety, permanency and well being, in addition to personnel and administrative requirements. In addition to the annual program evaluations, the PREP unit provides Technical assistance regarding the implementation of standards, investigations of reported service concerns, and holds quarterly meetings with providers for the purpose of facilitating continued collaboration and communication with contracted agencies.

While PREP continues to perform the traditional functions and activities described above, the advent of IOC and the shift of case management responsibility to the CUAs has brought about new means of monitoring and evaluation by PREP. In March 2014, PREP began a Quality Case File Review of CUAs and is currently reviewing 10% of each CUA's cases over each three month period. Using a Safety Assessment and Single Case Plan scoring tool which are based on CUA guideline requirements, PREP analysts review case record notes to ensure appropriate child visitation, quality of safety assessment, quality of safety planning, and quality service planning. Findings from these reviews are electronically provided to the CUA managers on the 15th of each month and are reviewed during quarterly ChildStat meetings. Beginning in July 2014, CUAs must develop plans of corrections when their score on any of the categories on either the Safety Assessment or Single Case Plan scoring tools fall below 75%. Plans of

corrections are due by the 25<sup>th</sup> of each month and will be reviewed and approved at a joint meeting between PREP and CUA leadership team.

In addition to quarterly case file reviews, CUAs are being monitored and evaluated in several other major areas, such as achievement of the IOC Outcomes and community engagement. CUA specific data is being daily and run on a quarterly basis in order to measure CUAs performance around repeat maltreatment, achieving reunification and other permanency outcomes, length of stay, return to care, and the use of congregate care.

PREP will monitor and evaluate CUA community engagement through an ongoing process of on-site visits to the CUAs and community events, stakeholder interviews and surveys, and other methods of data collection and analysis. Through these efforts PREP will be able to monitor and evaluate the CUAs efforts around some of the major components of community engagement such as the certification and availability of Resource Homes in or near the CUA area; the functioning of Community Advisory Board and the functioning of a network of Parent Cafes.

#### 4-2a. Human Services Block Grant

- ❑ Participating counties whose HSBG report does not capture the following information should describe what services and activities will be funded through the block grant and how this may change from the previous year. If services or activities will decrease, explain why this decision was made and how it will affect child welfare and juvenile justice services in your county and the NBPB. Describe any plans for increased coordination with other human service agencies and how flexibility from the block grant is being used to enhance services in the community.

Response will be submitted with final narrative.

#### 4-2b through 4-2e. Special Grants Initiatives

Response will be submitted with final narrative.

##### Requests to Transfer/Shift Funds

The following subsections permit the transfer or shifting of funds within the SGI categories of EBP, EBP-Other, PaPPs, Housing and ATP for FY 2014-15 within the maximum allocation amount. Counties must have sufficient local matching funds when requesting a transfer to those programs with a higher match requirement. CCYA may transfer within EBP funds and EBP-Other without OCYF approval. However, approval is required if transferring to/from EBP and other SG programs.

The requests must include detailed justification for the proposed changes. The PaPPs must relate to a specific outcome for a selected benchmark in the NBPB or the county's Continuous Quality Improvement (CQI) plan.

Counties that request to shift funds as outlined above must enter the revised amounts in the Budget Excel File in order for the revised amount to be considered final. All transfer requests

made should be considered approved unless the county is notified otherwise by the Department.

- From the list below, please indicate those Evidence-Based programs, Pennsylvania Promising Practices, Housing and Alternative to Truancy Prevention programs that the county will provide in FY 2014-15 and/or request funding for in FY 2015-16. Do not include funds for additional Nurse Family Partnership services. Describe the method for measuring and evaluating the effectiveness of staff provided services.

Response will be submitted with final narrative.

FY2014-15	FY 2015-16	Program Area
		a. Evidence Based Practices (Other)
		b. Multi-Systemic Therapy (MST)
		c. Functional Family Therapy (FFT)
		d. Multidimensional Treatment Foster Care (MTFC)
		e. Family Group Decision Making (FGDM)
		f. Family Development Credentialing (FDC)
		g. High-Fidelity Wrap Around (HFWA)
		h. Pennsylvania Promising Practices Dependent (PaPP Dpnt)
		i. Pennsylvania Promising Practices Delinquent (PaPP Dlqnt)
		j. Housing Initiative
		k. Alternatives to Truancy Prevention (ATP)

**FOR EACH OF THE SELECTED PROGRAMS, ANSWER THE FOLLOWING QUESTIONS (COPY AND PASTE AS NECESSARY TO ACCOMMODATE RESPONSES FOR ALL SELECTED PROGRAMS):**

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Program Name:	
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- Please indicate which type of request this is:

Request Type	Enter Y or N			
Renewal from 2013-14				
New implementation for 2014-15 (did not receive funds in 2012-13)				
Funded and delivered services in 2013-14 but not renewing in 2014-15				
Requesting funds for 2015-16 (new, continuing or expanding)		<b>New</b>	<b>Continuing</b>	<b>Expanding</b>

Complete the following table if providing this service or requesting a **transfer, shift, or revision** only of funds for FY 2014-15; and/or requesting funds for FY 2015-16. Enter the total amount of state and matching local funds.

Total Budget Amount	Original/Approved Allocation (Amt requested and approved)	Revision Amount Change + or -	Requested Amount (enter this amount in fiscal worksheets)
FY 2014-15			
FY 2015-16			

- Explain why the change is requested. What are the deciding factors to move from the originally requested program(s) to another(s)? Was this change discussed with the regional office?
- If a New EBP-Other is selected identify the website registry or program website used to select the model, describe the EBP, what assessment or data was used to indicate the need for the program, describe the populations to be served by the program, explain how the selected EBP will improve their outcomes and identify a key milestone that will be met after one year of implementation of the EBP.

**Complete the following chart for each applicable year.**

	1112	1213	1314	1415	1516
Target Population					
# of Referrals					
# Accepting Services					
# Successfully completing program					
Cost per year					
Per Diem Cost/Program funded amount					
# of MA referrals					
# of Non MA referrals					
Name of provider					

- Identify three service outcomes the county expects to achieve as a result of providing these services with a primary focus on FY 2015-16. Explain how service outcomes will be measured and the frequency of measurement.
- If there were instances of under spending or under-utilization of prior years grant funds, describe what changes have occurred or will occur to ensure that grant funds for this program/service are maximized and effectively managed. Also, identify the measures the county will utilize in both FY 2014-15 and FY 2015-16.

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- Please provide an overall summary of how the special grant programs selected under the SGI (including EBP, PaPP, Housing and ATP) will impact service delivery and child and family outcomes.
- Please explain how the availability of the services under the special grants will assist in the county's ability to achieve a specific outcome or a selected benchmark in the NBPB or the county's Continuous Quality Improvement plan. Specifically identify how the service outcomes will be measured and the frequency of the measurement.

#### 4-2f. Independent Living Service Grant

- In the table below, place an "X" for the services that will be provided by CCYA during FY 2015-16 (regardless of funding source.) Check as many boxes as apply. Enter the projected total amount of youth that will receive these services (regardless of age, placement status, or disposition.)

Mark "X" in this column	Total Youth	IL Services
x	1375	A. Needs Assessment/Case Planning
x	1375	B. Life Skills Training
		C. Prevention Services
x	375	Dental/Health
x	225	Drug Abuse Prevention
x	225	Alcohol/Tobacco/Substance
x	600	Safe Sex/Pregnancy
		D. Education
x	75	Vocational Training
x	525	High School Support and Retention
x	125	Preparation for GED
x	775	Assistance in Obtaining Higher Education
		E. Support
x	1375	Individual and Group Counseling
x	625	Stipends
x	100	Services for Teen Parents
x	239	Mentoring
		F. Employment
x	200	Job Placement
x	75	Subsidized Employment
x	400	G. Location of Housing
x	25	H. Room and Board
x	60	I. Retreats/Camps
x		J. Indirect Services
x		K. Program Administration

- Enter the county's total approved budget for FY 2014-15 and budget request for FY 2015-16 IL Services below. Include federal, state and local funds in the total amount.

Note: Fiscal information entered in the Narrative Template serves only as an estimate of projected program cost for FY 2015-16. If information entered into the Narrative

<b>Total Budget Amount</b>	<b>Original/Approved Allocation (Amt requested and approved)</b>	<b>Revision Amount Change to SGI + or -</b>	<b>Requested Amount (enter this amount in fiscal worksheets)</b>
FY 2012-13	\$2,997,323		\$2,997,323
FY 2013-14			\$2,997,323

Template and the Budget Excel File do not match, the Budget Excel File will be deferred to and considered as a final budget.

- The transfer of IL federal, state or local funds to other Special Grant programs or services is not permitted.

- ❑ Describe the county's expenditures history for IL Services for FY 2009-10, 2010-11, 2011-12, 2012-13 and 2013-14. What factors contributed to the successful or unsuccessful spending of grant funds for each year?

Philadelphia County has successfully used these grant funds since 2006. Careful fiscal and proactive programmatic management and success in meeting service objectives are critical contributors to this outcome.

- ❑ If there were instances of under spending of prior years grant funds, describe what changes have occurred to ensure that grant funds for this program/service are maximized and effectively managed.

N/A

- ❑ Provide a brief explanation if the county elects to submit an implementation budget for FY 2014-15 that is less than the certified allocation.

N/A

## IL Outcomes

- ❑ Identify and describe three program, or youth, IL outcomes the county plans to address and improve for FY 2015-16 (or earlier, if applicable). Also provide an overall summary of how the delivery of IL Services will ultimately impact these outcomes for youth.

The IL outcomes description must include:

- How and why the outcome was selected and whether it is new or identified in a prior year;

- Baseline information or how baseline information will be established and when available;
- The source of the data and the collection process or method;
- An explanation of the plan for services delivery to achieve the outcome and what agency(ies) will provide services if not the CCYA; and
- Any other information to support the outcome.

#### Outcome 1

To have 150 youth between the ages of 14 and 15 years old to attend The Young AIC.

How and why this outcome was selected: This outcome was selected to guide the youth 14 to 15 years old to achieve permanency and self sufficiency; to assure their well being; and to assist the youth in transitioning into adulthood. This outcome will also reduce homelessness, poverty, teen pregnancy, and criminal behavior through comprehensive services.

Baseline data information: As of June, 2014 there were 1193 dependent youth age 16 to 21 and 527 dependent youth between the ages of 14 and 15 years old. In addition, there were 1115 delinquent youth between the ages of 14-21 in placement.

The source of the data and the collection process or method: Data collection processes will be established through the use of referral forms, monthly COGNOS runs, exit surveys when the youth complete workshops, focus groups throughout the fiscal year, and the AIC database.

An explanation of the plan for services delivery to achieve the outcome and what agency(ies) will provide services if not the CCYA: Implemented at the beginning of FY13, service delivery has been and will continue to be through DHS staff as well as contracted employees at the AIC. Contracted employees are staff members from Temple University (educational services), Planned Parenthood (sexual and health education), Shalom, Inc (ATOD counseling and workshops), Valley Youth House (program operations, housing, employment, coaching). The mentoring component has been difficult to provide at AIC mainly due to inconsistency and ability to engage mentors long-term. We are exploring a new mentoring process "Natural Mentoring". This program will be in collaboration with a research project with University of PA. This process allows the youth to identify their mentor. This person can be a relative, teacher, or neighbor who has supported and encouraged the youth and is a resource for the youth. This program allows for more flexibility of the mentors and greater involvement because of the existing relationship. Services at the AIC are delivered through workshops as well as one-on-one counseling and interventions when needed. The AIC has a revised method of enrollment which involves a three tiered process. This process allows the youth to navigate through the workshops with consistency, building on each workshop until completion. This process should also increase retention, provide access to all of the services while supporting and encouraging optimal development. Youth engage in hands-on instruction such as the Consumer Science Culinary Program, Field Trips, and experiential exercises to reinforce independent living.

The Young AIC has served 101 youth ages 14 and 15 years old.

## Outcome 2

Improve effectiveness of IL Services, develop youth centered plans to transition them into independence, increase permanency outcomes for older youth, and improve the stability of transitions to independence for both dependent and delinquent older youth.

How and why the outcome was selected: This outcome was chosen because youth who age out of the child welfare system have very poor outcomes as adults. It is expected that by refocusing the Achieving Independence Center (AIC) and Older Youth services efforts on re-engaging parents and kin, and reconnecting youth with parents and kin, older youth who would have aged out could be safely reunited with parents or achieve permanency through adoption or PLC. For older youth who transition to independence both from out-of-home care and from a permanent home, there is evidence that providing IL Services to youth at a younger age will improve outcomes. DHS had not previously extended AIC services to delinquent youth, and doing so will help to improve their transition to independence as well.

Baseline data information: As of July 2013, there were 1384 youth between the ages of 16 and 21 who are being served by the AIC. Of those being served by AIC, 859 were in care; 443 were out of care and the status of 82 were undetermined. The populations that will be the focus of this expansion of services are youth in dependent and crossover placement cases from the age of 14 up to 21. As of July 2013, there were 226 dependent youth between the ages of 14 and 15 years old. In addition, there were 1031 delinquent youth between the ages of 14 and 21 in placement. With the implementation of Act 91, 19 youth were granted resumption of jurisdiction and eight youth are awaiting court dates in FY13. Also during FY13, 103 youth received housing through the Supportive Housing Program.

The source of the data and the collection process or method: Data regarding the effectiveness of Independent Living Services to increase permanency outcomes for older youth, and improve the stability of transitions to independence for both dependent and delinquent older youth will be measured through the Casey Life Skills Assessment and through the National Youth in Transition Database. The Casey Life Skills Assessment measures what youth know before and after services are provided. The National Youth in Transition Database measures outcomes of Independent Living services.

An explanation of the plan for services delivery to achieve the outcome and what agency(ies) will provide services if not the CCYA: The Department is being more intentional about developing and delivering services to older youth and young adults, specifically ages 18 to 21 years old, because services do not currently exist for this population. Services that are being developed to benefit these young adults include Natural Mentoring and partnerships with other City entities that provide employment, training, financial services, and health care (such as Power Corps and Americorps, and WorkReady). Natural Mentoring is a model where an adult who already has a relationship with the youth or young adult acts as a mentor. AIC and Older Youth services have been refocused on re-engaging parents and kin through Family Finding, teaming supportive services, and revisiting permanency goals for these youth. The age of youth to be provided IL Services has been reduced to age 14. In FY 15, the intent is also to begin to introduce crossover youth ages 14 to 21 within and outside of Philadelphia County to the AIC.

By offering support groups and using the Strengthening Families Model, Time Limited Reunification, Reunification, and parenting groups, youth and their families will be able to address issues that led to dependency and long-term care. These services support empowerment, resilience, self-sufficiency and help improve transition to independence

outcomes. Services will be provided through a combination of efforts both on-site at the AIC and in the community. DHS staff work in collaboration with AIC staff. Time Limited Reunification and Reunification programs will be provided through Lutheran Children and Family Services, Tabor Services, and Jewish Children and Family Services.

### Outcome 3

Reduce trauma-based social behaviors that act as barriers to successful transition to independence for dependent and delinquent youth.

Why the outcome was selected: This outcome was selected to promote successful transition out of care.

Baseline data information: In FY13, 91 youth between the ages of 14 to 21 years old and their families received Time Limited Family Reunification and Reunification services. During FY13, six youth were reunified with their families and 29 youth and their families who were receiving in-home reunification services were stabilized and their cases were closed.

The source of the data and the collection process or method: Data will be collected from monthly COGNOS runs identifying youth 14-21 years of age in placement and who are receiving reunification services.

An explanation of the plan for services delivery to achieve the outcome and what agency(ies) will provide services if not the CCYA: A program redesign of the AIC will promote engaging youth over a longer period of time. The redesign of the overall independent living program will consist of a gradual progression of service delivery to promote membership retention. The AIC has incorporated a "tier process" which allows the youth to move progressively through each workshop over a period of two years. The youth receives services that build upon the previous and moves the youth gradually toward independence. Bio psycho-social groups will be implemented to address the issues that dependent and crossover youth experience related to placement. The use of intensive group services allows youth to engage in dialogue with other youth with similar experiences and develop social relationships and social connectedness in a safe environment. This will be an effort of the DHS and non-DHS AIC Staff, Time Limited Reunification and Reunification programs through Lutheran Children and Family Services, Tabor Services, and Jewish Children and Family Services, and through strategically planned outreach utilizing direct contact with Social Work Services Managers, data bases, and teaming. Services will be provided on-site at the AIC and throughout the community.

### **IL Services Narrative** (please read the following bullets before responding)

- If the agency is requesting an increase of funds for FY 2015-16, clearly explain and justify the increased costs.

N/A

- ❑ Explain how the county plans to deliver IL services to meet the needs of youth who are transitioning from foster care, while in the agency's care, as well as those who have discharged up to age 21. Identify other provider agencies and their role.

As of June, 2014 there were 1193 dependent youth age 16 to 21 and 527 dependent youth between the ages of 14 and 15 years old. In addition, there were 1115 delinquent youth between the ages of 14-21 in placement.

The AIC serves both current and former foster youth until the age of 21. At the end of FY14, 1384 youth received case management and counseling services at the AIC.

The youth's plan for services is created and documented in the Member Development Plan (MDP). The MDP is an individualized plan outlining the needs and goals for each youth in the core areas of housing, education, life skill, and employment, and is based on the results of the Casey Life Skills Assessment which is completed every six months.

On-going services are provided on-site either by the AIC staff or partner agencies (Temple, and Planned Parenthood) or by referral to other community-based organizations according to the goals and objectives identified in the MDP. The MDP is updated at minimum, on a semi-annual basis, to ensure each youth is moving forward in achieving individual goals. These assessments and services support empowerment, resilience, self-sufficiency, and help improve transition to independence outcomes.

Services for youth in care are coordinated with the AIC and Provider staff to ensure coordination of services. The Child Permanency Plan (CPP) or CUA Single Case Plan (SCP) is included in the referral to the AIC and drives and informs the creation of the MDP. Services for former foster youth are coordinated in a self-directed manner with the AIC coaches through the MDP. All members, both in care and out of care, meet regularly with their Coaches to discuss progress toward individual goals.

Life Skills instruction is a vital component of services at the AIC and required of all Providers serving the county's older youth population. At the end of FY14, 962 youth received life skills training through the AIC, 104 % of the FY14 goal of 925. Life skills are a set of competencies that youth leaving foster care need in order to make a successful transition to independence and the foundation for all the services and activities provided by the Independent Living Services Unit at the Department and the AIC.

At the AIC, the primary life skills training component, "LSH Journals and Fundamentals," is provided by AIC staff via a 24 hour curriculum. It includes group-based workshops, individual lessons and a final assessment to measure the transfer of learning. AIC staff will monitor member participation in and completion of the series. Workshop topics include money management, financial decision-making skills, savings, taxes, banking and credit, budgeting and spending plans, consumer skills, building a positive self-image, conflict resolution, goal setting, and stress management.

Members also learn life skills in other workshops and activities offered at the AIC by its staff and affiliated programs. The subject areas include, but are not limited to:

- Locating and using community resources: police, clergy, lawyers, dentists, and bankers.

- Utilizing community socialization activities: churches, recreational centers, parks, and concerts.
- Healthy hobbies: fitness, arts, photography, and music.
- Obtaining personal identification documents.
- Human sexuality.
- Employability factors including responsibilities and professional attire.
- Resume development.
- Consumer and shopping skills.
- Physical and behavioral health care.
- Locating housing.
- Nutrition.
- Insurance.
- Home management skills: food preparation, laundry, cleaning, roommates, and basic maintenance etc).
- Negotiating a lease.

The life skills workshops and activities also focus on the development of “soft skills” that are key to independent living which include, but are not limited to:

- Decision making.
- Self-esteem.
- Communication and negotiation skills.
- Conflict resolution.
- Managing stress and coping strategies.
- Problem solving.
- Anger management and impulse control.
- Assertiveness.
- Peer Interactions.

- Describe how the agency will meet the educational needs of current and former foster youth to include post-secondary education. Identify agency and other agency supports available to assist youth meet their post-secondary education goals and improve retention rates and program completion.

Education is critical to a youth’s success and ability to live independently. The AIC provides programs to assist youth in remaining and succeeding in high school, attaining a GED, and enrolling in post-secondary institutions. At the close of FY 14, the education status of active AIC members was as follows:

- 338 High School Attendees.
- 47 2-Year College Attendees.
- 26 4-Year College Attendees.
- 15 Post Secondary Technical/Trade School Attendees.
- 1 Career Training Program Attendees.
- 8 GED Program Attendees.
- 1 Twilight School Attendee.
- 66 Not in school (no diploma or GED).
- 129 Not in school (high school graduates).
- 0 Graduates from Technical School during FY14.
- 51 High School Graduates.
- 4 GED Recipients.

- 0 2-Year College Graduates.
- 0 4-Year College Graduates.
- 6 Post-Secondary Training Programs, Trade, and Technical School Graduates

The AIC Coaches develop educational plans that are included in the MDP with youth. Coaches also track members' progression through their academic careers.

The AIC will work closely with DHS education support center to help address academic needs and/or social barriers to education. The AIC education liaison will assess each youth education needs upon enrollment. The youth will be connected to Education Support Center for on-going support.

The educational support staff specifically focuses on the supports and services high school students need to complete high school successfully, including identifying tutoring needs, coordinating homework help, tracking attendance, coordinating with AIC and Provider Staff, and the School District of Philadelphia to address challenges and recovery plans. Out of school youth are connected with the School District's Re-engagement Center. The support staff will provide guidance and support to the youth based on mandates established by the McKinney-Vento legislation.

High school graduates and graduation candidates receive guidance and assistance enrolling in post-secondary education, including individual and group counseling, completion of admission applications, financial aid applications, scholarship assistance, admission essay support, college prep workshops, and campus tours. College students received support including test preparation, continued financial assistance, and help navigating the different systems within post-secondary institutions.

AIC will provide educational and career resources stemming from the United States Military through job fairs and seminars. The U.S. Military offers educational opportunities (ROTC as well as free college education), career training and opportunities, stability, housing, benefits, and discipline as a foundation to their mission.

The AIC further supports its student membership, both high school and college, by providing filled backpacks, college care packages and other items at an annual education recognition program at the beginning of each school year. DHS Communications Office and AIC have secured sponsorships from local businesses and organizations which have grown this effort substantially over the last three years.

- Describe how IL Support services will be delivered and who will deliver the activities (provider or agency). Include the use of stipends and the total amount planned. Estimate the number of youth who will be referred to the SWAN prime contractor for Child Profile, Child Preparation and Child Specific Recruitment services.

All active AIC members receive individual counseling from the AIC staff. Further, an on-site licensed therapist and specialized practitioners provide short-term therapy and crisis intervention together with linkages and referrals to community-based behavioral health programs. They also run groups on adventure-based counseling, trauma, anger management, and anger reduction. These services are all provided collaboratively by the contracted programs at the AIC and DHS Staff.

AIC staff and the Parent Action Network (PAN) provide support and education to the LGBTQ youth community at the AIC. The objectives of these ventures are to meet the unique needs of this community and connect them with supportive resources specific to their needs.

The total amount planned for stipends is \$150,000.00. The amount includes incentives for completion of workshops and programs as well as needs-based funds to eliminate barriers to independent living, such as, school fees, tools and uniforms for work, and security deposits.

DHS estimates 150 IL youth will be referred to the SWAN prime contractor for Child Profile, Child Preparation Services.

- ❑ What housing related services, supports (including financial), and planning will be provided to prepare youth for living after foster care discharge and to reduce instances of homelessness.

Housing related services, supports, and planning include assistance obtaining affordable housing, education regarding safe and affordable housing options for youth, negotiating a lease, tenants' rights and responsibilities, and the link between credit and housing and permanency planning. The AIC and DHS Staff provides the on-site services related to housing referrals and education.

Additionally, on a bi-monthly basis, the Center holds "Real Talk Housing Family Dinners." The dinners are designed to allow youth to discuss adult housing resources, as well as their housing and permanency plans as they prepare to transition from both DHS and the AIC. The dinners also serve as the forum for the "Real Talk" panels. Through collaboration between the AIC and Covenant House PA, the "Real Talk" panels are comprised of youth willing to discuss the challenges of homelessness and other pitfalls of leaving care unprepared with other members and youth still making their transition decisions. It has been demonstrated, through these dinners, that peers are effective in conveying the need for planning and preparation as youth transition from care. Attendance at the two dinners averages 40 youth per month.

The AIC housing staff also coordinates quarterly informational sessions related to both Supervised Independent Living and Transitional Housing programs. These sessions bring together Providers to explain the details of their programs. The housing staff also target youth preparing for transition for special advanced housing workshops that incorporate experiential activities to reinforce skills learned in other life skills workshops.

Youth with more stable housing options have increased success at independence than those in unstable or overcrowded living situations including living with strangers, family and friends suffering from addiction, abandoned properties, and the streets. Members who are out of care and homeless or near homelessness are assessed for supportive needs and referred to a Transitional Housing Program (THP) that houses eligible AIC members in apartments or group living situations throughout the City. The goals of the THP are to help young adults obtain and remain in permanent housing; increase their skills, education, and income; and achieve self-determination. Youth must meet HUD

threshold requirements to participate in THPs. THPs provide financial support in the form of rent subsidies for 3 to 24 months. The following THP programs are utilized:

- Valley Youth House Supportive Housing Program, a scattered-site program with administrative offices located in downtown Philadelphia. Life Skills Counselors meet with youth on a weekly basis at the office, in the community, and at the participants' apartments to provide guidance, support, and individual instruction. Staff also make unscheduled visits at various hours a minimum of two times per month, usually in the night or early morning hours to ensure program compliance.
- The Carson Valley HUD Program, a clustered site (most youth are located in the same geographical region or location) program. The program is comprised of phases. In the first phase, youth reside in one of three houses with daily staff contact. This phase is consistent with a Transitional Living Program (TLP) step-down model with case management contact one to two times per week. Youth are transitioned to Phase II after meeting program requirements. During this phase, participants are housed in their own apartments, and staff contact is bi-weekly.
- Northern Homes Generations II Program serves parenting females and houses them in apartments on a campus-based setting. Staff support is available daily, and youth are required to participate in weekly group counseling sessions.
- Methodist Family Services' Fresh Start Program serves single females and females parenting one child in apartments in a campus-based setting. Staff monitoring and support are available daily. Participants must have a qualifying mental health diagnosis. The program provides individuals with housing vouchers that can be used anywhere in Philadelphia after the first two years of the program. Participants' rent is based on income.

Youth placed in THPs are encouraged to continue participation in the AIC for other support services. Tracking and evaluation is provided by both internal processes established by the individual Providers and DHS. DHS tracks youth placed (utilization rates) and their continued stability for up to one year after discharge. The Department maintains quality assurance protocols, inclusive of process and outcome evaluation in an effort to ensure programmatic integrity.

Referrals are also made to local emergency shelters, including the Covenant House PA youth shelter, for temporary and emergency housing.

- Describe the agencies projected use of Chafee Room and Board funds for youth who exit foster care after age 18.

The AIC uses Chafee funds for youth ages 18-21 who are discharged from care and need support identifying and maintaining stable housing. The program serves at least 15 youth annually. Participants must be employed and enrolled in high school, GED programs, vocational training programs, or post-secondary high school educational programs to qualify. Each youth receives \$1,000 to purchase furnishings upon move-in, up to 12 months of rental assistance, and a monthly transpass. Participants meet weekly with a case manager at the AIC, in the community, and in participants' apartments.

A portion of funds are also used for temporary or short-term housing to help decrease incidents of homelessness and "house hopping" among youth, as well as, to provide

housing to youth who attend post-secondary institutions outside of Philadelphia and return to the city during holiday and summer breaks.

- Identify and justify all planned purchases for equipment or assets for use by the agency during FY 2014-15 and FY 2015-16. Prepare this information separately for each year. Include a statement whether the purchase costs are included in the appropriate budget (All agency or staff computer purchases and IT needs must be requested to be reimbursed through the county's IT grant application and funds. Computers purchased, in full or part, for youth are not considered assets and are reimbursable with IL grant funds.)

The AIC lease expired in September 2013 and in October 2013, the Center moved to another location, the Leon Sullivan Building; 1415 N. Broad St. Suite 100, Philadelphia, PA 19121. Relocation, furnishings, equipment, supplies, and moving costs were included in the budget.

- Identify the county's primary contact or coordinator for each of the following initiatives (do not include the county administrator unless no other staff is available).

	<b>IL Services</b>	<b>NYTD</b>	<b>Credit Reporting</b>
Name:	Brenda Kinsler, Administrator (all services listed above)		
Email:	<a href="mailto:Brenda.d.kinsler@phila.gov">Brenda.d.kinsler@phila.gov</a>		
Telephone:	215-683-3555		

#### 4-2g. Information Technology

Response will be submitted with final narrative.

- Identify the Case Management System your county is using: \_\_\_\_\_
- Provide the county's approved staffing complement:
  - Certified Staff: \_\_\_\_\_
  - Other staff not included in certified who receive IT equipment and services – please identify the positions and the number in the position:
 

Position: _____	Number: ____

- Answer the following questions related to participation in the Child Welfare Demonstration Project:
- Indicate if your county participates in the Child Welfare Demonstration Project (CWDP) in FY 2014-15: **Yes** \_\_ **No** \_\_
  - Indicate if your county plans to participate in the Child Welfare Demonstration Project (CWDP) in FY 2015-16: **Yes** \_\_ **No** \_\_
- Indicate if your county is submitting a revised FY 2014-2015 IT budget along with your FY 2015-16 IT grant request: **Yes** \_\_ **No** \_\_
- Indicate if your county has the necessary contract language in all IT contracts to ensure compliance with federal and state regulations. (See appendix 4: Information Technology, section IV): **Yes** \_\_ **No** \_\_ **Do not have any contracts** \_\_
- Indicate if your county is requesting funding for ongoing or new development in FY 2015-16 that is not related to the statewide Child Welfare Information Solution (CWIS): **Yes** \_\_ **No** \_\_
- If **Yes**, provide the following details:
    - Business Need - describe the business need for the ongoing or new development.
    - High Level Requirements – provide a description of the high level business and technical requirements.
    - Project Cost Proposal – provide the total costs for the development, as well as, the total estimated project costs if the development is part of a larger project.
    - Identify contracts associated with the development project.
- Provide any additional information that will assist in the review of your FY 2015-16 IT request.

**4-2h. SWAN**

Response will be submitted with final narrative.

- Please explain any over or under utilization of SWAN services in the prior year; i.e. explain any differences when comparing the SWAN allocation to actual spending.
  
- If requesting new or additional paralegal support, please explain why and what services/activities the requested paralegal(s) will perform.

## Section 5: Required & Additional Language

### 5-1. Assurances

The following pages include assurance forms to be completed by counties. These forms are included:

Response will be submitted with final narrative.

## **ATTACHMENTS**

## Attachment A

**Initial Design and Implementation Report**  
**Component 3 – Evidence-Based Practice and/or System Changes**  
**PA County Response Template**

The following is a county response template for the content to be included in the March 31, 2014 ACF report. This report requires ACF approval prior to our implementation of the Evidence-Based Practice and/or System Change component of the CWDP.

**I. Overview**

*Write a short introduction to your Evidence Based Practice(s) (EBP) and/or System Change(s) that make up the county's third component of the Child Welfare Demonstration Project. Provide details as to how your engagement/assessment activities, as well as any other specific county activities defined the problem your county is attempting to address, the target population(s), and your specific interventions (EBPs and/or system changes).*

*In your previous IDIR you included a theory of change that provided the "big picture" of how the CWDP intended to use Family Engagement and Assessment to select appropriate county-specific interventions. At this point in the project, each county needs to develop a county-specific theory of change for your project interventions, including the expected short-term and long-term outcomes of the project as a whole and how and why the demonstration components and county-specific interventions are expected to address the identified needs of the target population(s). The theory of change should to tell a concise story of how the county is defining the problem(s) it hopes to address and to outline the intended outcomes. More importantly, the theory of change should demonstrate the series of connections that link the problems and needs being addressed with the actions the county will take to achieve desired outcomes. This overview might include a series of "if-then" statements that address the logical result of an action and should provide the county's conceptual link between the identified problem and potential solutions.*

**SUMMARY RESPONSE:**

In December 2013, the Department of Human Services (DHS) entered Year Two of the implementation of Improving Outcomes for Children (IOC) initiative. This new approach to service delivery focuses on the neighborhoods where children, youth, and families live and is critical to the design of the Child Welfare Demonstration Project (CWDP or Demonstration Project). Within IOC, case management services for children and youth involved with the child welfare system are delivered by community-based providers known as Community Umbrella Agencies (CUAs), while DHS maintains responsibility for the hotline and investigations functions, monitoring and, oversight, and quality assurance. Given the magnitude of this system change (which is ongoing and not specifically related to the CWDP), we will align the implementation of Evidence-Based Practices, in itself another significant system change, with IOC goals and objectives. Consequently, EBPs will be developed and delivered through the CUAs and through the provider network contracted by Philadelphia's Community Behavioral Health Department (CBH) to deliver behavioral health services and ensure comprehensive

coverage for the DHS population. We will be assisted in this process by consultants at Annie E. Casey (AEC).

In Year 1 of the Demonstration Project, as part of our ongoing IOC system change, DHS and the CUAs engaged child welfare clients, particularly those involved in congregate care, in a series of Family Group Decision Making (FGDM) and Family Team Conferencing (FTC) meetings (n=809) to support safety, permanency and well-being. At the same time, DHS worked toward the implementation of the FAST and CANS tools as a means to assess the needs of our client population and point the way to evidence-based practices that can serve those needs. Development of these tools in our Electronic Case Management System (ECMS) and training CUA staff to conduct these assessments was completed in the fall of 2103; to date, 1029 FAST and 546 CANS assessments have been completed, although these are not necessarily representative. This number is not quite large enough to gauge whether the findings support one evidence-based practice over another; however, preliminary analyses reveal that at least 32% of our youth are in need of higher level services that are currently available. Furthermore, we can see from our other assessment strategies – Quality Service Reviews (QSR), ChildStat, and routine case file reviews, that trauma-informed services are a necessity for the many children, youth and families in our population, particularly with regard to parent-child relationships and family functioning as the support youth functioning. Consequently, we have been able to work with the CUAs to select three interventions that fit the age range and diverse needs of our general population.

#### Selected Evidence-Based Practices

*Parent-Child Interaction Therapy (PCIT)* is an evidence-based behavioral health intervention that focuses on improving the caregiver-child relationship, increasing positive parenting strategies, and increasing children's positive behaviors while simultaneously decreasing negative child behaviors. PCIT is typically completed in 12 to 20 sessions focused on two distinct phases: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI). PCIT is for children ages 2 to 8 who have experienced stress or trauma. PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns. In Philadelphia, Child-Adult Relationship Enhancement (CARE) is being offered in conjunction with PCIT as part of a separate project conducted by the Children's Hospital of Philadelphia (CHOP). CARE is a field-initiated group training program for adults interacting with children in a variety of settings. This group model was informed by the principles of PCIT and other evidence-based frameworks for adult education. Although based on evidence-based models, this training program has not yet gone through rigorous evaluation of efficacy. However, research conducted by the PolicyLab at CHOP shows

promising results. Although we may potentially expand this program based on the research, we are not including it in this Demonstration Project.

*Positive Parenting Program (Triple P)* is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise to keep kids safely in their communities (IOC Goal 1). Triple P uses social learning, cognitive behavioral, and developmental theory to structure the intervention combined with research focused on risk factors associated with development of behavioral and social problems in children to better support parents and provide the skills needed to be self-sufficient and manage family issues. Parents are encouraged to set their own goals and choose the types of strategies that will work for their families. In this way, parents become independent problem solvers who gain the confidence to deal with issues as they arise in the future. Because it is not a one-size-fits-all model, it can be cost efficient and effective as families only receive the services they need for a time period suitable for them.

*Functional Family Therapy (FFT)* is an intensive, short-term family therapy model targeting at-risk youth ages 10-18 with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses. FFT has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts. Therapy can be conducted in the family's home by a trained therapist or in a clinical setting. Sessions occur as frequently as necessary to meet the family's needs and are provided over a period of about three months. The FFT model is organized around phases of treatment that emphasize engaging and enhancing the motivation of the youth and family, facilitating change within the family, and generalization of changes.

We feel that these three interventions align best with all of our IOC outcomes, provide the most comprehensive coverage for all eventualities, and complement an already robust set of services available in the city of Philadelphia. As you will see in the detailed descriptions of these interventions on pages 9-18, these programs have very specific criteria for inclusion and can be considered specialized interventions in the sense that they are neither necessary nor appropriate for every child and family open for service with DHS and the CUAs. Because of our long and productive collaboration with Philadelphia's Community Behavioral Health Department (CBH), we will continue to offer a well-tested and effective array of services for our clients who do not fit the criteria for PCIT, TRIPLE P or FFT.

In September 2013, Annie E. Casey sponsored a collaborative retreat for DHS and CBH that focused on our congregate care reduction initiative. As a result, they developed a service grid (*Appendix A*) listing the existing resources that have always functioned as our primary interventions. These interventions are still appropriate for many of our clients, but we will now add to these the specialized interventions that form the core of our demonstration project.

As we continue our engagement processes with regard to FTC and are able to analyze our assessment data, we will be in a good position to determine what percentage of our population is best served by our existing service array and what percentage would benefit from specialized services.

Intervention	Outcomes			
	Maintained Safely in the Home	Timely Reunification	Congregate Care Reduction	Improved Functioning
PCIT		X	X	X
TRIPLE P	X	X	X	X
FFT	X		X	X

#### Theory of Change:

The impetus for IOC was the realization on the part of DHS and the provider community that there were too many children being removed from their homes; that once removed they were staying in care for too long a period of time; that the longer they stayed in care the more likely they were to be eventually placed in congregate care; and that the cumulative impact of initial removal, lengthy stays, and the congregate care experience often resulted in an inability to function properly within given societal expectations. Our initial IDIR provided the following theory of change regard to components 1 (engagement) and 2 (assessment):

- *If* families are engaged as part of a team, and
- *If* children and families receive comprehensive screening and assessment to identify underlying causes and needs and assessment information is used to develop a service plan, and
- *If* that plan identifies roles for extended family members and various supports, including appropriate placement decisions and connects them to evidence-based services to address their specific needs and/or appropriate system changes,
- *Then*, children, youth and families are more likely to remain engaged in and benefit from treatment, so that they can remain safely in their homes, experience fewer placement changes, experience less trauma, and experience improved functioning.

Here we present an expanded theory of change regarding the implementation of the evidence based practices described above.

- *If* engagement and assessment are successful in determining appropriate interventions, children and families will receive services to address their specific needs and
- *If* the interventions are implemented with fidelity to the original model, the outcomes for children and families will experience improvement and

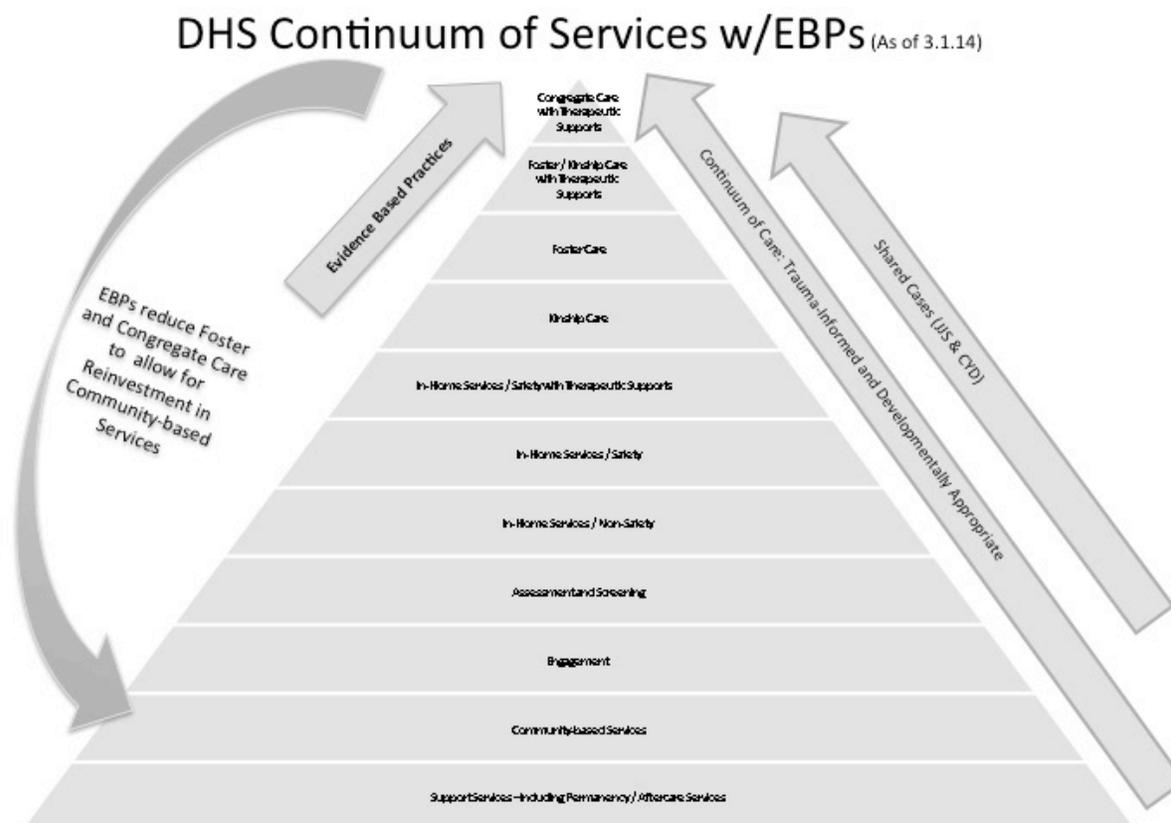
- *If* the interventions are monitored for efficiency and effectiveness, the results will be measurable and
- *If* system changes necessary to accommodate EBPs keep pace with client needs,
- *Then* children and youth can remain safely in their homes, experience fewer placement changes, experience less trauma, and experience improved functioning, and
- *Then* we will meet IOC short and long term outcomes as detailed below.

DHS' short and long-term outcomes connected the practice of family engagement and assessment strategies and the delivery of evidence-based interventions with the improved IOC safety, permanency, and well-being outcomes listed below:

1. Short-Term: More children and youth maintained safely in their own homes and communities
  - a. Fewer children and youth experiencing repeat maltreatment in 1 year
  - b. Fewer children and youth entering out of home care inappropriately
  - c. Fewer reentries within 1 year following exit to permanency
2. Long-Term: More children and youth achieving timely reunification or other permanence
  - a. More children and youth achieving permanency (reunification) within 1 year
  - b. More children and youth achieving permanency (adoption, PLC) within 2 years
  - c. Reduction in non-permanency outcomes for youth
  - d. Reduction in length of stay
3. Long-Term: A reduction in the use of congregate care
4. Both: Improved child, youth and family functioning
  - a. Long-Term: Increase placement stability
  - b. Short-Term: More children and youth placed in their own community
  - c. Short-Term: More siblings kept together while in placement
  - d. Long-Term: Increased child and family functioning (as measured by FAST and CANS tools)

Further,

- *If* IOC outcomes are realized
- *Then* there will be fewer children and youth in long-term foster or congregate care, and
- *If there is a reduction in long term foster care or congregate care, then* reinvestment can be made in community-based services, and
- *If* the prevention services are successful,
- *Then* a feedback loop will result in less need for long-term foster or congregate care.



*Selection of the following **Assessment Options** will help set the context for the work outlined in the county's implementation plan. Below, select the option that best fits your assessment of the degree to which program development work will be required to adopt tailor, or create the intervention to meet the needs of the target population. Provide a brief explanation of your choice or variation on the choice offered (assuming the details of your implementation plan will be expanded in the remaining sections of your submission) and provide the estimated date when you believe the intervention will begin to be delivered to benefit the identified target population.*

### **Parent-Child Interaction Therapy (PCIT)**

- Little to no program development work.** This intervention is a direct or nearly direct replication of an existing evidence-based or evidence-informed practice or program with an experienced “purveyor” who is willing and available to work with us (e.g., a program expert who has effectively assisted other agencies, counties, States).

**Brief Explanation:** The Children’s Hospital of Philadelphia (CHOP) adopted this model as part of their Child Stability and Wellbeing project (CSAW) Philadelphia. The implemented the intervention at two foster care agencies as part of a collaborative project with DHS and CBH.

**Estimated Date of Service Initiation:** Pilot complete; scaled for first two CUAs Fall 2013; will roll out as the CUAs roll out (see Timeline, *Appendix C*)

### Positive Parenting Program (TRIPLE P)

- Modest adaptation of an existing evidence-based or evidence-informed intervention.** We can work with a purveyor and other experts to maintain most of the core elements of the intervention that are required/recommended by the developer/expert. The developer/expert is willing and able to work with us.

Brief Explanation: This intervention includes five levels, which will be phased in over the next three years. We are connected to the trainer for the Philadelphia area.

Estimated Date of Service Initiation: Levels 1-3 will initiate Jan – March 2015; Levels 4-5 will initiate July – September 2015.

### Family Functional Therapy

- Modest adaptation of an existing evidence-based or evidence-informed intervention.** We can work with a purveyor and other experts to maintain most of the core elements of the intervention that are required/recommended by the developer/expert. The developer/expert is willing and able to work with us.

Brief Explanation: This intervention is already being delivered by CBH for delinquency clients but will need to be adapted for the dependency population.

Estimated Date of Service Initiation: Adaptation and capacity building will commence July 2014, training in July 2015, and service in October 2015 – March 2016.

## II. Clearly Defined Target Population(s)

*Describe the target population(s) for each of the Evidence Based Practice(s) and/or System Change(s), noting exclusions, geography/locations, or eligibility criteria as appropriate. In this section, the plan should:*

- Describe the **characteristics and needs** of the identified target population(s).

**PCIT Characteristics:** PCIT was initially targeted for families with children ages 2-to-7 with oppositional, defiant, and other externalizing behavior problems. It has been adapted successfully to serve physically abusive parents with children ages 4-to-12. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. Caregiver and child must have regular, ongoing contact to allow for daily homework assignments to be completed. We have been and will continue to serve children 2 through 8.

**PCIT Needs:** The emphasis with PCIT is on changing negative parent/caregiver child patterns by addressing the child's externalizing behaviors that reflect their history of stress or trauma, such as: Refuse or won't follow directions, engage in power struggles, lose temper easily/ tantrum, annoy others on purpose, always want attention, steal things, destroy things, start fights/hurt others, have difficulty staying seated, have difficulty playing quietly, have difficulty taking turns, etc. PCIT benefits parents who evidence harsh or overly punitive parenting by teaching them more appropriate management skills with young children.

**TRIPLE P Characteristics:** Two age groups are intended for the intervention, 0-5 and 6-12; but the childhood program of 6-12 can be extended to families with teenagers 13 to 16.

**TRIPLE P Needs:** Triple P has five intervention levels of increasing intensity to meet each family's specific needs. The intervention should be used on families with children who have disruptive behaviors, childhood developmental issues. Level 5 Triple P focuses on families where there are stressors on the parents such as relationship conflicts, parental depression, stress from external factors (work, poverty, etc.)

**FFT Characteristics:** FFT is an intensive, short-term family therapy model targeting at-risk youth ages 10-18.

**FFT Needs:** FFT serves youth with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses.

- *Provide an estimate of the number of children/families who will initially be enrolled in the demonstration*

#### **Estimate Response:**

We were able to complete a preliminary analysis of our FAST/CANS data, which indicated that while all our youth in care will benefit from Triple P Levels 1 and 2, approximately 30% of them may qualify for one of the three specialized interventions. The *Table Below* illustrates an estimate of how many potential referrals there will be for each of the EBPs. Of course, these referrals will be phased in over the next four years as we build capacity to implement all of the EBPs (see Timeline, Appendix E). These numbers will be finalized prior to implementation as we are able to conduct FAST/CANS analyses more thoroughly and specifically. As we move through implementation, it is possible the percentage of youth receiving a particular EBP will either increase or decrease depending on our ongoing monitoring and evaluation.

	<b>Estimated # Youth Meeting Age Criteria for Each EBP</b>	<b>Estimated # Youth Receiving Each EBP (30%)</b>
<b>PCIT</b>	<b>803</b>	<b>241</b>
<b>PPP (Levels 1-2)</b>	<b>2153</b>	<b>2153</b>
<b>PPP (Levels 3-5)</b>	<b>2153</b>	<b>646</b>
<b>FFT</b>	<b>1297</b>	<b>389</b>
<b>Total</b>	<b>6407</b>	<b>3429</b>

### **III. Clearly Defined Demonstration Components and Associated Interventions**

*Describe the EBPs and/or System Change(s) for each of the identified target populations. Each EBP and/or System Change must be described separately.*

**PARENT-CHILD INTERACTION THERAPY**

Parent-Child Interaction Therapy (PCIT) is an evidence-based behavioral health intervention that focuses on improving the caregiver-child relationship, increasing positive parenting strategies, and increasing children's positive behaviors while simultaneously decreasing negative child behaviors. PCIT is typically completed in 12 to 20 sessions focused on two distinct phases: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI). PCIT is for children ages 2 to 8 who have experienced stress or trauma. PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns.

- Trauma Type: Interpersonal complex trauma (i.e., physical, sexual and emotional abuse and neglect)
- Average Length of Service / Number of Sessions: 12-20 sessions, 6-9 months
- Service Delivered Where: Therapy space at community-based site
- Project Goals / Activities: Increase the positive attachment relationship between caregiver and child. Increase child compliance to adult directives and decrease reported behavioral concerns

Parent-Child Interaction Therapy focuses on two basic interactions:

- Child Directed Interaction (CDI): Caregivers learn to use the PRIDE skills: Praise, Reflect, Imitate, Describe, Enthusiasm, as they follow the child's lead during play. They ignore annoying or obnoxious behavior and control dangerous behaviors.
- Parent Directed Interaction (PDI): Caregivers learn to use effective commands and specific behavior management techniques as they play with their child. Caregivers are taught effective time out procedures and how to manage children's behaviors in real-world settings.

**Outcomes**

PCIT concludes with a post-treatment evaluation. In most cases, the pretreatment assessment procedures are repeated, including parent reports, teacher report, child report, and direct observation measures. The Dyadic Parent-Child Interaction Coding System-II observations are repeated at the end of the last discipline coaching session. Parents also complete a parent-report measure of consumer satisfaction called the Therapy Attitude Inventory. Parents and child return for post-treatment feedback sessions where pre- and post-treatment videotapes and accomplishments are reviewed. Brief parent report measures (Eyberg Child Behavior Inventory, Parenting Stress Index) can be completed at booster sessions to assist in tracking maintenance of behavioral improvements or for long-term follow-up of treatment. PCIT is an evidenced-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns. The goals of treatment are

- an improvement in the quality of the parent-child relationship;
- a decrease in child behavior problems with an increase in prosocial behaviors;
- an increase in parenting skills.

### Evidence Base

PCIT draws on the following theories: Baumrind's parenting styles, attachment theory (Bowlby), social learning theory (Bandura), Patterson's coercion theory, and behavior modification (Skinner). PCIT is empirically supported and has been empirically evaluated in dozens of controlled studies, with findings of: strong skill acquisition, more positive attitudes towards child, parent report of behavior problems to within normal limits, high parent satisfaction, improvements in self-reports of maternal depression and parental stress, maintenance of treatment gains up to 6 years after treatment, generalization to untreated siblings, generalization to the home and school.

### Studies that have highlighted PCIT's Effectiveness with Physical Abuse

- Urquiza & McNeil R21 Grant Submission (1995)
- Urquiza & McNeil Conceptual Paper (1996)
- Ware, Fortson, & McNeil (2003)
- Herschell & McNeil (2005)
- Borrego, Urquiza, Rasmussen, & Zebell (1999)
- Fillcheck, McNeil, Herschell (2005)
- Fricker, Ruggiero, & Smith (2005)
- Herschell, Calzada, Eyberg, & McNeil (2002)
- Chaffin and colleagues (2004, 2009; 2011)
- Urquiza, Timmer, Zebell, & McGrath (2005)
- McNeil, Herschell, Gurwitch, & Clemens-Mowrer (2005)
- Thomas, & Zimmer-Gembeck (2011)
- Galanter et al. (2012)

### Studies that have highlighted PCIT's effectiveness with Foster Parents

- Borrego & Burrell (2010)
- Urquiza, Timmer, Herschell, McGrath, Zebell, & Porter (2005)
- Timmer, Urquiza, & Zebell (2006)
- Timmer, Sedlar, & Urquiza (2004)
- McNeil, Herschell, Gurwitch, & Clemens-Mowrer (2005)

PCIT is empirically based recognized by the following:

- Society of Clinical Child and Adolescent Psychology, APA Division 53 ([www.effectivechildtherapy.com](http://www.effectivechildtherapy.com))
- The National Child Traumatic Stress Network (SAMHSA, 2005; <http://www.nctsn.org>)
- Chadwick Center for Children and Families (<http://www.chadwickcenter.org>)
  - National Crime Victims Research and Treatment Center (U.S. Department of Justice; <http://muscd.edu/ncvc>)
  - The California Evidence-Based Clearinghouse for Child Welfare (2006; <http://www.cebc4cw.org>)

- Youth Violence: A Report of the Surgeon General ([www.surgeongeneral.gov/library/youthviolence](http://www.surgeongeneral.gov/library/youthviolence))

#### PCIT Expansion in Pennsylvania

In 2010, the Department of Public Welfare received a two-year grant from *The Heinz Endowments* to assist with the goal of implementing Parent-Child Interaction Therapy in Pennsylvania and issued a Request for Applications to all licensed mental health agencies in the commonwealth. Eight providers from across the state received grant assistance to receive training in PCIT.

In 2012, the *University of Pittsburgh* received a five-year grant for \$3.3 million from the National Institute of Mental Health called “A Statewide Trial to Compare Three Training Models for Implementing an Evidence-Based Treatment (EBT).” The EBT that will be used in the statewide trial is Parent-Child Interaction Therapy (PCIT), comparing three training models for that treatment modality. The grant will help us understand what training methods are most effective for implementing an evidence-based treatment like PCIT. It will also help to build workforce capacity and significantly expand access to PCIT services in Pennsylvania for children ages 2½-7 beyond the 23 counties and 45 agencies currently offering PCIT. Seventy-two additional licensed outpatient mental health providers will be chosen to participate in the grant project. The grant will cover the cost of training four clinicians from each agency and some site preparation costs. Agencies will be recruited soon, and training is expected to begin in Spring 2014.

Discussion at Steering Committee meetings included methods for recruiting and selecting the agencies to participate in the grant and how to ensure that PCIT will be sustainable and cost-effective after the grant has ended. In addition to expanding PCIT across Pennsylvania, the grant provides an opportunity for the state to help inform PCIT International about the efficacy of various training models since currently the answer is not known to the question of which training method is most effective. For more information about the grant, contact [Dr. Amy Herschell](#), principal investigator, University of Pittsburgh School of Medicine.

#### **Positive Parenting Program (Triple P)**

Positive Parenting Program (Triple P) is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise to keep kids safely in their communities (IOC Goal 1). Triple P uses social learning, cognitive behavioral, and developmental theory to structure the intervention combined with research focused on risk factors associated with development of behavioral and social problems in children to better support parents and provide the skills needed to be self-sufficient and manage family issues. Parents are encouraged to set their own goals and choose the types of strategies that will work for their families. In this way, parents become independent problem solvers who gain the confidence to deal with issues as they arise in the future. Because it is not a one-size-fits-all model, it can be cost efficient and effective as families only receive the services they need for a time period suitable for them.

### Types of Approaches

- *Population Approach*: This approach of Triple P means that the program will be implemented across an entire community, such as a CUA, where all levels of Triple P service are rolled out in different manners to get the community involved, including one-on-one meetings, seminars, and group events.
- *Tailored Approach*: Tailored approaches mean one or several Triple P courses are selected that fit the needs of families being served and the intervention is given to a particular age range or risk level group through a specific delivery model.

### Outcomes

Outcomes of Triple P focus on decreasing negative and disruptive child behaviors, decreasing negative parenting practices as a risk factor for later child behavior problems, and increasing positive parenting practices to increase protective factors for last child behavior problems and positive parenting reactions.

### Logic Model

Triple P Logic Model: [http://www.blueprintsprograms.com/resources/logic\\_model/TripleP.pdf](http://www.blueprintsprograms.com/resources/logic_model/TripleP.pdf)

### Intervention Levels

Triple P is delivered in an outpatient or community setting for families. Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies at the previous level.

1. Level 1 (Universal Triple P): Media-based information strategy designed to increase community awareness of parenting resources, encourages parents to participate in programs, and communicates solutions to common behavioral and developmental concerns.
2. Level 2 (Selected Triple P): Specific advice on how to solve common child developmental issues and minor child behavioral problems. Parenting tip sheets and videotapes are used that demonstrate specific parenting strategies delivered through one or two brief face-to-face 20-minute consultations.
3. Level 3 (Primary Care Triple P): Children with mild to moderate behavior difficulties and includes active skills training that combines advice with rehearsal and self-evaluation to teach parents how to manage these behaviors. Level 3 is delivered through brief and flexible consultation, in the form of four 20-minute sessions.
4. Level 4 (Standard Triple P and Group Triple P): An intensive strategy for parents and children with more severe behavioral difficulties, designed to teach positive parenting skills and their application to a range of target behaviors. Level 4 is delivered in 10 individual or 8 group sessions totaling about 10 hours of intervention.

5. Level 5 (Enhanced Triple P): An enhanced family strategy in which parenting difficulties are complicated by other sources of family distress (ex. Relationship conflict, depression, high stress). Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills. This level adds three to five sessions tailored to meet the specific needs of the family to the level 4 intervention. There are other variations for parents with children with developmental disabilities (Stepping Stones Triple P) and for parents who have abused their children in the past (Pathways Triple P). Pathways Triple P covers anger management and other behavioral health strategies to improve a parent's ability to cope with raising children.

Triple P prides itself on its flexible delivery that ensures that it can be used on the maximum number of families and be used on different cultures of people within a community. There are different iterations of the program that will appeal to different family needs. This also allows for easy rollout of the system to meet the specific needs of some clients first and then rollout to other areas of the community with different needs. The multi-level system offers a suite of programs that can cater to a different level of need or dysfunction for a family so the family can receive exactly what they need in an efficient and effective manner.

#### Evidence Base

Triple P is ranked as number one on the United Nations' ranking of parenting programs based on the extent of its evidence base, including studies from around the world for different cultures. Over the last 30 years, there have been hundreds of studies around the world that included Triple P. In the United States, there have been several studies outlining effectiveness in achieving the outcomes and being a cost effective way of providing needed services:

Studies that have highlighted Triple P's effectiveness with behavioral and emotional problems

- Sanders, M.R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). Every Family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention*, 29, 197-222.
- Sanders, M.R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). Every Family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention*, 29, 197-222.
- Nowak, C. & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P - Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, 11, 114-144.

Studies that have highlighted the cost effectiveness of Triple P

- Prinz, R.J., Sanders, M.R., Shapiro, C.J., Whitaker, D.J., & Lutzker, J.R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10(1), 1-12.

- Foster, E.M., Prinz, R.J., Sanders, M.R., & Shapiro, C.J. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, 30, 493-501.

Triple P is empirically based and recognized by the following:

- Department of Justice, Office of Juvenile Justice and Delinquency Prevention
- United Nations
- The National Child Traumatic Stress Network

### **FUNCTIONAL FAMILY THERAPY**

Functional Family Therapy (FFT) is an intensive, short-term family therapy model targeting at-risk youth ages 10-18 with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses. FFT has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts. Therapy can be conducted in the family's home by a trained therapist or in a clinical setting. Sessions occur as frequently as necessary to meet the family's needs and are provided over a period of about three months. The FFT model is organized around phases of treatment that emphasize engaging and enhancing the motivation of the youth and family, facilitating change within the family, and generalization of changes.

#### Outcomes

- FFT has more than 40 years of research behind it and is widely recognized as a state-of-the-art evidence-based treatment program. Outcome assessment in FFT focuses on change within the family, such as improved parenting skills, improved communication, and reduced conflict, as well as whether the youth has refrained from substance use and criminal activity, stayed in school, and improved his or her behavior.
- Research shows that FFT achieves the following short-term outcomes: greater likelihood the youth remains at home (reduction of congregate care), improved family functioning, reduced substance use, and fewer youth mental health symptoms and/or behavior problems.
- In the long-term, FFT has been shown to reduce criminal recidivism and arrest rates, decrease substance use, and decrease behavioral health problems. Research has also shown that the younger siblings of youth who participate in FFT are less likely to have contact with juvenile court 2 ½ - 3 ½ years later.

#### Theoretical Rationale

- The FFT model draws from family systems theory and integrates behavioral approaches. FFT is based on the theory that youth's problem behaviors serve a function within the family. FFT is a sophisticated clinical model that increases a family's motivation to change and tailors interventions to each family's unique risk and protective factors.
- Family members develop ways of interacting that help them to get their relational needs for closeness or distance met, but these patterns of interacting may also create

or maintain behavior problems. When changes are made in how the family interacts (e.g., improving communication, problem-solving, and parenting skills), behavior problems will be resolved. Interventions must take into account the needs of each family member and be tailored to the family's unique risk and protective factors.

#### How it works: Core Intervention Components

FFT works with the entire family, so the youth and his/her caregivers are present at the sessions. Consequently, sessions are often held afterschool and on evenings and weekends. The FFT therapist will meet with the family as often as necessary. Sessions occur at least once per week, but the therapist can meet with a family multiple times per week at the beginning of treatment and during times of crisis or high need.

FFT proceeds through five phases of treatment, each designed to reduce specific risk factors and enhance protective factors.

- Early in treatment, the emphasis is on engaging the family and motivating them to participate in therapy.
- The therapist then conducts an assessment of the family, which is used to guide interventions for behavior change. Interventions often include psychoeducation/parent training and communication skills training, with a focus on changing patterns of family interaction that are maintaining the problem behavior.
- Once change has occurred within the family with respect to the presenting problems, the therapist helps the family generalize their new skills to other problems within the family as well as to situations outside of the home, such as problems that may be occurring at school. The therapist also helps the family develop supports and resources to support lasting change.

Link to Logic Model: [http://www.blueprintsprograms.com/resources/logic\\_model/FFT.pdf](http://www.blueprintsprograms.com/resources/logic_model/FFT.pdf)

#### Evidence Base

FFT is supported by 40 years of investigation that has demonstrated improvements with difficult to treat youths and their families in a range of settings and delivery sites. FFT has been evaluated in multiple studies in samples across the United States, and in Sweden.

There have been a few studies charting the effects of FFT in Pennsylvania specifically:

- According to the 2010 Outcomes Summary from the Evidence-Based Prevention & Intervention Support Center (EpisCenter), from data collected from 12 FFT providers across Pennsylvania:
  - Of the 1,175 youth discharged from FFT across 2010:
    - 95% had no new criminal charges during treatment.
    - 73% remained drug-free (as evidenced by negative drug screen[s] during their last three months in FFT)\*.

- 60% improved on school attendance\* and 60% improved on school performance\*.
- \*Only reported for youth who were identified with this problem at enrollment
- Of the 1245 parents/caregivers discharged from FFT across 2010:
    - 80% exhibited desired change.
    - 71% showed improvement in their parenting skills
  - From the Pennsylvania FFT Data Highlights Report ran on 1/24/14:
    - Based on 761 youth clinically discharged in Pennsylvania during the fiscal year 2012-2013: 76.4% had improved family functioning, 66.7% improved school attendance, 68.5% improved academic performance, and 90% of the youths were living in a community.
    - At 6 months post-discharge outcomes for these youth were measured again: 90% were not in out-of-home placements, 90% maintained their behavior change, 81% had no new substance abuse, and 96% were in school, graduated, or obtained their GED.

Although FFT has been traditionally used for youth in the juvenile justice system, it is increasingly being used for the child welfare dependency population as well.

#### Studies that have analyzed FFT's implementation

- EpisCenter (2011). "FFT and MST: What's the Difference."
- "Functional Family Therapy Program Costs." Accessed at: <http://www.blueprintsprograms.com/programCosts.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028>
- "Implementing FFT for new sites." Accessed at [http://www.fftinc.com/implement\\_new.html](http://www.fftinc.com/implement_new.html)
- "Phases of FFT implementation/certification." Accessed at [http://www.fftinc.com/resources/FFT\\_Implementation\\_Phases&trainings2009.pdf](http://www.fftinc.com/resources/FFT_Implementation_Phases&trainings2009.pdf)

#### Studies that have highlighted FFT's effectiveness with behavioral problems and delinquent recidivism:

- Center for the Study and Prevention of Youth Violence (2003). "Blueprints Model Programs: Family Function Therapy," *Blueprints for Youth Violence*.
- EpisCenter (2011). "Outcomes Summary from the Evidence-Based Prevention & Intervention Support Center."
- EpisCenter (2014). Pennsylvania FFT Data Highlights Report: Fiscal Year 2012-2013.
- Klein, N.C., Alexander, J.F., and Parsons, B.V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology* 45(3):469-474.
- Sexton, T. L., & Alexander, J. F. (2000). Functional Family Therapy: An Integrated Treatment System for Successfully Working with Adolescent Externalizing Behavior Disorders. *The Family Psychologist*.

- Rhoads, B. Campbell, L., Bumbarger, B. (2011). "Evidence-based Intervention Programs: 2010 Outcomes Summary". EpisCenter.
- Wasserman, Gail A., Laurie S. Miller, and Lynn Cothorn (2000). "Prevention of Serious and Violent Juvenile Offending," *Juvenile Justice Bulletin* (May). Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

#### IV. Assessing Readiness to Implement the Demonstration

*Include an analysis and overview of the requirements for the system, organizations, and community partners in implementing each EBP and/or System Change as intended, as well as specific activities to be completed prior to implementation. This includes:*

- *Assess the fit of each EBP and/or System Change with community values, culture, and context.*

#### **RESPONSE:**

We selected PCIT, TRIPLE P and FFT for this demonstration project because they are an excellent fit with our ongoing initiatives: IOC, Congregate Care Realignment, and Strengthening Families. IOC is designed to accommodate community values, culture and context because we now assign cases geographically and chose our CUAs based on their ability to deliver services in the community where the families and youth reside. The demonstration project will allow us to enhance our service delivery under the IOC model, while attempting to decrease the number of youth in congregate care and the number of youth in foster care overall so that funds can be used in the community to deliver a comprehensive array of prevention services. As our preliminary analysis of FAST/CANS data suggests and as anecdotal evidence from DHS/CUAs confirms, the selected EBPs will fill a service gap in terms of the range of ages served, the accessibility of these services, and the nature of these services. Interventions that address the specific trauma issues for children, youth and families are sorely needed. Integrating trauma-informed interventions that also provide parental guidance and behavior modification in a community setting is a more holistic approach than we have previously managed to provide. We anticipate that further analyses of FAST/CANS as those assessments grow to scale will further confirm our choice of these three EBPs.

- *Assess the leadership support for the CWDP in general and the county's selection of interventions.*

#### **RESPONSE:**

Given the ongoing collaborative work we have been doing with the CUAs on IOC implementation and with CBH on integrated service delivery, DHS is now in a position to maximize those efforts through the selection of PCIT, TRIPLE P and FFT as our EBPs of choice. All agencies are supportive of these interventions and are committed to developing capacity, organizing training, and implementing in a thoughtful rollout that complements the rollout of IOC. We are cognizant of the fact that, according to Implementation Science, implementation takes time and the literature suggests that comprehensive projects such as these take 4-5 years. We have assured our partners in this project that we will phase in the EBPs over time so

that initial implementation can be monitored and evaluated; adaptations to service delivery, particularly in the area of recruitment and retention, can be made if necessary; and system changes can be made when required.

As PCIT and FFT are already in limited use in Philadelphia, our stakeholders are familiar with them and have already begun to accommodate them. TRIPLE P, on the other hand, will be new for all of us, but everyone is enthusiastic about its implementation.

### Example of CUA Reactions to TRIPLE P

“We intend to use various aspects of the Triple P model, Levels 1-4. We like the model because of its flexibility and ability to be used in different contexts by persons of varying educational background. We envision using the model as our basic parent education model (i.e. facility based group parent ed classes), as well as being used directly with families receiving services through our case management team. In addition to prevention staff being trained to deliver parent ed classes, we would like to have several other CUA staff trained, including case managers, case aides, parent mentors, and visitation coaches. This will allow for a multitude of Triple P interventions to be used throughout our continuum of services.”

“This program can be offered in clinical and non-clinical settings which makes it versatile by design and offers clinical supports to parents. Parents model behavior to the child and the family surrounding the child. Triple P offers self sustaining characteristics that support the IOC goal to maintain children in their homes and communities. Social competence has not been a focus of other interventions; children need to know how to be socially appropriate, socially competent and successful in developing and maintaining social systems.”

“Positive Parenting Program (Triple P) is a multi-tiered system of education and support for parents and caregivers of both children and adolescents. Levels are determined by increasing need and range from brief preventive programs (public awareness campaigns, informational brochures, etc.) to interventions for children and adolescents with moderate to severe behavioral problems (individual and group programs for youth and families). Triple P interventions are offered in a variety of formats. Frequency and nature of contact varies according to program level. 2-3 months in duration and the program is also available in Spanish.”

- *Current processes and service system functioning that need attention because they are incompatible or not aligned with successful implementation and therefore will not facilitate achieving the desired goals and outcomes.*

### **RESPONSE:**

We do not really have incompatibility or misalignment as such, because the active efforts and system structure CBH has put into place to collaborate with CUAs and to facilitate referrals to appropriate behavioral health services have resolved a lot of those

issues. However we do have ongoing work that is needed to adjust to our changing environment and to accommodate the successful delivery of EBPs leading to desirable outcomes.

IOC Implementation: As IOC is still a relatively new system change, and the final CUA selection has only just been made, there are ongoing adjustments to the new processes that guide implementation. We are confident, however, that these adjustments can and will be made as necessary because we are all committed to the success of IOC. Given the number of collaborative meetings with the CUAs (case teamings, implementation team meetings, expedited permanency meetings (EPMs)), we feel that the partnerships are growing stronger on a daily basis.

Congregate Care Rightsizing: This initiative requires ongoing monitoring and adjustment as we try to reduce our congregate care population. While we have been successful so far, we think we can do better over time. We will be helped in this process by a grant we received from the Children's Bureau last fall that is designed to prevent homelessness for youth aging out of foster care. We hope to be able to provide services to older youth and their families that will prevent them from moving into congregate care and therefore avoid homelessness as they reach adulthood. We are currently reviewing the service array for older youth, including them in our planning group activities for the grant, and reviewing how the higher levels of TRIPLE P and FFT might work toward the goals of reducing the congregate care population and preventing homelessness at the same time.

Data Systems and Data Integration: Building an electronic case management system is an ongoing process and one that continually adapts to the needs of DHS and the CUAs. We continue to work ensuring the robustness of our data system and the reliability of our data, particularly as we integrate the CUA data into our system. At the same time, we continue to work with CBH on possibilities for data sharing that will enhance our ability to assess youth appropriately for the EBPs, maintain fidelity in implementation, and develop rigorous tracking, monitoring and evaluating mechanisms that allow us to be confident in the efficiency and effectiveness of the EBPs for our population.

In addition, there has been major progress made regarding data sharing at the aggregate level (see *Appendix B*). We received approval for data sharing between DHS and CBH which will allow us share information more freely.

- *Ensuring Staff Competence at the Practice Level*

*For each front-line person (e.g. caseworker, foster parent, therapist, etc.) involved in direct service with children or family members, please describe what is currently planned in relation to:*

- *Using criteria relevant to the intervention for recruiting and/or selecting the direct service provider (e.g. number of staff, qualifications, pre-requisites, experience, attitude, ability);*
- *The training needed, timing and length of training required, qualification of trainers, availability and access to qualified trainers;*
- *The supervision and coaching model, including the qualifications needed for the supervisor and/or coach.*

**RESPONSE:**

Our CUAs are our direct service providers, along with CBH for Medicaid reimbursable services. The staff responsible for implementation differs by EBP, but the process of training and supervision will be subcontracted out to an expert on each EBP. All CUA subcontracts are subject to DHS approval, including EBP provider organizations. Decisions on which providers will implement each EBP will be decided in collaboration with the CUAs, but with the exception of PCIT which is rolling out state-wide and through the PolicyLab's project, we anticipate sole providers. DHS is already meeting weekly with CUA staff to ensure that the IOC rolls out effectively. The project manager for CWDP will also meet weekly with CUA front line staff and EBP provider staff to ensure that the EBPs also roll out effectively.

**Parent-Child Interaction Therapy (PCIT)**

*Qualifications:* The training is for mental health professionals, employed by CBH and Medicaid reimbursable, with a minimum of a master's degree in psychology or a related field. It involves 40 hours of direct training with ongoing supervision and consultation for approximately the next four-to-six months. The latter can be accomplished through conference calls, videotapes, and distance-learning technology. Competency criteria will be assessed at the completion of the 40-hour training with fidelity checks throughout the supervision and consultation period. Assessment instruments and scoring forms as well as the step-by-step clinician guide are needed for training (Hembree-Kigin, T, & McNeil, C.B., Parent-Child Interaction Therapy. New York: Plenum, 1995). Manuals for detailed implementation of the treatment program, coding of sessions, and handouts for use in treatment will complement the guide.

*Clinician Training in PCIT*

- PCIT International's Training Guidelines (2009)
- Training Requirements for Clinicians
  - Master's degree or higher in the mental health field;
  - Actively working with children and families;
  - Licensed in his or her field or receive supervision from a licensed individual trained in PCIT.
- Training Program
  - 40-hours of face-to-face contact with a PCIT trainer;
  - 4-6 months later a 2-day advanced live training
  - Case Experience (at least 2 families, preferably 5)
  - Regular (bi-weekly) consultation/Supervision over 1 year
  - Skill review

*Costs:*

Estimated Training - \$35,000 for a group of 10-12 clinicians

- 7 face-to-face workshop days
- Weekly to monthly consultation calls
- Video review and feedback
- Site Set-up - ~\$2,000 per site

- Equipment – Bug-in-the ear, sound system, one-way mirror, toys, table & chairs, assessment measures
- Construction Costs – observation room, time-out space
- Clinicians in training
  - Initial lost productivity time as they are learning a new treatment

#### Update on PCIT Rollout in Philadelphia (2/25/14)

Philadelphia selected a behavioral health service provider in 2009 to deliver PCIT at two foster care agencies in Philadelphia; Bethanna and Jewish Family and Children's Services. The provider, Children's Crisis Treatment Center (CCTC), was selected via a competitive process, jointly sponsored by DHS, Children's Hospital of Philadelphia's PolicyLab and DBHIDS. In July 2013, CCTC's contract was expanded, with the addition of two additional child welfare agencies (Community Umbrella Agencies or CUAs), NET and APM, who began offering PCIT in July 2013. CCTC, with clinical support from PolicyLab, is responsible for adhering to national PCIT standards for training, coaching and supervision. The lead clinician at CCTC (Jessica Shore) and the clinical partner at PolicyLab (Susan Dougherty) are certified by PCIT International.

Bethanna, which recently became a CUA, also built internal capacity to deliver PCIT with the addition of two trained Bethanna clinicians, who started training in February 2013, with certification pending in March 2014.

Four CUAs (NET, APM, Turning Points for Children (TPFC), and Tabor Northern Community Partners (TNCP) are building internal capacity by potentially participating in the PCIT Across PA grant funded by NIMH. NET, APM and TNCP have identified outpatient staff who will participate in the training. TPFC will train staff at Juvenile Justice Center (JJC), who will merge with TPFC in 2014. For the four CUAs who are anticipated to participate in the NIMH grant, training, coaching and supervision will be provided by the grant staff in adherence to national PCIT standards.

Finally, two CUAs, Catholic Community Services (CCS) and Wordsworth (WW) are exploring collaboration with an external partner to deliver PCIT services. DHS and CBH are in discussions with these two CUAs regarding the provider selection process and how/when services will be delivered. Potential partners for delivery of services include Children's Crisis Treatment Center and Presbyterian Children's Village (PCV). PCV has been providing PCIT via their outpatient clinic since 2011 and has collaborated directly with the purveyor of PCIT (PCIT International) for training, coaching and supervision.

#### **Positive Parenting Program (TRIPLE P)**

*Qualifications:* Practitioners represent a wide range of professions because of the ease of delivery and the different levels available. Family support workers (social workers), doctors, nurses, psychologists, counselors, teachers, police officers, child safety officers, and others can be trained to provide Triple P to families.

**Training:** Triple P trainers conduct training courses with 20 participants over a 1-4 day period depending on the level selected. Triple P uses a skills-based training approached to introduce the practitioners to the range of consultation skills necessary for the effective delivery of the program. Various methods are used to do the training such as presentations, video demonstrations, clinical problem solving, rehearsals of skills, and peer tutoring. Practitioners must attend 80% of the training in order to be able to be an accredited Triple P provider, with full accreditation completed six to eight weeks after the training is completed in order to demonstrate their proficiency. Practitioners, managers, and coordinators can access periodic follow-up support via telephone with Triple P staff. Often a formal model of telephone support is used at the start of implementation and is phased out over time. Half-day professional development opportunities are offered around assessment, program fidelity vs. flexibility, cultural diversity, engagement of hard to reach families, and other workshops that staff can select based on personal needs.

**Costs:**

Item Description	Cost	Required Element
Parent Workbooks	\$20-32 per participant	Yes
Positive Parenting Booklets	\$6.50 per participant	Yes
Parenting Tip Sheets	\$8-11 for a set of 10	Yes
2- to 3-day, on-site training and half-day follow-up training	\$21,415-\$26,195 per site for up to 20 practitioners, depending on level of training	Yes
Telephone Consultation	\$200 per hour	No
Clinical Support	\$3,035 per day	No
Pre- and post-accreditation quality assurance support	\$3,035 per day	No

**Functional Family Therapy (FFT)**

**Qualifications:** Therapists should have a master's degree in psychology, social work or a related field. Supervisors must be licensed therapists.

**Ratios:** Trained supervisors can support up to eight clinicians. Full-time clinicians work with caseloads normally averaging 12-16 "active" cases at any given time.

**Time to Deliver Intervention:** Requires an average of 12 sessions over a three to four month period. Clinicians spend an average of 2.5 – 3 hours per family per week for face-to-face contact, collateral services, travel, case planning and documentation.

**Implementation**

**The Three Phase Process of Functional Family Therapy Site Certification**

- **Phase 1—Clinical Training:** The initial goal of the first phase of FFT implementation is to impact the service delivery context so that the local FFT program builds a lasting infrastructure that supports clinicians to take maximum advantage of FFT training/consultation. By the end of Phase I, FFT LLC.'s objective is for local clinicians to demonstrate strong adherence and high competence in the FFT model. Assessment of adherence and competence is based on data gathered through the FFT Clinical Service System, through FFT

weekly consultations and during phase one FFT training activities. It is expected that Phase One be completed in one year, and not last longer than 18 months. Periodically during Phase I, FFT LLC. personnel provide the site feedback to identify progress toward Phase I implementation goals. By the eighth month of implementation, FFT LLC. will begin discussions identify steps toward starting Phase 2 of the Site Certification process.

- Phase II—Supervision Training: The goal of the second phase of FFT implementation is to assist the site in creating greater self-sufficiency in FFT, while also maintaining and enhancing site adherence/competence in the FFT model. Primary in this phase is developing competent on-site FFT supervision. During Phase II, FFT LLC. trains a site's extern to become the on-site supervisor. This person attends two 2-day supervisor trainings, and then is supported by FFT LLC through monthly phone consultation. FFT LLC provides one 1-day on-site training or regional training during Phase II. In addition, FFT LLC provides any on-going consultation as necessary and reviews the site's FFT CSS database to measure site/therapist adherence, service delivery trends, and outcomes. Phase II is a yearlong process.
- Phase III—Maintenance Phase: The goal of the third phase of FFT implementation is to move into a partnering relationship to assure on-going model fidelity, as well as impacting issues of staff development, interagency linking, and program expansion. FFT LLC reviews the CSS database for site/therapist adherence, service delivery trends, and client outcomes and provides a one-day on-site training for continuing education in FFT. Phase III is renewed on an annual basis.

\*\*\*\*Current Provider Networks in Philadelphia with FFT already implemented: *The Consortium, Intercultural Family Services, and VisionQuest*

*Link to implementation costs:*

<http://www.blueprintsprograms.com/programCosts.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028>

*Start Up Costs:*

Initial Training and Technical Assistance

- FFT brings a program to full functionality over three phases that generally last one year each. Start-up costs are incorporated in phase one of program development. Training is team based with an optimal team size of 5-6 therapists. The cost of phase one training and technical assistance is \$36,000, plus an estimated \$16,000 for travel for a total of \$52,000. Some of these costs will be incurred after the program staff are trained and treating clients.

Curriculum and Materials:

All costs included in training and technical assistance costs above.

Licensing

All costs included in training and technical assistance costs above.

*Other Start-Up Costs:*

Staff salaries during the training period and the cost of developing office space (more space will be needed if implementation is to be office-based).

*Intervention Implementation Costs:*

Ongoing Curriculum and Material - None.

Administrative overhead can be projected at 10-30%, again depending on program size and on where the intervention will occur (home vs. office).

*Implementation Support and Fidelity Monitoring Costs*

Ongoing Training and Technical Assistance

All costs to support an FFT team are included in the annual fees charged by the purveyor. In addition to the first year cost of \$36,000 (plus \$16,000 for travel) discussed under Start-Up Costs, year 2 cost is \$18,000 (plus \$3,500 for travel), and the cost for year 3 and beyond is \$7,000 (plus \$1,000 for travel) per year.

Fidelity Monitoring and Evaluation

The annual fee includes support for the Clinical Services System (CSS), a web-based application for tracking progress notes, completing assessments, and reporting outcomes in accordance with the model design.

Ongoing License Fees - See above

Other Implementation Support and Fidelity Monitoring Costs - None

*Other Cost Considerations:*

The scale of an FFT program can affect costs, with multiple teams being able to take advantage of combined trainings and other required events for implementation. Some states have developed a statewide training process that can also reduce costs. With therapist caseloads of 12 and supervisors seeing 5 youth/families and an average service length of 12 weeks, the program could serve approximately 600 youth/families. Average youth/family cost in this example would be \$2,800.

For clarification on how the implementation of the EBPs intersects with the CUA rollout, see Timeline in Appendix C.

- *Organizational Supports Needed*

*Please describe whether or not host agencies have been identified at this time. If such agencies have not yet been identified, describe the agency recruitment and "buy-in" process you are planning to use.*

**RESPONSE:**

As mentioned previously, the CUAs are our host agencies and have been collaborating with us on this project for the last year. The CUAs will be primary drivers of EBP implementation; however, the DHS Project Manager will ensure that the interventions are implemented with fidelity to the model, consistency across the CUAs, and compliance with data reporting requirements.

*Describe how host agencies that will employ front-line staff (e.g. public child welfare, private providers) will need to change in order to support new ways of work or services that were not previously supported by their organization. What new policies, procedures, or resources likely will be needed at the agency level?*

**RESPONSE:**

DHS, CUAs and CBH will have to adjust to accommodate the provision of the selected EBPs. We believe will have to:

1. Hire a DHS Project Manager to oversee the day-to-day implementation factors and coordinate with a counterpart at CBH and each of the CUA agencies.
  2. Allocate resources, most likely staff-related, either in allocating time from current staff or hiring new staff, aside from the mental health professionals needed for PCIT and higher level TRIPLE P. Even on the lower levels of TRIPLE P, which do not require a mental professional, there will have to be dedicated staff at the CUAs to be trained and to implement the program. With regard to FFT, there will be a liaison with CBH to work on referrals as we expand the program to include dependency youth
  3. Collaborate with CBH and the CUAs to develop recruitment procedures for hiring staff, refine assessments, and finalize inclusion criteria.
  4. DHS will work with CBH and the CUAs to develop policies and procedures to guide the project to full implementation. We will consult with Annie E. Casey (AEC) as they have guided us so well in the past.
- *System Supports – Describe the systemic supports that will facilitate the implementation of these interventions/system changes, including:*

*Anticipated changes in funding mechanisms and streams during the demonstration period*

**RESPONSE:**

The collaboration between DHS and CBH to consider blended funding opportunities, such that MA billable services would be covered by CBH and non-billable services by DHS. This type of blended approach will ensure the sustainability of the services over time. From the DHS perspective, all three Evidence Based Programs will be funded via Special Grant. Absent the Child Welfare Demonstration Project, these programs would be funded using prevention/preventative funds in the Needs Based Budget.

*The financial resources that might/will be able to sustain this intervention after the demonstration project ends;*

**RESPONSE:**

Absent the child Welfare Demonstration Project, additional State and Local funds will be required to offset the loss of Federal funds. These additional funds are not currently budgeted.

*Any significant changes in policies, procedures, or contracting relationships that will be needed at any level (e.g. State, county, agency);*

**RESPONSE:**

In collaboration with our project partners, we will develop and distribute the protocols for each intervention and, if necessary, translate those protocols into policy. There should be no change to our contracting relationships.

*Systems partners who have agreed to collaborate (e.g. mental health, education, courts, substance abuse providers, other providers);*

**RESPONSE:**

The CUAs and CBH has already agreed to collaborate

*Systems partners who will need to partner or collaborate differently but are not yet on board (e.g. mental health, education, courts, substance abuse providers, other providers).*

**RESPONSE:**

We would like to enlist the support of the School District of Philadelphia and Family Court.

*The fidelity data system, including whether or not a data system and associated infrastructure (e.g. Web-based data entry) are available or you will be developing the data system to track fidelity;*

**RESPONSE:**

As discussed previously, we will work to integrate data related to this project into our Electronic Case Management System (ECMS) along with the CUA data that will be necessary to track outcomes.

*The outcome measures, monitoring, and data systems that are required or optional and that will be developed and sustained over time.*

**RESPONSE:**

The outcome measures will relate to the IOC outcomes of interest described previously. We will most likely develop additional measures that indicate improvement related to the present problems of participants in the EBPs. The Division of Performance Management will work with IT to develop compliance and outcome reports as each intervention is implemented.

**V. Work Plan**

*Provide a plan and estimated timeline for activities associated with the implementation of each EBP and/or System Change. This should be completed as an addendum to your currently approved Work Plan. If there are any changes necessary to your current work plan, this should also be submitted for ACF consideration. To the extent possible, this section should include a **description of the key tasks, responsible parties, timeframes for beginning and completing activities, and products or benchmarks of progress** that will serve as evidence of completing the activities, noting the phasing or staging of providers, services, or other activities if there are multiple implementation locations. Please review the attached template for the required details (the template contains an Instructions tab).*

*See Timeline, Appendix C*

*See Workplan, Separate Attachment*

## VI. Training and Technical Assistance Assessment

*Include a description of the State and/or Federal training and technical assistance (T/TA) resources the county anticipates it will need in order to implement the demonstration, making note of any strengths and gaps in those resources.*

### RESPONSE:

If it proves to be necessary, we will call on the state's Child Welfare Training Institute for assistance.

*The following responses are in regard to other outside experts needed to implement any aspect of the interventions selected by the county:*

- *Identify the experts available to you to assist in the use of this intervention.*

### RESPONSE:

As we are already collaborating with CBH, we will use their expertise in helping us finalize our implementation plan, particularly around capacity building, timing and adaptation of FFT for the dependent population.

We will continue to work with *Annie E. Casey (AEC)* on those same issues as they have been invaluable to us the past and with the present project. They will also be able to help us identify other jurisdictions with experience in delivering these EBPs so that we can learn from them in terms of successes achieved, problems encountered, and barriers likely to arise.

We will use the expertise of the PolicyLab at the Children's Hospital of Philadelphia (CHOP) who have been instrumental in piloting PCIT in Philadelphia and who are involved with the expansion of PCIT in Pennsylvania. We will learn from the trainers and coaches involved with start-up on TRIPLE P, all levels.

- *What information do you have or what activities have you undertaken to feel confident about the knowledge of these experts related to the intervention (e.g., can they describe the theory base, the core elements essential for effectiveness, the history of the development of the intervention, the research and evaluation efforts, and outcomes related to the intervention)?*

### RESPONSE:

We have worked with our partners for a very long time and our confidence in them has only grown stronger the longer we work together. CBH and the PolicyLab are particularly knowledgeable about the interventions themselves. AEC is very knowledgeable about dissemination of these interventions.

- *How have you assessed the experts' capacity to effectively assist you overall with practical implementation and effective implementation processes (e.g., have you interviewed the expert, interviewed other agencies and States, reviewed replication data, reviewed materials available)? Please describe your*

*assessment process and describe how much experience the expert has in helping others make effective use of this intervention (e.g., 2 or more years providing training, coaching, data systems, Learning Collaboratives, and advising around organizational change and sustainability in X number of States/counties/agencies)?*

**RESPONSE:**

Although we did not specifically assess for this particular project, the partners reference above have been involved from the beginning in our IOC efforts, Congregate Care Reduction, etc. as well as this current project. In terms of the outside vendors who will train, coach and supervise on the expansion of TRIPLE P, we have come to understand that they are the most respected providers of these services.

- *Some purveyors or experts have waiting lists or lack the capacity to engage in larger-scale efforts. Are these purveyors or experts available in a timely manner? Do they have the capacity needed to assist you?*

**RESPONSE:**

We have been in contact with Triple P America to assure ourselves that they are willing and have to capacity to respond when we are ready for that intervention. CBH is most familiar with FFT implementation and, given enough time, will be able to work with us on its extension to dependency cases. PCIT trainers are already on board (see Timeline in Appendix C).

- *Are they willing and able to help you build your own capacity (State or county level) to provide ongoing selection, training, coaching, data systems, etc.? Or will there be an ongoing relationship with the purveyor/experts and costs associated with maintaining this implementation infrastructure?*

**RESPONSE:**

Most of our partners are internal so they will automatically be involved in ongoing selection. Training and coaching will be an ongoing expense until we reach full implementation and possibly beyond to account for staff turnover. Our data systems are our own, although we will be working with a yet to be decided provider of technical products and services as we begin to explore predictive analytics to use for this project and others.

For a snapshot of the selected EBPs, populations to be served, service providers, and ongoing system issues involved in implementing the program models, please see *Appendix D*. For a description of our partner agencies, see *Appendix E*. For an updated Distribution Map of CUAs under IOC, see *Appendix F*.

- *Describe your budget for initial and ongoing involvement. Is it adequate?*

**RESPONSE:**

We will be developing a model of braided resource utilization. CBH will cover Medicaid billable services (Levels 4-5 Triple P and expansion of FFT) and DHS will provide for non-clinical components, as well as some of the financial and data costs related to child welfare services. We anticipate training costs for PCIT to be covered through the previously mentioned NIMH grant and we have additional staff costs covered in our Needs Based Budget. Levels 1-3 of Triple P are relatively inexpensive and can be covered through the use of discretionary funds.

## **VII. Anticipated Major Barriers and Risk Management Strategies**

*Identify any anticipated major barriers to executing the implementation of each EBP and/or System Change and any planned strategies to address them.*

### **RESPONSE:**

It is important to note that DHS is running a dual system while we continue to implement IOC over the next several years. Although all 10 CUAs have been selected, and full implementation of the IOC initiative is expected to be complete in the fall of 2015, the accelerated rollout of IOC and the anticipated rollout of EBPs, may present some logistical problems for the CUAs. Accordingly, DHS plans to hire a project manager with experience in resource development to ensure that the EBPs are developed appropriately, implemented with fidelity to the model, and integrated into IOC case management practice without jeopardizing case transfers as mandated by IOC or interrupting delivery of the current array of child welfare services being offered.

**APPENDIX A****CBH & DHS Services Currently Available**

<b>SERVICE</b>	<b>DESCRIPTION</b>
<b>C B H</b>	
Family Focused — Behavioral Health (Entire family)	(FFBH) – Implemented by NET designed to serve families with multiple siblings who are receiving or being referred to BHRS. Typically one or more of the children has been exhibiting chronic behavioral issues.
Family and Community Treatment (step down)	(FACT) – A one year in home family therapy service provided by one Masters’ level clinician in the role of family therapist but also able to provide individual therapy to family members.
Behavioral Health Rehabilitative Services	(BHRS)- Short term interventions to prevent placement into 24/7 psychiatric level of care and to promote youth being able to function in all domains, Can be delivered in home, school or community. Components include TSS, Mobile Therapy, and Behavioral Specialist Consultant.
TSS – Therapeutic staff support	Therapeutic staff (BA level) support may be provided in the home, school, or other community settings. The role of the TSS is to implement the clinical interventions that described in the child's treatment plan to help make positive changes in behavior. The TSS should also provide encouragement to the child as well as feedback about how the child's behavior affects others.
Mobile Therapy	A mobile therapist provides therapy to children to support children and families in coping with issues such as loss, developmental delays or disabilities, anger management, parenting, and behavior modification.
BSC	A behavior specialist is a Masters’ level professional who works with the child, the family, and the school to develop a plan for re-shaping the child's behavior. The behavior specialist observes the child's behavior in the child's own setting. The behavior specialist identifies the child's strengths and develops a treatment plan with to addresses the child's behavioral needs, while building on the child's strengths.
Clinical Transition and Stabilization Services (CTSS)	Short-term –max 90 days- that addresses MH and stabilization needs of children aged 4 to 21 years in

	foster care. In home individual and family therapy, crisis intervention and 1:1 support and modeling in home, school and community.
Family Based Mental Health Services	(FBMS) – Goal is to reduce out of home placement and to strengthen and maintain families through therapeutic interventions. Provided 24/7 by specific teams – 32 week program and provides transition to other community based services.
Functional Family Therapy (FFT)	JJ involved – Evidenced based treatment that addresses the youth with delinquency issues and designed to prevent or decrease delinquency, violence, disruptive behaviors and substance abuse. Duration 14 weeks.
Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)	High level of intensity and frequency, delivered in home, school, or community; incorporates treatment interventions place a high premium on approaching each client/family as unique.
Multidimensional Treatment Foster Care	MTFC is an alternative to regular foster care, group or residential treatment, and incarceration for youth (ages 13-18) who have problems with chronic disruptive behavior. The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.
Parent-Child Interaction Therapy (PCIT):	An evidence based practice that is a family focused approach for children 2-8 who present with moderate to severe BH challenges. Live coaching and treatment of both child and caregiver together. Expansion into CUAs currently.
Outpatient	Individual Family Group Enhanced (Evidence-based) ECSFT (Future)
High Fidelity Wraparound	Hi Fidelity Wraparound is a process to improve the lives of children with complex needs and their families. It is not a program or a type of service. The process is used by communities to support children with complex needs and their families by developing individualized

	plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is needs rather than services driven.
School based Services	STS – School Therapeutic Services is a MH treatment developed as an alternative to BHRS in a school setting. Full range of therapeutic services, tailored to be age appropriate BH interventions.
Acute Partial Hospital Program (PHP)	Combines elements of inpatient and outpatient in a structured therapeutically intensive program. Is an alternative to hospitalization for individuals who pose a threat to self or others. Used for indiv d/c from inpatient.
Enhanced CM (Catch)	
Drug and Alcohol	Outpatient IOP Residential (ST and LT)
<b>D H S</b>	
Family Empowerment Services (FES)	The Family Empowerment Services (FES) program is a prevention service designed to enhance the ability of families to provide for their children's well-being in a minimally intrusive, time-limited manner during the reunification process. Primary service includes case management, assessment of strengths and needs, interventions, arrangement/coordination of services to meet the family's specific needs. Service is provided for 90 days.
Achieving Reunification Center (ARC)	Is a "One Stop Center designed to assist parents with children in out of home placement overcome barriers toward family reunification. ARC offers a comprehensive range of services focused on ensuring child safety while strengthening the family's stability and self sufficiency by bringing systems together for positive family outcomes. All services offered are in one location including counseling; parent education, housing/financial counseling, workforce development, outpatient mental health, child care and supervised visits.
Intensive Prevention Services (IPS)	IPS is an Intensive intervention program designed to engage youth between the ages of 10-17 years old,

	who have been identified as exhibiting high and/or at risk behaviors. Service is provided for 4 months, 15 hours per week.
Family Reunification (FR)/Time Limited Family Reunification (TLFR)	Program provides 12 weeks of intensive services designed to assist families with the reunification process whose children are returning from out of home placements such as Congregate Care facilities, Treatment Foster Homes, Medical Foster Homes and Foster care.
Family School	Family School provides services to families with children from birth to 5 years old residing with the parent or in an out of home placement such as foster care. Services include early intervention, parenting education, education around abuse and neglect prevention, child health, and school based child care,
Achieving Independence Center (AIC)	The AIC is a "One Stop Center" designed to help youth achieve their future goals of self-sufficiency. Some of the services offered by the AIC include: Life Skills training, Education, Job Training, Employment, Technology and Mentoring. Youth must be between the ages of 14-21 years of age and be in or have been in out of home dependent placement.
Rapid Service Response Initiative (RSRI)	The Rapid Service Response Initiative is designed to offer services to families that have been reported to the Department of Human Services for child abuse and/or neglect as well as situations where the initial risk to the child is deemed moderate to high and services are needed by the families. These supportive services assure that families can effectively utilize their own strengths and community resources to maintain the safety of their children without long term intervention by DHS. RSRI services are limited to sixty calendar days from the date that the DHS referral is given to the RSRI provider. The RSRI provider makes weekly in person contact with the family.
In Home Protective Services (IHPS)	IHPS is a safety and family in-home service delivery model that is designed to reduce safety threats and increase the protective capacities of the family while maintaining children in their own homes with a safety plan. IHPS agencies work collaboratively with DHS and utilize a Safety Plan and a Family Service Plan to guide service delivery. IHPS specialties include: Sex Abuse, Cognitively Impaired Caregiver and Medically Fragile Children. Services must include minimally

	<p>home visits twice per week for children 5 and under and once per week for children over 5 years old. The service duration for General IHPS typically is 6 months and for Specialty IHPS, 12 months.</p>
<p>Family Stabilization Services (FSS)</p>	<p>FSS agencies offer in home services support to court involved families for stabilization purposes due to a youth in the home with identified concerns such as truancy and incorrigibility. Families who receive this service do not meet the safety threat guidelines. The FSS provider engages the youth and the family to implement the Family Service Plan goals and objectives.</p>

## APPENDIX B



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

June 19, 2013

Ms. Anne Marie Ambrose, Commissioner  
Philadelphia Department of Human Services  
1515 Arch Street, Eighth Floor  
Philadelphia, Pennsylvania 19102

Dear Commissioner Ambrose:

Thank you for your letter requesting the Department of Public Welfare's (DPW) permission for the Philadelphia Department of Human Services (DHS) to share information with Community Behavioral Health (CBH) in a cross-system collaboration between DHS and CBH. This study is to better understand the populations of children served by DHS, Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and Community Behavioral Health (CBH). Pursuant to 23 Pa. C.S., Section 6342 (relating to studies of data in records), 55 Pa. Code, Section 3130.44 (relating to confidentiality of family case records) and 55 Pa. Code 3490.38 (relating to authorized studies of child abuse data), your request is approved for the research study as described in your letter provided to DPW dated May 16, 2013.

We appreciate receiving the information that has been outlined in regard to the proposed research. We are including a copy of the Nondisclosure Agreement that all individuals with access to this information must sign. These documents must be signed and a copy emailed to DPW, attention Sharon Mathna [smathna@pa.gov](mailto:smathna@pa.gov). Please note the following requirements for approval to conduct studies. The person requesting the research data must provide DPW, through the Office of Children, Youth and Families, with the following:

- 1) An advance copy of the report at least three weeks prior to release of the report to the public;
- 2) An opportunity for comment and the inclusion of the comments in the report released to the public or otherwise;
- 3) A briefing on the finding of the study along with a list of the intended recipients; and
- 4) The opportunity to review confidentiality agreements executed by each employee with respect to release of/use of confidential information in any manner whatsoever.

OFFICE OF CHILDREN, YOUTH & FAMILIES  
PO BOX 2675 | HARRISBURG, PA 17120 | 717.787.4756 | Fax 717.787.0414 | [www.dpw.state.pa.us](http://www.dpw.state.pa.us)

Ms. Anne Marie Ambrose

- 2 -

June 19, 2013

If you have any questions, please feel free to contact Ms. Mathna of my staff at (717) 214-5982.

Sincerely,



Cathy A. Utz  
Acting, Deputy Secretary

Enclosure

c: Dr. Arthur C. Evans, Commissioner, Department of Behavioral Health  
Ms. Cynthia Schneider, Deputy City Solicitor  
City of Philadelphia, Law Department  
Mr. Brian Clapler, DHS Deputy Commissioner of  
Performance Management & Accountability  
Ms. Sharon Mathna, Office of Children, Youth & Families

## APPENDIX C

## TIMELINE

## EBP Implementation Aligned with CUA Implementation

DATE	PCIT	Triple P Levels 1-3	Triple P Levels 4-5	FFT	CUA STATUS Receiving All Referrals	
<b>YEAR 1</b>						
April13 – March14	Pilot complete; implementation initiated CUAs 1-2				CUA 1 (NET) and CUA 2 (APM)	
March14 - June14	CUA 8 certified clinicians (2)				CUA 3 (TPFC) and CUA 4 (CCS)	
<b>YEAR 2</b>						
July14 – Dec14	Training and implementation CUA 4	Begin discussions with DHS, CUAs 1-5 and PPP regarding content and schedule for delivery	Begin discussions with DHS, CBH, AEC regarding capacity building	Begin discussions with DHS, CBH, AEC regarding adaptation for dependency cases and capacity building	CUA 5 (Wordsworth), CUA 6 (TNCP) and CUA 7 (NET)	
Jan15 - March15	NIMH training CUA 1, 2, 3, 6, 7, 9; alternate training CUAs 5, 10	Training and Implementation initiated CUAs 1-5				
April15 – June15	Implementation remaining CUAs	Begin discussions with DHS, CUAs 6-10 and PPP regarding content and schedule for delivery	Complete discussions with DHS, CUAs 1-5 and PPP regarding content and schedule for delivery and finalize protocols	Complete discussions with DHS, CUAs 1-5 and FFT regarding content and schedule for delivery and finalize protocols	CUA 8 (Bethanna), CUA 9 (TPFC) and CUA 10 (Wordsworth)	
<b>YEAR 3</b>						
July15 – Sept15	ONGOING IMPLEMENTATION	Training and Implementation initiated CUAs 6-10	Training CUAs 1-5	Training CUAs 1-5	Tracking, Monitoring and Outcome Evaluation	
Oct15 – Dec15		ONGOING IMPLEMENTATION		Implementation CUAs 1- 5		Implementation CUAs 1- 5
Jan16 – March16				Training CUAs 6-10		Training CUAs 6-10
April16 – June16						
<b>YEAR 4</b>						
July16 – Sept16	ONGOING IMPLEMENTATION	ONGOING IMPLEMENTATION	Implementation CUAs 6- 10	Implementation CUAs 6- 10	Tracking, Monitoring and Outcome Evaluation	
Oct16 – Jun17						
<b>YEAR 5</b>						
July17 – June18	ONGOING IMPLEMENTATION				FINAL REPORT	



## APPENDIX D

## DHS SELECTED EVIDENCE BASED PRACTICES FOR CHILD WELFARE DEMONSTRATION PROJECT

EBP Models	Ages Served	DHS CW Populations Targeted	Who Provides	System Issues for Models		
				Programmatic	Operational	Fiscal
<b>PCIT</b>	2-8	<ul style="list-style-type: none"> <li>Children at-risk of removal</li> <li>Children in out-of-home family settings</li> </ul>	Training by experts; service by CBH	<ul style="list-style-type: none"> <li>Test in outpatient setting</li> <li>Expand the population served</li> <li>Utilizing a reliable screening assessment to determine clinical eligibility for service.</li> </ul>	<ul style="list-style-type: none"> <li>Methodology for projecting capacity needed</li> <li>Maintaining sufficient referrals to reduce financial risk</li> <li>PCIT provider relationship &amp; accountability to CUA (how does CBH track)</li> <li>Will service be provided by the CUAs, CUA sub-contractors, or both?</li> <li>CBH control of eligible providers (no back door entry) i.e. RFP, what?</li> </ul>	<ul style="list-style-type: none"> <li>Funding for non-Medicaid covered costs</li> <li>Financial viability if referrals are inadequate</li> </ul>
<b>FFT</b>	12-18	<ul style="list-style-type: none"> <li>Youth at risk of removal</li> <li>Youth placed in a family setting</li> <li>Truant Youth</li> <li>Youth stepping down from a CC settings</li> </ul>	A CBH Service currently for JJ youth; will expand as part of CWDP to include dependent youth	<ul style="list-style-type: none"> <li>Engagement rate of families</li> <li>Expand and tailoring service, as appropriate, to meet needs of CW youth</li> <li>Utilizing a reliable screening assessment to determine clinical eligibility for service.</li> </ul>	<ul style="list-style-type: none"> <li>Methodology for projecting capacity needed</li> <li>Maintaining sufficient referrals to reduce financial risk</li> <li>Establishing a formal referral process to CUA from CBH FFT providers</li> <li>FFT provider relationship &amp; accountability to CUA (how does CBH track)</li> <li>CBH control of eligible providers (no back door entry) i.e. RFP, what?</li> </ul>	<ul style="list-style-type: none"> <li>Financial viability if referrals are inadequate</li> <li>Funding for non-Medicaid covered costs</li> </ul>
<b>PPP</b>	0-16	Children & Youth who are: <ul style="list-style-type: none"> <li>At-risk of removal</li> <li>In an out-of-home family (foster and kin) settings</li> <li>Stepping down from a CC settings.</li> </ul>	New service proposed for Demonstration Project	Determine how service will be delivered.	<ul style="list-style-type: none"> <li>Who from DHS will oversee implementation?</li> <li>Will service be provided by the CUAs, CUA sub-contractors, or both?</li> </ul>	<ul style="list-style-type: none"> <li>DHS/CUA funded initiative Levels 1-3</li> <li>Mechanisms to potentially blend funding to cover costs Levels 4-5 (CBH-Medicaid)</li> <li>Mechanism for CBH to all billing for Level 4&amp;5</li> </ul>

## APPENDIX E

### PARTNERS IN DEMONSTRATION PROJECT

**APM** employs over 120 bilingual/bicultural professionals in several sites and serves over nine thousand persons a year with an annual budget of over \$11 million. APM's historic founding was a response to exclusion of Latinos, especially those for whom English was a barrier, from access to services and public resources. Over the years, APM has gained a positive reputation for its cultural sensitivity not just to the Latino community, but also to African American and other ethnicities within the community. APM's staff is diversified in that there are eighteen different ethnicities represented. In addition, APM provides bilingual and culturally appropriate services through its staff, especially its health and human services staff. APM assist families in achieving their greatest potential and envisions a healthy community, where all families are self reliant, where children are protected and nurtured to become APM is a non-profit agency that was formed in 1970 for the purpose of promoting the welfare of Puerto Rican/Latino residents in Philadelphia. APM works directly with the community to convene and directly consult with community residents and provider networks, stakeholders, business owners and investors to create a long term strategy for neighborhood change and improvement. APM is committed to and experienced in engaging a broad spectrum of community stakeholders to inform and enhance our services.

Founded in 1970, **NET** is one of the oldest and largest non-profit organizations in the region. They offer a wide range of behavioral health and social services to adults, adolescents, children and families in Philadelphia, the Lehigh Valley, and the state of Delaware. NET's mission is to provide a comprehensive recovery and resiliency-oriented system of behavioral health and social services utilizing a quality-driven, cost-

effective provider network. NET has over 20 years' experience offering child welfare services including in-home, all levels of resource home care, adoption, and residential. In the past fiscal year, they served over 400 children and youth and their families in various child welfare programs. They are committed to keeping children and youth in community settings, preferably their own community, and have only pursued program development opportunities consistent with this vision. NET's full-time staff are 68% female and 32% male. In terms of race/ethnicity, our staff are 44% Caucasian, 46% African American, 8.5% Latino, and 1.5% Asian. NET utilizes a number of independent contractors for clinical and school-based services, among other roles. Our current pool of contractors is 65% female and 35% male, with 24.5% Caucasian, 73% African American, 1.2% Latino, and 1.2% Asian.

**Wordsworth's** mission is to provide education, behavioral health and child welfare services to children and youth who are experiencing emotional, behavioral and academic challenges so that they are empowered to reach their potential and lead productive, fulfilling lives. The agency was founded in 1952 as a school to meet the needs of children with reading disabilities. During its sixty year history, the agency has continuously developed its array of services and approach to treatment in response to the changing needs of its clients and an ever-evolving body of research and best practices. With a full continuum of child welfare, behavioral health and specialized education services, the agency is able to use an integrated understanding of each child/youth that views them within the context of their family and larger environment. The agency has prioritized the development and expansion of community-based programs that engage children, youth and families in their own homes, and is committed

to the belief that services are most effective, in both the short and long term, when they actively engage and collaborate with all systems that impact the child and family.

Wordsworth is a multi-site organization, with multi-system programming and an organizational budget of \$38.5 million annually. For more than ten years, Wordsworth has maintained full accreditation through the Joint Commission (including full certification of its Foster Care program) which reflects the quality of the organization's administrative and program leadership. For over 60 years, Wordsworth has responded to the needs of children and families and has always demonstrated the flexibility to develop new programs and refine others when necessary.

Over the last 20 years, **Catholic Social Services** has created numerous programs responding to the requests and needs of the City of Philadelphia, DHS and Family Court. Some of the more notable examples include: Del La Salle Aftercare (now known as Reintegration Services), The Mitchell Hall Program (farm-based residential program), Brother Rousseau Academy (day treatment for pre-adolescents), and DelStar (outpatient sex offense specific treatment program). In addition, the Out of School Time Programs run by CSS consist of 12 Programs at 10 locations: 9 elementary, 2 middle schools and 1 high school program, serving 2,000 unduplicated children this past year, and which required the hiring of close to 100 full time staff. All of these programs required a start-up from scratch, and involved the recruitment and retention of a total of over 100 staff. CSS is a long-standing member of Catholic Charities USA, Pennsylvania Council for Children Youth and Families (PCCYFS), and the Philadelphia Alliance, all of which keep staff regularly posted on federal state and local policy requirements. Employees of CSS, CORA, JFCS and NFI are well trained in the state regulations which

govern their respective programs. Yearly license reviews for DPW licensed programs ensure that regulations and policies are being maintained; internal quality assurance mechanisms also exist within each agency of the CSS Partnership (see above). CSS has over 40 years experience providing outpatient mental health services utilizing therapists and psychiatrists as subcontractors. Quality service provision is ensured via CSS's continuous quality improvement (CQI) process, which monitors both quantitative and qualitative measures throughout the case lifecycle. All subcontractors are subject to rigorous qualifications, including a written contracting process.

### **Turning Points for Children (TPFC) and Public Health Management**

**Corporation (PHMC)**, have joined forces to create a transformative new approach to improving outcomes for children involved in Philadelphia's child welfare system. TPFC has long supported families in raising safe, healthy, educated, and strong children by partnering with caregivers to develop and strengthen protective qualities and by offering them the tools, skills, and resources they need to ensure their children's optimal development. PHMC, meanwhile, has been working to improve outcomes for children by incorporating children and family services into their array of integrated programs spanning behavioral health/recovery, nurse-managed primary care and homeless health services, nurse home visiting, chronic disease management and prevention, tobacco control, early intervention, HIV/AIDS, violence intervention, parenting supports for families, and much more, plus research and evaluation that allow PHMC to assess and address issues effectively.

On February 1, 2013, TPFC became an affiliate of PHMC, combining the expertise of leadership and rich programming in child welfare, managed care in health and

behavioral health, strategies for prevention, management services, and a range of programs essential for strengthening families, along with combining the mission-driven perspective of a non-profit with the fiscal control and management capabilities of a rigorous corporate structure. The Community Umbrella Agency in the 15<sup>th</sup> Police District will be led by TPFC, with shared staff in key leadership and administrative supports areas from PHMC, including information systems management, contracts management and quality assurance. The affiliation with PHMC will also provide TPFC with access to a well-established and supported technology infrastructure, including network and telephone support that PHMC already provides to 2000 users, data management systems which will be used to support the CUA. PHMC will provide services to TPFC via a management contract that will be reviewed and renewed on an annual basis.

**Bethanna** is a Christian organization that provides the highest quality system of care for children and families in order to ensure safety, restore emotional wellness, and build family stability. Core to Bethanna's mission is providing services with excellence. Embodied in this pursuit of excellence is ensuring that the worth and dignity of each child and family member served is respected and valued. This is reflected in Bethanna's absolute commitment to implement strengths based approaches in all aspects of service delivery. Bethanna offers two primary levels of service and family-based support services that address the challenges most children and families encounter

*Permanency Services: Pathways to Permanency - Adoption and Foster Care*

Permanency is our agency's highest priority. Adoption and Foster Care are Bethanna's largest service division. Many children entering into our care are eligible for multiple services depending on their needs. Bethanna's professional staff and

foster and adoptive parents are well trained and challenged daily to provide the best for the infants, children and teenagers.

*Community Treatment Services: Supporting children along their journey*

Finding the appropriate treatment option is the first step on the path to emotional recovery. Intensive mental health support is provided for youth and foster and adoptive parents.

In an unprecedented partnership initiative, Tabor Children's Services and Northern Children's Services have collaborated to create **Tabor Northern Community Partners (TNCP)**, a Pennsylvania nonprofit corporation designed to provide high impact community-based services. Both Northern and Tabor have a long and demonstrated history of providing high quality services and collaborating with other stakeholders in the Philadelphia area. The shared missions of both organizations, combined with their expertise in serving children and families, resulted in the creation of this entity. As the parent agencies, together Tabor and Northern bring TNCP extensive experience providing prevention services, in-home, placement, adolescent, behavioral health, child protective and community-based services.

TNCP is family-centered, community-based, trauma-informed, and culturally competent. Tabor and Northern have worked 105 and 160 years respectively to support individuals and families in their homes and communities through a continuum of care that is integrated and timely. Both agencies have demonstrated the ability to adapt to meet the changing needs of DHS, communities, and most importantly, the needs of individuals and families. TNCP is an example of building a strong community network that utilizes local solutions to meet the needs of individuals and families.

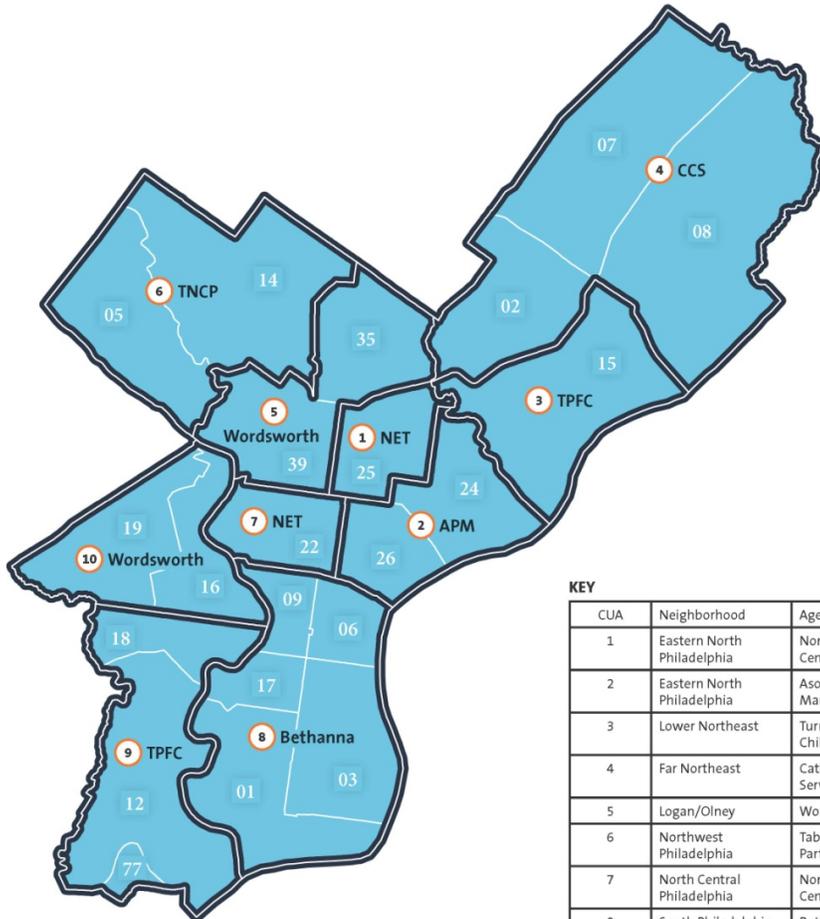
**Community Behavioral Health (CBH)** is a not-for-profit 501c (3) corporation contracted by the City of Philadelphia to provide mental health and substance abuse services for Philadelphia County Medicaid recipients. Supported through state funding, CBH works in partnership with the City of Philadelphia and the Commonwealth of Pennsylvania to provide vital behavioral health services. Today, CBH is responsible for providing behavioral health coverage for the City's 420,000 Medicaid recipients. Its primary activities include:

- Authorizing payment for behavioral health services
- Requiring provider agencies to deliver effective and medically necessary services
- Achieving management and operational efficiencies to lower healthcare costs

APPENDIX F

# Community Umbrella Agency Geographic Zones

City of Philadelphia | Department of Human Services



KEY

CUA	Neighborhood	Agency
1	Eastern North Philadelphia	NorthEast Treatment Centers (NET)
2	Eastern North Philadelphia	Asociación Puertorriqueños en Marcha (APM)
3	Lower Northeast	Turning Points for Children (TPFC)
4	Far Northeast	Catholic Community Services (CCS)
5	Logan/Olney	Wordsworth
6	Northwest Philadelphia	Tabor Northern Community Partners (TNCP)
7	North Central Philadelphia	NorthEast Treatment Centers (NET)
8	South Philadelphia	Bethanna
9	Southwest Philadelphia	Turning Points for Children (TPFC)
10	Mantua, Overbrook, Wynnefield	Wordsworth

CUA Boundary      CUA  
 Police District Boundary      Police District



Division of Performance Management & Accountability  
 January 3, 2014  
 Prepared by Research & Evaluation Unit



**Philadelphia Department of Human Services  
County Improvement Plan  
April 2014**

**Section I. Sponsor Team Members:**

The Executive Cabinet at DHS serves as the county improvement sponsor team. Cabinet members include:

Anne Marie Ambrose, Commissioner  
Doug Robinson, Finance  
Timene Farlow, Juvenile Justice Services  
Vanessa Garrett Harley, Children and Youth Division  
Brian Clapier, Performance Management and Accountability  
Paul Bottalla, Policy and Planning  
Alicia Taylor, Communication  
Barbara Ash, Law Department  
Khalid Asad, Administration and Management  
Jessica Shapiro, Chief of Staff  
Aubrey C. Powers, Quality Improvement

**Section II. Background:**

In developing the County Improvement Plan, the sponsor team reviewed the results from the state lead Quality Service Review (QSR) as well as the results from our local QSR reviews. Through this process the team found consistencies in both areas of strength (e.g. safety of children, physical health, culturally appropriate services) and areas for continued improvement (e.g. teaming, assessment and planning).

The team decided to prioritize our outcomes based on the key areas that need improvement and are consistent with Philadelphia's planning for the Pennsylvania Child Welfare Demonstration Project. Throughout the five-year project, Philadelphia's Department of Human Services (DHS) is implementing a cutting-edge child welfare approach, Improving Outcomes for Children (IOC). This is an exciting initiative aimed at improving safety permanency and well-being outcomes while safely maintaining children/youth in their own communities in the least restrictive settings possible.

**The Pennsylvania CWDP theory of change states:**

Philadelphia's initial theory of change presented in the CWDP stated, "If families are engaged as part of a team, and if children, youth, and families receive comprehensive screening and assessment to identify underlying causes and needs and assessment information is used to develop a service plan, and if that plan identifies roles for extended family members and various supports, including appropriate placement decisions and connects them to evidence-based services to address their specific needs and/or appropriate system changes, Then children, youth and families are more likely to remain engaged in and benefit from treatment, so that they can remain safely in their homes, experience fewer placement changes, experience less trauma, and experience improved functioning."

Philadelphia County has expanded theory of change to state:

- *If* engagement and assessment are successful in determining appropriate interventions, and
- *If* the interventions are implemented with fidelity to the original model, and
- *If* the interventions are monitored for efficiency and effectiveness, and
- *If* necessary system changes keep pace with client needs,
- *Then* children and youth can remain safely in their homes, experience fewer placement changes, experience less trauma, and experience improved functioning, and
- *Then* we will meet IOC short and long term outcomes.

### **Section III. Priority Outcomes:**

#### **Outcome # 1: Teaming**

This overarching outcome supports the family team's ability to achieve unity of effort and commonality of purpose.

#### **Outcome # 2: Assessment and Understanding**

This overarching outcome supports understanding the core story, underlying issues, needs and strengths of the child/youth family

#### **Outcome # 3: Planning**

This overarching outcome supports a planning process that is fully individualized and relevant to child/youth and family needs.

### **Section IV. Findings**

#### **Findings related to Outcome # 1: Teaming**

Findings from the state led QSR in December indicate that when Formation and Functioning scores were combined, 44% of the cases reviewed were found to be in the acceptable range in the Teaming practice performance indicator. This outcome looks to ensure teams work effectively together to share information, plan and provide effective services.

#### **Findings related to Outcome # 2: Assessment and Understanding**

Findings in the state led QSR in December found that 60% of the cases reviewed received acceptable ratings in the Assessment and Understanding practice performance indicator. Proper assessment sets the stage for unified change efforts so that the team can plan and modify joint strategies, share resources and find what works.

#### **Findings related to Outcome # 3: Planning**

Findings in the state led QSR in December found that 45% of the cases reviewed received acceptable ratings in the Planning practice performance indicator. Building on the paragraph above, we have developed Outcome #3 to address Planning. This outcome looks to support the use of ongoing assessment and understanding of the child and family situation to modify planning and intervention strategies in order for the child/youth/ and family to live safely together, achieve timely permanence and improve well being and functioning.

**Connecting the Work Plan with the Identified Outcomes:**

Philadelphia's work plan is aligned with the Pennsylvania Child Welfare Demonstration Project's (CWDP) logic model which connects engagement, teaming, assessment, planning and intervention. Because of this alignment, each of the action steps in the work plan below build towards better engagement (through the Teaming Process), better assessment (through FAST and CANS) and better planning (through linking families to meaningful interventions). As such, each action step works collectively towards each of the identified CIP Outcomes. In December 2013, DHS entered Year Two of the implementation of the IOC initiative. CWDP. Given the magnitude of this systems change, we will align the implementation of Evidence Based Practices, in itself another significant system change, with IOC goals and objectives.

**Philadelphia's Work Plan**

Outcome #1: Teaming								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
1. 1	<b><u>Selection and Contracting with Partners</u></b>	Phased implementation for CUAs 6&7		Report on number of referrals to CUAs	CUA Implementation Team	August 2014		
		Phased implementation for CUA 8, 9, &10		Report on number of referrals to CUAs	CUA Implementation Team	November 2014		

			RS/ BENCHM ARKS	OF COMPLETION	RESPONSIBLE		NEEDED	
<b>1.</b> <b>2</b>	<b>Staff Hiring and Training for Family Team Conferencing</b>	Hiring Teaming Coordinators and Practice Specialists for CUAs 6&7		List of transitioning staff	Children & Youth Division	July 2014		
		Hiring Teaming Coordinators and Practice Specialists for CUAs 8, 9 &10.		List of transitioning staff	Children & Youth Division	October 2014		
		Training for CUAs 6&7: Training for CUA Staff Training for Practice Specialists Training for		Curriculum and documentation of training participants.	DHS University	July 2014		

		Teaming Coordinators						
		Training for CUAs 8, 9&10: Training for CUA Staff Training for Practice Specialists Training for Teaming Coordinators		Curriculum and documentation of training participants.	DHS University	October 2014		

Outcome #1: Teaming								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
<b>1.3</b>	<b>Family Group Decision Making</b>	FGDM Conferences available for referred families accepted for in-home service		Report documenting how many families eligible for conferences and how many conferences occurred.	Children & Youth Division	July 2013 Ongoing		
		FGDM available for referred families experiencing a child or youth with an initial placement		Report documenting how many families eligible for conferences and how many conferences occurred.	Children & Youth Division	July 2013 Ongoing		

Outcome # 1: Teaming								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
1.4	<b><u>Quality Assurance</u></b>	PMA provides monthly reports regarding quantity and quality of Family Team Conferencing for CUA's 6&7		Monthly Reports	Performance Management & Accountability	September 2014		
		PMA provides monthly reports regarding quantity and quality of Family Team Conferencing for CUA's 8-10		Monthly Reports	Performance Management & Accountability	December 2014		
		PMA provides monthly reports regarding quantity and		Monthly Reports	Performance Management & Accountability	August 2014		

		quality of FGDM						
<b>Outcome #2: Assessment</b>								
	<b>STRATEGIES</b>	<b>ACTION STEPS</b>	<b>INDICATORS/ BENCHMARKS</b>	<b>MONITORING/EVIDENCE OF COMPLETION</b>	<b>PERSON(S) RESPONSIBLE</b>	<b>TIMEFRAME</b>	<b>RESOURCES NEEDED</b>	<b>STATUS</b>
<b>2.1</b>	<b><u>Staff Hiring and Training for FAST and CANS</u></b>	Hiring CUA Case Managers for CUAs 6&7		List of staff	CUA	July 2014		
		Training for CUAs 6&7: FAST and CANS training for CUA Case Managers Database training for CUA Case Managers		Curriculum and documentation of training participants.	DHS University	July 2014		

		Hiring CUA Case Managers for CUAs 8-10		List of staff	CUAs	October 2014		
		Training for CUAs 8-10: FAST and CANS training for CUA Case Managers Database training for CUA Case Managers		Curriculum and documentation of training participants.	DHS University	October 2014		

Outcome #2: Assessment								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
2.2	<b><u>FAST/CANS for Community Umbrella Agencies</u></b>	Implementation for CUAs 6&7: FAST assessment for any family in CUAs who are accepted for in-home or placement services		Report documenting how many families eligible for FASTS and how many FASTS occurred.	Performance Management & Accountability	August 2014		
		Implementation for CUAs 8-10: FAST assessment for any family in CUAs who are accepted for in-home or placement services		Report documenting how many families eligible for FASTS and how many FASTS occurred.	Performance Management & Accountability	November 2014		
		Implementation for CUAs 6&7: CANS assessment for any child or youth in CUAs who are		Report documenting how many families eligible for CANS and how many CANS occurred.	Performance Management & Accountability	August 2014		

		experiencing a placement						
		Implementation for CUAs 8-10: FAST assessment for any family in CUAs who are accepted for in-home or placement services		Report documenting how many families eligible for FASTS and how many FASTS occurred.	Performance Management & Accountability	November 2014		

Outcome # 3: Planning								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
3.1	<b><u>Plans for Initiating Service Delivery for Family Team Conferencing</u></b>	Implementation for CUA areas 6&7: Child Safety Conferences Family Support Conferences		Report documenting how many families eligible for conferences and how many conferences occurred.	Performance Management & Accountability	August 2014		
		Implementation for CUA areas 6&7: Permanency Conferences Placement Stability Conferences		Report documenting how many families eligible for conferences and how many conferences occurred.	Performance Management & Accountability	August 2014		
		Implementation for CUA areas 8-10: Child Safety		Report documenting how many families eligible for conferences and how	Performance Management & Accountability	November 2014		

		Conferences Family Support Conferences		many conferences occurred.				
		Implementation for CUA areas 8- 10: Permanency Conferences Placement Stability Conferences		Report documenting how many families eligible for conferences and how many conferences occurred.	Performance Management & Accountability	November 2014		

Outcome #3: Planning								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
3.2	<b>Plans for initiating Single Case Plan</b>	Implementation for CUA areas 6&7: Single Case Plan		Monthly report documenting how many plans were developed.	Executive Cabinet	August 2014		
		Implementation for CUA areas 8- 10: Single Case Plan		Monthly report documenting how many Plans were developed.	Executive Cabinet	November 2014		

Outcome #3: Planning								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
3.3	<u>Plans for initiating Evidenced Based Practice</u>	Identify Evidence Based Practice for the Child Welfare Development Plan		Documentation of selected Evidence Based Practices.	Executive Cabinet			Complete DHS has identified 3 Evidence Based Practices: <ul style="list-style-type: none"> <li>• Parent-Child Interaction Therapy (PCIT)</li> <li>• Positive Parenting Program (Triple P)                             <ul style="list-style-type: none"> <li>• Functional Family Therapy (FFT)</li> </ul> </li> </ul>
		Form Implementation team		List of Team members	Exec Cabinet/Project Manager	Sept. 2014		
		Development of Management Procedures/Positions/Functions		Management procedures and position functions will be available.	Exec Cabinet/Project Manager	Sept 2014		

Outcome # 4: All								
	STRATEGIES	ACTION STEPS	INDICATORS/ BENCHMARKS	MONITORING/EVIDENCE OF COMPLETION	PERSON(S) RESPONSIBLE	TIMEFRAME	RESOURCES NEEDED	STATUS
4.1	<b><u>Development of Monitoring Plan</u></b>	IOC Executive Leadership Team charged with monitoring the CWDP Implementation plan		List of Members	Performance Management & Accountability	April 2014		
4.2	<b><u>Communication Plan &amp; Strategies</u></b>	Monthly IOC newsletter provides updates on progress with the CWDP Implementation.		Monthly newsletters	DHS Communications Office	May 2014		
		IOC Website provides ongoing information regarding the CWDP Implementation		Website information	DHS Communications Office	May 2014		

**MEMORANDUM****CITY OF PHILADELPHIA****TO:** : To All CYD Social Work Services**DATE:** 8/2**FROM:** : Paul Bottalla, Policy and Planning Director **SUBJECT:** Shared Case Responsibility Reminder

The purpose of this memorandum is to remind all Social Work Services Staff (SWSS) about Shared Responsibility (SCR) visitation, Joint Assessment Meetings, and case closure as directed by the Re Joint Policy and Procedure Guide for Shared Case Responsibility (SCR Policy) dated December 12 2011. SCR requires collaboration and planning to ensure the best services and outcomes for youth are involved with CYD and Juvenile Justice Services.

**Visitation:**

CYD staff remains responsible for routine visitation to SCR children and youth accepted for services. When children and youth fall under SCR and are in delinquent placements, CYD must visit according to the revised Frequency of Ongoing Contact with Children and Youth AFS memo dated 3/1/2013. Before the revised policy memo regarding ongoing contact, JPO visits may no longer replace CYD visits as was permissible under the SCR Revised Policy of December 12, 2011. JPOs are not required to visit youth in Dependent placements, however communication and case planning between CYD and JPOs is expected.

**Joint Assessment Meetings:**

As stated in the SCR Policy, case plan consultation is required between the JPO and CYD. Joint Assessment Meetings are required to be held as soon as a child or youth is recognized as SCR. Joint Assessment meetings are to occur as often as needed. As a last resort, conference calls are acceptable in the event that parties are unable to schedule a meeting time when all may be present. The Delinquent/Dependency Unit (DDU) can assist with the Joint Assessment Meetings.

**Case Closure:**

CYD must keep Dependent cases open when youth are placed under supervision of juvenile court (i.e., adjudicated delinquent, deferred adjudicated consent decree, or placed on probation). Also, cases with SCR court order cannot be closed without court consent. As stated in the SCR Policy, current and anticipated needs of youth determine the continuation or discontinuation of SCR. When CYD intends to close a case, there must be a collaborative meeting with all involved parties, and the chains of command for CYD and JPO must be informed. Also, the Law Department must be notified prior to the court date of the intention to close SCR cases. If after consultation with the JPO there are no specific orders for and no child protection, welfare, or dependency issues, cases may be closed.

If there are any questions about Joint Assessment Meetings, please contact the Dependency and Delinquency Unit Supervisors Belinda Moody at 215-683-4108 or Ruth Johnson at 215-686-7059. If there are any questions or concerns about visitation and case closure please contact Policy and Planning Helpline at 215-683-4108.