

Report on Progress from the City of Philadelphia Community Oversight Board for the Department of Human Services

April 2013

Presented to
Mayor Michael Nutter
and the Philadelphia Community

Submitted by The Philadelphia Community Oversight Board:

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FROM THE
CITY OF PHILADELPHIA
COMMUNITY OVERSIGHT BOARD
FOR THE
DEPARTMENT OF HUMAN SERVICES**

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The City of Philadelphia Community Oversight Board (COB) is grateful for the many groups and individuals who have continued to provide insight, support, and guidance to us. Without this assistance, neither this report nor the COB's ongoing work would be possible.

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To all the dedicated individuals who work every day to ensure safety, permanency, and well-being for Philadelphia's most vulnerable children and families, we give special thanks.

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EXECUTIVE SUMMARY

The Community Oversight Board (COB) was created on June 14, 2007 by Mayor John F. Street and re-established by Mayor Michael Nutter in subsequent executive orders. The creation of the COB was one of a series of recommendations made by the Child Welfare Review Panel (CWRP) in its report *Protecting Philadelphia's Children: the Call to Action*,¹ issued on May 31, 2007. The CWRP made 36 additional recommendations that were intended to be a road map for DHS to reform its system and ensure the safety of children in its care. Since its establishment, the Community Oversight Board (COB) has continued to monitor and assess the Philadelphia Department of Human Services' (DHS) progress in implementing the recommendations of the CWRP.

Overall, DHS is to be highly commended for making significant progress in improving its management and operations. DHS also has expanded its capacity to implement a safety focused, community-based, child-centered, family-focused model of practice. The COB anticipates that these changes will result in measurable improvements in safety outcomes for children and youth. The COB has begun to monitor safety outcomes but at this point the impact of these changes on the outcomes being monitored by the COB is not yet clear.

At the request of Mayor Nutter, in 2011 the COB began to also include in its scope child well-being as a component of child safety. As a part of this well-being work, recently the COB began to look closely at the issues of older youth in care. Older youth are defined as children 13 to 21 years of age. The COB is particularly concerned about this population. Almost half of the DHS population in care is older youth (46% in 2012). In June 2012, the COB created the older youth work group (OYWG) to gain a better understanding of the issues of older youth in DHS' care, identify gaps in programs and services, and develop recommendations for Mayor Nutter regarding the need for cross-system collaboration to improve outcomes for older youth.

Highlights of DHS' progress on the implementation of the CWRP recommendations are provided below. In addition, a summary of the data on three outcome measures being monitored by the COB is presented. The data regarding compliance with visitation requirements, and data on fatalities and near fatalities, are also discussed.

CWRP RECOMMENDATIONS

The CWRP made 37 recommendations for reforming DHS' policies and practices to improve the safety of children in Philadelphia. DHS has fully completed 20 of the 37 CWRP recommendations. The 20 recommendations included the development of a new mission and core values centered on child safety, integrating the mission and values into practice and policy, developing safety and risk assessment tools, and improving accountability.

The goal of ensuring child safety and serving those at greatest risk for abuse and neglect is at the forefront of the new practices and policies that have been put in place by DHS in the last 5 years. These include the implementation of Hotline Guided Decision Making (HGDM), the new in-home safety assessment that includes an assessment of risk, and the requirements regarding conducting

¹ Philadelphia Child Welfare Review Panel (2007) *Protecting Philadelphia's Children: The Call to Action*. Available from, <http://www.phila.gov/dhs/PDFs/childWelfare.pdf>

criminal background checks on each adult member of the child's household during the investigation or assessment process and prior to reunification. Feedback from the participants in the focus groups conducted by the COB in 2010 indicated that the focus on child safety has been heard and embraced not only by DHS staff, but by providers and professionals serving children and families in the community.

In January 2009, DHS established the Division of Performance Management and Accountability (PMA) to evaluate DHS' performance and the performance of its contracted providers. Through case reviews and data analysis supported by PMA, DHS is better able to determine the effectiveness of its services, programs, and practices. DHS is currently conducting four types of case reviews—ChildStat², Quality Service Reviews³, fatality/near fatality reviews⁴, and Quality Visitation Reviews.⁵ In addition, DHS regularly performs on-site reviews of providers and assess' provider's performance in achieving the goals of the services provided and specific outcomes measures including benchmarks to measure performance related to safety issues.

The COB will continue to monitor 17 of the CWRP's recommendations. Eight of these recommendations have been implemented by DHS. However, the COB continues to monitor the activities related to these eight recommendations due to their importance for ensuring the continuing safety of children served by DHS. These recommendations address the areas of child visitation, child fatality review, the conduct of criminal background checks, the provision of health and behavioral health services, and implementing technology to support social work practice. In these areas, DHS has:

- instituted the Quality Visitation Review (QVR) process to evaluate the quality of the visits conducted by social workers
- implemented, or is in the process of addressing, all of the recommendations of the fatality/near fatality review team (known as the ACT 33 Review Team)
- issued a new policy regarding the requirements for obtaining and considering past DHS involvement, criminal history information, and Domestic Relations Court involvement of parents, caregivers, and other household members

² ChildStat are meetings held in which DHS staff collectively review a specific case or cases in a particular area of services (e.g., Child Abuse or Neglect Hotline, Ongoing Services, In-Home Protective Services). The meetings include a review of each case's detailed information, including what services were provided. Following the case presentation, attendees discuss the strengths and weaknesses of the service intervention, acknowledge exemplary services, identify potential areas for improvement, and develop recommendations to improve ongoing case practices.

³ The Quality Service Reviews (QSRs) process involves detailed and extensive review of a random sample of cases in a specific service area (e.g., congregate care, medically needy youth/children). QSRs are conducted by a team of reviewers composed of DHS staff members and staff from external agencies. The team conducts a three-day review of 12 sample cases. Interviews with social workers, supervisors, and family members also are conducted. QSRs use a structured process and a scoring tool to evaluate cases. The scoring tool consists of family indicators (safety, permanency, and well-being factors) and practice indicators (engagement with the child, family, and caregivers; interagency teaming; cultural awareness assessment; planning; and intervention).

⁴ Since calendar year (CY) 2009, DHS has had a comprehensive process for having fatalities and near fatalities reviewed by a multidisciplinary team, known as the Act 33 Review Team.

⁵ In November 2012, DHS implemented Quality Visitation Reviews (QVRs). The QVRs evaluate the quality of the interactions that DHS and contracted agency staff have with children and families during required child visits.

- made important foundational steps toward developing a comprehensive approach to addressing the physical, mental health and development needs of children involved with DHS
- implemented much of the information technology needed to support social work practice and assess system performance through the development of the Electronic Case Management System (ECMS)

The additional nine remaining recommendations monitored by the COB are being addressed through the implementation of the Improving Outcomes for Children (IOC) initiative. The IOC initiative is a multiyear reform plan aimed at improving the safety, permanency, and well-being of the children and families served by the DHS.⁶ The IOC initiative is a community-based model of service delivery with distinct and well-defined roles for both DHS and provider agencies. Through the IOC initiative, case management services for children involved in the child welfare system will be delivered by providers called Community Umbrella Agencies (CUAs) while DHS provides monitoring and oversight.⁷ Four areas that have been a concern of the COB are being addressed by DHS through the implementation of the IOC initiative.

- Clarification of Provider and DHS Roles and Responsibilities —The CWRP recommended that DHS clarify the roles and responsibilities of DHS workers relative to private agency workers. The IOC initiative model provides well-defined roles for both DHS and provider agencies. Case management services for children involved with child welfare will be provided through a network of Community Umbrella Agencies (CUAs). CUAs are community-based agencies that are responsible for the provision of direct case management services to families in their designated regions. DHS staff will provide monitoring, oversight, and quality assurance.
- Co-location —The CWRP indicated that DHS must complete the long-planned co-location of DHS, police, and medical and forensic interview personnel at a community site to facilitate collaborative decision making in the investigative phase of casework. The co-location site is scheduled to open in May 2013.
- Local Office Presence—The CWRP recommended that DHS create a local office presence in at least one high-risk location. Through the IOC initiative, DHS is planning to expand upon this recommendation to create local offices throughout the city. One of the cornerstones of the IOC initiative is the premise that positive outcomes are achieved through child welfare services that are community-based, family-centered, culturally competent, integrated, timely, and accountable for results.
- Family Teaming— The CWRP indicated that DHS should implement a team decision making process. DHS implemented Family Group Decision Making (FGDM) agency-wide in March 2009. To date, there are still challenges in fully implementing FGDM. Families are referred to FGDM by their social work service managers and families can voluntarily elect to participate. Referrals to FGDM are being made, but many are not resulting in completed

⁶ Additional information on the IOC initiative can be found at <http://dynamicsights.com/dhs/ioc/>.

⁷ Ibid.

conferences. Through the IOC initiative, DHS is implementing a new family team conferencing model. Conferences (known as “teamings”) will be conducted throughout the life of a case at key decision making points. The conferences are child-centered, family-focused gatherings of family members; friends; community resources; the CUA case manager; other child, youth, and family serving agencies; and other professionals involved in the case. FGDM is an event-driven meeting. The family team conference model is one in which family team meetings become a part of the ongoing process throughout the child’s involvement with DHS and hopefully beyond.

KEY OUTCOME MEASURES, VISITATION DATA, AND CHILD FATALITY DATA

DHS continues to report regularly on three child safety outcome measures:

- occurrence of repeat maltreatment and length of time between incidents of child maltreatment
- incidence of child maltreatment in placement
- reentry into foster care and other types of placement

The COB determined that the factors used to measure a fourth outcome measure, the level of severity of repeat maltreatment, should be revisited. Therefore, this outcome measure is not being reported. Following are the key findings on the three outcome measures.

- The occurrence of repeat maltreatment was 10.7 percent in State Fiscal Year (SFY) 2006 and declined to 7.0 percent in SFY 2008. This represents a 34.6 percent decrease in the occurrence of repeat maltreatment from SFY 2006 to SFY 2008. Since SFY 2008, the occurrence of repeat maltreatment increased to 8.5 percent in SFY 2010. This represents a 21.4 percent increase in the occurrence of repeat maltreatment from SFY 2008 to SFY 2010. Although the rate of repeat maltreatment was lower in SFY 2010 than in SFY 2006, it increased slightly during the last two years for which data is available.
- The total number of reports of maltreatment of children in DHS care decreased substantially from SFY 2006 (438) to SFY 2012 (270). The percentage of substantiated reports of maltreatment of children in care remained about the same from SFY 2006 to SFY 2010 (ranging between 5.0% and 6.2%). There was a substantial decrease from 6.2 percent in SFY 2010 to 2.4 percent in SFY 2011 (followed by 2.6% in FY 2012).
- The proportion of children discharged to permanency who reentered placement has remained about the same during the past five years, with approximately 15 percent reentering to dependency placements and approximately 4 percent reentering to delinquency placements.

In addition, the COB has continued to monitor data regarding compliance with visitation requirements, fatalities, and near fatalities. In this report, the COB reviewed and analyzed multiyear data. Following are the key findings.

- Compliance by DHS staff with visitation requirements has decreased from an average monthly compliance rate of 93.7 percent in calendar year (CY) 2010 to 90.0 percent in CY 2012. These compliance rates are, however, generally very high.
- Compliance by DHS staff with visitation requirements for children younger than 5 years of age increased from an average monthly compliance rate of 91.3 percent in CY 2010 to 95.4

percent in CY 2011, and then decreased to an average of 91.1 percent in CY 2012. These compliance rates are generally very high.

- Visitation performed by contract providers has improved from an average monthly compliance rate of 73.4 percent in CY 2011 to 83.3 percent in CY 2012. This percentage may be an underestimate because not all contracted agencies submitted visitation data into the Provider Visitation Tracking System ((PVTS). DHS has indicated to the COB that staff continues to work with contracted providers to improve visitation reporting and the correct use of the PVTS.
- From CY 2008–CY 2012, 55 of the 355 fatalities reported to the Child Abuse or Neglect Hotline generated a CPS report. Seven of the fifty-five reports (12.7%) were active with DHS at the time of the child’s death. Twelve of these reports (21.8%) involved children known to DHS in the 16 months prior to the child’s death. In each of the years from CY 2008 to CY 2012, among the deaths that generated a CPS report, there were one or two children who died that were active with DHS and between zero and five children who were known to DHS in the past 16 months at the time of death. There has been no change during the last five years. The number of fatalities generating CPS reports active or known to DHS has remained low.
- From CY 2008–CY 2012, 36 of the 355 fatalities reported to the Child Abuse or Neglect Hotline generated a GPS report. Four of the 36 (11.1%) fatalities that generated GPS reports involved children with active cases with DHS at the time of the child’s death. Twenty-one of the 36 (58.3%) cases involved children who were known to DHS within the 16 months prior to the child’s death. In each of the years from CY 2008 to CY 2012, between zero and two children who died were active with DHS and between one and six were known to DHS in the last 16 months prior to the child’s death.
- From CY 2008–CY 2012, 10 of the 72 (13.9%) near fatalities reported to the Child Abuse or Neglect Hotline were active with DHS at the time of the report and 10 (13.9%) were known to DHS in the last 16 months. In each of the years from CY 2008 to CY 2012, between zero and five children active with DHS experienced a near fatality. In the same years, between one and five children who were known to DHS in the last 16 months experienced a near fatality.

CONCLUSION AND NEXT STEPS

DHS has made significant progress in implementing a majority of the recommendations of the CWRP. Since the CWRP recommendations were made, numerous changes have been made in the management and operations of DHS. DHS has built a solid foundation for implementing the IOC initiative. DHS has:

- established a shared vision for change and clear values that guide the vision for implementing a community-neighborhood approach to improving the outcomes of safety, permanency, and well-being for children and families served by DHS
- involved stakeholders in the systems change planning and decision making process
- worked to strengthen the community response to the protection of children
- embraced a family-centered, strength-based, and solution-focused philosophy

- created a team of leaders within DHS and among its private providers that are committed to system reform

The COB commends DHS for its comprehensive and planful approach in planning for the implementation of the IOC initiative. In the upcoming years, a majority of the COB's efforts will be focused on monitoring the implementation of the IOC initiative. The COB will continue to monitor the outcomes of children and families being served under the existing dual case management model. This dual case management model is where DHS workers share casework responsibilities with private providers. IOC will not be fully implemented until the end of 2015. With full implementation of the IOC, the dual case management model will be eliminated.

The COB will continue to closely monitor the outcome measures discussed and the data on child visitation and fatalities. The COB understands that it may take a few more years to see the impact of the changes in the policies and practices implemented by DHS.

The COB understands that compliance with visitation requirements should be monitored carefully, especially given the small decline in visitation and the transition to a new model of practice. DHS will provide the COB with data on the number of children that received a monthly visit by DHS or provider social work staff. This information will be provided to the COB on a quarterly basis. Further, it is understood that the current requirements that a monthly visit for all children be conducted by both a DHS and provider social worker are being eliminated in March 2013. DHS is transitioning direct case management for families to CUAs. This means that providers will eventually be responsible for conducting all visitations with the children and families served by DHS. As a result of this gradual shift in responsibility, DHS social workers will conduct less frequent visits and providers will be required to conduct monthly visits. If a child has not been visited each month, a DHS worker will conduct the visit or ensure that a visit is conducted by the private provider. For children under 6 years of age, DHS social work services managers will continue to conduct monthly visits in addition to the visits being conducted by private providers.

Lastly, the COB will make recommendations regarding how the city can better address the multiple and complex needs of older youth in DHS' care. This will require the COB to gain a better understanding of the complex and different needs of the various age groups within the older youth population.

SECTION 2. KEY OUTCOME MEASURES

This section presents the status of the key outcome measures that were identified by the Community Oversight Board (COB) as indicators of the Department of Human Services' (DHS) performance related to child safety and well-being. The outcome measurement data were supplied by DHS' Division of Performance Management and Accountability (PMA) at the request of the COB. The COB uses the outcome measures, as well as DHS' routine data reports and various specialized studies, to report DHS' overall progress related to child safety and well-being.

BACKGROUND

In its August 2009 *Report on Progress*, the COB identified six outcome measures for monitoring overall performance of DHS related to child safety and well-being. Two outcome measures were removed from the initial set of six measures—length of stay in foster care and changes in level of placement—because they were deemed less relevant than the others to the COB's central oversight focus on issues related to child protection. More recently, the COB determined that the factors used to measure the level of severity of repeat maltreatment should be revisited. Therefore, this outcome measure is not being reported. The remaining measures are:

- occurrence of repeat maltreatment and length of time between incidents of child maltreatment
- incidence of child maltreatment in placement
- reentry into foster care and other types of placement

OUTCOME MEASURE 1: OCCURRENCE OF REPEAT MALTREATMENT AND LENGTH OF TIME BETWEEN INCIDENTS OF CHILD MALTREATMENT

This measure examines whether or not children experienced subsequent maltreatment after having been substantiated for maltreatment by DHS. It recognizes that the goal for protective services is to ensure the child's safety and to resolve the conditions that led to child maltreatment. A successful outcome is the absence of subsequent child maltreatment following the initial report. The COB and DHS agreed that using an 18-month follow-up period is the correct approach for assessing repeat maltreatment. This report examines trends in repeat maltreatment from State Fiscal Year (SFY) 2006 through SFY 2010.⁸

Pennsylvania law and regulations divide reports alleging maltreatment into two major types—Child Protective Services (CPS) and General Protective Services (GPS). The distinction is generally one of severity. For a report alleging child maltreatment to be registered as a CPS report, it must contain an allegation that, if true, would constitute child abuse as statutorily defined.⁹ A report is considered a GPS report if it (1) alleges that a child has been abused or neglected, but the allegation does not meet the statutory definition of child abuse; (2) is a non-incident-specific allegation of neglect; (3) is an allegation of lack of supervision or failure on the part of parents or the person responsible for

⁸ SFY 2011 data are not examined in this report because data through the 18-month follow-up period were not available at the time of the analysis.

⁹ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200.

the care of the child to provide for the essentials of life; or (4) alleges that a child is dependent as defined by the Juvenile Act.¹⁰

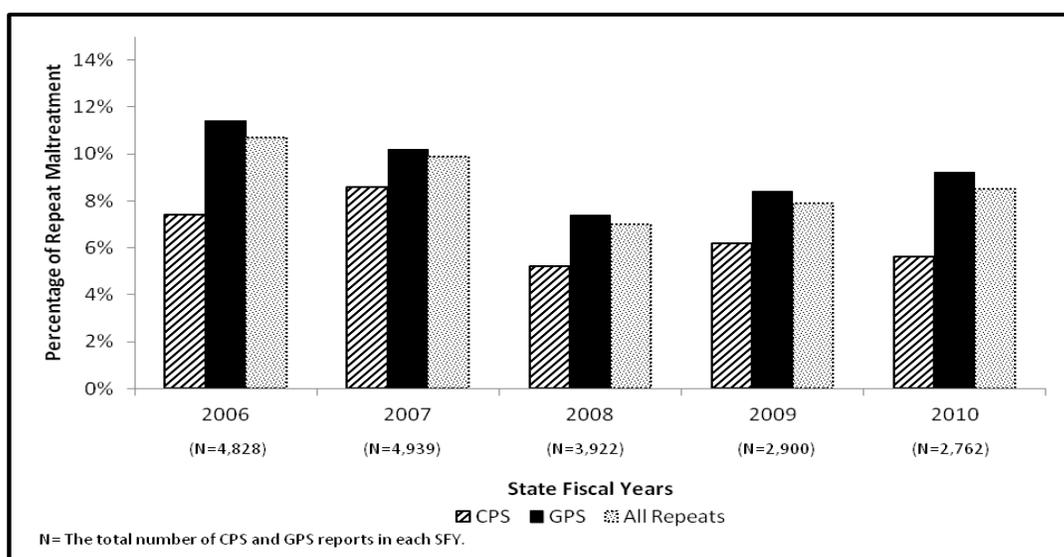
Both CPS and GPS reports can result in the provision of protective services for the child. Both types of reports represent some level of risk to the child. This Report on Progress examines the occurrence of repeat maltreatment for and across both CPS and GPS maltreatment reports. The data identify the number of children reported during each SFY who were involved in another substantiated incident of maltreatment within 18 months of the initial substantiated report.

Occurrence of Repeat Maltreatment

As shown in exhibits 2.1(a) and 2.1(b), the occurrence of repeat maltreatment was 10.7 percent in SFY 2006 and declined to 7.0 percent in SFY 2008. This represents a 34.6 percent decrease in the occurrence of repeat maltreatment from SFY 2006 to SFY 2008. Since SFY 2008, the occurrence of repeat maltreatment has been increased to 8.5 percent in SFY 2010. This represents a 21.4 percent increase in the occurrence of repeat maltreatment from SFY 2008 to SFY 2010. Although the rate of repeat maltreatment was lower in SFY 2010 than in SFY 2006, it has been steadily increasing in recent years (see exhibits 2.1(a) and 2.1(b)).

The trends in the percentages of repeat maltreatment are different depending on whether the initial report was CPS or GPS. GPS reports were substantially more likely than CPS reports to have a repeat incident (either GPS or CPS) within 18 months. Among initial CPS reports, the occurrence of repeat maltreatment decreased from 7.4 percent in SFY 2006 to 5.2 percent in SFY 2008 and 5.6 percent in SFY 2010, but initially it increased to 8.6 percent in SFY 2007. Among initial GPS reports, the occurrence of repeat maltreatment decreased steadily from 11.4 percent in SFY 2006 to a low of 7.4 percent in SFY 2008 before increasing slightly to approximately 9 percent in SFY 2010.

Exhibit 2.1(a). Repeat Maltreatment within 18 Months by Type of Initial Report, SFYs 2006–2010



¹⁰ Ibid.

**Exhibit 2.1(b). Repeat Maltreatment within 18 Months by Type of Initial Report,
SFYs 2006–2010**

Type of Initial Report	# of Initial Reports	Type	Repeats	
			Number	Percent
2006				
Initial CPS	748	All Repeats	55	7.4%
		Repeat CPS	13	1.7%
		Repeat GPS	42	5.6%
Initial GPS	4,080	All Repeats	464	11.4%
		Repeat CPS	56	1.4%
		Repeat GPS	408	10.0%
<i>All Reports</i>	4,828		519	10.7%
2007				
Initial CPS	723	All Repeats	62	8.6%
		Repeat CPS	20	2.8%
		Repeat GPS	42	5.8%
Initial GPS	4,216	All Repeats	428	10.2%
		Repeat CPS	54	1.3%
		Repeat GPS	374	8.9%
<i>All Reports</i>	4,939		490	9.9%
2008				
Initial CPS	635	All Repeats	33	5.2%
		Repeat CPS	11	1.7%
		Repeat GPS	22	3.5%
Initial GPS	3,287	All Repeats	242	7.4%
		Repeat CPS	50	1.5%
		Repeat GPS	192	5.8%
<i>All Reports</i>	3,922		275	7.0%
2009				
Initial CPS	632	All Repeats	39	6.2%
		Repeat CPS	17	2.7%
		Repeat GPS	22	3.5%
Initial GPS	2,268	All Repeats	190	8.4%
		Repeat CPS	27	1.2%
		Repeat GPS	163	7.2%
<i>All Reports</i>	2,900		229	7.9%
2010				
Initial CPS	570	All Repeats	32	5.6%
		Repeat CPS	12	2.1%
		Repeat GPS	20	3.5%
Initial GPS	2,192	All Repeats	202	9.2%
		Repeat CPS	18	0.8%
		Repeat GPS	184	8.4%
<i>All Reports</i>	2,762		234	8.5%

An examination of the types of repeat maltreatment relative to the type of initial report shows that there were more instances of an initial GPS report with a subsequent CPS report than instances of an initial CPS report with a subsequent GPS report, in every year except SFY 2010 (see exhibits 2.2(a) and 2.2(b)). However, most instances of repeat maltreatment were of the same type as the initial report. The trends from SFY 2006 to SFY 2010 were generally flat, although there was a spike in SFY 2008 in the percentage of occurrences of repeat maltreatment that went from an initial GPS report to a subsequent CPS report.

Exhibit 2.2(a). Changes in Type of Report for Repeat Maltreatment, SFYs 2006–2010

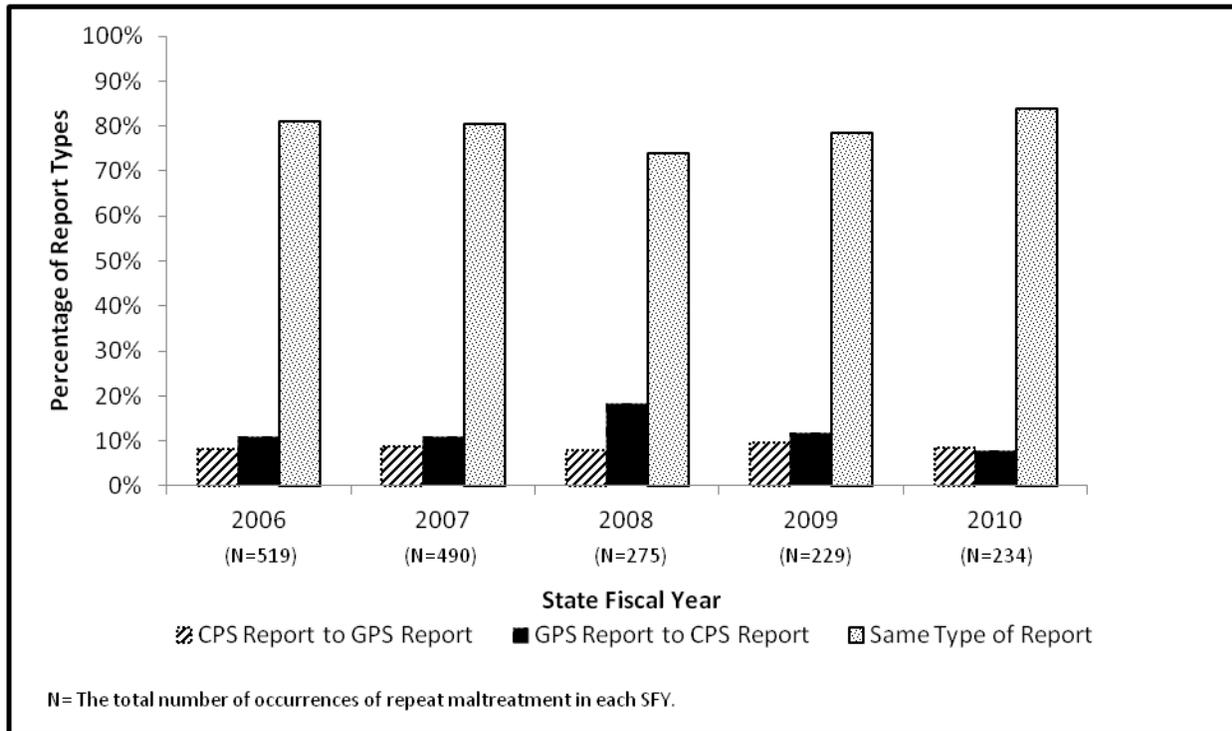


Exhibit 2.2(b). Changes in Type of Report for Repeat Maltreatment, SFYs 2006–2010

Fiscal Year	Total # Repeats	Repeats with Change from CPS Report to GPS Report		Repeats with Change from GPS Report to CPS Report		Repeats with Same Type of Report	
		Number	Percent	Number	Percent	Number	Percent
2006	519	42	8.1%	56	10.8%	421	81.1%
2007	490	42	8.6%	54	11.0%	394	80.4%
2008	275	22	8.0%	50	18.2%	203	73.8%
2009	229	22	9.6%	27	11.8%	180	78.6%
2010	234	20	8.5%	18	7.7%	196	83.8%

Time Between Reports

This outcome measure examines the time between recurrent incidents (6 months or less, 7-12 months, or 13-18 months). Approximately half of subsequent incidents of maltreatment occurred within the first 6 months following the initial report (see exhibits 2.3(a) and 2.3(b)). The percentage of repeat maltreatment that occurred within 6 months of the initial report was approximately the same from SFY 2006 to SFY 2010. The percentage of repeat maltreatment that occurred 7-12 months or 13-18 months after the initial also remained approximately the same.

Exhibit 2.3(a). Time Between Reports, By Type of Initial Report, SFYs 2006–2010

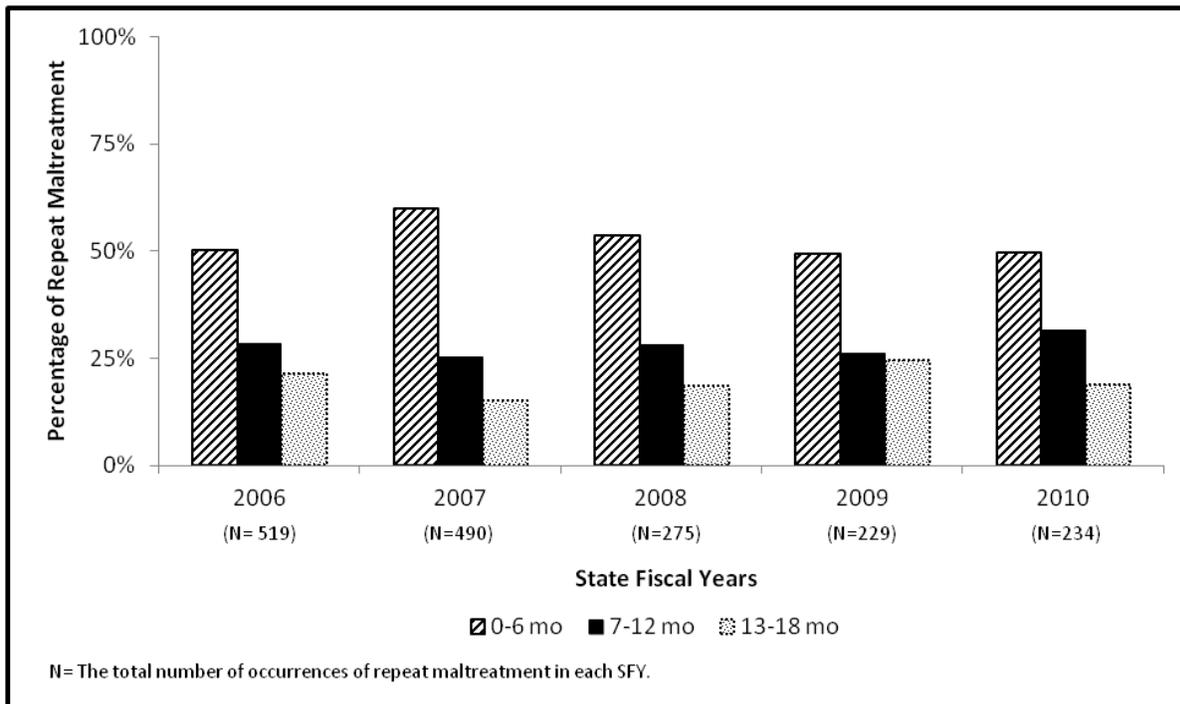


Exhibit 2.3(b). Time Between Reports, By Type of Initial Report, SFYs 2006–2010

Type of Initial Report	Type of Repeat	0-6 Months	7-12 Months	13-18 Months	Total Number of Repeats
2006					
Initial CPS	All Repeats	31	12	12	55
	Repeat CPS	7	4	2	13
	Repeat GPS	24	8	10	42
Initial GPS	All Repeats	230	135	99	464
	Repeat CPS	34	11	11	56
	Repeat GPS	196	124	88	408
All Reports		261 (50.3%)	147 (28.3%)	111 (21.4%)	519
2007					
Initial CPS	All Repeats	29	19	14	62
	Repeat CPS	8	5	7	20
	Repeat GPS	21	14	7	42
Initial GPS	All Repeats	264	105	59	428
	Repeat CPS	28	11	15	54
	Repeat GPS	236	94	44	374
All Reports		293 (59.8%)	124 (25.3%)	73 (14.9%)	490
2008					
Initial CPS	All Repeats	16	13	4	33
	Repeat CPS	5	3	3	11
	Repeat GPS	11	10	1	22
Initial GPS	All Repeats	131	64	47	242
	Repeat CPS	27	8	15	50
	Repeat GPS	104	56	32	192
All Reports		147 (53.5%)	77 (28.0%)	51 (18.5%)	275
2009					
Initial CPS	All Repeats	17	9	13	39
	Repeat CPS	8	3	6	17
	Repeat GPS	9	6	7	22
Initial GPS	All Repeats	96	51	43	190
	Repeat CPS	22	3	2	27
	Repeat GPS	74	48	41	163
All Reports		113 (49.3%)	60 (26.2%)	56 (24.5%)	229
2010					
Initial CPS	All Repeats	13	10	9	32
	Repeat CPS	5	5	2	12
	Repeat GPS	8	5	7	20
Initial GPS	All Repeats	103	64	35	202
	Repeat CPS	15	1	2	18
	Repeat GPS	88	63	33	184
All Reports		116 (49.6%)	74 (31.6%)	44 (18.8%)	234

OUTCOME MEASURE 2: INCIDENCE OF CHILD MALTREATMENT IN PLACEMENT

Pennsylvania's Office of Children, Youth, and Families (OCYF) is responsible for receiving and investigating reports of maltreatment of children in placement. The following annual data on the incidence of child maltreatment in placement in Philadelphia was provided to DHS by OCYF.

Exhibits 2.4(a) and 2.4(b) present these data for SFY 2006 through SFY 2012. The total number of reports of maltreatment of children in DHS care decreased substantially from SFY 2006 (438) to SFY 2012 (270). The percentage of substantiated reports of maltreatment of children in care remained about the same from SFY 2006 to SFY 2010 (ranging between 5.0% and 6.2%). There was a substantial decrease from 6.2 percent in SFY 2010 to 2.4 percent in SFY 2011 (followed by 2.6% in FY 2012).

Exhibit 2.4(a). Substantiated Reports of Maltreatment for Children in Care of DHS, SFYs 2006–2012

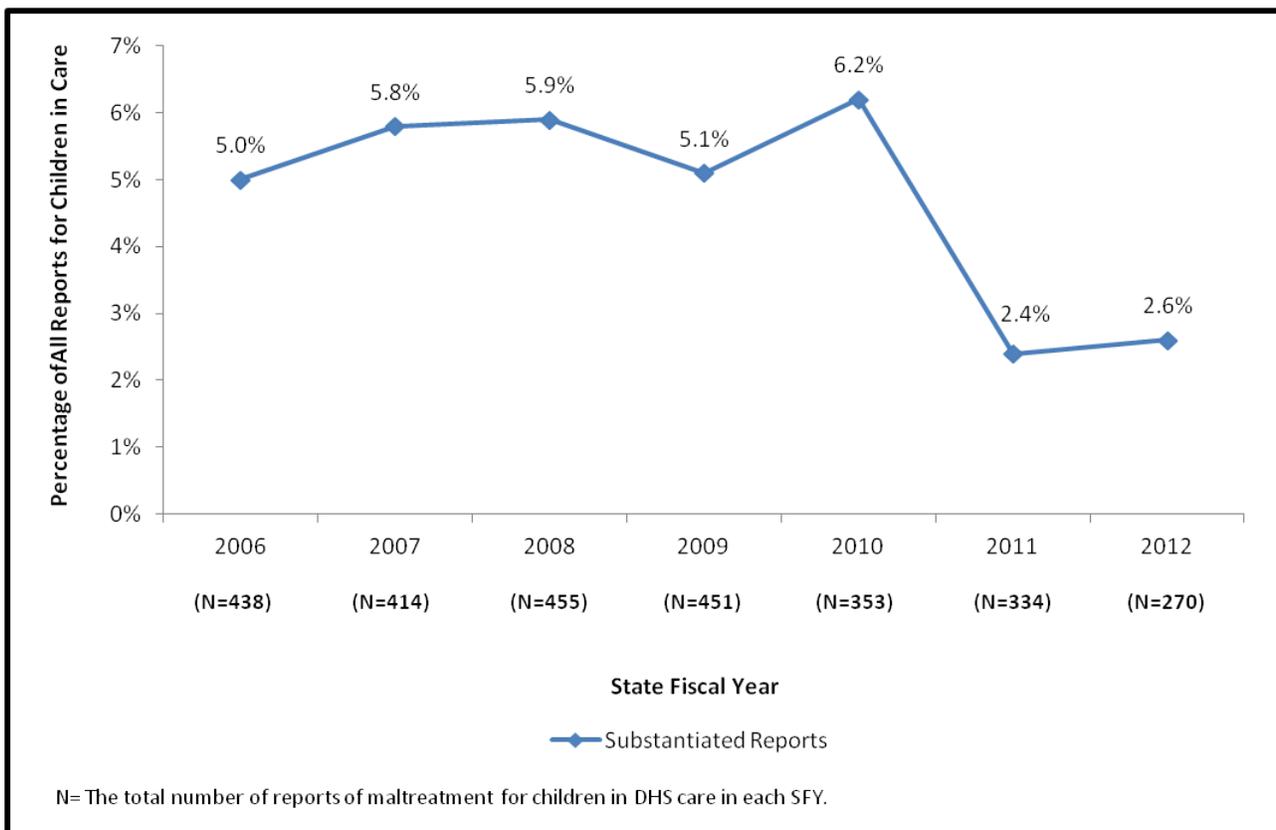


Exhibit 2.4(b). Reports of Maltreatment for Children in Care of DHS, SFYs 2006–2012

Results:	2006	2007	2008	2009	2010	2011	2012
Founded	1	0	2	1	0	0	0
Indicated	21	24	25	22	22	8	7
Substantiated Subtotal	22 (5.0%)	24 (5.8%)	27 (5.9%)	23 (5.1%)	22 (6.2%)	8 (2.4%)	7 (2.6%)
Pending Juvenile Court	0	0	0	0	0	0	0
Pending Criminal Court	1	1	0	2	0	1	1
Pending	1	1	0	2	0	1	1
Unfounded Subtotal	415	389	428	427	331	325	262
All Reports	438	414	455	451	353	334	270

OCYF has agreed to provide data on maltreatment in placement to DHS on a monthly basis. The COB believes that this is an important measure of DHS performance relative to the safety and well-being of children in care.

OUTCOME MEASURE 3: REENTRY INTO FOSTER CARE AND OTHER PLACEMENT TYPES

When a temporary placement is required to ensure the safety and well-being of a child, DHS seeks to return the child home as soon as the conditions that led to maltreatment or dependency have been remedied. If the issues cannot be resolved, the department seeks to place the child in an alternate permanent setting (adoption, permanent legal guardian, or a suitable relative). DHS’ objective is to accomplish reunification or placement into a permanent setting as soon as possible. The outcome measure examining reentry into foster care and other placement types examines the instances in which reunification or discharge to an alternate permanency option has failed. In these instances, the child requires a return to a temporary placement. The measure is a gauge of the DHS’ success in executing appropriate reunification and permanency placements.

Some children discharged to permanency during SFYs 2006–2010 reentered placement within 18 months. Some of these children reentered to dependency placements and some reentered to delinquency placements. The percentage reentering to dependency placements in each SFY was approximately four times greater than the percentage reentering to delinquency placements (see exhibit 2.5(a)). The sum of the two percentages displayed in exhibit 2.5(a) for each SFY equals the total percentage of all children discharged to permanency in that SFY who reentered placement within the following 18 months. As can be seen in exhibits 2.5(a) and 2.5(b), approximately 20 percent of all children discharged to permanency in SFYs 2006–2010 reentered placement within 18 months. The proportions of children discharged to permanency who reentered placement have remained about the same during the past five years, with approximately 15 percent reentering to dependency placements and approximately 4 percent reentering to delinquency placements. However, the total number of reentries fell from 411 in SFY 2006 to 319 in SFY 2010.

Exhibit 2.5(a). Reentry of Children and Youth within 18 Months of Discharge to Permanency, SFYs 2006–2010

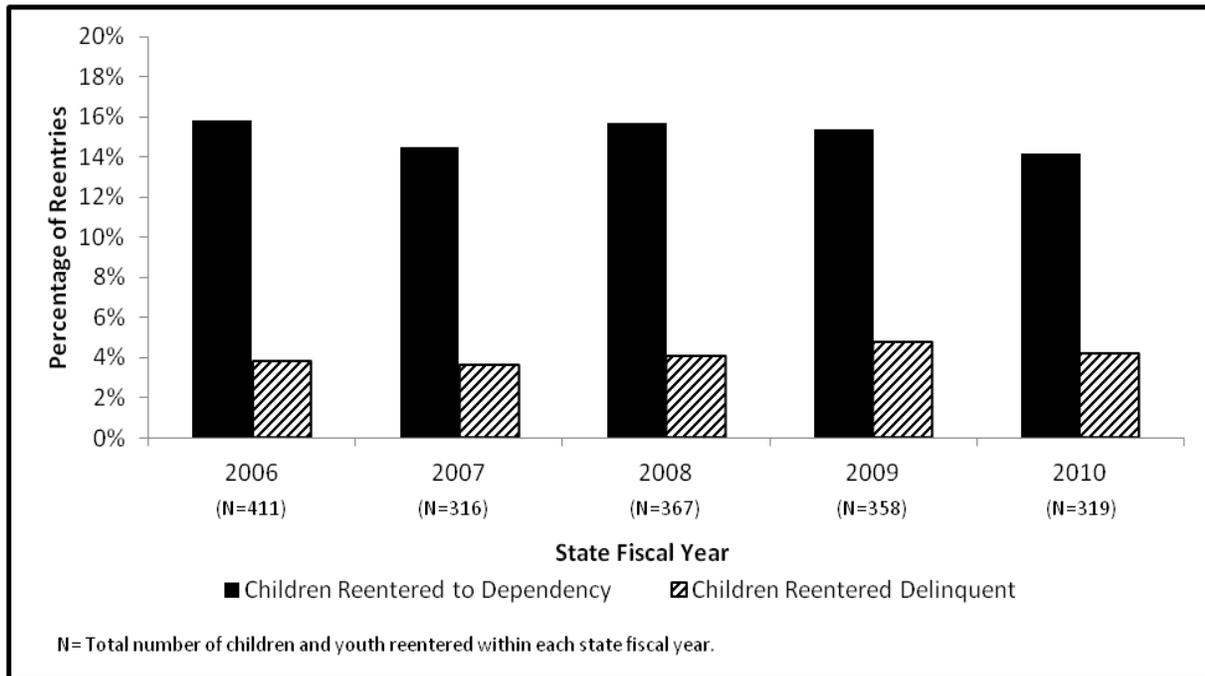


Exhibit 2.5(b). Reentry of Children and Youth within 18 Months of Discharge to Permanency, SFYs 2006–2010

Fiscal Year	Number Discharged to Permanency	Children and Youth Reentered		Children Reentered to Dependency		Children Reentered Delinquent	
		Number	Percent	Number	Percent	Number	Percent
2006	2,099	411	19.6%	331	15.8%	80	3.8%
2007	1,748	316	18.1%	253	14.5%	63	3.6%
2008	1,848	367	19.9%	291	15.7%	76	4.1%
2009	1,775	358	20.2%	273	15.4%	85	4.8%
2010	1,731	319	18.4%	246	14.2%	73	4.2%

When permanency discharges fail, it is hoped that a future permanency discharge will be successful after a period of additional services provided by DHS. Fortunately, this is the case for most children served (see exhibit 2.6). A very small proportion of children who reentered placement after being discharged to permanency experienced more than one failed reunification or placement in a permanent setting. However, the percentage of children who reentered multiple times within 18 months did increase from 0.5 percent of all reentries in SFY 2006 to 3.8 percent of all reentries in SFY 2010. As mentioned above, the total number of reentries fell from 411 in SFY 2006 to 319 in

SFY 2010. Therefore, the number of children who reentered placement multiple times after being discharged to permanency remained quite low, only increasing from 2 children in SFY 2006 to 12 children in SFY 2010.

Exhibit 2.6. Single or Multiple Reentries Within 18 Months of Discharge to Permanency, SFYs 2006–2010

Fiscal Year	Total Number of Reentries	Single Reentry		Multiple Reentries	
		Number	Percent	Number	Percent
2006	411	409	99.5%	2	0.5%
2007	316	313	99.1%	3	0.9%
2008	367	362	98.6%	5	1.4%
2009	358	348	97.2%	10	2.8%
2010	319	307	96.2%	12	3.8%

SUMMARY

The outcome measures are a means to examine DHS’ progress using quantitative measures of key areas. This is the first time that DHS has provided the COB with multiyear data on these outcome measures. A review of the data does not provide a clear picture of the impact of the many practice and policy changes that have been implemented by DHS.

Regarding Outcome Measure 1, the overall occurrence of repeat maltreatment decreased from SFY 2006 to SFY 2008 and then increased from SFY 2008 to SFY 2010. Approximately half of the occurrences of repeat maltreatment happen within 6 months of discharge.

Regarding Outcome Measure 2, the total number of reports of maltreatment while in DHS care decreased substantially from SFY 2006 to SFY 2012. The percentage of these reports that were substantiated remained about the same from SFY 2006 to SFY 2010 and then decreased sharply from SFY 2010 to SFY 2011.

Regarding Outcome Measure 3, the proportions of children discharged to permanency who reentered placement have remained stable from SFY 2006 to SFY 2010.

SECTION 3. STATUS OF THE RECOMMENDATIONS FROM THE CHILD WELFARE REVIEW PANEL

BACKGROUND

The Community Oversight Board (COB) continues to assess and monitor the Philadelphia Department of Human Services' (DHS) progress with implementing the 37 recommendations made in May 2007 by the Child Welfare Review Panel (CWRP). Overall, DHS continues to make important and measurable progress with implementing these recommendations.

In September 2012, the COB carefully reviewed all of the CWRP recommendations to determine whether or not the COB needed to continue to monitor and report on each recommendation. Based on the ongoing systematic collection and analysis of the information provided by DHS, the COB determined that 20 of the 37 recommendations no longer required ongoing monitoring. The COB has determined that these recommendations are fully integrated into DHS practice and policy and will be addressed through related outcomes or informational reports received annually by the COB. In addition, DHS continues to monitor the ongoing operational changes that resulted from the implementation of these recommendations. In future reports, the COB will no longer report on these recommendations. The remaining recommendations that will be the subject of ongoing monitoring by the COB fall into two categories:

- *Implemented and Sustained*—These recommendations were implemented by DHS and the COB determined that they have been sustained since implementation. However, the COB continues to monitor these recommendations annually, due to their importance for ensuring the continuing safety of children served by DHS.
- *Recommendations Being Addressed through the Improving Outcomes for Children (IOC) Initiative*—These recommendations were integrated into the IOC initiative. The IOC initiative is currently in progress, but will not be fully implemented until December 2015. These recommendations will be monitored on a quarterly basis.

COMPLETED RECOMMENDATIONS

Appendix A provides a list of the 20 completed recommendations and information regarding the completion of each recommendation. In summary:

- Four of the twenty completed recommendations are related to developing a new mission and core values centered on child safety and integrating them into practice and policy.
- Eight of the twenty recommendations are related to improving practice. These recommendations involve the development and use of safety and risk assessment tools to be used to assess the service needs and ensure child safety.
- Six of the twenty completed recommendations are related to improving outcomes and accountability. These recommendations include the development of report cards for DHS and contracted agency performance, and putting mechanisms in place to enhance oversight of contracted agencies and internal performance. They also include the recommendation for the development of the COB.

- Two of the twenty recommendations describe tasks related to improving the leadership and infrastructure of DHS.

IMPLEMENTED AND SUSTAINED RECOMMENDATIONS

Eight of the 17 remaining recommendations were implemented and sustained by DHS. Five out of the eight of these recommendations fall into three areas of focus:

- child visitation
- child fatality review
- criminal background checks

This section provides a discussion of DHS' progress in implementing and sustaining the CWRP recommendations in the three areas of focus. It also discusses the status of the remaining three recommendations that have been implemented and sustained related to improving the assessment and provision of health and behavioral health care for children in foster care and streamlining paperwork and records management practices. Appendix B provides a list of the 17 recommendations that have been categorized as implemented and sustained.

Child Visitation¹¹

The CWRP made three recommendations regarding the need for DHS to enhance both the frequency and quality of caseworker visits (see appendix B, recommendations 1-3). The COB believes that visits by DHS social work services managers and contracted agency staff are a critical component of DHS' practice. These visits are a key strategy for ensuring the safety of children and the well-being of families while pledging that children receive timely permanency.

DHS' policy during 2011 and 2012 required that all children with an active case in the Children and Youth Division (CYD) and receiving services, regardless of age or program, be seen at least monthly by a DHS social work service manager. In addition, monthly visits are required for children being served by contract providers. A CYD case is considered active when a family is accepted for services due to safety threats or dependency issues. DHS has continued to provide the COB with data on the number of visits conducted. These data are presented below.

Visitation by DHS Social Work Services Managers

Exhibit 3.1 presents data for three years on the percent of child visitations performed by DHS social work services managers out of the total number of children requiring visits. Compliance by DHS staff with visitation requirements has decreased from an average monthly compliance rate of 93.7 percent in calendar year (CY) 2010 to 90.0 percent in CY 2012. These compliance rates are generally very high.

¹¹ Visitation data are based on calendar years (January to December).

Exhibit 3.1. Average Monthly Child Visitation Compliance by DSHS Social Work Services Managers, CYs 2010–2012

Year	Average Monthly Number of Children Visited	Average Monthly Number of Children Requiring Visits	Average Monthly Percent Visited
2010	5464	5829	93.7%
2011	6107	6497	94.0%
2012	5885	6542	90.0%

Exhibit 3.2 shows the visitation compliance for the population of children ages five and younger performed by DHS social work services managers for 2010–2012. Compliance by DHS staff with visitation requirements for children younger than five years of age increased from an average monthly compliance rate of 91.3 percent in CY 2010 to 95.4 percent in CY 2011, and then decreased to an average of 91.1 percent in CY 2012. These compliance rates are generally very high. DHS informed the COB that the decrease in the percentages for visits by the DHS social work services manager is due to the fact that supervisors are not recording visits in the Visitation Tracking System (VTS) unless the assigned social work services manager has a corresponding case note. This is due to a directive requiring that VTS entries have a corresponding case note effective May 2012.

Exhibit 3.2. Average Monthly Child Visitation Compliance by DHS Social Work Services Managers for Children Younger than Five Years of Age, CYs 2010–2012

Year	Average Monthly Number of Children Visited	Average Monthly Number of Children Requiring Visits	Average Monthly Percent Visited
2010	2105	2305	91.3%
2011	1999	2096	95.4%
2012	1985	2179	91.1%

Child Visitation Performed by Contracted Agencies

On July 1, 2010, DHS implemented the Provider Visitation Tracking Systems (PVTS). For the first half of 2010, visitation compliance was at approximately 70 percent. As seen in exhibit 3.3, compliance with visitation by contracted agencies has improved. By the end of 2012, on average, 83.3 percent of the children requiring monthly visitation, received a visit. This percentage may be an underestimate because not all contracted agencies submitted visitation data into the PVTS. DHS continues to work with contracted providers to improve visitation reporting. In addition, DHS plans to track visitation compliance by contracted agencies separately for children five years old and younger in 2013.

**Exhibit 3.3. Average Monthly Child Visitation Compliance by Contracted Providers,
CYs 2011–2012**

Year	Average Monthly Number of Agencies Entering Visits into PVTs	Average Monthly Number of Children Requiring Visits	Average Monthly Number of Children Visited	Average Monthly Percent Visited
2011	59	4462	3277	74.4%
2012	56	4345	3618	83.3%

Quality Visitation Review

The Quality Visitation Review (QVR) process is used as part of a larger accountability and continual quality improvement process surrounding practice at DHS. During the QVR process, an independent evaluation firm under contract with DHS meets with and interviews children, youth, and caregivers to ensure that the documented DHS and contracted provider workers’ visitations actually occurred and that the documentation in the case record accurately reflects the services being provided to the family. Approximately 30 QVR visits are conducted each month. Cases are selected either randomly, from specified service delivery areas, or as a result of an audit of a caseload, unit, section, or agency. DHS began QVRs at the end of November 2010. As of February 2011, the QVR process was fully operational.

A QVR tool is used to evaluate the quality of the visits conducted by social workers and is organized around five practice principles. The five practice principles include Engaging, Teaming, Assessment, Planning, and Intervention. Below are brief descriptions of the five principles:

- Engaging—The practice of engagement focuses on the degree to which those working with the child and family are able to connect in a meaningful way with family members who can provide support and permanency to the identified child.
- Teaming—The practice of teaming focuses on the formation and functional performance of the family team in conducting ongoing collaborative problem solving, providing effective services, and achieving positive results with the child and family. Team functioning and decision making processes should be consistent with principles of family centered practice and system of care operations.
- Assessing—The practice of assessing focuses on the degree that the team has gathered sufficient information to have an accurate and comprehensive understanding of the child and family’s strengths and needs. All of this must be understood in the context of the family’s culture, hopes, and vision for the future.
- Planning—The practice of planning focuses on the degree that the planning process is individualized and relevant to meet the needs and goals of the child and family.
- Intervening —The practice of intervening focuses on the degree to which planned interventions, services, and supports being provided to the child and family have

sufficient power and beneficial effect to produce the results necessary to meet the present needs and achieve outcomes that fulfill the long term view for safe case closure.

During weekly meetings, the agency conducting the QVRs presents the progress and findings of the week's reviews to the Quality Improvement supervisor in PMA and the social worker assigned to QVR. This meeting also serves as an opportunity for DHS to answer questions about or provide direction for cases for which ratings remain unclear. Once the ratings for a case are jointly reviewed and approved by both the agency and DHS team, they are considered final. When all of the visits and ratings for one month are completed, the QVR agency forwards the ratings to DHS. DHS then uses this information to complete a report summarizing the themes of the review. Any individual case concerns, on either DHS' or the providers' side, are reported to the responsible worker and his or her supervisor and executive leadership. A quarterly report is generated that captures the themes of each month's review. The themes are then incorporated into the ChildStat process.¹²

During the QVR process, each practice principle is measured using four possible ratings. Ratings of "3" are considered to be optimal, indicating ongoing excellent quality visitation. Ratings of "2" are considered acceptable, indicating adequate visitation. Ratings of "1" indicate that minimal standards were not met. Ratings of "0" indicate substantially inadequate visitation or the falsification of documentation.

Discussion

During 2011 and 2012, DHS continued to implement the enhanced child visitation recommended by the CWRP.¹³ Compliance by DHS social work services managers was maintained at 90.0 percent. An increased number of contracted agencies are using the PVTs. Compliance by provider agencies for conducting monthly visits has improved from CY 2011 to CY 2012. The COB will monitor whether DHS is providing the needed oversight to ensure that children are visited monthly by either DHS or provider agency social work services staff.

The COB believes that the findings from the QVRs are an important component of DHS' ongoing accountability and continuous quality improvement process. Quality caseworker visits are associated with a range of child welfare outcomes. Child welfare agencies that conduct quality visits on a regular basis are better positioned to assess children's risk of harm and need for alternative permanency options, to identify and provide needed services, and to engage children and parents in planning for their future. The COB has requested that DHS provide a report of the findings from the QVRs conducted in 2011 and 2012. The COB will work with DHS to identify any issues in the quality of visits and how they may be addressed.

¹² Through ChildStat meetings, DHS staff collectively review a specific case or cases in a particular area of services (e.g., Child Abuse or Neglect Hotline, Ongoing Services, In-Home Protective Services). A review of each case's detailed information, including what services were provided is conducted. Following the case presentation, attendees discuss the strengths and weaknesses of the service intervention, acknowledge exemplary services, identify potential areas for improvement, and develop recommendations to improve ongoing case practices.

¹³ Enhanced visitation required DHS staff to visit all children on their caseload monthly regardless if the children were being seen by a provider agency worker.

Child Fatality and Near Fatality Data and Reviews¹⁴

The CWRP recommended that DHS enhance its child fatality review process and ensure that there is a mechanism to implementing the recommendations developed during the reviews. Since CY 2009, DHS has had a comprehensive process for having fatalities and near fatalities reviewed by a multidisciplinary team, known as the Act 33 Review Team.¹⁵ Since the implementation of the Act 33 Review Team, the COB has reviewed data regarding fatalities and near fatalities reported to DHS. The COB has also monitored the implementation of the recommendations developed by the Act 33 Review Team.

Child Fatality Data

As seen in exhibit 3.4, the number of child fatalities reported to the Child Abuse or Neglect Hotline from January 2008 through December 2012 ranged from a low of 60 in 2008 to a high of 85 in 2011, before decreasing again in 2012. During the last 5 years, the percent of fatalities reported to the Child Abuse or Neglect Hotline that generated CPS reports declined from 16.7 percent in CY 2008 to 13.8 percent in CY 2012. The percentage of fatalities reported to the Child Abuse or Neglect Hotline during the past five years that generated GPS reports also declined (from 20.0% to 4.6%, respectively).

Exhibit 3.4. Fatalities Reported to the Child Abuse or Neglect Hotline, CYs 2008–2012

Year	Number of Child Fatalities Reported to Hotline	CPS Reports Generated		GPS Reports Generated		General Reports Generated		Reports Not Generated	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
2008	60	10	16.7%	12	20.0%	21	35.0%	17	28.3%
2009	64	9	14.1%	7	11.0%	18	28.0%	30	47.0%
2010	81	12	14.8%	7	8.6%	17	21.0%	45	56.0%
2011	85	15	17.6%	7	8.2%	29	34.1%	34	40%
2012	65	9	13.8%	3	4.6%	26	40%	27	42.0%
Total	355	55	15.5%	36	10.1%	111	31.3%	153	43.1%

¹⁴ Fatality and Near Fatality data presented is based on calendar years (January to December).

¹⁵ The Act 33 Review reviews child fatalities and near fatalities that are allegedly caused by abuse and/or neglect. The team must review the circumstances of the child’s death or near fatality and the services provided to the family. Within 90 days of the review, the team must issue a written report to the DHS Commissioner which is then forwarded to the Mayor and the Department of Public Welfare. The report must include an assessment of the strengths and deficiencies in terms of compliance with statues and resignations and service to children and families, recommendations to prevent future child fatalities and near fatalities, and recommendations regarding the collaboration of community agencies and service providers to prevent child abuse and neglect.

Child Fatalities with Different Levels of DHS Involvement that Generated CPS and GPS Reports

As seen in exhibit 3.5, the majority of the child fatalities in which CPS reports were generated for CYs 2008 through 2012 were not cases involving children currently receiving services from DHS; children with a pending DHS investigation at the time of death (active cases); or children who had been known to DHS in the 16 months prior to the child’s death (inactive cases). During the last five years, 7 of the 55 (12.7%) of the child fatalities generating CPS reports were active with DHS, and 12 of the 55 (21.8%) were known to DHS in the 16 months prior to the child’s death. The remaining 36 (65.5%) child fatalities were instances in which the child was not known to DHS in the 16 months prior to the child’s death.¹⁶ Between CY 2008 and CY 2011, the number of child fatalities for which CPS reports were generated and were known to DHS ranged from a high of seven in 2011 and a low of one and two in CY 2010 and CY 2012, respectively.

Exhibit 3.5. Fatalities Where CPS Reports Were Generated, DHS Involvement, CYs 2008–2012

Year	CPS Reports Generated	Active ¹	Inactive ²	Not Known ³
2008	10	2	3	5
2009	9	1	3	5
2010	12	1	0	11
2011	15	2	5	8
2012	9	1	1	7
Total	55	7 (12.7%)	12 (21.8%)	36 (65.5%)

¹ Active is defined as the child receiving services or having a pending investigation at the time of death.

² Inactive is defined as the child being known to DHS in the past 16 months (i.e., DHS received a report alleging child abuse or neglect, conducted an investigation of child abuse or neglect, or provided services to the child within the past 16 months, but was not providing services to the child at the time of death).

³ Not Known is defined as the child not being known to DHS in the past 16 months.

For CYs 2007–2012, 4 of the 36 (11.1%) fatalities that generated GPS reports involved children with active DHS cases at the time of their deaths. Twenty-one of the 36 cases (58.3%) involved children who were known to DHS within the 16 months prior to their deaths. From CY 2008 to CY 2012, there was a decline in the number of fatalities that generated GPS reports that were active or inactive cases at the time of death, from eight cases in CY 2008 to one case in CY 2012 (see exhibit 3.6).

¹⁶ A case is considered active if the child was receiving services or had a pending investigation at the time of death. A case is considered inactive if the child was known to DHS in the past 16 months (i.e., DHS received a report alleging child abuse or neglect, conducted an investigation of child abuse or neglect, or provided services to the child within the past 16 months, but was not providing services to the child at the time of death). A case is considered “not known” if the child was not known to DHS in the past 16 months.

Exhibit 3.6. Fatalities where GPS Reports Were Generated, DHS Involvement, CYs 2008-2012

Year	GPS Reports Generated	Active ¹	Inactive ²	Not Known ³
2008	12	2	6	4
2009	7	1	6	0
2010	7	0	4	3
2011	7	1	4	2
2012	3	0	1	2
Total	36	4 (11.1%)	21 (58.3%)	11 (30.6%)

¹ Active is defined as the child receiving services or having a pending investigation at the time of death.

² Inactive is defined as the child being known to DHS in the past 16 months (i.e., DHS received a report alleging child abuse or neglect, conducted an investigation of child abuse or neglect, or provided services to the child within the past 16 months, but was not providing services to the child at the time of death).

³ Not Known is defined as the child not being known to DHS in the past 16 months.

Near Fatality Data

In January 2009, DHS was required by state statute to review cases of near fatalities and began tracking these cases in its Fatality Tracking Database. From CY 2008–CY 2012, 10 of the 72 (13.9%) near fatalities reported to the Child Abuse or Neglect Hotline were active with DHS at the time of the report and 10 (13.9%) were known to DHS in the last 16 months. In each of the years from CY 2008 to CY 2012, between zero and five children active with DHS experienced a near fatality. In the same years, between one and five children who were known to DHS in the last 16 months experienced a near fatality (see exhibit 3.7).

Exhibit 3.7. Near Fatalities, DHS Involvement, 2009-2012

Year	Near Fatalities Reported to the Hotline	Active ¹	Inactive ²	Not Known ³
2009	17	5	2	10
2010	25	2	2	21
2011	18	3	5	10
2012	12	0	1	11
Total	72	10 (13.9%)	10 (13.9%)	52 (72.2%)

¹ Active is defined as the child receiving services or having a pending investigation at the time of death.

² Inactive is defined as the child being known to DHS in the past 16 months (i.e., DHS received a report alleging child abuse or neglect, conducted an investigation of child abuse or neglect, or provided services to the child within the past 16 months, but was not providing services to the child at the time of death).

³ Not Known is defined as the child not being known to DHS in the past 16 months.

Implementation of Recommendations

The Act 33 Review Team continues to review cases in a timely manner and provide constructive recommendations to DHS. In response, DHS has conducted analyses of the recommendations to identify common themes and identify strategies for addressing the issues. DHS is using the information gained from the Act 33 Review Team to inform decision making and improve practice and policy. DHS has implemented, or is in the process of addressing, all of the recommendations of the Act 33 Review Team.

Discussion

The COB believes that DHS must continue to review fatality and near fatality data. DHS must also review, analyze, and implement recommendations from the Act 33 Review Team that may prevent future deaths. Data on fatalities and findings from fatality and near fatality reviews are an important component of DHS' process of continuous quality improvement. The COB will continue to monitor data on fatalities and near fatalities, and the findings and recommendations of the Act 33 Review Team.

Criminal Background Checks

The CWRP recommended that DHS "conduct a background check on each member in the child's household." If an adult household member has a history with DHS or a criminal record that includes a conviction, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child." The CWRP recommended this policy as one component in a comprehensive model of social work practice. The intent was for DHS to develop policy and practice regarding the use of criminal background checks during the child abuse and neglect investigation or assessment process, as well as prior to reunification after a child was placed in foster or kinship care. These criminal checks would be conducted in addition to DHS' current practice of conducting criminal background checks on adults living in the home in out-of-home placement resources.

During September 2012, DHS issued a policy outlining the requirements for obtaining and considering past DHS involvement with the family, including reviewing ChildLine reports,¹⁷ criminal history information, and Domestic Relations Court involvement of parents, caregivers, and other household members. It requires these screening requirements in the following instances:

- when children and youth move temporarily to live with Safety Plan caregivers
- when a new adult moves into the Safety Plan home
- prior to making a recommendation to enter an order for Temporary Legal Custody (TLC)
- prior to making a recommendation to enter an order for unsubsidized Permanent Legal Custody (PLC)
- prior to the reunification of children and youth
- as a useful tool during the investigation of an allegation of child abuse or neglect

Discussion

This new policy addressed the recommendation of the CWRP that DHS conduct a criminal background check on each adult member in the child's household during the investigation or assessment process and prior to reunification. The COB will monitor the implementation of this

¹⁷ The Pennsylvania ChildLine and Abuse Registry is known as "ChildLine." ChildLine accepts and assigns reports of child and student abuse to county children and youth agencies for investigation.

policy and ask that DHS report on the findings from the criminal background checks, such as how frequently a check uncovers information that would render the parent or other adult a safety risk to a child. In addition, the COB expects that DHS will report on the impact of this policy change to the COB.

Improving Health Care for Children and Adolescents in Foster Care

The CWRP indicated that “DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child’s medical and behavioral health is appropriately assessed.”¹⁸ In 2011, DHS hired Dr. Cindy Christian as the Medical Director to assist DHS in identifying strategies to ensure the physical health and well-being of children and adolescents in foster care. Dr. Christian is an original member of the COB and currently services as an ex-officio member of the COB. Dr. Christian holds the Children’s Hospital of Philadelphia (CHOP) Chair in the Prevention of Child Abuse and Neglect. She is also Director of Safe Place: The Center for Child Protection and Health at CHOP.

As DHS’ Medical Director, Dr. Christian develops policy and strategies to improve DHS’ focus on health issues and collaboration with partners in the health care community. She also leads the internal review of children with special health care needs served by DHS to ensure adequate medical care is provided and monitored; provides medical consultation to DHS nursing staff; recommends and reviews training curricula on physical health issues for DHS staff and provider agencies; and participates in team reviews of cases where medical issues are a central concern.

In addition, DHS is staffed with nine registered nurses who help DHS workers plan for the special health care needs of the children and families they serve. The registered nurses make home visits and answer questions about a child’s diagnosis and the side effects of medications. They also review health records; interpret acronyms or medical abbreviations; and serve as a liaison between clients, social workers, and medical professionals. There is also a policy in place that requires staff to consult DHS psychologists and nurses during the investigative period of a case, and when in-home protective services (IHPS) are being provided.

During the COB meeting held in September 2012, Dr. Christian provided an overview of the goals for addressing the health care needs of children involved with DHS. These goals include the following:

- identifying and including health indicators as part of the ChildStat process
- developing assessment systems
- redefining the role of the Health Management Unit

Dr. Christian and her team have documented the information collected on all the required forms about children’s health care, and are working with the information technology (IT) department to develop a new system that will allow all the information to be stored in one place. She is also working to identify which health indicators are most important to collect for children entering the child welfare system. Once identified, these health indicators will be included in the ChildStat review process.

¹⁸Philadelphia Child Welfare Review Panel (2007). Protecting Philadelphia’s Children: The Call to Action, Phase II, Recommendation 2.a.ii.3

The vision for sharing information across systems is to have a health release for each child in DHS' care and be able to request health information from multiple agencies. Many different agencies will be able to review the case management electronic file, but only a few individuals can edit or upload information. It will be possible to download information from health care institutions on a monthly basis. DHS will then be able to monitor health indicators on an individual basis or in the aggregate. DHS will work with Medicaid, the Department of Public Welfare (DPW), and other child-serving agencies at the state level to promote implementation. This work will begin in the upcoming months.

There also is a need to figure out the best way to work with primary providers and managed care organizations. Managed care organizations must have standards for their physicians who want to treat children in the DHS system. Ideally, when a child enters an out-of-home placement, the primary care physician should be identified and then contacted to find out the child's medical history and the last time the child had a visit. DHS has established a work group to work with managed care organizations around issues of confidentiality and services to children in the system.

DHS also is working toward the goal of ensuring that every child gets a health consultation when he or she enters the system, including a trauma assessment. DHS is working to identify which children require an immediate assessment, the goal of the assessment, who provides the assessment and where, and who funds the assessment. They are also identifying timeframes, goals, and expectations regarding comprehensive assessments and follow-up for addressing the identified needs.

DHS has obtained a copy of the trauma-informed Child and Adolescent Needs and Strengths (CANS) assessment instrument and treatment planning tool developed by the National Child Traumatic Stress Network. The tool is designed with three overall purposes: (1) to document the range of difficulties exhibited by traumatized children that cut across current diagnostic classification systems, (2) to describe the contextual factors and systems that can support a child's adaptation from trauma, and (3) to assist in the management and planning of services for children and adolescents who have had traumatic experiences.

Commissioner Ambrose informed the COB that she continues to meet regularly with Dr. Arthur Evans, Commissioner, Department of Behavioral Health and Intellectual Disabilities Services (DBHIDS). The purpose of these ongoing meetings is to identify strategies for addressing the mental health needs of children involved with DHS.

Discussion

The CWRP recommended that DHS "improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed."¹⁹ DHS put in place policies and practices to ensure that all children are assessed. In addition, DHS is taking steps to develop a comprehensive approach to addressing the physical, mental health, and developmental needs of children involved with DHS. These steps include identifying mechanisms for sharing health care data and information, strategies for coordinating care, and ways to increase access to services and treatment. On an annual basis, the COB will continue to monitor DHS' efforts to create a health and mental health system of care. The COB will

¹⁹ Ibid.

also urge DHS to identify the challenges so that the COB can provide recommendations for addressing them.

Implementation of the Electronic Case Management System

Since the inception of the COB, it has been clear that there is a significant need for enhanced automation to support DHS' work. During the past few years, DHS has experienced a number of starts and stops in meeting the goal of implementing a single electronic case management system that will be accessible to DHS staff and external providers. DHS' goal is to develop an integrated single system that will allow DHS and external providers to perform and complete all case-related work while providing management and monitoring staff with the appropriate tools to ensure compliance with state and Federal regulations and report complete and accurate data.

During the June 2012 COB meeting, DHS provided the COB with an update on the implementation of the Electronic Case Management System (ECMS) in FACTS². ECMS implementation began during 2011. The inclusion of the safety assessment form provides a way to ensure that important information is not skipped and all the threats are evaluated for each child or youth within the household. Once all the children, youth, and caregivers are identified, the system guides staff through the 14 threats. Staff members no longer need to fill out multiple forms with the same information. The system's "smart forms" guide workers through form completion and help prevent omissions and errors in documentation. There is also a web-based system in FACTS² that is used for functions related to the Child Abuse or Neglect Hotline, investigations, and intake. DHS is in the process of moving all case management functionality to the ECMS.

External providers use a web-based provider portal known as P-Web. P-Web is used to access the case management tools used by provider staff. DHS expects that it will connect and fully integrate P-Web and FACTS² by the end of 2013.

Discussion

DHS made significant progress in implementing the information technology needed to support social work practice and system performance. The COB believes that these changes in technology will assist DHS in improving day-to-day decision making, optimize case plans, and maximize children's safety and stability. The COB will continue to monitor the implementation of the ECMS. It will also monitor how DHS uses the data to identify ways for improving outcomes for children and families.

RECOMMENDATIONS BEING ADDRESSED THROUGH THE IMPROVING OUTCOMES FOR CHILDREN (IOC) INITIATIVE

Nine of the 17 remaining recommendations of the CWRP are being addressed through the implementation of the IOC initiative. The IOC initiative is a comprehensive, citywide, community-based approach for the provision of services and supports for children and families involved with the child protection and child welfare system in Philadelphia. The COB believes that the IOC initiative incorporates many of the CWRP recommendations that have not yet been implemented. Therefore, the COB has been focused on monitoring the planning and designing phases of the IOC initiative.

DHS has been very comprehensive in designing the IOC initiative and in the development of the plan for its implementation.²⁰ Throughout the designing and planning phases, DHS worked to ensure ongoing community participation and input. More than 150 people from key stakeholder groups throughout the city are actively engaged in the IOC's development. DHS also continues to build on existing relationships with providers and has expanded community relationships through the process of identifying and working with the Community Umbrella Agencies (CUAs) in each of the police districts.²¹ DHS also has remained focused on continually enhancing its comprehensive model of social work practice that includes a strong focus on child safety, permanency, and well-being; is family-focused and community based; and allows for individualized services.

This section provides more detail on the COB's assessment of the implementation of the recommendations in four focus areas being addressed by the IOC initiative. These include:

- clarification of roles and responsibilities
- local office presence
- expanded use of family case conferences
- co-location

Appendix C provides a complete list of the CWRP recommendations that are being addressed through the IOC initiative.

Clarification of Roles and Responsibilities

As reported in the February 2011 *Report on Progress*, DHS undertook steps to improve the clarification of roles and responsibilities of DHS and contracted agency staff during the development of the IOC initiative. DHS streamlined the performance standards and aligned them with the targeted outcomes of safety, permanency, and well-being as outlined in the Child and Family Services Reviews. The streamlined evaluation tool, which is used by the Provider Relations and Evaluation of Programs Division, delineates the performance standards for provider agencies under contract with DHS. Throughout the agency, DHS continues to hold provider meetings to clarify the roles and responsibilities of providers and DHS.

The IOC initiative model provides well-defined roles for both DHS and provider agencies. Case management services for children involved in child welfare will be provided through a network of CUAs. CUAs are community-based agencies that are responsible for the provision of direct case management services to families in their designated region. The CUAs are responsible for ensuring that a continuum of services and supports are accessible to children and families in their own communities. DHS staff will provide monitoring, oversight, and quality assurance. It is through the implementation of the IOC that DHS will shift from dual case management (DHS and providers) to single case management delivered by the CUAs.

²⁰ Additional information on the development of the IOC can be found at <http://dynamicsights.com/dhs/ioc/development.php>.

²¹ Community Umbrella Agencies (CUA's) are community-based agencies that will have contracts with DHS for the provision of direct case management services to families in their designated region. The CUAs will ensure that local solutions and resources are more accessible to children and families. They will develop connections to formal and informal neighborhood networks that can strengthen and stabilize families and will be responsible for recruitment and retention of foster and adoptive parents in the neighborhoods where children live.

In July 2012, the first two CUAs were selected. The Northeast Treatment Center (NET) was selected for the 25th Police District. Asociacion De Puertorriquenos En Marcha (APM) was selected for the 24th and 26th Police Districts. During the COB meeting held in December 2012, NET and APM provided the COB with an overview of their respective agencies. Since their selection, NET and APM have been receiving intensive training by DHS. All CUA case managers are required to complete core trainings. In addition, CUA and DHS staff have been meeting every Monday to discuss and prepare for the implementation of the IOC initiative. Initial guidelines for the CUAs have been developed. The guidelines will be revised as necessary and eventually become the practice standards.²² NET started receiving cases in January 2013 and APM will start receiving cases in April 2013. In January 2013, a second request for proposals was issued for three additional CUAs. Implementation of the IOC initiative is expected to be completed by December 2015.

Local Office Presence

The CWRP recommended that DHS create a local office presence in at least one high-risk location. As discussed above, through the IOC initiative, DHS has expanded upon this recommendation to create local offices throughout the city. One of the cornerstones of the IOC initiative is the premise that positive outcomes are achieved through child welfare services that are community-based, family-centered, culturally competent, integrated, timely, and accountable for results. CUAs are being established in defined geographic areas to serve as the primary contact and service coordinator for families.

Co-Location

DHS identified and is currently renovating the site for the co-location of the Philadelphia Police Department's Special Victims Unit, the DHS Sexual Abuse Investigations Unit, the Philadelphia Children's Alliance (PCA), and staff from the District Attorneys' office. PCA is also looking into the feasibility of including a unit of therapy treatment providers at the site. The co-location site in Hunting Park is scheduled to open in May 2013. DHS is planning on providing medical services to children at this location. A medical team of experts is being pulled together to examine existing national models of care that are being used in similar situations.

The COB strongly believes that having a co-location site is the first step toward enabling DHS and its partner agencies to better coordinate investigations and intervention services. The goal is to create a child-focused approach to child abuse and neglect cases and lessen the trauma of the investigation process. The COB recommends that DHS identify and track performance measurement data. This should include a range of investigation and post-investigation outcomes for the child and family, agencies, and community.

Expanded use of Family Case Conferences

DHS implemented Family Group Decision Making (FGDM) agency-wide in March 2009. A Second Chance, Inc., and It Takes a Village are the provider agencies responsible for receiving referrals from DHS social work services managers, coordinating services with the families, and facilitating the family conferences. The most recent analysis of the FGDM program is based on data provided by the FGDM provider agencies throughout 2011 and early 2012. The analysis of the data

²² The City of Philadelphia, Department of Human Services (January 4, 2013). *The Improving Outcomes for Children Initiative: Community Umbrella Agency Practice Guidelines*, Effective January 2013 through April 2013.

was presented to the COB during the March 2012 meeting.²³ The data are summarized below.

In 2011, 1,005 referrals were made to FGDM. This represents a 1 percent increase from the 994 referrals made in 2010. In 2010, most of the referrals were made for planning for placement discharge (28%) followed by emergency placement (19%). Fewer referrals were made for older youth permanency planning (16%), planned placements (15%), to prevent placement (14%), or to address placement disruption (8%). Nearly 84 percent of the families referred to FGDM in 2011 had at least one child removed from the home in the past. Approximately 95 percent of the families had some kind of service history with DHS. The data also show that a majority of referrals still do not result in completed family conferences (53%).²⁴ The most common reasons for cases being closed without holding a FGDM conference are the family was unavailable (39%) and the family declined to participate (36%). The FGDM model will continue to be used by DHS social work services staff for children and families on their caseload.

Family Team Conferencing

DHS presented the new family team conferencing model to the COB in December 2012. The model is similar to FGDM. FGDM is an event-driven meeting. The family team conference model is one in which family team meetings become a part of the ongoing process throughout the child's involvement with DHS and hopefully beyond.²⁵ Conferences (known as "teamings") will be conducted throughout the life of a case at key decision making points. They are intended to strengthen relationships and build supports to ensure child and youth safety, permanency, and well-being. They are child-centered, family-focused gatherings of family members; friends; community resources; the CUA case manager; other child, youth, and family serving agencies; and other professionals involved in the case. The model involves four key conferences:

- Child Safety Conference—The purpose of this conference is to create a viable safety plan to ensure children and youth are protected from identified safety threats.
- Family Support Conference—This conference will assist with the development, review, and modification of goals, objectives, and action steps for the Single Case Plan (SCP) for families receiving in-home services.
- Permanency Conference—The purpose of this conference is to develop, review, and modify the goals, objectives, and action steps for the Single Case Plan for families receiving out-of-home services.
- Placement and Stability Conference—This conference is designed to increase placement stability and prevent moves. This conference will be held within 72 hours of a child's move.

Under the new model, DHS practice specialists will facilitate the teaming decision making meetings. In this role, they will also have a quality assurance role by ensuring compliance with

²³ J. Goode (March 9, 2012) Analysis of Family Groups Decision Making-Calendar Year 2011.

²⁴ At the time of the report 23 referrals were still active and could result in a conference.

²⁵ A comparison of the different models is provided in the *Family Teaming: Comparing Approaches* developed by The Annie E. Casey Foundation, available at <http://www.ncjfcj.org/sites/default/files/teaming-comparing-approaches-2009.pdf>

relevant laws, policies, and regulations. They will also assist with identifying and resolving systemic barriers to reunification and permanency and identify additional support and services for the children and families. DHS practice specialists will not be assigned to families. They will be assigned to a CUA. All decisions about service plans will be the responsibility of the CUA case manager. DHS will review documentation and track each case as it moves towards permanency. Practice specialists will be very mobile and will facilitate conferences in the community. DHS is working on making more mobile technology available to these staff members.

The DHS teaming coordinator will schedule and coordinate the conferences, provide notifications, and work to get families involved in the meetings. They will identify extended family and supports for the children; identify and implement strategies to engage families in the teaming process; track progress and maintain records of all the team meetings; and prepare needed reports, forms, and correspondence. Teaming coordinators will report to practice specialists. There will also be a teaming director who will provide supervision to the practice specialists and teaming coordinators.

Family team conferencing will be phased in over time. The first family team conferences will begin in January 2014. As the family team conferences are being implemented, the COB will closely monitor the outcomes of the Child Safety Conferences. In particular, the COB will monitor the percentage of families participating in these conferences.

Discussion

The COB believes that implementing the IOC initiative will enhance the improvements made by DHS during the last few years. DHS is to be commended for its comprehensive and planful approach to implementing the IOC initiative. The COB will focus a majority of its efforts on monitoring the implementation of the IOC initiative. The COB believes that the IOC initiative effectively addresses the intent behind many of the CWRP's recommendations. As the IOC initiative is implemented, DHS must continually assess the effectiveness of the CUAs in both quantitative and qualitative terms.

SECTION 4. OLDER YOUTH

INTRODUCTION

Older youth represent a large number of children and youth in foster care throughout the United States.^{26, 27} In 2011, older youth represented 27.0 percent (68,183) of all children and youth entering foster care in the United States. Of those children and youth exiting foster care in 2011, 10.7 percent (26,286) of older youth were “emancipated” or aged out of the system.²⁸ Emancipation or aging out refers to situations when older youth leave foster care by virtue of their age, rather than achieving a permanency outcome such as reunification, kinship care, adoption, or guardianship. Research indicates that these older youth have a higher risk of homelessness, poor educational outcomes, unemployment, incarceration, sexual and physical victimization, substance abuse, mental illness, poor health, and early parenthood out of wedlock.²⁹

Data provided to the COB for State Fiscal Year (SFY) 2011 and SFY 2012 indicated that older youth represented a large percentage of children and youth in the Philadelphia Department of Human Services’ (DHS) foster care population. DHS defines older youth as children 13–21 years of age. Of the 6,942 children and youth in dependent care in SFY 2011, 46.9 percent were older youth. Similarly, in SFY 2012, older youth represented 46.1 percent of the 6,278 children and youth in dependent care. In SFYs 2011 and 2012, 10.2 percent of older youth aged out of care (see exhibit 4.1). In addition, 17.6 percent of older youth in SFY 2011 and 20.9 percent of older youth in SFY 2012 left care for “Other Discharge.” This category includes older youth who died, were discharged to an adult facility, were hospitalized, or ran away. Approximately one-fourth of older youth achieved permanency in SFYs 2011 and 2012 (27.7% and 25.0%, respectively).

Exhibit 4.1. Last Disposition Status of Older Youth, SFYs 2011 and 2012

Last Disposition Status (As of End of Fiscal Year)	2011		2012	
	Number	Percent	Number	Percent
Emancipation (Aged-Out)	332	10.2%	295	10.2%
Other Discharge	572	17.6%	604	20.9%
Permanency	902	27.7%	723	25.0%
Still in Care	1448	44.5%	1273	44.0%
Total	3254	100%	2895	100%

²⁶ For national data, older youth are defined as youth ages 13-20.

²⁷ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. (2012, July). *The AFCARS Report: Preliminary SFY 2011 Estimates as of July 2012, No. 19*. Retrieved from <http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf>

²⁸ Ibid.

²⁹ Casey Family Programs (2008). *Improving Outcomes for Older Youth In Foster Care*. Available from http://www.casey.org/resources/publications/pdf/WhitePaper_ImprovingOutcomesOlderYouth_FR.pdf

Given the large number of older youth in DHS' care and the large percentage of older youth who are aging out of care, the COB determined that it was critical to identify areas of strength and areas in which improvement was needed to improve outcomes. It is clear to the COB that DHS is aware of the urgency to meet older youth's permanency, educational, housing, physical, mental health, and independent living needs. Further, DHS has continued to assess and identify needed services for older youth. DHS acknowledges that they have some systemic work to do with the courts, advocates, and within their own agency. However, DHS and the COB recognize that the issues of older youth warrant an integrative approach among multiple city agencies. Addressing the multiple and complex needs of these youth and improving their outcomes is not just a DHS issue.

In June 2012, the COB created a work group to gain a better understanding of the issues of older youth in DHS' care, identify gaps in programs and services, and develop recommendations for Mayor Nutter regarding the need for cross-system collaboration to improve outcomes for older youth. The Older Youth Work Group (OYWG) is comprised of COB members and staff from DHS and the Department of Behavioral Health and Intellectual Disability Services (DBHIDS). Since its inception, the OYWG has held five meetings. The OYWG has also obtained and reviewed data on older youth in foster care and have been briefed on DHS policies and programs.

KEY FINDINGS FROM THE REVIEW OF DATA

DHS provided the OYWG with more detailed data about older youth in foster care during SFY 2011 and SFY 2012.³⁰ An overview of the key findings is presented below.

In SFY 2011, 3,254 older youth were in foster care. The number of older youth in foster care decreased 11.0 percent in SFY 2012 (2,895). Sixteen-year-olds represented the largest percentage of older youth in foster care in SFY 2011 and SFY 2012 (23.1% and 21.0%, respectively). In total, older youth in the age group of 16–18 years represented almost one-half of the older youth in care in SFY 2011 (48.8%) and SFY 2012 (46.2%). Appendix D, table 1, provides more information on the demographics of older youth in care.

Reason for Placement

Data indicate that approximately one-half of the older youth in foster care came into care due to a behavior problem. In SFY 2011, the percentage of older youth being placed due to a behavior problem was 49.1 percent. In SFY 2012, the percentage increased to 53.6 percent. Each of the other placement reasons accounted for 8.0 percent or less of the total placement reasons in SFY 2011 and SFY 2012 (see exhibit 4.2). The OYWG is working with DHS to gain an understanding of the types of "behavior problems" that are leading to placement in out-of-home care for these youth.

³⁰ These data represent numbers at the beginning of SFY 2011 and SFY 2012.

Exhibit 4.2. Placement Reasons for Older Youth, SFYs 2011 and 2012

Placement Reason	2011	Percent of Total in 2011	2012	Percent of Total in 2012
Abandonment	119	3.7%	120	4.1%
Alcohol abuse (child)	5	<1%	5	<1%
Alcohol abuse (parent)	18	<1%	11	<1%
Baby-mother/baby placement	20	<1%	10	<1%
Caretaker's inability to cope	251	7.7%	244	8.4%
Child's physical/mental/emotional/disability	110	3.4%	94	3.2%
Child's behavior problem*	1599	49.1%	1552	53.6%
Death of parent(s)	42	1.3%	57	2.0%
Drug abuse (child)	16	<1%	22	<1%
Drug abuse (parent)	116	3.6%	101	3.5%
Emergency family shelter/accompanied minor	6	<1%	2	<1%
Imminent risk (CPS law)	11	<1%	8	<1%
Inadequate housing	96	3.0%	102	3.5%
Incarceration of parent(s)	52	2.0%	42	1.5%
Missing (blank)	174	5.3%	1	<1%
Neglect	242	7.4%	217	7.5%
Other	28	<1%	15	<1%
Permanent legal custodian	1	<1%	3	<1%
Physical abuse	236	7.3%	199	6.9%
Placed for adoption	1	<1%	0	<1%
Relinquishment	7	<1%	6	<1%
Sexual abuse (alleged/reported)	104	3.2%	84	2.9%
Total	3254	100%	2895	100%

*There is not a current definition of "child's behavior problem."

Location of Placements

Older youth in foster care are more likely to be placed in group homes or institutions than their peers, and less likely to be placed with a family foster home or preadoptive family.³¹ In SFY 2011 and SFY 2012, more than one-half of the older youth in care were placed in group homes and institutions (54.3% and 54.9%, respectively). Approximately 40 percent of older youth were placed in foster homes or kinship care in SFY 2011 and SFY 2012. In SFYs 2011 and 2012, approximately five percent of older youth were placed in supervised independent living settings. Appendix D, tables 2 and 3, provide more information on the location of placements.

³¹ McCoy-Roth, M., DeVooght, K., & Fletcher, M. (2011). *Number of youth aging out of foster care drops below 28,000 in 2010*. Retrieved from Fostering Connections website:

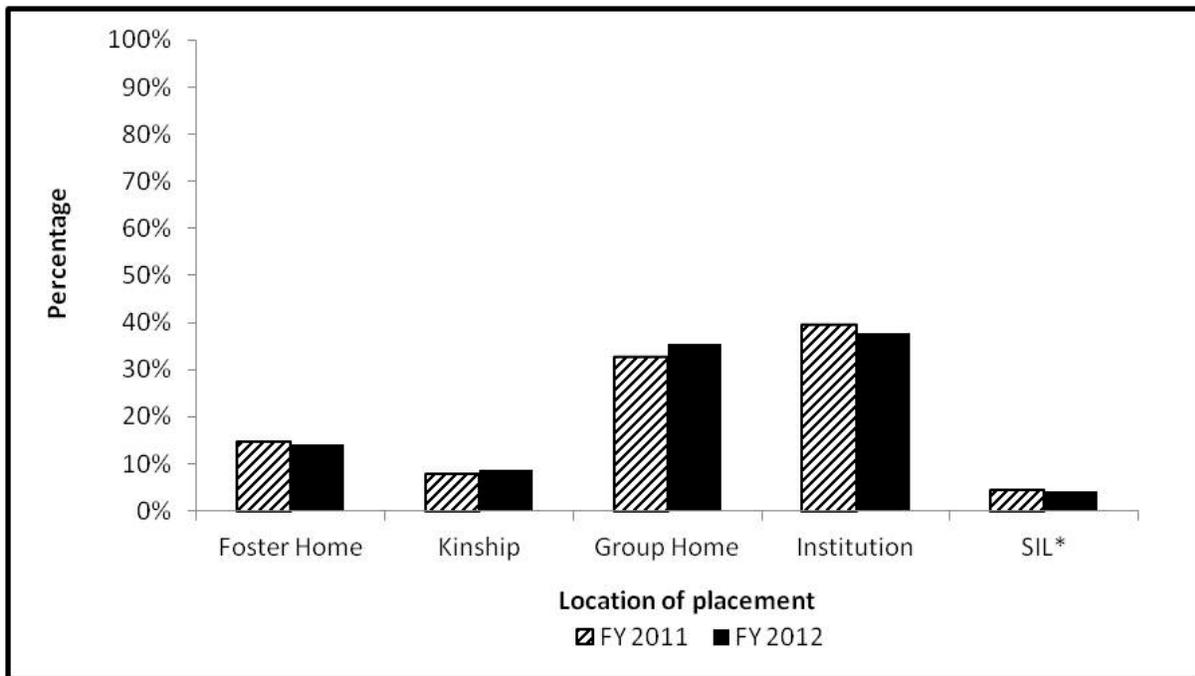
<http://www.fosteringconnections.org/tools/assets/files/Older-Youth-brief-2011-Final.pdf>.

Out-of-state placements for older youth decreased by 39.4 percent from SFY 2011 to SFY 2012 due to DHS' continued focus on returning youth to their communities. At the beginning of SFY 2011, 33 older youth were placed in out-of-state placements. At the beginning of SFY 2012, the number of out-of-state placements decreased to 21. At the end of the SFY 2012, there were 20 out-of-state placements.

Location of Placement for Youth Placed for Behavior Problems

A significant portion of those older youth placed in group homes and institutions were placed due to a behavior problem (see exhibit 4.3). In SFY 2011, 72.5 percent of older youth who came into care due to a behavior problem were placed in group homes or institutions. Similarly, in SFY 2012, 73.1 percent of older youth who came in with a behavior problem were placed in congregate care. See Appendix D, tables 2 and 3, for additional information on the placement reason by location.

Exhibit 4.3. Placement Location of Older Youth Placed for Behavior Problems



*Supervised Independent Living

Placement Reason for Emancipated Youth

Of the older youth who aged out of care at the end of SFY 2011, 39.5 percent were initially placed due to a behavior problem. Slightly more than half (57.3%) of the older youth who were discharged for other reasons had been placed due to a behavior problem.³² The percentages are similar for SFY 2012; 37.3 percent of older youth who aged out of care, and 64.7 percent of older youth who were discharged for other reasons, were initially placed because of a behavior problem. Appendix D, table 4 and table 5, provide information on the placement reason by last disposition status of older youth.

³² Other discharges include youth who died, were discharged to adult facility, were hospitalized, or ran away.

Discussion

DHS is concerned with the large number of older youth coming into care due to a behavior problem. Given this concern, DHS is conducting a review of 40 cases of older youth who were in dependent care due to a behavior problem. The goal is to better understand the particular issues of these youth and how they might be addressed to prevent dependent placement. It is believed that many of these youth have truancy issues or are being placed by the court because their parents are unable to cope with their youth's behavior.

Both DHS and the COB are concerned that many of the older youth are not achieving permanency outcomes or long-term connections with adults. It is critical that older youth have the foundation of family support or adult relationships to provide the social, emotional, and material support needed to successfully transition to adulthood. Without this foundation, these youth are likely to experience many negative outcomes that affect their safety and well-being.

LEGISLATIVE AND POLICY CONTEXT

In 2012, Pennsylvania Governor Tom Corbett signed two laws, Act 80 and 91, which provided more resources and support for older youth in foster care.^{33, 34} Act 80 amends provisions of the Public Welfare Code, extending adoption and permanent legal guardianship (PLC) subsidies to age 21 for youth who were adopted and youth for whom the Court granted an order of PLC at age 13 or older. Youth ages 18 to 21 may be eligible to receive a continued subsidy if they meet the same criteria as youth who remain committed and on a board extension.³⁵ The youth must be: (1) completing secondary education or an equivalent program, (2) enrolled in an institution that provides post-secondary or vocational education, (3) participating in a program actively designed to promote or remove barriers to employment, or (4) employed for at least 80 hours per month. Youth who are incapable of meeting the criteria due to a documented medical or behavioral health condition are also eligible for the continued subsidy.

Act 91 amends various provisions of the Juvenile Act, which allowed the court to grant board extensions to court-committed youth through age 21 who were completing an educational or training program or receiving or had received treatment or support services. Act 91 expands the criteria for a board extension for youth who request to remain in care past the age of 18. It also allows youth to reenter care before the age of 21 if they were discharged from care three months before they turned 18 or anytime thereafter if they meet the new board extension criteria. Act 91 requires that the court determine during a permanency hearing that an appropriate transition plan has been presented before a youth 18 to 21 can be discharged. Youth can remain in care past the age of 18 if they meet the same criteria as is required for Act 80.

Several policies that DHS implemented are specific to older youth in foster care. In 2007, DHS began to use interagency "teamings" to develop comprehensive plans for older youth in foster care with mental health needs. DBHIDS and DHS have collaborated with the Juvenile Law Center to

³³ Act 80 of 2012.

³⁴ Act 91 of 2012.

³⁵ A board extension is granted by the court. Youth in out-of-home care before their 18th birthday can request to continue in care until they turn 21 years of age. Youth must also be engaged "in a course of treatment or instruction" including education and training programs such as high school, college, or vocational programs.

convene monthly interagency teamings for older youth with complex and behavioral health needs who are moving toward discharge. These monthly teamings are intended to serve as a forum to address discharge planning issues of these older youth. Representatives from the school district, DHS, DBHIDS, youth and family, as well as the child advocate, are to be in attendance at these meetings. For youth with intellectual disabilities who are aging out of care, teamings ensure that these youth are registered for intellectual disability services and eligible for the Medicaid consolidated waiver. The teamings are aimed at ensuring that timely and thoughtful planning is occurring for older youth, all needed child-serving systems are involved in planning, and all parties remain accountable for fulfilling their roles. The goal of these teamings is to improve the planning process and resources available to youth who are getting ready to exit care.

In 2008, DHS developed a protocol for referring older youth for a child profile via the Statewide Adoption Network (SWAN). In 2010, DHS began to focus on outcome data by using the National Youth in Transition Database (NYTD). The NYTD collects outcome data on the youth receiving independent living services, as required by law.

Beginning in 2011, DHS required that transition planning begin at age 16 for youth who will be leaving care at 18 years of age or older. This planning should occur at least six months prior to a youth's anticipated discharge date. DHS also requires social workers and providers who had court cases involving older youth (ages 16 to 21) to provide a transition plan for the youth including services needed and progress made in areas such as life skills, educational progress, job readiness, health and mental health needs, housing, and the establishment of connections with supportive adults.

PROGRAMS AND SERVICES

In December 2012, DHS conducted a briefing for the OYWG. DHS currently offers an array of services for older youth in foster care and older youth who are aging out of the system. DHS also partners with a number of agencies to provide services in the areas of life skills, education, housing and independent living, mental health, juvenile justice, parenting, employment, etc. Some of these services and programs are discussed in more detail below.

The Achieving Independence Center (AIC), which is a DHS center, provides a majority of services to older youth in foster care. The AIC is a "one-stop" self-sufficiency program for youth ages 16 to 21 who have been in out-of-placement at or after the age of 16. The center provides services in the areas of career planning, computer literacy, educational support services, employment, family planning, housing assistance, life skills training, mentoring, and personal development. Agencies that partner with AIC to provide community events, one-to-one counseling, tutoring, and workshops include Action AIDS, Pathways PA, Planned Parenthood of Southeastern PA, and Temple University. As of July 2012, 1,249 youth ages 16 to 21 were receiving services through the AIC.

The Positive Youth Development (PYD) programs focus on the youth's psychological, educational, physical, and social development while working to prevent and minimize issues of neglect, abuse, and truancy. Services are provided to at-risk children and families, and include behavioral and academic support, and physical and social development and enrichment activities. Programs include after school and youth development, sports, social programs, parenting, education, and other community services. In addition, PYD supports the provision of referral and support services for

caregivers and other community supports. Some of these programs include The Attic Center, Philadelphia Youth Network, Temple University Center for Intergenerational Learning, Urban Tree Connection, Amongst Men, and Physicians for Social Responsibility.

DHS is also making sure that youth obtain the educational supports and resources to help prepare them for workforce, higher education, and ultimately a successful transition to adulthood. The Education Support Center (ESC) provides individual educational consultations to DHS staff, school district staff, and resource families regarding children and youth in DHS' care. More specifically, they provide consultation on transportation plans to ensure educational stability, special education concerns, school placement stability, poor grades, unexcused absences, and behavior problems. ESC serves as liaison between DHS, the School District of Philadelphia, and other public and private schools. The goal of ESC is to improve the educational stability and outcomes of children and youth in DHS' care by collaborating with the school districts and other public and private schools. In addition to ESC, DHS refers some foster care youth to the ARISE Academy Charter High School. ARISE provides education to foster care youth ages 14 to 21 by preparing them for the workforce and/or higher education.

Housing and independent living supports for youth aging out of foster care through the various systems of care including, but not limited to DHS and DBHIDS are provided. These services include Supervised Independent Living, Supported Assisted Living Transition Program for youth with mental health disorders requiring psychiatric supports, Supportive Housing Program, Transitional Living Program, and Staff Supported Independent Living. Other services and supports offered to older youth aging out of foster care in Philadelphia include mentoring, assistance in obtaining SSI benefits for those youth who are disabled, advocacy, child care, and parenting groups.

DHS is currently looking at the gaps and barriers in programs and services provided to older youth in foster care. DHS is conducting focus groups and interviews with youth to obtain their perspective about the programs and services provided. Currently, the PMA unit at DHS is not evaluating the outcomes of the youth participating in these programs. The OYWG believes that it is important that DHS develop a plan for capturing utilization rates and key outcomes of the youth utilizing these services.

NEXT STEPS

At the first meeting of the COB in 2013, DHS will present the findings from the focus groups and interviews that were conducted with older youth. These focus groups and interviews are being conducted to identify what is working well, system problems, and gaps in services and supports from the perspective of the youth. This information will serve as a foundation to the work of DHS and the CUA as they work to improve outcomes for older youth in care. This information also will inform the work and the recommendations of the OYWG.

In addition, the OYWG expects to receive a report from DHS on the findings of their review of 40 cases of older youth in care who were placed for a behavioral problem and an assessment of DHS' use of congregate being conducted by the Annie E. Casey Foundation. The OYWG plans to obtain additional information and data that can provide a better understanding of the needs of older youth

in DHS foster care, and what is required to improve outcomes for older youth in care. In particular, the OYWG will seek out answers to the following questions:

- What services and supports could reduce the number of older youth being placed in foster care for a behavioral problem?
- What are the current permanency goals for older youth in DHS foster care? If the goal is not reunification, adoption, legal guardianship, or permanent placement with a fit and willing relative, then how is DHS ensuring that each older youth receives a permanent connection to a caring adult?
- What do we know about the educational outcomes of older youth in foster care? More specifically, are there any similarities or differences between older youth enrolled at ARISE Academy Charter High School and other private and public schools in Philadelphia?
- What do we know about the physical and mental health status of older youth in foster care?
- What do we know about the outcomes of older youth with co-occurring physical health conditions and disabilities requiring lifetime nursing care?
- How many of the older youth in foster care are also involved with juvenile justice?
- What data is being collected on the outcomes of older youth in foster care?
- Of the older youth who are eligible to participate in Independent Living Programs, how many participate?
- What are the participation rates in the various AIC Programs?
- What do we know about the effectiveness of the current approaches to the provision of support and services to older youth?
- What additional work is required to develop an integrated approach to ensure that older youth are receiving the full range of transition services needed to improve outcomes?

By the end of 2013, the OYWG expects that it will make recommendations regarding what is required to improve the outcomes of older youth and ensure that there is an integrated process in place for continuous quality improvement.

APPENDIXES

APPENDIX A. COMPLETED CWRP RECOMMENDATIONS

MISSION AND VALUES	
RECOMMENDATION	NOTES
<p>1. DHS must develop a mission statement and core values that are centered on child safety (Phase 1, Recommendation 1.a).</p>	<p>In December 2007, DHS adopted a set of core values that included safety, permanency, well-being, respect, competence, teamwork, accountability, transparency, communication, and trust. DHS developed these values by (1) examining the mission and values that were in place in other comparable municipalities, (2) extracting the core principles that were consistent within DHS' principles, and (3) drafting a new mission statement and set of values.</p>
<p>2. DHS' core values must embody, at a minimum, the following principles: creating a culture of respect, compassion and professionalism; enhancing communication with, and responsiveness to, stakeholders; instilling a greater sense of urgency among DHS staff and providers; providing services that are readily accessible; fostering a culture of collaboration; providing culturally competent services; and creating a transparent agency (Phase 1, Recommendation 1.b).</p>	<p>See recommendation 1 above.</p>
<p>3. DHS must align prevention programs and resources with mission and values developed in Phase One, and also with the core principle of ensuring child safety (Phase 2, Recommendation 1.a).</p>	<p>The Division of Community Based Prevention has been officially phased out. The majority of the programs have been moved under the Children and Youth Division (CYD) under a newly established support center, The Family and Community Support Center (FCSC). FCSC was established to provide support to children/youth and families to strengthen and/or stabilize the family unit. FCSC strives to address the underlying problems that lead to abuse, neglect and delinquency and to support at - risk children/youth before their situation leads to involvement or more intensive involvement in the formal Child Welfare System. In addition, with this change, the Family Empowerment Services (FES) under the Family and Community Support Center can be offered to families active and closed with CYD. FES is an in-home case management service. These services can be used to assist and supplement support for families. Of course if the family has safety threats, IHPS would be used. Finally, families involved with CYD can also access Positive Youth Development and Domestic Violence services.</p>
<p>4. DHS must align more effectively in-home service programs and their utilization with the mission and values of DHS and with child safety (Phase 2, Recommendation 1.b).</p>	<p>The Safety Model of Practice provides the framework for In-home service programs and their utilization. DHS has developed a continuum of in-home services: IHPS is the in-home service available to families with active safety threats. There are also four specialty IHPS programs (Sex Abuse, Cognitively Impaired Caregivers, Medically Fragile Children, and Families in Shelters).</p>

PRACTICE	
5. DHS must implement an adequate evidence-based safety assessment tool (Phase 1, Recommendation 2.a.i).	DHS has fully implemented the in-home safety assessment tool developed by the Department of Public Welfare. DHS has begun to train staff on the out-of-home safety assessment tool which is expected to go into effect on July 1, 2013.
6. DHS must conduct a safety assessment for every child within its care—both children at home and children in out-of-home placements. The safety assessment must be updated at each contact with the child (Phase 1, Recommendation 2.a.ii).	DHS completed a safety assessment for all children receiving in-home and placement services in March 2008. <i>DHS</i> implemented a safety assessment tool for children receiving in-home services and for children for whom there is a current investigation of abuse and neglect. DHS initiated a quality assurance review process during April 2008 to monitor the quality and completeness of the in-home safety assessments. DHS continues to review approximately 100–150 safety assessments each month.
7. DHS must conduct immediate (within 2 hours) face-to-face visits for every child 5 years of age or younger for whom a report of suspected abuse or neglect is received by the Child Abuse or Neglect Hotline. This face-to-face contact must be made regardless of whether the Child Abuse or Neglect Hotline classifies the case as General Protective Services (GPS) or Child Protective Services (CPS) (Phase 1, Recommendation 2.b.i).	DHS abandoned the automatic 2-hour response time (regardless of allegation) for children 5 and under because it soon became clear that more trauma could be caused if young children were aroused in the middle of the night for what really did not amount to an immediate safety concern (e.g. a doctor calling the Child Abuse or Neglect Hotline at 8 PM to report a parent not tending appropriately to their 4 year olds lice). In addition, sending social work services staff on immediate reports that were not immediate priority reports based on safety concerns, diverted resources from vulnerable children over age 5.
8. DHS must move toward an evidence-based practice model and take active steps to determine the effectiveness of its practice with an evaluation process that it open and informs good practice (Phase 2, Recommendation 2.a.i).	The CWRP recommended that DHS develop a more analytical process, both to evaluate the effectiveness of services and to identify additional changes and improvements that could be implemented. The CWRP recommendation referred to this as evidence-based practice. DHS has implemented both case reviews and ongoing data analysis. The information from the case reviews and data analysis is being used to inform decision making, improve practice, and monitor outcomes. DHS is currently conducting four types of case reviews to assess service effectiveness— ChildStat, Quality Service Reviews (QSR), reviews of child fatalities/near fatalities, and Qualitative Visitation Reviews (QVR).
9. DHS must revise policies for case openings and closures—DHS must enhance the focus on team decision making to include team decision making for reviewing case closures. DHS must develop guidance for staff, and train them to work with cases where parents are uncooperative (Phase 2, Recommendation 2.a.ii.1).	DHS case opening and closure is driven by the in-home safety assessment process. DHS continues to reinforce the requirement that staff utilize FGDM and family engagement strategies. DHS continues to train staff in family engagement strategies and will continue to provide staff with the tools for effective interviewing, engagement, and family participation. The use of teasing as a strategy will also be enhanced through the implementation of the Family Teaming Conference Model as part of the Improving Outcomes for Children (IOC) initiative.

<p>10. DHS must reexamine the risk assessment in the context of the new safety assessment and integrate it into the new team decision-making model for placement and services (Phase 2, Recommendation 2.a.ii.4).</p>	<p>The concept of risk is embedded in the in-home safety assessment process and is addressed by staff through the implementation of the in-home safety tool. The cross walk between risk and safety is addressed by staff development in training curriculum on an ongoing basis. The team decision making process is also guided by the safety assessment process.</p>
<p>11. DHS must eliminate “boilerplate” referrals and ensure that each child receives appropriate referrals that are specifically tailored for his or her unique needs. DHS will follow-up and act to ensure that the services are actually obtained (Phase 2, Recommendation 2.a.ii.5).</p>	<p>To reinforce this recommendation, DHS continues to provide training and reinforce the need to prepare individualized plans and make referrals that reflect the individual needs of families. DHS expects service planning to be behaviorally-focused and individualized to meet the specific needs of family members taking into consideration the safety, risks, and protective capacity of the family. The new ECMS assists staff in developing individualized plans. In addition, DHS is moving towards the implementation of a Single Case Plan (SCP) which will be tailored to the needs of the family.</p>
<p>12. DHS must clarify the role of supervisors to support the DHS practice model being implemented (Phase 2, Recommendation 2.a.iv).</p>	<p>The Deputy Commissioner and Operations Director of the Children Youth Division hold monthly meetings with DHS supervisors. During these meetings, various supervisory and practice issues are discussed and reiterated. In addition, presentations regarding new policies/procedures as well as new initiatives are shared. Finally, CYD management also used this time to reinforce practice expectations as well as supervisory responsibility. DHS also is currently working with the Child Welfare Resource Center to have the ability to certify supervisors in-house to avoid having new supervisors train in various locations all over State.</p>
<p>OUTCOMES AND ACCOUNTABILITY</p>	
<p>13. DHS must develop an annual report card that measures and communicates its performance on outcomes of interest, including, at a minimum, those outcomes specified in Chapter 4 of the Report (Phase 1, Recommendation 3.a.i).</p>	<p>DHS continues to provide the COB with updates on the ChildStat process. More importantly, the performance standards from the ChildStat process are reported and shared with DHS and provider staff. PMA will produce a 3-year review of the ChildStat process and present it to the COB in 2013.</p>
<p>14. DHS must develop a comprehensive strategy for internal monitoring of its performance. DHS must be able to monitor the performance of regions, units and workers, and must use performance information to identify weaknesses and areas for improvement (Phase 1, Recommendation 3.a.ii).</p>	<p>DHS continues Child State, Quality Service Reviews, Fatality/Near Fatality Reviews, and Quality Visitation Reviews. DHS uses these ongoing reviews to evaluate the effectiveness of services and identify additional changes and improvements that could be implemented.</p>
<p>15. DHS must enhance oversight of contracted agencies (Phase 1, Recommendations 3.b).</p>	<p>DHS has improved its review tools that are used to evaluate provider performance. In addition, Provider Relation and Evaluation of Program (PREP) regularly perform on-site reviews of providers and works with providers to ensure improvements are made, when necessary. PREP convenes provider meetings</p>

	to discuss performance issues and to make sure that they are aware of practice changes and recommendations from the Act 33 Review Team. DHS has improved its internal review process that results in provider intake closures and contract terminations.
16. DHS must create an annual outcome report card for contracted agencies. At a minimum, the report card will focus on measures of child safety, which are detailed in Chapter 4 of the Report (Phase 1, Recommendation 3.b.i).	In 2009, DHS established the Division of Performance Management and Accountability (PMA) PMA is charged with developing a system by which DHS can monitor service delivery to the children and families in DHS care. PMA provides rankings to providers according to their overall performance. The ranking attempts to assess providers' performance in achieving the goals of the services provided and by considering outcomes related specific outcome measure including benchmarks to measure provider performance around safety issues and to assess best practices. More information on provider rankings can be found at http://www.phila.gov/dhs/pma.html .
17. DHS must establish Commissioner's Action Line (CAL) (Phase 1, Recommendation 3.c).	The CAL has been established. In 2013, DHS will provide the COB with an overview of the types of issues brought to the CAL and how they have been addressed.
18. DHS must establish a mechanism and process to establish ongoing community oversight. At a minimum, the City must establish a Community Oversight Board. (Phase 1, Recommendation 4.a)	The Community Oversight Board was established in (COB). The COB continues to monitor the reform efforts of DHS.
LEADERSHIP AND INFRASTRUCTURE	
19. DHS must enhance its ability to proactively and transparently manage crisis, including strengthening process related to child death reviews and increasing public access to information (Phase 2, Recommendation 4.c).	The Act 33 Review Team has significantly improved the child fatality review process and is a model for the rest of the state. DHS provides copies of fatality and near fatality reports upon request by members of the public, in compliance with state law and consistent with its emphasis on making DHS a more transparent agency.
20. DHS must take positive steps to enhance the healthiness of infrastructure and staff morale (Phase 2, Recommendation 4.b).	DHS continues to explore and implement a variety of approaches to increase staff morale with a focus on improved communication, the implementation of the Sanctuary Model, a trauma-informed approach to organizational change, and implementing steps for an employee recognition program.

APPENDIX B. IMPLEMENTED AND SUSTAINED CWRP RECOMMENDATIONS

CHILD VISITATION
1. DHS staff must—on at least a monthly basis—conduct face-to-face contacts with all families receiving any service supported through the Children and Youth Division (CYD) that have a child 5 years of age or younger and physically observe the condition, safety and behavior of any such child, as well as parental capacity (Phase I, Recommendation 2.b.ii).
2. DHS must enhance the frequency of face-to face contacts with children of all ages. Since face-to face contacts are the most important actions to ensure child safety, DHS staff must conduct a minimum of one face-to-face contact per month with each child in its care. More frequent contact may be warranted depending on the specific safety and risk factors in each case (Phase II, Recommendation 2.a.iii).
3. DHS must validate that contracted agencies are making face-to-face contact with children, that they are performing safety assessments at each contact, and that the contacts are sufficiently frequent and adequate to determine the safety of the child (Phase I, Recommendation 3.b.ii).
CHILD FATALITY REVIEW
4. DHS must enhance the child fatality review process. DHS must ensure that the child fatality review is multidisciplinary and that there is a mechanism for implementing its recommendations (Phase II, Recommendations 2.a.vi. and 2.a.vi.1).
CRIMINAL BACKGROUND CHECKS
5. DHS must conduct a background check on each member in the child’s household. If an adult household member has prior involvement with DHS or a criminal record that includes convictions for a felony that suggests danger for a child, then DHS must conduct an assessment to determine whether the household is safe and appropriate for the child (Phase II, Recommendation 2.a.ii.2).
CHILD HEALTH AND WELL-BEING
6. DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child’s medical and behavioral health is appropriately assessed (Phase II, Recommendation 2.a.ii.3).
IMPLMENTATION OF ELECTRONIC CASE MANAGEMENT SYSTEM
7. DHS must streamline its paperwork and records management practices (Phase II, Recommendation 2.a.v.).
OUTCOMES AND ACCOUNTABILITY
8. DHS must revisit and expand the list of outcomes to be measured—whereas Phase One was largely focused on child safety, Phase Two will expand the focus to include permanency and well-being measures (Phase II, Recommendation 3.a).

APPENDIX C. CWRP RECOMMENDATIONS BEING IMPLEMENTED THROUGH THE IMPROVING OUTCOMES FOR CHILDREN (IOC) INITIATIVE

LOCAL OFFICE PRESENCE
<p>1. DHS must establish a local office presence in a least one geographic location deemed highly at risk (Phase I, Recommendation 2.c).</p>
FGDM/TEAM CONFERENCING
<p>2. DHS must implement a team decision-making process to determine service plans for all children 5 years of age or younger. A pre-placement conference must be held for all non-emergency cases where a child 5 years of age or younger may need to be placed into a substitute care setting. The pre-placement conference must include the child's family, including potential kinship placement resources; the DHS worker; the provider agency worker (where applicable); a physician or nurse; and individuals representing mental health, substance abuse, and domestic violence services, as needed, who have the authority to commit resources of their respective agencies; and individuals requested by the family representing their social support network. When feasible, the supervisors of both the DHS and provider agency workers should participate in the team decision making conference. The initial Family Service Plan (FSP) must be developed during this process (Phase I, Recommendation 2.d).</p>
<p>3. DHS must ensure that ongoing team case conferencing occurs routinely every three months, for cases involving children age 5 years or younger, after the initial pre-placement conference, and the child's family, the DHS worker, the provider agency worker, and other interdisciplinary resources must be included as appropriate. Monitoring of service provided, progress, and revisions to the FSP must be made as part of this process (Phase I, Recommendation 2.e).</p>
CLARIFY ROLES AND RESPONSIBILITIES
<p>4. DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and worker level (Phase I, Recommendation 2.f).</p>
COMPREHENSIVE MODEL OF SOCIAL WORK PRACTICE
<p>5. DHS must develop a comprehensive model for social work practice that is based on DHS' core mission and values; includes a stronger focus on child safety, permanency and well-being; is family-focused and community-based; and allows for individualized services (Phase II, Recommendation 2.a).</p>
CO-LOCATION
<p>6. DHS must complete the long-planned co-location of DHS, police, medical and forensic interview personnel at a community site to facilitate collaborative decision making in the investigative phase of casework (Phase II, Recommendation 2.a.ii.6).</p>
PERFORMANCE AND ACCOUNTABILITY
<p>7. DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives (Phase II, Recommendation 3.b).</p>
<p>8. DHS must continue to expand its emphasis on making DHS a more transparent agency (Phase II, Recommendation 4.a).</p>
<p>9. DHS must ensure ongoing community participation and input into the improvements undertaken by DHS. This participation shall include, at a minimum, a series of ongoing town hall meetings, focus groups, and other events that facilitate the input of community members, private provider agencies, parents, clients, and other stakeholders (Phase I, Recommendation 4.b).</p>

APPENDIX D. OLDER YOUTH SUPPORTING TABLES

Table 1. Older Youth Demographics, SFYs 2011 and 2012

	Beginning of SFY 2011		Beginning of SFY 2012	
	Number	Percent	Number	Percent
Age				
13	298	9.1%	307	10.6%
14	422	13.0%	429	14.8%
15	620	19.1%	517	17.9%
16	751	23.1%	607	21.0%
17	563	17.3%	473	16.3%
18	273	8.4%	258	8.9%
19	205	6.3%	170	5.9%
20	122	3.7%	133	4.6%
21	0	0.0%	1	0.0%
Gender				
Male	1742	53.5%	1572	54.3%
Female	1512	46.5%	1323	45.7%
Race				
African American	2661	81.8%	2408	83.2%
Caucasian	407	12.5%	409	14.1%
Unknown	126	3.9%	38	1.3%
Asian	49	1.5%	31	1.1%
Pacific Islander	9	0.3%	7	0.2%
Unable to determine	2	0%	2	0.1%
Hispanic Indication				
No	1751	53.8%	2177	75.2%
Yes	1161	35.7%	377	13.0%
Blank	342	10.5%	341	11.8%
Total	3254		2895	

Table 2. Placement Reason by Location for Older Youth, SFY 2011

Placement Reason	Foster Home	Kinship	Group Home	Institution	SIL*	Total
Abandonment	32	36	19	24	8	119
Alcohol abuse (child)	2	1	1	1	0	5
Alcohol abuse (parent)	10	5	2	1	0	18
Baby-mother/baby placement	1	0	6	3	10	20
Caretaker's inability to cope	64	95	29	43	20	251
Child's behavior problem	239	128	525	634	73	1599
Child's physical/mental/emotional disability	29	3	34	40	4	110
Death of parent(s)	12	19	3	3	5	42
Drug abuse (child)	0	0	6	9	1	16
Drug abuse (parent)	33	48	10	11	14	116
Emergency family shelter/accompanied minor	0	1	0	5	0	6
Imminent risk (cps law)	6	3	0	2	0	11
Inadequate housing	36	31	10	12	7	96
Incarceration of parent	8	27	10	6	1	52
Missing (blank)	32	37	57	48	0	174
Neglect	103	47	27	42	23	242
Other	9	3	5	6	5	28
Permanent legal custodian	0	0	1	0	0	1
Physical abuse	81	53	39	56	7	236
Placed for adoption	0	0	0	1	0	1
Relinquishment	3	0	3	1	0	7
Sex abuse (alleged/reported)	33	28	17	16	10	104
Total	733 (22.5%)	565 (17.4%)	804 (24.7%)	964 (29.6%)	188 (5.8%)	3254

*Supervised Independent Living

Table 3. Placement Reason by Location for Older Youth, SFY 2012

Placement Reason	Foster Home	Kinship	Group Home	Institution	SIL*	Total
Abandonment	33	23	23	23	18	120
Alcohol abuse (child)	2	0	2	1	0	5
Alcohol abuse (parent)	5	1	5	0	0	11
Baby-mother/baby placement	1	0	2	1	6	10
Caretaker's inability to cope	63	109	29	25	18	244
Child's behavior problem	217	135	549	586	65	1552
Child's physical/mental/emotional/disability	22	4	30	34	4	94
Death of parent(s)	10	31	7	5	4	57
Drug abuse (child)	0	1	11	10	0	22
Drug abuse (parent)	23	46	9	14	9	101
Emergency family shelter/accompanied minor	0	0	1	1	0	2
Imminent risk (cps law)	3	3	1	1	0	8
Inadequate housing	42	29	13	11	7	102
Incarceration of parent(s)	12	22	3	4	1	42
Missing (blank)	0	1	0	0	0	1
Neglect	91	45	23	42	16	217
Other	3	2	2	4	4	15
Permanent legal custodian	1	0	1	1	0	3
Physical abuse	64	40	35	47	13	199
Relinquishment	0	1	2	2	1	6
Sexual abuse (alleged/reported)	29	19	13	15	8	84
Total	621 (21.5%)	512 (17.7%)	761 (26.3%)	827 (28.6%)	174 (6.0%)	2895

*Supervised Independent Living

Table 4. Placement Reason by Last Disposition Status for Older Youth, SFY 2011

Placement Reason	Permanency	Emancipation	Other Discharge	Still in Care	Total
Abandonment	21	18	21	68	128
Alcohol abuse (child)	3	1	1	1	6
Alcohol abuse (parent)	2	0	2	10	14
Baby-mother/baby placement	2	4	7	7	20
Caretaker's inability to cope	49	30	33	138	250
Child's behavior problem	476	131	328	665	1600
Child's physical/mental/emotional/disability	23	10	21	59	113
Death of parent(s)	3	10	7	20	40
Drug abuse (child)	5	2	6	5	18
Drug abuse (parent)	30	24	14	46	114
Emergency family shelter/accompanied minor	2	1	0	2	5
Imminent risk (CPS law)	3	1	3	4	11
Inadequate housing	24	12	14	54	104
Incarceration of parent(s)	15	6	7	24	52
Missing (blank)	114	2	9	30	155
Neglect	51	36	41	119	247
Other	4	6	5	13	28
Physical abuse	56	20	36	124	236
Place for adoption	1	0	0	0	1
Relinquishment	1	1	0	4	6
Sexual abuse (alleged/reported)	17	17	17	55	106
Total	902 (27.7%)	332 (10.2%)	572 (17.6%)	1448 (44.5%)	2895

Table 5. Placement Reason by Last Disposition Status for Older Youth, SFY 2012

Placement Reason	Permanency	Emancipation	Other Discharge	Still in Care	Total
Abandonment	21	23	17	59	120
Alcohol abuse (child)	3	2	0	0	5
Alcohol abuse (parent)	2	1	0	8	11
Baby-mother/baby placement	1	2	2	5	10
Caretaker's inability to cope	57	29	34	124	244
Child's behavior problem	424	110	391	627	1552
Child's physical/mental/emotional/disability	21	14	14	45	94
Death of parent(s)	9	6	10	32	57
Drug abuse (child)	7	1	4	10	22
Drug abuse (parent)	17	21	14	49	101
Emergency family shelter/accompanied minor	1	0	1	0	2
Imminent risk (CPS law)	1	1	3	3	8
Inadequate housing	25	13	18	46	102
Incarceration of parent(s)	12	6	8	16	42
Missing (blank)	0	1	0	0	1
Neglect	54	29	30	54	217
Other	0	3	8	4	15
Physical abuse	53	21	1	93	168
Permanent legal custodian	0	0	0	2	2
Relinquishment	2	2	32	2	38
Sexual abuse (alleged/reported)	13	10	17	44	84
Total	723 (25.0%)	295 (10.2%)	604 (20.9%)	1273 (44.0%)	2895

