

**PROTECTING PHILADELPHIA'S CHILDREN
THE CALL TO ACTION**

**Presented to
Mayor John F. Street**

Submitted by
The Philadelphia Child Welfare Review Panel

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The Panel also wishes to thank the many individuals who participated in the various public forums, focus groups, town halls, and individual interviews. Through these various methods, the Panel spoke with hundreds of individuals and received significant insight about the strengths and weaknesses of DHS programs, operations, and staff. Many of our recommendations are founded upon the data gathered through these various public consultation activities.

The Panel also appreciates the assistance provided by the members of the Resource Committee representing a broad spectrum of public and private agencies that serve Philadelphia's children and families. In the course of conducting our work the Panel interviewed numerous current and former DHS senior staff, sometimes individually sometimes in groups. We also received extensive and helpful comments from the courts and the legal community, private agency executives, managers, line staff, and their clients. We are appreciative of their openness and their candor.

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THE CALL TO ACTION

In an agency as large and complex as Philadelphia's Department of Human Services (DHS), any number of recommendations could be made to improve operations. No organization can successfully manage making innumerable changes simultaneously. The Philadelphia Child Welfare Review Panel (Panel) has prioritized its recommendations to identify those that the Panel strongly feels must be addressed in the immediate future, as well as those that are important but can be addressed over a longer period of time. We provide timelines to convey our sense of urgency that these steps must be undertaken so that other reforms can follow. We recognize that DHS will need to coordinate this plan with other changes that are in process. The Panel has focused its recommendations primarily on issues of child safety because that should be the core of DHS' mission. However, DHS also must address issues regarding child permanency and child well-being after the initial focus on safety.¹

The Panel has organized its recommendations along four key dimensions that are critical to bringing lasting reform to DHS. These dimensions are:

- Mission and values;
- Practice;
- Outcomes and accountability; and
- Leadership.

We chose these four topics because they represent core DHS areas, practice, and operations that must be improved immediately, and because they encompass all of the specific recommendations contained in this report. While there are other areas in which DHS has room for improvement, the Panel concurs that improving these areas are the first and most important steps that DHS must undertake. Because we believe that DHS must address its mission and values first, the recommendations addressing that area are presented first. In the body of the report, we have addressed our charge from Mayor John F. Street by first discussing the fatality reviews and the practice issues and recommendations that developed from them before discussing issues related to mission and values, outcomes and accountability, or leadership.

The recommendations contained within this report are *imperative* to improving the safety of children in Philadelphia. The failure of DHS and the larger Philadelphia community to act upon these recommendations with urgency will leave Philadelphia's most vulnerable children at risk of continued abuse and neglect.

¹ The Panel's analysis of the Philadelphia child welfare system focused primarily on the Hotline practices, investigation and intake processes, and the Services to Children in their Own Homes (SCOH) program. Foster care, adoption, and juvenile justice were not rigorously analyzed as part of the Panel's efforts.

PHASE ONE

The Phase One recommendations must be addressed within the next year. They should be dealt with immediately and most can be completed within the next 6 months.

Time frame: 0–1 year

1. Mission and Values

a. DHS must develop a mission statement and core values that are centered on child safety. The DHS Commissioner must lead this effort, and actively engage the DHS stakeholder community, including clients, community members and organizations, provider agencies, DHS staff, the courts, and other interested parties.
Time Frame: No later than December 31, 2007.

b. DHS core values must embody—at a minimum—the following principles:

- i. Creating a culture of respect, compassion and professionalism;
- ii. Enhancing communication with, and responsiveness to, stakeholders;
- iii. Instilling a greater sense of urgency among DHS staff and providers;
- iv. Providing services that are readily accessible;
- v. Fostering a culture of collaboration;
- vi. Providing culturally-competent services; and
- vii. Creating a transparent agency.

Time Frame: No later than December 31, 2007.

2. Practice

a. DHS must implement and use an appropriate Safety Assessment tool.

- i. DHS must implement an adequate evidence-based safety assessment tool.

Time frame: No later than June 30, 2007.

- ii. 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.

Time frame: No later than September 30, 2007.

b. DHS must revise its policies around face-to-face contacts with children.

- i. 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 Hotline. This face-to-face contact must be made regardless of whether the Hotline classifies the case as General Protective Services (GPS) or Child Protective Services (CPS).

Time frame: No later than June 30, 2007.

- ii. 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.²

Time frame: No later than June 30, 2007.

- c. **DHS must establish a local office presence in at least one geographic location deemed highly at-risk.** An at-risk geographic location is defined as a ZIP code where the proportion of the population that is part of an active CYD case is significantly above the citywide average and that has more than 400 open DHS cases.

Time frame: No later than May 31, 2008.

- d. **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.

Time frame: No later than August 31, 2007.

- e. **DHS must ensure that ongoing team case conferencing occurs routinely every three months,** for cases involving a child age 5 years and 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.

Time frame: No later than November 30, 2007.

- f. **DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and the worker level.**

Time frame: Roles and responsibilities must be clarified by August 31, 2007.

² As part of the reauthorization of the Promoting Safe and Stable Families Program that was signed into law on September 28, 2006, and becomes effective October 1, 2007, the title IV-B plan requirements have been changed to require states to “Describe standards for the content and frequency of caseworker visits for children in foster care, which at a minimum must be monthly and focus on case planning and service delivery.” The relevant Information Memorandum, which describes the requirements in greater detail as well as explaining the funding streams set aside to increase caseworker visits to foster kids, may be found at: http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/im0605.htm.

3. Outcomes and Accountability

a. DHS must assume greater accountability for its performance.

- i. 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 this report.

Time Frame: Strategy must be developed no later than November 30, 2007; report card must be delivered no later than May 31, 2008.

- ii. 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.

Time Frame: Strategy must be developed no later than November 30, 2007; tracking must begin no later than May 31, 2008.

b. DHS must enhance oversight of contracted agencies.

- i. 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 this report.

Time Frame: Measures and data sources to be identified no later than August 31, 2007; the report card must be delivered no later than May 31, 2008.

- ii. 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.

Time Frame: No later than June 30, 2007.

- c. **DHS must establish a Commissioner's Action Line (CAL).** The CAL will exist outside the formal DHS program offices, and will enable clients and other stakeholders to communicate issues related primarily to child safety directly to the office of the Commissioner.

Time Frame: No later than August 31, 2007.

4. Leadership

- a. **DHS must establish a mechanism and process to establish ongoing community oversight.** At a minimum, the City must establish a Community Oversight Board. The Community Oversight Board must be an external body that is appointed by, and responsible to, the Mayor and the City Council. The Board should be comprised of citizens and child welfare experts. The DHS Commissioner also must be an actively-participating member of the Board. The Board must have access to all data available

to DHS, and it must assess progress and issue annual reports to the public which, at a minimum, inform the community as to the progress DHS is making in the implementation of this report's recommendations.

The Community Oversight Board must be appointed no later than June 30, 2007.

- b. DHS must ensure ongoing community participation and input into the improvements undertaken at 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. In seeking out community support and input, DHS must make a concerted effort to leverage the work that other community agencies are already doing.

Time Frame: A plan for obtaining ongoing community support and input must be in place by July 31, 2007.

PHASE TWO

The Phase Two recommendations are important, but the Panel recognizes they may require some additional time to implement. They include three recommendations to the Commonwealth of Pennsylvania Department of Public Welfare (DPW). As soon as the urgent changes required in the Phase One recommendations have been addressed, DHS and its partners must begin focusing on these recommendations as well. Some may take 2 to 3 years to achieve completely.

Time Frame: 6 months–3 years

1. Mission and Values

- a. DHS must align prevention programs and resources with the mission and values developed in Phase One, and also with the core principle of ensuring child safety.**

Time frame: Analysis to begin no later than November 30, 2007, with alignment and necessary revisions to prevention programs and resources to occur no later than November 30, 2008.

- b. DHS must align more effectively in-home service programs and their utilization with the mission and values of DHS and with child safety.**

Time frame: Analysis to begin no later than July 31, 2007, with alignment and necessary revisions to the Services to Children in their Own Homes (SCOH) program to occur no later than March 31, 2008.

2. Practice

- a. **DHS must develop a more 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.** The model should focus not only on front-end practices, but on the entire continuum of care for children and families who come into contact with DHS. The following elements should be included in the practice model:

- i. DHS must move toward an evidence-based practice model, and take active steps to determine the effectiveness of its practices with an evaluation process that is open and informs good practice. When practices do not work, they should be replaced with a more appropriate and effective practice.

Time frame: The evidence-based practice model must be developed no later than May 31, 2008.

- ii. DHS must expand the use of team decision making to all children and utilize specialized resources in the case-planning process.
1. 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 the parents are uncooperative.
 2. 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.
 3. DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed.³
 4. 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.

³ Also as part of the reauthorization of the Promoting Safe and Stable Families Program, the title IV-B plan requirements have been changed to require states to "Describe how physicians or other appropriate medical professionals are consulted and involved in assessing the health and well-being of foster children and for determining appropriate medical treatment." This and other requirements may be found at http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/im0605.htm

5. 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.
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.

Time frame: These enhancements must be implemented no later than December 31, 2008.

- iii. DHS must enhance the frequency of face-to-face contacts with children of all ages.

1. Since face-to-face contacts are one of 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 contacts may be warranted, depending on the specific safety and risk factors in each case.

Time frame: Expanded monthly contacts must be implemented no later than May 31, 2008.

- iv. DHS must clarify the role of supervisors.

1. DHS needs to reevaluate and recraft the role of supervisors to support the DHS practice model being implemented and the professional development of social workers.

Time frame: This must be done no later than March 31, 2008

- v. DHS must streamline its paperwork and records management practices.

1. DHS must consolidate and reduce the number of forms that workers must complete. As a starting point, DHS should study and document the utility of the Family Assessment Form (FAF) and consider whether it can be consolidated into a unified assessment process that should result in a consolidated Family Service Plan (FSP) that is electronically based and customizable. A family should have only one FSP that is used by DHS and any private agency that is providing services to the family.

Time frame: This must be completed no later than August 31, 2008.

vi. DHS must enhance the fatality review process.

1. DHS must ensure that the child fatality review is multidisciplinary, and that there is a mechanism for implementing its recommendations.

Time frame: The revised fatality review process must be implemented no later than December 31, 2007.

3. Outcomes and Accountability

- a. **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.

Time frame: Beginning no later than June 1, 2008, following the development of the first DHS annual report card.

- b. **DHS must link its performance and the performance of its contracted providers to outcomes of accountability, including financial incentives.**

Time frame: Implemented no later than June 1, 2008.

4. Leadership

- a. **DHS must continue to expand its emphasis on making DHS a more transparent agency.** We applaud the efforts that DHS has made to move toward more open and transparent operations. We urge the current and future Administration to continue and accelerate these efforts. The Mayor has set a standard for transparency with the Panel, which DHS should strive to exceed.

Time frame: A plan to enhance transparency of the Department shall be developed no later than June 30, 2008, with implementation beginning no later than August 1, 2008.

- b. **DHS must take positive steps to enhance the healthiness of its infrastructure and staff morale.** Trust between DHS management and staff is vital, and DHS must support more consistent and open communication with its staff, and specifically with regard to providing clearer performance expectations for all staff. DHS also must establish performance expectations for staff that incorporate DHS' new mission, values, and practice changes—recommendations contained elsewhere in this report. Consideration also should be given to providing additional support to DHS social workers who deal with life and death situations regularly, and face an extremely stressful working environment. Counseling and other appropriate emotional and mental health supports would help DHS social workers to better cope with the emotional and stressful environment in which they work. Finally, DHS must take active steps to ensure the appropriate relationship with the labor union.

Time frame: These changes must be initiated no later than March 31, 2008.

- c. **DHS must enhance its ability to proactively and transparently manage crisis, including strengthening processes related to child death reviews and increasing public access to information.**

Time frame: Changes in crisis management must be implemented no later than March 31, 2008.

STATE RECOMMENDATIONS

The Department of Human Services is operated in partnership with DPW. DPW's Office of Children, Youth and Families (OCYF) assists the local department through the development of policy, funding, monitoring and technical assistance. It is OCYF's responsibility to assure that DHS achieves the objectives of safety and permanence for children. In the course of the Panel's work, several challenges were identified that require state action: confidentiality, GPS/CPS classification system, assessment protocols, state capacity, and monitoring.

1. **Confidentiality:** To promote transparency and public confidence, DPW, working with the local jurisdictions and the legislature, should modify the state's restrictive confidentiality provisions to bring them into alignment with federal law, which allows public disclosure of information when a child dies or is seriously injured as a result of maltreatment.
2. **GPS/CPS classification system:** Pennsylvania's unique way of classifying reports of possible maltreatment presents challenges as it may understate the urgency and risk levels for children reported for neglect. DPW should evaluate the substance and implementation of this policy to determine its utility in practice and the extent to which it places children at unnecessary risk. DPW should implement changes that will reduce risk to children.
3. **Assessment protocols:** DPW, in collaboration with local jurisdictions, should review their risk assessment and family assessment protocols in conjunction with the safety assessment protocol to assure they are evidence-based. In addition, careful guidance should be provided in order to facilitate the integration and streamlining of these protocols and their integration into the service planning process to make them more effective.
4. **State Capacity:** DPW should increase its capacity to provide policy direction, ongoing monitoring, and technical assistance to the City of Philadelphia and other local jurisdictions. This is necessary to assure that the agencies are increasing their capacity to advance the well-being of children through protective and permanency services.
5. **Monitoring Progress:** DPW should continue to monitor the progress and provide technical support to DHS in creating a more effective child welfare and child protective service program.

ACTION TO DATE

The Panel recognizes that DHS and DPW have been working actively to assess and respond to some of the systemic issues that have contributed to the fatalities. We in no way want to convey to our readers that the agencies have been waiting for our report to act.

Among the actions that DHS has taken to initiate the change process are the following examples:

- Developed an assessment tool and conducted safety visits of all children receiving SCOH services (2,656 families and 6,728 children) which resulted in the identification and placement of children who were found to be unsafe;
- Conducted a qualitative review of the SCOH agencies in which fatalities occurred, and the DHS units in which a fatality occurred, using the Child and Family Service Review standards and methods;
- Initiated review of all SCOH providers;
- Reviewed the status of all of the recommendations of the multi-disciplinary child fatality reviews for the period 2002-2006 and subsequently placed the MDT in the quality assurance unit to facilitate implementation of recommendations; and
- Terminated two service providers who did not meet minimum standards, closed intake to four others, and has action pending on another agency.
- Hired two new nurses to provide medical consultation to the staff.
- Secured a senior manager to coordinate the front-end reform efforts.

DPW has also worked to facilitate change by such activities as:

- Conducting a review of the fatalities and providing feedback to the agency on the practice and policy issues involved;
- Establishing a plan of corrective action with DHS;
- Finalizing a safety assessment tool to be used in the intake and investigation process;
- Providing training to DHS staff on the implementation of the safety assessment Protocol; and
- Conducting a special review of 80 DHS cases to assess the quality of practice.

These efforts, as well as other ongoing initiatives, will contribute to the needed changes.

CHAPTER 1. CHARGE AND APPROACH

The death of a child is always tragic. When a child dies from intentional abuse, the tragedy is an outrage against humanity. When a child dies while under the protective supervision of the government, outrage should shake the very foundation of our community. Sadly, that outrage is too often buried in governmental bureaucracy.

In the fall of 2006, *The Philadelphia Inquirer* reported on a series¹ of child fatalities involving families receiving services from the Department of Human Services (DHS), the agency charged with the primary responsibility for protecting children identified as being at risk of abuse and neglect. The news stories described egregious conditions under which some children died, and decried the lack of progress on earlier reform proposals as well as the lack of public accountability.

Mayor John F. Street responded by changing the leadership of the DHS and by appointing the Child Welfare Review Panel (Panel), composed of nine individuals who represent key stakeholders and/or are recognized nationally for their knowledge and expertise about child welfare. The Executive Order² creating the Panel charged the group with:

- **Reviewing all child deaths** by conducting a systematic case record review of all child abuse and neglect fatalities since the beginning of 2002³ in order to identify areas for corrective action.
- **Auditing the child safety assessment** being conducted by DHS as part of its Action Plan. This required the panel to: review the DHS safety assessment process; monitor the progress of the assessments and changes needed in case plans; and assure that the records were updated to reflect the appropriate service plans.
- **Recommending reforms** by assisting in the development of permanent reforms to DHS policies and practices. The panel was directed to:
 - Identify patterns of conduct and practice among caseworkers, contractors, social workers, and administrators that can be improved to protect the safety of children;
 - Review and evaluate DHS' procedures for investigating and substantiating child protective services cases, and adopt and implement service plans to identify areas that can be improved to protect the safety and lives of children; and
 - Develop recommendations to improve all the other components of the child welfare system including training, quality assurance, contract and case management, provision of direct services, case documentation, supervision of employees, and administrative oversight.

¹ The series of articles can be viewed at www.philly.com/inquirer.

² City of Philadelphia, Office of the Mayor Executive Order No __.06. *Child Welfare Review Panel and The Department of Human Services. November 2, 2006. See Appendix A.*

³ In actuality, the Panel reviewed child fatalities back to July 2001.

The Panel was designed to be “independent” and “driven solely by considerations of the safety and well-being of Philadelphia’s children.” It was also directed to be open and transparent and to seek broad community and professional input via focus groups and individual interviews.

The Panel had its first meeting with the Mayor in November 2006, and has convened monthly since that time. To support the Panel’s work a Community Resource Committee was established to provide input into the process and to provide linkage to key stakeholders.⁴ The Panel focused its work on child safety and the activities related to the Hotline, investigations, and early decision making for children.

The Panel’s review process involved the collection of quantitative data, qualitative data, and a review of relevant documents.⁵ In addition we have met with, interviewed, surveyed, and listened to a broad range of stakeholders in our community. In total, more than 800 individuals were consulted as part of this process. This has included DHS workers (line staff, supervisors, leadership, and union officials), contract agency leadership and staff, parents, teens aging out of the system, lawyers, judges, and community representatives. Many of these individuals provided guidance, insight, suggestions, and recommendations for our work, including several groups that provided thoughtful written comments and recommendations. We carefully reviewed and considered this information and it helped to inform the recommendations included in this report.

We learned that, over the last 20 years, DHS has been the subject of at least 22 reports, studies, and litigation that examined the operations of DHS and its capacity to protect children. The Panel reviewed these materials to understand the nature and duration of the problems confronting DHS and the progress that has been made addressing critical issues.

Throughout the reports there were themes that persist and remain unresolved today. The **lack of clarity of mission** and purpose of the agency is documented at the agency level and in key components such as the Hotline and the SCOH program. The **mechanisms for accountability** are weak at the direct service, managerial, and inter-organizational levels. Workers and supervisors have not been held to a clear standard of practice. Despite recommendations for reforms, managers seem unable to achieve the desired changes. Additionally, the relationship among contract agencies and DHS is characterized by a process orientation which has not required results for children and families. The need for **practice change** is documented with concern expressed for the Hotline triage process, investigations, risk and safety assessments, and the service planning process.

These reports and the results of our data collection, including extensive community consultation, also all point to a pervasive theme of **randomness** in DHS practice. The wide variation in practice—from front line worker to senior managers—suggests that practice is what the individual worker perceives it to be. The individual worker’s education, empathy, and level of competence, for all practical purposes, control performance.

⁴ The members of the Community Resource Committee are identified in appendix K.

⁵ The Panel was supported in this work by Walter R. McDonald & Associates, Inc. which provided technical, substantive and logistical support through a contract provided by the City of Philadelphia.

The absence of appropriate supervisory and managerial capacity has allowed such random responses to flourish. The lack of clarity about the practice approach has resulted in diffused training and supervision, all of which undermines the ability to develop and maintain a highly skilled workforce.

The Panel worked to extract findings from the various sources of data. We determined that reiterating in detail problem areas that have previously been exposed and continuing to focus on the negatives in the system would provide little guidance for improvement. Our emphasis would be in identifying strengths in the system and in deciphering what the impediments have been that have kept DHS from moving forward to adopt the recommendations or otherwise address problems that have been identified.

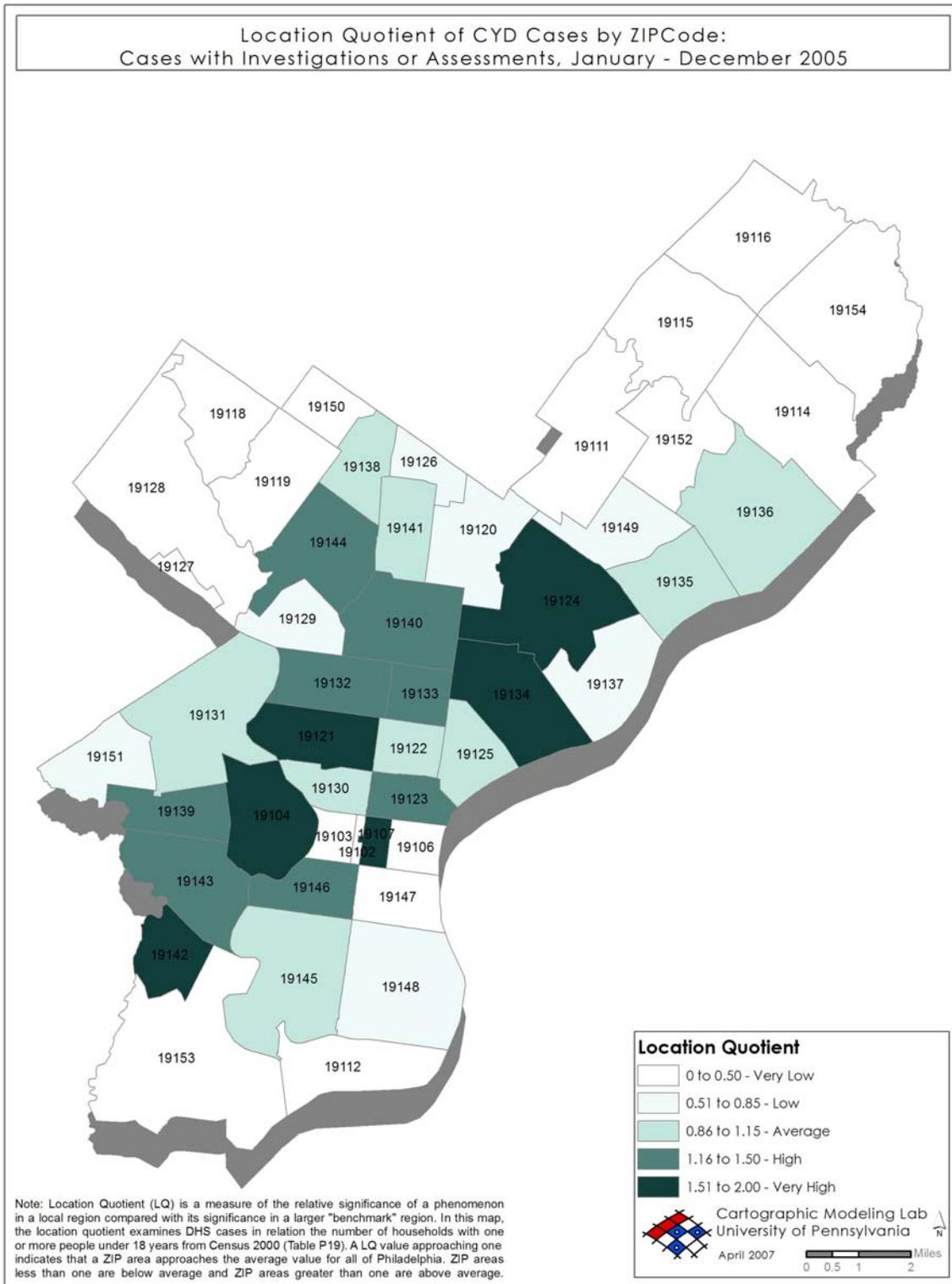
It is important to note that, throughout the community consultation, we heard repeatedly about the effectiveness of many DHS workers and a recognition of the stressful, frequently unsafe, and conflictual environments that they routinely encounter. A broad cross-section of the community praised DHS workers. It is clear that the greatest strength DHS has is its workforce. The good work that is done on a daily basis by most of its employees must be supported. It cannot be overshadowed by workers who do not or cannot perform in a manner that promotes the safety of children in their care. As an organization, DHS has not served its workforce nor its clients and community well by failing to build an appropriate infrastructure. Accountability cannot exist in such an environment. Fundamental to improvement is building an accountability structure that will both enhance and reward good performance, and correct or eliminate poor performance.

To a large extent the recent history of this agency has been crisis, analysis, report, and inadequate change. DHS is what the business literature would call a “stressed organization,” which is characterized as bureaucratic, hierarchical, and undemocratic. This extends not only to its internal organization (how many times have we heard the importance in DHS of the “chain of command”), but it extends to its relationships with its provider agencies, and most significantly to the community it serves. There is a total lack of community consultation or interaction.

Many of the problems DHS has encountered are similar to those in other major cities in the United States. It would be foolhardy to suggest that any system has been completely successful and effective in confronting and solving the multiplicity of problems implicit in child welfare work. However, in the Panel’s view, Philadelphia has lagged behind other major child welfare systems. This is particularly relevant because DHS is better financed and resourced than most, if not all, other major cities. One strategy that has been used successfully in other cities is developing a community orientation to service delivery. To this end the Panel identified areas of the City where the concentration of DHS cases relative to the population is high—indicating greater need. Those areas are identified in exhibit 1.1.

The challenge before DHS, the City of Philadelphia, and the citizens of Philadelphia is how to move from problem analysis to meaningful reform. We believe the recommendations we have set forth in the Call to Action can begin this process.

Exhibit 1.1



The Panel spent a good deal of time trying to think through how to leverage change using this report. The challenge is complicated by the fact that the report is being issued on the cusp of a political transition. This means that the commitment to systemic change within DHS must be not owned only by the current administration, but must be a priority for a new administration. The safety and well being of the City's children are dependent on it.

Lasting reforms will require leadership, a clear reform agenda, accountability and sustained political and community commitment. If the City of Philadelphia loses this opportunity to make changes, the belief in the ability of DHS to serve children and families will be eroded; the cycle of crisis, study and inaction will continue, and more children's lives will be lost.

CHAPTER 2. CHILD FATALITY REVIEW AND DHS PRACTICE

PURPOSE OF THE REVIEW

The Panel was asked to conduct a systematic case record review of fatalities of children in Philadelphia who were, or whose siblings were, receiving services from the Department of Human Services (DHS) during the period July 31, 2001 through August 4, 2006, in order to identify policy and practice changes that would reduce the recurrence of preventable fatalities.⁶

Our panel reviewed cases where children were beaten, strangled, starved, drowned—unspeakable acts towards society’s most vulnerable. We also reviewed cases where children died from natural causes, from Sudden Unexplained Infant Death, from unsafe sleeping practices, and from accidents. Although approximately one half of the deaths resulted from intentional abuse, these and most non-intentional deaths were potentially preventable.

The most disturbing aspect of the review was the sense that had the thorough assessment of factors related to the child’s circumstances been done while the child was alive, a number of these fatalities could have been prevented.

Our review also showed that a shocking number of the parents had been themselves children in the DHS system—more than half. As former victims of child abuse, they often were dealing with drug abuse, mental health problems, and domestic violence. This strongly suggests that the agency did not recognize the risk inherent in having been a victim of maltreatment. In addition, many of the parents who should have been protected by the state when they were children were not well served. The inattention to their traumatic experiences has resulted in predictable, intergenerational, devastating, dysfunctional behavior.

REVIEW PROCESS

From 2001 through August 2006, 52 cases underwent a DHS fatality review—44 because they met the State criteria and 8 by special request. **These 52 cases were the subject of this panel’s review.** The panel had access to most of the DHS case records and all of the agency’s fatality review reports. These records were read by panel members or by the panel’s consultant team. Five of these 52 DHS case records were not available for our review. In addition to reading through DHS case files, all panel members read the 52 DHS death review summaries completed by the state-mandated DHS review team.

The reading and synthesis of these materials was challenging. The case records were often voluminous, disorganized, internally inconsistent and incomplete. If the case involved a fatality of a child who was unknown to DHS at the time of death (usually born after a case had been closed), effectively there was no record on that particular child. Despite our careful attention to

⁶ State policy requires a Child Death Review of all reports of child abuse involving a death if the child’s family was open/active with the county agency or had been open/active with the county agency within 16 months prior to the death, whether or not the investigation resulted in an indicated determination. Other deaths that do not meet these criteria can be reviewed at the request of county social work officials.

the records, it was difficult to decipher all the policy and practice issues pertaining to individual deaths. Our work involved paper reviews only; we did not interview workers or supervisors and did not search FACTS to elicit additional case information. A more detailed report is contained in appendix F of this report.

On the other hand, the DHS internal fatality review process for child deaths was considerably more organized, comprehensive and coherent. Each of these fatality reviews has a section with recommendations for change or improvement.

FINDINGS

The following exhibit 2.1 presents the characteristics of the 52 children who died between 2001 and 2006 and were the subject of the Panel’s review.

Exhibit 2.1 Characteristics of Children who died (n=52)

<i>Cause of death</i>	
• Abuse	20
• Unsafe sleeping	12
• Sudden unexplained infant death	2
• Natural causes	6
• Unintentional accidents	4
• Undetermined (7 showed signs of injury consistent with abuse)	8
<i>Age of children who died</i>	
• Under 3 months	13
• 3 months to 1 year	23
• Toddlers	8
• 4 to 12 years old	4
• Adolescents	4
<i>Gender of children who died</i>	
• Male	31
• Female	21
<i>Race/ethnicity of children who died</i>	
• African American	31
• White	9
• Hispanic	3
• Unknown	9

Contact with DHS

Half of the children whose cases were reviewed were receiving services from DHS at the time of death. Sixty-six percent of the children had a previous report.

Vulnerability of infants

As noted above, infants were the most likely to die. At the same time, only 4 percent of children who received either a CPS investigation or GPS assessment were infants. Of the **34 infants** who died, 22 had been the subject of a previous report; half were part of cases that were still open at the time of the infant’s death. DHS was actively involved with 19 of the infants at the time of

their death: the 11 who had been subjects of a report and an additional eight who were added to a case that was opened in response to a report on another child in the family. In three cases, DHS had not been involved in any way with the infant who died.

In 17 of 34 (50%) of the infant deaths, at least one parent had received DHS services as a minor. Services had been provided by DHS to 24 of 34 (71%) of families prior to the infant's death.

Children who died and children who lived

In order to get a balanced picture of DHS and its clients, the case reading examined not only children who died but also cases involving children in which there was no fatality. In comparing the fatality records to the non-fatality records, relatively few differences in the records were identified. Although infants were over-represented in the fatality reviews, documentation of practices did not differ significantly between the two groups. This suggests that DHS practice was not inherently or strikingly different in cases in which a child died compared to those without a fatality.

DEFINITION OF PRACTICE ISSUES

Across the cases that were reviewed, there is evidence of great variability in the way in which DHS serves children and their families. This finding was supported in the interviews and focus groups. There appears to be the lack of a coherent framework to guide workers in their day-to-day work with families. The practices in these cases are symptomatic of the need for DHS to provide more direction and structure to guide practice and decision making for cases involving children. Following are major areas of practice in which there was inconsistency, confusion, or a lack of clear direction.

- Decision making is variable because of the lack of clarity about what should be assessed, how the assessment should be conducted and the criteria for decision making. This problem affects: the Hotline screening process; the risk and safety assessments processes; the service planning process; and the decisions to open and close a case. For example, there were instances when cases were closed based on parent's behavior (lack of cooperation) rather than the safety of the child.
- Safety assessments were compromised by: lack of understanding or misinterpretation of medical information and the need for health care; failure to treat the caretaker's history of child victimization as a risk factor; failure to assess the risk and protective capability of all adults in the home; failure to identify the impact of substance abuse, mental illness, and domestic violence on parenting, the safety of children, and child development. In numerous instances, the pending birth of a child was not factored into the assessment.
- The GPS/CPS classification and the response-time decisions that are made at the Hotline before the child is seen are inconsistent. These decisions are not predictive of risk nor are they responsive to the urgency, the danger, or the vulnerability of the child.

- The existing protocols needed to assure consistency in assessing risk often were not done or were absent from the record. There was little evidence that risk was regularly reassessed across the life of the case. There was no protocol for assessing safety and developing a safety plan.
- Supervision does not appear to be used to promote quality assessment and decision making. In the records reviewed, supervisors regularly signed off on decisions and documents as required. However, there was rarely a reference to supervisory consultation in the log. When it occurred it was more likely to occur in the non-fatality cases.

An adequate review of the fatalities would not have been possible without the summaries provided by two different review teams. These are DHS's Internal Child Fatality Review Team (ICFRT) or "Fatality Review Team," comprised of representatives from DHS, and the Multi-Disciplinary Team, which includes DHS and representatives from other City agencies and stakeholder groups.⁷ The Fatality Review Team and MDT reviews identified significant systems failures that might have changed the outcomes for children fatally injured. These included no clear service plan, missing or incomplete risk assessments, delays in assignment and initiation of SCOH and Family Preservation services, CYD missing required visits, alerts from SCOH providers to which there was no response, missing reports from SCOH providers, lack of careful review of records by assigned CYD workers, and turnover of CYD staff.

DHS has made substantial progress in recent years in terms of its collaboration with law enforcement in the investigation of child abuse cases. This has included development and use of common interview guidelines, introduction of the use of videotaping of child interviews, and regular multidisciplinary case conferencing to facilitate coordinated investigations of child sexual abuse. For more than a decade, DHS, the Police Department, the District Attorney's Office of Philadelphia, and area hospitals have been planning to co-locate operations in a joint facility. Recently, the site of the Police Special Victims Unit at Episcopal Hospital in North Philadelphia has been designated as the future home of a state-of-the-art program housing forensic interviewers, a medical clinic, and specialized sex abuse investigators from DHS. When completed, this new site will allow all child sex abuse cases to be handled in an efficient, high-quality, child-friendly manner.

⁷ The DHS Internal Child Fatality Review Team (ICFRT) is composed of representatives from DHS Policy and Planning, Quality Assurance, the Child Welfare Advisory Board, DPW-OCYF, and social worker supervisory and administrative-level staff. The fatality review process results in the most comprehensive, systematic, and thoughtful evaluation of the causes of the child fatalities and the policy issues that are required to remedy identified problems. Occasionally the Fatality Review Team referred cases to the Multi-Disciplinary Team (MDT) for broader review with community partners such as the School District, Community Behavioral Health (CBH), area children's hospitals, and the provider agencies. DHS convenes the MDT for cases involving a child who was previously abused, as well as for other complex cases upon request of the DHS staff.

RECOMMENDATIONS

Phase One Recommendations

- 1. DHS must implement and use an appropriate Safety Assessment tool.** Ensuring the safety of the children in DHS' care is critical, and to do so DHS must have an adequate evidenced-based tool in place for workers to assess the safety of children. This recommendation must be implemented no later than June 30, 2007.

DHS also 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. This recommendation must be implemented no later than September 30, 2007.

- 2. DHS must revise its policies around face-to-face contacts with children.** DHS must conduct immediate (within 2 hours) face-to-face visits with every child five years of age or younger for whom a report of suspected abuse or neglect is received by the Hotline. This face-to-face contact must be made regardless of whether the Hotline classifies the case as GPS or CPS. This recommendation must be implemented no later than June 30, 2007.

DHS staff must—on at least a monthly basis—conduct face-to-face contacts with all families receiving any service supported through CYD that have a child five years of age or younger, and physically observe the condition, safety and behavior of any such child, as well as parental capacity. This recommendation must be implemented no later than June 30, 2007.

- 3. DHS must establish a local office presence in at least one geographic location deemed highly at-risk.** An at-risk geographic location is defined as a ZIP code where the proportion of the population that is part of an active CYD case is significantly above the citywide average and that has more than 400 open DHS cases. This recommendation must be implemented no later than May 31, 2008.

- 4. 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 five 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. This recommendation must be implemented no later than August 31, 2007.

5. **DHS must ensure that ongoing team case conferencing must occur routinely every three months**, for cases involving a child 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. Revisions to the FSP must be made as part of this process. This recommendation must be implemented no later than November 30, 2007.
6. **DHS must clarify the roles and responsibilities for DHS workers relative to private agency workers, at both the supervisory and the worker level.** The clarification of roles and responsibilities must be completed by August 31, 2007.

Phase Two Recommendations

1. **DHS must develop a more 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; and is family-focused and community-based and allows for individualized services.** The model should focus not only on front-end practices, but on the entire continuum of care for children and families who come into contact with DHS. The following elements should be included in the practice model:

- DHS must move toward an evidence-based practice model, and take active steps to evaluate the effectiveness of its practices with an evaluation process that is open and informs good practice. When practices do not work, they should be replaced with a more appropriate and effective practice. This recommendation must be implemented by May 31, 2008.
- DHS must expand the use of team decision making and specialized resources in the case planning process. These enhancements must be completed by December 31, 2008.
 - 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 working with, and closing, cases in which the parents are uncooperative.
 - 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 a conviction 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.
 - DHS must improve integration with physicians, nurses, and behavioral health specialists to ensure that each child's medical and behavioral health is appropriately assessed.
 - 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.

- DHS must eliminate “boilerplate” referrals and ensure that each child receives appropriate referrals that are specifically tailored to his or her unique needs. DHS must follow-up and act to ensure that the referrals are actually obtained.
- 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.
- DHS must enhance the frequency of face-to-face contacts with children of all ages. This increase must be effective no later than May 31, 2008.
 - Since face-to-face contacts are one of 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 contacts may be warranted, depending on the specific safety and risk factors in each case.
- DHS must clarify the role of supervisors.
 - DHS needs to reevaluate and recraft the role of supervisors to support the DHS practice model being implemented and the professional development of social workers. This must be done no later than March 31, 2008.
- DHS must streamline its paperwork and records management practices.
 - DHS must consolidate and reduce the number of forms that workers must complete.
 - As a starting point, DHS should study and document the utility of the Family Assessment Form (FAF) and consider whether it can be consolidated into a unified assessment document. This assessment should result in a consolidated Family Service Plan (FSP) that is electronically-based and customizable. A family should have a single FSP that is used by DHS and any provider agency that is providing services to that family. These changes must be implemented by August 31, 2008.
- DHS must enhance the fatality review process
 - DHS must ensure that the child fatality review remains multidisciplinary, and that there is a mechanism for implementing its recommendations. This must be completed by December 31, 2007.

CHAPTER 3. MISSION AND VALUES

DEFINITION OF ISSUES

The Department of Human Services' (DHS) mission statement includes a focus on child safety, permanency, and general child and family well-being, with Children and Youth Division's (CYD) mission focusing more narrowly on ensuring child safety. While seemingly clear, the Panel found that DHS staff, provider agencies, and other stakeholders harbor a great deal of confusion regarding DHS' mission, goals and values, particularly with regard to those staff and agencies that work in, or in concert with, CYD. As a result, there is evidence that programs and service delivery have lost focus, staff are confused over their roles and responsibilities in providing services via DHS programs, and partner agencies and their staff do not fully understand their role within the DHS continuum of care.

Much of the confusion regarding DHS' mission is attributable to its inability to reconcile and prioritize the dual goals of ensuring child safety and fostering greater family well-being. Like many large public child welfare agencies, DHS has struggled with the balance between child safety and family well-being, and in assigning specific responsibilities across the various divisions within DHS. Within DHS, the Division of Community-Based Prevention Services (DCBPS) has primary responsibility for prevention of abuse and neglect among the general population and specifically the at-risk community. CYD however, is where the child protection services work resides within DHS; therefore, CYD has the responsibility for protecting children and ensuring their safety. The Panel found that many CYD workers—and indeed CYD as an organization—have taken on enhanced responsibilities for prevention activities that often make it difficult for CYD workers to focus on safety to the extent necessary. This is particularly true with the location of the SCOH program (primarily a prevention program as it is currently implemented) within CYD.

This lack of organizational clarity among DHS divisions for adhering to principles of safety, permanency, and well-being presents challenges to (1) clearly defining and implementing effective policies, (2) creating an appropriate practice model for good social work, and (3) collaborating with partners who need clearly-defined expectations regarding the scope and intent of the services they are contracted to provide. Because DHS has failed to reconcile these goals, staff are confused and programs lack clear objectives. This confusion has obfuscated what should be the overarching goal of DHS—to protect children and ensure their safety. It also has resulted in the implementation of a program array that casts an expansive net yet fails to protect some of Philadelphia's most vulnerable children.

DHS must clearly define and articulate its mission and values and communicate these to DHS staff, as well as to all of DHS's external partners and stakeholders. Clarity of mission will bring focus and purpose to activity. It will help to better target programs, policies, and operations, and will provide a more solid foundation against which change and improvement will be measured. A sense of urgency will be restored. In redefining its mission and values, DHS must work collaboratively with all stakeholders, including staff, provider agencies, clients, parents, advocates, and the other public and private agencies with which DHS interacts.

RECOMMENDATIONS

DHS must continue the momentum the Mayor initiated with the creation of the Panel by developing the mission, vision, and priorities for DHS in partnership with staff and stakeholders. Specifically:

Phase One Recommendations

- 1. DHS must develop a mission statement and core values that are centered on child safety.** The DHS Commissioner must lead this effort, and actively engage the DHS stakeholder community, including clients, community members and organizations, provider agencies, DHS staff, and other interested parties.
- 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.

Both of the Phase One recommendations must be completed no later than December 31, 2007. It is imperative that DHS take this effort very seriously, and that the executives and staff of DHS work through the process of mission and value definition in collaboration with its community partners, private provider agencies, parents, clients, DHS staff, and other external stakeholders, including the broader Philadelphia community. It is equally imperative that DHS **implement** the new mission and values within the context of its practice and casework, so that the new mission and values do not simply “hang on a wall” but truly guide the way in which DHS interacts with its stakeholders and provides services to the children and families it serves.

The importance of working with the community cannot be overstated—the process of defining the new mission and values, while driven by DHS, must have shared ownership among the child welfare stakeholders in Philadelphia. To that end, as DHS redefines its mission and core values, it must also develop a specific set of implementation steps and strategies that will ensure their integration into the social work practice at DHS.

Phase Two Recommendations

- 1. DHS must align prevention programs and resources with the mission and values developed in Phase One, and also with the core principle of ensuring child safety.**

This recommendation must begin no later than November 30, 2007. The alignment and necessary revisions to prevention programs and resources must be implemented no later than November 30, 2008.

2. DHS must more effectively align the in-home service programs and utilization with the mission and values of DHS and with child safety.

This recommendation must be started no later than July 31, 2007, with final implementation of the recommendations starting no later than March 31, 2008.

As with the recommendations included in Phase One, both Phase Two recommendations also must be undertaken in concert with DHS' community stakeholders, and implementation steps must be developed that will ensure these recommendations are integrated in DHS' social casework practice.

SUPPORTING EVIDENCE

The Panel found overwhelming evidence that DHS currently lacks clarity in its mission, values and programs, and that this has contributed to staff confusion and decreased the quality of service delivery. Perhaps the most significant finding is that DHS has become the "agency of last resort" in Philadelphia, and is the one that many clients and other agencies turn to for assistance when all other systems fail. As a result, DHS has moved away from a rigorous focus on child safety, and broadened its focus to include programs that provide preventive and in-home services targeted at children whose safety is not a primary concern. These programs are admirable, and we applaud Philadelphia's efforts related to prevention, and encourage Philadelphia to maintain its investment in these programs. However, the investment has occurred without integration into the larger context of DHS services and without targeted programming to divert children and youth from further involvement with the child welfare system. The central focus of DHS must remain with ensuring the safety of Philadelphia's most vulnerable children, and it was clear from our focus groups, interviews, case readings, and administrative data analysis that DHS' significant expansion into other programmatic areas has reduced its ability to safeguard children.

While the lack of a clear overall mission at DHS is a grave concern, equally alarming is that individual programs also lack clarity in many instances. For example, the Panel found that the scope, intent, and target population of the SCOH program, as it is currently implemented, is unclear. Many staff and managers expressed differing ideas about whether SCOH was intended as a preventive program or an in-home service focused on child safety and permanency. SCOH's location in CYD also is questionable, as CYD is the division whose focus should primarily be on child safety. Moreover, CYD's significant expenditure of effort on the SCOH program is partially the reason why the focus at DHS has drifted away from ensuring child safety. The Panel also found that the scope and intent of SCOH relative to programs in the DCBPS was unclear, and more generally, that the overall relationship between DCBPS and CYD did not foster effective communication and intra-agency collaboration.

Significant confusion around role clarity also was a key finding from the Panel's work. Both DHS and private agency staff expressed uncertainty regarding their roles and expectations, as well as what their responsibility was for delivering services to clients. At least some of this confusion is attributable to the lack of mission and clarity of program, as DHS and private agency staff often expressed conflicting views on the role of programs such as SCOH, and even

the types of services that are available to clients receiving SCOH. This has a direct impact on service delivery, as the conflicting beliefs regarding the role of DHS staff versus private agency staff result in mixed messages and suboptimal service coordination for clients.

It also is important to understand that some of the confusion results—at least partially—from policies that are established by the Commonwealth. In particular, the distinction between CPS and GPS cases diverts attention away from children at risk of neglect, in those cases where the Hotline designates a report as GPS because there is no immediately identifiable risk to the child. Similar confusion has resulted from the Commonwealth’s inability to implement a safety assessment, which has resulted in significant confusion in Philadelphia as to how to measure and ensure child safety.¹¹

¹¹ As this report was being completed DPW issued a safety assessment form and procedure for intake and investigation, which DPW is using to train its staff.

CHAPTER 4. OUTCOMES OF IMPORTANCE AND MECHANISMS OF ACCOUNTABILITY

DEFINITION OF ISSUES

Spurred in part by federal initiatives that date back to the Adoption and Safe Families Act of 1997, public child welfare agencies have in recent years sharpened their focus on child safety, permanency, and well-being as the core outcomes used to manage the system. Child safety embraces the idea that children should be free from abuse and neglect; permanency refers to the idea that children should be raised by a family, if not by their own family; and well-being captures the idea that children often need support to develop to their full potential. For children involved with the child welfare system, ensuring access to mental health services, appropriate education, and physical and behavioral health care are part of sound policy and practice.

The focus on outcomes is part of the broader accountability movement within the public sector, and child welfare in particular. Resources for child welfare programs are limited, and accountability provides one way to connect public investments to program goals and accomplishments. Accountability also serves as a way to connect the work of an agency to its stakeholders as a matter of transparency. In the words of Philadelphia's own Committee of Seventy, government works "*...if there is active participation of its citizenry, which completely depends on ...transparency and accountability.*"¹²

With transparency and full accountability in mind, DHS must deepen its commitment to letting its partners and other stakeholders inside the agency. To meet this objective, DHS must adopt a vision of accountability that is both broad and deep. The breadth of its initiative will come from the range of community stakeholders and partners the agency engages. The depth of the initiative will depend on how the agency uses accountability to guide those who work directly with the children and families served by DHS.

For the most part, DHS is well positioned to fulfill its broader responsibilities to the public. DHS' investments in information technology over the years have resulted in a significant, relatively large reservoir of untapped information. Nevertheless, DHS is far behind other urban jurisdictions (e.g., New York City and Los Angeles) in the extent to which the agency reports routinely and effectively to the public. One simple example: DHS does not provide any reports of client experiences with the child welfare system through its public website. If reports are not accessible, accountability and transparency suffer.

RECOMMENDATIONS

Accountability begins with a clear set of outcomes linked to the agency's core mission that is then embedded in the way the agency manages itself, through upper management, to caseworkers, and with public stakeholders. A sense of the children and families the agency serves and how well the agency serves them should be reflected in all the decisions DHS makes,

¹² Accessed on May 2, 2007, from <http://www.seventy.org/transparency/index.html>.

from core funding decisions to the location of services to the decisions that directly affect children and families. In other words, knowledge about how well the system works has to flow freely throughout the agency.

DHS is the public child welfare agency serving the City of Philadelphia. The Department's fundamental responsibility is to protect children from maltreatment and to ensure their safety. When protecting children means moving children from their homes, then DHS has a responsibility to reunite the family or find other adults willing to care for the children, through adoption or guardianship, as quickly as possible. DHS also shares a broader responsibility for the well-being of children. Children generally should get health care, attend school, and receive appropriate mental health services. When children are served by DHS, the Department has a special responsibility to make sure its sister agencies respond to the needs of the children it serves.

Out of these core responsibilities, child welfare agencies around the country have settled on safety, permanency, and well-being as the domains that best capture the outcomes at the center of the accountability framework. DHS uses the same framework in its accountability process. That said, the Panel offers the following as ways to improve the Agency's use of information within the overall accountability framework.

Phase One Recommendations

1. DHS must assume greater accountability for its performance.

Although DHS has rich information resources, the Panel found that the agency's efforts to exploit the information resources were weak. Strengthening accountability such that the information resources are used more fully involves several key steps.

- *Establish an external accountability process that includes an annual public report card that covers the core outcomes.* Responsibility for the report, which should be funded by the City, should be placed in the hands of an independent body that is granted full, unfettered access to the data resources of DHS. At a minimum the report should provide an historical context, describe circumstances at the community level, and highlight the differential experience of high-risk populations. The report should include goals and expectations with specific references to baseline performance and improvements over baseline. The report must also contain DHS' performance along outcomes that measure its performance on key dimensions. At a minimum the following outcomes must be measured and reported:
 - Safety
 - Maltreatment rate – There are numerous measures related to child maltreatment that should be measured. Maltreatment rate refers to the number of children who are the subject of a substantiated (or founded) CPS or GPS report per 1,000 children at risk. The maltreatment rate serves as a basic indicator of child safety and should be monitored over time as a way to understand how service demand is affected by changes in the local economy and other contextual factors. The data should be prepared for communities.

Ideally, the calculation would center on first-ever victims as a way to better isolate the issue of recurrence of maltreatment, which is another measure that has to be tracked. The following maltreatment measures should be reported by DHS:

- Likelihood of maltreatment
 - Maltreatment rate for the general child population (by geographic areas)
 - During the time in-home services are being provided
 - During the time a child is in out-of-home care
- Likelihood of recurrence of maltreatment
 - Following case closing

b. *Establish a comprehensive internal accountability process that is connected to, but goes deeper than, the public accountability process.* That is to say, the internal and external accountability process should form a coherent whole such that internal accountability feeds the external process. Management must engage offices, units within offices, supervisors, and caseworkers in the accountability process, in order to effectively identify areas of poor performance and target the right improvements.

The strategy for both internal and external accountability processes should be developed by November 30, 2007, and fully implemented and the report card delivered no later than May 31, 2008.

2. DHS must establish a more rigorous methodology for monitoring contract service providers, which includes an annual report card for all contracted provider agencies.

At the present time, contract monitoring falls to the CAPE unit within DHS. It is appropriate that a single unit should have broad oversight for the provider performance. However, the metrics used to monitor performance have to shift in order to achieve a better balance between compliance with regulatory standards and outcomes for the children and families served. Compliance with appropriate standards is a component of quality but compliance by itself is not tantamount to quality. To this end, DHS must do a much better job of linking outcomes to measures that capture the process and quality of care, and reporting these outcomes via an annual report card for contracted service providers. Moreover, the system of metrics has to be connected to the incentive structure within the system used to fund contract agencies. DHS has moved in this direction with its performance-based contracts (PBC). However, there are several features of the current PBC system that have to be reconsidered within the accountability framework. Among them, the way children needing placement are assigned to agencies (the so-called wheel) has undermined the willingness of private agencies to develop programs tailored to the needs of children. The wheel should be replaced with a process that matches children to the agency best able to meet their needs. In addition, DHS should bring its in-home service system into a performance-based context that links funding to outcomes and the quality of care. The identification of revised annual measures for contracted agencies must be in place no later than August 31, 2007, and a report card for contracted agencies must be published no later than May 31, 2008.

An additional recommendation regarding the monitoring of contracted service providers is that DHS must ensure that contracted service providers are conducting the required face-to-face visits, and that a safety assessment is being performed at every visit. This recommendation must be in place by June 30, 2007.

3. DHS must establish a Commissioner's Action Line (CAL).

To foster greater responsiveness to the community, particularly the parents and clients served by DHS, the department should immediately implement a Commissioner's Action Line (CAL) which will offer clients, parents, and other stakeholders the opportunity to bring issues primarily related to child safety directly to the Office of the Commissioner. The CAL will exist outside the formal DHS program offices, and therefore enable clients and other community members to contact someone other than their worker or their worker's supervisor when the worker or supervisor fails to respond appropriately. The CAL must be implemented by August 31, 2007.

Phase Two Recommendations

1. The list of core measures within the safety and permanency domains should be expanded. As a rule, the list of core outcome measures should be relatively short and straightforward. The Panel does, however, see benefits in adding the following measures to those now monitored by the Department. These measures must be added to the annual report that DHS produces, as described in the preceding recommendation. The expansion of the outcome measures must be implemented by June 1, 2008, and updated annually thereafter.

- *Permanency*

Similar to the maltreatment rate, there are a number of permanency and placement measures that must be collected and reported by DHS. The placement rate refers to the number of children placed in foster care per 1,000 children in the population. The placement rate is a basic indicator that should be monitored over time as a way to gauge demand for services. Again, first-ever admissions should be differentiated from children returning to care, as they are captured in measures of reentry. Specific permanency and placement statistics to be reported include:

- Likelihood of placement;
- Likelihood of permanency and the timing of the exit;
- Likelihood of non-permanent exit and the timing of those exits;
- Likelihood of reentry and the timing of the return; and
- Placement stability.

- *Well-being*

Measures of well-being are important to report, though somewhat more elusive to design. Many factors that influence child well-being are outside of DHS' span of direct control, such as meeting a child's educational, emotional, and behavioral health needs. DHS should evaluate and measure the referrals it makes to these other systems. It is also important to understand that a child's well-being is directly related to two areas that DHS does control—safety and permanency. To the extent a child is

safe and in a permanent care setting, that child's overall well-being is likely to increase. The following are measures related to child well-being that DHS must collect and report:

- Appropriate connections to, and follow-up with, health care services;
- Appropriate connections to and follow-up with educational supports; and
- Appropriate connections to and follow-up with behavioral health care.

On an annual basis, DHS must revisit these outcome measures and evaluate whether additional measures are needed. Specifically, one year after the implementation of these measures, we recommend that DHS broaden the focus of the outcome measures to include additional measures focused on permanency and child well-being. To this end, DHS must broaden the accountability framework to include partner systems including the courts, schools, and the health and behavioral health systems.

- 2. DHS must link its performance and the performance of its contracted providers to outcomes of accountability**, including financial incentives. This recommendation must be implemented no later than June 1, 2008.

SUPPORTING EVIDENCE

In general, the Panel found that although child safety is at the center of DHS' work, there is a fundamental lack of clarity with respect to what DHS, together with its partners, is expected to do vis-à-vis safety. This is typified by the various categories used to classify reports of maltreatment and the children involved. To name a few of the ways DHS thinks about the continuum of child victimization and the continuum of child welfare services, there is a response priority classification, the GPS/CPS distinction, and prevention versus SCOH service types. From the limited analysis of data the Panel completed, we found that these labels often had little discriminant value. That is, the added benefit of each category, in the context of case planning, is not immediately clear. The Panel is concerned that the distinctions actually draw attention away from the two most fundamental questions—Is the child safe and, if not, what is the best way to protect the child? A more comprehensive and direct focus on outcomes will help to provide greater focus on the questions of whether DHS is doing an adequate job ensuring the safety of the children in its care.

The essence of program improvement is the ability to improve outcomes for children and families over time; therefore, it is vital that DHS continue to broaden and deepen its outcome measurement as time passes. In the context of the public child welfare system, achieving better outcomes for children means reducing the *likelihood* of maltreatment and the recurrence of maltreatment; reducing the *likelihood* of placement without increasing safety risks; increasing the *likelihood* of permanency for children placed in foster care; and reducing the *likelihood* of reentry to care, all else being equal. Although the Panel found evidence that DHS has its eye on system improvement in these areas, the measures the agency uses are not robust enough to capture change over time. The Panel is not in a position to recommend specific measures per se,

but state and local jurisdictions at the forefront of using information to manage their child welfare programs rely much more heavily on longitudinal data that track the experiences of children from the first contact to the last over the life course of the child.

It is the Panel's sense that the infrastructure for bringing partner agencies into an overarching accountability framework exists. Yet, the Panel also senses that much of the work that has been done remains at what amounts to a nascent stage of development. Foster children stay in care longer than they might otherwise because the legal system is not as efficient as it could be. Children who have been maltreated often have difficulty in school. To foster their well-being, DHS and the public schools in Philadelphia have to put forward a joint effort to improve educational outcomes. Children in the child welfare system need access to appropriate health and behavioral health care. If the services improve the well-being of children, it is a fact that should be celebrated. If not, or if the services are not provided, then the child welfare system cannot stand alone when it faces its critics. A broad-based accountability system draws everyone together around a common purpose: better outcomes for children. Public systems need to open themselves up to scrutiny, in equal measure and without exception.

CHAPTER 5. LEADERSHIP

DEFINITION OF ISSUES

Information from the Panel's research and analysis activities highlights common themes regarding DHS. There is significant consistency and, in many instances consensus, in the description of the challenges confronting Philadelphia's child welfare system. In addition, numerous recommendations have been provided regarding safety assessments, front end reform, worker training, and other subjects that would improve child safety. However, what has been consistently missing is the creation and implementation of a long-term, prioritized strategic action plan, which is developed with the broader community and proactively communicated and reported on to instill trust within the system, with other systems, and with the community at large.

The responsibility for creating and implementing a strategic action plan rests largely with the Commissioner of Human Services and senior DHS management. They have the responsibility to provide leadership both within DHS and in the broader community that is reflected in a plan with clear benchmarks that staff and community understand and are able to implement and that result in measurably improved outcomes for the children and youth of Philadelphia.

However, the responsibility also extends to the Mayor, Administrative Judge of the Family Court, and the City Council. The Mayor has specific responsibility for selecting DHS leadership. The Judge and City Council help the Mayor to establish and support DHS direction, and assure accountability for all of the systems involved in decision making regarding children and youth served by DHS.

Finally, leadership responsibilities also extend to Commonwealth leaders in the administrative and legislative branches who have direct responsibility for developing laws and policies, funding services, and aligning system goals and oversight for the child welfare system in Philadelphia.

RECOMMENDATIONS

To move from problem identification to solution development and implementation, the Philadelphia child welfare system needs leadership that commands authority and influences a direct course of action. DHS needs to identify and create leadership responsibility at all levels. As Philadelphia leaders identify and implement a course of action, attention to the following items, which child welfare leaders in other jurisdictions have proven to be critical, is necessary.

Phase One Recommendations

- 1. DHS must establish a mechanism and process to establish ongoing community oversight.** DHS must mobilize community stakeholders—including both supporters and dissenters—to develop and sustain a structure and process which recognizes that child safety

is a community responsibility. It is critical that DHS assures community involvement in its reform efforts, and shares responsibility for change with other systems. Specifically, to facilitate community involvement in protecting children, DHS must:

- Establish a community oversight body consisting of both DHS and community leadership, including parent and youth constituents. The community oversight board will be appointed by, and responsible to, the Mayor and the City Council, and will provide opportunities for community members, parents, clients, and other stakeholders to provide regular input into the child welfare system through activities such as town hall meetings and an annual survey of client satisfaction;
- Engage the press in the planning and documenting of the change process to ensure system transparency; and
- Initiate ongoing discussion with the family courts about shared responsibility and accountability, as well as more effective working relationships with improved outcomes for children and families.

- 2. DHS must ensure ongoing community participation and input into the improvements undertaken at 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. In seeking out community support and input, DHS must make a concerted effort to leverage the work that other community agencies are already doing.

The Community Oversight Board must be appointed no later than June 30, 2007, and a plan for obtaining ongoing community support and input must be in place no later than July 31, 2007.

Phase Two Recommendations

- 1. DHS must continue to expand its emphasis on making DHS a more transparent agency.** We applaud the efforts that DHS has made to move toward more open and transparent operations. We urge the current and future Administration to continue and accelerate these efforts. The Mayor has set a standard for transparency with the Panel, which DHS should strive to exceed. The Department must have a plan to enhance transparency of DHS developed no later than June 30, 2008, with implementation beginning no later than August 1, 2008.
- 2. DHS must take positive steps to enhance the healthiness of its infrastructure and staff morale.** Trust between DHS management and staff is vital, and DHS must support more consistent and open communication with its staff, and specifically with regard to providing clearer performance expectations for all staff. DHS also must establish performance expectations for staff that incorporate DHS' new mission, values, and practice changes—recommendations contained elsewhere in this report. Consideration also should be given to providing additional support to DHS social workers who deal with life and death situations regularly, and face an extremely stressful working environment. Counseling and other appropriate emotional and mental health supports would help DHS social workers to better

cope with the emotional and stressful environment in which they work. Finally, DHS must take active steps to ensure the appropriate relationship with the labor union. This recommendation must be initiated no later than March 31, 2008.

- 3. DHS must enhance its ability to proactively and transparently manage crisis**, including strengthening processes related to child death reviews and increasing public access to information. This recommendation must be implemented no later than March 31, 2008.

SUPPORTING EVIDENCE

From interviews, focus groups and staff surveys, the Panel clearly heard that DHS and provider personnel want stable and informed leadership that will respect and communicate openly with them, clarify their roles and responsibilities, give them the resources and structure to do their jobs well, and communicate proactively on their behalf to the public. In particular, many individuals commented that the system tends to lose perspective or overreact when there are negative press reports. This implies that staff would like leadership that is consistent and has a long-term view so that continual progress is made.

From the policy review, the Panel heard that more effective leadership is needed in the organization and administration of policy. Improvements must be made in defining the legal mandates and requirements of DHS as they relate to the authority of the Commonwealth, especially regarding child protective services. Improvements also are needed to define procedures for implementing specific policies more clearly, such as distinguishing between CPS and GPS or using assessments. Clear guidance is also needed on the respective roles and responsibilities of the Commonwealth, DHS leadership, supervisors, social workers and those of providers.

The DHS labor force has an important role advancing the mission of the agency and as a partner for reform. The public meets the agency most frequently in the person of DHS investigative and case management social workers and their supervisors. Whether using a new form or advancing a new priority, worker and supervisor buy-in are necessary, yet the labor-management relationship often is cited as an impediment to reform. The agency needs to find and restore balance in this most important relationship.

Staff morale is a key determinant of success in any organization, and most observers find that morale at DHS is not high at present. The pressures of child welfare work are familiar and weighty, as conflictual situations and secondary trauma erode one's spirit and effectiveness. DHS should build mechanisms for emotional support of workers to ameliorate the stress of engaging resistant families, confronting abusive situations, and the secondary trauma associated with services to victims of abuse and neglect.

Supervisors are expected to manage the work, educate caseworkers, provide support, and ensure accountability. There seems to be confusion in the dual roles of supporting caseworkers and accountability. This dynamic is complicated in a workforce where most of the supervisors *used*

to be workers and both groups are represented by locals of the same union. The labor relations agreement sets forth the mechanism for adjudicating DHS employee disciplinary matters. Morale and performance would be improved with more consistent response to both good and bad practice.

The DHS website offers the observation that the Philadelphia Child Welfare System cannot “...*protect children from abuse, neglect, and delinquency and ensure their safety and permanency in nurturing home environments...*” and “...*strengthen and preserve families by enhancing community-based prevention services*” without leadership that creates shared responsibility and accountability with other systems and the community at large. The leaders of our child welfare system and its companion public systems and private enterprises must step up their efforts to improve the safety, permanency, and well-being of children in Philadelphia.

CHAPTER 6. SUMMARY

While there are numerous areas where the Philadelphia Department of Human Services (DHS) performs at an acceptable level, it is clear that DHS as a whole needs to undergo a serious transformation along the most basic management and operational dimensions noted in this report—practice, mission and values, outcomes and accountability, and leadership. While recent changes in the Department’s management have given rise to some improvements in these areas, serious deficiencies still exist. Significant and swift progress is needed to remediate DHS’ performance along each of these dimensions.

ACTION TO DATE

The Child Welfare Panel recognizes that DHS and DPW have been working actively to assess and respond to some of the systemic issues that have contributed to the fatalities. We in no way want to convey to our readers that the agencies have been waiting for our report to act.

Among the actions that DHS has taken to initiate the change process are the following examples:

- Developed an assessment tool and conducted safety visits of all children receiving SCOH services (2,656 families and 6,728 children) which resulted in the identification and placement of children who were found to be unsafe;
- Conducted a qualitative review of the SCOH agencies in which fatalities occurred and the DHS units in which a fatality occurred using the Child and Family Service Review standards and methods;
- Initiated review of all SCOH providers;
- Reviewed the status of all of the recommendations of the multi-disciplinary child fatality reviews for the period 2002-2006 and subsequently placed the MDT in the quality assurance unit to facilitate implementation of recommendations; and
- Terminated two service providers who did not meet minimum standards, closed intake to four others, and has action pending on another agency.

DPW also has worked to facilitate change by such activities as:

- Conducting a review of the fatalities and providing feedback to the agency on the practice and policy issues involved;
- Establishing a plan of corrective action with DHS;
- Finalizing a safety assessment tool to be used to document the safety of children in foster care; and
- Providing training to DHS staff on the implementation of the safety tool.

These efforts, as well as other ongoing initiatives, will contribute to the needed changes.

The children in DHS' care are among the most vulnerable citizens in Philadelphia. DHS interacts with these children during critical times in their lives, when the highest degree of commitment, professionalism, and care is needed. These children cannot defend or care for themselves, and it is clear that DHS frequently has not risen to the challenge to protect these children. The recommendations contained in this report are targeted at improving DHS' capabilities to serve and protect these children successfully. Urgent adoption and implementation of the Panel's recommendations are critical in order to ensure the safety of children in Philadelphia, provide more stable and permanent care settings, and enhance the overall well-being of Philadelphia's at-risk children.

There is hope. The Panel received an e-mail from one DHS social worker, who said,

“DHS has a lot of problems, but it has been worse in my memory. Because so many past deficiencies have been corrected; I have hope for future reform. Most social workers, supervisors, administrators, and other personnel really want to make children's lives better. They want to do a better, more efficient job but many are overwhelmed.”

APPENDIX A. The Mayor's Executive Order

11/2/2006

EXECUTIVE ORDER NO. ___ - 06

CHILD WELFARE REVIEW PANEL AND THE DEPARTMENT OF HUMAN SERVICES

WHEREAS, meeting the needs of abused and neglected children presents the most urgent mandate and requires the provision of the most complex set of services faced by the human services system; and

WHEREAS, in Philadelphia the Department of Human Services (DHS) is responsible for investigating allegations of abuse and neglect and protecting children who are brought to its attention; and

WHEREAS, although child abuse is often among the most secretive of behaviors and is perpetrated too often on those children least able to protect or speak for themselves, DHS has the extraordinary responsibility to protect a child from being harmed in the privacy of the home by the child's own parent or caregiver; and

WHEREAS, the needs of the children and families served by DHS encompass challenges that include teen parenthood, homelessness, substance abuse, mental health problems and sexual and physical abuse and neglect. Many families face multiple problems that require extensive referrals and coordination with other parts of the human service, education, healthcare and court systems; and

WHEREAS, the scope of DHS's work is considerable. It generally serves children and youth ranging from birth to 18 years old. The DHS system serves more than 100,000 children every year. In fiscal year 2006, DHS received 4,346 new reports of suspected child abuse and neglect, received 11,442 new reports for general protective services, and provided prevention services to 78,385 children. Every day, on average, DHS provides in-home services to more than 8,500 children, provides foster care and residential services to more than 5,800 children and provides adoption-related services to more than 7,000 children; and

WHEREAS, it is imperative that the child welfare system go above and beyond the normal call of duty. The system's failure to perform at a consistently high level can heighten the risk of lifelong scars for a child, permanent impairment, and even death; and

WHEREAS, a child who is not protected by his/her parent or caregiver often must rely on the child welfare system to intervene and protect him. Government must be put on notice everyday to fulfill this extraordinary responsibility; and

WHEREAS, child abuse is preventable, not inevitable. It must not be tolerated. The City of Philadelphia must take every reasonable measure possible to protect each and every child, each and every day, to prevent the loss of any child's life;

NOW, THEREFORE, I, John F. Street, by the power vested in me as the Mayor of the City of Philadelphia, do hereby order as follows:

Section 1. Purposes of this Order

The purposes of this Order are to create a Child Welfare Review Panel that will assist the City in fulfilling its mission of protecting the safety of its children and to provide certain direction to the Department of Human Services in the performance of its work.

Section 2. Creation of the Child Welfare Review Panel

The Child Welfare Review Panel is hereby created as an advisory body to the Mayor. It shall consist of nine appointees of the Mayor, who shall be individuals from within and outside Philadelphia who are either nationally recognized for their knowledge and expertise about child welfare services and/or represent critical stakeholder interests, including child advocates, parents and foster parents, government agencies and professional organizations with a particular role in the child health and welfare system. The Review Panel shall be led by two co-chairs, appointed by the Mayor.

Section 3. Role of the Child Welfare Review Panel

The purpose of the Child Welfare Review Panel is to engage in a comprehensive review process to assist the City by ensuring the immediate safety of all children in its care, reviewing all child deaths in the last five years as outlined below, and recommending reforms in DHS policies and procedures.

Section 4. Duties of the Review Panel

A. Audit Child Safety Assessments. To assist in the process of assuring the immediate and ongoing safety of all children in the DHS system, the Review Panel will conduct an audit of the safety assessments of all children with active cases under DHS. To assure the safety of all children in the DHS system, the following actions shall be initiated immediately:

1. Child Safety Assessments. All children with active cases in the DHS system shall be visited and reassessed for health and safety by a social worker under the direction of DHS. The timing of visitations will be prioritized, with the children in the highest risk level cases visited first. DHS shall immediately make all risk level and service plan changes as necessary based on these assessments.

2. Case Record Reviews. DHS shall review the case record in each active case in the DHS system to assure accurate and timely documentation of investigations and the documentation of the adoption and implementation of appropriate service plans, and shall update and correct all records as necessary. The Review Panel shall review any such files it deems necessary to determine whether investigations are being accurately and timely documented and that appropriate service plans are being adopted and implemented. The Review Panel will evaluate areas in which any gaps in documentation and service planning exist and propose any necessary corrective actions.

B. Review All Child Deaths. The Review Panel will conduct a systemic case record review of abuse and neglect fatalities in Philadelphia since the beginning of 2002 to identify areas for corrective action to help avoid recurrence of such situations.

C. Recommend Reforms. The Review Panel shall assist in the development of permanent reforms to DHS policies and practices by reviewing DHS policies and practices through, among other things, the audit of child safety assessments and the review of all child deaths cases as outlined above.

1. Identify patterns of conduct and practice among caseworkers, contractors, social workers and administrators that can be improved to protect the safety of children.
2. Review and evaluate DHS procedures for investigating and substantiating child protective service cases, and adopting and implementing service plans, to identify areas that can be improved to protect the safety and lives of children.

3. Develop recommendations to improve all other components of Philadelphia's Child Welfare System, including training, quality assurance, contract and case management, the provision of direct services, case documentation, supervision of employees, and administrative oversight.

Section 5. Cooperation and Implementation

A. All City personnel shall cooperate fully with the work of the Review Panel, shall provide the Review Panel with all documents and information requested by the Review Panel in an expeditious manner and shall provide the Review Panel with the resources and assistance necessary to carry out the Review Panel's duties.

B. DHS and other City personnel shall implement, as further directed by the Managing Director, the recommendations of the Review Panel.

Section 6. Guiding Principles for the Review Panel

A. The Review Panel shall provide independent guidance, and its advice shall be driven solely by consideration of the safety and well-being of Philadelphia's children.

B. The Review Panel's deliberations, findings and recommendations shall be open and transparent to the full extent allowed by state and federal confidentiality laws and regulations, while respectful of the confidentiality of specific information pertaining to families with cases in the DHS system.

C. The Review Panel will seek input and information from as wide a body of sources as deemed necessary and useful, including outside experts, DHS staff, City officials, DHS clients, other stakeholders in the child welfare system and members of the public. The Review Panel shall utilize focus groups and individual interviews as necessary in this process.

D. The Review Panel and its agents shall have access to all DHS documents and files, subject to the signing of appropriate confidentiality agreements.

E. The Review Panel will both identify currently effective practices in addition to recommending improvements to existing policy and practice.

Section 7. Final Report

In addition to any recommendations made during the course of its evaluations, the Review Panel shall provide a comprehensive final report regarding its efforts both with respect to immediate child safety and with respect to practice reforms by May 1, 2007.

Section 8. Effective Date

This Order shall take effect immediately.

Date: By:

John F. Street, Mayor

APPENDIX B. SYNTHESIS OF PRIOR REPORTS

“The Multi-Disciplinary Team (MDT) is very aware that the issues and recommendations in this report have been put forth for consideration by various advocacy groups, advisory groups, and indeed the administration of the Philadelphia Division of Children and Youth (CYD) many times before. On some fronts, there has been progress. But, more often than not the implementation of earlier recommendations has been left to chance or set aside in deference to budgetary constraints...Unless the commitment to do this is evident from the top, little can be accomplished by the supervisors and workers. Worse yet, in a few years’ time, another multi-disciplinary team will be convened to report its findings on circumstances that will be all too familiar.”

Foreword

Philadelphia Child Protective Services: A Report to the
Secretary of Public Welfare, John F. White, Jr.
Multi-Disciplinary Team
November 12, 1987

BACKGROUND

Written almost exactly two decades before Mayor John Street appointed the Philadelphia Child Welfare Review Panel (Panel), these words have proven to be prophetic. Many of the issues raised by the Multi-Disciplinary Team (MDT) in their 1987 report continue to have importance today. Although many of the MDT’s recommendations were implemented, some solutions—as implemented—are now perceived as problematic. For example, in 1987, caseworkers spent an inordinate amount of time locating resources. CYD formed the Central Referral Unit (CRU) to help alleviate this problem and also to facilitate performance-based contracting. The CRU is now viewed by some staff as a source of delays in service implementation.

Philadelphia’s child welfare system has not been ignored in the intervening 20 years since the MDT report. Despite ongoing attention, and many genuine attempts to resolve identified problems, Philadelphia’s child welfare system remains troubled by several issues.

HIGHLIGHTS

Most of the reports about the system since 1987 have identified, to one extent or another, the following concerns:

- Unclear agency mission;
- Inadequate accountability; and

- Practice concerns, in the areas of:
 - Screening, intake, and investigation;
 - Risk, safety, and needs assessment; and
 - Service planning and selection.

Many of the reports, in addition to addressing these core themes, also voiced concern about agency staffing and supports for caseworkers and supervisors, particularly in the area of training. The commentary of the reports over the last 20 years with regard to these common themes is summarized in this appendix.

A number of studies have found that services are working in CYD. Examples of findings that reflect improved, adequate, or satisfactory performance also are mentioned.

METHODS

The Department of Human Services (DHS), CYD, provided 22 reports for review. The complete list of reviewed reports is provided as a reference list at the end of this appendix. Of these, one was from 1987, one from 1991, two from 1993, one from 1999, three from 2001, three from 2002, one from 2003, three from 2004, four from 2006, and three from 2007. Not all of the reports were undertaken as assessments of the child welfare system in the City. Some were evaluation or research reports related to child welfare services. Some reports are not, or were not, final official public reports. Several were completed this year.

MAJOR FINDINGS

The following themes are discussed:

- Agency mission;
- Accountability;
- Child welfare practice; and
- Infrastructure.

Agency mission

Almost every outside review of Philadelphia’s child welfare system has noted, to some extent, that the mission of the agency is unclear. This lack of clarity in mission has led to some confusion on the part of caseworkers, service providers, and sometimes even leadership. However, as is clear from the following quote, mission statements—while useful—are broad statements that must be interpreted in detail for each phase of child welfare services. Child welfare is responsible for providing services to children and their families and sometimes this leads to potential conflicting roles and responsibilities. The MDT (1987) laid this confusion squarely on state law. *“Because the statutes...are child-specific procedurally, the same standard of evidence is required for the removal of each child. The social worker...is left with conflicting mandates. She/he is to assure the safety of other siblings within the home, yet may be lacking the*

judicial tools to effectuate safety ...[The] apparent dichotomy between family preservation and individual child protection repeats itself in other areas. There appeared to be confusion as to whether case workers in the Investigations and Evaluations Unit are to follow up all children in the family.”

In a recent report that specifically focused on the Hotline, Ajilon Consulting (2004) noted the following in the Executive Summary. *“Over the twelve-week assessment, there was one question that kept appearing and creating an obstacle for all improvement initiatives. That question is: What exactly is the DHS Hotline?...It may seem that the answer is obvious, but generally the answer is vague and inconsistent among the entire DHS management team...The answer influences and impacts the daily operations, the expectation of performance and service delivery, and the recommendations or implementation of improvements.”*

Accountability

Another issue that was raised in most reports was that of accountability. This issue was considered on several levels, but most frequently at the level of caseworkers being held accountable for meeting performance standards by their supervisors. In addition, most reports raised the issue of holding service providers accountable for the contracted services they provide to families and children under the supervision of CYD. Fewer reports indicated that DHS should be held accountable to the public for ensuring that it meets its legally-mandated responsibilities.

Caseworker Accountability

The MDT’s 1987 report raised concerns about the effectiveness of supervision and noted, in several instances, the need for improvement in the ways in which supervisors hold their caseworkers accountable for meeting expected standards of casework. The MDT recommended, *“Establishment of clear parameters of expected behavior and action along with well defined consequences for failure need to be developed and implemented. Accountability needs to be stressed at the first line supervisor level.”* (MDT, 1987).

Other reports also raised concerns about the level of supervision. For example, the report prepared jointly by the Child Welfare League of America (CWLA) and the Center for the Study of Social Policy (CSSP) stated flatly, *“Supervision of workers needs to be strengthened in every area of the agency...Supervisors need to be expected to accompany workers to the field ...Supervisors must also be expected to periodically review all of a worker’s cases and to assess each worker’s caseload for progress toward meeting plan goals...Case records need to document the occurrence and substance of supervisory reviews.”* (CWLA and CSSP, 2001).

In a similar vein, the strategic action plan prepared by DHS with the assistance of CWLA reported a number of improvements in service delivery in general, but noted a need for improved supervisory oversight for the retention and closing of cases. *“The rate at which cases move through the service delivery system appears to be quite slow...One result of slow case movement is relatively modest rate of caseload closings...By inference it is reasonable to conclude that a pattern of inadequate case review and decision-making has contributed to the lack of case resolution.”* (DHS and CWLA, 1993).

Service Monitoring and Accountability

Services are provided to CYD's families and children both directly by DHS caseworkers and by the numerous private providers under contract to DHS. Most reports raised some concerns about the quality of both types of services and the extent to which the service providers—whether in DHS or in private agencies—are held accountable for providing acceptable levels of care.

In its CFSR self assessment, DHS noted several weaknesses in its service accountability process.

- *“DHS is strong in process measurement and orientation but weak in applied statistical and methodological approaches. The absence of an information/data analysis unit also means that data is collected and reported by various entities across the agency without a structured way to analyze the results and develop an action plan to improve the results.*
- *DHS does not connect the services delivered with the results achieved for programs.*
- *The outcome measurement process for children in foster care is successful in providing a comprehensive and systematic method of collecting detailed client data regarding well-being and permanency. However, it must be an integral part of policy and programmatic decision-making in order to guide service planning and service delivery.*
- *Decisions regarding resource allocation and program planning need to be based on systematic process and outcome data.” (DHS, 2002).*

The *Baby Neal* report commented on the confusion of roles between DHS and provider caseworkers, noting the need to, *“clarify the roles and responsibilities for case management and service delivery by DHS workers and contract agency workers to promote improved accountability and positive outcomes for children and families. The current system permits a lack of clarity about case decision-making; decisions are sometimes made by the people who have the least knowledge about what is occurring in a case.” (CWLA and CSSP, 2001).*

Federal standards have been set for achieving certain milestones in child welfare and are measured through the Child and Family Services Reviews (CFSR) process. One such standard is that children in placement should achieve permanency within 24 months. The Fels Institute of Government studied two cohorts of children younger than 9 years old who were in placement through DHS for 24 months or less (young short stayers—YSS) and 48 months or more (young long stayers—YLS). The primary focus of the study was the YLS group. Rather than the 24 months to adoption under Federal standards, the 91 members of this cohort of 242 children who actually achieved permanency through adoption required an average of almost 75 months—even longer than the Pennsylvania standard of adoption within 54 months. The study states, *“It is...clear...that the second stage of the adoption process, the time from TPR filed to TPR decision, exhibits one of the largest variations from the ideal. Given the 17.5 months average between TPR filing and Court granting termination of parental rights for the YLS group, this suggests more than three court hearings were required for each child (1 every five months). This indicates significant delays in the Court, the control of which is a shared responsibility of the Court, DHS, the Law Department, and the advocates. Furthermore, there appears to be*

significant reluctance towards beginning the TPR process in the DHS system probably due to respect for the rights of parents, and continued efforts towards reunification. This finding may indicate that concurrent planning and the early identification of potential adoptive parents may be useful to prevent children becoming 'young long stayers'." (Fels, 2004).

Direct Service

The quality of direct service provided by DHS caseworkers and supervisors came in for considerable criticism in almost every report. For example, the MDT (1987) includes the following comment in its report, *"It is not clear that workers have read the records carefully after they receive a case... Workers seem to start from 'scratch,' belying the fact that some families have had a history with the agency."* (MDT, 1987).

Provider Service

One way of holding providers accountable for the service they provide is to assess the outcomes of the programs in which they participate. For example, the American Humane Association (AHA) used Family and Child Tracking System (FACTS) administrative data, in conjunction with data from the Family Assessment Form (FAF), to examine the safety, permanency, and well-being of children in families that had been receiving Services to Children in their Own Homes (SCOH), but had been discharged. These outcomes were examined for a period of four fiscal years—2001 to 2004. These families were followed for a period of one year after discharge and assessed in terms of whether they *"experienced any one of three critical events: a new SCOH spell, a determined [i.e., substantiated] report; or a child placed out of home following the close of SCOH service... The overall outcomes for discharged SCOH families had been steady from 2001 to 2003. The percentage of families having **no** further system involvement for one year following discharge from SCOH was 70.2% in 2001, to 69.9% in 2003. Families with a subsequent critical event declined even further in 2004. The percentage of families having **no** further system involvement for one year following discharge from SCOH was 71.7% in 2004. The FY 2004 outcomes are dramatically improved when compared to the past three fiscal years."* (AHA, 2006).

Another examination of SCOH is being conducted by the Center for the Support of Families. This team, lead by Frank Petrus, has not yet completed its report but indicated to the Panel that its findings indicate the need for clarifying expectations, requirements, policies, procedures, and practice regarding SCOH services.

As part of a national evaluation of intensive family preservation services, Westat conducted a comparison of family preservation services (FPS) and SCOH in Philadelphia, with families being randomly assigned to one or the other service. The Philadelphia FPS served children who were at intermediate risk of removal from the home and provided 12 weeks of service at approximately 10 hours per week of direct in-home service through three private providers. DHS family preservation caseworkers generally had a caseload of five families or less as established by State law. During the study FPS caseworkers reported almost twice as much casework activity as SCOH caseworkers (4.6 vs. 2.9) and the service recipients from the FPS group found these activities to be significantly more helpful than those in the SCOH group.

Despite these differences, however, the outcomes for the two groups were essentially the same. *“Family preservation is believed to prevent unnecessary placement in substitute care. Prevention of placement is not as central an objective of family preservation in Philadelphia as in other locations, but it is, nonetheless, an outcome of interest...At the one year interval, 18% of experimental group families and 15% of control group families experienced substitute care placement...The survival analyses suggest that there were no differences between the rates of placement in the experimental and control groups...In addition to the analysis of subsequent placement, it is important to explore the likelihood of subsequent allegations of maltreatment. Family preservation programs are intended to resolve crisis and therefore lower the risk of harm within the family home...Two hundred sixty-eight children in 110 families (54%) in the experimental group were the subjects of investigated allegations of maltreatment...compared with 161 (children in 69 families (50%) in the control group. The difference was not statistically significant at the family level...The proportion of positive life events reported by caretakers in the experimental group remained higher...however, the difference was not statistically significant. On the measures of negative life events and life events reflecting depression there were no statistically significant differences between the experimental and control groups. ...There were no significant differences...with regard to the positive and negative child care practice[s] of the families.]...Overall, we are unable to claim consistent evidence of positive effects of the family preservation services in Philadelphia that were examined in this study.”* (Westat, 2001).

Another example of provider program evaluation involves the evaluation of the Enhancing Parenting Skills Initiative conducted by Branch Associates in 2005–2006.¹ This evaluation of a series of parenting programs across the City involved the use of several methodologies: a pre-and post-program survey of parenting knowledge; telephone interviews; structured, standardized instruments; focus groups; site visits; and case studies. The results of all these approaches were similar, as the following excerpts indicate.

- *“The results of the pre- and post-program surveys showed increases in knowledge in the area of child development, and information on what constitutes abuse and neglect.”* (2006a).
- *“The overall results of this survey are very positive. Parents reported high levels of satisfaction with the program.”* (2006b).
- *“The data clearly indicate that the program was effective in helping parents have more realistic expectations of children...Parents appear to be learning about empathy and the importance to attend to the needs of children...The program has a positive effect on helping people consider alternatives to corporal punishment as a means of discipline...Parents appear to be gaining a clearer understanding of the roles of parent and child and are accepting and understanding those roles...Parents appear to want their children to feel empowered and can appreciate and applaud cooperation from their children.”* (2006c).

¹ This initiative was under the jurisdiction of the DHS Division of Community-Based Prevention Services rather than CYD.

Public Accountability

Some reports, beginning with the 1987 MDT report, noted the need for DHS to be more accountable to the public at large for its utilization of public tax funds. For example, the MDT, in its Executive Summary, states, “*The City has not made children a priority, has not provided enough workers or support services...The Department of Human Services needs more money², better organization, more accountability and more leadership. We need to respect the good work that is done, but demand more of it.” (MDT, 1987).*

The Human Services Task Force appointed by Mayor Rendell to review DHS, recommended centralizing a focus on all human services in the Mayor’s office, to ensure better accountability, visibility and coordination. “[T]he City should seize the opportunity to move toward a more comprehensive human services system which maximizes opportunities to end fragmentation which leads a community-wide effort to improve the quality of life for all Philadelphians. The center for much of that activity must be the Mayor’s office. The Task Force urged that the Mayor be a strong advocate for human services, particularly for children and their families, to the public and the political leaders in the City, Harrisburg and Washington.” (1991).

The Task Force went on to note several organizational issues regarding the delivery of services, but focused primarily on the need for DHS to become more community focused. “*There was also a strong consensus that The Department of Human Services become more community based, comprehensive and prevention focused. We Therefore recommend that: 1) The Department’s Children and Youth division develop and implement, together with the private contract agencies, a presence in the communities in the City (decentralize).*” (1991). Although several of the Task Force’s recommendations have been implemented—develop prevention services, bring children’s behavioral health under DHS, expand family preservation, emphasize permanency planning, and expand the number of deputies—apparently there has been no sustained effort to decentralize services in conjunction with the private provider community.

Child welfare practice

Previous reports included comments on, and recommendations about, several practice areas. Notably they focused primarily on the earlier parts of the child welfare system which are encountered by a new client:

- Screening, intake, and investigation;
- Risk, safety, and needs assessment; and
- Service planning and selection.

This is not to say that none of the prior reports expressed concerns about the process of delivering in-home, placement, or permanency services; however, the consistent focus was on the front end of the child welfare system upon which the service delivery process is dependent.

Screening, Intake, and Investigation

The initial involvement of CYD with a new client family occurs when a report is first made alleging that a child has been the victim of abuse or neglect, or is at risk of being maltreated.

² Since 1987 the DHS budget and staffing have both increased substantially. These changes are discussed in Chapter 2 of this report.

This initial report is received either by the DHS Hotline or ChildLine, which is the statewide intake system operated by the Pennsylvania Department of Public Welfare (DPW). The DHS Hotline, in addition to serving as the initial contact point for most referrals, also initiates the investigations and placements, if necessary, for referrals that are received between 4:00 p.m. and 8:00 a.m. For referrals that are received during regular hours, if the Hotline worker determines that further action is warranted, the investigation is assigned to another CYD unit.

The Ajilon (2004) study of the Hotline reported a number of problems with the Hotline structure that affect practice.

- *“An operations or procedural guide for the staff to use as a reference does exist, however, it is not maintained on a regular basis to be kept current with the business policies.”*
- *“The current FACTS system is...cumbersome to navigate through...while a caller is on the phone. So many of the DHS Hotline staff members will jot handwritten notes then initiate a CPS/GPS or General Report after the call has ended...If there are many calls in queue, DHS Hotline staff members may postpone entering a report or request and take another call or two. When the volume has reduced, the DHS Hotline staff member will enter the report or request...At this point, it may take longer than the estimated 15-45 minutes. During the time that a DHS Hotline staff member is entering a report or request, he or she is not available to receive another call or inquiry. Walk-ins...[or] emergency field investigations and placements...also take staff members away from their desk.”*
- *“Whereas the assignment of CPS, GPS and/or General Reports can be [done] electronically, the culture within the entire DHS organization is that it works off of paper copies...Most of the units receiving reports from the DHS Hotline will not formally acknowledge receipt of the report until they have received the paper copy. This creates duplication and redundancy, as well as confusion as to which is the ‘official’ copy of the report if both versions (electronic and paper) do not contain the same information.”*

During 2003–2004 DHS undertook a complete review and redesign of the front end of the child welfare system. This review was conducted by a team from the Chicago Center for Child Welfare Strategies, led by John Goad. The resulting redesign was never implemented but is currently being reconsidered. The “Goad Report” included some insightful observations about the screening, intake, and investigation processes in DHS, as the following excerpts indicate.

- *“Workers from Screening have a substantially different view of their job as compared to Hotline workers. Screening workers understand their mission as identifying available services responsive to the problems of reported families and taking a fairly active role in making service linkages...Hotline workers say that they believe it is their job to accept reports. They claim that when they try to screen reports out their decisions are often reversed by higher ups after reporters complain....*
- *Decision making at the Hotline is not well structured. Staff at all levels have difficulty defining some of the abuse/neglect categories currently in use....*

- *The workplace culture at the Hotline doesn't seem to include the sense of urgency that one might expect at a hotline. There seems to be a fair amount of milling around while lights on the phones are flashing. While this is a fairly subjective observation, it may be part of the reason for the wild disparity in the number of reports individual workers accept....*
- *GPS reports are initiated within the designated time frame of five days from assignment...Since the GPS designation is not made on the basis of specific and rigorous standards, the five day initiation requirement is potentially problematic. Although the apparent rationale for the longer response time for GPS is to permit focus on the presumably more serious CPS reports, there is not much benefit to delaying GPS initiation...Since there is a continual flow of GPS referrals into Intake, the delay only means last week's referrals are being assessed instead of this week's referrals....*
- *Investigations typically involve one in person contact with the child and family at the home, a phone contact with the reporter, and one other collateral contact...There does not appear to be much variation in the depth of investigative activity related to the level of risk suggested by the allegations, the nature of the allegations, or whether the report was designated CPS or GPS.*
- *Once the decision to provide in-home services to families has been made the process for connecting the family to an actual service provider is slow and circuitous...As a result, in many cases weeks separate the family's last contact with the investigating Social Worker and the initial contact with the service provider. Since the process does not necessarily involve the investigating and service providing workers ever speaking to each other, investigation and service provision are not well connected....*
- *Investigation documentation does not provide the reader with a chronological narrative of the activities that are included in investigations. Furthermore, there is a great deal of redundancy in investigative recording. Investigations are difficult to read and must be frustrating to document." (Goad, 2004).*

Risk, Safety, and Needs Assessment

One of the most important tasks in protecting children involves assessing each child's risk of being abused or neglected in the near and more distant future, their current safety, and their needs for services to overcome risk, safety, and other issues. Concerns about risk assessment are long-standing. For example, the MDT (1987) noted, *"the CYD workers do not follow a standardized risk assessment instrument; hence, significant indicators are overlooked, recordings are inaccurate and ambiguous, and validation is poor or nonexistent."* While a statewide standardized risk assessment instrument has been in place for several years, it still has not been possible to develop and implement statewide regulations regarding safety assessment using a structured, standardized form. As recently as February 2007, DPW withdrew its proposed regulation for safety assessment, at least partially because of concerns expressed by DHS.³ Standardized measures for use in assessing needs apparently have not been addressed.

³ On April 3, 2007, DPW issued a *Draft Safety Assessment and Management Process*. This latest draft of a standardized statewide safety assessment policy and procedure still has raised some concerns about its adequacy and it has not been implemented yet.

Little seems to have changed with regard to ensuring safety of children under DHS' care. In its Quality Services Review (QSR) of Philadelphia's Department of Human Services' SCOH Review Initiative, the DPW Office of Children, Youth and Families (OCYF, 2007) noted:

- *“In many cases, reviewers could not conclude that any consistent method of ensuring safety of children in their homes existed;*
- *Safety assessment and documentation varied from caseworker to caseworker and from provider to provider;*
- *Safety plans are almost non-existent;*
- *Reviewers are unable to ensure that safety visits are occurring at each face to face contact with family;*
- *Safety assessments seemed to be based mainly on the physical conditions of home;*
and
- *Lack of universal understanding of assessing risk and implementing a plan that reduces risk factors.”*

Service Planning and Selection

Family service plans have come in for criticism throughout the past 20 years. Despite this, there seems to have been little effective change. The language in the earliest and one of the latest reports reviewed is remarkably similar—the MDT report stated (1987), *“Family Service Plans are generally lacking in specificity. The presenting problems are not clearly identified by the worker and lack statements of objectives and actions designed to alleviate the situation.”*

A standardized Family Service Plan tool was implemented by CYD that specifically required statements of objectives and actions designed to address them. A monitoring process to document the extent to which those objectives were reached was also implemented. Numerous other “promising practices” have been implemented to improve the planning process. (DHS, 2002). Despite these efforts, the plans appear to have remained rather generalized documents that do not reflect a careful and comprehensive assessment of the child's and family's needs, risks, or safety concerns with a planful, inclusive approach to addressing those concerns.

The QSR report (OCYF, 2007) stated, *“Family Service Plans are:*

- *General in scope, not individualized and specific to strengths and needs of family;*
- *Lacking in the engagement/inclusion of all potential family and supportive Caretakers...;*
- *Sometimes not modified when there is evidence of new household members or new babies; and*
- *Generally not being shared/discussed with providers which often times causes disjointed service planning.”*

The process of selecting services and service providers has received extensive criticism over the years. For example, AHA and Temple University Center for Public Policy (2002) completed an analysis of SCOH assessments and service planning for 4,865 families who received SCOH services in 1999, 2000, and 2001. The authors compared the Family Assessment Forms (FAF) that were completed by SCOH staff and used for service planning purposes, with family self-

report ratings and the Behavioral Observation Checklist (BOC), and found them highly consistent with one another. An item on the FAF must be rated at 3.5 or higher to indicate a sufficient need to be addressed in the family service plan. The authors found, *“There is a 30% greater likelihood that families, which are coded as non-White and non-Hispanic and are enrolled in SCOH, will have no assessment item that warrants a service plan. There is a 40% greater likelihood that families, which are coded as having a single caretaker and are enrolled in SCOH, will have no assessment item that warrants a service plan...Families... coded as White Race were highly unlikely to have no rating on the FAF reaching the threshold for service planning.”* This finding suggests concern about the adequacy of the CYD assessment process used in making service referral decisions, as well as the possibility of some institutional bias in determining which families to serve.

Several reports have raised concerns about delays in service selection and provision. The MDT noted, *“Workers spend inordinate amounts of time searching for placement resources and specialized services because there is no efficient system for determining the availability of openings for service among the various providers.”* Similarly, the MDT noted, *“There are often lengthy gaps of time between the identification of a problem and the actual delivery of services. Even when the case is in the system, inordinate time delays occur, often resulting in the ineffective implementation of family service plans.”* (MDT, 1987).

In recent years, partly in conjunction with the implementation of performance-based contracting, DHS created the Central Referral Unit which serves as the gatekeeper for all out-of-home placements. Other efforts have been implemented to facilitate the selection of in-home service resources, such as SCOH or Family Preservation. (DHS, 2002) Nevertheless, a variety of sources have indicated that initiation of service delivery is often delayed for extensive periods of time. For example, the QSR report (OCYF, 2007) states *“Services are not implemented until after investigatory period, sometimes as long as 90 days from the time that the initial referral is made to DHS.”*

Similarly, the Mayor’s Blue Ribbon Commission on Children’s Behavioral Health addressed the issue of lengthy waiting lists and service delays in the Executive Summary of its Final Report (2007). It stated, *“Children and families seeking services should be able to find out what services are available and where to get them. They should also be able to receive those services when and where they need them. This can be accomplished if children and families can easily identify and obtain services without barriers; if there are no gaps in the full array of needed services; and if sufficient resources are committed, so that all children in need are treated promptly.”*

Infrastructure

Child welfare work is labor- and information-intensive. Resolving staffing issues is an essential component of successful performance. This was noted as a concern in the majority of reports about DHS.

Staffing

Most of the reports noted various problems in having sufficient—and the right kind of—staff to perform the complex work required by child welfare. The MDT (1987) took the Civil Service system to task, indicating that the *“eligibility criteria and preferential systems do not*

accommodate the needs for workers in a highly specialized area.” The MDT went on to note that child welfare caseworkers who are *“adequate by civil service standards, but are unable to handle the demands of the job”* were hired from the civil service list to cover unassigned caseloads. (MDT, 1987).

DHS examined staffing and workload issues at least twice in the past 20 years. In 1993 a CWLA analysis recommended that DHS address three principal areas: *“A broad-based long term assessment of the overall operation of the Department’s service delivery system should be initiated with the goal of designing a more efficient, accountable and supportive system. Further analysis should be done immediately of the feasibility of establishing a number of more specialized caseload functions in order to operate more efficiently, but also to improve the overall quality of the agency’s services. Immediate action should be taken to initiate reviews of cases which perhaps should be closed or provided with more intensive service.”* (CWLA, 1993).

The principal issue that these three strategies targeted was the demands of a generalized caseload. *“The current design of family center workloads is unrealistic and, ultimately, unmanageable. The scope of generalist skills and knowledge required of an average caseworker is too broad to expect a consistent level of performance.”* (CWLA, 1993).

The second workload study, conducted by Hornby Zeller Associates in 2001, also addressed the issue of generic vs. specialized caseloads. *“CYD is traditionally and still primarily structured in a generic way, i.e., workers handle a variety of types of cases. There are, however, a number of specialized units which are designed to provide special expertise in the handling of some types of cases, or simply more intensive services than are possible with the caseloads and mixtures of cases carried by generic workers. From a workload perspective, the question to be answered is: What would be the implication of moving the agency from a generic structure to one that is more specialized? ... With only a few exceptions, the time reported being spent on cases when they were assigned to specialized units was more than that on cases assigned to generic units. However, because even these estimates are based on relatively small numbers of cases for one or the other group, only one of the comparisons achieves statistical significance... [A]ssuming a more completely specialized structure maintained the same level of intensity of service as the current specialized units, more time would be required to handle nearly all the cases currently carried in the generic units.”* (Hornby Zeller, 2001).

This study also examined the effect of private agencies on DHS workload and found: *“[T]he involvement of a private agency is associated with more time reported by the CYD worker involved than if no private agency had been involved. Perhaps equally surprising is the fact that the time devoted to required tasks is generally less when there is a private agency involved, while the time devoted to nonrequired tasks is generally more... What is clear, however, is that the study provides no basis for concluding that workload pressures can be relieved by outsourcing services.”* (Hornby Zeller, 2001).

The Hornby Zeller workload study also concluded that the data resulted in *“the need for a staffing level roughly equivalent to that which currently exists. The existing workload shows a need for 666 workers, while the current staffing shows... a total of 6... There would appear to be at least two sources for this finding. First... the level of participation in the case time study was*

low...The likely impact of low levels of participation is that not all of the time spent on cases was reported, reducing the overall estimates. The second reason is...that the standards for the frequency of the required activities are low, when compared to those in other jurisdictions. For instance most states require that children and their parents both be seen monthly when the child is in foster care. In Philadelphia, the child only needs to be seen once every six months.” (Hornby Zeller, 2001).

CWLA and CSSP addressed staffing concerns by recommending that DHS “Reduce caseloads substantially by expanding the total number of DHS staff through recruitment, retention and professional development strategies. Having a stable and diverse workforce with manageable caseloads is an absolute prerequisite to effective practice.” (CWLA and CSSP, 2001).

Later, the Ajilon study of the Hotline (2004) indicated that *“The general consensus is that there are not enough people to handle the workload.”* This report went on to highlight a related issue, *“Currently, there is not a specific job description or title associated with the DHS Hotline. Program Director, Program Administrators, Supervisors, and Social Workers have the same job classification and descriptions as their counterparts who manage, supervise and/or handle caseloads and investigations. There is no distinction between Hotline and the rest of the agency.”* (Ajilon, 2004).

Training

Every report commented on training issues—both within DHS and statewide.

- *“There is no formal training program and/or orientation for the DHS Hotline.”* (Ajilon, 2004).
- *“While standards relate to the way individual cases are handled, training addresses the knowledge and abilities of individual caseworkers, supervisors and others overseeing or providing services. For this reason, training becomes a contributor to progress towards the PIP goals when the lack of performance on a given item is attributable, at least in part, to deficiencies of knowledge and abilities.”* (DPW, 2003).
- *“All levels of staff in the public and private sector indicated a desire for more time for training. Transfer of learning activities vary widely depending on the supervisor’s experience, expertise, and relationship with their unit. Transfer of learning activities were identified as necessary to prepare staff for a minimal level of work.”* (DHS, 2002).
- *“DHS needs to review the pre-service and in-service training curricula and training requirements for both DHS and provider agency staff and strengthen training in several areas...Improvement is needed in the areas of engagement with families, assessment and service planning, and service coordination. In addition, workers need training in documentation requirements. An ongoing and significant investment in improving the practice skills of front-line workers is needed.”* (CWLA and CSSP, 2001).
- *“The Department [of Public Welfare] should expand the drug and alcohol training included in a county caseworker’s core certification training...County C&Y officials should begin to implement relevant recommendations contained in this report.”*

Several recommendations in this report call for DPW regulatory or policy changes. Rather than wait for such action, we recommend counties begin now to implement recommendations such as expanded drug and alcohol training for caseworkers.” (Legislative Budget and Finance Committee, 1999).

- In 2001–2002, at DHS’ request, a team from the Child Welfare Policy & Practice Group, headed by Paul Vincent, addressed the need for improved supervisory training. By joint decision, this effort was expanded to include defining a practice framework, delineating clearly which tasks are to be performed by DHS staff and which by private providers, and the need to coordinate with the plans for performance-based contracting. This effort resulted in *“a working model of a practice framework... a working model defining the roles and relationships between DHS and private provider staff... a conceptual design...for a training effort centered on family team meetings and aimed at both line staff and supervisors, with DHS and private provider staff to participate together as part of an effort to integrate the roles of public and private providers.”* (Vincent et al, 2002).

Despite the extensive work that was done to develop a comprehensive schedule for training all DHS staff, it was never implemented. An internal DHS memo to Paul Vincent and his colleagues suggests this was due to *“issues that are discussed in the training-related documents... that are in tension with the way the issues seem to be playing out in the PBC context. Emphasis on “Leading.” Providers have advocated... that they should be invested with the leadership role in service planning and with decision-making authority. By contrast language in the training documents stresses the DHS worker’s primary role and ability to trump agency staff. ...Dispute Resolution 1. By specifically listing the ability to resort to a conflict resolutions process only in... “Preparing for and Testifying in Court,” the...document suggests that the process is only available when a dispute arises over court...Dispute Resolution 2...Issues that have been raised about [the conflict resolution process] include whether issues of non-responsiveness, for example should be handled differently than genuine disagreements over practice; the role of the chain of command; and who will serve as the decisionmaker in resolving disputes. Re-placements. [T]he question has been raised, and not resolved, as to whether an agency will be permitted to make decisions about whether a placement move within the agency is desirable for a child. Need for Meetings, Need for Speed. Under PBC providers will be expected to move a certain percentage of their caseload to permanency in each year. Understandably, this has caused them to be concerned about points in the life of a case that can delay its resolution. The need for a full family case conference every time services need to be adjusted...would therefore be problematic. This problem would be heightened if the provider does not have the ability to ensure that the conference even occurs.”* (Guss, 2002).

Technology

Growing out of criticisms from various groups, DHS recognized and acted on the need to implement a case management information system. In the DHS County Self Assessment Report (2002), prepared as part of the State’s Child and Family Services Review (CFSR), DHS stated, *“Since 1993, DHS has used the Family And Child Tracking System (FACTS), which was developed by DHS to manage, collect, track, and report information regarding children and families...FACTS allows the DHS caseworker to track child and family history, including investigation and service history, over time.”*

Addressing technology support systems for caseworkers, especially in the DHS Hotline, was the primary focus of the study conducted by Ajilon Consulting in 2004. This study was motivated by the installation of a new Automated Call Distribution (ACD) system for the Hotline. It necessitated assessing the *“processes, technology, and structure...needed to support the implementation and configuration of the new ACD system.”* In addition to the expected recommendations regarding the ACD system, Ajilon also had several comments and recommendations regarding FACTS. For example, *“The current version of FACTS does not contain the ability to act as an incident or inquiry request system and updates to this version is [sic] not possible or prudent.”* (Ajilon, 2004).

Interagency Collaboration

Many of the reports noted that DHS had difficulties in collaborating with other public and private agencies. The MDT (1987) stated flatly, *“Child welfare has become the safety net for all children who are not serviced by other systems.”* (p. 59). The MDT went on to lay on the state responsibility for addressing the need for child welfare to provide *“service in the place of other service systems such as mental health and mental retardation when their resources are exhausted”*, recommending that DPW, the Department of Health, and the Department of Education *“...must define the case management and fiscal responsibilities for each service system in multi-problem families, and in the dually diagnosed client. At a minimum this should be done immediately within the Department of Public Welfare; i.e., among the Offices of Children, Youth and Families, Mental Health and Mental Retardation.”*

In its self assessment in preparation for the CFSR, DHS noted that several interagency collaboration issues affected the development of effective family service plans.

- *“Barriers to smooth inter-agency operations identified include: competitive and uncoordinated time frames of other cross-systems planning processes; complex and inaccessible information sharing system with the school district; mental health, substance abuse and other community providers feeling left out and uninvolved in the dependency planning process.*
- *TANF work requirements limit clients’ availability for planning meetings during regular work hours.*
- *Different child-serving systems have conflicting laws regarding confidentiality, which impede sharing information necessary for effective planning.*
- *Planning roles and responsibilities are unclear when an already dependent child becomes involved with the juvenile justice system.”* (DHS, 2002).

In the *Baby Neal* report, the recommendation was made that *“DHS, in cooperation with the Philadelphia public schools, should take a close look at how the education needs of children in foster care are being met...It appears that there is no clearly assigned responsibility for workers to monitor a child’s educational progress and assure that their educational needs are fully met. Further, there was no evident capacity for educational transition planning when children are moved among facilities or from foster care to a relative or home.”* (CWLA and CSSP, 2001).

DHS and CWLA (1993) noted that DHS and the private agencies both identified the following points of concern regarding interagency collaboration: *A common interpretation of policies and standards...Clarity regarding the service delivery responsibilities of DHS and private agency workers...Greater compliance with necessary paper work requirements from DHS to private agency workers...Greater collaboration with regard to attending case conferences and joint meetings with families. Greater support and trust between DHS workers and private agency workers with regard to case decision making. Clarity by private agency workers regarding their role in the court process.*”

SUMMARY

The Philadelphia child welfare system has been the subject of numerous reviews by expert panels, outside consultants, program evaluators, State and Federal officials, and internal staff over the past two decades. In large part, these reviews have all reached the same general conclusion—CYD does not live up to its potential for serving children and families in Philadelphia.

All of these numerous reports, investigations, and studies have offered recommendations for improving the system. While many of these recommendations have been implemented in some fashion, core problems appear to be of continued concern.

Twenty years ago DHS worked with insufficient resources. With changes in leadership, and some creative financing solutions, DHS now appears to be well-resourced. None of the reports in the past few years has raised funding as a major issue. Similarly, staff resources have grown so that workloads have become generally manageable, both in DHS and its private service providers. Nevertheless the difficulties of recruiting and retaining competent, well-trained staff have remained issues that have been highlighted in almost every review of the system. Both DHS and the Pennsylvania DPW have implemented extensive training programs for new and experienced personnel. While many of the reports have noted this extensive investment in training, few, if any, have questioned whether it has resulted in the expected benefits.

Most of the families with whom CYD staff work have multiple issues to address. Many are involved with substance abuse or domestic violence. Some are coping with mental illness. Some are homeless. Many live in substandard housing. Many families have members who are incarcerated or otherwise involved with the criminal justice system. Some families must cope with members who have serious and chronic health concerns or are developmentally-delayed. Families with children beyond the toddler stage must cope with educational issues. The majority of families served by CYD are poor and have few prospects for financial improvement. The single element that all of these families have in common is that some family members are vulnerable children. As a result of these complex and interwoven problems, virtually all of these families must deal with multiple officials from different agencies and organizations. Many of the reports over the past two decades have highlighted the need to improve collaborative efforts between CYD and other agencies involved with the same families. Some improvements have been made, but clearly there remains room for significant growth in this regard.

Despite the single common denominator among CYD's client families—vulnerable children—the agency has received consistent criticism of its lack of a standardized mechanism for assessing the safety of children in their current environment. It has also been criticized, often indirectly, for a lack of understanding of the value of conducting a comprehensive assessment of risk of future maltreatment for the children in the family—then using that assessment in actively seeking services that will address the unique risks posed by each family's combination of strengths, needs, and circumstances. Collectively, the reports during the past two decades suggest that CYD personnel tend to view assessing safety and risk as “paperwork” rather than as processes that can, and should, be used to plan and provide services that will meet the unique combination of needs presented by each family. In short, service planning does not seem to be based on assessment, but on routinely plugging in the services that are easily available whether or not they are most appropriate for addressing the family's needs.

Virtually all of the reports suggest that what is probably the single most difficult-to-address core problem is in some way causative of all the others. That problem is that the mission of the agency is unclear. There appears to be a constant tug-of-war between the need to focus on ensuring that children are safe and the need to address all the multiple problems faced by the families of children who have come to CYD's attention because their safety has been questioned. These competing interests are not unrelated: children are unsafe because of the multiple problems and stressors faced by their parents and other family members. However, other public agencies have been assigned the responsibility for addressing education, housing, mental health, physical health, substance abuse, and public safety issues. Through a combination of laws, funding streams, and desire to help, *“Child welfare has become the safety net for all children who are not serviced by other systems.”* (MDT, 1987).

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APPENDIX C. SUMMARY OF CHILD WELFARE LAW AND POLICY

INTRODUCTION

This appendix summarizes the major child welfare practice requirements for the City of Philadelphia, Department of Human Services (DHS), Children and Youth Division (CYD). The primary focus is on key front-end functions including:

- Initial intake and screening of child abuse and neglect reports;
- Investigation and assessment of cases;
- The accept-for-service decision;
- Risk and safety assessment;
- Family service planning; and
- Home-based services with a focus on requirements regarding Services to Children in their Own Homes (SCOH).

After providing a brief summary of laws governing child welfare practice in the Commonwealth of Pennsylvania (Commonwealth), policy regarding each of the above functions is discussed.

BACKGROUND

CYD operates its child welfare program under the mandates of laws of the Commonwealth. The General Assembly of the Commonwealth, in establishing its child welfare law, also enacts provisions to ensure compliance with Federal requirements governing child welfare practice. A brief summary of the major Federal laws is provided in exhibit C.1, at the end of this appendix.

The primary laws of the Commonwealth governing child welfare practice include the Child Protective Services Law (CPSL), the Juvenile Act, and the implementing regulations found in Title 55 of the Public Welfare Code, Chapter 3490.¹ CYD is responsible for providing child welfare services to children and families in concert with the laws of the Commonwealth. “*All services of the agency are directed toward ensuring the safety of children and youth, preserving families and ensuring permanent, secure, nurturing homes for all children and youth; preventing juvenile delinquency, and remediating the causes of juvenile delinquency; and enhancing the capacities of families and communities to assume responsibility for their children.*”² CYD sets out its policies and procedures regarding the provision of child welfare services in the CYD Policy Manual and Policy and Procedure Guides, which revise or introduce new policies.³

The CPSL, the Juvenile Act, the Commonwealth’s regulations, and the CYD Policy Manual are the basis for the summary provided in this appendix. Discussions with staff from the Policy and Planning Division provided additional information.

¹ Additional regulations related to child welfare can be found in Title 55 of the Public Welfare, Sections 3100, 3600, 3700, and 3800.

² Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*.

³ Most of these Policy and Procedure Guides were not reviewed as only a few of them were pertinent to this summary.

The laws of the Commonwealth and its corresponding regulations mandate DHS to:

- Be the sole civil agency in Philadelphia County responsible for receiving and investigating reports of suspected child abuse and assessing reports of neglect (unless the alleged abuse is reported to have been perpetrated by an agent or employee of the county agency);
- Ensure the safety of children alleged to have been abused or neglected, as well as any other children in the home or facility where the abuse occurred;
- Provide, or arrange for, appropriate services during the investigation period; and
- Make an independent determination of reports of suspected child abuse or neglect regardless of whether a corresponding investigation is being conducted by another agency, the court, or law enforcement officials.⁴

When reports are accepted for service at the conclusion of an investigation or assessment, or a child has been alleged to be dependent or delinquent in a court petition, DHS is mandated to:

- Provide for the care, protection, safety, and the mental and physical development of the child or children;
- Provide services designed to preserve the unity of the family, keep children in their own homes; prevent abuse, neglect and exploitation; and help the family and children overcome the problems that result in dependency and delinquency;
- Provide services in a family environment, whenever possible, separating children from parents or caregivers only when necessary for their welfare, safety or health, or in the interest of public safety;
- Provide for out-of-home placement, in the least-restrictive setting possible to meet the needs of the child or children, and reunite families, as quickly as possible;
- Provide services for securing a permanent, legally-assured family for the child or children in out-of-home care when the unity of the family cannot be accomplished and the child or children cannot return home; and
- Provide, for children committing delinquent acts, programs of supervision, care, and rehabilitation that provide balanced attention to the protection of the community, the imposition of accountability for offenses committed, and the development of competencies to enable youth to become responsible and productive members of the community.⁵

⁴ City of Philadelphia Department of Human Services Web site. Retrieved March 21, 2007, from <http://dhs.phila.gov>; 23 Pa. C.S.A. §6301 et. seq; 42 Pa. C.S.A. §6301 et. seq.

⁵ Ibid.

INITIAL INTAKE

Commonwealth law mandates the creation of ChildLine, the statewide toll-free number to receive reports of alleged child abuse and neglect.⁶ In addition to ChildLine, CYD has its own Child Abuse Hotline (Hotline) which receives reports of suspected child abuse and neglect. CYD Hotline staff are responsible for receiving and evaluating reports of suspected child abuse and neglect 24 hours per day, 7 days per week.⁷ In addition, CYD Hotline staff are responsible for screening voluntary requests for services, third-party referrals for service, and self-referrals of a nonprotective nature. The goals of Initial Intake (Hotline/Screening) are listed below:

- To provide the children and families of Philadelphia access to the appropriate services offered by CYD as determined by risk of abuse, neglect, and dependency;
- To provide information and referral to services to children and families within the community;
- To screen requests for agency services in accordance with risk assessment criteria to determine whether further investigation or assessment is needed; and
- Receive calls and reports from ChildLine.

The Hotline social worker is responsible for conducting a careful and complete interview to determine whether to accept the report for investigation or assessment, refer the report to another service, or screen the report out. In processing the reports, the Hotline social worker must screen the reports for validity and gather information about the child and family, the alleged maltreatment, and previous reports of abuse and neglect to:

- Determine whether the reported information meets the statutory and agency guidelines for child maltreatment and whether to accept the report for investigation or assessment, or whether information and/or referral to other agencies are needed;
- Determine if the report constitutes one of the following:
 - Child Protective Service (CPS) report;
 - General Protective Service (GPS) report;
 - Student Abuse Report;⁸
 - A general request for services; and
- Make an initial determination of risk based on screening risk factors and assign a risk tag and response priority to the report.

CPS and GPS

Commonwealth law and state regulations divide reports alleging maltreatment into two major types—CPS and GPS. The key considerations for determining if a report is a CPS or GPS case and the concomitant responsibilities of the CYD Hotline are discussed in greater detail in the following sections.

⁶ 23 Pa C.S.A §6332.

⁷ It is also the Hotline's responsibility to accept and process reports of student abuse and general requests for service.

⁸ Student Abuse Reports (SAR) will not be discussed in this report. Reports of alleged student abuse are only received by the Hotline from law enforcement officials of the District attorney. SAR reports involve allegations of serious bodily injury, sexual abuse, or sexual exploitation of a student by a school employee when the employee is functioning in his/her role as a school employee despite when or where the abuse or injury occurred.

CPS Reports

For a report alleging child maltreatment to be registered as a CPS report, it must contain an allegation which, if true, would constitute child abuse as statutorily defined.⁹ (See exhibit C.2.) For an initial report to constitute a CPS report, four criteria must be met.

- There must be *reasonable* cause to suspect that the evidence regarding the incident or the circumstances surrounding the injuries or harm were caused by the acts or omissions of an alleged perpetrator and cannot be explained by available medical history as being accidental.
- The report must involve a child less than 18 years of age.
- Harm or substantial risk of harm must be present.
- The alleged abuse or neglect was caused by someone who is defined as a perpetrator under the law.¹⁰

All reports that come initially to the CYD Hotline and meet the definition of child abuse are forwarded to ChildLine. All reports involving certain allegations or equivalent crimes under Federal law or the law of another state must be reported to the district attorney or appropriate law enforcement officials. The CYD Hotline social worker must file a report with law enforcement officials on all reports alleging the following:

- Serious bodily injury perpetrated by persons, whether or not related to the victim;
- Child abuse perpetrated by persons who are not family members;
- Serious physical injury involving extensive and severe bruising, burns, broken bones, lacerations, internal bleeding, shaken baby syndrome or choking, or an injury that significantly impairs a child's physical functioning, either temporarily or permanently;
- Criminal homicide;
- Sexual abuse and exploitation; or
- Other crimes.¹¹

Cases involving the death of a child also are reported to the Office of the Medical Examiner when there is reasonable cause to suspect that the child died as a result of child abuse.¹² In addition, when a child dies allegedly from abuse, a systemic review of the case circumstances is conducted to improve child protection and to reduce the likelihood of future child fatalities. The Commonwealth's protocol for conducting these reviews is discussed in appendix D.

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

¹⁰ 23 Pa. C.S. §6334(b); Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200.

¹¹ 23 Pa. C.S. §6340(a)(10); Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200. Other crimes include: harassment, kidnapping, unlawful restraint, rape, statutory rape, involuntary deviate sexual intercourse, aggravated assault, indecent exposure, concealing the death of a child born out of wedlock, dealing in infant children, prostitution and related offenses, and corruption of minors.

¹² 23 Pa. C. S. §6317.

Exhibit C.2 Definition of Child Abuse

The term “child abuse” means that a *perpetrator* has committed any of the following:

1. Any recent act, or failure to act, which causes nonaccidental *serious physical injury* to a child under 18 years of age. Serious physical injury is an injury that causes a child severe pain or significantly impairs a child’s physical functioning, either temporarily or permanently.
2. Any act, or failure to act, by a perpetrator, which causes *nonaccidental mental injury* to a child under 18 years of age. Serious mental injury is a psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment, that:
 - a. Renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic or in reasonable fear that the child’s life or safety is threatened; and
 - b. Seriously interferes with a child’s ability to accomplish age-appropriate developmental and social tasks.
3. A recent act, or failure to act, or series of acts or failures to act, which creates *an imminent risk of serious physical injury to, or sexual abuse or sexual exploitation of*, a child under 18 years of age.
4. An act, or failure to act which causes sexual abuse or *sexual exploitation* of a child under 18 years of age. Sexual abuse or exploitation is the employment, use, persuasion, inducement, enticement or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or any simulation of any sexually explicit conduct for the purpose of producing any visual depiction, including photographing, videotaping, computer depicting or filming, of any sexually explicit conduct or the rape, sexual assault, involuntary deviate sexual intercourse, aggravated indecent assault, molestation, incest, indecent exposure, prostitution, statutory sexual assault or other form of sexual exploitation of children.
5. *Serious physical neglect* constituting prolonged or repeated lack of supervision or the failure to provide the essentials of life, including adequate medical care, which endangers a child’s life or development or impairs the child’s functioning.

A child will *not* be deemed to be physically or mentally abused:

1. Based on *injuries that result solely from environmental factors* that are beyond the control of the parent or person responsible for the child’s welfare, such as inadequate housing, furnishings, income, clothing and medical care.
2. If, upon investigation, the county agency determined that the *child has not been provided needed medical or surgical care because of seriously held religious beliefs* of the child’s parent... which beliefs are consistent with those of a bona fide religion

“Perpetrator” is an individual residing in the same home who has committed child abuse (either directly or due to a failure to act) and is (1) the child’s parent, (2) a person responsible for the welfare of the child, (3) an individual residing in the same home (14 years of age or older) as a child, or (4) a paramour of a child’s parent. A person responsible for the child’s welfare includes a person who provides temporary care, supervision, mental health diagnosis or treatment, training or control of a child in lieu of parental care, supervision or control.

SOURCE: 23 Pa. C.S. §6303; 55 Pa. Code §3490.4.

GPS Reports

A report is considered a GPS report if it alleges that a child has been abused or neglected, but the allegation does not meet the statutory definition of child abuse, is a nonincident-specific allegation of neglect, is an allegation of lack of supervision or failure on the part of parents or the person responsible for the care of the child to provide for the essentials of life, or alleges that a child is dependent as defined by the Juvenile Act.¹³ (See exhibit C.3.)

Exhibit C.3 Definition of a Dependent Child

A dependent child is a child who:

1. Is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals. A determination may be based upon evidence of conduct by the parent, guardian or other custodian that places the health, safety, or welfare of the child at risk, including the evidence of the parent's, guardian's or other custodian's use of alcohol or a controlled substance;
2. Has been placed for care or adoption in violation of law;
3. Has been abandoned by his parents, guardian, or other custodian;
4. Is without a parent, guardian, or legal custodian;
5. Is habitually and without justification truant from school while subject to compulsory school attendance;
6. Has committed a specific act of habitual disobedience of the reasonable and lawful commands of his parent, guardian or other custodian and who is ungovernable and found to be in need of care, treatment, or supervision;
7. Is under ten years of age and has committed a delinquent act;
8. Has been formally adjudicated dependent under section 6341 of the Juvenile Act (relating to adjudication) and is under the jurisdiction of the court, subject to its conditions or placements, and who commits an act which is defined as ungovernable;
9. Has been referred under section 6323 of the Juvenile Act and who commits an act which is defined as ungovernable; or
10. Is born to a parent whose parental rights with regard to another child have been involuntarily terminated within three years immediately preceding the date of birth of the child and the conduct of the parent poses a risk to the health, safety or welfare of the child.

SOURCE: 42 Pa. C.S. §6302.

General or Nonprotective Reports

If the Hotline social worker determines that the report is a third-party referral for services, a family is requesting voluntary services, or a self-referral of a nonprotective nature, the report is considered a General Report.¹⁴

¹³ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200.

¹⁴ 23 Pa. C.S. §6334(b); Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2300.

Hotline’s screening factors

Once the Hotline worker accepts the report, an initial determination of risk must be made to determine how quickly the county must respond to the case.¹⁵ The initial assessment of risk is completed on the Hotline Screening Risk Factors Form for all referrals accepted for a CPS investigation, a GPS Assessment, or General Request for Services. (See exhibit C.4.)

Exhibit C.4 Hotline Screening Factors

Child Factors	Perpetrator Factors	Environmental Factors
Did the child sustain a serious injury?	Does the alleged perpetrator have access to the child?	Does the family have a life-threatening living arrangement?
Does the child have multiple injuries?	Has the alleged perpetrator or caretaker exhibited bizarre behavior?	Do you anticipate that the family’s living situation will change quickly?
Is the child 6 years old or younger?	Is the parent isolated?	Do you suspect that the family is hiding or will hide the child?
Was medical care needed?	Are there any domestic violence concerns?	Are the children residing in an alleged “crack house?”
Was the child 10 years old or younger left unsupervised?	Are there allegations involving drug or alcohol use?	Is the family without utilities?
Are there several victims?	Is the family a flight risk?	Is the family homeless?
Does the child have a mental health history?	Are either of the child’s parents or caretakers ill or dead?	
Is the child exhibiting provocative behaviors?	Was there an implement used?	
Are there allegations of sexual abuse?	Is the parent a teenager?	
Is the abuse or neglect habitual or ongoing?	Are there any prior indicated or substantiated reports?	
SOURCE: McCone, G. & Flite. Hotline Practice Training (May 2006). Received March 2007, from DHS.		

In addition to the designation of the report to CPS, GPS or General Report, the risk determination is based on the following factors:

- Child factors;
- The alleged perpetrator’s factors including access to the child and prior indicated/substantiated reports;
- Family environment; and
- The nature of the allegations¹⁶

¹⁵ 55 Pa. Code §3490.321(g).

¹⁶ McCone, G. & Flite. Hotline Practice Training (May 2006). Received March 2007, from DHS.

These Hotline Screening Factors determine the risk level and drive response priority given to the report. CYD must begin the investigation and see the child immediately when emergency protective custody has been taken, is needed, or it cannot be determined from the allegations whether emergency custody is needed. All children for whom a CPS report or other type of report, based on the response priority, must be seen within 24 hours or sooner.¹⁷ The response priorities are defined as follows.

- **Response Priority 1:** Immediate response CPS and emergency GPS (E-GPS) reports.
- **Response Priority 2:** 24-hour response. The 24 hours begin when the Hotline receives the report; the time is noted on the referral form (the response for all CPS reports and E-GPS reports designated as requiring a 24-hour response).
- **Response Priority 3:** Non-24-hour response (the response for all Student Abuse Reports (SAR) and all nonprotective requests for service and GPS reports not designated as Response Priority 1 or 2).¹⁸

Once the Hotline staff member accepts the report and designates the appropriate response priority, and the case is reviewed and signed by the Hotline supervisor, the case is then immediately forwarded to appropriate staff for assignment to a social worker for investigation or assessment. The assigned social worker will begin the investigation/assessment based on the response priority determined by the Hotline, as outlined above.¹⁹

INVESTIGATION/ASSESSMENT REQUIREMENTS

The term investigation is used to refer to the process of determining whether a child abuse report (CPS) is founded, indicated, or unfounded. The term assessment is used to refer to the process of determining the need for protective services for nonabuse cases (GPS). Caseworkers conducting investigations or assessments must perform the following functions, at a minimum.

- Assess, assure, and document the safety of *all* the children in the home.
- Document specific issues which impact on maintaining child safety in the case narrative, the Investigation/Assessment Summary, the Risk Assessment, and during supervisory reviews.
- Provide or arrange services necessary to protect the child during the investigation/assessment.
- Determine the risk of harm to the child or children if they continue to remain in the existing home environment.

¹⁷ 23 Pa. C.S. §6368; 55 Pa. Code 3490.55.

¹⁸ 23 Pa. C.S. §6368; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 2200; Philadelphia Department of Human Services, Children and Youth Division, (August 2004). *Updated Policy and Procedure for Assigning and Responding to Reports of Abuse or Neglect*.

¹⁹ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 3110.

- Conduct at least one home visit, and additional home visits as often as necessary, to complete the investigation/assessment and assure the safety of the child.
- Contact appropriate collateral persons.²⁰

Supervisory responsibilities also are the same during an investigation or assessment. The supervisor must review the report to determine:

- The safety of the child;
- The progress made toward reaching a determination and/or accept-for-services decision; and
- Whether the level of services are consistent with the level of risk to the child.

Supervisory reviews must begin by the tenth calendar day after the date of the report. Reviews must be conducted at 10-calendar day intervals during the investigation/assessment period. The supervisor must maintain a log of these reviews.²¹

CPS investigations

All CPS investigations must be initiated and the child must be seen within 24 hours of the report. The investigation must begin immediately if the child, who is the subject of the report, is in emergency protective custody or if it cannot be determined from the report whether emergency protective custody is needed.²²

A CPS investigation is a fact-finding and decision making process that must determine whether the CPS report is “indicated,” “founded,” or “unfounded.”²³ The following definitions of these terms apply.

- A report is considered “indicated” when substantial evidence²⁴ of the alleged abuse exists, based on available medical evidence, the CPS investigation, or when the perpetrator admits the act of abuse. In instances of current serious physical injury, medical documentation is required for a report to be indicated, in most cases, even if there has been an admission by the perpetrator.²⁵

²⁰ 55 Pa. Code §3490.55.

²¹ 55 Pa. Code §3490.61; Philadelphia Department of Human Services, Children and Youth Division. (January 2000). *Policy Manual*, Sections 3170, 3200.

²² 55 Pa. §Code 3490.55.

²³ 23 Pa. C.S. §6368(c).

²⁴ 55 Pa. Code §3490.4. Substantial evidence refers to evidence which outweighs inconsistent evidence and which a reasonable person accepts as adequate to support a conclusion.

²⁵ 23 Pa. C.S. §6303; 55 Pa. Code §3490.4; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual* Section 3190.1.

- A report is “founded” if the case goes to Juvenile Court and adjudication is made on the basis of abuse and neglect, or if the case goes to Criminal Court and the perpetrator is found guilty, pleads guilty, or enters a plea of *nolo contendere* to the charges corresponding to the allegations of the report.
- A report is considered “unfounded” if the allegation cannot be confirmed based on the criteria for abuse and neglect as defined in statute.²⁶

A report of abuse or neglect is *not* considered to constitute a CPS report if, upon investigation, it is determined that:

- Needed medical or surgical care was withheld from a child due to seriously held religious beliefs that are consistent with those of a bona fide religion; or
- The injuries to the child resulted solely from environmental factors that were beyond the control of the parent or person responsible for the child’s welfare, such as inadequate housing, furnishings, income, clothing, and medical care.²⁷

For cases regarding the withholding of needed medical or surgical care due to a seriously held religious belief, the CYD social worker must monitor the child closely and seek court-ordered medical intervention when the lack of medical or surgical care threatens the child’s life or long-term health. All correspondence with the subject of the report and all references in the case record must not mention child abuse and must acknowledge the religious basis for the child’s condition. If appropriate, the family shall be referred for general protective services.²⁸

If the child has been a victim of a previously substantiated incident of child abuse, the case must be reviewed by the Multi-Disciplinary Team (MDT). The MDT is composed of professionals from a variety of disciplines who provide consultation and assistance to CYD social workers in determining if child abuse has occurred.²⁹

CYD must complete and send the Child Protective Service Investigation Report to ChildLine within 30 calendar days of the initial report.³⁰ If an investigation of a report of suspected child abuse does not determine, within 60 days of the date of the initial report, that the report is indicated, founded, or unfounded, the report will be considered to be an unfounded report. The exception to this rule is if, within that same 60-day period, court action has been initiated and is responsible for the delay.³¹ At the end of the investigation, a Risk Assessment Summary must be completed.³² The Risk Assessment Summary is discussed later in this appendix.

²⁶ Ibid.

²⁷ 23 Pa. C.S. §6303(b)(2),(3).

²⁸ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual* (Section 3190.1).

²⁹ 55 Pa. Code §3490.62.

³⁰ 55 Pa. Code §3490.67.

³¹ 23 Pa. C.S. §6337(b).

³² Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 3190.8.

If the county agency concludes that the child is in danger of further child abuse, the county agency shall take the following actions:

- Accept the case for service;
- Provide direct case management; and
- Monitor the provision of services, whether provided directly by the county agency or through purchase or agreement.³³

Additional casework requirements for CPS investigations are provided in exhibit C.5.

³³ 55 Pa. Code §3490.53.

Exhibit C.5 CPS Investigation Requirements

<p>Initiating the CPS Investigation</p> <ul style="list-style-type: none">• Immediately begin the investigation and see the child if emergency protective custody is required or has been taken, or if it cannot be determined from the report whether emergency protective custody is needed.• Within 24 hours, see the child.• Within 24 hours, confer with supervisor to determine safety of the child and whether the child is in imminent danger.<ul style="list-style-type: none">○ If in imminent danger, attempt to eliminate or reduce the danger through voluntary means, utilizing family resources, whenever possible.○ If no alternatives to placement, obtain a Voluntary Placement Agreement or seek an order of protective custody.• If time permits, review previous investigative and service activity in FACTS and existing case record before initial attempt at contact.• Make contact with the reporter to uncover information related to possible ages of children, schools the children might attend, times they are likely to be home and anything that would indicate a safety risk to the social worker or might indicate that police assistance is needed.
<p>Notification</p> <ul style="list-style-type: none">• Within 72 hours, provide written notification to all subjects of the report.• Prior to interview, verbally notify all subjects, except child, of the existence of a report and the allegations, the right to counsel, the perpetrator's rights to amendment and expungement of the report by Administrative Appeal. A verbal notification must be documented.
<p>If Caseworker is Unable to Gain Access and Interview the Subject of the Report</p> <ul style="list-style-type: none">• If a child is believed to be in immediate danger, the social worker should dial 911 to obtain immediate police assistance.• If immediate placement is necessary to secure the child's safety, the social worker must obtain a restraining order and take child custody.• When a CYD social worker is refused access to any child by the parent(s)/caregiver(s), whether by being refused entry or by evasion, the social worker must consult with the supervisor about seeking immediate court intervention and/or police assistance. An appropriate course of action may include an immediate unannounced visit by the CYD social worker, attempting to see the child at another location, e.g. school, or seeking court intervention or obtaining police assistance.
<p>Initial Interview</p> <ul style="list-style-type: none">• Ensure safety of the child and any other children in home.• Make preliminary determination of severity of the injury or neglect and risk of harm.• Collect additional information to include in case record or verification from collateral contacts.• Assess adequacy of the home environment.• Begin to assess family's dynamics, functioning, and circumstances.
<p>Required Interviews</p> <ul style="list-style-type: none">• For each investigation, it is absolutely necessary that the social worker interview all involved adult and child subjects of the report and other children who are regular members of the household.• For all children in the household, contact with the child's regular source of medical care and, if age appropriate, the child's school is required as well as any other sources which may have information relevant to the allegations.
<p>Involving Law Enforcement Officials</p> <p>A caseworker may obtain assistance from police when:</p> <ul style="list-style-type: none">• Executing a Restraining Order;• When there is a Court Order authorizing entry or break down;• When the social worker's safety is endangered; and• Any time that a social worker has evidence to believe a child is in immediate danger; <p>Notice must be provided to the Philadelphia police prior to closing a case on any missing family if:</p> <ul style="list-style-type: none">• The last safety assessment indicated the child to be unsafe or conditionally safe;• The last risk assessment on the family indicated a high level of risk; and/or• The family has been uncooperative with the safety plan or with services. <p>Reports must be made to the police for specific types of allegations:</p> <ul style="list-style-type: none">• For example, rape, sexual abuse, serious bodily injury or serious physical injury involving burns, broken bones, and lacerations.
<p>Examining and Photographing the Subject Child</p> <ul style="list-style-type: none">• Conduct visual examination of the child in order to determine nature and extent of the injuries. If child has sustained visible injury, obtain a color photograph of the injury.
<p>Completing the Investigation</p> <ul style="list-style-type: none">• Must complete Child Protective Service Investigation Report (CY-48) within 30 days of the report and send it to ChildLine.• Must include written summary of the facts obtained during the course of the investigation in the case record.
<p>SOURCE: 23 Pa. C.S. §6368; 55 Pa. Code §3490.55; 55 Pa. Code §3130.32. Philadelphia Department of Human Services, Children and Youth Division (January 2000). <i>Policy Manual</i>, Sections 3000, 3100, 3170.</p>

GPS assessments

As with CPS cases, the Response Priority and Risk Tag drive all initial activity on the assessment.

- *Response Priority 1*—for any report designated Response Priority 1, the assigned social worker must see all subject children and assess safety immediately.
- *Response Priority 2*—for any report designated Response Priority 2, the social worker must see all subject child(ren) and assess safety as soon as possible within the first 24 hours of the receipt of the report by the Hotline.
- *Response Priority 3*—for reports designated Response Priority 3, the social worker must see all subject children and assess safety within seven working days of receipt of the report by the Hotline.³⁴

CPS policies that govern assessing the safety of all children in the household, home visits, interviews, collateral contacts, use of Court, confidentiality, visual examination of the child, maintenance of a written record of information gathered, and the use of the Risk Assessment Tool, also apply to all GPS assessments.³⁵ During an assessment, if there is evidence of serious abuse or neglect, the social worker must report the information to the Hotline immediately after ensuring the safety of all children in the household.³⁶ The assessment of GPS cases must be completed within 60 days of the date of the referral, and findings must be documented in the case record. A written summary of the facts obtained during the course of the assessment and from each interview is due when the assessment is complete.³⁷ Requirements regarding home visits and notification for GPS Assessments are provided in exhibit C.6.

³⁴Philadelphia Department of Human Services, Children and Youth Division.(August 2004). Updated Policy and Procedural Guide *for Assigning and Responding to Reports of Abuse or Neglect*.

³⁵ Philadelphia Department of Human Services, Children and Youth Division. (January 2000). *Policy Manual*, Section 3200.

³⁶ Ibid.

³⁷ Ibid.

Exhibit C.6 GPS Assessment Requirements

Home Visits

- For cases lacking supervision, the first home visit is to be unannounced.
- After two unsuccessful scheduled attempts to meet with the family, a third visit is to be scheduled by letter indicating that failure to meet with the social worker may result in court intervention.
- The decision to file a petition to cooperate with the assessment must be made, after consultation with the supervisor, between the 30th day, but not later than the 60th day, after the report.
- Failure to locate a child/family within three attempts must be discussed by the social worker and supervisor with the social work administrator and director. If there is no response from the family within 24 hours after the third unsuccessful visit, the social worker and supervisor should discuss seeking court intervention. Court intervention should be sought when the worker believes that someone has information as to the family's whereabouts and is deliberately concealing or refusing to reveal the information.

Notification

- At the initial interview, must verbally notify the parent or the person responsible for the care of the child, of the referral and that the CYD will be conducting an assessment to determine the need for general protective services.
- Within 7 calendar days of making the determination to accept or not to accept the family for general protective services, provide written notice to the parents and, if applicable, to the person responsible for the care of the child, of the decision.
- No written notification is required for substantiated³⁸ GPS reports for parents/caregivers whose cases were already open and accepted for service at the time the referral was received.

SOURCE: 55 Pa. Code §3490.232; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 3200.

EXPUNGEMENT

The law of the Commonwealth provides explicit policies regarding expungement of CPS reports on ChildLine. The statewide central register maintains a record of CPS reports under investigation.³⁹ Expungement is “*to strike out or obliterate entirely so that the expunged information may not be stored, identified or later recovered by any mechanical or electronic means or otherwise.*”⁴⁰

CYD must also amend or expunge a record of child abuse upon notification from ChildLine. CYD must “*expunge all information in its possession in unfounded, founded and indicated reports of child abuse.*”⁴¹ CYD must also “*notify those to whom it gave information to take similar action.*”⁴²

Following are the policies regarding maintaining unfounded, founded and indicated reports of suspected child abuse on the statewide central registry.

³⁸ The terms “substantiated” and “unsubstantiated” are not defined in state law or policy or DHS policy. These terms were introduced in the early 1980’s to describe the decision resulting from the GPS assessment. Effectively, “substantiated” means that there was evidence in the assessment that allegations in a GPS report were accurate, true and correct.

³⁹ 23 Pa. C.S. §6331.

⁴⁰ 23 Pa. C.S. §6303.

⁴¹ 55 Pa. Code §3490.70.

⁴² Ibid.

- **Unfounded Reports**—Information concerning a report that is determined to be unfounded is maintained for a period of one year after the date the report was received. No later than 120 days after the one-year period the report must be expunged.
- **Founded and Indicated Reports**—When a child who is the subject of a founded or indicated child abuse report reaches the age of 23, the reports must be expunged. However, the names of perpetrators, with date of birth or social security number are kept indefinitely.⁴³

Generally, the Secretary of the Department of Public Welfare is authorized to expunge any record if there is good cause and notice is provided to the appropriate subjects of the report. In addition, any person named as a perpetrator may request an amendment of expungement within 45 days of being notified of the report. If the request is refused or not acted upon in 30 days, the subject has a right to a hearing before the Department’s Bureau of Hearing and Appeals.⁴⁴

CYD must also amend or expunge a record of child abuse upon notification from ChildLine. CYD must “*expunge all information in its possession in unfounded, founded and indicated reports of child abuse.*”⁴⁵ CYD must also “*notify those to whom it gave information to take similar action.*”⁴⁶

Commonwealth law also requires that CPS reports, summaries of child abuse and written reports, and any other information obtained concerning alleged instances of child abuse in the possession of the Department of Public Welfare or DHS, are confidential. Information in confidential reports is made available only to specific delineated individuals including law enforcement officials investigating certain types of crimes in which the information is relevant, the district attorney, and a court of competent jurisdiction.⁴⁷ Information obtained by CYD in the course of an assessment for the need for general protective services is also confidential.⁴⁸

THE ACCEPT-FOR-SERVICE DECISION

Once the CYD social worker has completed the investigation or assessment, a decision must be made as to whether the family will be accepted for services.⁴⁹ This decision is made based on the family’s needs and problems, and the safety of the child as determined by the investigation or assessment and the Risk Assessment Summary.⁵⁰ Two factors are involved in a decision to accept the family for services:

⁴³ 23 Pa. C.S. §6338.

⁴⁴ 23 Pa. C.S. §6341.

⁴⁵ 55 Pa. Code §3490.70.

⁴⁶ Ibid.

⁴⁷ 23 Pa. C.S. §6340; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 1101.1.

⁴⁸ 55 Pa. Code §3490.242. Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 1100.

⁴⁹ 23 Pa. C.S. §6303; 55 Pa. Code §3490.4.

⁵⁰ 23 Pa. C.S. §6303.

- The overall rating of risk must be at the moderate or high level unless ordered by the Court; or
- The case should not be accepted for services if the risk of harm to the child is eliminated and no services are necessary, or if the level of risk is low.⁵¹

If a case has not been closed by the 60th day after the date of the report for investigation or assessment, the case is considered open and accepted for service. If a family is accepted for service as a result of abuse or neglect, or is accepted for in-home service only, all children are considered open and accepted for service. If a family is accepted for service and a placement occurs from causes other than abuse or neglect, and the other children in the household have been assessed as being at no or low risk, and there are not other issues around their care and supervision, the remaining nonplaced children are not accepted for service.⁵²

Petitioning the Court

Families may voluntarily participate in services or be ordered by the Court to participate in protective services. If the family refuses to participate, CYD petitions the Court if:

- Placement or continued placement of a child is necessary;
- A subject of the report of suspected child abuse refuses to cooperate with the county agency in an investigation and the county is unable to determine whether the child is at risk; or
- The parent(s) refuses services, and CYD determines that services are in the best interest of the child.⁵³

Removal of the child or court-ordered services may occur only if clear and convincing evidence of dependency is found by the Court.⁵⁴

SAFETY AND RISK ASSESSMENT/PLANNING

Both Commonwealth and Federal law establish that child safety is to be the paramount concern that guides the provision of all child welfare services.⁵⁵ In the Commonwealth, “[e]very decision made in a case, program development, or agency policy and procedure should be filtered through child safety concerns.”⁵⁶ Safety and risk assessment are key determinations that must be made throughout the life of a child welfare case, whether the child remains at home receiving services or is in placement. At every contact CYD has with the child, his or her caregivers or any other persons or entities that are involved with the child, issues of safety must be evaluated.⁵⁷

⁵¹ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 3500.

⁵² *Ibid.*

⁵³ 55 Pa. Code §3490.73.

⁵⁴ 42 Pa. C.S. §§6341, 6351.

⁵⁵ Adoption and Safe Families Act (ASFA), P.L. 105-89; Commonwealth of Pennsylvania, Department of Public Welfare, Children, Youth and Families. (November 2000). *Bulletin 3490-00-02: Safety Assessment and Safety Planning Protocol and Format*.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

A safety assessment evaluates whether there is an immediate threat of harm to the child. It is the process of determining the present level of safety of a child, the seriousness of the threat or harm to the child, the strengths and resources that may be used to increase the child’s safety, and the steps, if any, needed to provide protection for the child. A risk assessment evaluates the impending threats of harm to a child. It helps to identify the individuals who need to be served and the factors that must be addressed to reduce impending risk levels. Both safety and risk assessments are continuous, ongoing processes that a social worker must undertake and should not be limited to the point in time during which the formal risk assessment matrix is completed on the Risk Assessment Form.⁵⁸ Exhibit C.7 below provides 15 risk factors which must be assessed in order to determine the level of risk, whether to accept for service, and types of services needed. The factors are described in more detail in exhibit C.8, which is presented at the end of this appendix. When reviewing each of the factors, the caseworker must:

- Consider the degree of risk relevant to each of the factors and determine if the factor puts the child at “no risk,” “low risk,” “moderate risk,” or “high risk;”
- Identify behaviors which affect the factor;
- Assess the extent of risk for each of the factors; and
- Complete a review of all the relevant factors and consider the totality of the factors and their overall impact on the determination of risk of harm to the child.⁵⁹

Exhibit C.7 Risk Assessment Form Factors

Child Factors	Caretaker, Household Member, Perpetrator Factors	Family Environment
1. Vulnerability 2. Severity/Frequency and/or Recentness of Abuse/neglect 3. Prior Abuse/Neglect 4. Extent of Emotional Harm	5. Age, Physical, Intellectual or Emotional Status 6. Cooperation 7. Parenting Skills/Knowledge 8. Alcohol/Substance Abuse 9. Access to Children 10. Prior Abuse/Neglect 11. Relationship with Children	12. Family Violence 13. Condition of the Home 14. Family Supports 15. Stressors
<small>SOURCE: Pennsylvania Child Welfare Training Program (June 1996). <i>A Reference Manual for the Pennsylvania Model of Risk Assessment</i>.</small>		

Safety must be assessed and assured at every contact with the child or family by both the CYD social worker and the provider social worker. All social workers have a duty to take all appropriate measures to protect a child’s life and health. When a child is assessed to be in immediate danger, a safety plan must be put in place. A broad range of interventions may be employed to protect the child. Safety interventions “should be viewed on a continuum of response alternatives, but may include placing the child outside of the family or termination of

⁵⁸ Ibid.

⁵⁹ 55 Pa. Code §3490.321; Pennsylvania Child Welfare Training Program (June 1996). *A Reference Manual for the Pennsylvania Model of Risk Assessment*. Received March 2007 from DHS.

parental rights.”⁶⁰ Protective custody should be requested only if the immediate safety and well-being of the child requires removal from the setting in which the alleged child abuse occurred.⁶¹

Formal risk assessments, requiring the completion of the Risk Assessment Form, must be completed on all children in the home regardless of case status, at the following points in time in the case, following acceptance for an investigation or assessment:

- At the beginning of the assessment/investigation;
- At the conclusion of the investigation/assessment which may not exceed 60 calendar days;
- Every six months, in conjunction with the semiannual family service plan or judicial review, unless the case was accepted at low or no risk, or the child has been placed out of the home for more than six months and there are no other children in the home;
- Thirty calendar days before and after the child is returned to the family home unless the risk to the child remains at low or no risk or the child’s return home was not anticipated by the county agency;
- Thirty calendar days prior to case closure;
- As often as necessary to ensure the child’s safety; and
- When circumstances change within the child’s environment.⁶²

A safety assessment must be completed at the initial in-person contact during the investigation/assessment process and be updated as the situation changes. If at any time a child is determined to be unsafe, the child welfare worker must develop a safety plan which will ensure the child’s immediate safety. A safety plan must address the step-by-step actions needed to assure the safety of the child(ren). Safety interventions are intended to control immediate safety threats. Safety interventions:

- Are put in place in the absence of protective capacities within the family;
- Directly target a specific threat of immediate harm; and
- Have an immediate effect on a situation.⁶³

Safety interventions should be viewed on the continuum of response alternatives, from least to most intrusive with the most severe safety intervention being placement of the child. There is a wide range of safety interventions that can be put in place to supplement the family’s protective capabilities.⁶⁴

⁶⁰ Ibid.

⁶¹ 55 Pa. Code §3490.57.

⁶² 55 Pa. Code §3490.321; Commonwealth of Pennsylvania, Department of Public Welfare (November 2000). *Bulletin 3490-00-02: Safety Assessment and Safety Planning Protocol and Format*; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual* (Section 4200). Pennsylvania Child Welfare Training Program (June 1996). *A Reference Manual for the Pennsylvania Model of Risk Assessment*. Received March 2007, from DHS.

⁶³ Ibid.

⁶⁴ Ibid.

While it is the caseworker who conducts safety assessments and recommends the safety plan, the caseworker is not the sole person responsible for safety decision making. The supervisor's role in the decision making process involves discussion with the caseworker regarding his or her assessment and recommendations. The supervisor must provide final approval to agree with, alter, endorse, and collaborate on, the caseworker's recommendation and implementation of the safety plan.⁶⁵

CASE PLANNING: THE FAMILY SERVICE PLAN

For each family accepted for services, a written family service plan (FSP) must be developed. The FSP outlines the goals of CYD's intervention with the family and children, the objectives to achieve the goals, and the actions to be taken by CYD and the parties during a specified period of time. Family members, including the child, their representatives and service providers, must have the opportunity to participate in the development of the FSP. For cases with a previous indicated or founded report of child abuse, the FSP is to be revised, if necessary, to reflect and implement the Multidisciplinary Team (MDT) recommendations.⁶⁶ The FSP must include the following components:

- A description of the specific circumstances under which the case was accepted;
- The service objectives for the family and changes needed to protect children and prevent placement;
- The service to be provided to achieve the objectives of the plan; and
- The actions to be taken by the parents, children, the county agency or other agencies, and the dates when these actions will be completed.⁶⁷

The FSP must be signed by the county agency staff person responsible for management of the case. The parent or legal guardian and the child, if 14 year of age or older, must be given an opportunity to sign the FSP. They also must be informed that signing the plan constitutes agreement with the service plan.⁶⁸ Within 10 calendar days of the completion of the FSP, the supervisor must review the plan to assure that the level of activity, in-person contacts with the child, oversight, supervision and services for the child and family are consistent with the level of risk determined by the county agency for the case. Documentation of this review shall be in the case record.⁶⁹ In addition, a Risk Assessment must be completed in conjunction with the semiannual review of the FSP unless:

⁶⁵ 55 Pa. Code §3490.61; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 1500.

⁶⁶ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 3600.

⁶⁷ 23 Pa. C.S. §6375(e); 55 Pa. Code §3130.61; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 3500.

⁶⁸ Ibid.

⁶⁹ 55 Pa. Code §3490.235(f).

- The case has been accepted at low or no risk and has remained at low or no risk; or
- The children have been in care for six months or more, the FSP goal is not reunification and there are no other children in the family home.⁷⁰

The specific time frames for completion and review of the FSP are:

- Within 60 days of the date the agency accepted the family for in-home services;
- Within 30 days of the placement date; and
- At least every six months.⁷¹

The supervisor is required to review the FSP within 10 calendar days of the plan's completion to assure that the level of activity, in-person contacts, oversight, supervision, and services provided to the child and family are consistent with the child's identified level of risk.⁷²

THE PROVISION OF SERVICES

Once a case is accepted for services, CYD is responsible for providing, or arranging the provision of, placement, prevention and reunification services, and other required services or care as ordered by the Court. The service array available to the child and family is the same for all cases regardless of the initial designation of the case as CPS or GPS. All decisions regarding services planned or provided are based on the child's safety and well-being. The CYD social work supervisor directs the scope and extent of all casework functions and guides all decision making in consultation with the CYD social worker.⁷³ Services may include home-based services, placement services, adoption services, and other appropriate programs. Services to Children in their Own Homes (SCOH), which is one type of home-based services, and placement services, will be summarized below.

Home-based services are provided—when practicable—to maintain children safely in their own homes, prevent placement, avert placement, and reduce the likelihood of abuse and neglect. Depending upon the needs of the child and family, home-based services can include, but are not limited to:

- Services to Children in their Own Homes (SCOH);
- Family Preservation and Reunification Services;⁷⁴
- Sexual Abuse Services;
- Day care services;
- Day treatment services;

⁷⁰ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 4200.

⁷¹ 55 Pa. Code §§3490.61, 3490.235; 55 Pa. Code §§3130.61, 3130.63.

⁷² Ibid.

⁷³ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5000.

⁷⁴ The Family Preservation (FP) Program is composed of a section of case-carrying CYD social workers who work directly with specific provider agencies to deliver intensive, time-limited services in a crisis-intervention modality. It is a short-term intervention of no more than 12 weeks, clear accessibility of service providers, and in-depth service of as much as 20 hours a week, seven days a week if necessary.

- Mental health services;
- Counseling; and
- Drug and alcohol treatment.

SCOH services

SCOH services are purchased for every family accepted for service whose children remain at home. The Central Referral Units (CRU) are noncase-carrying units of social workers who provide resource and planning assistance to CYD social workers in accessing SCOH and Placement services.⁷⁵ SCOH services include at least the following:

- Initial and ongoing family assessment;
- Counseling intervention and direct social service intervention for members of the client family;
- Structured interventions which promote life-skills development by members of the client family;
- Advocacy for acquiring, coordinating, and monitoring the use of other community resources needed to meet family needs; and
- Service coordination to plan and monitor client family participation in the total array of services from the provider agency and other community resources.⁷⁶

SCOH Case Management and Casework Contacts

When a family is receiving SCOH, it is the responsibility of the SCOH-provider social worker to help in assuring the child's safety. Required casework contacts are driven by the level of risk as determined using the Risk Assessment Form Factors. The provider social worker (or the CYD caseworker if there is no provider social worker in place) must perform the following activities:

- Document the safety of the children during every face-to-face contact;
- Report concerns regarding service delivery and safety to the county social worker and supervisor;
- Conduct weekly face-to-face contacts with the parent and child while the case is considered high-risk; and
- Conduct monthly face-to-face contacts for indicated CPS cases and substantiated GPS cases, where the child is not at high risk for at least six months after the determination, or until the case is closed, if closed prior to the six-month period.

After the initial six-month period, the following procedures must be followed:

- Moderate-risk cases must continue to be seen monthly;
- Low-risk or no-risk cases must be seen quarterly; and
- For all other reports, if the case is moderate-risk, the child and parent must be seen monthly; if the case is low- or no-risk, the child and parent must be seen quarterly.⁷⁷

⁷⁵ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5720.

⁷⁶ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5111.

The county social worker is responsible for case management and oversight of the provision of SCOH. Case management and oversight responsibilities of the county social workers are provided in exhibit C.9.

Exhibit C.9 Case Management and Oversight Requirements for SCOH

The county social worker must:

- Conduct a joint visit with family and SCOH provider within seven, but no later than ten, working days of the SCOH agency's acceptance of the referral;
- Verify that SCOH provider completed an initial Family Service Description (FSD) at the joint visit or within 30 days of the joint visit;
- Have at least monthly phone or letter contact with the family and SCOH provider to ensure services are being provided;
- Visit the family home, assess and document the safety of the children at least quarterly after the first review cycle;
- Review quarterly reports provided by the SCOH agency and monitor the quality and quantity of contact with the family and children;
- Review the necessity for ongoing SCOH and support every 6 months with the SCOH agency and the family; and
- If a formal alert is sent by the provider social worker regarding an inability to meet with the child and family, the county social worker must, within three working days, contact the agency and the family. If contact has not resumed, the county social worker must visit the household within the next 3 working days to ensure child safety and determine a course of ongoing action.

SOURCE: 55 Pa. Code §3490.61; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5112.

Placement services

Children can enter foster care by court order or based on a voluntary placement agreement. When evidence shows that continuation of the child in his or her home would be contrary to the welfare, safety or health of the child, or it is in the best interest of the child to be removed from the home, the court can order placement. The court also must find, by clear and convincing evidence, that:

- Reasonable efforts were made prior to the placement of the child to prevent or eliminate the need for removal of the child from his home, if the child has remained in his home pending a court order for placement;
- If preventive services were not offered due to the necessity for an emergency placement, that such lack of services was reasonable under the circumstances; or
- If the court has previously determined through an informal hearing that reasonable efforts were not made to prevent the initial removal of the child from his home that reasonable efforts are under way to make it possible for the child to return home.⁷⁸

⁷⁷ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5112.

⁷⁸ 42 Pa. C.S. §6351(b). A finding of reasonable efforts is not required if the court previously determined that aggravated circumstances exist and no new or additional reasonable efforts are required.

In order for a child to be voluntarily placed and remain in foster care for more than 30 days, the court must determine that continued placement is necessary and issue a court commitment.⁷⁹

Case Planning, Case Management, and Casework Contacts

For every child placed in foster care, an initial FSP must be completed within 30 days of placement. Prior to a planned placement, an amendment to the service plan must be prepared which must include:

- Health and educational information;
- The types of efforts that have been made and the services provided to prevent placement;
- The anticipated duration of the placement, stated in months;
- The permanency goal for the child;
- A description of the service objectives that must be achieved by the parents or child prior to reunification;
- An identification of the services to be provided to the family, the child and the foster family by the county agency and other service providers to achieve the goal for the child;
- An identification of the steps the county agency must take to ensure that the service plan is implemented, including a schedule for review of the status of each child; and
- A description of the program and services that will be provided for a child 16 years of age for transition from foster care to independent living, as deemed appropriate.⁸⁰

The provider social worker or the CYD social worker (if a directly-supervised home), is responsible for providing ongoing social services for the child(ren) and family as outlined in the FSP. In addition, the social worker must:

- Meet with the child(ren)'s biological family in their own home and with the child(ren) in the foster home at least once a month;
- Assess, assure, and document the safety of the child(ren) during every face-to-face contact;
- Ensure that the child receives regular medical/dental care; and
- Report critical and unusual incidents or reports alleging abuse or neglect.

The CYD social worker conducts the FSP reviews and the provider social worker conducts the Individual Service Plan (ISP) reviews.⁸¹

⁷⁹ 42 Pa. C.S. §6341, §6351(a); 55 Pa. Code §3130.65.

⁸⁰ 55 Pa. Code §3130.67.

⁸¹ Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5222.

When a child is placed with a private agency under contract with the county, the county social worker is required to:

- Visit the out-of-home care setting, see the child and assess and document his/her safety every 6 months;
- Visit the family home every 6 months, if the goal is reunification, to assess and document child safety and/or the potential for the child's safe reunification;
- Review the FSP, in conjunction with his/her supervisor, every 6 months;
- Prepare reports for court hearings and reviews;
- Coordinate and oversee the services provided and ensure the provider agency meets the expectations for service delivery; and
- Maintain regular contact with the provider agency staff and the child to ensure that the services are consistent with the FSP and the identified medical, educational, and therapeutic needs of the child.⁸²

Court reviews and permanency hearings

A court review is held for all children placed in foster care and for cases receiving court-ordered supervision in conjunction with the FSP review cycle of every 6 months. At the court review, the county agency presents the results of assessments and determinations made during the development of the FSP for the Court's approval.

For all children in placement, permanency hearings are held concurrently with the court review. Permanency hearings are held to:

- Determine the continuing necessity for, and appropriateness of, the placement;
- Determine the extent of compliance with the service plan;
- Determine the extent of progress made toward alleviating the circumstances which necessitated the original placement; and
- Project a likely date by which the goal for the child might be achieved.⁸³

TRAINING AND SUPERVISION

Development of the knowledge and skills necessary to provide services to children and families through training and supervision is required in the policy of the Commonwealth and CYD. All child welfare professionals delivering service to children and families must complete a competency-based training and certification program consisting of a minimum of 120 hours of CORE training. Each year thereafter, direct service caseworkers must participate in 20 hours of training. Supervisors of direct service caseworkers must also be certified as direct service caseworkers.⁸⁴ In addition to training, supervisors play a critical role in case decision making. At

⁸² Ibid.

⁸³ 55 Pa. Code §3130.71; 42 Pa. C.S. §6351; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 4500.

⁸⁴ 55 Pa. Code §§3490.311-3490.313; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5850.

each step of the case planning and implementation, the supervisor is expected to assist the caseworker in decision making and to review and monitor casework activities.⁸⁵ The supervisor-to-direct-service-staff ratio for the county must be no more than five to one.⁸⁶

SUMMARY

The Pennsylvania CPSL and state regulations distinguish allegations of child maltreatment into two major categories—CPS and GPS. The designation of the case as GPS or CPS is made at initial intake (Hotline/Screening). The determining factor between CPS and GPS, as defined by the CPSL, appears to be the presence or absence of an injury or the imminent risk of injury. GPS cases involve families in which there is a likely *potential for harm* to the child.

There are more rigorous requirements that must be met by a CYD social worker for investigation of CPS cases. The CPS investigation is a legal fact-finding process. The evidence gained through the investigation must support a standard of clear and convincing evidence in order for the juvenile court to enter a finding that a child has been abused. If the court makes such a finding, the abuse report is considered founded. For the case to be substantiated, there must be substantial evidence that the alleged abuse occurred. If the report is founded or indicated, the subject of the report will be placed on the statewide register.⁸⁷ The register serves as a screening device to prevent perpetrators from being accepted into employment or caregiving situations where they will have extensive contact with children. For certain jobs an employer cannot hire an individual who, according to the central register, has committed child abuse in the last 5 years: child-care services worker, foster parent, adoptive parent, and self-employed family day care providers.⁸⁸ The information from a CPS investigation may also support a finding of a criminal charge involving the same factual circumstances involved in the allegation of child abuse. Therefore, when conducting the CPS investigation, the social worker must ensure that the subject of the report is notified of his or her rights, particularly the right to counsel, and that support for the determination is well-documented. In addition, the time frames for CPS cases are shorter. At a minimum, all investigations must be initiated within 24 hours. In addition, the time frame for completing the investigation is shorter than for completing a GPS assessment. In most cases, CPS investigations must be completed in 30 days and a report filed with ChildLine compared to 60 days for GPS assessments.

However, once a case is accepted for service, the service array available to the child and family is the same, whether they have received a CPS investigation or a GPS assessment. The level of risk, and the needs of the family and child, determine what services a family receives. Families may receive a single service or a variety of services from CYD. CYD may purchase and utilize the services of any appropriate public or private agency to meet the needs of the child and family. All services, except those that are ordered by the court, are voluntary. A family does not

⁸⁵ 55 Pa. Code §3130.32; Philadelphia Department of Human Services, Children and Youth Division (January 2000). *Policy Manual*, Section 5000.

⁸⁶ *Ibid.*

⁸⁷ 23 Pa. C.S. §6331.

⁸⁸ 23 Pa. C.S. §6344.

have to accept services that are recommended or offered. CYD, however, must petition the court to order services if a determination is made that services are in the best interest of the child, placement or continued placement is necessary, or the subject of the child abuse report refuses to cooperate in an investigation and CYD is unable to determine whether the child is at risk.

Exhibit C.1 Federal Statutory Framework for Child Welfare

Child welfare programs are supported financially and shaped, in part, by Federal law. Some of the major pieces of legislation that have impacted the development of child welfare programs are summarized below.

The Child Abuse Prevention and Treatment Act (CAPTA) of 1974¹

One of the early pieces of Federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA). It was originally enacted in 1974. This Act has been amended several times and was most recently amended and reauthorized in 2003 by the Keeping Children and Families Safe Act.² CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities. It also provides grants to public agencies and nonprofit organizations for demonstration programs and projects.³

Indian Child Welfare Act of 1978⁴

In response to concern about the high number of Native American children being removed from their families and placed outside Native American communities, Congress enacted the Indian Child Welfare Act of 1978 (ICWA). Under ICWA, all child welfare court proceedings involving Indian children must be heard in tribal courts, if possible, and tribes have a right to intervene in State court proceedings. ICWA also established specific guidelines for family reunification and placement of Native American children.

The Adoption Assistance and Child Welfare Act of 1980⁵

In 1980, Congress enacted the Adoption Assistance and Child Welfare Act to address concerns regarding the length of stay of children in foster care. This landmark legislation created a major Federal role in the administration and oversight of child welfare services. The Act created title IV-E of the Social Security Act, which provides financial incentives to States to comply with the provisions of the Act. It does so by making Federal assistance available to States with foster care systems that meet the Act's requirements for children in foster care who meet specific eligibility requirements. The Act:

- Establishes Federal procedural rules governing child welfare case management, permanency planning, and foster care placement reviews;
- Requires States to develop a State plan detailing how child welfare services will be delivered;
- Requires States to make "reasonable efforts"—prior to the placement of a child in foster care—to prevent or eliminate the need for removal of the child from his or her home and a reasonable effort to make it possible for the child to return home;
- Created an adoption assistance program; and
- Requires a case review system for the child through which the status of the child is reviewed by a court at least every six months and a dispositional hearing held not later than 18 months after the original placement.

Family Preservation and Support Services Program⁶

In 1993, out of concern that States were not making enough efforts to prevent foster care placement and reunify children with their families, Congress established the Family Preservation and Support Service Program, as part of the Omnibus Reconciliation Act. This program provided flexible funding for

¹ P.L. 93-274.

² P.L. 108-36.

³ Most recently, Pennsylvania passed House Bill 2670 which amended state law to bring its statutory provisions in line with CAPTA. Among the provisions of House Bill 2679, there are requirements regarding: (1) the establishment of citizen review panels; (2) mandatory reporting of infants born and identified as being affected by illegal substance abuse; (3) grounds for involuntary termination of parental rights; and (4) Mandates regarding the release of information in confidential reports.

⁴ 25 U.S.C. §1901 et. seq.

⁵ P.L. 96-272.

⁶ P.L. 103-66.

community-based services to (1) prevent child abuse and neglect from occurring and (2) help families whose children were at risk of being removed. As part of the Adoption and Safe Families Act, the program was reauthorized and expanded to include funding for: (1) time-limited family reunification services, and (2) adoption promotion and support activities.

The Adoption and Safe Families Act (ASFA) of 1997⁷

In 1997, Congress passed the Adoption and Safe Families Act with the goal of refocusing the child welfare system on achieving safety, permanence, and well-being for children. It requires more frequent judicial reviews, criminal records screening, extensive judicial monitoring, and documentation of children's progress toward achieving a permanent family. In addition, the timelines for filing petitions to terminate parental rights, and imposes monetary sanctions if a State does not comply with these Federal requirements. The major provisions of ASFA are summarized below:

- Promotes the child's health and safety as the "paramount concern" for child welfare services. As a result, greater action is required at intake to ensure that children are placed outside the home immediately if certain aggravated circumstances would endanger their safety if they remain in the home;
- Provides that "no reasonable efforts" need to be made under certain circumstances;
- Except under specified circumstances, requires States to start proceedings to terminate parental rights if children have been in a State's custody for 15 of the most recent 22 months;
- Requires that there be a permanency plan and that a permanency hearing be held within 12 months of the date that a child "is considered to have entered foster care," or within 30 days of a judicial determination that reasonable efforts to reunify the child and family are not required;
- Establishes a new requirement that reasonable efforts must be made to achieve permanency for children and to finalize a permanency plan; and
- Provides a formal policy statement that concurrent planning for reunification and for another permanency option is not only acceptable, but is good practice.

The enactment of ASFA led to an increased focus on accountability in the child welfare system. Improvement in safety, permanence, and well-being became the outcome goals for the system. As a result of this focus on outcomes, it became necessary for outcomes to be measured, which had never been done before in a systematic way. During March 2000, the U.S. Department of Health and Human Services (DHHS) finalized regulations establishing the Child and Family Services Reviews (CFSR).⁸ The CFSR is a monitoring process for reviewing States' performance and compliance with Federal requirements for Child Protective Services, Foster Care Services, Adoption Services, and family preservation and support services (Preventive Services) under titles IV-B and IV-E of the Social Security Act. These reviews focus on assessing agency performance against more than 20 indicators in key outcomes related to child safety, permanency, and well-being. The reviews also include an assessment of the States' systems and processes such as case review, quality assurance, foster and adoptive parent licensing, and staff training. The Federal review of Pennsylvania's child welfare program occurred during 2002. Pennsylvania developed, and began implementing, a Performance Improvement Plan in 2003.

Multi-Ethnic Placement Act⁹

Enacted in 1994, the Act prohibited States from delaying or denying adoption and foster care placements on the basis of race, color, or national origin of the foster or adoptive parent, or of the child. MEPA also required the States' Title IV-B plan to provide for the diligent recruitment of prospective foster and adoptive families that reflect the different racial and ethnic backgrounds of children needing placement. In 1996, MEPA was amended by the Inter-Ethnic Placement Provisions¹⁰ which repealed the MEPA

⁷ P.L. 105-89.

⁸ 45 C.F.R. §1355.31-37.

⁹ P.L. 103-382.

¹⁰ P.L. 104-188.

provision that permitted consideration of race and ethnicity as one of a number of factors that could be considered in making placement decisions.

Strengthening Abuse and Neglect Courts Act of 2000¹¹

The Strengthening Abuse and Neglect Courts Act of 2000 authorized a grant program for State and local courts to:

- Reduce the backlog of abuse and neglect cases by hiring additional court personnel or lengthening court hours;
- Improve individual case monitoring, and expedite the flow of cases through the court system by automating case-tracking and data-collection systems; and
- Train Court-Appointed Special Advocates (CASA) volunteers to give children support during court proceedings.

Foster Care Independence Act¹²

In 1986, Congress amended Title IV-E of the Social Security Act and created the Independent Living Program, which provided Federal funds to the States to assist youth aged 16 and over in making the transition from foster care to living independently. In 1999, it was replaced with the John H. Chafee Foster Care Independence Program (CFCIP) by the Foster Care Independence Act. CFCIP expanded the range of social services available to: (1) former foster youth (age 21 or younger) who have aged out of the foster care system, and (2) adolescents who are transitioning from foster care to self-sufficiency. In 2001, the Act was amended to provide a new educational and vocational program for older youth leaving foster care.¹³

¹¹ P.L. 106-314.

¹² P.L. 106-169.

¹³ P.L. 107-133.

Exhibit C. 8 Risk/Severity Continuum

No Risk	Low Risk	Moderate Risk	High Risk
<p>1. VULNERABILITY</p>			
<p>Over age 18</p>	<p>Cares for and can protect self with minimal assistance and has no physical or mental handicap. Typically age 12-17.</p>	<p>Requires adult assistance to care for and protect self or has minor limitation or has mild to moderate impaired development. Typically age 6-11.</p>	<p>Is unable to care for or protect self without adult assistance. Has severe physical or mental handicap or limitation. Is severely impaired developmentally. Typically age 0-5.</p>
<p>2. SEVERITY, FREQUENCY AND/OR RECENTNESS OF ABUSE/NEGLECT</p>			
<p>No injury. No discernable evidence of abuse or neglect. No discernable pattern of inappropriate punishment or discipline. Has basic medical, food and shelter needs met. Receives adequate supervision at all times.</p>	<p>Has minor injury as a result of abuse or neglect which requires no medical attention. May show rare incidence of inappropriate punishment or discipline. Usually has basic medical, food and shelter needs met. On occasion may experience minor distress or discomfort due to neglect or lack of supervision.</p>	<p>Has significant physical injury possibly requiring medical diagnosis or treatment as a result of CAN. May have an ongoing history or pattern of harsh discipline or punishment. CAN is repetitive or cumulative. Injury to torso or back. Implement used resulting in marks or bruises. Not a high-risk implement. Imminent risk of above. Child is 6-11 years of age left alone periodically or left with unsuitable caretakers. Inconsistently has basic medical, food and shelter needs met.</p>	<p>Has serious physical injury. Has been sexually abused. May need immediate medical treatment and/or hospitalization. Suffers severe pain or ongoing history of harsh punishment or discipline. Injury to head, face, neck or genitals internal injuries or sexual assault. High-risk implement used. Imminent risk of above. Child is 0-5 years of age, left alone or with an unsuitable caretaker. Rarely has basic medical, food and shelter needs met.</p>
<p>3. PRIOR ABUSE/NEGLECT</p>			
<p>No signs symptoms, credible statements or reports that suggest that prior CAN has occurred.</p>	<p>Isolated report or incident of inappropriate physical discipline. No conclusive or credible statement suggesting prior CAN.</p>	<p>Previous substantiated report of abuse and/or neglect. Observable physical signs of previous CAN. Credible statements of previous abuse or neglect not investigated.</p>	<p>Previous substantiated reports of serious bodily injury. Severe abuse or neglect resulting in a serious condition. Credible statements or documentation of serious bodily injury or neglect not previously investigated. Multiple reports of moderate-risk issues.</p>
<p>4. EXTENT OF EMOTIONAL HARM</p>			
<p>Has no emotional harm or behavioral disturbance related to abuse and/or neglect. Is comfortable in caretakers home.</p>	<p>Has minor distress or impairment in role functioning, or development related to CAN. Has doubts or concerns about the caretaker's home.</p>	<p>Has behavioral problems that impair social relationships, development or role functioning related to CAN. Has fear of caretakers or home environment.</p>	<p>Has extensive emotional or behavioral impairment or serious developmental delay related to CAN. Is extremely fearful about caretakers or home environment.</p>
<p>5. AGE, PHYSICAL, INTELLECTUAL OR EMOTIONAL STATUS</p>			
<p>Has no intellectual or physical limitation. Is cognitively able to understand and provide for child's best needs. Seems mature and able to cope.</p>	<p>Has some physical or mental limitations but there is no evidence of any negative impact on family functioning. Parent is aware of limitations and has made adaptations, including use of appropriate resources.</p>	<p>Is physical/emotionally/Intellectually limited. Has past criminal/mental health record/history. Has poor impulse control. Is under 20.</p>	<p>Is severely handicapped. Has poor conception of reality. Has severe intellectual limitations. Is unable to control anger and impulses. Under 16.</p>

6. COOPERATION

Caretaker appropriately responsive to requirements of investigation. Actively involved in case planning and services. Participates in services provided to him/her and child. Acknowledges problems. Initiates contact with caseworker to improve services and may seek additional services.

Caretaker offers minor resistance to investigation. Does not take initiative in obtaining needed services. Occasionally fails to follow through with services. Requires reminders and encouragement to follow through. Appears to make use of services by altering behavior in ways that reduce risk to the child. Willing to take some responsibility for the problem.

Caretaker is hostile or cooperates reluctantly with investigation only with direct instructions. Fails to follow through with case plan despite repeated reminders. Passively undermines interventions by canceling appointments, failing to attend meetings or following up with referrals. Although expressing compliance, makes no effort to alter behavior lowering risk to the child. Fails to accept responsibility for the problem or his or her own behavior.

Caretaker actively resists any agency contact or involvement. Will not permit investigation to occur. Is very hostile or will only cooperate with police involvement, may threaten worker or service provider with physical harm. Refuses to take child for treatment or assessment and is disruptive to the point that makes services impossible to deliver. Completely denies problems and has no motivation to change behavior affecting the risk to the child.

7. PARENTING SKILLS/KNOWLEDGE

Exhibits appropriate parenting skills and knowledge pertaining to child rearing techniques or responsibilities. Understands child's developmental needs. Does not use implements or physical means to discipline.

Exhibits minimal deficits in parenting skill and knowledge pertaining to child-rearing techniques or responsibilities and/or in understanding child's developmental needs. Does not use high-risk implements to discipline.

Is inconsistent or has moderate deficits in necessary parenting skills/knowledge required to provide a minimum level of care. Frequently uses physical means to discipline. Implement used, not a high-risk implement.

Is unwilling/unable to provide the minimal level of care needed for normal development. Usually resorts to physical means of discipline. High-risk implement(s) used.

8. ALCOHOL/SUBSTANCE ABUSE

No past or present abuse.

History of abuse with no current problem. Use without inappropriate consequences.

Reduced effectiveness due to abuse or addiction. Regular use results in problem behavior and/or incapacity.

Substantial incapacity due to abuse.

9. ACCESS TO CHILDREN

Responsible caretaker is available or perpetrator has no access.

Supervised access or shared responsibility for care of child

Perpetrator has limited unsupervised access or child being cared for in nonsupportive or neglectful environment.

Immediate unlimited access or full responsibility for care of child.

10. PRIOR ABUSE/NEGLECT

Not neglected or abused as a child. No information or indication of caretaker as perpetrator of abuse or neglect.

No history of abuse or neglect as a victim or perpetrator. Isolated instances of inappropriate discipline as a victim and/or a perpetrator. Inconclusive statements of CAN history by subjects or collaterals.

Prior indicted or substantiated incident of abuse/neglect as a victim or a perpetrator. Admission of prior instances of abuse or neglect (perp or victim) not yet investigated. Credible statements of above.

History of chronic and/or severe abuse/neglect, or abuse causing serious bodily injury as a perpetrator. Two indicated reports of CAN. Credible statements suggesting history of severe abusive or neglectful incidents towards children.

11. RELATIONSHIP WITH CHILDREN

Caretaker/child interaction is frequent and pleasurable to both. Mutual affection is prominent and appropriate. Child is aware of, and consistently responds to, verbal cues of caretaker.

Caretaker anger regarding child's behavior is rarely directed toward the child inappropriately. Anger is generally controlled. Child occasionally does not respond to verbal cues. Attachments of caretaker and child are obvious and extensive. No indication of role blurring (scapegoating or parentification).

Caretaker anger is occasionally extreme. Child's behavior regularly serves to provoke negative response. Displays of affection are intermittent or irregular. Child is occasionally scapegoated or parentified.

Caretaker anger is usually extreme and results in physical abuse, verbal abuse or extreme criticism. No appropriate affection shown to child. Child is consistently scapegoated or parentified. Role blurring occurs frequently. There is a complete lack of attachment or positive interaction between caretaker and child. Or conversely child is inappropriately dependent upon, or clinging to, caretaker. Child's behavior quite provocative.

12. FAMILY VIOLENCE

No use or threats of violence to resolve conflicts. No history of violence in adult relationships or between adults in family of origin.

Indirect or implied verbal threats only in adult relationship or in family of origin. Some success with problem-solving techniques.

Direct physical and/or verbal threats. Use of violence between adults. History of physical threats and injury in family of origin. Other methods of dealing with issues rarely used.

Physical violence between adults resulting in injury. Physical violence primary method of conflict resolution. History of violence in family of origin. History of protection orders or criminal charge.

13. CONDITION OF THE HOME

No health or safety concerns on property.

Minor health or safety concerns on property. Some minor problems posing no immediate threat and easily correctable.

Serious substantiated health or safety hazards, i.e. overcrowding, inoperative or unsafe water and utility hazards, other health and sanitation concerns.

Substantiated life threatening health or safety hazards, i.e. living in condemned and/or structurally unsound residence, exposed wiring and/or other potential fire/safety hazards.

14. FAMILY SUPPORTS

Frequent supportive contacts with family/friends. Involved with community resources as needed. Child monitored by two or more outside adults.

Occasional contact with supportive family/friends. Effective use of community resources, but could benefit from a larger variety of resources. Child monitored by one outside adult.

Sporadic supportive contact, under-use of community resources. Child is inconsistently monitored by outside adults.

Caretaker geographically or emotionally isolated. Community resources not available or not used. Child has minimal or no contact with outside adults.

15. STRESSORS

No recent losses or disruptions to family routine. Stable housing history. Coping skills are varied and adequate. One child living in household.

Family circumstances have led to anxiety and/or irritation or minor depression. Caretaker appears to have the ability to care for the children in the household. Housing is stable. Coping skills are functional. Two to three children living in the household.

Family crises, losses or circumstances have led to intense anxiety or major depression. Caretaker has difficulty caring for the children in the household. Family has difficulty maintaining stable housing. Coping skills are limited. Four to five children in the household.

Family crises, losses or circumstances have led to serious psychiatric or emotional problems. Caretaker unable to adequately provide for the number of children in the household. Family has a pattern of frequent moves and homelessness. Coping skills are severely limited. Six or more children living in the household.

References

55 Pa. Code §3130 et. seq.

The Child Protective Services Law, 23 Pa. C.S. §6301 et. seq.

The Children, Youth and Families Manual, 55 Pa. Code §3490.01 et seq.

The Juvenile Act, 42 Pa. C.S. Sections 6301 et. seq.

Commonwealth of Pennsylvania, Department of Public Welfare, Office of Children, Youth and Families. (November 2000) *Bulletin 3490-00-02: Safety Assessment and Safety Planning Protocol and Format*.

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Pennsylvania Child Welfare Training Program. (June 1996). *A Reference Manual for the Pennsylvania Model of Risk Assessment*.

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Philadelphia Department of Human Services, Children and Youth Division. (August 2004). *Updated Policy and Procedure for Assigning and Responding to Reports of Abuse or Neglect*.

Philadelphia Department of Human Services, Children and Youth Division. (November 2004). *Policy and Procedure for Gaining Access to Children and Searching for Children and Families During Investigations/Assessments or When Accepted for Services*.

APPENDIX D. SUMMARY OF FATALITY POLICY

INTRODUCTION

This appendix is a summary of the review protocols for when a child dies from alleged abuse. The reviews are known as Child Death Reviews. The summary is based on policy issued by the Commonwealth of Pennsylvania, Department of Public Welfare, Office of Children Youth and Families (OCYF) and guidance developed by the City of Philadelphia Department of Human Services (DHS), Children and Youth Division (CYD).¹

BACKGROUND

The purpose of Child Death Reviews is twofold:

- To examine the circumstances of a child death as a result of suspected child abuse from a systems perspective; and
- To make recommendations for change to reduce the likelihood that future child fatalities would result from child abuse and neglect.²

Two processes must occur concurrently when there is a child death that is a result of suspected child abuse: a CPS investigation, and one or more of four types of Child Death Reviews.

As with all CPS investigations, the county agency and law enforcement officials must cooperate and coordinate their efforts to the fullest extent possible, to respond to, and investigate, reports of suspected child abuse. Either the appropriate county agency, or OCYF, must review the report of suspected child abuse and determine the status of the case as unfounded, indicated, or founded. The responsibilities regarding a CPS investigation of a child death are outlined below.

- If a report is made directly to CYD, CYD must immediately notify the state ChildLine.
- If the child who died was not in the custody of the county agency, the CYD supervisor must: review the allegations contained in the report, immediately initiate an investigation and assure the safety of any other children in the household, and arrange necessary services if the case involves any agent of the county agency.
- In cases in which the child who died was in the custody of CYD, then OCYF must: review the allegations contained in the report, immediately initiate an investigation and assure the safety of any other children in the household, and arrange necessary services, if the case involves any agent of the county agency.
- The CYD supervisor must immediately notify the director, or person designated by the director, of the receipt of a report of suspected child abuse resulting in a child's death. The director or his/her designee notifies OCYF and the county authorities of

¹ Commonwealth of Pennsylvania, Department of Public Welfare, Children, Youth and Families (October 10, 2000). *Bulletin 3490-00-01: Child Death Review and Report Protocols*; Philadelphia Department of Human Services (ND). *Internal Child Death Review Team*. Received March 2007, from DHS.

² Commonwealth of Pennsylvania, Department of Public Welfare, Office of Children, Youth and Families (October 10, 2000). *Bulletin 3490-00-01: Child Death Review and Report Protocols*.

the report including: (1) the child’s name; (2) date of birth; (3) date of death; (4) identities of other household members; (5) alleged manner of death; (6) name, date of birth, and address of the alleged perpetrator; (7) relationship of the alleged perpetrator to the child; and (8) chronology of county agency involvement, if any, with the child or the child’s family.

- Within 72 hours from the date of the oral report, the county agency must provide a copy of the case record to OCYF, including the chronology of county agency involvement, if any, with the child or the child’s family.
- CYD shall notify OCYF and law enforcement officials of the status determination, upon completion of the CPS investigation.

The level of CYD involvement with the child or family prior to, or on the date of, the child’s death determines the type of Child Death Review that must be conducted. OCYF and CYD must work collaboratively to determine the level and type of review to be conducted. Exhibit D.1 provides definitions of the four categories related to the different levels of involvement of CYD in a case prior to a child’s death.

Exhibit D.1 Case Definitions

Type of Case	Definition
Active	Cases that are open and contain a county agency documented contact with any of the following: the child, other siblings, immediate family and household members, the alleged perpetrator and the alleged perpetrator’s immediate family and household members at the time of the death. This includes any and all types of contact from telephone referrals (whether acted upon or not), intake, or ongoing services, including subsidized adoptions.
Inactive	Closed cases with any county agency contact with any of the following: the child, other siblings, immediate family or household members, the alleged perpetrator, and the alleged perpetrator’s immediate family, at any time within the past 16 months. This includes all types of contact from telephone referrals (whether acted upon or not), intake, or ongoing services including subsidized adoption.
Not Known	Cases with no children and youth agency documented contact with any of the following: the child, other siblings, immediate family and household members, the alleged perpetrator and alleged perpetrator’s immediate family or household members at any time prior to the abuse report regarding the child’s death.
Should Have Been Reported	Cases with concerns resulting from discussions or other contacts with the community or family members that result in a reasonable cause to suspect abuse or neglect and suggest the need for a referral to the county agency.
<small>SOURCE: Commonwealth of Pennsylvania, Department of Public Welfare, Children, Youth and Families (October 10, 2000). <i>Bulletin 3490-00-01: Child Death Review and Report Protocols</i>; Philadelphia Department of Human Services (ND). <i>Internal Child Death Review Team</i>.</small>	

One or more of four types of reviews will be conducted based on the level of involvement with the county at the time of the report or within 16 months of the report. These reviews are described below and include:

- Internal Death Reviews (by CYD and the provider agency, if applicable);
- Multidisciplinary Team (MDT) Reviews;
- Community Reviews; and
- State Compliance Reviews.

CYD AND PRIVATE AGENCY INTERNAL REVIEWS

CYD and private agency internal reviews must be conducted for all child deaths that resulted in a report of suspected child abuse when the child or family was known, for any reason, to the county agency, regardless of the final CPS investigation status determination. This includes cases that are currently active and those that were active within the past 16 months. When private agencies were providing services to a child that died as a result of suspected child abuse, the private agency is required to complete an internal review. Internal reviews by CYD and a private agency (if involved) must be conducted within 60 days from the date the report was received by ChildLine.³ The internal reviews must address:

- Compliance with agency policy and procedure;
- The level and quality of services;
- Compliance with supervisory and training requirements;
- Compliance with implemented Pennsylvania Child Welfare Practice Standards;
- Whether a Multidisciplinary Team or Community Review must be convened; and
- Any recommended changes to agency and state law, policy, procedure, or regulation.

An Emergency Response Team must be appointed by the county administrator to address the quality of services provided to the child and family and to review the county and any private agency's involvement with the family. The county must develop a protocol that specifies the procedures used to appoint members of the Emergency Response Team.

MULTIDISCIPLINARY TEAM (MDT) REVIEWS

MDT reviews are required to be conducted when the family was known to the county agency within the past 16 months. In addition, an MDT review is required when the family was, or should have been, receiving services from multiple agencies. The reviews address cross-system issues by analyzing service system communication and service provision. The objectives of the MDT are to:

- Review the results of the internal reviews by CYD and any private agency involved;
- Collect and evaluate standardized data to improve the level and quality of services;
- Identify system issues including gaps in services and community resources;
- Recommend system change at the local and state levels;
- Identify the need for changes to the Pennsylvania Child Welfare Practice Standards; and
- Issue a written report that includes findings and recommendations.

The chairperson of the MDT must issue a written report within 60 days of the MDT review and send a copy of the review report to OCYF.

³ The child welfare administrator must submit the Child Death Data Form and a copy of the CPS Investigation Report (CY48) to OCYF within 90 days of the date the report was received by ChildLine.

COMMUNITY REVIEW

CYD or the appropriate community agency must convene a community review to examine child deaths that have been substantiated to be the result of child abuse and the children were not known to the county agency. The purpose of the community review is to assess the community protections system and to determine if there are any steps that need to be implemented at the community level to improve child protection. These reviews should include county and private agency staff, community agency staff, and representatives from education, health care, law enforcement, and private citizens, when appropriate. The results of the internal review must be shared with the Community Review Team which must issue a report within 60 days of the review.

OCYF REVIEW AND RESPONSE

The OCYF Review process includes a review of the county and private agency (if involved) internal reviews, MDT reviews and community reviews. In addition, OCYF conducts interviews with appropriate county and private agency staff, and any other parties involved, and conducts a document review. The purpose of the interview process is to clarify information contained in the record and to understand the basis for agency decision making in the case. The document review includes:

- A review of the nature and intensity of services provided;
- A review of the investigation of prior reports of suspected child abuse and assessment reports of general protective services;
- A determination of whether the risk assessment was completed in accordance with regulatory time frames, whether the facts supported the level of risk identified and whether the actions taken and the services provided were appropriate to the risk indicators;
- An assessment of the frequency, appropriateness, and quality of collateral contacts with agencies providing services to the child or family;
- A review of the coordination and implementation of the family service plan to determine whether the plan met the child's and family's needs and addressed the indicators of risk;
- A review of the safety plan to determine whether the plan adequately addressed the risk indicators and safety needs;
- An assessment of regulatory compliance;
- An appraisal of the health and safety of all children in the family; and
- A review of the level and quality of services provided in accordance with the Pennsylvania Child Welfare Practice Standards.

Upon completion of the review, OCYF prepares a written report (child death report) and provides it to the appropriate County Governing Authority including a Licensing Inspection Summary (LIS) if there are regulatory violations identified during the review. The county agency must submit a plan of correction and response to the OCYF child death report within 30 days of receiving the LIS report when regulatory violations or practice, policy or procedure issues are identified. OCYF will determine if the plan of correction is acceptable. If the plan is not

acceptable, OCYF will work with the county to develop an acceptable plan of correction. Technical assistance will be provided to the county by OCYF as deemed appropriate. Upon approval of the plan of correction, OCYF will conduct site visits to ensure that the elements of the plan of correction are being implemented.

SUMMARY

The current policy regarding child death reviews provides overall guidance regarding the protocols for review of case circumstances involving child deaths as a result of suspected child abuse. These reviews must be completed in a very tight time frame. There are many agencies that may be involved in these reviews including CYD, the private child welfare agencies, law enforcement officials, public health officials, and policymakers. The current policy does not provide in-depth guidance on implementation of the policy and the respective roles and responsibilities for all the different agencies that may be involved.

APPENDIX E. KEY INDICATORS FROM ADMINISTRATIVE DATA

INTRODUCTION

This appendix provides a contextual background in which to understand the Philadelphia child welfare system based on an examination of administrative data from the City of Philadelphia Department of Human Services (DHS), Children and Youth Division (CYD). Data sources include selected management reports, case-level data of children who received investigations in 2005 (followed through 2006), and paper case records on child fatalities.

HIGHLIGHTS

The analysis of administrative data provided several indicators of key parameters and results of child welfare services by CYD.

- Of all reports to CYD, 82 percent of children were referred by the Hotline to General Protective Services (GPS) and 18 percent were referred to Child Protective Services (CPS).
- While almost all reports alleging neglect were referred to GPS, reports alleging physical abuse, sexual abuse, and/or multiple maltreatments were referred to both CPS and GPS.
- Thirty-six percent of children referred to GPS and 30 percent of children referred to CPS received determinations of indicated, founded, or substantiated.¹
- African American² children comprise half the child population in Philadelphia and 58 percent of investigations or assessments by CYD.
- Sixty-seven of every 1,000 African American children in Philadelphia experienced an investigation or assessment by CYD; this rate is considerably lower for White (24 of 1,000) and Hispanic (18 of 1,000) children.
- Hispanic children were more likely (43%) than African American (38%) or White (33%) children to be determined to be victims of child maltreatment, following determinations of indicated, founded, or substantiated.
- Approximately one-third of CPS children (37%) and GPS children (32%) received services. Of the children who received services, nearly 40 percent were involved in investigations or assessments that were unfounded (CPS), or unsubstantiated (GPS). A slightly higher proportion of GPS children whose reports were substantiated (61%) compared with CPS children whose reports were founded or indicated (52%) received services.
- Hispanic children were more likely (45%) than African American (38%) or White (29%) children to receive services following an investigation or assessment by CYD.
- Of all children who received investigations or assessments, 18 percent received in-home services without any other services; 6 percent received foster care services

¹ The term “victim” is used for children who were involved in CPS investigations that were founded or indicated or in GPS investigations that were substantiated.

² The terms African American, White and Other should be understood to indicate non-Hispanic.

without any other services; and 8 percent of children were placed in foster care while their families received services at home.

- Approximately two-thirds of all children who received either a GPS or a CPS investigation did not receive any further services. These children included some of those who had received a disposition of indicated, founded, or substantiated.
- Recurrence of a finding of indicated, founded, or substantiated maltreatment within 6 months of such a finding among GPS children was approximately 9 percent; among CPS children it was 5 percent.
- Two-thirds of the children who died due to abuse and neglect were younger than one year old.

METHODS

Three primary sources of data provided the basis for these analyses—management reports provided by CYD staff, the administrative data set of all children with investigations of maltreatment in Philadelphia during 2005, and case records for all children who died in Philadelphia between 2001 and 2006 as a result of child maltreatment.

The management reports included the following:

- Statistics - OCTOBER 2006.xls (caseload numbers)
- Philadelphia CYD's Children's Safety Net Action Plan (Hotline numbers)
- CWLP_SUMMARY_03162007.xls (system numbers)

The administrative data set was created using a series of files containing the case records of all children in Philadelphia who received an investigation or assessment due to a report alleging child maltreatment during 2005. These files were combined to produce a primary data set for analyses. This file contains 22,841 records of children who received a GPS assessment or a CPS investigation. For each investigation or assessment (14,755 records of investigations or assessments were included), there is a record for each child in the family. Children may appear more than once in the file if their families have experienced multiple investigations in the same year; 19,244 children and 11,805 families are represented in this file.

In conducting these analyses, two conventions as to the assignment of services were used. In-home services were reported in a file at the family level, so if the family record included the receipt of in-home services, all children in the family were considered to have “received” in-home services. Services provided outside the home, including placement and nonplacement services (such as day care) were linked only to the specific children whose records indicated they had these services.

Data on fatalities were obtained from the review of case records of 47 fatalities between 2001 and 2006. Child demographic data, in addition to the child’s service history and any history of prior reports of abuse or neglect involving the caregiver, were collected.

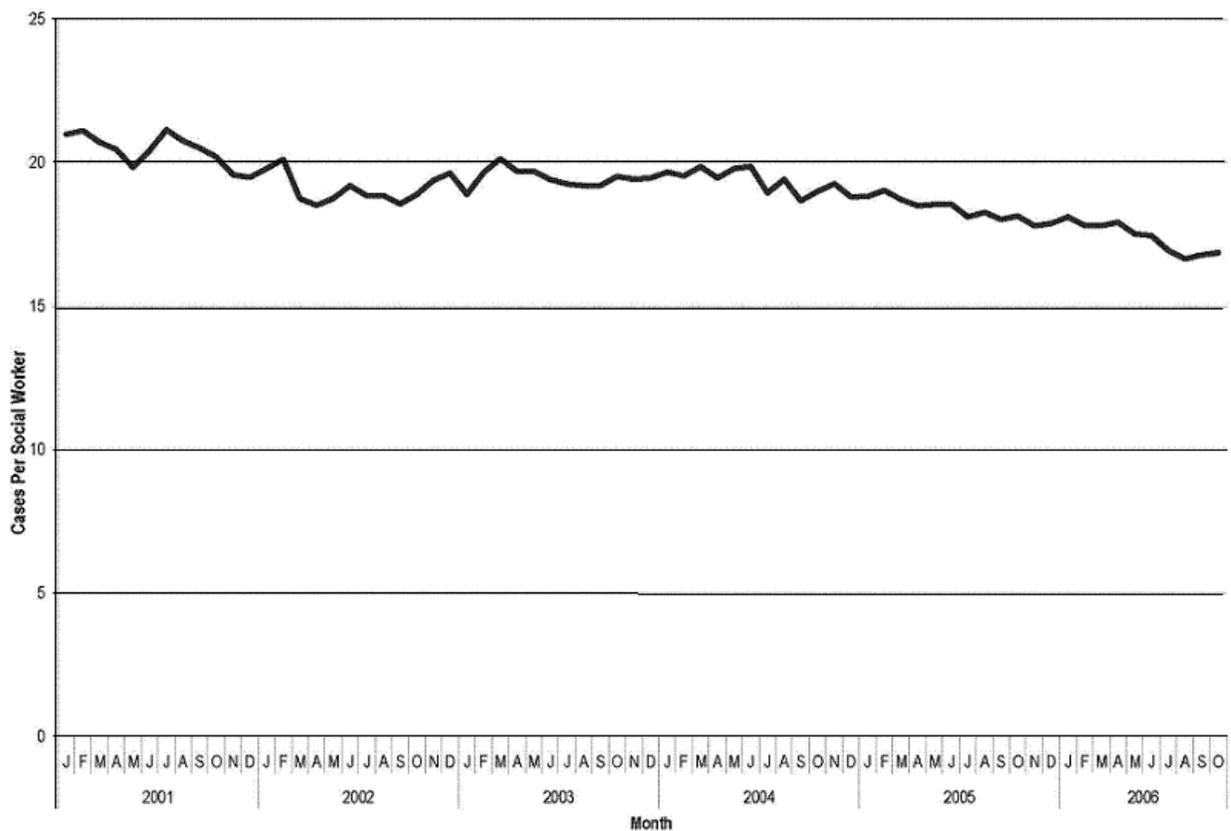
FINDINGS FROM MANAGEMENT REPORTS

Analyses of management reports provided by CYD staff were conducted to examine caseloads of CYD caseworkers and assignment of reports received by the Hotline.

Caseloads

Caseload trends from January 2001 to October 2006 were obtained from the CYD October 2006 Statistics report.³ These data reflect a decrease in the number of family cases per social worker from January 2001 to October 2006. In January 2001, the average caseload per social worker was 20.99. This decreased 20 percent over time to an average caseload of 16.85 in October of 2006.

**Exhibit E.1 Number of Cases per Social Worker by Month
2001–2006**



Data for each Family Service Region were obtained from a September 2006 report by CYD. The total caseload in September 2006, including pending cases and cases transferred between regions, was 7,375, which included 15,636 children. Family Service Region 4 had the highest number of cases with 2,303 cases resulting in an average of 19.85 cases per caseworker. The region with the highest number of cases per caseworker was Family Service Region 3 with 21.58

³ Statistics – October 2006.xls.

cases per caseworker. Family Service Region 3 includes adoptions and central services. The average caseload across regions in this report was 16.43 per caseworker.

Exhibit E.2 Caseload per Region

Family Service Region	Families (including cases pending and transferred)	Children	Social Workers	Caseload Ratio
FSR1 (includes Sexual Abuse and Floaters)	1,965	3,702	106	18.54
FSR2	470	887	29	16.21
FSR3 (includes Adoptions and Central Services)	561	920	26	21.58
FSR4	2,303	4,237	116	19.85
Family Preservation	164	365	25	6.56
Intake	1,912	5,525	147	13.01
Total	7,375	15,636	449	16.43

Assignment of reports received by the Hotline

A presentation made by DHS Commissioner Evans included data obtained from the Hotline showing the number of reports accepted each month between October 2005 and October 2006, and whether the report was referred to CPS, GPS, Emergency General Protective Services (EGPS), or General.⁴ Approximately 27 percent of Hotline calls during this time period (as low as 21% one month, as high as 31% in another month) were referred to CPS.

Exhibit E.3 Hotline Calls

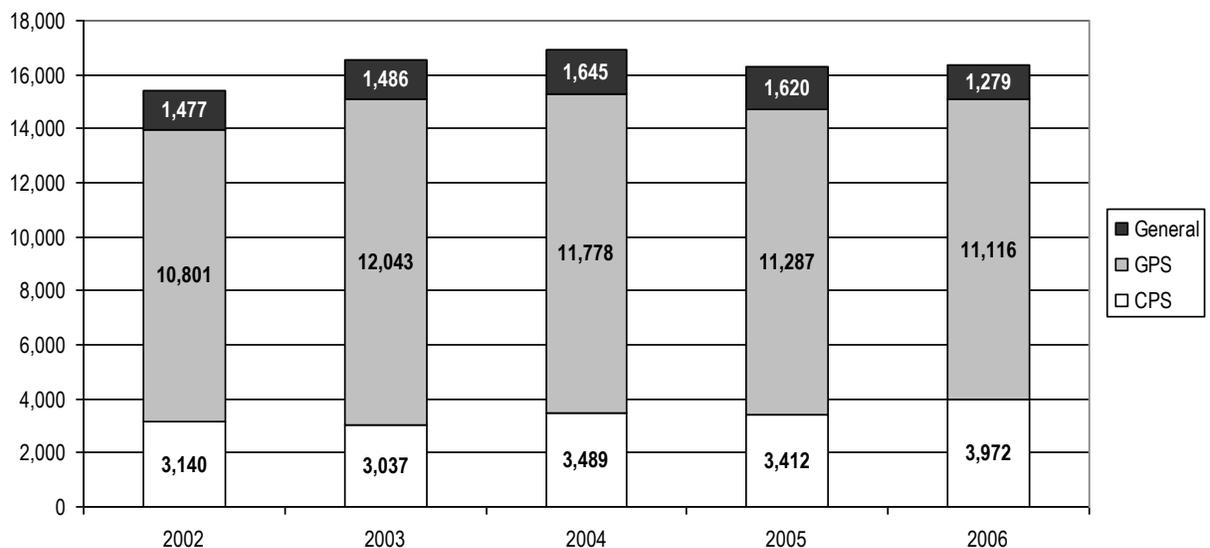
Year	Month	CPS	EGPS	GPS	General	Total
2005	October	341	450	453	21	1,265
	November	341	473	406	12	1,232
	December	302	425	386	16	1,129
2006	January	357	499	480	30	1,366
	February	332	439	384	24	1,179
	March	440	497	470	34	1,441
	April	304	391	403	26	1,124
	May	410	443	547	15	1,415
	June	320	441	439	16	1,216
	July	248	435	362	27	1,072
	August	240	495	364	19	1,118
	September	284	464	407	14	1,169
	October	341	473	406	12	1,232
	Total	4260	5925	5507	266	15,958

⁴ Philadelphia CYD's Children's Safety Net Action Plan.

A summary report obtained from CYD showed the number of reports investigated each year, beginning in 2002.⁵ According to this report, approximately 16,000 reports were investigated each year. This number increased slightly from 2002 to 2004, then decreased slightly during the following 2 years.

The proportion of reports assigned to either GPS or CPS fluctuated over the 5 years. The percent of reports referred to GPS increased from 70 percent in 2002 to 72 percent in 2003, then decreased to 68 percent in 2006. The percent of reports that were referred to CPS dropped from 20 percent in 2002 to 18 percent during 2003, then increased to 24 percent in 2006.

Exhibit E.4 CYD Investigations 2002–2006



FINDINGS FROM ANALYSIS OF ADMINISTRATIVE DATA SET

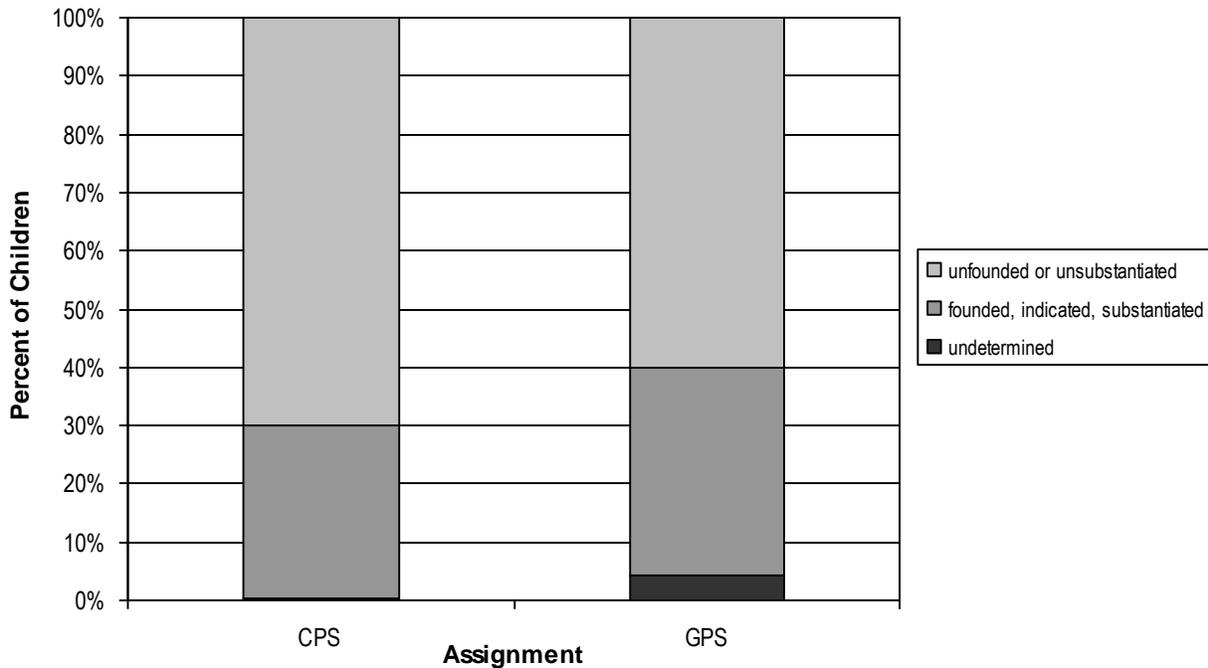
Analyses of the administrative data set from 2005 were conducted to examine patterns of referral, determination, and service provision among children in investigations and assessments in Philadelphia.

Assignment to CPS and GPS, determination, and services

The majority of children were referred to GPS (82%), while 18 percent were referred to CPS. Overall, 35 percent of all children in the Philadelphia child welfare system were determined to be victims of child abuse or neglect, due to a founded or indicated CPS report or a substantiated GPS report. Approximately one-third of children in GPS (36%) and in CPS (30%) were found to be victims.

⁵ CWLP_SUMMARY_03162007.xls.

Exhibit E.5 Determination by Assignment to CPS or GPS



The data set included information on whether the child or family received services. Information about several different service types was provided: services to children in their own homes, including family preservation; foster care placement; and other nonplacement services to families in the community. For purposes of these analyses, services provided to children were divided into four basic categories;

- Children who did not receive any services themselves and whose families did not receive any services (no services);
- Children who were considered to have received in-home services if any member of the family was found to have received in-home services (in-home services);
- Children who were removed and received placement services (foster care services); and
- Children who were removed and whose families received in-home services (foster care and in-home services).⁶

The majority (67%) of children in investigations and assessments by CYD were not accepted for services. Approximately 18 percent received in-home services, 8 percent received a combination of in-home and out-of-home services, and 6 percent received foster care services. A slightly higher proportion of children in CPS (37%) than children in GPS (32%) received any kind of

⁶ Nonplacement services such as after care and day care were combined with in-home services, because they were provided to children living with their families in their own homes.

service. Among those children who received services, a slightly higher proportion of GPS children (46%) than of CPS children (39%) were placed in foster care. Among CPS cases that were indicated or founded, 48 percent did not receive services compared to 39 percent of GPS cases that were substantiated. Among CPS cases that were unfounded, 64 percent did not receive services compared to 79 percent of GPS cases that were unsubstantiated.

Exhibit E.6 Service Type by Assignment to CPS or GPS

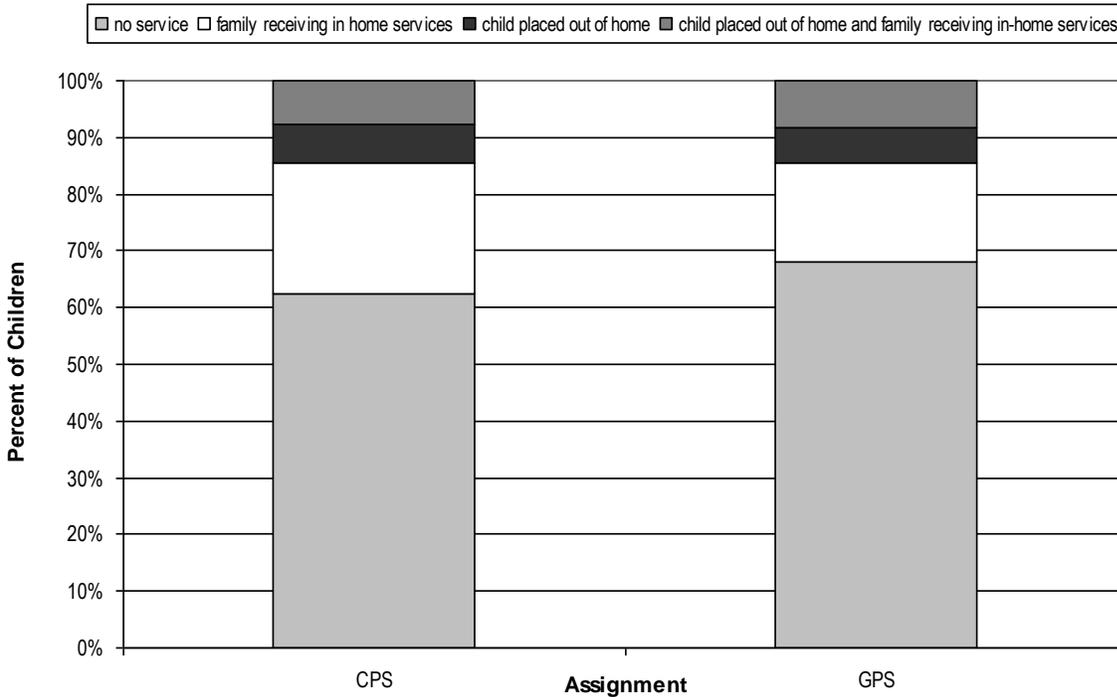


Exhibit E.7 Services Provided to Children by Assignment to CPS or GPS and Determination

	CPS			GPS			Total		
	Founded, Indicated, Substantiated	Unfounded or Unsubstantiated	Total	Founded, Indicated, Substantiated	Unfounded or Unsubstantiated	Total	Founded, Indicated, Substantiated	Unfounded or Unsubstantiated	Total
No service	49%	68%	62%	42%	82%	67%	43%	79%	66%
Family receiving in-home services	31%	20%	23%	30%	11%	18%	30%	13%	19%
Child placed out of home	10%	6%	7%	12%	3%	6%	12%	3%	7%
Child placed out of home, family receiving in-home services	11%	6%	8%	16%	4%	9%	15%	5%	8%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

* 792 children for whom no determination was made were omitted from this table.

Prevalence within the population

Data on children included in investigations or assessments by CYD were examined in the context of the population of children in Philadelphia. The population of children age 19 and younger in Philadelphia was 418,814 in 2005.⁷ Of every 1,000 children in the city, 55 were involved in an investigation or assessment of child maltreatment during 2005.

Prevalence of DHS involvement varied for children of different racial groups. African American children have a considerably higher rate of involvement than White or Hispanic children. During 2005, per 1,000 African American children in the population of Philadelphia, 63 experienced an investigation or assessment by CYD, 24 were found to be victims in either GPS or CPS, and 11 were placed in foster care. These rates were considerably lower for White and Hispanic children. Per 1,000 White children in the population, 24 experienced an investigation or assessment, 8 were found to be victims, and 3 were placed in foster care. Per 1,000 Hispanic children in the population, 18 experienced an investigation or assessment, 8 were found to be victims, and 4 were placed in foster care.⁸

Exhibit E.8 Involvement in Child Welfare Services by Race of Child

	Children in Population	Number of Children			Rate Per 1,000 Children in Population		
		Reports	Victims	Out-of-Home Placement	Reports	Victims	Out-of-Home Placement
African American	208,196	13,167	4,962	2,353	63.2	23.8	11.3
White	121,153	2,874	945	321	23.7	7.8	2.6
Hispanic	59,758	5,460	1,464	261	18.4	7.9	4.4

Assessment of risk and response priority

At the time of a report, an initial assessment of risk is made using the Hotline Screening Form. Each child, caretaker, household member, and perpetrator is determined to be at no risk, low risk, moderate risk, or high risk for a variety of risk factors. Risk factors pertaining to the whole family are also assessed. The highest risk factor applied to any child in the family, becomes the risk level of the family as a whole.

A response time priority is also assigned, indicating whether the report requires immediate response (Response Priority 1), response within 24 hours (Response Priority 2), or response in more than 24 hours (Response Priority 3). Risk levels and response priorities are assigned by CYD to the family in the investigation or assessment.

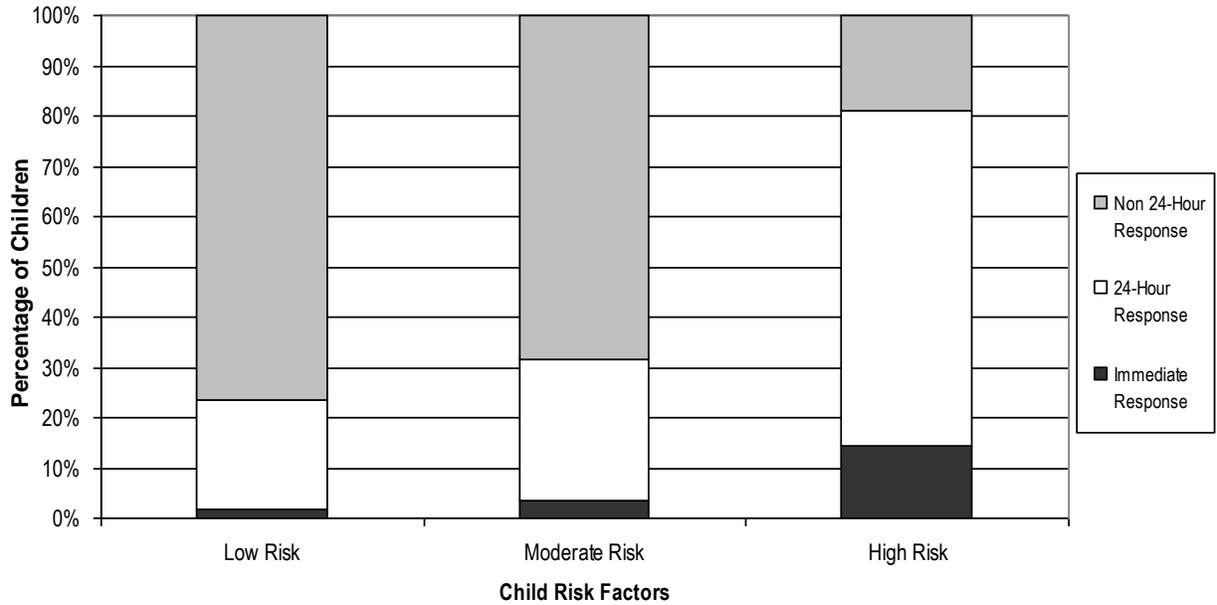
More than half (56%) of children reported to CYD were designated as being at high risk. Most of the remainder (39%) were designated as being at moderate risk, with only a few children (1%) designated as being at low risk, and some (4%) with missing risk information. While clearly a

⁷ U.S. Census Bureau, downloaded from www.census.gov on March 29, 2007.

⁸ These are duplicate counts of children; a child is counted multiple times if he or she experienced multiple investigations or assessments.

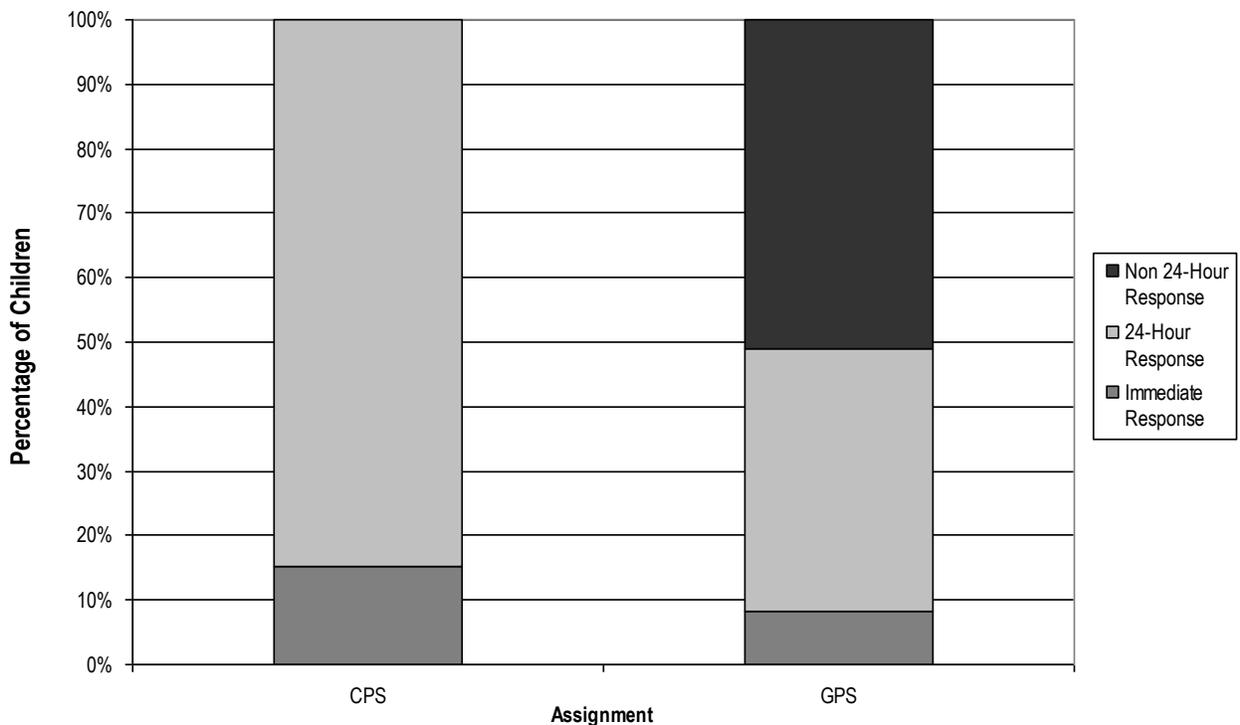
higher proportion of children with high child risk factors were given priority for a 24-hour response time, 19 percent of children with high child risk factors did not receive a priority 1 designation.

Exhibit E.9 Child Risk Factors and Response Priority



Assignment of response times was examined in terms of assignment to CPS or GPS. All reports referred to CPS were prioritized for either immediate response (15%) or response within 24 hours (84%). Among GPS reports, 8 percent were prioritized to receive an immediate response, 41 percent received a 24-hour response priority, and 51 percent were not prioritized to receive a response within 24 hours.

Exhibit E.10 Response Priority and Assignment to CPS or GPS



Demographic characteristics of children who were identified as being at low, moderate and high risk were examined. Younger children were more likely to have been assigned as being at high risk. Among children younger than age 1, 72 percent were at high risk, while among children between 12 and 17, 43 percent were at high risk. A slightly higher proportion of African American children were designated as being at high risk (57%) compared with the proportion of White children who were designated as being at high risk (52%), and a slightly lower proportion of African American children were designated as being at moderate risk (37%) than the proportion of White Children that were designated as being at moderate risk (44%). Among Hispanic children, 53 percent were at high risk, and 49 percent were at moderate risk. Less than 1 percent of each group were designated as being at low risk.

Among the small percentage of children who were identified as being at low risk; nearly three-quarters were between ages 12 and 17 years old, and only five children were younger than age 5 years. Two-thirds of children identified as being at low risk were African American.

Exhibit E.11 Child Risk Factors and Age

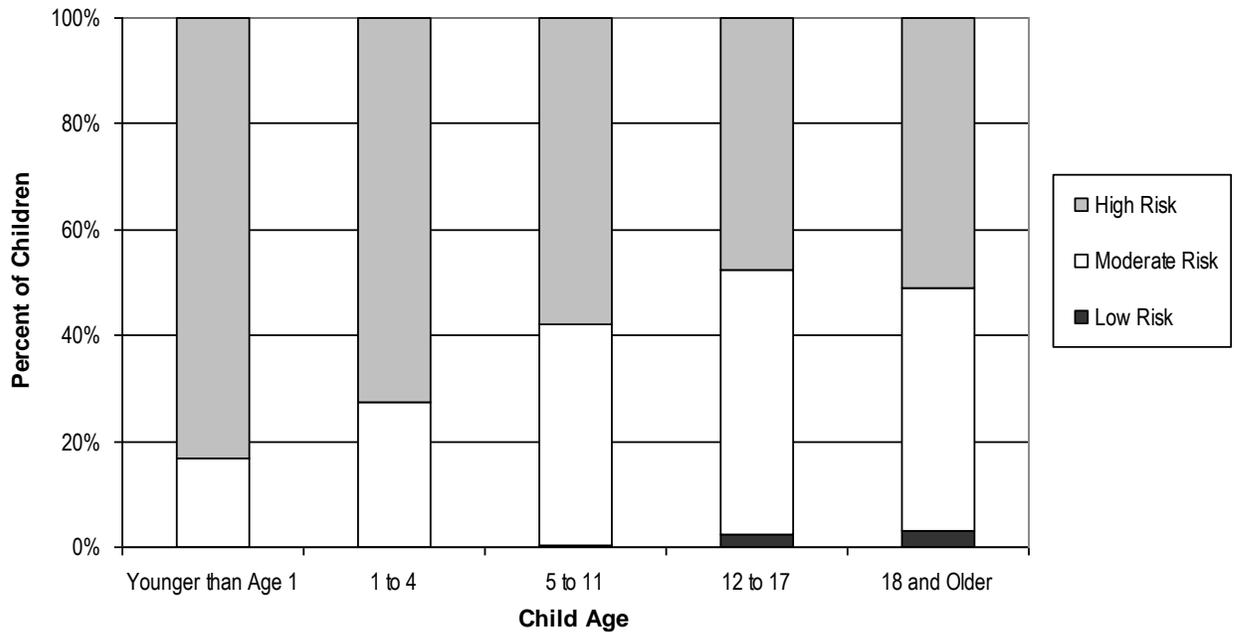
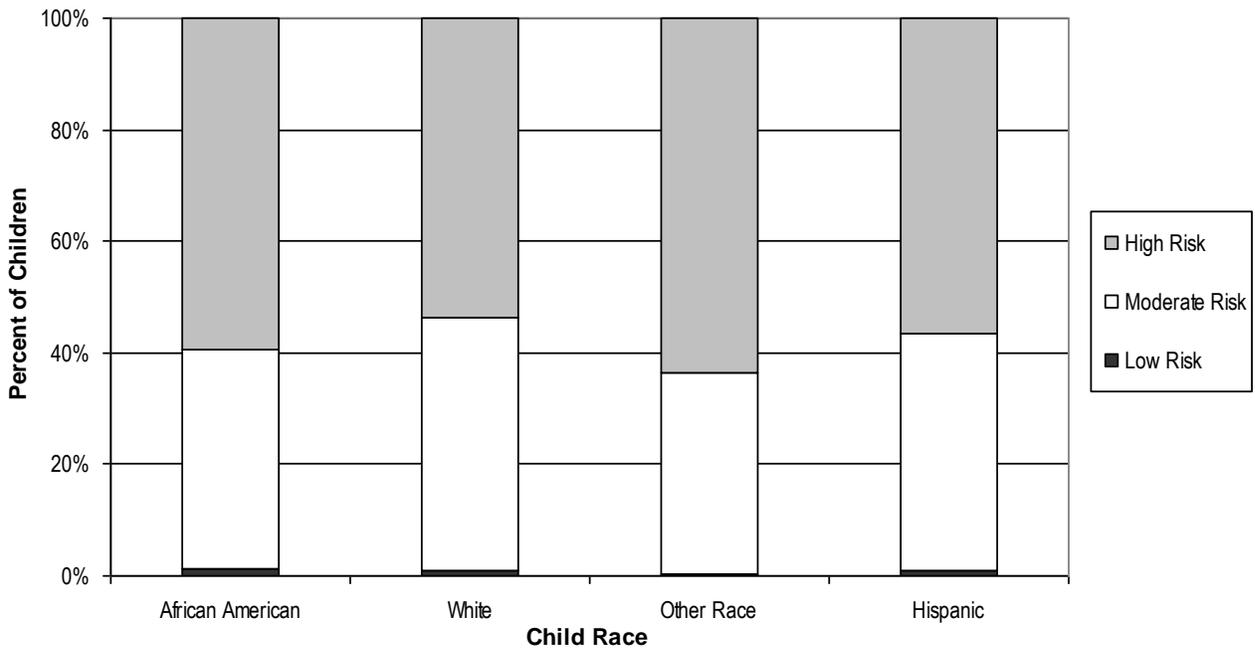


Exhibit E.12 Child Risk Factors and Race



The level of child risk assigned at intake appeared to have little relation to the determination. Similar proportions of children of each risk level were found to be unfounded or unsubstantiated. Child risk factors also did not appear to be associated with the receipt of services; 34 percent of children with high risk factors received services, while 33 percent of children with low child risk factors received services, and 28 percent of children with moderate child risk factors received services.

Exhibit E.13 Risk Level by Disposition

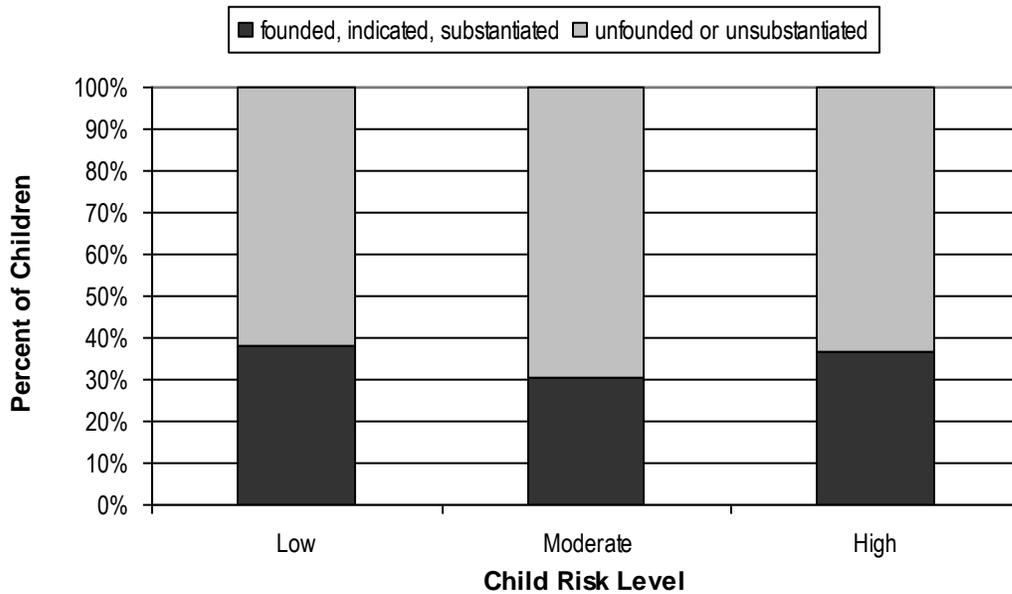
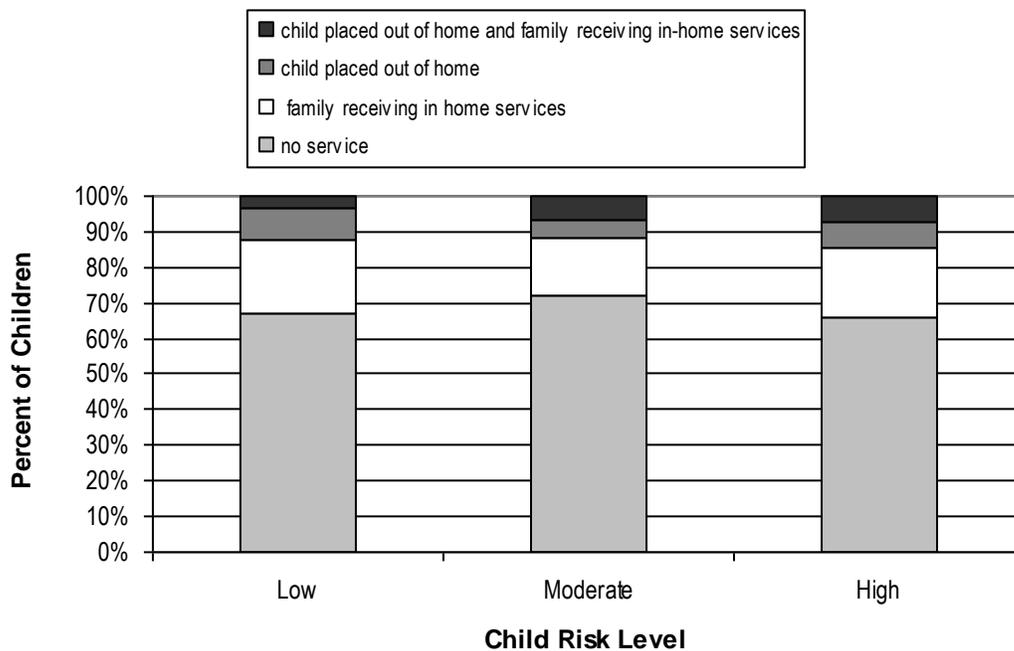


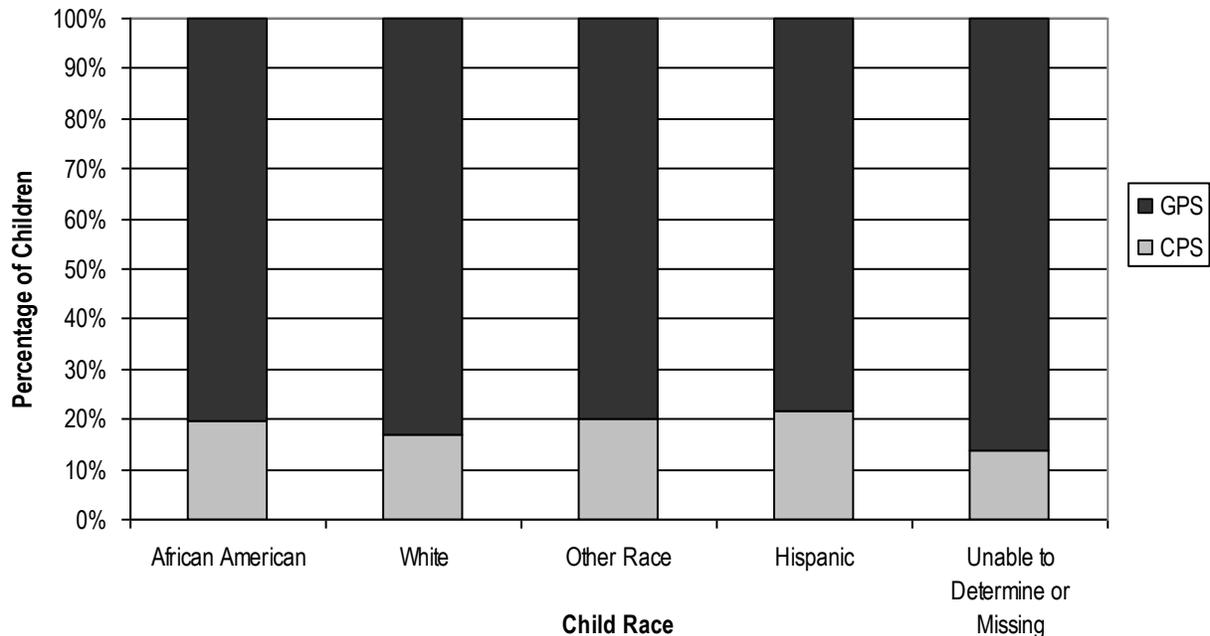
Exhibit E.14 Services Provided to Children by Risk Factors



Child race

African American children comprise half the child population in Philadelphia and 58 percent of investigations or assessments by CYD. Hispanic children comprise 14 percent of the City's population and 5 percent of investigations or assessments by CYD.⁹ White children comprise 29 percent of the children in the City, and 13 percent of investigations or assessments by CYD. Exhibit E.15 shows that the proportion of children of each race and ethnicity referred to CPS and GPS does not vary significantly.

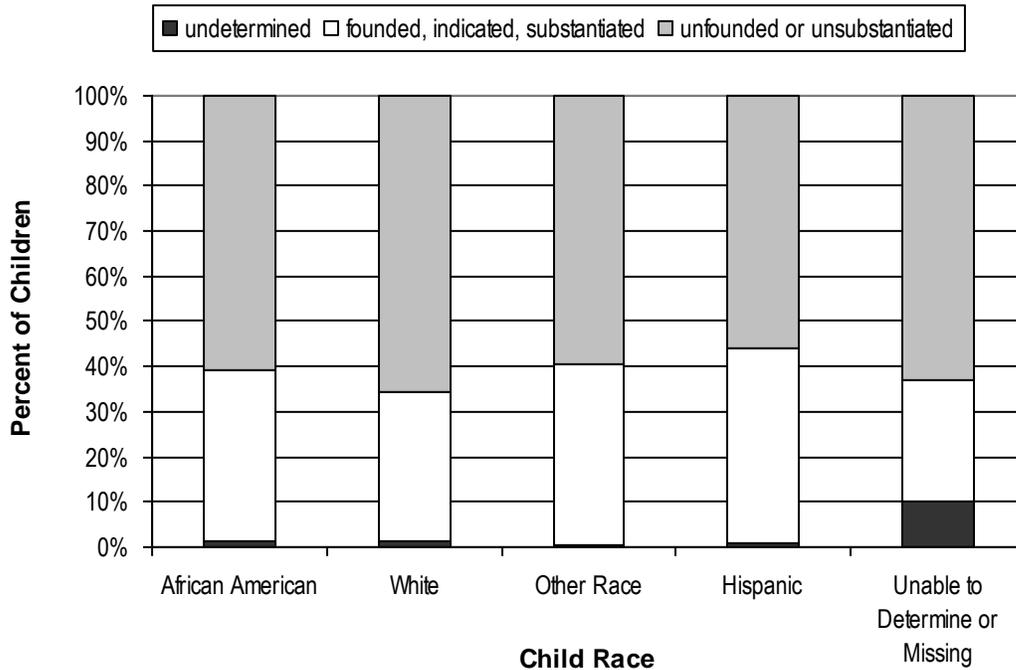
Exhibit E.15 Race of Children in CYD Investigations



Hispanic children were more likely to be found to be victims than children of any other race or ethnicity. Among children of Hispanic ethnicity, 43 percent of reports of child abuse or neglect were founded, indicated, or substantiated. Among African American and White children 38 and 33 percent of reports, respectively, were founded, indicated, or substantiated.

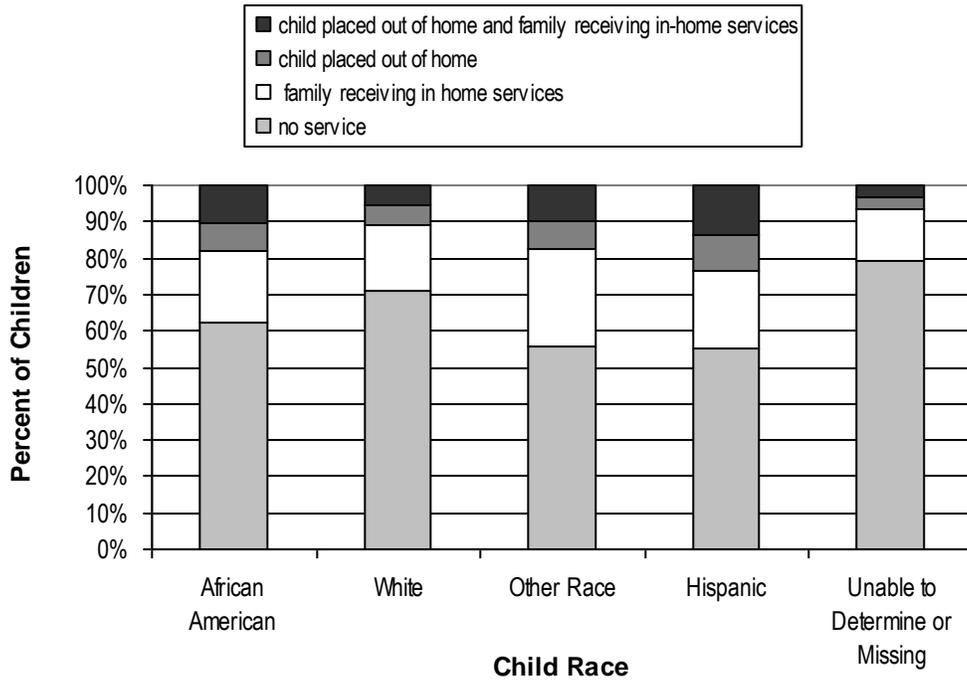
⁹ An indicator of Hispanic ethnicity is recorded separately from the indicator of race in the administrative data set. For purposes of these analyses, these variables were merged together so that any child with Hispanic ethnicity was identified as Hispanic (and no other race). However, it is important to note that on the Hispanic ethnicity indicator, 5 percent were "Yes," 31 percent were "No," and 64 percent were missing, so CYD involvement of Hispanic children may be underrepresented in this data set.

Exhibit E.16 Determination by Child Race



Hispanic children in maltreatment reports were more likely to receive services than were White or African American children. Among Hispanic children, about 45 percent received services compared with 38 percent of African American children and 29 percent of White children. White children in maltreatment reports were the least likely to be placed in foster care (without in-home services provided to their families); 6 percent of White children received only out-of-home placement, compared with 8 percent of African American children and 10 percent of Hispanic children. Hispanic children (14%) were most likely to both receive in-home services and their families out-of-home services.

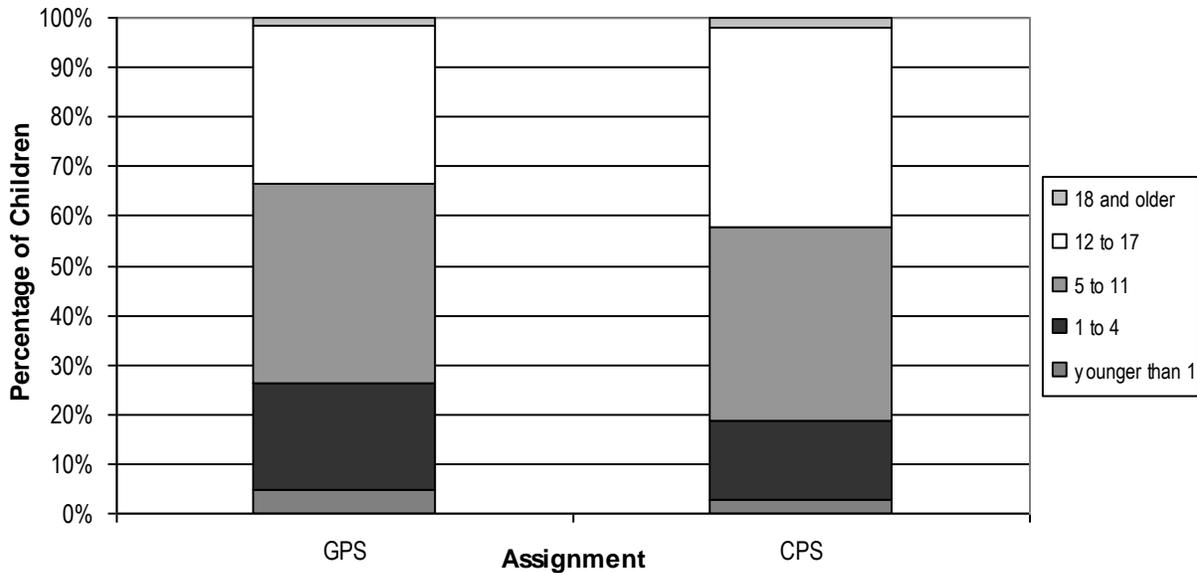
Exhibit E.17 Child Race and Services



Child age

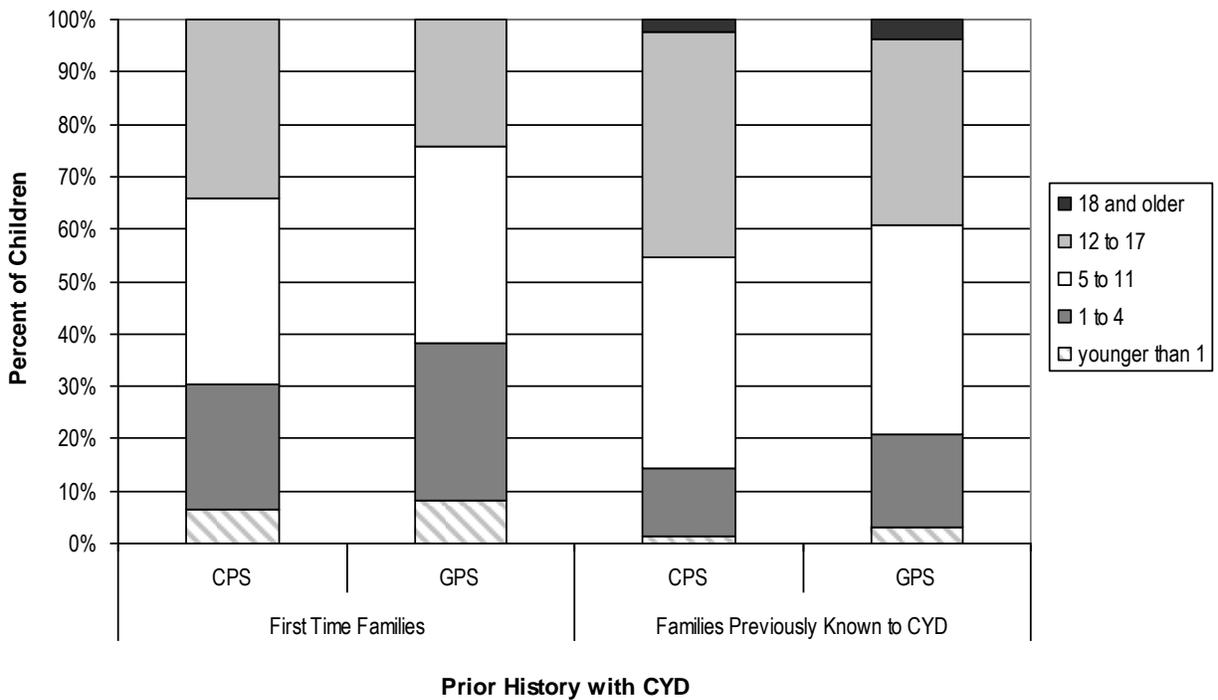
Children in CPS were older, overall, than children in GPS. Among children referred to CPS, 40 percent were between ages 12 and 17, while 30 percent of children in GPS were between ages 12 and 17.

Exhibit E.18 Age of Children in CYD Investigations



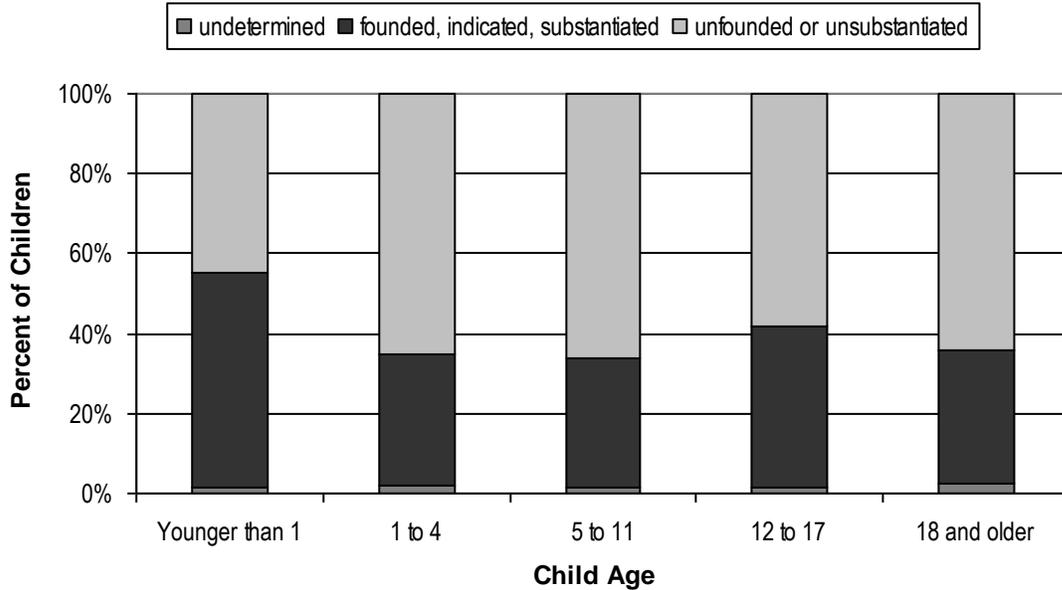
The age of children varied considerably among children whose families had previous experience with CYD and those who had not. Among children in both first-time families and those with prior CYD experience, children in GPS were younger overall than children in CPS. Approximately 37 percent of children with no prior family CYD history were younger than age 5 years, while no more than 20 percent of children with a prior family CYD history were younger than age 5 years.

Exhibit E.19 Age of Children in CYD Investigations by Prior Experience with CYD



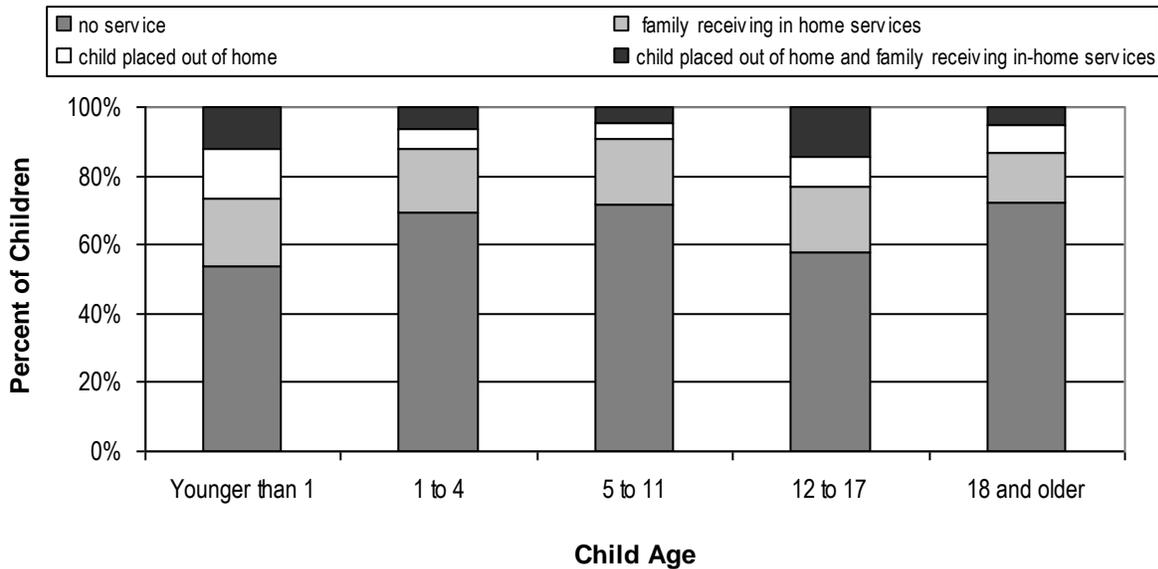
More than half (54%) of all infants in investigations or assessments by CYD were found to be victims, which is a higher percentage than among any other age group. Among children ages 1 to 4 years and ages 5 to 11 years, 32 percent were found to be victims, and 40 percent of children ages 12 to 17 years old were found to be victims.

Exhibit E.20 Determination by Child Age



Infants younger than age 1 year and children ages 12 to 17 years were more likely than other age groups to get services of any type (46% and 42% respectively received some services). Among other age groups, approximately 30 percent of children received some service.

Exhibit E.21 Child Age and Services

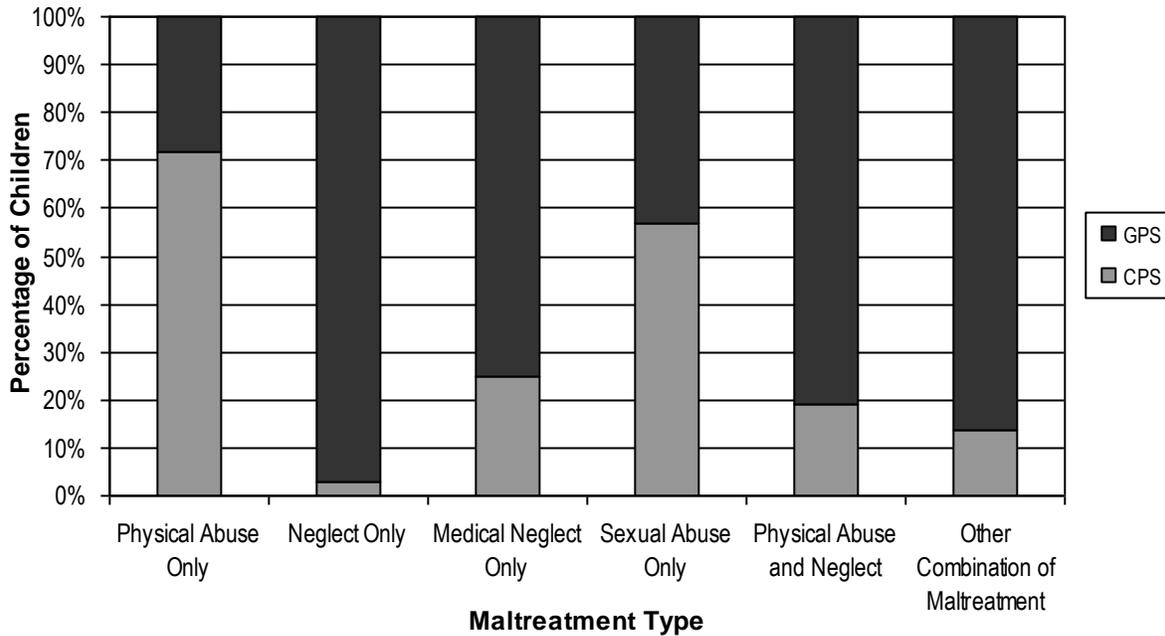


Maltreatment type

An examination of the type of maltreatment shows one of the clearest distinctions between GPS and CPS assignments. Nearly all (97%) of children for whom neglect was the only reported maltreatment were referred to GPS. Nearly three-quarters (72%) of children for whom physical abuse was the only reported maltreatment were referred to CPS. However, sexual abuse

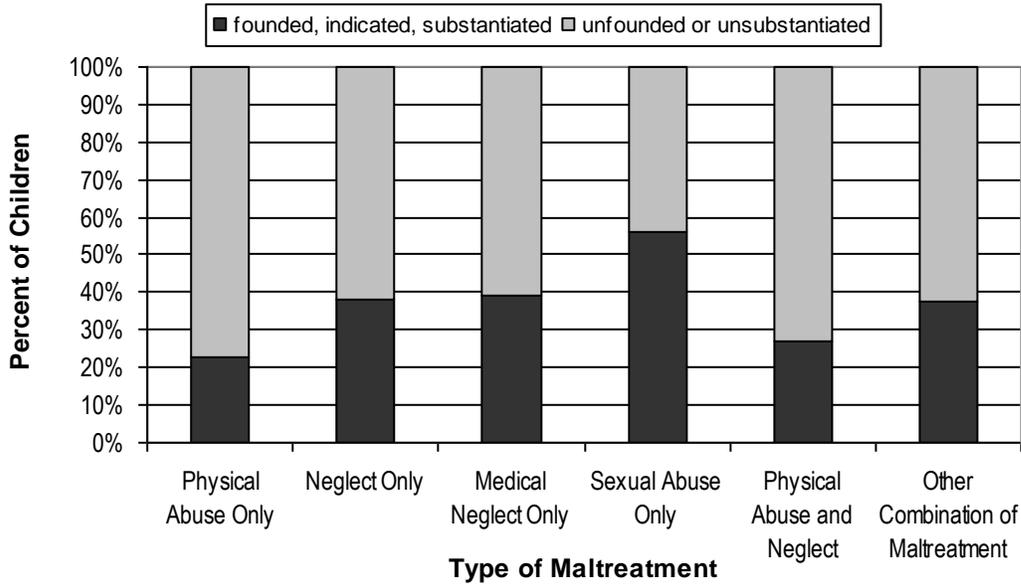
allegations could result in either CPS or GPS assignments (43% were assigned to GPS). Moreover, among children for whom multiple types of maltreatment were alleged (medical neglect, emotional abuse, other abuse, and neglect in combination with physical abuse and other combinations), 86 percent were referred to GPS.

Exhibit E.22 Type of Alleged Maltreatment of Children in CYD Investigations



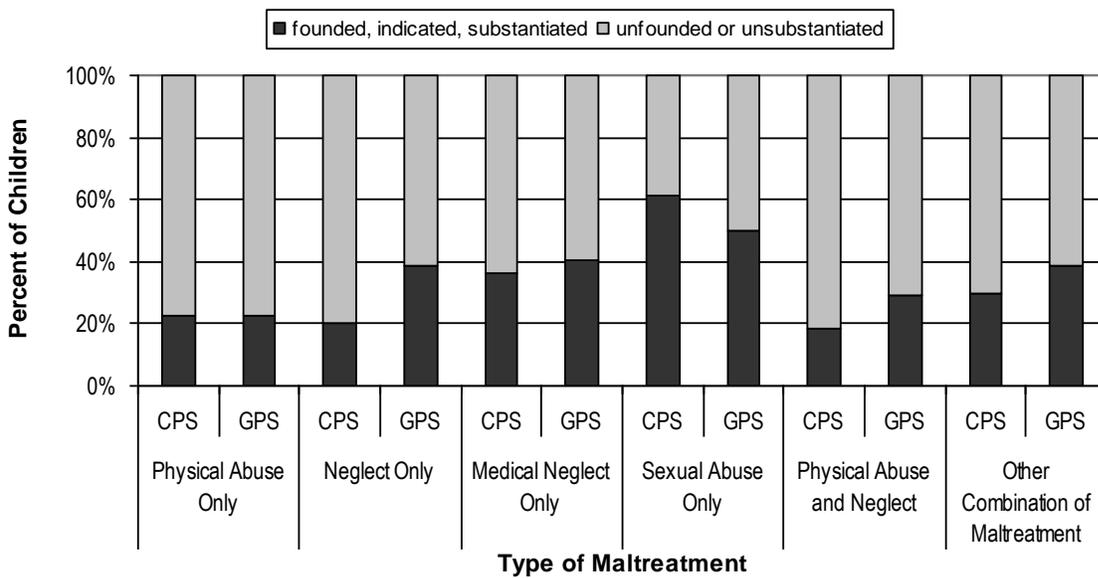
Among children with reports of sexual abuse, 56 percent had a finding of either founded, indicated, or substantiated. Approximately 26 percent of reports in which neglect was the only maltreatment were founded, indicated or substantiated, and fewer than one-quarter of reports of physical abuse (23%) had a finding of founded, indicated, substantiated.

Exhibit E.23 Determination by Maltreatment of Children



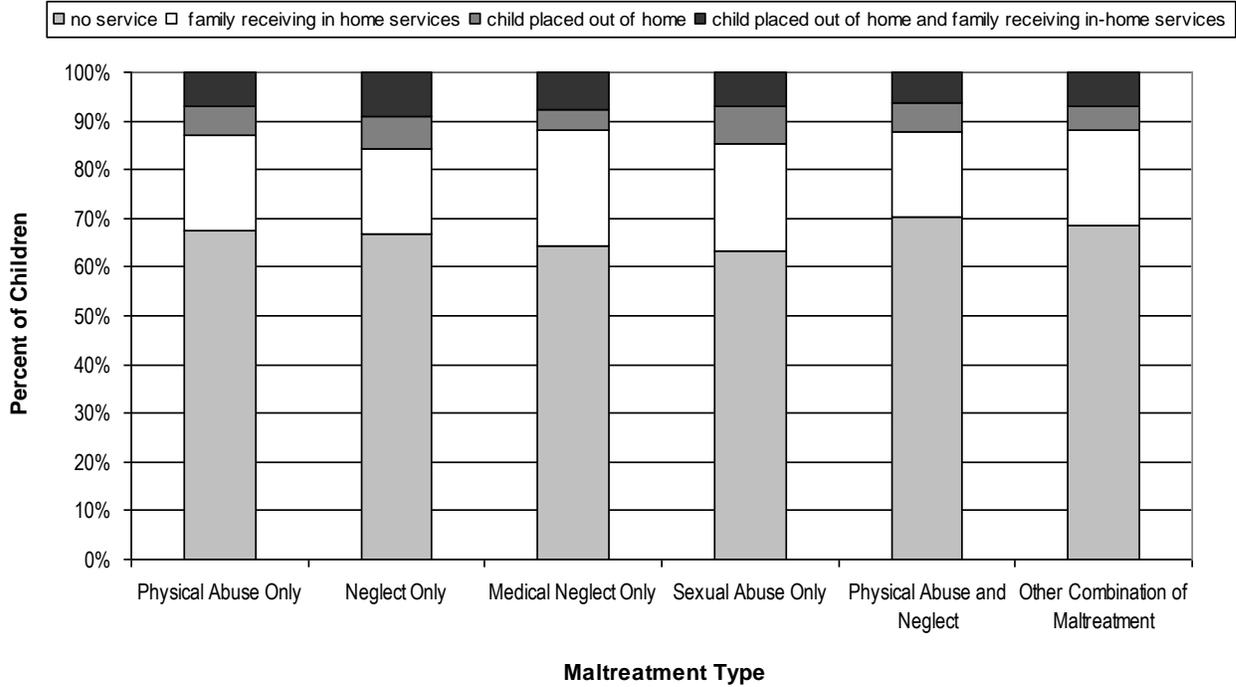
The percentage of reports that were founded, indicated or substantiated was similar for CPS and GPS for some maltreatment types and different for others. Among children with reports of physical abuse only or medical neglect only, similar proportions of children in CPS and GPS were found to be victims. Among children with reports of sexual abuse, those who were in CPS were more likely to be found as victims than those in GPS. Among children with reports of neglect only, physical abuse and neglect, or other combinations of maltreatment, a greater percentage of children in GPS than CPS were found to be victims.

Exhibit E.24 Determination by Maltreatment of Children by Assignment to CPS or GPS



The type of maltreatment did not appear related to the decision to accept a case for services. About two-thirds of children, regardless of maltreatment type, did not receive services.

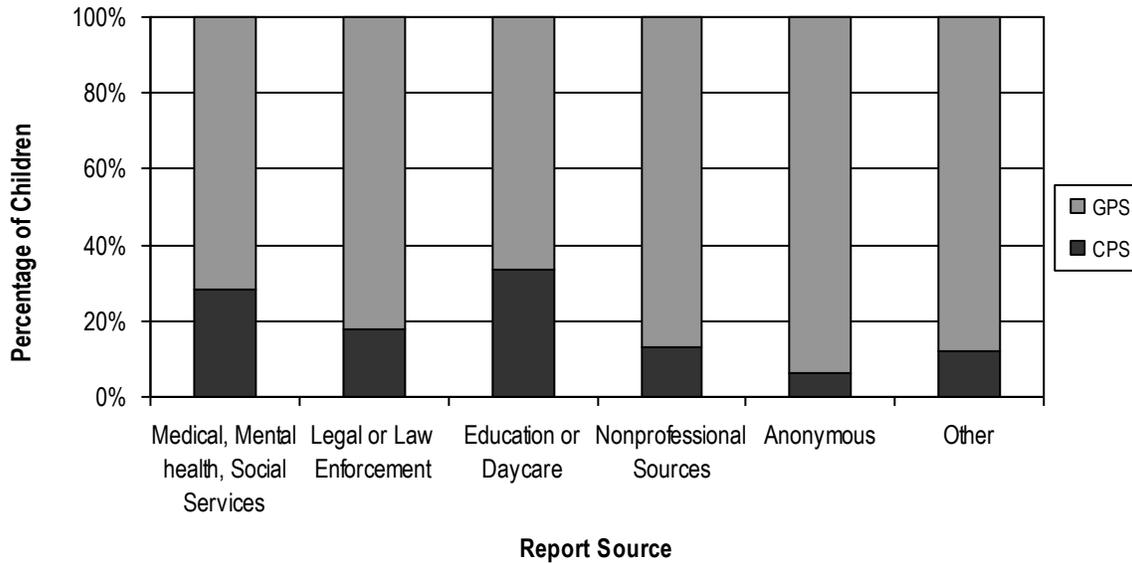
Exhibit E.25 Child Maltreatment Type by Services



Report source

Consistent with the finding that four-fifths of reports were referred to GPS; the majority of reports from all reporting sources were referred to GPS. Reports made by education personnel or day care providers, and medical, mental health or social services personnel were more likely to be referred to CPS than were reports from other sources.

Exhibit E.26 Source of Maltreatment Reports Among Children in CYD Investigations



Profiles of children receiving Services to Children in their Own Homes (SCOH)

Additional analyses were conducted to examine specifically the population of children whose families received SCOH. A higher proportion of children in CPS (28%) than children in GPS (23%) were provided SCOH. Overall, nearly one quarter of children received SCOH; among African American children, 27 percent received SCOH, and among Hispanic children, 29 percent received SCOH, among White children, 22 percent received SCOH. Among children younger than one year old, 29 percent received SCOH, and among children ages 12 to 17 years, 28 percent received SCOH.

**Exhibit E.27 Profiles of
Children Whose
Families Received SCOH**

	Number of Children			Percentage of Children		
	Not Receiving SCOH	Receiving SCOH	Total	Not Receiving SCOH	Receiving SCOH	Total
CPS	2,991	1,149	4,140	72%	28%	100%
GPS	14,311	4,390	18,701	77%	23%	100%
Total	17,302	5,539	22,841	76%	24%	100%
	Not Receiving SCOH	Receiving SCOH	Total	Not Receiving SCOH	Receiving SCOH	Total
African American	9,585	3,582	13,167	73%	27%	100%
White	2,239	635	2,874	78%	22%	100%
Other Race	159	79	238	67%	33%	100%
Hispanic	783	319	1,102	71%	29%	100%
Missing Race	4,536	924	5,460	83%	17%	100%
Total	17,302	5,539	22,841	76%	24%	100%
	Not Receiving SCOH	Receiving SCOH	Total	Not Receiving SCOH	Receiving SCOH	Total
younger than 1	690	286	976	71%	29%	100%
1 to 4	3,451	1,050	4,501	77%	23%	100%
5 to 11	6,638	2,054	8,692	76%	24%	100%
12 to 17	5,294	2,071	7,365	72%	28%	100%
18 and older	310	57	367	84%	16%	100%
missing age	919	21	940	98%	2%	100%
Total	17,302	5,539	22,841	76%	24%	100%

Recurrence

Recurrence is defined as a second founded, indicated or substantiated maltreatment within a six-month (183 day) period. Of the 4,008 children who were victims (with a founded, indicated, or substantiated maltreatment in either CPS or GPS) during the first six months of 2005, 295 children (7%) experienced a subsequent founded, indicated or substantiated maltreatment prior to the end of 2005.

The proportion and number of children in GPS who experienced a repeat maltreatment was larger than those in CPS. In 2005, 270 of the 3,382 children in GPS (8%) who were victimized during the first six months experienced a second victimization within the next 183 days. In CPS, 25 of the 601 children (4%) who were victimized during the first six months of the year experienced a recurrence.

FINDINGS FROM CASE RECORD REVIEW

Based on the review of child fatality cases, exhibit E.28 shows the distribution of child fatalities by year. More than 25 percent of the fatalities occurred during 2004.

Exhibit E.28 Child Fatalities in Philadelphia by Year

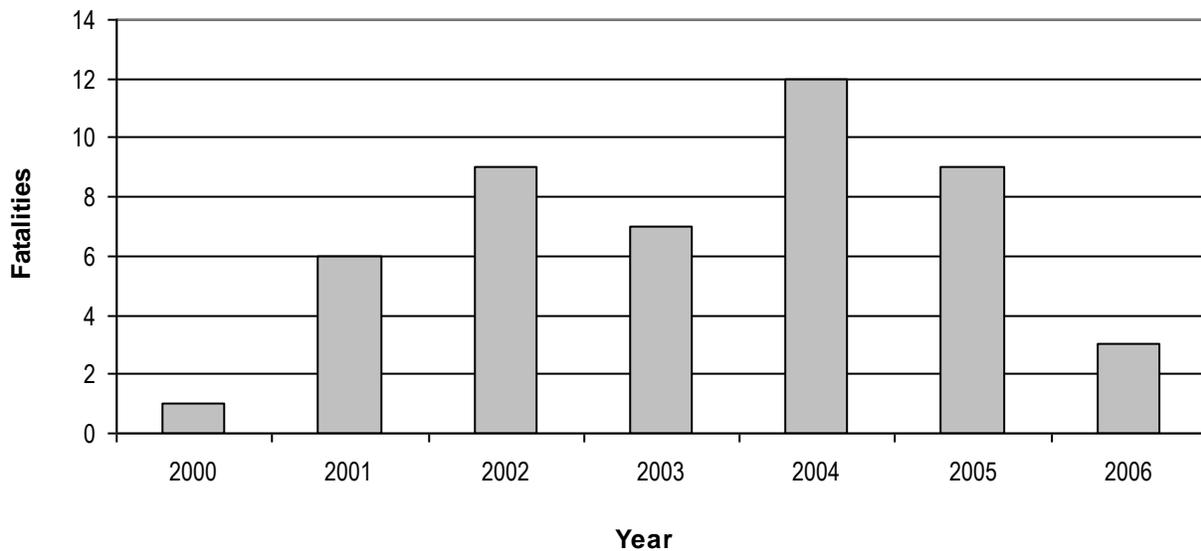


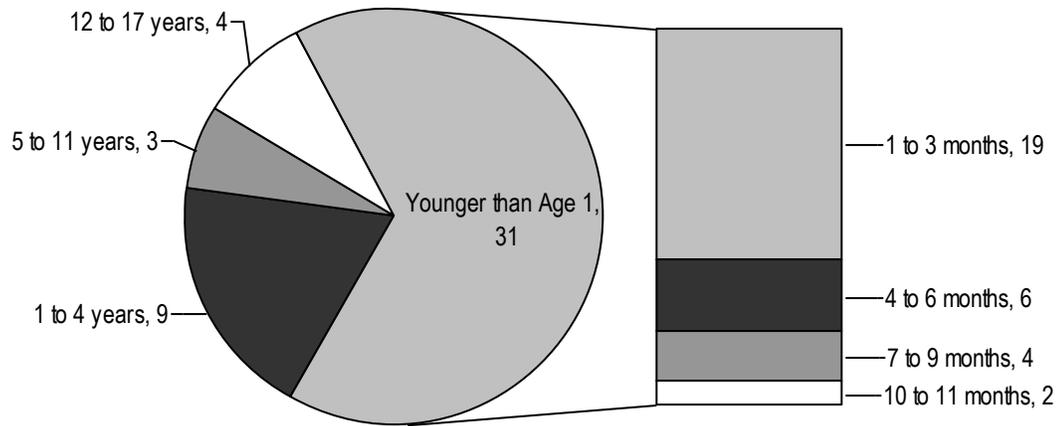
Exhibit E.29 shows the characteristics of the children who died as a result of alleged abuse or neglect. The majority of caregivers (66%) responsible for the children who died were previously known to CYD. Furthermore, more than one-half (51%) of children who died from child abuse or neglect were receiving services at the time of their death. Of the 24 children that had a known type of service, 58 percent were receiving SCOH and 9 percent were in either foster care or residential placement.

Exhibit E.29 Characteristics of Children Who Died Due to Abuse or Neglect 2000–2006

	N	%
Was there a prior report of child abuse or neglect involving the caregiver?	No	21%
	Yes	66%
	Unknown or Missing	13%
	Total	100%
Was the child receiving services at the time of death?	No services	34%
	Services	51%
	Unknown or Missing	15%
	Total	100%
Child sex	Male	49%
	Female	43%
	Unnown or Missing	9%
	Total	100%
Child age	younger than 1	66%
	1 to 4	19%
	5 to 11	6%
	12 to 17	9%
	Total	100%
Child race and ethnicity	White	19%
	African American	66%
	Hispanic	6%
	Unable to Determine or Missing	9%
	Total	100%

Of the 47 child deaths, 23 were boys, 20 were girls, and child sex was not known for 4 children. Two-thirds (66%) of the children who died between 2000 and 2006 were African American. Two-thirds (66%) of children who died were infants, younger than 1 year old. One-third of these infants were three months old or younger and two-thirds were ages seven to nine months. Of the seven infants who died during 2005, 5 were younger than three months of age.

Exhibit E.30 Age of Child Fatalities



SUMMARY

Sufficient data were available from CYD to analyze the major outline of service delivery in Philadelphia. This rather intense but brief analysis of the data routinely collected by CYD indicates that the potential for using data to track service delivery patterns is quite great for CYD. Given the difference in overall mission and objectives of CPS and GPS, the similarities in the characteristics of these populations are striking.

APPENDIX F. REVIEW OF FATALITY AND SELECTED NONFATALITY CASES

INTRODUCTION

The creation of the Philadelphia Child Welfare Review Panel (Panel) was precipitated by a number of child deaths that were attributable, in some part, to child abuse or neglect. In the Executive Order creating the Panel, Mayor John F. Street charged the Panel with engaging “*in a comprehensive review process to assist the City by ensuring the immediate safety of all children in its care, reviewing all child deaths in the last five years...and recommending reforms in DHS policies and procedures.*” The Panel was directed specifically to conduct the following activities.

- *“The Review Panel shall review any such files it deems necessary to determine whether investigations are being accurately and timely documented and that appropriate service plans are being adopted and implemented.*
- *The Review Panel will conduct a systemic case record review of abuse and neglect fatalities in Philadelphia since the beginning of 2002 to identify areas for corrective action to help avoid recurrence of such situations.”*

The purpose of this appendix is to report the results of the Panel’s review of case records involving reported fatalities, as well as a selection of records of families involved with the Department of Human Services (DHS), Children and Youth Division (CYD) in which no child died.

HIGHLIGHTS

The review undertook to examine cases that were reported to CYD in which children had died, possibly because of abuse or neglect (fatalities), and a subset of other cases that were reported to CYD, but in which no children had died (nonfatalities). The review of the nonfatality cases was conducted to see what similarities and differences in characteristics and practice might be apparent between the two groups of cases. The review of the administrative data (appendix E) also provides a context for such a comparison.

The case record review was constrained by data quality issues, which are described in the Methods section below. The consultants found considerable similarity between the fatality and nonfatality cases. Families in both groups of cases faced multiple problems including parental substance abuse, domestic violence, mental illness, physical disabilities and substandard housing. If the case was accepted for service, DHS often responded to these families by providing Services to Children in their Own Homes (SCOH), although typically these services did not begin until at least two months after the initial referral.¹ (The administrative data review in appendix E indicated that approximately two-thirds of children who received an investigation or assessment did not receive services.)

¹ DHS has recently initiated a “Rapid Response” program in which services are initiated simultaneously with the conduct of the investigation.

The most striking difference between the two groups of cases was the age of the children. Children who died as a result of possible child maltreatment were usually infants younger than one year old. The children in the other cases were older. The administrative data showed that approximately 4 percent of children who received either a Child Protective Services (CPS) investigation or General Protective Services (GPS) assessment were younger than one year old.

METHODS

The Panel and consultants engaged in several discussions with knowledgeable CYD personnel to identify the number of child fatality cases, to select a sample of nonfatality records, and to develop procedures for reviewing both fatality and nonfatality records.

Sample selection

DHS, Panel members, and the consultants reviewed a number of options for identifying the case records for review. These options differed for the fatality and nonfatality groups.

Fatality Records

State policy requires a Child Death Review of all reports of child abuse involving a death if a case involving the deceased child was open/active with the county agency, or had been open/active with the county agency within 16 months prior to the child's death, whether or not the investigation or assessment resulted in an indicated or substantiated determination. Other deaths that do not meet these criteria can be reviewed at the request of county social work officials. According to data provided to the Panel by CYD, 52 deaths, which occurred from 2001 through 2005, had been reviewed—44 because they met the State criteria and 8 by special request of DHS administrators.

Initially, Panel members and the consultants examined some case records of children who had not been known previously to CYD and, therefore, whose cases had not met the criteria for a Child Death Review. This review of case records found very little information in the case records—and no information about the circumstances prior to the child's death. Consequently, the Panel and CYD agreed that the Panel would review only those 52 records that had been subject to the Child Death Review process.

The consultants reviewed 47 fatality case records. Of the remaining five records, two were expunged and three could not be provided. Additionally, Panel members also read 13 of the 47 records and all of the Child Death Reviews.

Nonfatality Records

Experience in previous studies that had used a random selection of case records indicated that such an approach was not likely to provide information on all types of cases in Philadelphia because the number of GPS cases was so much larger than the number of CPS cases. To avoid a sample that was too heavily weighted toward GPS cases, the Panel, the consultants, and CYD agreed on the following stratified random sampling procedure.

- The sampling universe included the 1,336 cases that were referred to CYD between January 1, 2006, and January 31, 2006, and that were accepted for an investigation or assessment. No data were available for cases that were referred but not accepted.
- Ten cases that were determined to be unfounded (regardless if CPS or GPS), were randomly selected.²
- Ten cases that were founded, indicated, or substantiated (regardless if CPS or GPS), were randomly selected.
- Ten cases that were accepted for service, and for which the first service provided was either SCOH or family preservation, were randomly selected.
- Ten cases that were accepted for service and for which the first service provided was placement were randomly selected.
- Ten cases that were not accepted for service were randomly selected.

These procedures were expected to provide the Panel with the opportunity to examine the process for determining the type of case (CPS or GPS), whether a report was substantiated or unfounded, as well as the decision to accept a case for service regardless of the investigation or assessment outcome. Using these procedures resulted in a sample that placed a heavier burden on one CYD unit from which seven records of open cases were selected. To minimize this burden, three of the cases were replaced by randomly selecting cases that met the same criteria but were from other units. Of the 50 cases included in the sample, six had been expunged or could not be located, and 44 records were reviewed by the consultants, with four also being reviewed by a Panel member.³ Approximately one-half of the records involved cases that were open at the time of the review.

A standard data extraction form was developed and used in the review of all fatality and nonfatality records. A copy of the case review instrument is provided as exhibit F.1, at the end of this appendix.

Sampling concerns

The physical case records for both the fatality and nonfatality cases were provided on a piecemeal basis, to prevent their being unavailable to CYD casework staff for an extended period of time. The consultants maintained ongoing lists of which records were being reviewed and, after all reviews were completed, compared the records that were reviewed against the original DHS-provided list of 62 cases in which at least one child died between 2001–2005 and had some history of DHS involvement. Ten of those cases did not meet the criteria for a Child Death Review. The fatality records that were reviewed included three cases in which the child death occurred outside the agreed-upon time frame—one in 2000 and two in 2006. The consultants reviewed case records of an additional 25 fatalities that were not on the DHS list of 62, but did not receive records for 38 of the cases that were on the list. Of the 62 fatality cases on the original list, 25 were reviewed. It must be noted that ten of the records that were not reviewed

² Each of these five strata was further divided into subgroups to ensure representation of cases by type, response time, disposition and, where applicable, service.

³ While the physical case record was expunged, sufficient data to identify the case for sampling purposes was retained in the Family and Child Tracking System (FACTS).

did not meet the state requirements for a Child Death Review and, thus, were outside the scope of the Panel review procedure as well. These discrepancies raised serious concerns about the DHS record-keeping procedures.

Case record concerns

Other record-keeping concerns were raised by the review of the actual case records. Virtually all of the fatality and nonfatality case records were poorly organized. There were difficulties with the structure of the case record, duplicated or missing information, and with documentation of assessments and service plans.

Case Record Structure

The case records were usually voluminous, some requiring multiple file boxes. They usually, but not always, began with several pages of mailing instructions that included data that often was not consistent with information about client location elsewhere in the record. Most often, a copy of the relevant report to ChildLine or to the DHS Hotline and a narrative under the heading “Investigation,” was found. Sometimes the report of the investigation or assessment was included in this section and sometimes not. In some cases they were found at the bottom of the case record binder, often not labeled.

Duplicate or Missing Data

Multiple copies of most forms were found, placed in no apparent order. Most records had a section for each child receiving CYD services, but sometimes information on specific children was filed in sections pertaining to other children in the family. Usually the child-specific records included extensive documentation of the child’s medical history and, for a school-age child, his or her educational history. Such critical information as a parent’s drug use or a child’s physical limitations was noted once or twice in progress notes, but rarely carried into discussions about the case plan goals. In approximately two-thirds of the records, some reports from service providers were included; however, they often were not filed by provider so that it was not possible to determine if all the contractually-required reports were completed.

Assessment and Service Plan Data

The inconsistency of information, and the difficulty in locating it within the case record, was reflected in the assessments of the family group and its individual members. While most records included a copy of the state-required standard risk assessment instrument, there was no standard approach to safety assessment, nor was there any evidence of a standardized procedure for conducting and recording a comprehensive assessment of the family’s dynamics and the needs of its members. To the extent that assessments were conducted, they usually were recorded in the progress notes, making the data impossible to retrieve for management planning purposes. Assessments rarely seemed to bear any relationship to the services that were planned for, or provided to, family members. Psychological evaluations of children and other family members were an exception to this observation. Such evaluations generally were documented and a report from the psychologist or psychiatrist was placed somewhere in the child’s portion of the case record. The recommendations from such reports were generally incorporated into service plans. Vignette 1 describes a case in which the assessment and service planning process proved effective.

Vignette 1

A school called to make a CPS report about a 13-year-old who had been absent and then returned to school with a healing cut on his eye. The child reported that, since his parents were both dead, he lived with his sister and that her paramour had hit him.

The investigation founded the report. The boy was removed from his sister's care to a foster home. He subsequently ran away from several foster homes. The CYD caseworker eventually placed the youngster in a facility with an on-grounds school, to stabilize his behavior.

While in this placement, CYD conducted an extensive review of his relatives and eventually made contact with an older sister who lived out-of-state and who the child did not really know. Using the Interstate Compact for Placement of Children, CYD arranged for an investigation and home visit to that family and eventually made a permanent placement with her and her family.

Case record review process

The consultants attempted to locate in the case record the report that led to inclusion of the case in the review sample. If it was a fatality case, the report in which the fatality first became known to DHS was sought. For nonfatality cases, the consultants reviewed the Hotline Screening Form for the first report that was received in January 2006 and which resulted in the case being included in the review sample. If these reports could not be located, the consultants attempted to locate the first report on the family to CYD and reviewed as much information about the fatality or other relevant incident as could be located in the record.

The consultants attempted to understand each family situation, the facts of the fatality or the report that was made in January 2006, and CYD's handling of the relevant incident. In several cases the consultants found that the case record of the fatality or the report that was made in January 2006 had been expunged and, in such cases, the rest of the record was reviewed.

The observations in this appendix were made after considerable and careful attention to the records. The deficiencies of the paper record were not addressed through any additional process, such as interviewing the caseworker or searching the Family and Child Tracking System (FACTS) to elicit additional case information. For fatality cases, the consultants also read the documentation of the Child Death Review, after the rest of the record had been reviewed. The reviews of both record samples addressed the following issues, where applicable:

- Screening and intake of reports;
- Case characteristics;
- Risk and safety assessments;
- Accept-for-service decisions and service planning;
- Supervision; and
- Child fatality review process.

MAJOR FINDINGS

Screening and intake

The initial report of an alleged incident of child abuse or neglect comes to DHS' attention through its Hotline. Some reports are made directly to the Hotline and some to the state-operated ChildLine. If the report is made to ChildLine initially, it is forwarded to the DHS Hotline for

further action. If the report is made to the Hotline and it is determined that it meets legal standards for a CPS report it is forwarded to ChildLine for assignment of an official number then is returned to the Hotline for further action. Regardless of where the report is made, the social worker who takes the call is expected to screen it to determine if it meets the legal criteria for child abuse and, therefore, is a CPS report or, if it does not appear to meet those criteria, is a GPS report. The Hotline social worker is expected to assign a response time, based on the apparent urgency of the reported situation, within which the investigation (CPS) or assessment (GPS) should be initiated by the assigned intake social worker. To assist in making these determinations, the Hotline social worker is expected to use a standard screening tool and to check the state child abuse registry and FACTS to determine if the child or family involved in the reported incident had a prior history of reports or service.

When the Hotline social worker finishes the initial screening of the report, based on the available information, he or she makes the decision to screen out the report and take no further action, assign it to a CYD intake unit for investigation or assessment or, possibly, to refer the family involved for community-based prevention services. These decisions, along with basic information provided by the person making the report, are expected to be documented in the case record.

Hotline social workers are responsible for making quick and thorough decisions, based on state and city laws and policies of whether a report should be investigated further. In most of the records, reviewers thought the Hotline assignments were handled with dispatch and with sufficient information for an investigation or assessment to be initiated. The exceptions were records in which the paperwork was so disorganized that the narratives that accompanied the form, and/or the form itself, could not be located by the readers.

In reviewing the nonfatality cases, the consultants could not identify the policies or patterns that led to the distinction between a CPS and a GPS assignment. Specifically, there did not appear to be any particular differences between alleged sex abuse reports that were classified as GPS or those classified as CPS. Three of the reports alleging sexual abuse were classified by the Hotline as CPS, four of them were classified as GPS. One ChildLine report was classified as CPS and one report by a mandated reporter was not classified. (The administrative data review indicated that 53 percent of reports alleging sexual abuse were referred to CPS and the remainder were referred to GPS.)

Case characteristics

Several characteristics of the fatality and nonfatality cases were examined. In most respects the families in both the fatality and nonfatality cases were similar to the DHS service population. The families were usually poor, African American or Hispanic, drug- and/or alcohol-involved, often homeless or living in substandard conditions, and frequently headed by a single caretaker. Many of the families in both samples were quite large, with up to nine children, and often at least one family member had serious mental or physical health issues. The two groups were compared in terms of the ages of the child victims involved, the type of case, the response time, the family's prior history, and the determination resulting from the investigation or assessment.

Victim Age

Only one characteristic substantially distinguished the two groups from one another—the age of the child who was the primary focus of the investigation or assessment. As may be seen in exhibit F.2, the children who were the majority of victims in fatality cases were infants younger than one year old. This is true nationally as well, with children younger than one year old accounting for 42 percent of the child abuse fatalities nationally in 2005. (ACYF, 2005).

Exhibit F.2 Age of Child Victims

Age	Fatalities	Nonfatalities
Younger than 1 Year	34 (72.3%)	3 (6.8%)
Age 1-17 Years	13 (27.7%)	41 (93.2%)
Total	47 (100.0%)	44 (100.0%)

$\chi^2=40.4$
 $p<.001$

Of the 47 fatality records reviewed, 34 involved a report of a child younger than 1 year old. The ages of the remaining 13 children ranged from 1 to 17 years old; two of the older children died in institutional settings where they had been placed by DHS. By contrast, only three of the 44 children who were the primary victims in the nonfatality cases were infants younger than one year old. The children who are most vulnerable due to their age are most likely to be alleged victims of fatal child maltreatment.

Case type and response time

The start of the investigation or assessment is triggered by the determination of whether the report is classified as CPS or GPS and, additionally, by whether immediate response, a 24-hour response, or another response is required. While the basis of the Hotline decision to classify a report as CPS or GPS was not clear to the reviewers, the differentiation between immediate response and 24-hour response generally seemed appropriate.

Fatality cases were somewhat more likely than nonfatality cases to be determined to meet the state criteria for CPS, with 51 percent of the fatality cases reported and 34 percent of the nonfatalities being considered CPS reports (exhibit F.3). Reports of child fatalities also were more likely to be responded to immediately, rather than within 24 hours or longer (exhibit F.4). Of the fatality reports, 55 percent were responded to immediately; 27 percent of the nonfatality reports received an immediate response.

The intake caseworker initiated the investigation or assessment within the identified time limits. In at least two cases, several days passed before the caseworker was able to locate the dead child's parent(s) for interview purposes, but the investigation or assessment was initiated with interviews with police and/or medical personnel.

Exhibit F.3 Type of Case

Case Type	Fatalities	Nonfatalities
CPS	24 (51.0%)	15 (34.1%)
GPS	23 (48.9%)	29 (65.9%)
Total	47 (99.9%)	44 (100.0%)

$\chi^2=3.3$
 $p<.05$

Exhibit F.4 Response Time

Response Time	Fatalities	Nonfatalities
Immediate Response	26 (55.3%)	12 (27.3%)
24-Hour Response	8 (17.0%)	18 (40.9%)
Other Response	1 (2.1%)	5 (11.4%)
Undocumented/Unknown	12 (25.5%)	9 (20.4%)
Total	47 (99.9%)	44 (100.0%)

$\chi^2=12.0$
 $p<.01$

Prior history

Past behavior is one of the best predictors of future behavior, so that virtually every child welfare agency searches its records to determine if a child or family had been reported previously for alleged child abuse or neglect or was otherwise involved with the agency. As exhibit F.5 demonstrates, there were no differences between the fatality and nonfatality samples in this regard. Slightly more than half of both groups were documented as having a previous report on at least one child in the family. For approximately one-third of each group there was no discernible documentation of previous history in the case record.

Exhibit F.5 Prior Report History

Prior Report on at Least One Child in the Family	Fatalities	Nonfatalities
Prior Report	30 (63.8%)	24 (54.5%)
No Prior Report	3 (6.4%)	4 (9.1%)
Undocumented/Unknown	14 (29.8%)	16 (36.4%)
Total	47 (100.0%)	44 (100.0%)

$\chi^2=0.8$
 p NS

Eleven of the 34 infants who died had prior reports on them that were closed at the time the deaths were reported. Nineteen of the infants who died were part of an active CYD case that was either open in the intake unit or receiving CYD services at the time of death. Of those 19 infants, 11 had a prior report and an additional eight infants had been added to a case that was opened in response to a report on another child. CYD had never had a report on three of the dead infants and, in one record, it was not possible to determine if the dead infant had been the subject of a prior report.

Most of the 34 families in which an infant died had prior histories of CYD services either for the parent(s) as minor children and/or on other children of the parents. In 17 families, at least one parent had received services from CYD as a minor. In 24 cases, one or more parents had received services for some of their children prior to the infant's death.⁴ Four of the case records did not reveal any prior family involvement with CYD; and five additional records did not yield useful information on prior reporting and/or service.

The consultants noted the following report history for the families in the nonfatality cases:⁵

- Ten of the families had between one and four reports noted, in addition to the January 2006 report that brought the case into the sample;
- Ten families had between five and ten additional reports;
- Two families had 10 to 15 reports;
- One family had 16 reports;
- One family (in which the mother was a twelve-year-old when she first gave birth) had 23 reports; and
- No information on prior reports was found in 16 records.

In summary, in 85 percent of the nonfatality records, in which information was available, there were multiple previous or subsequent reports to CYD. This compares with 85 percent of the fatality-involved families which had one or more reports in addition to the one involving the fatality. These families are well-known to CYD for the most part.

A process for checking criminal history is available to CYD workers. When law enforcement personnel were involved in an investigation, they conducted the criminal history check in most cases. In the nonfatality case records, two case records had evidence that criminal history was checked on adult members of households. The remaining case records did not contain any information on whether criminal records checks were done, even when the narrative or a case-planning document noted that at least one of the parents was in jail or had been jailed previously.

Investigation or assessment determination

At the conclusion of the CPS investigation or GPS assessment, the CYD intake caseworker, with supervisory approval, makes a decision regarding the validity of the report. If the facts discovered during the investigation or assessment support a conclusion that child abuse, as defined in state law, occurred the determination is made that the report was "Founded" or "Indicated;" otherwise it was "Unfounded." Similarly, if the GPS assessment indicated that neglect or other forms of maltreatment required protective services, but did not rise to the level of the state criteria for abuse, the report is "Substantiated." If this standard is not reached the report is "Unsubstantiated." For purposes of analysis, the two sets of terms were combined, as displayed in exhibit F.6. Essentially there were no substantive differences between the fatality and nonfatality cases reviewed. In slightly more than half of both groups, the reported maltreatment was found to have occurred. In a few fatality cases the determination had not yet

⁴ In some families the caretakers had received services as a child, as well as on behalf of their other children.

⁵ The numbers reported here include reports received subsequent to the January 2006 target date because, in many cases, additional reports were received after that date and were recorded/filed through December 2006.

been made, sometimes after a period of many months, because the police or medical examiner’s investigation into the child’s death was still ongoing and the CYD decision was dependent on the conclusion of that investigation.

Exhibit F.6 Investigation Determination

Determination	Fatalities	Nonfatalities
Founded/Indicated/Substantiated	21 (55.3%)	23 (52.3%)
Unfounded/Unsubstantiated	11 (17.0%)	11 (25.0%)
Not Yet Determined	3 (2.1%)	0 (0.0%)
Undocumented/Unknown	12 (25.5%)	10 (22.7%)
Total	47 (100.0%)	44 (100.0%)

$\chi^2=7.9$
 p NS

Risk, safety and needs assessments

As part of the investigation/assessment process, intake social workers are expected to assess the risk of future abuse or neglect for all children in the family using the standard state risk assessment instrument. After the initial risk assessment that is completed as part of the investigative process, social workers are expected to update the risk assessment periodically—approximately every 6 months—or as needed because of changed circumstances. A brief description of each child’s current safety is also expected. The assessment process is also expected to result in a service plan that reflects the needs of the various family members.

Risk Assessment

At least one risk assessment form was found in approximately two-thirds of the fatality records. In about one-third of the records no risk assessment form was found. The records in which risk assessment forms were located revealed some divergent uses of the instrument.

- Risk assessments that were completed after the fatality occurred focused on the remaining children in the family, if any. None of these cases that were reviewed revealed a risk that was rated higher than “Moderate.”
- Risk assessments completed prior to a fatality sometimes included the infant who died and sometimes did not. In most of the instances in which the infant was not included, the case had been closed before the child was born. Almost all of the assessments that included an infant the risk was rated as “High” due to the child’s age.

For the nonfatality cases initial risk assessments were located in 34 records. Of those, 12 were rated as low risk, 13 as moderate risk, and 9 as high risk. There were no discernible patterns of characteristics or outcomes related to these ratings, except that most cases involving an infant were rated as high risk because of the child’s age. In contrast to the fatality records, however, few assessments were found of other children in the home other than the child who was the primary focus of the investigation or assessment. Assessments of adults in the home were rare.

Safety Assessment

Risk assessment instruments that were completed included observations about child safety that were noted in the narrative recordings, i.e. “*child looked clean and had appropriate clothing;*” “*child had no visible injuries or scars.*” In most records, safety of the environment also was described. It was noted specifically if utilities were operational or not, whether living quarters were clean or not, whether there was food or not. Based on these evaluations of children and their physical environment, decisions were made about whether to investigate further, close the report, or accept for service. There were some safety assessments that appeared to reflect questionable judgment, however, such as “*the child is safe because he is in foster care,*” or “*Mother (the alleged perpetrator of the fatality) is keeping the child safe.*”

In the 35 nonfatality case records in which assessment narratives were found, there were safety assessments on 20 target children. Fourteen children were assessed to be safe; four children were assessed to be unsafe and three of them were immediately placed; two children were noted as “conditionally safe.” Only four other children (not the subject of the report) were assessed; all were deemed safe. Of seven target children who were assessed to determine if they had service needs, five children were said to have no service needs; two children were found to have need for services. Nineteen children were already part of a service case. No assessments were found on any of the other children.

Needs assessment

The consultants found very few assessments of the parent(s) or other adults in both fatality and nonfatality records. Most of the records involving fatalities included parents who had substance abuse problems, domestic violence histories, and/or physical and mental health problems, and who sometimes were homeless or living in very precarious circumstances. The contribution of these conditions to the fatality, or the impact on the safety of the surviving children, was often not documented in the case record. For example, in a majority of records where the mother was reported for substance abuse, there was little, if any, evaluation of the impact of substance abuse on the safety of the children. In the homeless families, there was little if any evaluation of the impact of constantly moving on the safety of the children. Identities of other adults in the household were not established, for the most part. In at least three records, it was noted, after the fact, that another adult in the household had an active CYD case. History checks of prior child maltreatment and criminal record checks did not appear to have been initiated for adults other than the alleged perpetrator(s). Nonfatality records had similar issues.

There was an absence of verification of parenting knowledge and parenting skills. In the fatality records it was observed that intake social workers did not address parental abilities in making the assessment of safety or risk to any of the children—before or after the fatality. Assessments of parents in the nonfatality cases were found in 12 of the 35 case records in which there were assessment narratives. Parental abilities were assessed for 12 of the parents; three parents were found to be able and the remaining nine parents were assessed as needing help with parenting skills. For these same 12 parents, 11 parents were assessed as needing services and/or supports for themselves.

Intake social workers are charged with making collateral contacts to verify children's safety. Narrative recording in the fatality records established that collateral contacts were initiated for most families. However, when contacts could not be completed, the investigation/assessment often appeared to be kept open without making a decision about the safety of the children who were known to DHS at the time of the investigation or assessment. In contrast to the fatality reviews for which there were substantial, time-consuming efforts to make collateral contacts, the nonfatality records documented far fewer collateral contacts. In many cases, intake social workers seemed intent on closing the investigation or assessment as quickly as possible. In several cases in which the investigation or assessment was completed in less than 2 weeks,

collateral contacts could have provided a much more comprehensive picture of family dynamics and needs, but such contacts were never initiated.

The need to move quickly and professionally in making a decision on whether a child needs protection is the heart of the investigative process. There were records in which it seemed that the child should be removed; in some instances this occurred, in others it did not. Investigations and assessments appeared to move slowly without a concentration on the continued safety of the child. (This may be a function of the case record rather than actual practice.) Completing all the tasks of investigation or assessment took precedence over assessing safety and identifying the services needed by the children and parents. In the end, many of the investigations and assessments did not appear to address consistently the core questions of overall safety and did not identify immediately children who needed to be protected, either in the home or with out-of-home placement.

For example, seven of the investigations or assessments in nonfatality cases were on reports of alleged sexual abuse; one additional report alleging sexual abuse was received from a mandated reporter on an active case. One of the cases was investigated and accepted for service. The other six were not accepted. For these reports, the investigations or assessments were done very quickly; for three of the reports, investigations/assessments took less than 3 weeks to complete. In another alleged sexual abuse case, the worker closed the CPS investigation because the "mother declined services."

Vignette 2, summarizing a case record, illustrates some of these issues.

In the majority of records read, the investigation and assessment focused solely on the reported incident. A full picture of individual family strengths, concerns and needs was absent in almost all records read.

Vignette 2

Mother and father of a 6-month-old baby were reported to CYD anonymously because they were seen shaking their infant daughter. A GPS investigation was conducted, and the family was accepted for family preservation services. The case was closed after 3 months but soon after, the 16-year-old mother requested services for herself, her daughter, and her newborn daughter.

The mother and her two children were living in a shelter but were expelled because of mother's non-compliance with the rules.

CYD could not find the mother for several weeks. When located, the CYD caseworker learned the mother had given birth prematurely to a son. Six weeks later, the baby died due to Sudden Unexplained Infant Death. The infant was found not breathing while sleeping on his maternal aunt's chest.

Following the infant's death, SCOH services were implemented and delivered to mother and her two children in a relative's home.

ACCEPT-FOR-SERVICE DECISIONS AND SERVICE PLANNING

When the investigation or assessment is completed, and a determination has been made, the caseworker must decide whether to accept the case for service and, if so, develop a service plan based on the information compiled during the investigation or assessment process. The decision to accept for service appears to be made on the basis of the identified need for services and the parental willingness to accept and cooperate with services. This need may exist in cases that are unfounded/unsubstantiated and the case is accepted for service, just as cases that are founded/substantiated may not be accepted because no need is evident.

As may be seen in exhibit F.7 the fatality and nonfatality cases were quite different in terms of the accept-for-service decision. Fatality cases were generally either already open for service or the service decision was undocumented in the case record. Among the nonfatality cases a case was about equally likely to be accepted or not accepted, with fewer cases already being open and almost none left undocumented.

Exhibit F.7 Accept-for-Service Decision

Service Decision	Fatalities	Nonfatalities
Already Open for Service	19 (40.4%)	9 (20.5%)
Accepted	5 (10.6%)	17 (38.6%)
Not Accepted	2 (4.2%)	14 (31.8%)
Referred to Prevention	0 (0.0%)	2 (4.5%)
Undocumented/Unknown	21 (44.7%)	2 (4.5%)
Total	47 (99.9%)	44 (99.9%)

$\chi^2=34.7$
 $p<.001$

With fatality cases that are not already open, the worker generally makes the decision to accept the case for service based on the needs of any surviving children in the family. If the case is already open, the needs of these children are considered in deciding whether to change the existing service plan. For nonfatality cases the needs of all children in the family are expected to be considered in making the accept-for-service decision, but the review of case records suggests that only the needs of the target child are reviewed in most instances.

If a family is already receiving services when the fatality or new report becomes known, in most instances the existing service array is continued although service intensity may be increased. If no children are in placement, some or all may be moved to an out-of-home placement setting.

In families where there was no active case, one of three different accept-for-service decisions was usually made.

- If there were (other) minor children in the household of an alleged or possible perpetrator, children were removed from the home to a CYD placement, either through a voluntary placement agreement by the parent-perpetrator or after a restraining order was obtained from Juvenile Court. The children who were removed were accepted for service and the family's case was transferred to a Family Service Region for on-going services to the placed children.

- If responsible relatives are known to CYD (usually a maternal or paternal grandmother), children were moved to the relative's home. It was noted that this was a course that was pursued even when the parent had moved in and out of the home of the children's caretaking grandmother or other relative who had expressed concerns to CYD workers about the safety of the children and wanted to care for them. If the relative's home was deemed "safe," the children were not accepted for service, in most cases. Only when there was no other placement available through CYD or when there was uncertainty about the safety and stability of the relative's home was the case accepted for service.
- When there were no surviving minor children in the household of the perpetrator, the case was not accepted for service. There were at least five cases in which the parent/perpetrator was known to be pregnant at the time of her child's fatality but in which there were no decisions to accept for service.

Vignette 3 illustrates some of the accept-for-service and service-planning decisions for surviving children in the case of a fatality.

Most direct services are provided through a cadre of private provider agencies under contract to DHS. It was difficult in the case review process for the reviewers to note much about the quality of services provided by contracted agencies. In the uncommon cases in which contracted agencies provided most or all of their required reports, it was found that the reports contained information that was useful in understanding the full course of services provided and the involvement of the CYD worker with the family.

In many case records, all the required reports were not found, and it could not be determined if they had been received, but not filed, or had not been received—CYD narratives did not usually discuss action or inaction by the contracted agencies.

Vignette 3

The mother of a baby girl, age 4 months, called 911 when she woke up and found the baby cold and unresponsive. At the hospital, a doctor pronounced the baby DOA. When the hospital social worker called DHS, she stated that the mother's description of what happened was not clear. The DHS worker arrived at the home less than 3 hours later, but the mother was not home. A neighbor was taking care of her 2-year-old boy and accused the mother of using crack cocaine and leaving her two children in the care of strangers while she was away for several hours.

When the worker met the mother, she admitted to substance abuse. Concerned about the safety of the surviving sibling, the worker consulted with her supervisor and then arranged for a hearing at Family Court that same day. The judge ordered that the boy be placed into foster care. The autopsy revealed that the baby had died from suffocation. There was no other evidence of trauma or exposure to alcohol or other drugs. The police declined to arrest the mother; however, the DHS worker founded the case for child neglect.

Three days later the boy's biological father, age 24, called DHS wanting information about his son. He had been released from prison two weeks earlier and was living with his mother. The DHS worker arranged appointments and home visits with both parents. The father's concern for his son impressed the worker. The mother accepted a referral for inpatient substance abuse treatment. After some initial success, she relapsed. The father agreed to take parenting classes and pursue his GED.

Two months after the infant girl's death, the court ordered the 2-year-old boy to be placed with his father. They continued living with the child's paternal grandmother and complied with DHS-provided services. The court also granted the mother visitation rights, but only under supervision.

In several of the cases SCOH took more than 3 months from the initial report date to be implemented although it was unclear if that was the responsibility of the provider, of CYD, or of both entities. Some cases did not begin receiving SCOH until more than 2 months after the referral to the provider had been made. A few of the CYD narratives contained information about the initiation of SCOH. Documentation of provider services noted several difficulties and inconsistencies: *“it has been difficult to contact the family,” “the provider worker is unclear about family goals,” “child reports seeing the provider worker twice, while the provider records indicate that weekly face-to-face meetings have been held.”*

As noted above, there was good casework and good case recording in several of the records. When comparing families that were actively receiving services at a time a fatality occurred, and families in which no fatality had been identified, there did not appear to be any differences in how families were assessed and served other than whether or not they were already receiving services. If the fatality part of the records were to be removed, there would appear to be no discernable differences in handling of those cases from the nonfatality cases.

SUPERVISION

The decision to remove a child during the investigation or assessment, or to open a case, is a difficult one. CYD procedure calls for consultation with supervisors when such key decisions are imminent and for recording that consultation in the progress notes. Few narrative discussions about consultation with supervisors were noted, although such consultations may have occurred. Supervisor signatures were seen on the record forms. Only one fatality record reviewed included documentation of the involvement of a DHS administrator.

Far more confirmation of supervisory involvement and approvals, including from the administrator staff, was found in the nonfatality records than in the fatality records. In most records, required supervisory signatures were found on forms and reports. In addition, case-handling suggestions were noted in many records; and in some records supervisors requested corrective actions and/or made corrections to forms, plans and narratives themselves.

CHILD FATALITY REVIEW

The Panel members and consultants were given copies of the CYD death review reports for 46 records. The reviewers first read the caseworker’s record and then read the death review report as a supplement to the record.

The death reviews were comprehensive in content, following the Pennsylvania Department of Public Welfare (DPW) format for what should be addressed. The review process identified findings from the case records. Many major issues, which are important to the care and safety of children, were identified as having not been addressed and/or with little or no attention to

follow-up. Factors presented by the parents included active drug and alcohol abuse, domestic violence, physical punishment of children, out-of-control anger, lack of parenting skills, and

mothers' need for physical health, mental health and mental retardation assessments and services.

Environmental factors present for the families were: unsuitable housing, shelter housing and/or multiple addresses; father not included in assessment of needs or strengths; and, multiple people sleeping together. Child factors included child health, education, and school attendance problems that needed follow-up. In addition, there were, as noted by the death review teams, significant systems failures that might have changed the outcome for children fatally injured. These included: no clear service plan; missing or incomplete risk assessments; delays in assignment and initiation of SCOH and family preservation services; CYD missing required visits; alerts from SCOH providers to which there was no response; missing reports from SCOH providers; lack of careful review of records by assigned CYD worker; and turnover of CYD staff.

The death review teams noted good practices in some records. *“There was good documentation by the DHS worker of efforts to interview all parties, as well as consultations with the DHS supervisor, Administrator and the Law Department.” “Active involvement of the DHS supervisor.” “Care and responsiveness (in a foster care death) of the foster mother appears to meet all established policies and standards.”* In short, some records revealed thorough documentation and involvement of supervisors and other DHS officials, while other records did not.

The death review teams also made several recommendations. These are summarized below. Recommendations for improvements in training or new training for CYD staff also were made:

- *Basic training in understanding psychological evaluations and other medical records;*
- *Training social workers on how to assess sleeping arrangements and counsel families about co-sleeping arrangements for babies;*
- *Training on how to relate family histories and conditions in the home to the risk assessments and case plans;*
- *Training on indicators of drug abuse and domestic violence and how to do safety planning and evaluate child risk in such homes; and*
- *Significant need for more training about post-partum depression and for involving pediatricians in identifying depressed parents.*

Systems development and systems change subjects were also identified.

- *Greater supervisory oversight must be provided whenever a new child is born into a family that is active.*
- *Additional guidelines are needed to improve supervisory oversight of investigations and to document supervisory conferences in the narrative case records.*
- *Specialized medical care providers must be identified and used for all medically-compromised children.*
- *Guidelines are needed for working with uncooperative families.*

Recommendations were made about the need to improve contracted services for SCOH:

- *Need to develop specific requirements for SCOH agency staff qualifications, for required SCOH services, and for SCOH reports;*
- *Need to develop clear guidance for social workers to follow to report non-compliance by SCOH providers, including provider performance lapses; and*
- *Need to establish clear procedures for CAPE to use in reviewing providers that are non-responsive or irresponsible.*

Recommendations were made regarding community collaboration:

- *Need to establish a protocol for collaborative investigations of abuse cases by CYD and law enforcement entities;*
- *Need to establish a protocol for collaboration with the shelter system;*
- *Need to establish clear standards and procedures for community providers; and*
- *Need to develop training for mandated reporters, especially hospital staffs, in how to recognize child abuse, coupled with their mandated responsibilities to report child abuse.*

A Death Review Report, completed in May 2002, clearly summed up the recommendations that were made to that point and in reviews conducted thereafter.

“The Department must acknowledge that the particular combination of factors that occurred on this case and countless others constitute a very dangerous situation for children. We need to clearly articulate to our line staff that this combination—newborn baby with a drug addicted mother, with no stable residence, none of her children in her care and a non-relative identified as a placement resource—should point us in the direction of placement, unless there is a very compelling reason not to.”

“Workers need to be provided with guidelines for conducting home evaluations. In some situations, the pressure to make a quick decision and explore less restrictive alternatives to foster care can heavily influence a worker’s response. A checklist might be a good way to standardize the home evaluation process that occurs every day throughout the Department, but is subject to wide interpretation.”

“The Department must do a better job of ensuring that workers make decisions that take all available information into account. In this case, it appears that critical information about family history and a related case was overlooked, with tragic results.”

“DHS must address pervasive problems concerning the documentation of our case files. The condition of many of our records may discourage workers from actually reading case histories. Current expectations for recording activity and organizing files need to be clarified and disseminated to line staff.”

SUMMARY

Review of the case records revealed relatively few differences between cases involving a fatality and those in which no child died. The primary difference appears to be the age of the child. Infants are extremely vulnerable, especially those in families in which the mother is a substance abuser and/or is homeless. Many of the infant fatalities apparently resulted from suffocation due to co-sleeping in environments in which several people were sleeping in the same bed and/or the mattress was bordered by trash bags full of clothing.

There were few differences in the handling of cases that involved a fatality compared to those cases that did not. The typical pattern was that CYD received a report and, regardless as to whether CPS or GPS was used, and whether or not the case was substantiated, SCOH services were provided to the family, except in the rare instances in which the maltreatment was so severe that children were removed, or the parents refused to accept SCOH. In short, for most families SCOH services were offered without explicit links to meeting the family’s needs.⁶ Often this appeared to be the case because family needs were rarely documented—although assessments may have been conducted.

⁶ The reader is reminded that the families who received services were over-sampled for this review.

**Exhibit F.1 Philadelphia Child Welfare Review Panel
Case Review Instrument**

1. **Date of Review:** _____
2. **Reviewer Initials:** _____
3. **Case Name:**

4. **Case Number:** _____
5. **Child(ren) Subject of the Report. Indicate which of these children is the primary subject of the report?**
(Select the most severely abused, the youngest child or the most vulnerable due to other condition, or if a fatality the deceased child. If two or more children are equally vulnerable list them all and clarify responses to other questions as appropriate and necessary.)
- | | | | | |
|--------------------|-------------------|-----------------|----------|----------|
| Name: _____ | Age: _____ | Primary? | Y | N |
| Name: _____ | Age: _____ | Primary? | Y | N |
| Name: _____ | Age: _____ | Primary? | Y | N |
- Number of Additional Children in Family:** _____ **Age Range:** _____ **to** _____
6. **Alleged Perpetrator(s):** *(Indicate relationship to the Primary Subject child.)*
- | | | |
|--------------------|-------------------|----------------------------|
| Name: _____ | Age: _____ | Relationship: _____ |
| Name: _____ | Age: _____ | Relationship: _____ |
7. **Describe the conditions that were reported to the Philadelphia Hotline or Pennsylvania ChildLine.**
8. **Call Taken By? (Check one):**
- _____ DHS Hotline
_____ PA ChildLine
9. **What type(s) of maltreatment was(were) alleged? (Check all that apply):**
- _____ Physical Abuse
_____ Neglect or Deprivation of Necessities
_____ Medical Neglect
_____ Sexual Abuse
_____ Psychological or Emotional Maltreatment
_____ No Alleged Maltreatment
_____ Other
-
10. **Did the Hotline/ChildLine worker check to determine if any family members had a prior history with DHS or DPW? (Check one):**
- _____ Yes
_____ No

_____ Unable to Determine

If a history check was conducted, please describe briefly what was done and the results.

11. Hotline/ChildLine Decision (*Check all that apply*):

- _____ GPS
- _____ CPS
- _____ Not Accepted
- _____ Immediate Placement
- _____ Immediate Family Preservation

Response Time (*Check one*):

- _____ Immediate
- _____ 24 Hours
- _____ Other _____

Please summarize documentation in record explaining Hotline/ChildLine decision and response time? Explain whether documentation indicates compliance with existing expectations and reflect on the adequacy of those expectations in terms of the work expected by the Hotline/ChildLine workers.

12. Date and Time of Hotline/ChildLine Report:

13. Date and Time of Initial Face to Face Contact with Primary Child:

14. Lapsed Time till Initial Contact with Primary Child (*computed*):

15. Describe the assessment process. Who was seen? What was found? Did it result in an understanding of the strengths, concerns, and needs for both the parents/caretakers and the Primary Child?

16. Summary of Investigation/Assessment Findings: Was the information gathered by the Hotline/ChildLine worker sufficient to make a decision regarding the response time? Summarize the adequacy of the initial decision in light of what is known as a result of the investigation/assessment. In retrospect, was the Hotline/ChildLine decision appropriate?

17. Assessment/Investigation Disposition (*Check one*):

- _____ Substantiated/Indicated
- _____ Not Substantiated/Unfounded

Was the case forwarded for investigation or assessment? Direct to Family Preservation? Direct to Placement? Other? (*describe*):

18. Risk Level (*Check one*):

- _____ Low
- _____ Moderate
- _____ High

19. Risk Level Date:

20. Was the information documented during the investigation or assessment sufficient to support a risk assessment decision and did it support the decision that was made? Did the record include a discussion of safety issues and a plan for overcoming them? If so, what did it include? *(Describe)*:
21. Was the Risk Assessment ever updated during the life of the case or was the initial assessment repeated? *(Describe)*:
22. During the Investigation/Assessment process (whether or not a Hotline/ChildLine search was done), was a search conducted for prior child welfare history and/or criminal history for the Primary Child and the Alleged Perpetrator(s)? Was a search conducted for any other members of the household? Describe whose history was searched, if any, and findings documented.
23. Was a referral to law enforcement and/or the Contract Administration Program Evaluation (CAPE) unit made when it was mandatory? *(Describe)*:
24. Does the record include any evidence that DHS/CYD personnel who have some involvement with a contracted provider that was referred to CAPE were made aware of the referral and the reasons for it? In particular, were other workers with children and families being served by the provider made aware of the potential problem? *(Describe)*:
25. Was the case accepted for service? Was the decision related to the risk level? Did the conditions affecting risk change between the Hotline/ChildLine call and the service decision, and are the changes documented in the record and reflected in the risk assessment? Summarize documented reasons why the case WAS or WAS NOT accepted for service. *(Describe)*:
26. What type of service was provided initially? *(Check one)*:

- SCOH
- Family Preservation
- Placement
- Other _____

Was the type of service selected justified by facts and observations documented in the record? Did the service plan make clear reference to the assessment and risk level? Did the service plan spell out what the service was expected to accomplish? Did the Primary Child receive this service or a different service? *(Describe)*:

27. Was there any conferencing regarding the service plan for the case, either initially or later? Was the service plan ever updated or was the initial one repeated? *(Describe)*:
28. What level of service was initially selected? Was it actually provided? Did this level of service continue on an ongoing basis or did it change (higher or lower) over the life of the case? *(Describe)*:
29. Name of initial service provider agency:

 How was the initial service provider agency selected to provide services to this family? If not documented in record please indicate. Did the service provider agency's capabilities appear to match the family's and Primary Child's needs? Did the service provider agency change over the life of the case? If so, how and why? Please record the name of the new provider agency. *(Describe)*:
30. How long were services provided, and to whom were they provided? Were services extended beyond the initial planned period? If service was extended, how was the decision reached and was it based on changing family composition or needs? Was it based on a case review or case conference? *(Describe)*:

31. **If the provider closed the case, did DHS/CYD close also? Were the reasons for closing/terminating services documented in the record? Were the criteria for closing clear, consistent with the case plan, and were they met? Did provider access other services the family needed? (Describe):**
32. **What documentation of supervisory and/or administrative oversight of the case exists in the record? Does the record include the required compliance reviews, supervisory signatures on progress notes, plans, etc.? Were supervisory logs tracking investigations, tracking compliance with court orders, and minutes or notes from supervisory conferences provided when they should exist? (Describe):**
33. **What involvement of social work administrators in providing more general oversight of the quality of practice and compliance with regulations and DHS policy is documented in the case record? (Describe):**
34. **Overall Comments. Please summarize the overall impression of the way the case was handled by both DHS/CYD and the involved provider agency(ies). In particular was the documentation stated as facts that were observed or opinions of the worker? (Describe):**
35. **Key Issues. Please summarize the 2 or 3 key issues regarding DHS/CYD practice and performance in this case. Please reflect on the most critical points that need resolution? (Describe):**
36. **Type of Case (Check one):**
- Fatality that was known to DHS and active when referred to the Hotline/ChildLine.
- Fatality that was known to DHS but did not have an active case at the Hotline/ChildLine referral.
- Fatality that was not previously known to DHS, but had a prior child welfare history elsewhere.
- Fatality that was not previously known to any public child welfare agency.
- Non-fatality that was accepted for services as a result of this referral.
- Non-fatality that was not accepted for services as a result of this referral.

References

U. S. Department of Health and Human Services, Administration on Children, Youth and Families (2007). *Child Maltreatment 2005*. Washington, DC: U.S. Government Printing Office. Cited as (ACYF, 2007).

APPENDIX G. REVIEW OF CONTRACTING PROCEDURES

BACKGROUND

The City of Philadelphia (City), Department of Human Services (DHS) contracts with an extensive array of private providers to deliver services to the children and families in its care, with more than 80 percent of the DHS' budget allocated to purchase services.¹ In an effort to understand better the extent, process, and success of the City's contracting efforts, the Philadelphia Child Welfare Review Panel (Panel) reviewed the various types of contracts, how they are managed, and how provider agencies are monitored and evaluated relative to contract specifications. The goal of this review was to understand the strengths and weaknesses of the City's contracting methods, identify contract-related challenges that may impact the quality of services delivered, and identify potential areas of improvement.

HIGHLIGHTS

Performance standards are focused primarily on procedural and compliance issues.

Numerous performance standards and Acceptable Quality Levels (AQLs) for performance on these standards, are provided in each of the various Children and Youth Division (CYD) contract templates. The majority of these standards are focused on procedural, reporting, and documentation requirements, rather than on desired outcomes. This focus may have the unintended effect of diverting the attention of private agency staff away from achieving the desired outcomes for their clients, such as child safety, permanency, and well-being. The significant number of performance standards also may divert providers' attention away from what CYD considers the most important child outcomes—safety, permanency, well-being, and stability.

CYD exercises little authority over poorly-performing providers.

Standard contracts provide CYD with significant authority to deal with poorly-performing contracted agencies. An annual evaluation by the DHS Division of Contract Administration and Program Evaluation (CAPE) provides information regarding each contracted provider's performance during the preceding year and, based on that information, DHS can take remedial action, such as establishing a plan for improvement, closing the provider to intake, assessing financial penalties, and suspending and/or terminating the contract. However, it seems as though CYD exercises this control only minimally. To the extent that this is true, the performance standards and annual evaluations may have increasingly little impact on providers.

Performance-based contracting (PBC) offers unique challenges that may adversely incent providers.

The use of performance-based foster care contracts has grown significantly over recent years. While PBC brings a renewed focus on child outcomes, there are concerns that providers may be incented to move children to placement options based on the financial incentives inherent in the

¹ www.phila.gov Web site, contract administration home page.

PBC contracting structure. There also are concerns that referral mechanisms that are used to assign children to providers do not always optimize the “fit” of the match between the child and the provider.

METHODS

To evaluate the City’s contracting methods, the Panel reviewed the components of the various types of contracts used to contract for services with private provider agencies. These included the standard contract templates used for Services for Children in their Own Homes (SCOH), Treatment Foster Care, Family Foster Care, and Group Home Care. Performance-based contracts also were reviewed, as were the City’s standard terms and conditions that apply to all DHS contracts. Sample contracts with private provider agencies also were reviewed, to understand the extent to which they followed the standard contracts and templates.

The Panel also conducted interviews with individuals knowledgeable about the City’s contracting methods. These interviews included members of the DHS executive leadership team, individuals from CAPE, and private agency staff. While these interviews generally did not have an exclusive focus on the City’s contracting procedures, they did provide valuable information related to the topic of this appendix.

MAJOR FINDINGS

Within DHS, the CYD uses a variety of contracts to procure services. Each contract template is unique, yet has common elements. In the following sections, we provide an overview of the types of contracts CYD uses, and then provide a more detailed overview of the variations among the different types.

Types of contracts

For each program under its purview, CYD has published “Service Description and Contract Requirements.” This document functions as a contract template, which outlines the basic program for which services are being contracted, and specifies service delivery requirements, performance standards, and measures. CYD maintains these contract templates for purchasing services in the following programs:

- Comprehensive Family-Based Services (SCOH);
- Foster Family Care;
- Treatment Foster Care;
- Group Home Care; and
- Performance-Based Foster Care (applies to Foster Family Care and Kinship Care).

Each template consists of a standard format, designed to ensure consistency in the contracting for services delivered to the children and families in CYD’s care and supervision. Generally, each template contains the following information:

- *Service Description*, which describes the program’s scope, defines the population to be served, and discusses the program’s goals and objectives;
- *Performance Standards*, which provide requirements for service delivery, supervision of service delivery, documentation of service delivery, and reporting on service delivery;
- *Acceptable Quality Levels*, which define the requirements for each of the required performance standards, and also indicate the potential liability or financial penalty to contracted providers if the standards are not met;
- *Rate Structure*, which clarifies the ways in which providers will be reimbursed for the services they provide; and
- *Incentives*, which articulate the incentives or bonus payments that are available to providers for some types of programs.

In addition to the contract templates, CYD also maintains a document titled “Exhibit PA–Performance Standards for Placement Care Services” (subsequently referred to as Exhibit PA in this document).² Exhibit PA applies to all contracts in which a child is removed from the home and placed in a substitute care setting, including Foster Family Care, Group Home Care, Institutional Care, and Supervised Independent Living. The performance standards included in this document are applicable to contracts for these programs. Exhibit G.1 provides a high-level overview of the basic contract elements for each program.

² *Exhibit PA–Performance Standards for Placement Care Standards*, City of Philadelphia Department of Human Services.

Exhibit G.1 Major Elements in CYD Contract Templates

Contract Element	SCOH	Foster Family Care (non PBC)	Treatment Foster Care	Group Home Care	Performance-Based Foster Care
Service Description	Brief discussion of SCOH goals, program, and levels of intensity	Extensive discussion of goals, services, client population, and rate structure	Detailed discussion of program goals, TFC components, and policies and procedures	Extensive program definition, statement of goals and principles, and policies and procedures	Detailed definitions, outcomes, goals, and processes for terms and conditions related to payment
Performance Standards	Specified for: <ul style="list-style-type: none"> - Service delivery (varies by level of intensity) - Supervision of service delivery - Documentation of service delivery - Reporting on service delivery 	Specified for: <ul style="list-style-type: none"> - Service delivery (varies by reunification goal) - Supervision of service delivery - Documentation of service delivery - Reporting on service delivery 	Specified for: <ul style="list-style-type: none"> - Service delivery (varies by level of intensity) - Documentation of service delivery - Reporting on service delivery 	Specified for: <ul style="list-style-type: none"> - Service delivery - Supervision of Service delivery - Documentation of service delivery - Reporting on service delivery 	Specifies expectations for: <ul style="list-style-type: none"> - Caseload - Referral and admissions - Service planning - Service delivery - Permanency outcomes - Foster parent recruitment & screening - Documentation of service delivery - Reporting on service delivery - Personnel - Financial & billing
Performance Measurement and Evaluation	Acceptable Quality Levels	Acceptable Quality Levels (included in Exhibit PA Only)	Acceptable Quality Levels (included in Contract Template and Exhibit PA) Positive Outcome Score (measures permanency, step-ups and Older Youth Independence) Qualitative Evaluations	Acceptable Quality Levels (included in contract template and Exhibit PA)	AQLs are specified for approximately 50 service requirements, however it is unclear whether these are ever associated with a financial penalty
Financial Penalties and Incentives	Based on extent to which AQLs are met No incentives specified	Based on extent to which AQLs are met No incentives specified	Based on extent to which AQLs are met Incentives based on Positive Outcomes Report Score	Not specified in contract template	Based on the agency's caseload size and achievement of permanency outcomes
Payment	Daily rate, based on level of intensity	Daily rate, based on level of intensity	Daily rate, with some variations based on whether the provider agency is functioning under a PBC contract	Rate per child per day of service	Fixed monthly payments to providers based primarily on caseload size

REVIEW OF CONTRACT TYPES

The following sections describe the major components of each contract template currently in use at CYD. While some of the contracts have extensive discussions of each program, we have focused on the contract specifications regarding performance standards, outcomes, and financial penalties and incentives, to the extent that these elements exist in the documents.

Comprehensive family-based services contracts

Specifications for service delivery requirements and performance evaluations for comprehensive family-based services are presented in the document titled “Service Description and Contract Requirements for Comprehensive Family Based Services.”¹

Service Description

CYD contracts with many agencies to deliver comprehensive family-based services, also called Services to Children in their Own Homes (SCOH). SCOH provides in-home supportive services to children and families deemed at risk for potential abuse and neglect. As stated in the Program Description and Contract Requirements, “*ongoing safety of the children in the home is the primary target of social work counseling and services to SCOH families.*” Services provided to client families vary according to SCOH’s three levels of intensity (Levels I, II, and III).

Service Requirements and Performance Standards

The contract template for SCOH agencies contains an extensive description of what are called “performance standards.” As presented in the document, the performance standards are more akin to service delivery requirements, as they focus primarily on the direct services that contracted agencies must provide to clients and their related support functions. The specific performance standards included in the contract template are consolidated into the following four categories.

- *Service Delivery* requirements apply to the frequency, nature, location, and scope of the direct provision of services to client.
- *Supervision of Service Delivery* requirements apply to provider agency’s supervision of the social work staff providing direct services.
- *Documentation of Service Delivery* requires provider agencies to establish a Family Case Record, maintain contacts with the family, document and conduct case reviews, and include copies of all City- and state-required documents in the case record.
- *Reporting of Service Delivery* requirements specify the required reports provider agencies must complete for each case receiving services. These include the Family Assessment Form (FAF), Behavioral Observation Checklist (BOC), Quarterly Reports, and documentation relating to closing and terminating cases.

Performance standards for service delivery and supervision of service delivery vary according to the level of intensity of services provided to the client family. Requirements for the documentation and reporting of service delivery are static across all three SCOH intensity levels.

¹ *Service Description and Contract Requirements for Comprehensive Family Based Services*, effective July 1, 2004.

Performance Measurement and Evaluation

Private agencies providing SCOH services are measured against a series of AQLs that represent the minimum level of quality that provider agencies must meet for each performance standard (i.e., service requirement). AQLs are established for all of the performance standards for service delivery, as well as for the supervision, documentation, and reporting of performance standards. While the AQLs are established separately for each level of SCOH (I, II, III), there is no perceptible variation in the required AQLs across the three levels. AQLs for virtually all of the performance standards are set at 90 percent. Exceptions to this are the following:

- The standard for providing services to clients for the required number of days per week (based on the level of intensity), where the AQL is set at 100 percent;
- The standard for the number of face-to-face client contacts (80%);
- The standard that all supervisory personnel hold a Masters Degree (100%);
- The standard that each social work staff member receive supervision at least twice per month (95%); and
- The standard for establishing a Family Case Record for every family in care (100%).

Financial Penalties and Incentives

In addition to an AQL, each performance standard is assigned a “proportion of contract price,” which ranges from 2 to 5 percent. In the event that CYD determines that the provider agency has not met the AQL for any individual performance standard, payments to the provider may be reduced, based on the proportion of the contract price assigned to the individual service requirement. For example, if a performance standard with an AQL of 90 percent is assigned a 5 percent proportion of contract price, the agency’s failure to meet the 90 percent AQL could result in a financial penalty of up to 5 percent of the total contract value. The contract template does not specify whether the financial penalty is variable, based on the extent to which the contracted agency misses the AQL (i.e., whether a score of 89 percent on a standard merits a smaller financial penalty than a score of 50 percent). The SCOH contract template does not specify any incentives for providers.

Foster family care

Services contracted for foster family care follow the contracting guidelines and requirements in the document titled “Service Description and Contract Requirements for Foster Family Care.”² The requirements in this document are for contracted foster family care services that are not part of the performance-based foster care system.

Service Description

The service description for foster family care is very detailed, and articulates the program goals, the levels of service provided (Levels I, II, III), the high-level overview of the services provided, and the purchase-of-service categories. A discussion of the foster family triad (child, legal family, foster family) also is provided.

² *Service Description and Contract Requirements for Foster Family Care*, Pennsylvania Southeast Regional County Children and Youth Agencies, effective July 1, 2001.

One note of interest is that, while the service description specifies the goals of the foster family care program, it also states that the “*goals represent a philosophy rather than a mandate and are not intended for program monitoring and evaluation purposes.*” This suggests that goal achievement and contract evaluation may not be linked appropriately, thereby placing a greater emphasis on measuring procedural contract requirements rather than on outcomes.

Service Requirements and Performance Standards

The types of required services specified in the contract template for foster family care can be categorized into three overarching categories. The first category is the set of services that a contracted agency must perform to operate its program, which includes such activities as foster parent screening and recruiting, referral and admission, and foster parent training. There is little specificity in these requirements.

The second broad category of required services is direct services provided to the child, the legal family, and the foster family. Specific, detailed requirements are presented in the areas of service planning, provision of ongoing placement services, reunification services, and discharge planning.

The final category includes requirements for the documentation and reporting of service delivery activities. Required documentation includes the Client Record and the Foster Family Record. Regarding reporting, agencies are required to submit Quarterly Reports, Critical Incident Reports, the Family Assessment Form and, where necessary, an Individualized Service Plan for the child.

As mentioned previously, Exhibit PA includes a set of performance standards that applies to all placement programs, including foster family care. (Again, the performance standards may be characterized more appropriately as service requirements.) The performance standards are grouped according to one of three permanency goals for the child: 1) Reunification with the family, 2) Adoption, or 3) Emancipation. Within each of these categories, there are specific requirements for the direct provision of services, supervision of service delivery, documentation of service delivery, and reporting on service delivery.

Exhibit PA also includes a limited number of additional performance standards that are applicable only to the foster family program. These relate primarily to the provision and documentation of training and supervision of foster parents, as well as providing pre-adoptive services to the foster family when adoption is the specified permanency goal.

Performance Measurement and Evaluation

The performance of contracted agencies is assessed against the various service requirements. Provider agencies are evaluated against the AQLs that are established for each service requirement. Again, there is little variation in the AQL levels—of the more than 70 possible performance standards that are potentially applicable to agencies providing foster family care services, only two have AQLs that are not set at 90 percent. These are the requirement that provider caseworkers must notify the CYD caseworker if they believe the placement home is unsafe, and the requirement that the provider caseworker visit the foster family home prior to placing the child. AQLs for both of these requirements are established at 100 percent.

Financial Penalties and Incentives

For purposes of evaluating compliance and determining whether there is a potential for financial penalty, CYD uses the performance standards and AQLs that are included in Exhibit PA. Along with the AQL, each performance standard is assigned a proportion of contract price, which drives the extent to which a financial penalty can be imposed if an agency fails to meet the AQL for that standard. There is no discussion of whether the degree to which a provider fails to meet a performance standard is related to the amount of the financial penalty. The standard contract template does not specify any incentives for providers of foster family care services.

Treatment foster care

Services contracted for treatment foster care (TFC) follow the contracting guidelines and requirements in the document titled “Service Description and Contract Requirements for Treatment Foster Care, Fiscal Year 2007.”³

Service Description

The “Service Description and Contract Requirements for Treatment Foster Care, Fiscal Year 2007” includes an extensive description of the TFC program. This includes CYD’s definition of TFC, required components in a TFC home, population to be served, and goals of the TFC program. Included in the program description for TFC are the specifications for program operations, which include a description of the referral and eligibility processes, the pre-placement process, and requirements and qualifications for TFC parents and provider staff. TFC can be contracted via performance-based contracting methods or traditional contract methods where providers are reimbursed with a daily rate.

Service Requirements and Performance Standards

Embedded within the program description are requirements that provider agencies must meet as they coordinate and deliver services to children in TFC placements. Specific requirements are grouped within the following categories:

- *Referral and Eligibility Determination Processes*, which include several policies to which a provider agency must adhere, such as “No-Reject, No-Eject” and the completion of the Child and Adolescent Needs and Strengths Assessment;
- *Pre-Placement Process*, which provides guidelines for placement decisions (the extent to which these guidelines are mandatory is unclear);
- *Continuing Eligibility*, which specifies the step-down and step-up procedures. These procedures vary based on whether the child’s goal is to return home or to find another suitable permanency arrangement;
- *TFC Parents*, which includes requirements for TFC parent homes, and the responsibilities and services the contracted agency will provide to TFC parents. General (i.e., not required) principles also are presented for TFC parent recruitment and retention;

³ City of Philadelphia *Service Description and Contract Requirements for Treatment Foster Care, Fiscal Year 2007*, effective July 1, 2007.

- *TFC Provider Staff*, which provides requirements for the scope and frequency of services that contract agency staff will provide to children, TFC parents, and biological/legal parents; and
- *Documentation*, which provides requirements for documenting service planning activities and completing quarterly reports.

Rate Structure

The “Service Description and Contract Requirements for TFC” document contains a section that articulates the rate structure, which is unique among the various contract templates that were reviewed. The document specifies the extent to which contract agency costs are reimbursable under the TFC contract. These include requirements for agency staff that must be met for the agency to receive funds, as well as rates for fringe, administrative, and operating costs (set at 28 percent, 15 percent, and 26 percent respectively, for fiscal year 2007). This section also includes the allowed per diem rates for the contract agency, foster care supports, and foster parents.

As noted previously, TFC can be provided either through traditional contracting mechanisms or through performance-based contracting. Accordingly, the rate structure and financial incentives are based on the type of contract under which the TFC provider is hired.

Performance Measurement and Evaluation

CYD uses a number of both quantitative and qualitative performance indicators to evaluate the effectiveness of TFC services provided by contracted agencies. These indicators are explained in exhibit G.2.

Exhibit G.2 Performance Indicators for Treatment Foster Care Providers

Performance Indicator	Definition	Data Source
Permanency	Percent of youth who achieve permanency	FACTS (Family and Child Tracking System)
Step-downs	Percent of youth who step down to a lower level of care	FACTS
Step-ups	Percent of youth who step up from TFC to a higher level of care, including group home, institutional and residential treatment facilities	FACTS
Program Evaluation	The overall CAPE yearly evaluation score, which evaluates performance on AQLs for numerous contractual requirements	CAPE Evaluation
Older Youth Independence	Eligibility for Older Youth Independence	FACTS
Qualitative Evaluations	Qualitative evaluations to supplement the quantitative program evaluations and data collection, based on focus groups, surveys, and interviews.	Evaluations are conducted by the PMHCC’s Best Practice Institute.

An additional tool used to evaluate the performance of contracted TFC agencies is the Positive Outcomes Score (POS). The POS was developed “...to recognize the positive work that TFC providers are doing.” It is a composite measure consisting of three of the positive outcomes

presented in exhibit E.2: number of permanencies, number of step-downs, and the number of youth who meet the older youth independence criteria. The sum of these numbers is divided by the agency's ever-served caseload to arrive at the POS.

Financial Penalties and Incentives

The yearly program evaluation conducted by CAPE follows the same methodology used to evaluate contracted agencies delivering services for other CYD programs. CAPE establishes numerous performance standards for a variety of contractual and service delivery requirements in 15 different areas. The AQL is set at 90 percent for all requirements. If an agency's performance falls below the acceptable quality levels, financial penalties may be imposed. It is notable that, unlike the Service Description and Contract Requirements template for several other programs, there is no specification as to the proportion of contract monies that may be impacted for failing to meet each specific requirement.

Contracted agencies are eligible for financial incentives based on a combination of their POS, their step-up rate, and their annual CAPE evaluation. Providers with a POS of at least 30 percent, a step-up rate less than 7 percent, and a minimum score of 90 percent on their annual CAPE evaluation are eligible to receive a one-time bonus payment of \$500 for each child that achieved permanency during the contracted year.

It also should be noted that negative consequences may result from a poor POS. Agencies with a POS of less than 15 percent will be required to provide DHS with a Permanency Improvement Plan, which has details for each youth in the agency's caseload. Providers with a POS of equal to, or less than, 5 percent will be closed to intake, and DHS will conduct a permanency review of the agency. Interviews with various stakeholders were inconclusive as to whether and how often this occurs.

Group home care

Group home care services follow the contracting guidelines and requirements in the document titled "Service Description and Contract Requirements—Group Home Care."⁴ Performance standards for placement care are specified in Exhibit PA, which includes the general standards for all placement contracts, as well as specialized requirements for group home care contracts.

Service Description

The group home care contract template contains the most extensive service description of all the contract templates reviewed. It provides a thorough definition of group home care services and the population to be served, and has an extensive discussion of the program's goals and principles. Detailed descriptions of the referral process, the Child and Adolescent Needs and Strengths assessment, and eligibility requirements also are included.

⁴ City of Philadelphia, Department of Human Services, *Service Description and Contract Requirements, Group Home Care, Fiscal Year 2007*, effective October 2001.

Service Requirements

Detailed service requirements are included in the group home care contract template. While the requirements are not organized in the same fashion as other contract templates, they, nevertheless, present similar requirements for direct delivery of services, as well as for the supervision, documentation, and reporting of service delivery.

The group home care service requirements are, arguably, the most specific of all the contract types reviewed. Perhaps this is because the clients in group home care placements are generally older youth, less likely to have a goal of reunification, and require a unique set of services to assist with transition to emancipation. There is a significant focus on partnering with the youth to design and execute the service delivery plan, and also an extensive discussion of the requirements for providing culturally-sensitive and appropriate group home care settings.

Performance Measurement and Evaluation

Similar to other contracts, the group home care contract template contains a section that delineates the AQLs for service delivery requirements (note that while the AQLs are presented in a different order and categorization than the service requirements, they are essentially the same). The notable departure from other contract templates is that the group home care contract does not specify an actual performance target—it only includes a description of the requirements that must be met. However, all of the placement care performance standards in Exhibit PA apply to group home care placements, and the standards in Exhibit PA do specify targets that contracted agencies must meet. Presumably, the Exhibit PA standards act as the entire set of standards when a quantitative review is performed.

Financial Penalties and Incentives

To evaluate compliance and determine the potential for a financial penalty, the Exhibit PA performance standards and AQLs are the only identified standards used. As discussed previously, each performance standard is assigned a proportion of contract price, which drives the extent to which a financial penalty can be imposed if an agency fails to meet the AQL for that standard. The group home care contract template does not include any discussion of incentives.

Performance-based foster care contracts

Requirements for performance-based foster care contracts are specified in a variety of sources. The primary document that clarifies the service description and financial components is the “Service Description and Contract Requirements for General Foster Care.”⁵ This is the standard contract template which includes numerous attachments that provide further specification regarding required services, roles and responsibilities of CYD and provider agencies, outcome standards, acceptable quality levels, and the dispute-resolution process.

Service Description and Performance Standards

Performance-based foster care contracts can apply to agencies delivering services to children placed in both foster family homes and kinship homes. The service description articulates the baseline standards and expectations that each contracted agency will provide to children,

⁵ *Service Description and Contract Requirements for General Foster Care (Including Family Foster Care and Kinship Care; Levels I, II, III)*, Philadelphia County Children and Youth Agencies, effective July 1, 2006.

birth/legal parents, and foster/kinship caregivers. By definition, the requirements incorporate the Pennsylvania Department of Welfare regulatory requirements, as well as standards for practice in the Pennsylvania Child Welfare Practice Standards, the Five County Service Description and Contract Requirements, the Philadelphia Department of Human Services Children and Youth Division Policy Manual and the Council of Accreditation Family Foster Care Standards.

The outcome standards that will be used to evaluate whether and when a contracted agency realizes its goal of achieving permanency for the children in its care are also presented in the services description. Both permanency and nonpermanency outcomes are included, as are the quality outcomes that must be met. Quality outcomes include child safety, stability of placement, and sibling placements. The service description also discusses the goals for family foster care and kinship care programs: safety, permanency, well-being, and stability.

The service description also includes a detailed discussion of the terms and conditions that will be used to monitor, evaluate and pay providers. However, the primary focus is to specify the methodology that CYD will use to establish and, as necessary, subsequently modify a contracted agency's funding level, which is structured around the agency's Dynamic Caseload of family foster and kinship care.

Payment and Financial Components

The payment procedures and rate structure for performance-based contracts are significantly different than other contract types. Providers delivering services under performance-based contracts receive payments that are divided into four categories, each of which has various sub-components. A summary is provided in exhibit G.3.

Exhibit G.3 Payments for Performance-Based Contracts

Payment Component	Subcomponent	Use of Monies	Payment Details
Administrative	Baseline case management	Case management services to meet normal developmental needs	Paid monthly, based on the agency's DC Supplemental short-stay funds are not paid in the monthly administrative payment
	Placement capacity enhancement	To enable providers to handle emergency referrals	
	Recruitment	To support foster parent recruitment	
	Permanency worker	To support permanency worker	
	Resources for stability	To develop and deliver the contents of individualized service plans for children most in need of additional services	
	Supplemental short-stay payments	Additional funds for children staying less than 30 days	
Foster Parent Payments	NA	Pass through to foster parents to support care of the child in placement	Paid monthly to agency, based on the number of days of care
Adoption and PLC Funding	Child profiles	To complete child profiles for every child for whom parental rights have been terminated	Fixed rate paid upon completion of child profile
	Child preparation for adoption	For children to receive adoption prep services	Not specified
	Adoption payments	To complete all adoption activities	Bundled rate for all services, paid after adoption
	PLC family profiles	Completion of family profile in preparation for Permanent Legal Custodianship (PLC)	Fixed rate, providers invoice DHS directly
Additional Components	After care services	To provide services at and after the return of the child to a family	Separate fixed rates for reunified child and for child placed in PLC

The structure of the components are essentially the same for both foster family care and kinship care, with the only differences being the manner in which agencies are reimbursed for emergency clothing allowances, and the amount of funds available for foster parent recruitment.

Outcomes, Performance Standards, and Financial Considerations

Financial considerations in performance-based contracts are significantly different than in other forms of contracts in use at CYD. As seen in exhibit G.3, the agency's monthly administrative payment (its principal source of funds derived from the contract) is based primarily on its Dynamic Caseload, which agencies are required to maintain at specific levels in foster family care and kinship care cases. Therefore, the primary factors driving an agency's monthly administrative payment are the number of children in the caseload and the extent to which the agency does or does not meet its required permanency and nonpermanency outcomes. When the agency exceeds its permanency-related performance objectives, the caseload will decrease and the administrative payment will remain constant, creating a contract surplus. If the agency fails

to meet its performance targets, however, the caseload will increase with new referrals and the administrative payment will not increase.

The standard contract template includes approximately 50 performance standards (i.e., service requirements) and AQLs. However, in practice these do not have the same impact on contract funding as they may in other forms of contracts. While the standard contract template includes language stating that an agency performing poorly on these standards may be subject to reduction in contract funds (or alternatively, may be closed to new referrals or placed “on hold”), it appears that agencies rarely, if ever, receive a reduction in funds for this reason.

DISCUSSION

The review of the various contract templates raises several issues with regard to CYD’s contracting procedures. Additional issues and challenges emerged from the interviews that were conducted with various members of DHS leadership, staff, and private agencies. These issues and challenges are discussed in this section.

Challenges with contract performance standards and AQLs

As seen in the review of the contract performance template, the majority of the performance standards and AQLs focus not on the outcomes that CYD wishes to achieve, but rather on compliance with process and procedural elements, such as documentation and reporting. Even standards that relate to the provision of direct services to clients have a primary focus on events, such as the number of times that a worker meets with a client. This focus may have the unintended effect of diverting the attention of private agency staff away from achieving the desired outcomes for their clients, such as child safety, permanency, and well-being—outcomes that are discussed significantly in many of the service descriptions included in the contract templates. There is some anecdotal evidence from the focus groups, interviews, and community consultation sessions to support this hypothesis.

A second issue is the lack of variation in the AQLs and “Proportion of Contract Type” that are assigned to each service requirement. Across all contract templates that were reviewed, AQLs were set at, or near, 90 percent. Similarly, the amount of contract funds that were allocated to each contract type typically ranged between 0 and 5 percent. While this may encourage contracted agencies to apply attention across all of the service requirements, it may not convey adequately the relative importance of the service requirements in comparison to one another. In addition, this system does not align necessarily the focus of the annual provider evaluation with the goals of the program or DHS’ mission. A notable exception to this is the Positive Outcome Score for the treatment foster care program, which rewards agencies on outcomes they achieve—outcomes that are clearly aligned with the TFC goals and mission, most notable permanence and stability.

DHS’s exercise of authority over poorly-performing contractors

The extent to which DHS exercises authority over poorly-performing contractors is unclear. Overall, DHS has significant latitude to deal with contracted agencies that do not meet the terms of their contracts. Within DHS, the Division of Contract Administration and Program Evaluation (CAPE) is vested with the responsibility for contract monitoring and oversight. CAPE performs annual evaluations of all contracted providers, to ensure that they are in compliance with

applicable contract regulations, performance standards, and administrative procedures. As necessary, CAPE will perform more frequent evaluations, typically when information is received that suggests a provider is not meeting contract standards. As part of the annual provider evaluation, a CAPE analyst(s) will conduct a review to determine whether the service delivery and performance standards have been met.

If the CAPE evaluation finds that a provider agency is not meeting the required service delivery and performance standards, there are numerous provisions in each of the individual contract templates that enable DHS to take action. In addition, the City's "General Conditions for Department of Human Services Contracts" also includes terms and conditions that vest significant authority in the City to leverage financial and non-financial penalties to providers that do not satisfy contract requirements. However, it was reported that DHS rarely imposes financial penalties or otherwise uses evaluation data to leverage improvement on the part of provider agencies, except in high-profile cases or other emergent situations. To the extent that this is true, the performance standards and annual evaluations may have increasingly little impact on providers.

Issues related to performance-based contracting

Several individuals suggested that PBC may encourage the overuse of Permanent Legal Custodianship (PLC) as a permanency option for children. It was noted in at least one of the one-on-one interviews that, while PLC is sometimes the best permanency option for children, this is not always the case. In some cases, staff felt that since PBC agencies are rewarded for achieving permanency within specified time frames, the use of the PLC option may be attractive as a way to maximize funding and financial incentives.

Misalignment of contracting procedures with practice standards

The consultants identified several ways in which the administration and management of contracts may conflict with good practice and, as a result, negatively impact delivery of services to clients. Many of these issues were not identified by the review of contracts, but rather through discussions with provider agencies, workers, and community members.

Operations of the Central Referral Unit

The most significant issue raised regarding the disconnection between contracting procedures and practice standards is the assignment of private providers to individual SCOH and placement cases. This is one of the issues that came up frequently during several focus groups and community consultation sessions, as well as during interviews with social workers from DHS and with private providers. It was stated repeatedly that the Central Referral Unit (CRU) did not always act expediently when referring a case for services. Several caseworkers and private agency staff reported that it was not uncommon to wait thirty days or more for a referral to be made for a case, particularly when the case required a provider with specialized expertise (e.g., caring for a child with special needs). Several managers and caseworkers also expressed frustration that they felt there was little they could do to accelerate a referral, as the CRU was not directly under the control of CYD. One caseworker noted that while the CYD caseworker "*is still holding the baby...no one owns the case*" when he or she is waiting for a referral from the CRU. As a result, the CYD caseworker generally is not able to expedite the referral.

It should be noted that there seems to be some disagreement within CYD as to the effectiveness of the CRU. While some social workers believe that there is significant room for improvement, others felt that it is effective. Among the DHS social work staff, there may be a belief that the leadership of DHS does not recognize what many feel are significant concerns regarding the performance of the CRU.

An additional issue identified with regard to the CRU is that often there are instances where a child's service needs are not aligned appropriately with a provider's expertise. This was reported as a problem more often when a child had a highly specialized service need, such as a serious health issue, development disability, or mental health issue. Caseworkers repeatedly expressed frustration that these children—who are often the most in need of services—are not placed with providers that can accommodate their needs.

The mismatch between a child's need and a provider's expertise was reported as being most significant for children placed in performance-based foster care, as these referrals typically are made to the provider agency that is "next up" in the assignment rotation. One caseworker identified two SCOH agencies he works that have excellent track records in two areas—one serving medically-needy children and another serving teens with behavioral problems. He then discussed the irony of how he has several teen cases currently, and most of the teens have been placed with the provider that excels with medically-needy children.

SUMMARY

CYD uses a standard set of contract templates and a well-established methodology for contracting with private provider agencies for services. In many ways, this is an effective means of ensuring consistency in the contracting process, and promoting standards for the delivery of services to CYD clients. More practically, with more than 200 provider agencies currently contracted to provide services on behalf of CYD, the use of standard practices and boilerplate contracts is an effective management tool.

While there are strengths in the uniform contract process at CYD, there are many significant challenges and issues that merit further examination. The evaluative focus on procedural and compliance issues may inhibit a true understanding of the quality of services provided by contracted agencies. It also may preclude the identification of highly-performing agencies that may have best practices and service delivery methods that potentially could be replicated by other provider agencies. In addition, the sheer number of performance standards on which providers are measured conveys little sense of importance, and potentially dilutes the attention of providers over a large, and perhaps less important, set of performance standards.

Performance-based contracting is a relatively new initiative that CYD has instituted, and while there are some promising results, the true effectiveness of PBC merits further study. PBC's focus on outcomes related to permanency, safety, well-being and stability are notable, but the extent to which PBC rewards movement toward permanency objectives that are not appropriate (e.g., Permanent Legal Custodianship) are not known, and should be looked at in greater detail.

APPENDIX H. SUMMARY OF INTERVIEWS, COMMUNITY FORUMS, AND TOWN HALL MEETINGS

BACKGROUND

There is a strong tradition of commitment to serving Philadelphia's children and families, both through public agencies such as the Department of Human Services (DHS), Children & Youth Division (CYD), as well as through private social welfare organizations and community groups that provide needed services to this population. In analyzing CYD programs and operations and developing recommendations for improvement, the Panel wished to ensure that the expertise, opinions, and perspectives from these organizations were appropriately represented and used in the development of the recommendations contained within this report.

To accomplish its goal of maximizing the input from CYD staff, as well as from community organizations, the Philadelphia Child Welfare Review Panel (Panel) conducted a series of interviews and consultation sessions with individuals and groups that included CYD leadership and staff, private provider agencies, child welfare advocates, and other stakeholders within the Philadelphia area. The objective of the consultation process was to gather information from CYD internal stakeholders and from external stakeholders that interact with CYD across multiple dimensions.

HIGHLIGHTS

CYD lacks clarity in its mission and programs.

Clearly the most common issue raised—which was discussed in virtually every interview and consultation session—was the lack of clarity in CYD's mission, programs, and operations. This lack of clarity was pervasive at all levels of CYD, from executive levels to social work staff. A fundamental question that arose was the extent to which CYD should focus narrowly on ensuring child safety and protection from abuse, or more broadly on providing family supports and prevention services to at-risk families and the general population. While there were widely varying opinions regarding the focus that CYD *should* have, there was a wide consensus that CYD's mission and intent must be articulated more clearly. Without more clarity regarding CYD's programs and mission, there will continue to be confusion, threatening the quality of services for CYD clients.

Staffing and infrastructure issues inhibit performance of CYD social work staff.

While many groups and individuals discussed the quality and effectiveness of the CYD social work staff, many of the challenges and issues identified were not targeted directly at social workers. Rather, many of the issues raised signaled larger challenges with CYD's infrastructure in general, and with the training, staff development and leadership functions in particular. It was believed widely that the inability of CYD to set performance expectations, maintain clear lines of accountability, or provide adequate training and support structures for social workers is contributing to any deficiencies that may be common among the CYD social work staff.

The relationship between CYD and provider agencies is strained, particularly at the caseworker level.

The relationship between CYD caseworkers and private agency caseworkers was discussed frequently. In many instances, individuals reported that staff from provider agencies and CYD often are not able to work together effectively, and frequently have serious problems maintaining any sort of regular communication and dialog about their cases. In some instances, provider and CYD caseworkers find themselves in a combative relationship. Anecdotal evidence suggests that this results from a general misunderstanding and lack of clarity of the roles and responsibilities of CYD staff and the provider caseworkers. Regardless of the cause, many mentioned that the relationship must be improved in order to facilitate a more seamless and effective delivery of services.

CYD must find more effective ways of collaborating with other City, state, and provider agencies.

A consistent theme that emerged from the sessions was the inability of CYD to collaborate effectively with other City and state agencies that serve the same children. Poor information sharing across agencies, and the lack of access to specialized resources in other agencies, were commonly cited as issues that impact the ability of caseworkers to coordinate services effectively. It was also noted that there are some underutilized private agencies that are willing to take additional referrals from CYD, but have difficulty in getting CYD to make these referrals. This is particularly true for residential drug and alcohol treatment programs for women with children. While few concrete recommendations were made regarding how to improve CYD's relationship with other public and private agencies, there was widespread agreement that this is a critical area in which CYD needs to undertake a review of its operations and policies and to identify potential improvements.

Many clients, parents, and former clients of the agency feel that the CYD staff lack professionalism and fail to treat their clients with respect.

During the town hall meetings and focus groups with parents and former clients of CYD, many individuals stated that the CYD workers with whom they interacted often failed to act professionally. This perceived lack of professionalism was manifested in actions that ranged from the serious, such as CYD workers failing to include parents in the service planning process, to the more routine, such as a general lack of professionalism in CYD caseworker attire and demeanor.

CYD's use of data for planning, evaluation, and improvement is disorganized and unsupportive of social workers' needs.

Most individuals recognized that CYD has made a genuine commitment to data collection, but there is a widely held opinion that CYD has no real plan for using the data it collects in a constructive fashion. Generally, it was believed that CYD should move toward analyzing the data that it currently has, rather than attempt to collect more data. In particular, it was felt that data—particularly outcome-related data—should be used to monitor and evaluate the performance of programs, provider agencies, and CYD staff.

METHODS

The primary methods used to gather input from stakeholders included one-on-one and group interviews, semistructured group consultation sessions, and two Town Hall meetings included the following:

- The interviews were conducted either by the entire Panel or a subset of Panel members, and included many current and former CYD executives and managers, community leaders, and other child welfare experts. Interviewees were asked questions regarding their specific areas of expertise, as well as more general questions about the work of CYD. Interviewees also were afforded the opportunity to provide whatever additional information they felt was pertinent to the Panel's work, and both positive and negative feedback was encouraged and solicited. Prior to each interview, a Panel member provided the interviewee with an overview of the Panel's work, and asked the interviewee for any comments or clarifications needed about the interview. Each interviewee also was told that he or she could go "off the record" and provide comments that would not be recorded.
- Semistructured group consultation sessions were held with approximately a dozen community groups, provider agencies, and current and former CYD clients. The consultation sessions were designed to collect opinions and ideas from participants about several key areas, including CYD's perceived strengths and weaknesses, challenges, and recommendations for improvement. Participants also were encouraged to offer insight into other areas that they deemed relevant. Prior to each focus group, a member of the Panel provided an overview of the Panel's work, discussed the format for the focus group sessions, and asked for any comments or clarifications on either the Panel's work or the focus groups. Participants also were told that they could go "off the record" and provide comments that would not be recorded.
- Two Town Hall meetings were conducted to permit any interested community member to provide input to the Panel. During the meetings, individuals were able to provide comments of up to five minutes in length, on whatever topics they felt were relevant for the Panel. The meetings were held in two different locations to maximize participation. The first was held in West Philadelphia at the First District of the AME Church, and the second in North Philadelphia at Temple University. In both locations, approximately twenty individuals provided comments verbally, with several individuals providing written testimony.

Both the interviews and the consultation sessions were structured flexibly to allow for maximum input and participation. A digital audio recording was taken in those cases where the interviewee consented. All interviewees were informed that their remarks were confidential and that they could go "off record" if they wished to make comments that would not be included in the audio recording. The interviewees also were informed that their comments would be used to inform the final report and recommendations, but that specific comments would not be attributed directly to them. Information gathered was analyzed and summarized by the consultants, and used by the Panel as input to the development of the recommendations included in this report.

In addition to the activities conducted directly by the Panel, staff from Casey Family Programs conducted individual interviews and focus groups with social workers and social worker supervisors from both CYD and provider agencies. Casey Family Programs also conducted an online survey for CYD and provider agency social workers and supervisors. Results from these activities are detailed in a separate appendix.

A list of the various interviews and consultation activities conducted is included in Exhibit H.1, at the end of this appendix.

MAJOR FINDINGS

While the consultation sessions, interviews, and Town Hall meetings each used a different data collection method, and focused on different segments of the CYD stakeholder population, several common themes emerged. The most common theme centered on the lack of clarity within CYD—a lack of clarity that was pervasive throughout all levels, from the mission of the department, to the scope and intent of its programs, to the organization of staff and resources. Other common themes discussed in this section include: CYD staff and infrastructure issues; the relationship between CYD and its private providers, particularly at the caseworker level; casework and practice issues within CYD; service integration and collaboration across agencies; and the use of data for planning and evaluation purposes.

CYD organizational and cultural issues

Within this category are issues that relate to the organizational and cultural aspects of CYD. The issues addressed in this section are based on many of the high-level comments that were received about the DHS's overarching mission, and how its programs and services relate to its mission. Clarity of the scope and intent of CYD programs is an overarching theme that was discussed frequently—often at length—by virtually every group consulted. Also included in this section is a discussion of the organizational culture at CYD, and the extent to which that culture supports a commitment to continuous improvement.

Lack of Clarity in CYD's Mission

Individuals and groups consulted held widely varying perspectives regarding the mission of CYD. Many groups expressed confusion regarding whether CYD is (or should be) broadly focused on addressing issues related to poverty (which may be under the purview of other City agencies) and providing general family supports to at-risk children and families, or whether it is focused more narrowly on ensuring child safety and protection. While opinions on this question varied significantly, there was uniform agreement that CYD has not defined and articulated its mission clearly to its social workers and service delivery partners. In turn, both CYD social workers and provider agency staff often are uncertain about selecting services for families that both are appropriate for the family and consistent with CYD's mission. As a result of this uncertainty, many individuals felt that services provided to families varied significantly, with some caseworkers looking at CYD as a family-support and antipoverty agency tending to provide a broader group of services.

Scope and Structure of Prevention Programs

Significant confusion exists regarding the scope and intent of many CYD programs, particularly prevention programs. Perhaps most confusing to the individuals and groups consulted was the

Services to Children in their Own Home (SCOH) program, and its relationship to DHS’s Prevention Division. Many individuals stated that DHS has not clearly delineated and communicated the true intent of the SCOH program, particularly as to how it relates with programs operated by the DHS Division of Community-Based Prevention Services. This causes confusion regarding appropriate service delivery strategy. There were varying opinions regarding whether SCOH should focus on ensuring child safety or on providing more general family supports which, while important for overall family and child well-being, have less of a direct relationship to child protection and safety. Examples of these types of services—many of which are provided very commonly to families via the SCOH program—include reducing truancy, providing transportation, and assisting with household activities such as turning on utilities and procuring adequate infant furniture.

Adding to the confusion about SCOH is the fact that provider agency staff and CYD staff often have different interpretations of the program, and sometimes provide conflicting information to clients about what services are available. There was anecdotal evidence offered in several of the consultations and interviews that suggests that families may be told they will receive certain services by the CYD caseworker, and then are informed by their private agency caseworker that these services are not appropriate or even available through SCOH. Many individuals realized that CYD has policies and documentation that provide some level of clarity on types of services that are available and appropriate for families receiving SCOH. However, many individuals—particularly members of the provider community—felt that these policies are not adhered to strictly and that additional services could be added when deemed appropriate.

It bears notice that, while there was significant confusion over the role and intent of SCOH, there was universal agreement on the importance of SCOH and other prevention programs. Participants in the consultation sessions understood that Philadelphia continues to make a significant investment in its prevention programs, and there is widespread consensus that these programs provide critical support for at-risk families. The groups were adamant that the level of funding for prevention programs be maintained, so as not to jeopardize any of the families who receive services through these programs.

Organizational Culture Lacks Commitment to Continuous Improvement

A common theme that arose among many of the interviewees when discussing the culture of CYD is that the organization does not promote or foster a commitment to excellence or a culture of continuous improvement. Further, many individuals felt that CYD often fails to recognize its mistakes and learn from them. When directly questioned, several individuals and group members made the following remarks regarding the CYD organizational culture:

- CYD is “an *organizational bureaucracy that needs to maintain itself;*”
- “...*there is an organizational immaturity that stymies DHS’ professional growth;*”
- “*There is an attitude of ‘we are really smart and we know best;’*” and
- “*I am amazed by the lack of curiosity.*”

Many individuals believe that the lack of commitment to continuous improvement has impacted seriously the ability of CYD to identify and implement reforms, which would improve both internal CYD operations as well as services to clients. One individual noted that CYD staff often

revert to a position of “*we could never do that in Philadelphia*” when a new idea is introduced when, in fact, there is no supporting analysis for this position. Several individuals, including some CYD employees, recounted examples of prior reform efforts, which were initiated but never reached the implementation stage. Virtually all of the groups made some reference to CYD’s lack of response to prior reports and recommendations for improvement. The lack of a DHS-wide quality assurance model also was cited frequently as an area that signified CYD’s inability to assess and improve itself continually. Also noted was DHS’ failure to implement many of its own initiatives. Several individuals mentioned that a number of prior studies had been conducted in which recommendations for improvements were provided, and the CYD took little or no action toward implementing any of the recommendations. One respondent described this cycle as “*the problem is identified, the initiative is created, the training is created, but nothing changes.*”

The provider community also had several comments regarding CYD’s lack of commitment to ongoing improvement. One of the consultation groups was particularly verbal on this point and noted that CYD has no institutionalized mechanism through which service delivery partners can provide feedback or offer suggestions for improvement. In particular, one provider representative noted that, while many community-based organizations have developed effective treatment models and strategies for specific segments of the child welfare population, there lacks a formal mechanism to share these strategies with other agencies or with CYD.

Provider staff also made references to CYD as a “*closed agency*” that is reluctant to share information or work collaboratively with service delivery partners in the community. The observation that CYD is a closed agency underscores the prior comments about the perceived inability of the department to grow and improve continually. However, the notion that CYD is reluctant to work with provider agencies also signals a greater shift away from the collaborative casework practices that virtually every group said was important. To the extent that CYD is unwilling to share information and work cooperatively with provider agencies, private providers may become increasingly less able to access and coordinate services effectively.

On a more promising note, generally it was felt that the current leadership within CYD appears to understand the value of change, and is committed to fostering reform and creating a culture of continuous improvement. However, individuals expressed the opinion that it will be important that this commitment be institutionalized as a core value of CYD, so that it is not lost when the next set of individuals assumes the leadership of the division.

CYD Staffing and Infrastructure Issues

The issues and accompanying recommendations in this section primarily relate to the experience and qualifications of CYD staff members. Most of the discussion within the consultation groups focused on one of three areas: 1) the skills and experience levels of CYD staff providing services; 2) the adequacy of staff development and training opportunities for CYD staff; and, 3) the degree of specialized resources that exist to support social workers in their jobs. Almost all of the various groups and individuals consulted during this process had thoughts as to the primary staffing issues that CYD faces, and there were numerous recommendations for improvement. It should be noted that, while virtually all of the discussion was focused on CYD staffing issues, some of the issues identified in this area also apply to provider agency staff.

Staff Qualifications and Experience

In several consultation sessions, there were discussions surrounding the overall qualifications of the CYD social work staff. Several groups identified challenges that CYD faces currently, or is expected to face in the coming years as the child welfare caseload continues to increase and diversify. Some examples of the challenges identified are discussed below.

- Many social workers, supervisors and managers are in the DROP (early retirement) program, which increasingly will result in what one individual referred to as the DHS “*brain drain.*”
- Many CYD social workers lack significant child welfare experience, and there are insufficient training opportunities to provide social workers with the skills they need to manage effectively a child welfare caseload. Many individuals felt that this problem will continue to increase over the coming years, as the CYD staff matures and more social workers depart CYD for higher paying jobs with other City and state agencies.
- There are inadequate supports to help social work staff cope with the emotional and psychological hardships that they often experience given the difficulty of their jobs. Many felt that this will increasingly contribute to burnout and turnover.
- CYD does not provide clear expectations for social worker performance and demands little-to-no accountability for social workers. As a result, there is little attempt systematically to identify poorly-performing social workers and identify ways to improve.
- CYD caseworkers do not have the skills to recognize when children have serious and highly specialized issues, such as health problems or developmental disabilities. Many individuals believe this problem has increased in recent years, and agree that it is an alarming trend, as the failure to recognize serious needs can result in caseworkers missing certain issues (particularly health-related issues) which, in turn, can result in increased fatalities.
- Some individuals stated that the majority of CYD staff have a background in social work, and as direct work continues to shift toward private agencies, CYD social workers will grow more frustrated as their jobs focus increasingly more on contract management activities than on providing direct services to clients.
- One individual noted that CYD caseworkers are often too familiar with their clients, and should be trained to act more professionally when interacting with children and families in their caseload.

It is difficult to draw conclusions from the information offered during the consultation sessions concerning the qualifications and skills of CYD social workers. Many of the preceding observations, while focused on social worker skills and abilities, suggest larger issues about CYD’s training, staff development and human resources infrastructure. For example, the impending retirement of many senior managers and the potential migration of social workers to other City agencies, which offer better salaries and working conditions, are certainly a signal that CYD must actively engage in activities such as succession planning, recruiting, and staff development. However, it was noted that these activities are not necessarily on the CYD radar screen.

Another common theme that appeared in many of the discussions regarding the CYD social workers is that, while some may feel that social workers lack the necessary skills and experience, this is more attributable to lack of support at CYD than to the social workers themselves. The inability of CYD to provide infrastructure support was mentioned several times. Also notable is the lack of clear expectations and lines of accountability for CYD social workers, without which it is difficult to further social worker development and improvement.

There also were several discussions about the role and work of CYD social work supervisors. Some individuals noted that they rarely, if ever, saw a CYD supervisor accompany caseworkers on home visits to supervise the work being done and to ensure that the CYD standards were being met. Others noted that the CYD supervisors often view their role as primarily administrative, rather than as supporting and supervising direct service workers. A recommendation made by several individuals was that CYD should require that supervisors accompany caseworkers in the field regularly, to ensure that the CYD standards of providing care are being applied properly. The implementation of such a recommendation would need to take workloads into consideration.

Staff Development and Training

Training is another area that was scrutinized by participants in the consultation process, and was discussed, to some degree, in most of the consultation sessions. Various perceived deficiencies with CYD's training programs were identified.

- There is a lack of specialized training to help caseworkers identify children with special needs (such as health and educational), or with developmental disabilities.
- There is no structured evaluation of training programs to understand whether the training provided is appropriate, relevant, and being retained by the staff who take the training classes. To remedy this issue, pre- and post-testing should be conducted for training programs to assess better the effectiveness of the training provided by CYD.
- Training for new caseworkers bears little resemblance to the “real world” that will be experienced when the caseworker assumes a regular caseload. One individual noted a specific instance where a supervisor told a newly trained caseworker that, once he had his own caseload, then he would understand “*how things are really done.*”
- The state-mandated training for new supervisors is generic, does not sufficiently focus on the interpersonal and managerial skills needed to be an effective supervisor, and increasingly results in supervisory staff that are not capable of supporting their caseworkers.
- There is little follow-up from the training classes to ensure that caseworkers are retaining the material they learned, and correctly applying it to their daily work.

These comments and suggestions represent the overall nature of the training recommendations offered throughout the consultation period. It is evident that many individuals and groups believe the lack of effective training to be a contributing factor—perhaps *the* contributing factor—to poor performance whenever and wherever it is identified within CYD. However, a minority of individuals took the view that training is often the scapegoat for larger CYD issues. One interviewee felt that CYD is too willing to look towards training as a panacea to satisfy all its staff development needs, and that this approach inhibits the identification of deeper issues that

may be impacting CYD's performance. This does not imply that the training programs offered by CYD are beyond reproach or have no room for improvement. Rather, it is the recognition that not all issues can be solved easily by requiring more training.

Staff Professionalism

During the Town Hall meetings and focus groups with parents and former clients of CYD, many individuals stated that the CYD caseworkers with whom they interacted often failed to act professionally. While this lack of professionalism was a consistent theme, very different types of unprofessional behavior was reported. A common complaint was that CYD caseworkers do not spend enough time with the family to understand family needs, issues, and strengths adequately. As a result, the service plan often did not contain the appropriate combination of services. Another frequent comment was that the CYD caseworker would not meet with the family until immediately before a critical event, such as a hearing or a case planning conference. Another focus group participant remarked that CYD caseworkers use "*scare tactics*" to get clients to attend nonmandatory counseling sessions, and this makes it difficult for clients to trust their CYD caseworker.

Lack of communication on the part of CYD caseworkers was cited repeatedly by parents and former clients. Parents reported having to call caseworkers every day for extended periods of time in order to get a return phone call. Also reported were complaints that the CYD caseworker would not communicate with direct service providers, such as therapists, foster families, or provider agencies. One child reported that he was sent inappropriately to a juvenile detention center because his CYD caseworker never met with his therapist until right before the court date.

In addition to complaints about poor service coordination, there was a general feeling among the individuals who spoke at the Town Hall meetings that CYD caseworkers do not treat clients with respect. Many of the participants reported that they felt their caseworker did not care about the client or his or her family. One noncustodial father said that, when he found out his son was involved with DHS, he was extremely upset and "*...my worker made me feel even worse.*" Another individual stated that "*disrespect is the number one issue*" and that she felt more "*disrespected by DHS workers than by thugs on the street.*" In addition to the more serious concerns above, there were many remarks about the lack of professional attire, manner of address, and general demeanor of the CYD caseworkers, all of which clients felt contributed to a general lack of respect.

Despite the general dissatisfaction with CYD caseworkers that was reported throughout the consultation process, most individuals realized the value of having a good caseworker. One individual felt that having "*a good worker makes all the difference*" and this was a general theme with which most participants agreed. One former child client said that a good caseworker "*looks at you like a person and not a caseload.*" Understanding the value of a good caseworker was perhaps a contributing factor to the very negative feelings many individuals expressed because they felt their caseworker was not a good caseworker, and was simply not committed to helping their family.

Lack of Specialized Resources and Supports for Workers

Many of the children in CYD's care have special needs and require treatment from staff with highly specialized expertise. It was noted repeatedly that CYD lacks personnel with the

appropriate training and expertise to recognize when children have specific needs, such as mild developmental disabilities or nonpresenting health care needs. As a result, children often have needs that go unrecognized and are not addressed in their service plan and, frequently, the services they receive do not address their needs. Groups that come into contact with children with special needs were especially vocal on this point.

It was widely believed that CYD needs a larger cadre of specialized resources to help caseworkers identify children with special needs and develop appropriate treatment plans. It was recommended by one group that CYD consider creating specialized units that deal with certain types of children, such as those with chronic health care needs and developmental disabilities, and staff these specialized units with the appropriate personnel. One specific example was the creation of a specialized medical unit, with full-time pediatric nurses to identify a child's medical needs.

Several individuals noted that, while CYD caseworkers may lack expertise in specific areas, it is not realistic to expect caseworkers universally to be fluent in identifying all needs that a child may have, and it may not be viable financially to create specialized units. One group noted that these specialized resources already exist, either in CYD or in other City agencies, but that these resources "*remain a mystery*" to many CYD and provider agency staff. It was recommended that CYD work within its own infrastructure first to identify any existing specialized workers, and then to determine an appropriate mechanism to leverage these resources in support of CYD's work in preventing and responding to child abuse and maltreatment.

While few suggestions were made about specified supports and resources that could be established for caseworkers, one group developed an idea for a Help Desk, staffed with experienced social workers, available by phone, to provide technical assistance, advice and support to CYD and private agency social work staff while they are outside of the office. This would provide caseworkers with a needed resource to assist in responding to critical and emergent challenges, particularly when those challenges lie outside of a caseworker's chain of command. The group that developed this idea felt that a support system such as this, which is available to caseworkers at a moment's notice, "*could possibly make a difference between life and death situations.*"

CYD staff and provider agency relationships

An area that received considerable discussion during many of the consultation sessions was that of the relationship between CYD caseworkers and private agency caseworkers. There was a general lack of clarity about the roles and responsibilities of CYD staff and the provider staff when assigned to the same case. The discussions signal a general misunderstanding, perhaps even mistrust, between some private agency staff and CYD caseworkers. Anecdotal evidence taken from the consultation sessions suggests that this sub-optimal relationship may decrease the quality of services provided to a family. To a certain extent, this sub-optimal relationship may be attributable partly to the lack of clarity over the role of CYD versus the role of private agencies in serving families and children, once the family has been accepted for services. Regardless of the causes, it is clear that the relationship between private agency staff and CYD caseworkers must be improved, so that providers and CYD can work more collaboratively toward providing services to clients.

Lack of Communication between CYD Staff and Provider Staff

Several individuals cited a lack of communication between CYD and provider agency staff as a key area needing improvement. Many provider agency staff indicated a growing frustration with CYD staff that are unresponsive to phone calls, e-mail inquiries, and requests for information. There was also a great deal of frustration regarding the system of alerts that providers use to notify CYD caseworkers about important changes or case events. Provider staff noted that CYD caseworkers rarely respond to an alert, except in urgent cases or when an alert signifying a provider's intent to terminate a case is received. Some provider staff admitted to sending termination alerts even when there was no intent to terminate, since that was "*the only way to get CYD's attention.*" Comments also were registered regarding the caseloads that CYD caseworkers carry relative to those of private agency staff—that these caseloads are significantly lighter and less demanding than those carried by private agency staff. In response, CYD staff indicated that they believe that often private agency staff do not provide families with all relevant and available services, particularly for those families receiving SCOH. CYD caseworkers, as well as many community groups, also believe that private agency staff are not always fulfilling the true service delivery requirements for SCOH, and that there are instances where quarterly reports misrepresent the total amount of time that private agency caseworkers spend with families.

It also was mentioned that the lack of effective communication between CYD caseworkers and private provider staff leads to clients receiving different and sometimes conflicting information regarding participation requirements, particularly for SCOH programs. Client participants in focus groups recounted several examples where their CYD and private agency caseworkers gave them conflicting sets of instructions regarding what was required as part of the Family Service Plan (FSP). As an example, one woman noted that her CYD caseworker told her that participating in services for victims of domestic violence was required, whereas her SCOH caseworker told her it was not required.

There were a number of practical suggestions for improving the collaboration between private agencies and CYD. Most suggestions focused on case-specific requirements, such as mandating joint provider/CYD meetings with the client, increasing requirements for face-to-face meeting with the family, and requiring increased case conferencing with CYD and private agency staff present. To a lesser extent suggestions focused on larger, more systemic items, such as "*fixing the alert system*" or "*enhancing the communication between providers and CYD workers.*" In general, specific recommendations for resolving these larger systemic issues were not offered.

Casework and practice issues

Focus on Prevention

Despite the investment that Philadelphia continues to make in its prevention programs, many groups felt that an even greater focus on prevention activities and programs is warranted. In some groups, the overarching recommendation was to focus more efforts on prevention among the at-risk and general populations. There was a high level of agreement among these groups that families already in the care of CYD should have additional prevention services to avoid the

recurrence of abuse. One group discussed the need for current clients to have preventive services to inhibit the intergenerational transfer of abuse and neglect behaviors, so that children currently in CYD's care will not abuse or neglect their own children in the future.

In other groups, discussion related to prevention programs centered more on the perceived need for CYD to develop prevention activities designed for at-risk families and the general population, and less on programs to provide support to families where maltreatment has already occurred. While CYD already expends significant funds on programs such as SCOH and Safe & Sound, which are targeted specifically at these populations, many individuals felt an even greater focus on these, and other similar programs, is needed. More focus on community-based programs, and greater CYD/community-based collaboration efforts were identified as ways to enhance the focus on prevention.

While the consultation sessions did not produce a unified opinion on the scope, intent or focus on prevention programs, it is clear that prevention remains a very important topic of concern among the private provider agencies and community groups consulted.

Case Referral and Transitions

Some of the individuals with whom the Panel met noted difficulties with the Central Referral Unit (CRU). It was reported that, once a case is transferred to the CRU, the process of matching a case with a provider is often lengthy and not communicated to the family, resulting in unnecessary delays prior to the commencement of services. It also was noted that frequently the referral does not match family needs with the expertise of the provider appropriately. For example, it is not uncommon for children requiring special care and expertise—such as teens or children with medical issues—to be placed with providers that do not have that expertise on their staff. Improvements to the CRU should be made so that referrals are made more expediently and that children with special needs are placed in appropriate settings. One individual noted that, with the advent of performance-based contracting, the mismatch between family needs and provider expertise is growing larger, and happening more frequently, as “*whatever provider is next*” is assigned to the case, regardless of the needs of the child or family.

The process of transitioning children between providers and placements also was something that several individuals flagged for potential evaluation and improvement. It was noted by some provider groups that, when a child's placement setting changes, there are often pieces of the child's case record that are not received by the new provider. In some cases, information is received significantly after the child is placed. In other cases, information is never received by the new agency, thereby limiting the ability of the provider to plan accurately for the child's needs. There is a need for a more orderly and structured method for transferring cases across providers.

Confusion Regarding the Family Service Plan

Many of the clients who participated in the focus groups commented on the Family Services Plan (FSP). While many clients stated that they understand the value of the FSP at a conceptual level, they felt that the plan is not being implemented properly. A concern frequently expressed by clients was that they felt as though the goals and services identified on the FSP are often “*generic*” and not sufficiently tailored to their unique situation and needs. One client noted that clients are not empowered to speak and request needed services and that caseworkers often want

to make the appointments and not allow the client to be involved. It also was noted by clients that often they were not involved in the development of the FSP itself, and were merely asked to sign an FSP that had already been developed by a caseworker. It was further noted that, in the execution of the FSP, a client would often receive conflicting instructions from the SCOH and CYD caseworkers.

Noninvolvement of Fathers

A general concern raised at the Town Hall meetings was that CYD fails to include absent or noncustodial fathers adequately in the family service plan. It was stated that CYD generally fails to support fathers not residing in the household, and will not help them access services they may need in order to participate more fully in their children's lives. There were several absent fathers who spoke at the Town Hall meetings, and indicated that CYD caseworkers do not seem to care whether the absent father is included, so long as the mother and child were receiving services.

Additional Service Delivery Comments

The majority of the consultations focused on broader issues, such as those discussed previously, and typically did not include detailed discussions of service delivery strategies and requirements. However, specific recommendations for improving service delivery were interspersed throughout the various consultation sessions; some comments are listed below.

- CYD should mandate collaborative case conferences and team meetings, which require the presence of any CYD or private agency staff assigned to the case. CYD also should consider requiring the presence of CYD and private agency supervisors on a regular basis.
- Several comments were received regarding smaller caseload sizes that would allow caseworkers to see clients more frequently.
- One individual suggested caseload weighting to balance the caseloads assignments more effectively.
- Several discussions occurred regarding the need for after care services, and specific recommendations included a mandatory 6- or 12-month after care requirement depending upon the severity of the case.
- Development of a minimum standard for visits by SCOH caseworkers to assess and provide standard service visits.
- The child welfare system forces a “triage process” because of all of the demands and insufficient staffing to address them. Attention is not provided to all who need it. Situations escalate and, in some instances, result in tragedies involving clients who may have been categorized as not needing immediate attention.

Service integration and collaboration issues

Most of the groups and individuals interviewed discussed the need for a more holistic approach to working with children along all dimensions of the CYD care continuum. A common, yet general, criticism heard was that CYD often does not collaborate effectively—if at all—with other agencies that serve the children in CYD's care, such as Health, Housing, Education and the School District. Some stated that CYD does not collaborate effectively even with the DHS Division of Community-Based Prevention Services. Participants found this problematic in that the majority of children within CYD's care and supervision have an array of needs that cannot be

addressed adequately solely through CYD programs and services. It was felt that the lack of collaboration is present throughout the CYD continuum of care, including prior to a child's placement, during the placement, and after a child has been removed from placement and reunified with his family.

While the groups focused almost exclusively on deficiencies related to service integration and collaboration, one group pointed to the notable success CYD has achieved in collaborating with Community Behavioral Health and other mental health agencies to serve children with developmental disabilities. However, there were no other examples of CYD collaborating effectively with other agencies.

While much of these discussions offered high-level comments about the need for enhanced collaboration across agencies, and the extent to which they obstruct effective service delivery, several specific issues were discussed in greater detail. In particular, specific deficiencies were noted in the areas of information collection and sharing across agencies, lack of collaboration at the case level, and the inability of CYD caseworkers to leverage resources outside of CYD to assist with a child's care plan.

Lack of Information Sharing

The most common theme that emerged from discussions on service integration and collaboration was the lack of information available to caseworkers when coordinating services. Participants stated that they have limited, and sometimes no, access to child and family information that is known to CYD and/or other public agencies. In many cases, these data already reside in either CYD or another agency's management information systems, and include information related to the child's physical and mental health needs, education attainment and learning disabilities, and participation in other City- and state-funded social services programs that are not under CYD's purview. Less frequently, information is not available because it simply does not exist. One participant noted that, because she does not have access to all of the available information about a child, she has to coordinate services "*with only part of the picture.*" In general, participants felt that, without access to all relevant information regarding a child, they cannot assess effectively that child's true overall needs and develop an appropriate service plan.

The types of information-sharing issues experienced by private providers were also different—and generally more extensive—than those of CYD caseworkers. Whereas private agency and CYD caseworkers both have difficulty gaining access to information that resides in information systems outside of CYD's purview, private agency staff had the added difficulty of obtaining CYD information that is often not provided to the private agency. In some instances, information is not available to private providers due to confidentiality restrictions. However, it also was noted that there are many instances where private agencies do not receive a child's case file from CYD until well after the case has been assigned to the agency. This makes the initial planning process more difficult for private agency caseworkers, at a time when the child is most vulnerable and in need of the right combination of services.

To improve the current situation, participants recommended enhanced information collection and sharing across agencies. While one private agency social worker felt that the ultimate goal should be to create a unified information system across the various City agencies, generally it was felt that this approach is not realistic, and certainly would not provide any immediate relief.

As a more immediate measure, it was recommended that a common data collection process be implemented across agencies, where a core set of child information would be collected and shared among all of the agencies serving a child (*how* this information would be shared was not discussed). As an example that was provided in one of the group sessions, either the CYD or private agency caseworker (whoever is assigned to the case) could collect basic information regarding the child (e.g., health status, educational needs, mental health situation, etc.) and then provide this information either manually or electronically to other caseworkers assigned to the child's case.

Leveraging Resources Outside of CYD

Along with enhanced information collection and sharing, several groups noted that CYD caseworkers need further education as to the types of resources and services that are available in other agencies, and how these resources can be accessed. This was specifically noted for children with severe mental or physical health needs and children with developmental disabilities.

The status of children's health was raised several times, both by groups that focus primarily on the health-related needs of children, but also by other community groups who feel that the health care needs of children require a more significant focus. In particular, it was felt that more attention could be paid to health issues both during the investigation period and also when the child is first accepted into care, so that initial service plans can be established with the child's health care needs in mind. It was noted that getting the child the right set of health supports early on is critical, in order to avoid the potential for more significant health care problems later on in the child's life.

There were several recommendations for improving the focus on children's health status. Enhanced data collection and sharing was offered as a low-tech opportunity that would require little in the way of resources, but would necessitate greater collaboration between agencies. High-tech options were not offered, largely because many respondents felt that DHS had neither the resources nor the will to implement a large, multiagency technology solution. Several individuals cited a recent, failed effort to implement a Health Passport that would have benefitted children by enhancing caseworker access to health care data. The use of specialized resources, such as pediatric nurses, also was suggested as a way to properly evaluate children when they enter care, to ensure that nonpresenting health issues are not overlooked.

Collaboration with the Philadelphia School District

It was observed repeatedly that the Philadelphia School District often presents significant challenges to coordinating services for youth. This is particularly true as children move between school districts and need to transfer credits. Credits from schools outside of Philadelphia—and, in particular, out-of-state schools—often are not accepted by the Philadelphia School District, or are otherwise difficult to track and recapture when the child returns to Philadelphia. In many instances, children are forced to remain outside of Philadelphia in order to retain their credits and graduate. This presents a great deal of difficulty for the child, and the caseworker coordinating services for the child, as it often presents a difficult choice between remaining in a placement setting and finishing school, or reunifying the child with his family and potentially retarding the

child’s educational progress. Generally, the groups who discussed the inability to transfer credits back to Philadelphia when the child returns from a placement in another city or state, stated that it represents a significant service delivery hurdle, particularly when reunification is the primary goal.

Legal Representations for Parents

An additional concern—particularly in the Town Hall meetings and in focus groups with parents—is that parents generally have very poor legal representation within the family court system. Many parents noted that their publically-appointed attorney was often extremely overworked, and that it was often impossible to meet with their attorney prior to a court hearing. It was further noted that, in many instances, the attorney would not adequately represent the parent’s side of the story in court because the attorney had not had the opportunity to speak in-depth with and get to know the parent. A final concern among parents was that they felt as though their court-appointed attorney did not trust them. Many parents noted that while they were unable to speak with their attorney until immediately before a court hearing, and could not get their attorney to return their phone calls, they knew that, frequently, their attorney had been speaking with the CYD caseworker assigned to the case. Many parents expressed a great deal of frustration, in some cases anger, about this as they felt their attorney should be listening to them, and not to CYD.

Data, evaluation, and service-monitoring issues

CYD’s use of data was a topic that was discussed frequently during the consultation sessions. There were several general conversations regarding CYD’s inability to use the data it collects to provide insight into program planning and evaluation activities, as well as to help inform case-level decision making.

Use of Data

Most of the groups who discussed this issue believe that CYD collects a “*significant*” or “*vast*” amount of data on its programs and clients. However, it is believed widely that CYD has no plan for using these data to evaluate its programs or operations. Several individuals commented that, while CYD has a great deal of data, there is little information, and future efforts should focus on enhancing the analysis of existing data, and not on capturing additional data. It also was believed that greater analytical focus would help CYD better understand program effectiveness and identify successful service delivery practices and strategies that could be expanded or replicated elsewhere.

Preceding discussions in this appendix illustrate the challenges CYD and provider agency staff face with regard to accessing data needed to make case-level decisions. This also was a common theme in the context of the larger discussions about data analysis and evaluation. Caseworkers expressed frustration with having to make decisions based on incomplete information. In some cases, information did not exist but, in other cases, there was information that was unavailable to the caseworker when needed. While few suggestions were offered to remedy this issue, it was noted repeatedly as one of the most significant challenges that caseworkers face.

Program, Provider and Staff Evaluation

Many groups made remarks about the overall quality of the private service providers that contract with CYD. Individuals generally believe that the majority of agencies provide adequate

services, but there are a limited number of provider agencies that are not providing acceptable services. Many individuals felt that CYD must conduct a more rigorous evaluation of provider agencies to identify the poorly-performing providers and, either develop a plan to improve services, or discontinue contracting with that provider. Several groups also noted that the evaluation of SCOH agencies should focus more on outcomes, rather than on service delivery processes that many feel are currently the focus of provider evaluations. Some individuals had a general sense that CYD was conducting provider evaluations already, but there was little discussion in the groups about the quality of these evaluations.

It also was noted that, just as private provider agencies must be monitored and evaluated more carefully, so, too, must CYD provider agency caseworkers be evaluated. Many provider staff interviewed felt that CYD did not establish clear performance expectations for their caseworkers, and that caseworkers were rarely, if ever, held accountable for their work.

SUMMARY

It is clear that there are several challenges facing CYD as it moves through this critical period and begins to identify and implement improvements to its operations and programs. As seen through the community consultation process, CYD must focus on refining and communicating its mission both to its own staff and service delivery partners, and the children and families that it serves. It was stated clearly in the consultation sessions that the current lack of specificity in CYD's mission, programs, and operations is causing confusion that is impacting negatively on the services for children and families.

While the lack of clarity of mission was the most widely-discussed issue, CYD should consider the other suggestions and recommendations received. There were numerous comments regarding the relationship between private agencies and CYD caseworkers. Combined with the lack of programmatic clarity and an inadequate support network for caseworkers, there is a seemingly significant potential for the quality of care to be impacted adversely, potentially threatening child safety, permanency, and overall well-being.

Exhibit H.1 Interviews and Focus Groups Conducted

The activities outlined in this section were conducted as part of the interviews and community consultation process.

Town Hall Meetings

West Philadelphia:	First Episcopal District African Methodist Episcopal Church 3801 Market Street Philadelphia PA 19104
North Philadelphia:	Temple University Student Center Annex, Room 200A 13th Street (between Montgomery & Cecil B Moore) Philadelphia PA 19122

Focus Groups

- Community groups
- Advocacy
- Provider agency administrators and directors
- Children formerly in foster care
- Client families

Interviews

Note: To preserve confidentiality of the individuals interviewed, only the general categories of individuals interviewed during this process are identified below.

- DHS and CYD executive leadership and managers, current and past;
- Leadership of community agencies;
- Leadership of relevant stakeholder groups;
- Union officials;
- Family Court judges;
- Philadelphia Resource Committee;
- Philadelphia Safe and Sound;
- CYD workers and supervisors (conducted by Casey Family Programs); and
- Provider agency workers and supervisors (conducted by Casey Family Programs).

APPENDIX I. PERSPECTIVES REPORTED BY DHS AND PROVIDER AGENCY STAFF

BACKGROUND

The information in this report was provided by Department of Human Services (DHS) and provider agency personnel, and was gathered at the direction of Dr. David Sanders, Executive Vice President of Systems Improvement at Casey Family Programs and a member of the Philadelphia Child Welfare Review Panel (Panel). In March 2007, staff from Casey Family Programs gathered perspectives from the Department of Human Services (DHS) and provider agency staff using three methods of inquiry: online surveys, individual interviews, and focus groups. The purpose of these inquiries was to assist the Panel in identifying strengths, challenges, and potential improvements within the DHS.

- *Online survey:* Two separate online surveys were conducted, one made available to DHS personnel and another to provider agency workers, supervisors, and administrators. The provider agency survey was available to prospective respondents for approximately 12 working days between March 8 and March 23, while the DHS survey was available for approximately ten working days between March 12 and March 23. Both allowed personnel to complete the surveys without providing their names or other identifying information. After data cleaning, 122 total DHS surveys and 279 total provider agency surveys remained in the respective datasets.
- *Individual interviews:* Sixty-two individual interviews were conducted between March 13 and March 17. The interviews included 35 DHS staff and 27 provider agency staff. The interviews were voluntary, confidential, and lasted approximately one hour. The interviewees consented to being recorded and the interview transcripts were used to identify frequent and/or consistent messages.
- *Focus groups:* Eight focus groups were conducted between March 20 and March 22, two sessions each with DHS social workers, DHS supervisors, provider agency social workers, and provider agency supervisors. A total of 52 individuals participated. Sessions were conducted off-site in a formal focus group setting, and participants were assured anonymity. Each session lasted approximately two hours. Participants self-selected for the voluntary focus groups, and participant names were held confidential. Consent was obtained to audio record the focus groups.

Constituent review

Draft DHS survey and interview questions were reviewed and edited by some members of the Panel, DHS leadership, and union representatives. Draft provider agency survey and interview questions were reviewed and edited by some members of the Panel and provider agency management staff.

Limitations of process

Because respondents to the survey and participants in the interviews and focus groups were self-selected, it cannot be assumed that representative samples of personnel from either DHS or provider agencies were included. Although DHS LAN support staff worked with Casey Family Programs survey personnel throughout the online survey period to resolve technical issues, some

DHS staff reportedly were unable to access the online survey. The provision for anonymous participation also precludes certainty that survey respondents only completed the survey once, or that respondents, in fact, held the type of positions they indicated. It was also possible for an individual staff person to participate in the survey, an interview, and a focus group.

Information gathered in the focus groups, in-person interviews, and open-ended survey items consisted of qualitative data. Respondents provided a wide range of views and suggestions in these components of the information-gathering process. Qualitative data are summarized in this report by phrases or statements intended to capture frequently-occurring themes in participant responses. Response themes are not mutually exclusive and may overlap in some cases. The processes by which themes were identified consisted of informal qualitative analysis. While the authors have worked to present accurately the views and suggestions of survey, focus group, and interview respondents rather than their own opinions in this report, any qualitative analysis inherently contains elements of subjectivity.

Despite these limitations, there is reason to believe that the interviews, focus groups, and online surveys produced valuable information regarding the experiences and perceptions of personnel serving in a variety of roles both within DHS and in provider agencies. Many respondents in each group identified the same or similar assets within, and concerns about, the DHS and provider agency system. Taken together, the responses to all three methods of inquiry offer considerable detail about the system's strengths and problems, along with potentially valuable suggestions for areas of focus and steps which could be taken to improve the DHS system's ability to protect children and provide quality services to families.

Report structure

Information from all three components of inquiry is summarized together in the narrative. Following sections of narrative, there are recommendations that were provided by the respondents; and there are many recommendations inherent in the comments by provider agency and DHS staff. Also included in this report are:

- Online survey responses;
- Matrix showing general information about all respondents; and
- Interview questions and focus group discussion guide.

SUMMARY

In general, consistency was found in the feedback from both DHS and provider agency personnel across the modes of inquiry. Interviews and discussions were led with a strengths-based approach (i.e., asking them to focus on programs, policies, and practices that are working well), and a number of programs were cited (listed later in this appendix). In addition, both DHS and provider agency personnel expressed their support for the mission of DHS and many noted that, despite challenges, they like their jobs, receive satisfaction from their work, and want to improve the system. As might be expected, when informants were given an opportunity to share information that might improve a system, conversations shifted to that which is not working. It is notable that there was consensus about those issues.

Response and reaction to child deaths reported by the media was a major theme. DHS and provider agency personnel described the stress they feel in being held accountable for situations over which they sometimes have little or no control, and the programmatic and personal impacts of negative media, and lack of positive public relations. Respondents also described increased workloads due to, in their opinions, reaction to the media resulting in opening the “flood gates” of intakes and additional requirements, and the negative impact of this overload on services.

Other areas of particular concern included: communication and lack of administrative support (resources, tools, and infrastructure) within DHS; deficiencies in current intake and Central Referral Unit (CRU) processes, the Services to Children in Their Own Homes (SCOH) program, case flow procedures; lack of role clarity between DHS and provider agencies; and problems in the family court system. Both DHS and provider agency personnel remarked on the excessive case load size for some DHS workers, as well as the low pay for provider personnel, as hindrances to good practice.

A frequent observation of DHS and provider agency personnel responding to this inquiry was the sometimes-strained relationship between DHS caseworkers and provider agency personnel and the impact of this dynamic on service provision. However, both DHS and provider agency personnel expressed interest in increased opportunities to train and work together to develop more productive working relationships.

MISSION

Personnel commitment

“The opportunity to make some kind of impact on the families, positive impact on the families. I like the “thank you” that I get from the folks who feel that I helped them, or at least I know I tried to help them.”

In interviews, surveys, and focus groups, both DHS and provider agency personnel made it clear they do the work they do because they believe in the mission—to provide for the safety, permanency, and well-being of children who experience abuse and neglect in their families. Many emphasized that they love their jobs; seeing success for children and families gives them great satisfaction. Several provider agency directors and supervisors noted that the commitment of personnel held additional significance for them considering the low pay and stressful nature of the job. Both DHS and provider agency personnel want to contribute to an improved system and noted that progress has been made.

Public perception and the media

DHS and provider agency personnel consistently said that the way they are portrayed in the media discredits them and undermines their ability to work with children, youth and families. Many respondents indicated that they feel media communications are negative and reactive. Many employees commented that the current public perception seems to be that they are the cause of the problems children and families experience. Several respondents also said the Mayor was quoted as saying they are at work only for their paychecks; they said they are worried that the public believes this. Some cried when talking about the circumstances of the children and

families with whom they work; they shared stories about breakdowns and medical leave among DHS personnel. Some respondents stated that the current assumption seems to be that all abuse or neglect is due to their errors.

In light of recent child deaths, DHS workers described the stress (“*state of fear*,” “*a cloud over my head*”) they feel in having accountability for situations over which they sometimes have little or no control, and face the prospects of “*having [their] name in the paper*,” provider agency personnel cited similar stress. But personnel emphasized that response to the media is much more than a morale issue—it increases intakes and caseloads, paperwork, and reviews, all of which do not change or improve practice necessarily and which may, in fact, dilute the time available for risk assessments and case work.

Communication

Lack of communication within DHS was cited frequently. While personnel reported feeling policies and procedures are generally good, lack of information about changes was cited as an issue. Some provider agency personnel commented that often they are aware of DHS policy changes before DHS frontline personnel; sometimes DHS personnel are still operating from old procedures (e.g., change from hours to number of visits required in SCOH), which not only creates problems with service delivery but with audits as well.

Also frequently cited was lack of communication within DHS and with provider agency communities regarding definitions or interpretations of policies and procedures. One positive response to this is the Philadelphia Council for Children, Youth and Families (CCYF), a consortium of a number of SCOH provider agencies that meets monthly to discuss policies, best practices, etc. DHS administrative personnel have been invited and have attended on several occasions to clarify policy/procedural changes.

Both DHS and provider agency personnel said the flow of information is inefficient and inconsistent and this is compounded by changes in personnel within DHS, worker turnover in provider agencies, and case reassignments. Concerns were expressed regarding the amount of time DHS workers and supervisors must spend negotiating their internal system that takes away from direct time available for cases. The view was expressed that success lies with individual workers versus the system as a whole. DHS and provider agency staff indicate that there continues to be a need for further role clarification between DHS case managers and provider agency social workers.

DHS infrastructure

DHS staff said that there is inadequate DHS infrastructure to support efficient, timely work. Many respondents reported that the phone and computer systems are unreliable, although DHS personnel noted that personal computers are now assigned to each person. Staff also said that lack of Internet access among workers is an inconvenience and is also seen as a sign of distrust. Respondents said that current phones have limited voice message capabilities and that duplicative paperwork, file maintenance, and scheduling take time away from casework. The fact that clerical support was cut for DHS was mentioned many times as a source of time demands that limit opportunity for direct work with children and families.

DHS workers reported being expected to use public transportation for work-related travel. Agency cars frequently are not available when needed (e.g., when schedules are tight or when there are security issues for staff needing to make visits at night) and are often in disrepair.

SYSTEM ORGANIZATION

“The department does try to learn not just from its mistakes, but from the things that we do right and we want to expand on. In all fairness, we really do try to learn from it.”

Both DHS and provider agency personnel reported that, as seen from the youth or family perspective, the child welfare system is overly complicated. Youth and families meet an array of different providers that appear to do many of the same tasks. Both provider agency and DHS personnel also remarked that, within the community, DHS is seen as having more power or clout than provider agencies, and in some cases, DHS personnel have had to intervene with families and tell them to cooperate with provider agency personnel.

Many DHS employees said that they appreciate the advocacy role of the union; a few others said they feel that the union chooses representatives that do not necessarily reflect their positions. Some staff from both DHS and provider agencies stated they feel that union involvement slows change and, sometimes, progress.

Geographic challenges

Personnel commented that requiring families to come to DHS headquarters is seen as a burden on families, especially as the building is not family-friendly. Similarly, the locations of various resources and service providers were reported as apparently not being factored in when cases are assigned, causing inconvenience and greater barriers for in-person meetings and service delivery. Personnel further said that the placement of children outside of Philadelphia seems to have increased, increasing barriers to birth family visits and sibling contact.

COURT SYSTEM

“The most rewarding part of it...is being able to see some of the cases really come full circle like permanency for children. In the court unit, we do get a chance to really see that.”

The court system was reported by both DHS and provider agency staff as being a major challenge, in terms of both time and support. A number of respondents reported that, despite attempts at reform, waiting at court is a huge and unpredictable time drain. Respondents said personnel and families can spend entire days waiting and, even then, not have their case called. Concerns also were expressed regarding lack of confidential spaces or computers where DHS personnel can work efficiently while waiting. In addition, they reported that the physical environment is very inhospitable for families who also are required to wait and who may have to return multiple times when their cases are not heard.

A number of DHS personnel reported that judges do not respect their recommendations and, in fact, sometimes place children in undesirable or unsafe conditions. They said that this occurs even when DHS, public agency personnel, and Child Advocates concur on recommendations.

Recommendations by respondents

- *Continue to seek and consider input from DHS and provider agency personnel to improve the system;*
- *Acknowledge personnel for work that is well done;*
- *Establish PR advocates within DHS and develop media coverage of child welfare successes and improvements in order to foster respect and credibility with the public;*
- *Create an ombudsman or other similar position in DHS as a “go to” for personnel to find the latest information on policies, procedures, and personnel locations;*
- *Implement a paperwork reduction process;*
- *Implement a consistent, uniform standard for email addresses within DHS;*
- *Provide adequate clerical support in DHS;*
- *Set up satellite DHS facilities (not just 1515 Arch St) with smaller neighborhood-focused units;*
- *Improve facilities for families and personnel at DHS headquarters (e.g., private meeting rooms, waiting areas suitable for children and families, cafeteria, break room for personnel, gym [or membership]);*
- *Establish a call-in system to let child welfare personnel and families know in advance whether or not a judge will be available to hear their case;*
- *Train judges about child welfare laws, policies, and issue;*
- *Develop opportunities for DHS personnel, judges, advocates, and others involved in the court process to talk to resolve issues, rather than simply having them “play out” in court proceedings; and*
- *Provide space/computers at court where workers can do confidential work.*

SCREENING AND INTAKE/INVESTIGATION

Screening

Both DHS and provider agency personnel talked about the fact that, when a child death occurs or there is bad press, the “flood gates” are opened with regard to the reports accepted by intake staff. DHS personnel reported they feel too many cases that do not really require investigation are then sent through because no one wants to risk harm to a child. Yet, the sheer quantity of investigations reduces the quality.

Mandated acceptance of nonchild abuse and neglect cases

Personnel reported that truancy cases for older youth also reduce the capacity of the system to protect children truly at-risk of harm. Respondents said that, with older youth, delinquency and dependency get confused. In both cases, it is hard to find homes for older youth when the real issue is not abuse/neglect by their family, but the youth’s behavior, which is often repeated when a placement is found.

Recommendations by respondents

- *Improved screening criteria and tools;*
- *Provide more training for hotline personnel;*
- *Develop another way to deal with truancy in older youth other than referral to the child welfare system;*
- *Improved court understanding and agreements regarding child abuse and neglect versus delinquency; and*
- *Recruit for more provider agencies to serve families closer to home.*

RISK/SAFETY/NEEDS ASSESSMENT

Assessment for SCOH and home inspections

A number of DHS and agency providers mentioned concerns about the lack of specific criteria for assessing the need for SCOH. DHS and provider agency personnel are unsure if SCOH services are having the intended impact on children and families because of a lack of clearly-defined standards, benchmarks, or outcomes.

Provider agency SCOH workers commented on the inconsistency they observe in DHS home assessments, which they believe are too subjective. Respondents said a particular concern is the lack of physical home inspections completed by DHS personnel. Some provider agency staff said they have begun to do the assessments themselves as they feel that children and families as well as workers are placed in unsafe situations due to unsafe housing conditions.

Assessment for kinship care

Personnel mentioned that kinship care providers are too often motivated by money (e.g., retroactive payments) and youth in those placements are not being cared for properly. Several provider agency respondents cited concerns that kinship home assessments are often rushed due to unrealistic time frames within DHS; most assessments are completed after the placement with kin has already taken place.

Incomplete or inaccurate assessments

Provider agency personnel frequently cited concerns that they are not provided with adequate information from DHS personnel at the time of placement or when initially receiving a SCOH case. Respondents said this is of particular concern when inadequate information results in a case not being assigned to the appropriate level of SCOH (there are three tiers in SCOH related to intensity of services needed). Respondents also mentioned that more immediate mental health evaluations are needed.

Use of assessments for placement

While some personnel mentioned that intake information and assessments might be more complete, respondents noted that, no matter how carefully the assessments are done, placements to respond to those needs are made through the CRU. And the CRU is one of the main concerns about the DHS system identified through the interviews and focus groups. DHS and agency

personnel stated that the placements often are not made based on the assessment. Respondents indicated that the CRU currently assigns most agencies based on a “wheel,” with the next available provider getting the assignment (rather than the best possible provider for the case) and regardless of how inconveniently located the provider may be to the family. Respondents reported that the process can take days. While many said the concept of centralized placement is a good one, many also reported that the reality of CRU needs attention. Similarly, the concept of integration with CBH (Community Behavioral Health) garnered positive comment, but a number of the respondents said in reality there are issues to be resolved, such as the delay for mental health assessments.

Recommendations of respondents

- *Establish training, guidelines, and checklists for consistent home assessments.*
- *Provider agency personnel recommended DHS personnel have more assessment training to give them skills to go beyond “what meets the eye” or beyond the surface level of what a family might be saying.*
- *Create smaller units within DHS, and match each with specific SCOH providers, to foster better, longer-term relationships.*
- *Conduct joint inspections and assessments with provider agency and DHS personnel (e.g. physical home assessment).*

SERVICE PLANNING

Case loads

Both DHS and agency providers frequently commented that DHS case loads are inequitably distributed and/or are too high—in particular, they cited the fact that a family equals a case, no matter how many children are in the family or the complexity of issues facing the family, as problematic. Respondents also said cases that have special needs (e.g., medical issues) may not be matched with case managers who have training in these areas. In addition, some respondents reported that sex abuse cases may not be referred to the trained sex abuse unit.

DHS staff

There were a number of positive comments made by provider agency personnel for DHS staff and a number of provider agencies acknowledge the difficulties DHS personnel face in the current environment.

At the same time, there was some provider criticism of DHS personnel that included: unreturned phone calls; not showing up for family meetings and court hearings; not being willing to make family visits after hours (5 p.m. or later, or on weekends); trying to complete Family Service Plans (FSP) over the phone; and not notifying the provider when a case is transferred within DHS.

SCOH

Both DHS and provider agency personnel noted that a lack of structured services and benchmarks for SCOH makes it difficult to develop service plans. Provider agency SCOH

workers also reported that DHS workers often set up inaccurate or unrealistic expectations with families as to services and resources to be provided by SCOH; respondents noted that, in addition to confusing the clients, this is likely to create an “us versus them” dynamic between DHS and agency personnel. DHS staff said that services provided by SCOH agencies differ according to their separate contracts and there is no way for DHS staff to know what is included in a particular contract.

Planning resources, tools, and techniques

The parent locator and child search services and the AutoFSP are resources personnel said facilitate planning, even though some reported seeing the AutoFSP tool as “buggy” and as sometimes resulting in overly uniform “cut and paste” FSPs applied to a variety of unique situations.

Provider agency personnel reported that accessing medical, educational, law enforcement, and judicial records is difficult and time consuming. They also indicated that, in some cases, despite signed authorizations from parents, medical and school personnel are willing to release information only to DHS personnel and not to provider agency personnel.

Both DHS and provider agency personnel commented how well it works when DHS and provider personnel meet together with families and youth to complete the Individual Service Plan (ISP) and FSP jointly.

Recommendations by respondents

- *Offer training and guidelines as to how best to set expectations for services and resources among clients;*
- *Provide training on how to better communicate with families to gain their cooperation versus telling them what they have to do;*
- *Investigate ways of equalizing work loads among DHS personnel, such as assigning a “level” for each case, as SCOH does;*
- *Implement differential (or alternative) response;*
- *Send a letter to the provider agency saying who at DHS is assigned to a case after intake (and at case changes); and*
- *Establish a practice of joint meetings to develop ISPs and FSPs.*

SERVICE DELIVERY

“Well, first, I like working with the people I work with. And secondly, I like working with the people I work with because they really are committed to working and serving the families that we serve.”

Issues between DHS and provider agencies

DHS personnel commented on the inexperience of some provider agency staff and frequent turnover in provider agencies. Conversely, provider agency personnel noted the sometimes inconsistent messages among DHS personnel, lack of responsiveness, and inexperience of some staff. This mutual lack of communication and teamwork between DHS and their contract

agencies, and the impact on service provision is one of the most notable observations made by DHS and provider agency personnel in this information-gathering process. However, both DHS and providers agency staffs expressed interest in increased opportunities to train and work together to develop more productive working relationships.

“I know that, for the most part, I’ve met some of the most wonderful social workers out there. I have to give them credit because they’re getting paid a lot less than we are. They’re using their own vehicles. They’re out there at all hours of the day, night and weekends. I have to give them credit because my job is hard. Their job is even harder because they’re the ones facing what’s going on in the home and reporting back to me.”

DHS case flow

Case flow was reported as a major area of concern. A case is assigned to intake to do the assessment; it then goes to CRU depending on the services needed, and is assigned to an ongoing worker for case management. Respondents noted that a case can sit on a supervisor’s desk for weeks before being assigned; in the meantime a family is not receiving services. Some respondents reported that if an ongoing worker leaves a unit, his or her case may not be reassigned due to the backlog of cases.

SCOH provider agency personnel said that, once they receive a referral, they are not supposed to provide services until the case has been “opened” by DHS, which is done with a visit to the family by the provider agency and DHS workers jointly. Provider agency personnel noted that this can take a while to happen and, sometimes, a worker schedules an appointment and then doesn’t show up. Provider agency respondents said that, in the meantime, the family is without services, adding that, in some cases, the provider agency may start to work with the family before the case is open but they cannot be compensated for the time they put in until it is officially “open.”

A number of provider agency personnel voiced concern that DHS caseloads and policies do not allow DHS personnel to be in the home often enough. There are also concerns about the actual number of visits made by DHS workers. Respondents indicated that, in a number of situations, (SCOH) cases were closed without the children and family ever meeting the DHS worker or only meeting them at intake. Several respondents from both entities said that when DHS and provider agency personnel do joint visits and have increased contact with one another, provision of services is better.

Personnel from DHS and provider agencies reported as a potential safety concern the fact that, due to caseload size and other factors, DHS personnel do not have the time to read or review all of the reports sent to them by provider agency personnel. Provider agency personnel voiced concern that potential safety or risk issues that are noted in reports and “formal alerts” are not responded to at all or in a timely manner by DHS personnel. In addition, provider agency respondents said these potential safety and risk issues then are not addressed in DHS plans and court reports. At the other end of the spectrum, provider agency personnel cited several instances in which they felt DHS became aware of a situation and then over-reacted (e.g. removing a child from a family that day) without consulting the SCOH provider. DHS personnel noted that

administrative supports for cases have been reduced; case file maintenance is the work of the case manager and this limits opportunity for direct work with families. Some respondents indicated that cases are sometimes kept open unnecessarily because, in the current climate of fear, workers are afraid of repercussions if a Hotline report is made within 60 days of a closure. DHS and provider agency personnel shared this observation.

“When we get trained in a vacuum, I think it doesn’t work as well as when we get trained on things together. I’m all for when there’s a new initiative, don’t train the private providers separately from the DHS workers. Let’s come together and get that training.”

Permanency

“Achieving some sort of permanency for the kids, whether it’s stabilizing the family or reuniting them with their birth family, or seeing them through an adoption process to be with a new family. Whatever works. It’s really, really nice when it works with a bio family. That’s the best. But short of that, seeing the kids in a good home and being taken care of.”

Generally, DHS and agency provider personnel said they feel that the system has made positive movement in its emphasis on permanency, with admirable practices such as the permanency roundtables, kin searches, etc. However, almost all wished to see continued improvements including more aftercare services. With regard to kin, several provider agency personnel noted that, although kinship searches may be occurring, in some cases, in others it is not or the search for kin is happening much too late in the course of the case history.

One of the concerns raised by some provider agency personnel is the potential overuse of Permanent Legal Custodianship (PLC) versus adoption or other options. While this option may be appropriate for some youth, a number of providers cite concern that performance-based contracting and DHS personnel requirements around the Adoption and Safe Families Act (ASFA) are the impetus for PLC being used too frequently. They reported concern that adequate time is not given to other options, adding that, in some cases, adoption is never looked at; and that some cases come in with PLC predetermined as the best option before there is any discussion. Several provider agency and DHS personnel remarked that they do not consider PLC “permanency.” Provider agency personnel also cited concerns that DHS personnel are pushing kinship providers into PLC instead of adoption so that parental rights will not be terminated, rather than having the decision made by DHS or the courts.

Provider agency personnel noted that, although there are supposed to be permanency review meetings held by DHS, provider agency staff often are not invited or are not told until the last minute that these meetings are occurring.

Programs and resources

Both DHS and provider personnel identified a number of DHS and community programs they feel are “working”: Achieving Independence Center (AIC), Achieving Reunification Center (ARC), Fatherhood Initiative, Family Preservation, the teen diversion project, Job Corps, Adolescent Violence Reduction Partnership (AVRP), CAP4KIDS, Safe and Sound, Family

Therapy Treatment Program, Parents United for Better Public Schools, Parent Antiviolence Network, Philly S.O.S. web site, Parent Locator (national search), emergency Philadelphia Health Management Corporation (PHMC) funds.

Recommendations by respondents

- *Increase the number of family and placement visits required of DHS personnel;*
- *Increase the duration of Family Preservation Services;*
- *Establish a time limit for SCOH services;*
- *Develop a “hands-on” parenting skills program.*
- *Provide more training for foster parents;*
- *Conduct more joint visits between DHS and provider agency personnel;*
- *Increase follow-up by DHS personnel on “formal alerts”, home assessment, and crisis situations. (This was particularly noted for SCOH);*
- *Add clerical personnel to reduce burden on case managers, including filing, record retrieval, scheduling, and arranging transportation;*
- *Impose a time limit on case resolution, unless progress is being made; several suggest limits of one, and perhaps up to two, years;*
- *Enlist the private sector to provide enrichments. Providers would like more support for family activities (e.g., trips to the zoo, bowling, roller skating, etc.); and*
- *Providers suggest DHS update the summer camp book by February (not June) so clients can take advantage of summer programs.*

SERVICE MONITORING/ACCOUNTABILITY

Accountability and authority

DHS personnel frequently noted they feel they are accountable for outcomes but feel they have no real authority. Provider agency respondents often note a sense of powerlessness despite the fact that they are the ones doing most of the day-to-day work with children and families and are the ones actually in the homes. The respondents said this is especially noted when there are differing opinions between DHS and provider agencies regarding placement or permanency decisions.

Supervision/Leadership

“I have a lot of new staff, new to the agency within a year, who I’m watching grow in their positions, becoming independent and not needing a lot of supervision to make decisions—their ability to handle crisis or situations without needing to depend on me.”

Leadership and support from DHS administration

Many personnel commented that improved teamwork throughout DHS would improve services. Some DHS personnel indicated that they would benefit from more interaction with those in administration. Provider agency respondents said they would like to be asked to provide input about the system and to be given more explanation when changes are made.

DHS respondents noted that the building with case-carrying personnel does not have basic personnel amenities (e.g., a break room, cafeteria). Several DHS personnel said that access to resources and opportunities (e.g. DHS vehicles, clerical support, opportunities for training, etc) is often challenging.

DHS training

“Getting those new social workers—it’s a good feeling to see them kind of emerge, you know. They come in not knowing the system, and to walk them through the entire 12 weeks and to see them at the end in units—doing well, I like that. I like that feeling. It’s nice.”

DHS personnel said the On the Job Training (OJT) program works well. They commented that more “hands-on” or “real world” training would be an added improvement. Respondents said OJT gives DHS workers training on forms and case files but they then must rely on instruction from supervisors once they’re on the floor.

DHS personnel said they appreciate the continuing education program for employees with 3+ years experience to pursue master’s degrees full-time and would like to see it expanded.

Provider agency personnel noted the need for “specialized” training, especially for both DHS and provider agency personnel who do not have social work backgrounds. They also noted that, currently training is not done jointly with DHS and provider agency personnel, resulting in different understandings and interpretations of standards, policies and procedures.

Provider agencies

Overall, most provider agency personnel said they feel that their own agency is doing a good job providing the best services they can despite limitations in the system. Many of the agencies cite going above and beyond what is required of them by DHS with regard to training, understanding policies, monitoring, supervision, supports to families, etc. Provider agency respondents indicated that several agencies are COA accredited or in the process of becoming accredited.

Respondents noted that one of the most difficult aspects of their job is negotiating the contract, policies and procedures with DHS and working with DHS personnel.

Recommendations by respondents

- *Sponsor internal personnel focus groups and retreats with line personnel and upper management, including the commissioner, to foster teamwork and relationship building;*
- *Create forums for DHS and provider agency administrators and personnel to meet quarterly to address issues, concerns, get clarification, and build trust and sense of team;*
- *Emulate the private sector by rewarding positive reviews with meaningful incentives.*
- *Provide joint trainings for both DHS and provider agency personnel;*
- *Establish a regular training cycle;*

- *Provide more training on the “current” clinical issues (e.g., youth of crack-addicted parents who’ve been exposed to drugs, violence, pornography);*
- *Provide personnel rotations for cross-training; and*
- *Evaluate the length of mandatory training sessions, to ensure there is adequate content for the time allocated.*

Contract/Provider monitoring

DHS and provider agency personnel cited concerns that DHS monitoring of provider agency contracts is “paperwork or file audit” only and that compliance emphasizes quantity (i.e., number of visits or timeliness with reports) versus child and family outcomes or quality of service provision. Respondents reported that this compromises the services received by children and families

With regard to auditing of contract compliance, provider agency personnel commented that the process seems inconsistent and subjective and that results are largely impacted by who is the DHS analyst. Provider agency personnel reported experiences with DHS personnel who audited based on old versions of standards and policies, or who relied on personal preferences as to how a report or case note should be completed.

A number of DHS personnel reported feeling that the Contract Administration and Evaluation (CAPE) mechanism is not effective as a place to address concerns with provider agencies. Some reported that they often do not have time to send their concerns to CAPE due to workload issues and that, when concerns are sent, CAPE is unresponsive and of little help in getting issues addressed.

Performance-based contracting

Many DHS and provider agency personnel reported that the performance-based contracting system is punitive, difficult, and, in some cases, creates a barrier to best practice. Provider agency personnel indicated that the contracting system creates an adversarial relationship with DHS personnel and competition between provider agencies. A number of provider agency respondents reported performance-based contracting as one of the biggest hindrances to being able to provide the best services possible. Some of those respondents indicated that this has to do not only with the issue of low reimbursement rates, which impact the ability to attract and maintain quality staff, but also with the impact of performance-based contracting on placements and permanency.

Provider agency personnel explained that, in the current contract process, if they turn down a placement or referral, if an adoption or reunification disrupts, or if the children of a family receiving SCOH need to be placed in care, they are given negative marks or “rejections” on the agency’s contract. Respondents indicated that the number of rejections an agency gets not only impacts their current budget, but also limits the number of referrals they can get the following year. Both DHS and provider agency personnel reported that, because of this and financial incentives, performance-based contracting may impact negatively safety, permanence, and well-being. Some examples given include children or families possibly having been pushed towards a

specific permanency option (i.e., reunification, adoption, etc) before they were ready, after-care money being saved by providers instead of being spent on children or families, or a continuation of SCOH to give a family additional chances rather moving a child to placement in care.

Case assignment

DHS and provider agency personnel both noted that the CRU process, while good in concept, has problems that may negatively impact services to children and families. Respondents indicated that the overall process is seen as being contract centered versus child or family centered. DHS staff noted that, although CRU is intended to relieve them of some placement responsibilities, which they said it does in some ways, the overall process to make and follow-up on referrals internally is often time consuming and overly complex. Specific issues that were mentioned are listed below.

- The short timeline for an agency to accept or deny a placement (or referral);
- Having to make a decision despite the lack of adequate information at the time of referral or placement. Some provider agency personnel noted that the result of rushed placements and a lack of case history information and good initial assessments sometimes means that they have to place a child with a family that may not be prepared to meet the child's needs;
- The fact that placements are made, in general, to the next provider on the list rather than to the most appropriate provider; and
- Potential consequences to provider agencies for not accepting a case or placement assignment which may lead providers to accept cases they are not truly prepared to serve.

CONCLUSION

As stated in the beginning of this report, the authors have tried to summarize objectively the comments of DHS and provider agency personnel. It is not the mandate or the intention of this report to draw conclusions or make recommendations.

Exhibit I.1 Online Surveys

The tables below summarize questions and responses separately for the DHS and the contract agency online surveys. Initial tables in each section (two for the DHS survey, three for the contract agency survey) present information about the types of respondents who completed each survey. The main table in each section presents categorical survey questions and aggregated responses to them. Open-ended questions and themes identified in responses to them follow the main table in each section.

Open-ended item response summaries consist of phrases which capture frequently-occurring themes in the responses to each item, and may not correspond in a verbatim sense to all responses in a given category. Response themes are not necessarily mutually exclusive and may overlap in some cases.

DHS Survey: Who Responded

Survey Question	Job Title						Mean		Range	
	Hotline Worker	CPS Investigator	Family Service Region Social Worker	Social Work Supervisor	Family Preservation Social Worker	Other / Not Sure	Years	Months	MIN Years	MAX Years
What is your DHS job title? (n=121)	1.70%	9.90%	33.10%	34.70%	5.00%	15.70%				
How long have you held <u>this position</u> with DHS? (n=122)							4	7	0	23
How long have you worked at DHS (including all positions held)? (n=122)							9	2	0	30

DHS Survey: Categorical Items

Survey Question	Strongly Agree	Agree	Disagree	Strongly Disagree
I have received enough training for my current job. (n=121)	14.0%	61.2%	20.7%	4.1%
My supervisor gives me the guidance I need to do my job. (n=120)	27.5%	50.0%	17.5%	5.0%
I can count on my supervisor for help with tough decisions. (n=121)	33.9%	43.8%	15.7%	6.6%
I can count on upper management for help and support in my job. (n=121)	11.6%	53.7%	28.9%	5.8%
I can get support from my peers when I make critical decisions in my job. (n=122)	37.7%	56.6%	4.9%	0.8%
My job keeps me busy but it isn't overwhelming. (n=120)	5.8%	34.2%	36.7%	23.3%
I can get resources and services for children and families when they need them. (n=118)	4.2%	43.8%	35.6%	11.9%
I get the information I need to make good case decisions. (n=120)	10.8%	76.7%	8.3%	4.2%
I feel good about my job overall. (n=119)	20.2%	63.9%	11.8%	4.2%
I believe my work helps to keep children safe and support their families. (n=120)	38.3%	51.7%	5.8%	4.2%
I can help DHS make changes to keep more children safe and serve families better. (n=119)	31.9%	55.5%	11.8%	0.8%
I use consistent measures to decide if children are safe at home. (n=113)	29.2%	64.6%	6.2%	0.0%
I can describe how to find the right foster home or group home for a child who needs one. (n=114)	14.9%	50.0%	30.7%	4.4%
I can tell if a child or family is getting good services. (n=114)	19.3%	60.5%	16.7%	3.5%
I can help children build strong connections with adults who care about them (n=114)	14.9%	59.6%	21.9%	3.5%
DHS works well with other systems such as schools and mental health. (n=114)	3.5%	41.2%	47.4%	7.9%
DHS's screening and investigation of reports of child abuse and neglect keep children safe. (n=113)	11.5%	69.9%	15.0%	3.5%
DHS's monitoring of services to children and families keeps children safe. (n=113)	7.1%	65.5%	26.5%	0.9%

DHS Open-Ended Survey Questions (*Response Themes in Order of Frequency*)

Survey Question	Responses
Please describe three achievements that you are most proud of in your work.	<p>A) Positive client outcomes B) Helping children achieve permanency C) Gaining personal skills, recognition, or advancement D) Mentoring or contributing to the development of junior staff E) Connecting clients to community resources F) Contributing to organizational quality improvements</p> <p><i>Some respondents also reported feeling pride in teamwork with colleagues, or in their personal values or commitment to their work.</i></p>
Please describe three things that help you do your job most effectively.	<p>A) Support & guidance of supervisors or management B) Support of co-workers or supervisor staff C) Personal attributes including skill, competency, and attitudes and beliefs C) Technical or other resources D) Education and training E) Organizational culture (expectations of professionalism, quality work, collaboration or support between colleagues, etc.) F) Services and collaboration of other agencies</p> <p><i>Some respondents appeared either to have misread this question or to have decided to bypass listing "things that help" in favor of "things that should change".</i></p>
Please describe three changes that would help you do your job more effectively.	<p>A) Changes to policy or organizational structure B) Improved technical or other resources C) Lower caseloads, improvements in supervision / leadership D) More support staff E) Other changes to staffing levels or patterns F) Better internal or external communication G) Less paperwork</p> <p><i>Several respondents also pointed to a need for more efficient case transfers, and a number also pointed to the need for better relations with news media or the community at large.</i></p>
Please name three things that would help DHS better protect children and serve families.	<p>A) Improvements to practice or staffing B) Lower caseloads, better community resources C) Better placements & services D) Better relationships with provider agencies E) Policy or program improvements (internal or external) F) More DHS staff G) More education and better training for staff</p> <p><i>Several survey respondents pointed to a need for improvements in family court judges and court procedures. Several respondents pointed to a need for better collaboration with external entities including police, schools, etc. A number of respondents also pointed to improved public relations as being important to DHS's success.</i></p>

Contract Agency Survey: Who Responded

Survey Question	Agency									
Which of the following best describes the agency where you work? (n=273)	Foster Care General Non Performance-Based Contract	Kinship Care General Non Performance-Based Contract	Foster Care Performance-Based Contract	Kinship Care Performance-Based Contract	Adoption	Medical Foster Care	Treatment Foster Care	Mother/Baby Foster Care	Rapid Service Response	SCOH
	4.40%	2.60%	23.40%	3.70%	2.60%	4.40%	6.20%	0.00%	1.50%	10.30%
	Agency									
	Institutional Care	Residential	Residential Treatment	Day Treatment	Supervised Independent Living	Other / Not Sure	Group Home Care	Mother/Baby Group Home Care	Emergency Shelter	Family Preservation
	0.40%	2.90%	11.70%	0.70%	0.40%	12.10%	1.50%	0.40%	6.60%	4.40%
Which of the following best describes your current position? (n=277)	Current Position						Mean		Range	
	Program Component Director	Social Service Supervisor	Social Services Staff	Direct Child Care Staff	Case Aide	Other/ Not Sure	Years	Months	MIN Years	MAX Years
	22.40%	25.60%	37.90%	4.70%	1.40%	7.90%				
How long have you held this job at your agency? (n=279)							4	11	0	35
How long have you worked at your agency (including all jobs you have held)? (n=279)							7	10	1	37

Contract Agency Survey: Categorical Items

Survey Question	Strongly Agree	Agree	Disagree	Strongly Disagree
DHS staff and I work well together. (n=277)	9.0%	61.7%	27.1%	2.2%
DHS staff share with my agency what we need to know about children and families they refer to us. (n=278)	5.0%	47.8%	37.8%	9.4%
DHS staff make required visits with children receiving services from my agency. (n=269)	3.7%	34.9%	48.3%	13.0%
DHS staff make required visits with families of children receiving services from my agency. (n=269)	3.7%	31.6%	53.2%	11.5%
I am able to access behavioral health services for children when they need them. (n=277)	7.6%	61.7%	24.9%	5.8%
I am able to access physical health services for children when they need them. (n=272)	11.0%	65.1%	20.2%	3.7%
My agency and DHS work together on Family and Individual Service plans. (n=272)	4.4%	46.0%	43.4%	6.3%
I have received the necessary training to do my current job. (n=275)	44.4%	50.9%	4.0%	0.7%
My supervisor gives me the guidance I need to do my job. (n=275)	48.0%	45.1%	5.1%	1.8%
I know when I must communicate with DHS about a child receiving services from my agency. (n=278)	46.8%	49.3%	3.6%	0.4%
DHS staff respond to requests for assistance/ notification of concerns. (n=276)	4.0%	41.3%	43.1%	11.6%
I believe my work helps to keep children safe and support their families. (n=278)	47.8%	51.1%	1.1%	0.0%
DHS staff and staff of my agency understand each others job responsibilities. (n=276)	7.6%	44.9%	37.0%	10.5%

Contract Agency Open-Ended Survey Questions (*Response Themes in Order of Frequency*)

Survey Question	Responses
<p>Please describe three achievements that you are most proud of in your work.</p>	<p>A) Positive client outcomes B) Helping children achieve permanency C) Connecting clients to community resources D) Gaining personal skills, recognition, or advancement E) Mentoring or contributing to the development of junior staff F) Contributing to organizational quality improvements</p> <p><i>Respondents also reported taking pride in providing quality services, and in meeting or exceeding program guidelines.</i></p>
<p>Please describe three things that help you do your job most effectively.</p>	<p>A) Support & guidance of supervisors or management B) Organizational culture (expectations of professionalism, quality work, collaboration or support between colleagues, etc.) C) Collaboration with other agencies including DHS D) Technical or other resources E) Education and training F) Personal attributes including skill, competency, and attitudes/beliefs G) Support of co-workers or supervised staff H) Knowledge and experience</p> <p><i>Some respondents appeared either to have misread this question or to have decided to bypass listing "things that help" in favor of "things that should change".</i></p>
<p>Please describe three changes that would help you do your job more effectively.</p>	<p>A) Better communication, collaboration, & information sharing from DHS B) More involved / responsive DHS social workers C) More or better training (not just for self, often specifically for DHS workers) D) Improved program funding and salaries E) Better client services or access to services F) Less paperwork, clarification of roles / policies G) Better technology for information management and communication</p> <p><i>Respondents also pointed to a need to improve the PBC process, and to a need for improved relationships with the media and the community at large.</i></p>
<p>Please name three things that would help your agency work with DHS more effectively.</p>	<p>A) Better communication, collaboration, & information sharing from DHS B) More involved / responsive DHS social workers C) Better clarification of roles / policies D) More or better training (not just for self, often specifically for DHS workers)</p> <p><i>Respondents also mentioned a need to streamline the process for achieving permanency, and for improvements in family court judges and court procedures.</i></p>

Exhibit I.2 Interview Respondents

DHS Interviews: Who responded

Survey Question	Job Title				Years			
What is your DHS job title? (n=31) <i>Note: Many interview respondents identified themselves as Social Worker I or Social Worker II without further detail. These are counted as "other."</i>	CPS Investigator 3.20%	Family Service Region Social Worker 3.20%	Social Work Supervisor 48.40%	Other / Not Sure 45.20%	0-2 Yrs	2-5 Yrs	5-10 Yrs	Over 10 Yrs
How long have you held <u>this position</u> with DHS? (n=31)					16.10%	22.60%	35.50%	25.80%
How long have you worked at DHS (including all positions held)? (n=30)					0.00%	16.70%	20.00%	63.30%

Contract Agency Interviews: Who Responded

Survey Question	Agency									
Which of the following best describes the agency where you work? (n=27) <i>Note: Many interview respondents reported multiple types of work at their agencies, and/or described work categorized as "other."</i>	Kinship Care General Non-Performance-Based Contract 3.70%	Foster Care Performance-Based Contract 3.70%	Kinship Care Performance-Based Contract 3.70%	Adoption 14.80%	Medical Foster Care 3.70%	Treatment Foster Care 7.40%	SCOH 37.00%	Family Preservation 3.70%		
	Group Home Care 3.70%	Mother/Baby Group Home Care 3.70%	Emergency Shelter 3.70%	Residential 3.70%	Residential Treatment 3.70%	Other / Not Sure 55.60%				
Which of the following best describes your current position? (n=27)	Current Position						Years			
	Director or Other Administrator 40.70%	Social Service Supervisor 33.30%	Social Services Staff 7.40%	Direct Child Care Staff 3.70%	Case Aide 3.70%	Other/Not Sure 11.10%	0-2 Yrs	2-5 Yrs	5-10 Yrs	Over 10 Yrs
							30.80%	38.50%	15.40%	15.40%
How long have you held this job at your agency? (n=26)							16.00%	28.00%	16.00%	40.00%

Exhibit I.3 Focus Group Participation

DHS Focus Groups: Who Participated

Survey Question	Job Title				Years			
What is your DHS job title? (n=22)	CPS Investigator 0%	Social Worker 64%	Social Work Supervisor 36%	Other / Not Sure 0%	0-2 Yrs	2-5 Yrs	5-10 Yrs	Over 10 Yrs
How long have you worked at DHS (including all positions held)? (n=22)					18%	5%	45%	32%

Contract Agency Focus Groups: Who Participated

Survey Question	Current Position				Years			
Which of the following best describes your current position? (n=30)	Director or Other Administrator 3%	Social Service Supervisor 50%	Case Worker 47%	Other 0%	0-2 Yrs	2-5 Yrs	5-10 Yrs	Over 10 Yrs
How long have you worked at your agency (including all jobs you have held)? (n=30)					10%	27%	40%	23%

APPENDIX J. THE CONTEXT OF CHILD WELFARE IN PHILADELPHIA

The Philadelphia Department of Human Services (DHS) is the agency within the City of Philadelphia that administers child well-being programs designed to promote the safety, permanency and well-being of children within the City. This appendix provides a basic overview of DHS and its mission, organization of services, staff, and budget.

DHS MISSION AND GOALS

DHS articulates its overarching mission in three parts: prevention, protection, and permanency; accessibility; and, integration and accountability.

Prevention, protection, and permanency

Philadelphia's Department of Human Services works to protect children from abuse, neglect, and delinquency; to ensure their safety and permanency in nurturing home environments; and to strengthen and preserve families by enhancing community-based prevention services.

Accessibility

In partnership with community organizations, DHS provides services to strengthen the overall well being of Philadelphia children, youth, and families using a customer focused approach that is responsive to evolving community needs.

Integration and Accountability

DHS develops and implements policies and programs to continuously improve, measure, and achieve positive outcomes for children; manage public resources efficiently; communicate with customers and the general public; and integrate systems in order to effectively deliver services to children and families.¹

DHS articulates its primary goals as follows:

- Harness organizational energies to produce sound outcomes for children;
- Prevent abuse, neglect, and delinquency;
- Ensure safe, stable, and quality out-of-home care for children and youth who cannot be cared for in their own homes;
- Assure timely achievement of permanency for children and youth in placement; and
- Create an enhanced and integrated service delivery system that is responsive to the needs of children, families, and communities.²

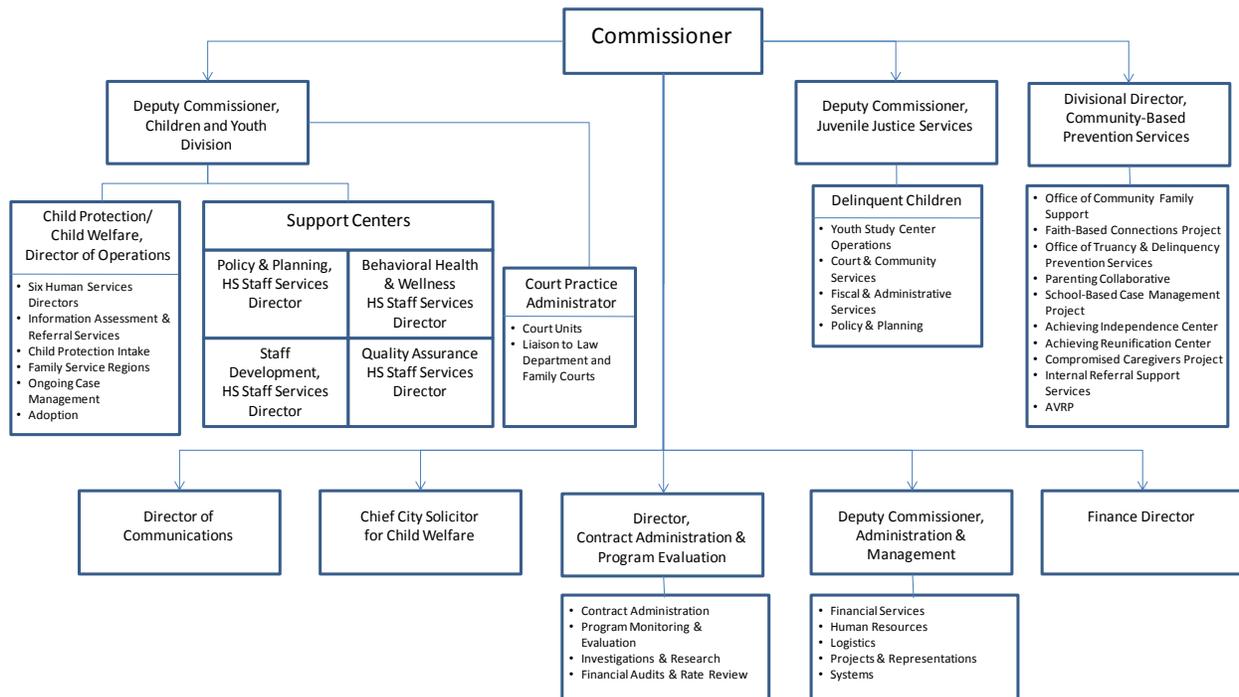
¹ DHS website, at www.phila.gov/dhs

² Ibid.

ORGANIZATION OF SERVICES

DHS has three primary divisions that administer programs and services for the children and families within Philadelphia. The Children and Youth Division (CYD) is vested with the authority to ensure the safety, protection and well-being of Philadelphia's children. The Division of Community Based Prevention Services (DCBPS) focuses on families deemed at-risk for potential child neglect and abuse behaviors, and manages programs designed to eliminate causes of potential neglect or abuse. The Division of Juvenile Justice Services (DJJS) administers programs for children that are adjudicated delinquent by the Court. The high level organization of DHS is seen in exhibit J.1.

Exhibit J.1 DHS Organizational Structure



Further information on these three primary divisions is presented in the following sections.

CYD

The focus of the Panel's research, data collection, and recommendations relate to CYD. CYD provides services to children and families that focus on ensuring child safety and permanency, and promoting overall child well-being. CYD has the responsibility for investigating child abuse and neglect reports, determining the level of risk in each situation, and determining the appropriate services plan for each child that is the subject of an investigation. In FY 2007, CYD estimates that it will investigate more than 15,500 reports of child neglect and abuse.³

³ Philadelphia Department of Human Services, *Target Budget, Fiscal Years 2007*.

CYD manages many of DHS' largest child welfare programs that provide services to the children and families that come into contact with DHS. These include programs that place children into substitute care settings to ensure their protection, such as family and kinship foster care, as well as in-home services designed to preserve the family unit and prevent the placement of children in care. These programs include Family Preservation and Services to Children in their Own Homes (SCOH), which provide services to a family that will help stabilize the family's functioning in order to prevent future neglectful and/or abusive behaviors.

While the preservation of the family unit is the primary goal when working with families, CYD also manages several programs for children for whom reunification is not specified as a goal. CYD manages all activities around child adoptions, and also administers the Independent Living Program, targeted at youth who will "age out" of the child welfare system rather than returning home.

Currently, CYD is the largest division within DHS, with Fiscal Year (FY) 2008 estimated obligations of \$376.7M, representing approximately 53.9 percent of DHS' total expected obligations for FY 2008. Total staff within CYD is expected to be approximately 1,083 employees in FY 2008.

DCBPS

DCBPS manages many preventive programs targeted at identifying and eliminating risk factors for child neglect and abuse prior to the need for more intensive services, such as removal of a child to a substitute care setting. DCBPS recognizes that factors such as poverty, unemployment and a lack of access to necessary services are contributing factors to child abuse and neglect and, therefore, targets services and programs that are designed to eliminate these factors from the family environment.⁴ DCBPS also manages several after discharge programs that focus on preventing re-entry into the DHS child welfare system.

For FY 2008, estimated obligations for DCBPS programs and services are estimated at \$178.8M, representing approximately 25.6 percent of DHS' total expected obligations. The estimated DCBPS staff for FY 2008 is 112 employees. The small number of staff reflects the fact that the vast majority of programs and services offered through DCBPS are contracted out to private providers.

DJJS

DJJS is responsible for managing programs and coordinating services for youth that are adjudicated delinquent by the Court. DJJS offers a variety of services through both secure and non-secure residential detention facilities, as well as in-home treatment programs for delinquent youth who have committed less serious offenses.

DJJS offers several types of programs and services, primarily targeted at youths adjudicated delinquent by the Court. DJJS manages the Youth Study Center, a residential facility that provides the highest level of secure detention for youth adjudicated delinquent, and houses children between the ages of 13 and 18 years. For alleged delinquent youth, DJJS contracts with a network of providers for non-secure detention services for youth who would otherwise be

⁴ Philadelphia Department of Human services website, prevention page.

placed at the Youth Study Center. DJJS also coordinates a variety of in-home and day treatment programs for youth, to avoid placing them in a residential detention facility.

In FY 2008, DHS estimates that obligations for DJJS programs and services will equal approximately \$125.6M, or about 18 percent of the total DHS budget. Total staff assigned to DJJS programs is estimated at approximately 356 employees for FY 2008.

Additional DHS divisions

Two additional divisions within DHS that impact the program and services offered throughout DHS are the Contract Administration and Program Evaluation (CAPE) and the Division of Administration and Management (DAM).

CAPE is the division within DHS with responsibility for managing contracts with external private providers, monitoring their compliance with contract terms and conditions, and evaluating the extent to which contracted provider agencies meet the specified performance standards contained within their contracts. CAPE has units with specific responsibility for:

- *Contract administration*, which has the responsibility for managing the various contracts that DHS maintains with its providers. Contract administration staff prepare and submit contract documents, and serve as the liaison between DHS and provider agencies in the identification, analysis and resolution of contractual issues;
- *Contract audit*, which conducts financial audits, assists with establishment of contract reimbursement rates, and provides technical assistance to providers for budget and audit preparation. This office also participates in reviews of contracted agencies to determine compliance with contract provisions and regulations; and
- *Program monitoring and evaluation*, which performs annual evaluations of contracted agencies to measure their performance and evaluate their compliance with contract terms. This office also conducts field investigations when necessary, and provides technical assistance as appropriate and requested.

For FY 2008, CAPE has an estimated budget of \$3.1M and a staff of approximately 51 analysts and managers.

DAM supports the ongoing management of the three programmatic (operating) divisions of DHS, discussed previously. DAM provides services to support budgeting and financial management, human resources, information technology, logistics, and administrative services. For FY 2008, DAM has an estimated budget of \$14.2M and a staff of approximately 217 employees.

BUDGET AND RESOURCES

Exhibit J.2 presents the annual operating budget for the major divisions within DHS, for fiscal years 2006 through 2008 (estimated).

Exhibit J.2 Annual Operating Budget, Department of Human Services

	FY2006	FY2007	FY2008
Admin and Management	\$ 13,736,553	\$ 13,469,475	\$ 14,225,138
CAPE	\$ 2,518,576	\$ 2,820,210	\$ 3,129,924
Juvenile Justice	\$ 117,511,836	\$ 116,461,569	\$ 125,627,143
Children and Youth	\$ 339,004,292	\$ 343,661,853	\$ 376,744,981
Community Based Prevention	\$ 99,924,288	\$ 131,338,657	\$ 178,827,529
Total	\$ 572,695,545	\$ 607,751,764	\$ 698,554,715

Source: City of Philadelphia, Fiscal 2008 Operating Budget Submission for the Department of Human Services.

* FY 2006 numbers are actual obligations; FY 2007 numbers are estimated obligations; FY 2008 numbers are obligation level.

As seen in exhibit J.2, the overall operating budget for DHS is expected to increase significantly between FY 2006 and FY 2008. The increase from FY 2006 to FY 2007 is approximately 6 percent, while the increase from FY 2007 to FY 2008 is more significant, at an estimated 15 percent. The most notable increase is within DCPBS, which is increasing more than 30 percent per year during this time frame. CAPE is also increasing more rapidly than the other divisions, with an annual increase in operating budget of more than 10 percent each. As CAPE is the unit with responsibility for monitoring contracted providers, it stands to reason that its budget will increase as the overall expenditures for purchased services increases. However, since the overall budget for the division is small, it has little impact on the overall DHS budget.

Exhibit J.3 presents the percentage of total DHS obligations that were, are being, and will be purchased from external providers in fiscal years 2006, 2007, and 2008.

Exhibit J.3 Purchased Services

	FY2006		FY2007		FY2008	
	Expenditures	Percent	Expenditures	Percent	Expenditures	Percent
Admin and Management	\$ 3,748,159	27.3%	\$ 3,849,167	28.6%	\$ 3,926,660	27.6%
CAPE	\$ 43,995	1.7%	\$ 41,616	1.5%	\$ 42,448	1.4%
Juvenile Justice	\$ 99,798,482	84.9%	\$ 97,816,477	84.0%	\$ 106,266,240	84.6%
Children and Youth	\$ 279,086,640	82.3%	\$ 281,107,041	81.8%	\$ 311,552,526	82.7%
Community Based Prevention	\$ 95,809,952	95.9%	\$ 126,483,896	96.3%	\$ 173,014,248	96.7%
Total	\$ 478,487,228	83.6%	\$ 509,298,197	83.8%	\$ 594,802,122	85.1%

Source: City of Philadelphia, Fiscal 2008 Operating Budget Submission for the Department of Human Services.

* FY 2006 numbers are actual obligations; FY 2007 numbers are estimated obligations; FY 2008 numbers are obligation level.

Exhibit J.4 presents the total expected staff in each of DHS' main divisions, for fiscal years 2004 through 2008.

Exhibit J.4 Staff Levels within DHS, FY2004-2007

	FY 2006	FY 2007	FY 2008
Admin and Management	197	209	217
CAPE	42	46	51
Juvenile Justice	343	355	356
Children and Youth	1,050	1,056	1,083
Community Based Prevention	71	94	112
Total	1,703	1,760	1,819

BUILDING BLOCKS FOR CHANGE

The focus of this report is on recommendations for improvement within DHS. However, during the Panel’s research and data collection activities, numerous strengths were identified which offer a solid foundation for implementing change. Some of the building blocks for change that have been identified include the following.

- *Permanency*—CYD is dedicated to the notion of ensuring permanency and has experienced notable increases in the number of children residing in permanent settings. Some of this increase is attributable to the introduction of performance-based contracting in recent years, and the Panel has targeted its recommendations toward similar efforts that increase permanency in the population served by CYD.
- *Investment in prevention*—DHS continues to make significant investments in prevention activities, both through the SCOH program and through services coordinated by the DCBPS.
- *DHS work underway*—DHS has already taken action and is moving forward on a number of initiatives to improve child safety through refinements to DHS programs, policies, and operations.
- *Child Fatality Reviews*—The current Multidisciplinary Team (MDT) that conducts the child fatality reviews does admirable work, leverages interdisciplinary resources to investigate child fatalities and offers prescriptive recommendations for change. This example proves that DHS is capable of conducting solid internal reviews.
- *Viable and committed private sector*—Philadelphia has a strong network of private agencies that provide the majority of preventive, placement and treatment services to children and families. Many of the notable successes that CYD has achieved in recent years have leveraged this significant network of providers, and the Panel believes that the ongoing expansion of DHS’ partnership with the private sector is a critical building block for success moving forward.
- *Staff resources*—Coupled with the private provider network, DHS has a large pool of social workers and support staff that provide direct and indirect services to children in DHS’ care and their families.
- *Achieving Independence Center (AIC); Achieving Reunification Center (ARC)* – Achieving permanency is a core outcome of the child welfare system, and both the AIC and the ARC have interdisciplinary models for reaching permanency, either through independence or through family reunification, that can be examined as models for the work DHS is about to undertake.

- *Courts* – Philadelphia is fortunate to have a family court system that is interested in improving outcomes for children, and has a bench that is dedicated to working proactively with DHS to identify and implement necessary changes.
- *Community concern* – There is strong support within the greater Philadelphia community to take positive steps to improve the child welfare system and, thereby, increase the overall well-being of the City’s children. We believe that public concern is a significant resource to leverage as the CYD reform process moves forward, particularly in providing insight, ideas, and recommendations for the ongoing implementation of the recommendations included in this report.
- *Commitment to Working with Law Enforcement* – DHS has been working for many years to partner and co-locate with the Special Victims Unit and the DA in order to improve responsiveness to cases of child sexual abuse. This is a first step and represents a building block for change; it demonstrates how DHS can collaborate with other City entities to create new models for serving vulnerable populations.
- *Available data* – DHS collects a significant amount of data on the children and families it serves, and the outcomes of those services. DHS also has invested significantly in its reporting infrastructure and now has the tools and staff to conduct detailed analyses of its data to inform future program changes and additions. As DHS begins to implement the recommendations outlined in this report, the ongoing use of these data will help the DHS to understand the progress and effectiveness of its reform.
- *Supportive technology* – In response to prior calls for enhanced information systems, DHS also has invested in technology and case management systems to support its workers and enable them to coordinate and deliver services more effectively. The Family and Child Tracking System (FACTS) and the systems supporting the Central Referral Unit are examples of this investment. A significant revision to the technological basis and functionality of FACTS is underway and will result in a web-enabled FACTS². It will be important to maintain this commitment as future reform efforts are undertaken.

APPENDIX K. PARTICIPANTS IN THE CHILD WELFARE REVIEW

A large number of individuals participated in the review of the Philadelphia child welfare system. Because of promises of confidentiality, the Philadelphia Child Welfare Review Panel (Panel) cannot name everyone; however, it is important to recognize the contributions of these many stakeholders. The remainder of this appendix includes biographical sketches of the nine members of the Panel, the names and affiliations of the 24 members of the Child Welfare Resource Committee, and a summary of the types and numbers of participants in the various venues that were a part of the community consultation process.

PANEL MEMBERS

Biographical summaries of the nine members of the Panel follow.

Carol W. Spigner, D.S.W., Co-Chair

(AKA Williams)

Kenneth L. M. Pray Distinguished Professor
University of Pennsylvania School of Social Work

Carol W. Spigner, D.S.W. joined the University of Pennsylvania's School of Social Work faculty in July, 1999 as a visiting professor and joined the faculty permanently in September, 2000. Prior to her arrival at Penn, Carol had been the Associate Commissioner of the Children's Bureau at the U.S. Department of Health and Human Services' Administration for Children and Families (ACF). As Associate Commissioner, Carol was responsible for the administration of federal child welfare programs.

Carol has received numerous awards including the University of Southern California's award for Lifetime Contributor to the Development of Policies and Programs for Underserved Populations; the National Association of Black Social Workers' Outstanding Contributors Award; and the National Association of Public Child Welfare Administrators' Award for Leadership in Public Child Welfare.

Carol has also served as a senior associate at the Center for the Study of Social Policy, Washington, D.C. and as the Director of the National Child Welfare Leadership Center, University of North Carolina at Chapel Hill. Carol held professorships at the University of North Carolina at Chapel Hill and the University of California, Los Angeles. Carol has published a variety of articles in the areas of cultural competency, permanency planning and relative care. Carol began her career working for the Los Angeles County Departments of Adoption and Probation. A native of Los Angeles, Carol received her undergraduate degree from the University of California at Riverside, and her graduate and postgraduate degrees from the University of Southern California.

Bill Mills, M.A., Co-Chair

J. William Mills, III is president of the Philadelphia and Southern New Jersey region of PNC Bank, a member of The PNC Financial Services Group. PNC is one of the largest diversified financial services companies in the United States, and Bill, a 34-year financial services veteran, oversees PNC's largest region, which includes 170 branches and offices, and nearly 7,000 employees.

Bill joined Provident National Bank, (a PNC predecessor), in 1989, as bank Treasurer and President of the PNC Funding Corp. He later became Senior Vice President and Managing Director of Fixed-Income Investments for PNC Investment Management and Research. Bill was promoted to Executive Vice President in 1993 in charge of Capital Markets and the bank's Asset Liability Committee. He was most recently Executive Vice President in charge of PNC Advisors Wealth Management Division in Philadelphia and Southern New Jersey. Bill started his career as a trader and Vice President at Merrill Lynch Government Securities Inc. in New York City and moved to Industrial Valley Bank as Senior Vice President and Treasurer. In 1986, Bill was named Managing Director of the Capital Markets Division at CoreStates Financial Corporation.

Bill is active in the Philadelphia and Southern New Jersey communities, serving on the executive committee of the Greater Philadelphia Chamber of Commerce Board, The Philadelphia Museum of Art's corporate executive board, The City of Philadelphia's Children's Commission, Temple University Health System Board of Overseers, Temple University President's Advisory Board, the Gesu School, the Pennsylvania Horticultural Society Executive Committee, the Thomas Shelton Harrison Foundation and the Police Athletic League Emeritus.

He holds a master's degree in economics from Niagara University, a bachelor's degree in mathematics from Ohio State University and is a graduate of the University of Illinois School of Bank Investments.

Frank Cervone, J.D.

Frank P. Cervone is Executive Director of the Support Center for Child Advocates, the lawyer pro bono program for abused and neglected children in Philadelphia. Previously, Frank was a Staff Attorney at Delaware County Legal Assistance Association and Adjunct Clinical Professor at Villanova University School of Law, where he instructed law students in domestic abuse and child support litigation, and served as counsel for Saint Gabriel's System, an agency providing treatment services for juvenile offenders.

Frank serves as Vice Chair of the Pennsylvania Children's Trust Fund and a member of the Supreme Court of Pennsylvania's Juvenile Court Procedural Rules Committee. He has recently chaired the Advisory Committee on Child Welfare Services, and served as a member of the Advisory Committee on Adoption Law of the Joint State Government Commission, the research arm of the Pennsylvania General Assembly. He is a member of the board of the Philadelphia Children's Alliance and member of the American Bar Association Section of Litigation's Children's Rights Litigation Committee Working Group. He is a founder and co-director of the National Children's Law Network.

Frank is a graduate of the University of Pennsylvania and Villanova University School of Law, and he has a masters degree in Theology and Ministry from LaSalle University. Frank lectures and trains both lay and professional audiences in child abuse and child advocacy, and he enjoys working with students and teachers of all ages. His publications include works on children's rights and the legal representation of children, collaboration of lawyers and professionals from other disciplines, and spirituality and social justice. In 2006 he received the Philadelphia Bar Foundation Award. He was recognized as a Pennsylvania Superlawyer by *Philadelphia Magazine* in 2004, 05 and 06, and he received the 2004 Signum Fidei Award from La Salle University. Frank was honored by Villanova University School of Law with the 2001 Donald W. Dowd Alumni Association Award for Public Service; by Rutgers-Camden Law School with the 2000 Mary Philbrook Public Interest Award; and by the Philadelphia Bar Association Committee on the Legal Rights of Lesbians and Gay Men with the 2001 Advocate for Justice Award. Frank was the first recipient of the Pennsylvania Bar Association's Child Advocate of the Year Award in April 1998. He received the American Bar Association's Young Lawyers Division's Child Advocacy Law Award in August 1998, and in 1997, he received the St. Thomas More Award, presented by St. Thomas More Society of Philadelphia.

Marc Cherna, M.S.W.

Marc Cherna was appointed the Director of the Allegheny County Department of Human Services in January 1997. As Director, he is responsible for overseeing the ongoing operations of this Department, which brings under one umbrella, with a shared vision and goals, five programmatic offices: Aging; Behavioral Health; Children, Youth and Families; Community Services; and Mental Retardation/Developmental Disabilities. The Department operates with a combined budget of \$850 million, has approximately 1200 employees, contracts with over 400 service provider agencies, and serves approximately 250,000 county residents a year. Marc first came to Allegheny County in February 1996 as a result of a national search for someone to take charge of the county's child protective service agency, and immediately implemented system-wide changes that have resulted in better permanency outcomes for children. These reforms received national recognition and were showcased twice by ABC World News Tonight and by CNN's NewsNight with Aaron Brown. Under Marc's direction, the Allegheny County Department of Human Services' State Forensics Program was the recipient of a 2005 Innovations in American Government award given by the Ash Institute for Democratic Governance and Innovation at Harvard University's Kennedy School of Government.

Marc's innovative practice and leadership abilities have also garnered him prestigious awards by numerous child welfare, humanitarian, and civic organizations such as; the Betsey R. Rosenbaum Award for Excellence in Child Welfare Administration from the National Association of Public Child Welfare Administrators; the Urban League's Ronald H. Brown Civic Leadership Award; the Good Government Award from the League of Women Voters; and Social Work Citizen of the Year from the National Association of Social Workers. He serves on many boards and committees such as the University of Pittsburgh School of Social Work's Board of Visitors, the Executive Committee of the National Association of Public Child Welfare Administrators, and the Child Welfare League of America's National Advisory Committee on Foster Care.

Marc began his career in human services as a youth worker over 30 years ago. He has extensive work experience in the field, including four years as the Director of Planning, Allocations and Agency Relations with the United Way of Union County, New Jersey and 13 years with the New Jersey Department of Human Services as an Assistant Director with the New Jersey Division of Youth and Family Services.

Marc received his B.A. degree from the State University of New York at Binghamton and an M.S.W. from the Hunter College School of Social Work in New York.

Cindy W. Christian, M.D.

Cindy W. Christian, M.D. holds the Children's Hospital of Philadelphia Chair in the Prevention of Child Abuse and Neglect. She is co-director of Safe Place: The Center for Child Protection and Health at the Children's Hospital of Philadelphia, and Associate Professor of Pediatrics at the University of Pennsylvania School of Medicine. Cindy directed the pediatric clerkship for the University of Pennsylvania School of Medicine for more than a decade. Cindy devotes much of her clinical and academic work to the care of abused children.

She directs the hospital's CARE clinic and provides care to children admitted to the hospital with abusive injuries. She is a faculty director of the Field Center for Children's Policy, Practice and Research at the University of Pennsylvania. She is a member of the American Academy of Pediatrics' section on Child Abuse and Neglect, and presently serves on the Academy's Committee on Child Abuse and Neglect. Cindy is a founding member of the Ray E. Helfer Society, and is a member of a number of other local and national organizations devoted to the care of abused and neglected children. Cindy's research and educational efforts are related to the medical evaluation and care of abused children.

David Sanders, Ph.D.

David Sanders has spent his entire 21-year career in the human services field. Prior to joining Casey Family Programs as Executive Vice President of Systems Improvement, David directed all operations for the Los Angeles County Department of Children and Family Services (DCFS), the largest county system in the country, with about 6,000 staff serving approximately 22,000 children in care. During David's tenure, the department saw its foster care population decrease, while improving safety and stability for children involved in the foster care system.

From 1985-2003 David was in Minneapolis, Minnesota, first working as a Senior Clinical Psychologist at the Hennepin County Mental Health Center, then Chief Clinical Psychologist from 1987-1990. From 1993-2001 he served as Senior Department Director at the Hennepin County Children and Family Services Department (DCFS). Before joining DCFS as Director, David held the post of Senior Human Services Director at the Hennepin County Children, Family and Adult Services Department, managing a social service department of 1,450 staff, responsible for all state and federally-mandated social services to children, families and adults.

David graduated with honors from Princeton University with a bachelor's degree in psychology and received his Ph.D. from the University of Minnesota in Clinical Psychology.

David served as Vice President for the National Association of Public Child Welfare Administrators. In 2003, David received the Congressional Angels in Adoption Award, and in 2005 he received the Princeton Club of Southern California's Service to the Community Award. Since 2005, David has been a senior fellow at the University of California's Los Angeles School of Public Affairs.

Linda Spears

Linda Spears has worked in frontline practice and at the senior management levels in child welfare services for 27 years. Linda currently serves as Vice President for Corporate Communications and Development of the Child Welfare League of America (CWLA). She heads up CWLA's publication of best practice materials as well as its work in communications, foundation, corporate and individual development activities. She previously served as Associate Vice President for Programs where she provided leadership for CWLA's work in child welfare programs, research, consultation and training. While at CWLA, Linda has also served as Director of Child Protection and as Senior Child Welfare Consultant working with numerous state and local jurisdictions to assist them with program and practice evaluation, organizational improvement, agency management and accountability. She has facilitated community-wide needs assessment, multi-system case analysis, child fatality reviews, and children's services planning in local and state jurisdictions.

Prior to joining CWLA in 1992, Linda served as the Director of Field Support with the Massachusetts Department of Social Services. As a member of the department's senior leadership team she oversaw agency-wide services in foster care and out-of-home placement, family preservation, child protection, domestic violence, housing, permanency planning and adoption, child care, cultural competence, health care, independent living, and Indian child welfare. During her tenure she was responsible for developing new solution-oriented foster care service models, several of which gained national attention and ultimately helped to drive increased spending in state foster care programs, and resulted in recognition by the National Foster Parent Association and others.

Linda is an enrolled member of the Narragansett Indian Tribe. She is a member of the Board of Directors for The Family Violence Prevention Fund, a national organization concerned with violence in the lives of women and children. She has served as an advisor to the National Council of Juvenile and Family Court Judges' Family Violence program and serves on their Greenbook Policy Advisory Committee. She currently serves as an advisor to the American Bar Association's Project for Judicial Excellence in Child Abuse and Neglect. Linda has published several works on domestic violence and child welfare. She served on New York City's Nicholson Review Committee monitoring compliance with court-ordered improvements for battered women and their children in the child protection system. She was awarded the Pioneer Award for her innovative work in integrating services to women and children who are victims of violence.

Because of her depth of knowledge and breadth of experience, Linda has emerged as a key national spokesperson on today's core child welfare issues. She recently testified before Congress on child protection and family support concerns and has been interviewed numerous times for national and local print and broadcast media.

Carol Tracy, J.D.

Carol Tracy, is the Executive Director of the Women's Law Project (WLP), a public interest law center committed to improving the legal, economic and health status of women and their families through high-impact litigation, policy development, public education, and systems reform.

Carol's recent work has involved several initiatives regarding violence against women, including leading a major reform effort on the police handling of sex crimes in Philadelphia. As a result of this work, Mayor John Street appointed her to co-chair, along with Police Commissioner Sylvester Johnson, a Domestic Violence Task Force to improve the city's law enforcement and health and social services response to domestic violence. She has also been appointed to the City's Office of Behavioral Health Trauma Task Force to create a plan to develop a trauma-informed system of care in Philadelphia.

Carol has been engaged in a variety of efforts to improve the Philadelphia civil and criminal court's response to domestic violence, with a strong emphasis on Family Court. She issued a report, *Justice in the Domestic Relations Division of Philadelphia Family Court: A Report to the Community* (2002) which, among others things, called for a new unified Family Court facility. The WLP also co-authored with the Support Center for Child Advocates, "Deciding Child Custody When There is Domestic Violence: A Benchbook for Pennsylvania Courts."

Carol is also a lecturer at the University of Pennsylvania and the Bryn Mawr College Graduate School of Social Work and Research. She received her B.A. from the University of Pennsylvania and her law degree from the Temple University School of Law.

Fred Wulczyn, Ph.D.

Fred Wulczyn is a Research Fellow at Chapin Hall Center for Children at the University of Chicago. He is the recipient of the National Association of Public Child Welfare Administrators (NAPCWA) Peter Forsythe Award for leadership in public child welfare.

Fred is lead author of *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform* published by Aldine Transaction in 2005.

Fred is director of the Center for State Foster Care and Adoption Data, which provides cutting edge information technology to member states for use in research and management. An expert in the analysis of administrative data, Fred was an architect of Chapin Hall's Multi-State Foster Care Data Archive and constructed the original integrated longitudinal database on children's services in Illinois, now in use for over 25 years. The databases he has developed give state administrators a powerful capacity to analyze key child welfare outcomes, compare outcomes across agencies and jurisdictions, project future service patterns, test the impact of policy and service innovations, and monitor progress.

Earlier in his career, he designed two major social experiments: the Child Assistance Program and the HomeRebuilders Program. The Child Assistance Program was awarded the Innovations in Government award from Harvard University and the Ford Foundation. Also in the realm of public policy, Fred developed the nation's first proposal to change the federal law limiting the ability of states to design innovative child welfare programs, which then led to the development of the Title IV-E waiver programs now used by 25 states to undertake system reform in child welfare programs. He continues to lead the field in developing alternative approaches to financing child welfare programs.

Fred received his Ph.D. from the School of Social Service Administration (Social Welfare Policy) at the University of Chicago in 1986. A graduate of Juniata College, he was awarded the distinguished Alumni Award in 2005 for his contributions on behalf of children and families. He earned his M.S.W. from Marywood University in 1979. The University honored him with its distinguished Alumni Award in 2004.

CHILD WELFARE RESOURCE COMMITTEE

To assist the Panel in its work the Mayor appointed a committee representing the broad spectrum of Philadelphia agencies and organizations that work in, or are affected by, the child welfare system. These individuals, and their affiliated organizations where appropriate, are listed below.

Tera Brown, M.S.
Department of Human Services, Behavioral Health Services

Brandon S. Bruce
Villanova Law School

Reverend Bonnie Camarda
Salvation Army

Kahim Boles
Local 2187, DHS Workers

Margarita Davis-Boyer
Temple University

Pat DeCarlo
Norris Square Civic Association

The Honorable Judge Kevin Dougherty
Philadelphia Family Court

Katherine Gomez
Community Legal Services

Gloria Guard
Peoples Emergency Center

Khudsiya Khan, M.D.
Philadelphia Department of Public Health

Diane Kiddy
Universal Health Services, Inc.

Robert L. Listenbee
Defender Association of Philadelphia

Christopher Mallios
Assistant District Attorney

Linda Mauro
School of Social Administration, Temple University

Jacki McKinney
Mental Health Association of Southeastern Pennsylvania

Pastor Jose Montes
New Jerusalem Church and Project

Robert Schwartz
Juvenile Law Center

Kathy Scott
Local 2187, DHS Workers

Toni Seidl
Psychotherapist in private practice

Anne Shenberger
Philadelphia Safe and Sound

Brenda Taylor
School District of Philadelphia

Rita Urwitz
Local 2186, DHS Supervisors

Shelly Yanoff
Philadelphia Citizens for Children and Youth

Margaret Zukoski
PA Council of Children, Youth and Family Services

COMMUNITY CONSULTATION PARTICIPANTS

The community consultation process involved soliciting the viewpoints of a large and varied number of stakeholders in the Philadelphia child welfare system. These viewpoints were shared in a variety of forums: Town Hall meetings open to the general public; surveys, interviews, and small focus groups of DHS and provider staff conducted by Casey Family Programs staff; and interviews conducted by the Panel as a whole or by individual members. A total of approximately 800 individuals were involved in this process.

Town Hall Meetings

A total of 103 citizens participated in Town Hall meetings held on April 10 and 11, 2007. The participants included birth, foster, and adoptive parents of children in DHS custody; current and former children in DHS custody; relatives of children in DHS custody; parents of families that were receiving SCOH or other services; private agency personnel; DHS staff; media representatives; social work students and faculty; representatives of the faith community; and other interested citizens. Approximately 25 people spoke at each Town Hall meeting, and four additional individuals provided brief comments in writing at a later date.

Casey Family Programs Consultation

Casey Family Programs staff assisted the Panel by collecting information on the perspectives of DHS and provider agency staff using online surveys, individual interviews, and focus groups. The full report on these activities is included in Appendix I.

- *Online survey:* Two separate online surveys were conducted, one made available to DHS personnel and another to provider agency workers, supervisors, and administrators. After data cleaning, 122 DHS surveys and 279 provider agency surveys remained in the respective datasets.
- *Individual interviews:* Sixty-two individual interviews were conducted, including 35 DHS staff and 27 provider agency staff.
- *Focus groups:* Eight focus groups were conducted, with two sessions each being held among DHS social workers, DHS supervisors, provider agency social workers, and provider agency supervisors. A total of 52 individuals participated.

Panel Meeting Interviews

The Panel, in its regularly scheduled monthly meetings, conducted a number of interviews with critical stakeholders in the Philadelphia child welfare system. These stakeholders included 14 current or former DHS administrators, 7 advocates, a judge, 3 union representatives, and 2 representatives of DPW.

Community Consultation Interviews

In addition to the interviews conducted by the Panel as a whole, there were a number of group and individual interviews that were conducted by various members of the Panel and/or the consultants. These interviews included:

- Fifteen Provider agency directors;
- Five members of the DHS Child Fatality Review team;

- Seven parents of children served by DHS, in addition to other parents who participated as members of other groups;
- Ten children and youth who were current or former DHS clients, addressing issues of independence;
- Ten child advocate attorneys;
- Ten parent advocate attorneys;
- Fifteen staff and clients of various programs operated by a large social service agency;
- Twenty members of the Law Enforcement Child Abuse Project;
- Twenty medical and health care professionals who serve children in DHS' care;
- Seven Family Court judges;
- Eight staff from various domestic violence programs;
- Sixteen representatives of women's drug treatment providers;
- Four members of the DHS contracts staff;
- Four members of the DHS information technology staff;
- Two administrators from the DHS fiscal and operations staff;
- Eight DHS administrators interested in reviewing other programs;
- One member of the medical examiner's staff with experience in child abuse fatalities;
- Two members of the DHS policy staff; and
- One member of the Law Department.

While there was some duplication among the various groups, there were also a number of individuals who were not included in the counts above because they preferred not to identify themselves in any way. During the course of the Panel's deliberations it consulted with at least 800 individuals regarding issues surrounding DHS services to children and their families.