The exit conference with the Safe Children Coalition for the 4th quarter side by side QA review was held on June 2, 2010. Representatives from the lead agency, Sarasota YMCA, their three case management organizations, and Department of Children and Families Quality Management participated. The review period was from July 1, 2009 through March 31, 2010. Eight side by side cases were reviewed. Six of these children were in out of home (OHC) care throughout the review period. The remaining two children were initially in OHC but were reunified with their fathers. The children who remained in OHC at the end of the review period had the following permanency goals: adoption – 2; APPLA – 1; and reunification – 3. Two of the three children with the goal of reunification were reunified the month following the end of the review period.

There was one RFA generated in this review. The case involved an infant who had been removed from her parents’ custody due to verified physical injury sustained during alleged domestic violence incidents. Although the infant remained in out of home care, there were concerns as to the safety and emerging risk for a four-year-old sibling, who remained in the home with the mother and the mother’s paramour (the father of the infant). At the time the case manager learned that the sibling had returned to her mother’s home (after being in the care of her biological father), appropriate procedures were followed to address the child’s safety and assess whether dependency proceedings were needed. As per the Ludwig protocol, a staffing was held December 7, 2009. The Office of the Attorney General (OAG) attorney determined that there was no probable cause to shelter the sibling and recommended that: 1) the case manager obtain an opinion from mother’s treating psychiatrist as to whether the sibling was safe in her care and, 2) the case management agency was to offer the mother voluntary protective services. The mother was actively completing case plan tasks and working toward reunification with the focus child and agreed to voluntary protective services supervision of the sibling. However, her attorney reportedly advised the mother against signing the voluntary services case plan, which in effect nullified the services. At that point, case documentation does not support that case management re-staffed the case with the OAG to explore the possibility for a non-shelter petition to provide court-ordered in-home services for the sibling. Minimally, the OAG could have consulted with the mother’s attorney and explained the ramifications (for the child’s safety) of advising the mother against signing the voluntary plan.

<table>
<thead>
<tr>
<th>Outcomes</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>88%</td>
<td>75%</td>
<td>63%</td>
<td>85%</td>
</tr>
<tr>
<td>Permanency</td>
<td>71%</td>
<td>73%</td>
<td>55%</td>
<td>82%</td>
</tr>
<tr>
<td>Well-Being</td>
<td>82%</td>
<td>66%</td>
<td>60%</td>
<td>77%</td>
</tr>
<tr>
<td>Overall</td>
<td>79%</td>
<td>69%</td>
<td>59%</td>
<td>78%</td>
</tr>
</tbody>
</table>
The Case Management Organization (Youth and Family Services) held a staffing on May 21, 2010 to address the RFA. The OAG indicated that in cases involving egregious abuse court action pertaining to other siblings requires a nexus between the target child and the other sibling. The OAG stated no clear nexus had been established at this juncture with the four year old sibling. She was in the mother’s custody at the time of the removal of the infant. A full skeletal survey was completed at that time which indicated there had been no injuries to that child. Staffing documentation indicated the case manager was closely monitoring the mother’s participation in services and would contact the OAG immediately should any changes occur in that regard. Documentation also indicated the mother’s attorney believed the four year old sibling was being seen regularly by the case manager and still maintained there was no need for the mother to sign a VPS agreement. Unsupervised visitation in the home with the target child, the parents and the four year old sibling was initiated in April 2010, after the period under review. Overnight visits have been initiated recently as well. The case management organization reported that the case manager has visited the home frequently during the unsupervised visits and that the sibling has also been seen in the home during these visits. No concerns pertaining to the care of the children or the parents’ interactions with the children have been documented.

**Strengths**

- **There were no instances of re-abuse, re-neglect during the period under review.** None of the children in the review sample experienced re-abuse/neglect in the review period. One child was a victim of child on child sexual abuse in the period under review. He was participating in sexual abuse treatment at the time of the incident due to past reports of child on child and a history of sexual abuse prior to removal. A safety plan was developed in response to the report, incorporating recommendations from the child’s sexual abuse therapist.

- **Placement Stability – each child in the review sample experienced no more than two placement settings in the period under review**

  Every child in the side-by-side sample was in out of home care (OHC) for part or all of the review period and all but one child was in the same out of home care placement during the entire review period. The teen with the goal of APPLA had two placement settings, including the YMCA shelter and a foster home, as well as a brief run away episode in the review period. A Multidisciplinary Team (MDT) Staffing was held prior to placement in the foster home. There was evidence that placement and case management staff discussed the rules of the foster home with the teen prior to placement in an effort to facilitate the teen’s transition into the home.

- **Evidence of support to stabilize non-relative and relative placements when necessary**

  There was evidence of funding being requested to stabilize the relative placement of a child whose relative caregiver was unable to work for a time and fell behind with rent. In another case, a retired non-relative couple accepted the focus child and two siblings into their home. When the financial burden began to overwhelm the couple, the case manager obtained funding to help stabilize the placement.
There were current case plans in seven of the eight side-by-side cases. Permanency goals were appropriate in each applicable case. The case which did not have a current case plan involved a child who had been reunified with her father on August 3, 2009 and the case plan with a goal of maintain and strengthen expired December 12, 2009. There was no evidence an updated case plan was filed prior to February 2, 2010, when supervision was terminated.

Appropriate services were provided to address the child’s mental/behavioral health needs in each applicable case. The five children in the sample, assessed as needing mental health services, received ongoing therapy. The teen with the goal of APPLA was in treatment to address past sexual abuse and her fragmented relationship with her mother who blamed her for reporting the abuse and the resulting disintegration of the family. The mother was subsequently reunified with the siblings, but due to her anger toward the focus child, she did not want her back in the home. At the end of the review period it appeared that through individual counseling both mother and daughter had begun to work through their anger and that they may be able to begin to mend their relationship. Other children were in counseling for sexual abuse, to address loss issues or the affects of past abuse/neglect.

Family engagement
Outcomes in the area of engaging mothers and fathers in this review sample increased significantly over the previous side by side review. There was clear documentation in most cases of efforts to support parents’ engagement with services through ongoing contact with the parent and at times addressing the barriers that prevented the parent from completing required tasks. There were also efforts to engage non offending fathers in the process of gaining custody of their child. The case manager had frequent contact with a father in New York and ICPC in that state to ensure the focus child could be reunified with his father and twin brothers, already in the father’s custody. While overall performance in the area of family engagement improved, once the case manager determined one parent or the other was on track to be reunified with the child, it appears efforts to engage the other parent faltered.

Timely reunifications
One child was reunified with her father eight months after she had been sheltered from the mother and him. The second child was reunified with her father when he was discharged from the military. She had been in out of home care 14 months at the time of reunification. Two other children were reunified in April 2010, the month after the review period ended. Each of those children was reunified after 12 months in out of home care.

Exceptional case management/service provision was evident regarding the teen with a goal of APPLA
Documentation indicated appropriate Independent Living (IL) staffings were held, the Daniel Memorial Assessment was completed, there was an education/career path and a normalcy plan had been developed. It was evident the case manager spent a great deal of time building a solid relationship with the teen at restaurants, doctor and dental appointments, transporting the teen to extracurricular activities, sibling visits or therapy. They discussed case goals, weighing adoption as opposed to APPLA, Independent Living services and progress toward achieving independence. The case
manager advocated for the teen, ensured her needs were met and that the teen had an opportunity to provide input before any decisions were made concerning her future. The teen was assessed for Subsidized Independent Living (SIL) services and once SIL was initiated the case manager visited the teen a minimum of twice weekly to assist with the transition.

- **Evidence of critical thinking**
  In one case where the family had moved to Florida from Texas just a few weeks before the children were sheltered in Florida, the case manager obtained the prior abuse history from Texas which revealed a history of domestic violence in that state. This information was included in the updated family assessment and the case plan was also amended to include domestic violence tasks for the parents.

- **ICWA**
  There was an increase in compliance with this requirement since the prior review; from 0% to 63%.

**Opportunities for Improvement**

- **Six month family assessments were not always completed timely or at critical junctures in the case and lacked specific, detailed, current case information.**
  Family assessments in half of the cases were rated as being qualitative; meeting the basic requirements of the standard. Case managers are required to rate the various components/sections of the family assessment as a strength or a need. The summary statements need to be detailed enough to thoroughly support the rating. Instead of vague, global statements that don’t explain why something is a strength or need, each summary statement requires specific information to support the rating. Updated assessments must contain current information and are required to be completed at critical junctures in the case such as reunification, when there is a new report of abuse/neglect or there are changes in family factors. In this review, the family assessments were not updated when two children were reunified with their fathers in the review period.

- **Lack of qualitative supervisory oversight and ensuring follow-up on recommendations**
  Supervisory reviews were completed monthly in most cases and the reviewers noted that the supervisory discussion guide was used by most supervisors; however, only three of the cases were identified as having qualitative supervisory guidance throughout the review period. Supervisory reviews not considered to be qualitative repeated the same generic recommendations month to month, involving basic tasks that are required such as “see the child every 30 days” and “assess safety ongoing”. Recommendations or action steps were not case specific or there were no timeframes for completion assigned to the action steps. It was noted that in some of the cases having repetitious, generic action steps the case was on track for achieving the permanency goal (this aspect of the case not being impacted by poor guidance); however, other required areas such as ensuring the child received needed developmental screenings, obtaining copies of assessments, dental or physical records were not addressed by the supervisor in the action steps for these same cases. In one particular case, the supervisory reviews did not provide appropriate
guidance to update the family assessment at the time of reunification and case closure. In this case supervisory guidance also did not include the development of a safety plan at case closure to address the need for supervised visitation with the mother to continue after closure due to her continued substance abuse. The expired case plan was also not addressed by the supervisor in this case. In some instances supervisory reviews were described as choppy and disjointed with conflicting information within the same supervisory review. Qualitative supervisory reviews were noted to be thorough, with evidence of a quality discussion between supervisor and case manager. There were case specific directives pertaining to safety, permanency and well being with due dates as well as ongoing follow up each month on action steps from the previous month. There was also a summary of current information provided at the close of each supervisory review.

- **Communication with service providers to determine the effectiveness of services being provided to case participants**
  There was evidence of adequate communication with service providers in half of the cases. In cases that did not meet this standard, there was no documented communication with the children’s mental health therapists as to the progress being made before or after reunification (in one case). There was also a lack of ongoing communication with the providers of speech and occupational therapy to another child. The case files also did not contain progress reports for the services that were provided to the children. The same cases lacked appropriate communication with providers of parenting training and substance abuse treatment for parents in order to determine the effectiveness of treatment. In another case, even though the child was reunified with the father, the mother continued to work on her court ordered tasks, but there was no documentation of communication with her service providers or progress reports in the case file.

- **The frequency of service worker’s visits with all case participants**
  Outcomes in this area were impacted by a lack of documentation of quarterly unannounced visits with the child or not seeing parents monthly when there was a reunification goal. In one case the supervisory directives indicated the child was to be seen biweekly but this did not occur consistently. In another case the case manager did not see the father every month after the child was reunified with him.

- **The quality of the service worker’s visits with case participants**
  Documentation indicated that in half the cases the case managers’ visits with case participants were qualitative. The two cases involving reunification with fathers were not rated as having qualitative contact with case participants. In one case there was no documentation of father/child interaction after reunification nor was there discussion of the father’s parenting strengths/needs or the child’s progress in her speech and occupational therapies as well as in home play therapy. In the second case there was no documentation of discussions with the father about the child’s development after experiencing drug withdrawal symptoms at birth. In other cases there was or no documentation of one on one interaction with the child or no follow-up regarding the child’s developmental assessment. Documentation in some cases lacked detail as to what issues were discussed at the visit and the child was not seen alone each month.
Continuing Improvement Initiatives

- While the supervisory discussion guide has been deployed throughout the system of care, overall it does not appear to have impacted the quality of supervisory oversight. It is recommended that the lead agency ensure Case Management Organizations develop a process for enhanced oversight of supervisors to ensure all case documentation is reviewed on a regular basis; supervisory recommendations are case specific, address safety, permanency and well being and address the status of action steps from the previous review.

- Although six month family assessments are being completed in FSFN in many cases, continued efforts are needed to ensure they contain an accurate assessment of immediate and emerging safety concerns pertaining to the family and that updated information is provided to support the safety decision. Prior to approval of the assessment, supervisors need to ensure all information provided is thorough and detailed. In addition, family assessments need to be updated every six months or at critical junctures in the case, such as reunification, when new reports of abuse and/or neglect are received or there are changes in family factors.

Thank You!