Outcomes:

<table>
<thead>
<tr>
<th></th>
<th>4th Quarter FY 08/09</th>
<th>2nd Quarter FY 09/10</th>
<th>3rd Quarter FY 09/10</th>
<th>4th Quarter FY 09/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>61%</td>
<td>57%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Permanency</td>
<td>66%</td>
<td>45%</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Well – Being</td>
<td>64%</td>
<td>51%</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>63%</td>
<td>54%</td>
<td>73%</td>
<td></td>
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</table>

The 3rd quarter side by side review period spanned nine months from April 1 to December 31, 2009. The sample was comprised of six children who were in out of home care the entire period review period, one child who was in out of home care and reunified with his parent during the review period and one child who resided with his parent the entire period under review. Three of the children in out of home care have the goal of adoption while the remaining three children have the goal of reunification. The two in-home cases have the goal of maintain and strengthen. Two of the children in out of home care are in foster homes; three are in relative placements and one child is in the custody of a non-relative.

Positive Steps

- There were no instances of re-abuse, re-neglect during the period under review.

- Use of FSFN Family Assessments.
  Six month family assessments are now being completed in FSFN. There was a family assessment completed for 7 of the 8 cases although five of the assessments were considered to meet the minimal requirements which is to ensure the immediate and prospective safety of the child as well as any changes and implications in the family’s situation related to emerging danger and service needs. Continued efforts are needed to ensure that family assessments are updated at least every six months and at critical junctures in the case, such as when new reports of abuse and/or neglect are received or there are changes in family factors.

- No child experienced more than 2 out of home care placements and all children’s current placement was stable and appropriate to meet the child’s needs with no apparent or significant risks or projections for disruption.
  Seven children were in out of home care at least a portion of the review period. Only one of these children experienced a placement change and this child went from a non-relative to a relative placement which could be a permanent home should the parents fail to comply with their case plan.
• Sibling groups were placed together in out of home care or there was clear evidence separation was necessary to meet the child’s needs. Sibling contact was maintained and encouraged when not placed together. The child’s important other connections were maintained as well. Three of the focus children in this review have siblings who were also in out of home care. Two of the sibling groups were placed together, however the third child and her half-brother were separated as the maternal grandmother was unable to care for both children. The half-brother was placed with another relative. These siblings had regular visitation arranged by the relatives. Concerted efforts were made to maintain important connections for six of the seven applicable children which included children remaining in their same school and maintaining contact with extended family members including siblings who were not in out of home care.

• One foster parent engaged the child’s mother by facilitating visitation and encouraged ongoing contact and support after reunification. The foster parent also involved the child in extracurricular activities while residing in her home. Another foster parent who was out of state ensured the sibling group in her care were involved in extracurricular activities such as baseball and football.

• Concerted efforts were made to ensure visitation or other forms of contact was sufficient between the child and parents to maintain or promote the continuity of the relationship in out of home cases. There were four cases where visitation and contact between the child and parents was applicable. Visitation between children and mothers was supported in all cases. Visits or contact between children and father’s was supported in three of four applicable cases. In one case the child was placed out of state with a relative and weekly phone contact was encouraged. Several of the caregivers facilitated appropriate visitation without the assistance of case managers.

• Appropriate steps were taken to process and approve an adoptive family that matched the child’s needs for children placed in identified adoptive placements as well as those needing recruitment. There were two children in this review whose parental rights were terminated. One child is in a non-relative placement where the family is in the adoptive home study process. The other child has been in out of home care since 1996 and has had his parental rights terminated since 2000, but due to his mental health condition has required specialized treatment. An adoptive home was identified for this child during the review period and he was placed with this family in January, 2010. A third child in this review has had a termination of parental rights petition filed on her behalf and is placed with relatives who would like to adopt her. They have been provided an adoption packet to initiate the adoptive home study process.
• Educational needs were assessed and when needs were identified, necessary services were engaged and services effectively reduced or resolved the issues that interfered with the child’s education. Six children met the criteria for educational assessments. Two children were found to have educational needs, had an IEP and were receiving special education services through the school system. Two other children were assessed and did not require intervention as the report cards located in the file reflected they were meeting or exceeding grade level expectations. The remaining two children were preschool age and either a developmental evaluation was completed or a comprehensive behavioral health assessment. Both children were determined to be developmentally on target.

• Quality of contacts with the child was sufficient to address issues pertaining to safety, permanency and well-being. In all cases there was documentation that contacts with children were of a qualitative nature. In the past this documentation has been limited to “no marks or bruises” or a description of the child’s clothing. During this review it has been noted there was increased documentation of the child’s interactions with other family members, the child’s adjustment to the home, behavioral issues, the child’s health/well-being, milestones the child may have achieved and permanency planning if age appropriate.

Opportunities for Improvement

• Concerted efforts to engage case parents in the case planning process. Engaging parents in general continues to need additional efforts particularly in attempts to locate and engage parents who are absent or incarcerated. This is slightly more apparent with fathers (50%) than mothers (67%) when it comes to involvement in the case planning process. None of the fathers and a third of the mothers were visited with frequency sufficient to adequately address all aspects of permanency, safety and well-being. When visits occurred the quality of discussion was mainly on the parent reporting what case plan tasks had been completed rather than thoroughly addressing the outcome and impact services had on ameliorating the reason for service intervention, aspects of the child’s health, dental, mental health, and adequately addressing safety issues. Most parents were not encouraged to participate in making decisions about the child’s needs and activities such as involvement with medical, dental, mental health or education appointments.

• Addressing immediate and emerging safety concerns including developing a safety plan. There were four children where immediate and emerging safety concerns were evident during the review period. An adequate safety plan was developed for two of these children. There were 2 safety plans developed with one family to ensure the father did not have contact with the child and in another case there was a thorough safety plan developed with caregivers to address concerns that
surfaced from therapists and medical providers regarding their ability to care for the child. However in the two other cases issues emerged such as lack of background checks completed for unauthorized adult caretakers and a lack of follow through on a psychologist’s recommendations related to safety concerns regarding a father’s capability to care for his children. Neither of these situations was accurately addressed in the family assessment or solicited an immediate response from case management staff.

- **Documentation of ongoing verbal communication with service providers regarding the effectiveness of services for case participants.**
  Six of eight case files contained written documentation from providers regarding the parent’s compliance with case plan tasks. However there continues to be little if any verbal communication with providers to determine the level of impact services had on the parent’s ability to care for their child or rectify the reason for agency involvement. This poses a problem for the court when evidence shows parental compliance on the number of sessions that may have been completed vs. the effectiveness of the service provision.

- **Independent Living Services to children 15 to 18 years of age.**
  There was one child who met the criteria for evaluation of the independent living questions. This child was residing with a relative out of state who was a licensed foster parent. There was no documentation that any type of independent living services had been initiated including an assessment, a normalcy plan or training skills classes.

- **Psychotropic medication.**
  One child in this review was on psychotropic medication. He has been prescribed medication for a number of years due to ongoing mental health issues. The psychotropic medication treatment plan and court order were in place until the prescribing practitioner changed the medication dosage in July, 2009. A new treatment plan was received by the case manager, but an amended court order was not located in the file. The case manager is in the process of obtaining an amended court order at this time. This was a considerable delay.

- **Increased supervisory oversight.**
  Supervisory reviews were conducted quarterly on six of eight cases. One case did not document any supervisory reviews during the nine month period under review while another had a review during two of the three quarters. Although the agency has changed the reporting format which appears to be conducive to better documentation of the reviews; only half of the supervisors covered all aspects of safety, permanency and well-being during reviews, and only one of these supervisors ensured follow through on recommendations by the case manager. Three of the supervisors that lacked a thorough review of case facts did ensure case management follow-up on their recommendations. Some supervisors are addressing whether recommendations from past reviews are completed; however may not state the reason the task was not done. There
appear to be positive steps in the quality of supervisory reviews, but it is a work in progress.

• **Lack of thorough documentation.**
  There have been positive steps made with some case manager’s documentation, but it is sporadic and appears to be on a case by case basis. There were a couple of cases considered as having thorough detailed documentation, while the others reflected mostly home visits or a general account of ongoing activities such as court hearings, staffings, etc. rather than the specific particulars of these events. Each case was debriefed with the case manager, supervisor, and program administration so each agency is aware of their case findings and where improvements may be warranted. During QA reviewers case debriefings and discussions that ensued it became even more evident that not all casework activities were being detailed or included within the case file or FSFN notes and some documentation was inaccurate when compared with details in the family assessments. When reviewing court orders and staffing forms it is not clear what actually transpired during these events and what facts were considered that resulted in the outcome decision. FSFN notes at minimum should reflect the facts and discussion that occurred during these events.

**Initiatives to be Considered**

1. **Continue prior initiatives** including completing qualitative ongoing assessments throughout the life of the case and implementation of Family Centered Practice which is heavily focused on improving family assessment and engagement.

2. **Be creative in supervisory functions.**
   - Read FSFN chronological notes to determine current case activity.
   - Supervisors go on field visits with case managers periodically.
   - Verify what case managers are discussing with supervisors
   - Supervisors and Assistant Program Directors can mentor case managers by documenting activities themselves (i.e. - staffings or court hearings they may have attended) or reviewing documentation of activities where they were jointly involved.
   - Peer reviews by supervisors.

3. **Peer review validation** by Eckerd QA staff to ensure inter-rater reliability.