

**April 2015- September 2015**

**Child Welfare Quality Assurance Trend Report**

**Child and Family Services Review Preliminary Findings**

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# I. PURPOSE

The Child Welfare Quality Assurance (CWQA) Unit was approved by the Children’s Bureau to conduct Round 3 of the Federal Child and Family Services Review (CFSR) from April 2015 to September 2015 for the State of Georgia. The CFSR Review is conducted to evaluate the quality of child welfare services provided to children and families. This document presents the findings of this CFSR assessment of the state’s performance with regard to seven child and family outcomes and the regions’ systemic factors.

The findings were derived from the following documents and data collection procedures:

* A review of **150** (90 Permanency, 30 Family Preservation, 30 Family Support) social services cases in all regions.
* The input of **274** internal and external stakeholders was incorporated into this report. Case specific interviews and/or surveys were conducted in counties and at the region level with community stakeholders, including but not limited to: children; parents; foster parents; social services supervisors; social services case managers; DFCS administrators; collaborating agency personnel; service providers; court personnel; school and public health personnel; and attorneys.
* Information reflected in state, regional and county level data reports.

Regional data from the CFSR are combined to produce State Trend Reports, and the data are included in the State’s APSR required by the Federal ACF as part of the State’s CFSP. Additionally, CFSR findings are used by local agency leaders and practice partners to improve child welfare practices which will lead to better outcomes for children and families receiving child welfare services in Georgia.

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# II. METHODOLOGY

To conduct the review, the current CFSR On-site Review Instrument and federal Online Monitoring System (OMS) were utilized, and case-specific interviews were conducted on all cases reviewed to evaluate the quality of casework and adherence to policy as related to safety, child and family well-being and permanency planning for children. Secondary oversight of the completed review instrument was completed on the majority of cases by the Children’s Bureau (part of the federal Administration for Children and Families) prior to final approval of the cases.

Additionally, a standardized questionnaire was utilized and interviews conducted by the CWQA Review Team in order to assess the agency’s relationship with stakeholders in the community and its effectiveness in helping children move toward permanency. These surveys were conducted independently from the CFSR stakeholder interviews on the seven systemic factors, which were conducted by the Children’s Bureau.

Cases were randomly selected by zones. A rolling statewide sample was drawn from active cases beginning with the period of April 1, 2014 to September 30, 2014 and moved forward one month for each sample pulled during the review cycle (i.e. the second sample would be pulled from May 1, 2014 to October 31, 2014 and so on).

All program activity (Family Support, CPS Investigations, Family Preservation, and Permanency) in selected case records was reviewed. An overall rating of Strength or Area Needing Improvement (ANI) was assigned to each of the 18 items. In order for the state to be in substantial conformity with a particular item, **90%** of the cases reviewed must be rated as a strength. State performance on the seven outcomes is evaluated as Substantially Achieved, Partially Achieved and Not Achieved. In order for the state to be in substantial conformity with a particular outcome, **95%** of the cases reviewed must be rated as having substantially achieved the outcome.

Although the statewide sample was randomly selected by zones, Regional and District data included in the report are reflective of the reconfigured regions and established Districts which were implemented in July 2015.

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# III. ANALYSIS OF REVIEW FINDINGS

**Demographics of cases**

Figure 1

Of the 150 cases reviewed, there were a total of 258 children (0-18 years) served by the Division. The race and ethnicity of the children served included 115 African American, 111 White, 16 Hispanic, 14 Bi-Racial and two whose ethnicity was unable to be determined. (Figure 1)

Figure 2

Of the 258 children, there were **130 (51%)** females and **128 (49%)** males represented in the statewide sample (Figure 2). From the sample, 90 children were in foster care, while the remaining 168 children were served through in-home services (Family support and Family Preservation).

The primary reason for agency involvement with the 150 cases included neglect, physical abuse, emotional abuse, medical neglect and sexual abuse. In addition, most of the cases were complex and had multiple reasons for agency involvement including, but not limited to: mental health issues by parents and children; substance abuse and/or domestic violence issues; physical health of the parents; behaviors of the children; and Department of Juvenile Justice involvement and abandonment. Of the 150 cases reviewed, approximately **60** cases (**40%**) involved some form of substance abuse issues by parents. Domestic violence was also present in approximately **27** **(18%)** of the case reviewed.

**Review Findings:**

For the second six months of FFY 15 (April 2015 to September 2015), a case review of the seven overall outcomes and 18 items was conducted in all regions within the state. Based on review findings, there continued to be minimal progress in the achievement of items and some overall outcomes have declined since FFY 2014.

Round 3 review criteria specifically focused on the quality of the initial and ongoing case practice with families to improve overall family functioning as it related to safety, permanency and well-being. An emphasis was placed on the initial and ongoing assessment phase, as well as the initial and ongoing service provisions and monitoring.

***The State did not meet the federal definition of Substantial Conformity for any of the overall seven outcomes (a rating of 95%) or for any of the 18 items reviewed (a rating of 90%).*** The highest performance was found for the following items:

* Item 4- Stability of foster care placement, which had a **68%** strength rating; and
* Item 7- Placement with siblings, which had a **77%** strength rating.

The State’s lowest performance was with:

* Item 6- Achieving reunification, guardianship, adoption, or other planned permanent living arrangement rating at **27%**
* Item 9-Preserving connections rating at **39%**
* Item 11- Relationship of child in care with parents rating at **34%**
* Item 12- Needs and services of child, parents and foster parents rating at **25%**
* Item 15- Case worker visits with parents which rated at **31%** and
* Item 18- Mental/Behavioral Health of the Child which rated at **29%.**

Systemically, many regions continued to report staff turnover, newly hired staff learning their current roles, and increases in case load sizes as contributing factors which impacted the ongoing assessment of children’s risk and safety. Many families had multiple case managers during the period under review which often resulted in the cases remaining stagnant and not moving toward safety and risk reduction and/or permanency.

The trends identified during the Round 3 CFSR CWQA Review team as State-wide opportunities for improvement remained as follows:

## Lack of Adequate Risk and Safety Assessment (including service provision, collateral contacts and quality contacts and engagement with parents and children)

Some of the more frequently identified issues identified by reviewers included:

* Insufficient frequency and/or quality of case manager contacts with children and parents.
* Lack of assessment/screenings for and contacts with other household members/caregivers, and insufficient contacts with relevant collaterals.
* Lack of implementation and monitoring of needed interventions and services.
* Lack of case planning with families

Services were often “generic” and not individualized to meet the needs of the family. For example, parents would be referred to parenting classes, without specific details on what areas the parents needed to improve on (i.e., parenting a teenager, learning to meet the needs of a special needs child, learning to address issues of a medically fragile child, etc.). In many instances, the lack of quality contact and engagement of the families served had a negative impact on service provision.

Documentation and case specific interviews did not consistently support that regions adequately addressed or identified all concerns and risk issues, and there appeared to be a lack of recognition of child vulnerabilities and diminished parental capacities. It should also be noted that appropriate directives or recommendations to facilitate progress were often not given during a majority of supervisory case staffings. Too often staffing documentation was a summary of the case activity for the month and did not provide follow up from previous staffings or directives to progress the case toward reducing safety threats and/or achieving permanency.

# Lack of establishing appropriate and timely permanency plans/meeting ASFA timeframes

* ASFA timeframes continued to be an area where improvement is needed in regards to Permanency Outcome 1. There was a failure to ensure that permanency plans were approved by the court in a timely manner, that approved permanency goals were appropriate for the child based on case circumstances, that services were provided in a timely manner, and that Termination of Parental Rights petitions were filed in a timely manner.
* Court continuances, the lack of court orders in case files/SHINES and the delay by the county to request approval of a new permanency goal when the current goal was no longer appropriate affected the timely approval of permanency goals.

# IV. OUTCOMES/ FINDINGS

## SAFETY OUTCOMES

### Safety Outcome 1- Children are first and foremost protected from abuse and neglect

The purpose of this assessment was to determine whether responses to all accepted reports of child maltreatment received during the period under review were initiated, and face to face contact with the child(ren) made within the assigned response time.

Figure 3

**Item 1-Timeliness of initiating investigations/family support assessments of child maltreatment** rated **66%** substantially achieved for the last six months of FFY 2015. (Figure 3)

A total of 88 applicable cases were reviewed (initial report received and assigned for Investigation or Family Support during the period under review) for Safety Outcome1.

Timeliness of initiating investigations occurred when face to face contact was made with all victim children identified in the intake report, and age appropriate children were interviewed within the assigned response time. The item was rated as an Area Needing Improvement when diligent efforts were not made to initiate the assessment and have face to face contact and interviews (or observations of non-verbal children) with all identified maltreated children within the assigned response time.

Issues that contributed to the agency’s failure to substantially achieve this item included the following:

* failure to initiate the investigation or assessment in a timely manner (i.e. not initiating the case until the last day of the response time);
* failure to make concerted efforts to locate the identified victim children (i.e. making contact with the children at school when home visits were unsuccessful);
* assigning the case to an outside provider who failed to initiate the case timely;
* not interviewing all alleged children identified in the intake report (i.e. contacting/interviewing the primary victim but not the siblings who were also alleged to be victims); and
* failure to identify all victim children in the intake.

Staff turnover impacted the agency’s ability to identify if response times were actually missed and/or if there were other contributing factors which resulted in the failure to meet response times. This was primarily due to the assigned case manager no longer being employed by the agency at the time of review and available for an interview by the reviewer, and/or documentation not being entered into the case file prior to case manager’s departure.

Figure 4

As noted in Figure 4, Regions 2, 7 and 10 rated at **100%** substantially achieved with Regions 3 and 6 rating at **20%** and **33%** respectively. In regions that received lower ratings, there was no documentation of concerted efforts made to meet response times. In larger counties who utilized outside agencies to assist in Family Support cases, the outside agency did not seem to understand the importance in meeting a response time and/or did not notify the county office, when they were having difficulty in locating or contacting the family in a timely manner.

Figure 5

When ratings were broken down to the different program areas (Figure 5), Family Support cases reviewed rated **37%** substantially achieved, Family Preservation cases reviewed rated **74%** substantially achieved, and Permanency cases reviewed rated **81%** substantially achieved for Safety Outcome 1. Taking it further, of the reports of child maltreatment where children were not interviewed within the response time, **72%** were assigned as Family Support and **28%** were assigned as Investigations.

### Safety Outcome 2-Children are safely maintained in their homes whenever possible and appropriate

Overall Safety Outcome 2 encompasses two items: Item 2- Services to family to protect children and prevent removal or re-entry into foster care; and Item 3- Risk assessment and safety management. Safety Outcome 2 rated **43%** substantially achieved for the last six months of FFY 2015. (Figure 6)

Figure 6

Permanency cases reviewed rated **53%** substantially achieved, Family Support cases rated **37%** substantially achieved, and Family Preservation cases rated **20%** substantially achieved for Safety Outcome 2.

Figure 7

**Item 2- Services to family to protect children and prevent removal or re-entry into foster care**, was rated as strength when appropriate services were provided to mitigate safety concerns and ensure children could safely remain in their home. There were a total of 46 applicable cases and this item rated at **59%** strength. In **35%** (16 cases) of these cases, children appropriately entered foster care without safety related services having been provided to ensure their safety.

This item was rated as an Area Needing Improvement when the agency failed to provide appropriate services (to address identified safety issues for children and ensure their safety), such as services to address inadequate supervision of children, domestic violence in the presence of children, and parent/caregivers’ untreated substance abuse and/or mental health issues.

Examples of needs reflected in the overall rating of an Area Needing Improvement included the following: failure to identify a safety concern (i.e. a mother’s failing to abide by a safety plan); failure to provide appropriate services to mitigate the safety concerns (i.e. safety concerns regarding parents’ ongoing domestic violence and methamphetamine use in the presence of their child).

Figure 8

As noted in Figure 8, Regions 2, 3, 8, 9, and 10 rated **100%** strength for Item 2. Regions 1, 4, and 12 did not reach **50%**. Region 7 did not have any applicable cases for this item.

Figure 9

Permanency cases rated **77%** strength, Family Support cases rated **25%** strength and Family Preservation cases rated only **18%** strength for Item 2. (Figure 9)

The substantial difference in ratings between Permanency and Child Protective Services (Family Support and Family Preservation) cases for Item 2 can be attributed to Permanency cases rating higher because immediate action was(usually) taken to protect the child (i.e. foster care), whereas in CPS cases the children often remained in the home with noted safety concerns.

**Item 3- Risk assessment and safety management** received an overall **43%** strength rating with all 150 cases reviewed being applicable. The purpose of this assessment was to determine whether, during the period under review, the agency made concerted efforts on a continual basis to asses and address the risk and safety concerns for children in their own homes or while in foster care. It should also be noted that Item 3 now includes recurrence of maltreatment, which in previous CFSR rounds was captured under Safety Outcome 1.

Figure 10

Permanency cases rated higher at **53%** strength for this item than either Family Support, which rated at **37%**, or Family Preservation cases, which rated **20%**. (Figure 10)

There are multiple factors involved in completing thorough assessments (initially and ongoing) to ensure children are in an environment in which there are no threats that pose a danger or, if there are threats, there is a responsible adult in a caregiving role who demonstrates sufficient capacity to protect the child. In the 56 cases where initial assessments were applicable, appropriate assessments to accurately assess all risk and safety concerns were completed in **55%** (31 cases) of the cases. In the 139 applicable cases which needed ongoing assessments, **46%** (64 cases) were completed accurately to ensure all risk and safety concerns had been assessed. However, in the 46 applicable cases where the development and monitoring of a safety plan would have been warranted, only 18 cases (**39%**) were completed appropriately.

Some of the more frequently identified issues negatively impacting this item were:

* insufficient frequency and/or quality of case manager contacts with children and parents;
* lack of assessment/screenings for and contacts with other household members/caregivers;
* insufficient contacts with relevant collaterals;
* failure to fully address present and newly identified concerns;
* insufficient supervisory oversight as indicated by lack of quality staffings and supervisory approval for closure in cases where all concerns had not been fully addressed;
* failure to review and consider CPS history;
* taking the parent’s explanation about the family situation and/or alleged allegations without further corroborating evidence;
* lack of a safety planning when there were identified safety/risk concerns; and
* in cases where there had been multiple case managers during the period under review, there were gaps in documentation, and if the case manager was no longer with the agency, there was no way to identify or recover information to support adequate assessments were being completed throughout the period under review.

Figure 11

As noted in Figure 11, Region 10 rated at **100%** substantially achieved for Item 3. Regions 1, 6, 12, and 13 had the lowest ratings, with ratings falling between **13%-21%** for Item 3. Regions that performed well in Item 3 had thorough, current and ongoing risk/safety assessments on the children and families served. These regions also maintained quality contacts with families and consistently made relevant collateral contacts.

## 

## PERMANENCY OUTCOMES

### Permanency Outcome 1-Children have permanency and stability in their living situations focused on the establishment and achievement of permanency goals for children in foster care, and their stability in their foster care placements. The items comprising Permanency Outcome 1 are: Item 4- Stability of foster care placement; Item 5- Permanency goal for child; and Item 6- Achieving reunification, guardianship, adoption or other planned permanent living arrangement.

Figure 12

### Permanency Outcome 1 was substantially achieved in 14% of the reviewed cases for the CFSR. (Figure 12)

Figure 13

As indicated in Figure 13, Permanency 1 continued to be an overall challenge for most of the regions. Regions 1, 9 and 10 achieved the highest strength ratings at **50%**.

**Item 4- Stability of foster care placements** was rated at **68%** strength in the 90 applicable cases. In looking at the stability of placements, reviewers noted the use of temporary placements (also referred to as receiving homes), an inadequate assessment of the child’s needs, and delays with securing child care funds for placement providers as issues resulting in placement moves.

It continued to be a practice in some urban regions for children to initially be placed in a temporary placement when they first enter care. In reviews it was learned that a lack of support from the agency and a lack of communication with the case managers and/ or case manager turnover were also problems that contributed to children being moved.

Based on review data, in **33%** (13) of 39 applicable cases, placement changes for the child were planned by the agency in an effort to achieve the child’s case goals or to meet the needs of the child. In addition, at the time of the review, the child’s most recent or current placement setting was considered stable in **90%** of the cases reviewed.

Figure 14

A breakdown by regions shows Regions 1, 6 and 9 all at **100%** substantially achieved for Item 4 (Figure 14). Region 6 indicated they conducted training for staff around improving foster parent/ parent relationships and conducting better assessments, both of which may have contributed to keeping the children stable in their placements.

Figure 15

Out of the 90 children in foster care reviewed, 51 had only one placement, but 19 had three or more placements. Out of those 19 cases, five had six or seven placements, one had 10 and one had 12 placements in the one year review period. At the time of review, **10%** of the children assessed were in placements that were not considered stable.

Figure 16

In looking at the number of placements by the age of the child, the number of the youngest children (age 0-5) and the children aged 6-12 that had only placement were the same. Half of the teens, 13 out of the 26 reviewed, had only one placement. Children age 6-12 were just as likely to have two or more placements as the teens, but the teens were more likely to have more than three placements. (Figure 16)

**Item 5- Permanency goal for child** focused on the permanency goal for children in foster care- what the permanency goal is, if the permanency goal is established timely, if the goal is appropriate to the case circumstances, and if the child has been in care 15 out of the last 22 months did the agency file for Termination of Parental Rights (TPR).

Item 5 had a **42%** strength rating for the 86 applicable cases. Of these cases, **77%** had permanency goals established in a timely manner, with **60%** of these permanency goals being appropriate based on the child’s needs and case circumstances (Figure 17). In addition, the agency either filed or joined a TPR petition in a timely manner or documented an exception to filing TPR in **54%** of the 39 applicable cases.

Figure 17

When item 5 was rated as an Area Needing Improvement, it was most often because the TPR was not filed timely when there was no compelling reason not to do so. Other problems noted were that reunification was kept as a case plan goal after it was no longer appropriate; the case plan goals were not established timely; and the identified plan was not deemed to be appropriate to the case circumstances.

Although less frequent, other significant issues identified were:

* The goal was set as guardianship when adoption was the more appropriate plan due to the age of the child. In interviews it was learned this was done because guardianship was quicker and easier than an adoption, and it was done without the appropriate state office waiver for young children.
* Lack of consistency between the court-ordered permanency plan, the permanency plan identified in SHINES, and the permanency plan the staff reported they were working from.

Figure 18

The permanency goal most frequently identified was reunification, then adoption, guardianship, and APPLA (Figure 18). There were four cases not applicable out of the 90 foster care cases because the children were not in care long enough for a plan to have been established. The numbers of permanency plan goals in Figure 18 total more than the number of applicable cases due to some cases having concurrent goals.

Figure 19

Region 6 was the only region that rated well in item 5, achieving **100%** in this area (Figure 19***). It was later discovered that the Region 6 CQI team had focused on permanency achievement in their Quality Improvement Plan, and the review outcomes support that this effort was successful.*** The region’s success helped to pull the state average up, as 10 of the 14 regions rated at **50%** or below.

**Item 6- Achieving reunification, guardianship, adoption or other planned permanent living arrangements**  purpose was to assess whether concerted efforts were made, or are being made, during the period under review to achieve reunification, guardianship, adoption, or APPLA. If concurrent goals are in place, both goals were assessed. To meet ASFA, the following time frames must be achieved-- Reunification by 12 months, Guardianship by 18 months and Adoption by 24 months. If the child had been in foster care for more than the identified time frame for a particular goal, and the goal had not been achieved, item 6 was most likely rated as an Area Needing Improvement. Of the 90 applicable cases, Item 6 was substantially achieved at **27%.**

Item 6 was most often an Area Needing Improvement when the ASFA timeframes were not met, noted in **39%** of the reviewed placement cases. Issues identified were the agency failing to work the identified plan, delays in providing services so the permanency plan was not achieved timely, lack of contacts with parents on reunification cases, and having concurrent permanency plans with only one plan being worked.

Court delays were cited as a problem in some cases, and reviews showed that multiple case managers and supervisors assigned to a case during the period under review hampered goal achievement. There were several cases where adoption was the identified goal, the child was placed with an adoptive resource (often a relative or foster parent), but no work was being done to finalize the adoption. In interviews it was learned that those cases don’t require much attention and there was no safety concerns, and because the child was with the identified permanent resource, there was no sense of urgency to finalize the adoption and close the case.

Figure 20

Concerted efforts to achieve the identified goal were least likely to be made when adoption was the identified goal (**11%** of the 38 reviewed adoption cases). The agency and court made concerted efforts to place a child with a goal of APPLA in a living arrangement considered permanent until discharge from foster care in **50%** of the reviewed applicable cases. (Figure 20)

Figure 21

None of the regions received high ratings for Item 6 (Figure 21). Regions 1, 9 and 10 rated the highest at **50%.**

Figure 22

The length of time the children had been in foster care ranged from one month to 75 months. Thirteen of the reviewed children (**14%**) had been in care 37 months or longer. (Figure 22)

The achievement of the case plan goal was successful, or on target to be achieved timely, in 21 cases of the 85 applicable cases. Achievement of the goal was most likely to be successful when the plan was reunification (14 children), or guardianship (5 children). Two specific cases of children with a plan of adoption rated as a strength, one that was finalized timely, and another that was on target to be achieved timely and was still within the 24 months.

**Permanency Outcome 2- The continuity of family relationships and connections is preserved for children**

**Permanency Outcome 2** was measured by looking at efforts to ensure siblings are placed together (item 7); efforts to ensure adequate visitation between children in care and their parents and siblings who are also in care (item 8); efforts to preserve the child’s connections to his or her neighborhood, community, extended family, Tribe, school and friends (item 9); placement with relatives (item 10); and efforts to promote, support or maintain a positive relationship between the child in care and his or her mother and father (item 11). This Outcome solely focuses on relationships and connections the child(ren) had prior to entering foster care.

Figure 23

Overall the state rated at **33%** substantially achieved for Outcome Permanency Outcome 2. (Figure 23)

**Item Ratings for each Item in Permanency Outcome 2**

Figure 24

The state did not achieve substantial conformity for Outcome Permanency 2, nor in any of the five items comprising this Outcome in the six month reporting period. The ratings were lowest in item 9 (preserving connections) at **39%** and item 11 (relationship of child in care with parents) at **34%.** (Figure 24)

Reasons for the decrease in ratings included the agency’s failure to engage the parents in visiting with their children, not inquiring about the child’s important connections, and not encouraging the parents to participate in any and all of the child/children’s medical or school appointments or other activities outside of visitation.

Figure 25

**Item 7- Placement with siblings** focused on whether concerted efforts were made during the period under review to ensure siblings in foster care were placed together unless a separation was necessary to meet the needs of one sibling. Overall, most regions were performing well in this area, ensuring there was a valid reason for sibling separation or that siblings were placed in the same homes when deemed appropriate.

Identified issues most frequently causing an Area Needing Improvement rating included:

* failure to clearly document the reasons for sibling separation when it was not evident the separation was necessary to meet the needs of a sibling;
* foster homes were not able to take large sibling groups; and
* when children were initially separated for a valid reason, the agency did not re-evaluate the need for continuing separation through the life of the case.

Of the 56 applicable cases, this item had a **77%** strength rating. In **52%** of these cases, the child was placed with all siblings who were also in foster care. In 14 of 27 cases **(52%)** where siblings had been separated, a valid reason existed for the separation.

Figure 26

**Item 8-** **Visiting with parents and siblings in foster care** assessed whether concerted efforts were made during the period under review to ensure visitation between a child in foster care and the mother, father and siblings were sufficient (frequency and quality) to promote continuity in the child’s relationship with family members. Based on federal guidance, the agency should consider the needs of the child to support frequency of the needed visitation between children and parents and/or siblings. For example, a younger or special needs child may require weekly or daily visits to meet their need for frequency of visitation. In addition, special attention should be paid to the quality of visitation (i.e. location, family interaction, etc.).

Figure 27

Lack of substantial conformity in this item was reflected in both the frequency and the quality of the visits with mothers, fathers and siblings. One major contributing factor was the lack of visitation plans with families to ensure that appropriate visitation between parents and siblings occurred regularly.

It was also noted in a few cases when one or both parents were incarcerated, the agency did not make concerted efforts to ensure visits or other type of contact (letters, phone calls, etc.) were occurring, when deemed appropriate. Siblings who were not placed together, and at times placed hours from each other, also negatively impacted their ability to have needed visitations. Again, the agency was not making any concerted efforts to arrange visits or utilize other forms of contact between siblings.

When children were placed in foster homes that were hours away from their parents, this also negatively impacted the child/parent visits. In addition, the agency often was not making concerted efforts to locate fathers, and/or encouraging visitation with their children.

Based on the 69 applicable cases, Item 8 rated as a strength in **45%** of the cases reviewed.

Figure 28

There was only a slight difference in the frequency of visits with mothers, fathers, and siblings. The quality of the visits rated slightly higher for the mothers and fathers, but rated lower for the siblings. It appeared the agency had service providers in place that at times monitored and clearly documented the quality of visits with the parents. However there was a lack of quality documented contacts between siblings, as well as missing sibling visits. (Figure 28)

**Item 9**- **Preserving Connections** determined whether concerted efforts were made during the period under review to maintain the child’s connection to his or her neighborhood, community, faith, extended family, Tribe, school and friends.

During the review period, this item rated as a strength in **39%** of the 87 applicable cases. The factor that negatively impacted this item was the lack of discussion with the child(ren) and/or parents to identify important connections such as school, friends, former caretakers and/or extended family members. In some instances, important connections may have been identified but there were no efforts to maintain or support these connections for the child. (Figure 29)

Figure 29

**Item 10- Relative Placement** considered whether concerted efforts were made to place the child(ren) with relatives (maternal or paternal) when appropriate.

Of the 85 applicable cases, only **46%** had a strength rating. At the time of the review, only **25%** ofthe children in the applicable cases were placed in the home of a relative, with **95%** of these placements being stable.

The agency often did not make concerted efforts to locate, identify or evaluate both maternal and paternal relatives. In some case the relatives were known, but the agency never contacted them or completed a relative assessment. In other cases, the agency did not even inquire about the possibility of relative placements and/or did not follow up on the possibility of relative placements after an initial discussion of this with families.

The agency also failed to consistently talk with children on an ongoing basis to inquire about whom they see as their relatives, and who they would like to be placed with. The search for relatives did not continue throughout the life of the case to ensure all possible maternal and/or paternal relatives had been identified and considered as a placement possibility.

Figure 30

It was noted during the review that there appeared to be more efforts to search for maternal relatives than paternal relatives. The lack of paternal relatives being contacted could also be attributed to the lack of efforts to locate absent fathers. (Figure 30)

Figure 31

**Item 11-Relationship of child in care with parents** focused on concerted efforts during the period under review to promote, support and/or maintain positive relationships between the child in foster care and his or her mother and father or other primary caregiver(s) from whom the child was removed (through activities other than just arranging visitation).

Of the 62 applicable cases, Item 11 rated at a **34%** strength. Concerted efforts were made to promote, support and otherwise maintain a positive nurturing relationship between the child in foster care and their mother in **39%** of the 57 applicable cases, and with their father in **40%** of the 40 applicable cases.

This item was rated as an Area Needing Improvement due to the agency not making efforts to notify the parents of medical appointments, school activities, involve them in the child’s therapy, or invite them to other activities their child(ren) were involved in (such as sports, plays, church activities, etc.).

Figure 32

Interviews sometimes pointed to the agency expecting the foster parent to communicate this information to the biological parents, which could be appropriate. However, the foster parents were more likely to notify the parents after the fact that the appointments had taken place rather than invite the parent to attend with them. It was also noted that the agency was not informing or encouraging the parents at time of entry into care to continue involvement with their child(ren)’s activities and medical appointments.

## WELL-BEING OUTCOMES

### Well-Being Outcome 1-Families have enhanced capacity to provide for their children’s needs

Well-Being 1 assessed services provided to children, parents and foster parents, engagement of children and families in the case planning process, and the frequency and quality of contacts with children and their parents.

Figure 33

The state’s overall rating for this Outcome was **26%** substantially achieved. (Figure 33)

Figure 34

Individual region ratings varied across the state with Region 9 rating highest at **57%** substantially achieved, while the lowest ratings (**0%** achieved) occurred in Regions 7 and 10. (Figure 34)

Performance ratings were higher for the overall Outcome in Family Support cases (**33**% substantially achieved) than Permanency cases (**27%** substantially achieved) or Family Preservation cases (**17%** substantially achieved).

Insufficient contact with case participants (parents, children, foster parents and other relevant collaterals) was a primary issue identified as negatively impacting Well-Being Outcome 1. In some cases, particularly when multiple case managers had been assigned during the period under review, there were months when there was no evident contact with principals in the case. There was also a notable lack of supervisory oversight. Often there were gaps in documentation and no one available for interviews that had knowledge of case activity during the undocumented periods. Reviewers were unable to identify what occurred or determine the quality of any case activity which may have occurred during those gaps. Consequently, applicable items were rated as needing improvement. In other cases, various staff members were assigned to monitor the case until it could be officially assigned to a case manager. The resulting inconsistency often led to loss of valuable case information, contacts which were not meaningful, delays in providing needed services and stalled cases.

Well-Being Outcome 1 is comprised of four Items:

**Item 12- Needs and services to children, parents and foster parents**

The purpose of assessment for Item 12 was to determine whether, during the period under review, the agency (1) made concerted efforts to assess the needs of children, parents and foster parents (both initial, if the child entered care or the case was opened during the period under review, and on an ongoing basis) to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency’s involvement with the family, and (2) provided the appropriate services.

In general, this item would be applicable in all 150 cases. The exception was in Family Support Cases where reviewers determined that a comprehensive assessment of risk and safety was conducted and no safety concerns were identified. In those cases Item 12 (and Item 13) would not be applicable. Based on this criterion, there were eight Family Support cases which were not applicable for Item 12.

Figure 35

Figure 36

Permanency cases reviewed rated higher for Item 12 at **28%** substantially achieved than either Family Preservation cases, **20%** substantially achieved, or Family Support cases, **18%** substantially achieved. (Figure 36)

Figure 37

Item 12 is broken down into three sub-items: **12 A --** the assessment of needs and provision of services to meet identified needs for children; **12 B** – the assessment of needs and provision of services to meet identified needs for parents; and **12 C** – the assessment of needs and provision of services to meet identified needs for foster parents.

The expectation is that a comprehensive assessment of needs is completed initially and ongoing (throughout the life of the case), and the agency ensures that appropriate services are provided in a timely manner to meet identified needs. (Figure 37)

In regards to the assessment of children’s needs and services to meet the identified needs, reviewers considered: the circumstances of the case; age(s) of the child(ren); how needs were assessed, including frequency and quality of visits; whether the worker asked the children, the child(ren)’s caretakers and/or foster parents about their needs; and whether services were provided, monitored and appropriate to meet the identified needs. Needs and services considered in this item included those related to social competencies, attachment and caregiver relationships, social relationships and connections, social skills, self-esteem, and coping skills. If the case was a foster care case and the child was an adolescent, the child’s needs for independent living services were also considered here.

Commonly cited issues which negatively impacted this item were infrequent or poor quality contacts with children and caregivers which led to a lack of comprehensive, ongoing needs assessments, failure to assess and/or address issues related to children’s attachment, family relationships and caregiver relationships (when there were strained family relationships identified or there was an absent or out-of-home parent), failure to provide assessment and/or services to address children’s poor social skills and self-esteem issues, and failure to ensure ILP services were being provided when applicable. In Family Preservation and Family Support cases, needs assessments for all children residing in the home were not always completed. Review results indicated assessment of children’s needs was completed adequately in **63%** of the cases, but services to meet identified needs were only provided in **37%** of the cases.

Figure 38

Assessment of a mother’s and father’s needs refers to a determination of what the mother and/or father needed to provide appropriate care and supervision and to ensure the well-being of his/her children. This could include mental and physical health needs if those needs impacted the parent’s capacity to care for the children. This could also include an assessment of needs related to supporting a biological parent’s relationship with the child if they did not have an established relationship prior to the child’s entry into foster care, or if the parent/child relationship was strained. Appropriate assessments for birth mothers were completed in **38%** of the applicable cases and for birth fathers in **34%** of the applicable cases. Appropriate services were those that enhanced the mother’s or father’s ability to provide care and supervision and support the well-being of his or her child(ren). Examples of services provided include substance abuse treatment, parenting skills classes, and/or family counseling services. Appropriate services were provided to birth mothers in **30%** of the applicable cases and **33%** of the applicable cases for birth fathers. (Figure 38)

With regard to parents, a lack of ongoing, comprehensive assessment of parents’ needs was a frequently cited concern. Reviewers most often noted infrequent contact with parents as negatively impacting adequate assessment and engagement with parents. This was cited for both mothers and fathers, and often there was no evidence of diligent efforts to locate or contact out-of home or absent parents. When needs were identified, the agency frequently failed to initiate services or there was a delay in providing services to address identified needs. And when services were initiated, there was often no follow up to monitor parents’ participation and progress.

Assessment of foster parents’ needs and provision of services to meet their needs rated **56%** achieved overall. A frequently cited issue for this item was failure to adequately assess a relative resource’s needs and/or provide services to meet their needs, particularly related to financial assistance. In some cases, there had been no discussion of available resources, and in others, there had been discussion but no follow-through to initiate services. Another identified concern was failure to provide adequate assessment or services to support foster parents and enhance their ability to meet the needs of children with notable behavioral issues.

**Item 13- Child and Family Involvement in Case Planning**

Ratings for this item are based on whether there were concerted efforts made to involve parents and children (if developmentally appropriate) in the case planning process on an ongoing basis. Of the 139 applicable cases, the state had a strength rating in **42%** of the cases reviewed.

In cases which rated as a strength for this Item, reviewers identified positive family engagement in the case planning process including Family Team Meetings (FTM) conducted with the participation of children and parents, ongoing discussion with parents and children related to identification of family strengths and needs, and monitoring the participation and progress towards completing case plan goals.

Figure 39

Region 6 rated **83%** substantially achieved for Item 13, with five of six applicable cases in Region 6 being rated as a strength. (Figure 39)

Figure 40

For Item 13, Permanency cases had the highest strength ratings at **48%**, while both Family Support and Family Preservation cases rated at **30%**. (Figure 40)

Figure 41

The agency made concerted efforts to actively involve the child(ren) in the case planning process in **58%** of the applicable cases, mothers in **46%** of the applicable cases and fathers in **39%** of the cases. (Figure 41)

Insufficient contact with parents and children (in both frequency and quality) was most often cited as an underlying issue resulting in the failure to include parents and children in the case planning process. Often there were multiple months when there was no contact made with parents or children, and in many cases when contacts were made there was no discussion relevant to the case planning process or monitoring of progress. There often also were no efforts to include out-of-home fathers even when there was ongoing contact between the child and that parent. Ratings were higher for inclusion of children in the case planning process than parents, and corresponding to that, quality visits between case managers and children (Item 14) rated higher than between case managers and parents (Item 15).

In some cases parents reported that they did not know what their case plan goals were (some cases did not have a case plan developed despite being open for many months), particularly when staff turnover or changes resulted in multiple case managers and supervisors being assigned to a case during the period under review. Case plans were not always current and/or approved, and some case plans were not individualized for the family’s needs.

**Item 14- Caseworker visits with child**

This Item focused on whether the frequency and quality of visits between case workers and children were sufficient to ensure safety, permanency and well-being as well as promote timely achievement of case plan goals.

Figure 42

The state’s overall rating for this Item was **59%**, and this was the highest rated item under Well-being Outcome 1. All 150 cases were applicable to Item 14. **Region 10 achieved substantial conformity for this item at 100%** (3 applicable cases), and ratings across the regions were generally higher for this item than other items for children within Well-being Outcome 1. (Figure 42)

Figure 43

Permanency cases had a **74%** strength rating for this item, while Family Support and Family Preservation cases rated considerably lower at **37%**. (Figure 43)

For cases rated as a strength, reviewers noted private conversations and interaction with children, discussions relevant to ongoing assessment, monitoring and case planning, and observations of environment and developmental levels/needs (particularly for younger children. Issues negatively impacting this item included multiple months of missed contacts and, in Family Preservation and Family Support cases, failure to have contact with all children living in the household. Reviewers often noted little or no meaningful engagement or discussion relevant to assessment, monitoring and case planning with children during visits.

The typical pattern of visits between the case manager and child(ren) was sufficient in **71%** of the cases, with the quality of these visits being sufficient **67%** of the time.

**Item 15- Caseworker visits with parents**

This item is focused on whether the frequency and quality of visits between caseworkers and the mothers and fathers of the children were sufficient to ensure the safety, permanency and well-being of the children and promote achievement of case plan goals.

Figure 44

The state of Georgia had a **31%** strength rating for this item out of 132 applicable cases, with the highest performing region being Region 9 at **57%** and the lowest performance being Region 10 at **0%**. (Figure 44)

Figure 45

For this same Item, Family Support cases had a **37%** strength rating, while Permanency cases rated at **33%**. Family Preservation cases rated the lowest at **20%**. (Figure 45)

Figure 46

Reviewers most often cited infrequent contacts with parents as negatively impacting this item. This included multiple months during the period under review when there were missed contacts and no evidence of concerted effort to maintain contact with parents. Quality was often lacking when contact was made, with reviewers noting a lack of relevant discussion to address new or previously identified issues, to ensure services were in place, or to monitor progress and case planning.

Often there were no efforts made to contact and/or engage out-of home/absent parents. In some instances, approved contact standards were not appropriate for case circumstances (i.e. letters to locally incarcerated parents), and though contact standards were met they were insufficient to assess and address concerns.

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### Well-Being Outcome 2- Children receive appropriate services to meet their educational needs

Well-Being Outcome 2 evaluates whether, during the period under review, the agency made concerted efforts to assess children’s educational needs initially and ongoing, and whether the identified needs were appropriately addressed in case planning and case management activities. There is only one item associated with this outcome, **Item 16- Educational needs of the child.**

Figure 47

For the period under review, the state overall substantially achieved this Outcome in **54%** of the 104 applicable cases. (Figure 47)

Figure 48

In comparing ratings for Item 16 across programs, Permanency cases rated only slightly higher than the state overall at **58%** of applicable cases rating as a strength. Very few Family Support cases were applicable for item 16 (7 out of 30), and overall rated at **43%**. More than half of the Family Preservation cases reviewed were applicable for item 16, but had the lowest rating at only **39%** of applicable cases rating as a strength. (Figure 48)

The agency made concerted efforts to accurately assess children’s educational needs in **64%** of the applicable cases, as well as made concerted efforts to provide appropriate services to meet any identified educational needs in **46%** of the applicable cases.

Figure 49

Regions varied widely in achievement of Item 16. Six out of 14 Regions rated at **50%** or less for item 16. Only Region 9, with **100%** of applicable cases rating as a strength during the period under review, met the federal rating standard. Regions 5, 6 and 12, while not meeting the standard, all rated higher than **75%** for this item. (Figure 49)

Regions that performed better in this area demonstrated thorough ongoing assessment of children’s educational needs as well as timely provision of services to meet the identified needs.

The most common factor negatively affecting ratings for this outcome was the lack of contact with the school/educational provider. This affected cases across all program areas. Out of 104 total applicable cases, 31 cases did not contain adequate (and for the most part no) contacts with schools to gather information regarding the child’s educational performance, needs or progress with provided educational services. A full quarter of Permanency cases reviewed lacked any contact with the school. Even when children were interviewed at school, no collateral information from the school was gathered.

Cases also rated low due to the agency’s failure to adequately assess the child’s educational needs, either through formal (EPAC assessments, psychological or psychoeducational assessments, collateral information from school) or informal means (discussing grades/issues with child and caretakers, observing child at school, etc.). Even in cases where academic deficits are present, documentation and case interviews did not support adequate agency intervention to formally assess or provide services to meet identified needs.

Documentation and case interviews during the CFSR indicated the majority of information regarding the child’s school performance and educational needs were gathered from the caretaker, without any independent assessment or confirmation. However, in several cases where significant educational needs had been identified, no discussion with the caretaker regarding school had occurred. In many Permanency cases, the agency relied solely on the foster parent or Child Care Institution (CCI) to assess the child’s academic needs, provide services and oversee progress. In several cases, case managers were unable to state whether a foster child had an Individualized Education Plan (IEP), what it was for, what services a child was receiving and if the child was making any progress with provided services.

Another issue impacting performance in meeting children’s educational needs was a lack of understanding of how a child’s academic performance was influenced by his/her current situation and history of trauma, abuse and neglect. In multiple instances, case actions did not support adequate agency intervention to provide safety, stability or other therapeutic services which would enable the child to feel safe, heal and therefore succeed in school.

### Well-Being Outcome 3-Children receive adequate services to meet their physical and mental health needs

This outcome focused on whether, during the period under review, the agency assessed and addressed the physical, dental and mental health needs of children.

Figure 50

For the CFSR period under review, the state overall achieved substantial conformity in only **25%** of 119 applicable cases. (Figure 50)

Figure 51

In keeping with the overall state rating of **25%** for Well-Being Outcome 3, half of the Regions rated at or below **20%** for the overall Outcome. Of the remaining seven Regions, six rated at or below **50%** with only Region 9 rating higher at **67%.** (Figure 51)

Figure 52

In comparing ratings across program areas in Well-Being Outcome 3, Family Support cases rated highest at **41%** substantially achieved. Permanency cases rated at **24%** and Family Preservation cases rated at only **18%**. However, it should be noted that a total of 17 Family Support cases were rated for this item. The majority of Family Support cases reviewed were not applicable as this Outcome was not relevant to the reasons for agency involvement, and/or there were no issues affecting physical or mental health of the children reported. All Permanency cases (90 total) were eligible for assessment of at least item 17 (physical/dental health of the child), and all but two of the Family Preservation cases were evaluated for either item 17 or item 18. (Figure 52)

**Item 17-Physical health of the child** evaluated the agency’s assessment of and provision of services to meet a child’s physical and dental health needs.

Figure 53

Assessment and service provision of physical/dental health was achieved overall in **49%** of the 119 applicable cases reviewed. Both Permanency and Family Support cases rated higher than Family Preservation, with only five out of 20 applicable Family Preservation cases (**25%**) rating as a strength for item 17. (Figure 53)

Figure 54

Regions individually fared somewhat better in achieving item 17, with more than half of the Regions receiving a strength rating for at least **50%** of applicable cases. Higher performing Regions reflected adequate assessment of children’s medical needs as well as follow up to ensure that services were provided to meet identified needs. (Figure 54)

One particular issue which led to lower ratings in most cases was a lack of contact with medical and dental providers, either to assess the child’s physical/dental needs or to ensure appropriate treatment for identified needs. For 12 out of 20 applicable Family Preservation cases with identified physical or dental health issues, the agency failed to have consistent, quality contact with medical/dental providers that addressed the issues of the case. These included medical issues such as heart murmurs, metabolic disorders, decayed teeth and prenatal drug exposure. All Permanency cases were applicable to be rated for item 17 because the agency had a responsibility to ensure that children in the Division’s care receive adequate treatment to meet their medical and dental needs. In 33 of 90 applicable cases, documentation and case interviews did not support even cursory contact with a foster child’s medical or dental provider, or contact with specialists treating children with special needs (ENT Specialist, Orthodontists, Allergists, Pulmonologists, etc.).

In 18 of the applicable cases, documentation and case interviews did not support adequate agency oversight of medication prescribed for physical health issues (asthma, enuresis, anemia etc.). Often the oversight lacking was observation of the child’s medication, the required medication log and contact with the prescribing physician to ensure appropriate administration and that the medication was addressing the child’s identified health need. However, in many cases, documentation and case interviews did not support that the medication (administration, side effects, and effectiveness) was discussed with the child or the child’s caretakers. In several instances, the review uncovered discrepancies between what the agency believed the child was taking and what the child was actually prescribed. In a few cases, the agency was unaware that the child was taking any medication at all. Many case files overall were lacking even basic medical records and the health/medication log in SHINES was underutilized and not kept up to date.

In several Permanency cases, issues were identified with a relative caregiver not meeting a child’s physical or dental health needs. Lack of contact with the agency was a contributing factor, as was a lack of discussion with the caregiver about the requirement for children in foster care to have regular physical and dental health checks. However, case interviews with relative caregivers revealed several instances where a foster child had identified physical health needs and the caregiver requested assistance from the agency in meeting the child’s needs (transportation, Medicaid, previous medical records, etc.), but the agency failed (or in some cases refused) to act in a timely manner to meet the child’s needs.

Overall, the state adequately assessed the physical health needs of children in **66%** of applicable cases reviewed, and only provided needed services in **55%** of these cases. The state assessed the dental needs of children in **76%** of applicable cases reviewed and provided needed services in **64%** of those cases.

**Item 18-Mental/Behavioral Health of the child** evaluated the agency’s assessment of and provision of services to meet a child’s mental and behavioral health needs.

Figure 55

Assessment and provision of services to meet children’s mental and behavioral needs was achieved overall in only **29%** of applicable cases reviewed. Both Permanency and Family Support cases rated higher than Family Preservation, with only four out of 20 applicable Family Preservation cases rating as a strength for item 18. (Figure 55)

Figure 56

Both Region 6 and Region 9 achieved a rating of **100%** for applicable cases reviewed for item 18. As noted in Items 16 and 17, thorough ongoing assessments as well as provision of services to meet identified needs were present in cases that were rated as a strength for item 18. The remaining 12 Regions all achieved a strength rating in **50%** or less of cases reviewed for item 18. (Figure 56)

As noted in both Items 16 and 17, a lack of consistent contact with mental health providers negatively impacted cases in all program areas. Twenty six percent (**26%**) of overall cases lacked contact with mental health providers to evaluate service provision or identify additional needs.

Family Preservation cases were rated very low overall for Item 18, mainly due to a lack of assessment for identified mental or behavioral health issues. In almost **80%** of applicable cases, documentation, case interviews or even the allegations that initiated agency involvement identified issues with children’s behavior or mental health functioning, but the agency failed to initiate or ensure that appropriate assessments were performed to identify service needs. In both Family Preservation and Family Support cases, cases were closed prior to needs being assessed or confirmation that families were receiving referred services.

In **25%** of applicable Family Preservation and Family Support cases, it was known to the agency that the children had been exposed to Intimate Partner Violence yet the agency did not take any steps to informally assess any impact that exposure may have had on the children.

The Permanency cases reviewed also had specific issues that negatively impacted performance. In eight cases, the agency did not know what mental or behavioral health services were being provided to a foster child. Fourteen Permanency cases reflected identified needs (acting out behaviors, anger issues, abandonment, grief, sexualized behavior, etc.) but the agency did not conduct a formal assessment. In an additional 15 Permanency cases, services (substance abuse treatment, grief counseling, family therapy, individual counseling for sexual abuse, etc.) had been recommended to meet specific needs, but those services were not provided. Multiple cases reflected children being in foster care for extended periods of time before even basic assessments were completed.

Documentation and case interviews reflect that the agency was still failing to consistently comply with the psychotropic medication protocol that has been required since May 1, 2013. The agency has failed to maintain contact with prescribing physicians, document County Director approval for medication, maintain medication logs, and discuss the medication (compliance, side effects, effectiveness in treating symptoms) with foster children and caregivers. For this period under review, of the 34 applicable cases, only six cases reflected adequate adherence to the protocol. **Eighty-three percent (83%)** of applicable cases failed to demonstrate appropriate oversight, most often because contact was not maintained with the prescribing physician. Of the 47 Permanency cases that did not receive a strength rating for item 18, ten of those were solely due to a failure to follow the psychotropic medication protocol. If the protocol had been followed, the overall Permanency rating for Item 18 would move from **32% to 46%.**

For this Outcome overall, the agency provided adequate assessment of mental and behavioral needs in **54%** of cases across all program areas (Permanency, Family Support and Family Preservation) and provided services to meet identified needs in **40%** of cases.

# V. Areas of Concern/Critical Issues

During the six month review period, 19 cases were brought to the attention of the Regions as either an Area of Concern or Critical Issue. Twelve cases were identified as an Area of Concern and three were identified as a Critical Issue related to a child’s immediate safety. There were also four administrative concerns. Of the 19 cases requiring attention, seven were from the Family Preservation program, five from the Family Support program, and six from the Permanency program. One case involved a child residing in a foster home at the time of review.

The following definitions are utilized to identify cases that are Areas of Concerns or Critical Issues:

**Critical Issues**- are defined by situations where a child is in present or impending danger and immediate action should be taken by the agency to ensure the safety of the child, and/or a situation where there has been no contact or risk and safety assessment completed on the child in recent months.

**Agency Liability Critical Issues** -are defined by situations in which the agency has allowed a court order to expire and no longer has legal custody of the child, but the child is still in the physical custody of the agency and the agency is still acting in a legal role for the child. It can also be defined by a child having been placed in an unapproved placement setting (i.e. safety resource, etc.) that has not been appropriately approved or assessed, whether the child is in the legal custody of the agency or not.

**Areas of Concern**- are defined by situations where a child or family is in need of a specific intervention, the case management practice is inadequate, and/or the family situation is deteriorating to the point that if the agency does not intervene appropriately in a timely manner the children could be placed at significant risk or danger.

Two Permanency cases identified as an Area of Concern involved inadequate assessment of parents and caretakers, failure to provide needed services and insufficient contact with the children and family. In one of the cases, a child in foster care was placed in the home of her maternal uncle, his girlfriend and her child without a home evaluation being completed and no criminal background check on either the uncle or his girlfriend. In the second case, the agency began allowing a child to have unsupervised visits with his mother without assessing the mother’s parenting ability and ensuring the needed services had been provided to address her needs. For this same case, there were also several months during the review period when the agency failed to maintain contact with the mother, child and foster parent. It was actually during a Termination of Parental Rights (TPR) hearing when the decision was made to begin working reunification with the mother and allow the unsupervised visitation.

Inadequate assessment of risk and safety was an issue in all of the Family Preservation and Family Support cases brought to the attention of the Regions as an Area of Concern or Critical Issue. Trends identified included the failure to fully investigate and/or address allegations of maltreatment, failure to fully assess caretakers, lack of frequent and quality contact with children, parents and caretakers and the failure to provide needed services.

Other examples include when a family denies specific allegations, but there is little to no further effort made to obtain additional information and assess the child’s safety. Lack of frequent and quality contact with children and families was an issue in seven cases, failure to fully assess caretakers and household members was an issue in four cases and the failure to provide needed services was an issue in four of the cases.

There were eight cases in which allegations were not fully investigated and/or addressed. For example, in a case where a child disclosed he had been sexually abused by his father and admitted to sexually abusing his niece and nephew, the agency did not initiate the case for almost eight months after the report was received. The agency also failed to make contact with the perpetrating child, discuss with the mother her plan for supervision of the child, and did not assess whether the father, (who did not live in the home), would have access to the child upon his release. The agency also failed to obtain basic information on the niece and nephew and their parents in order to make contact with them to assess the parents’ understanding of the concerns and determine whether services were needed. Neither the Department of Juvenile Justice (DJJ) nor the treatment facility was contacted to discuss the child’s needs and the plan for the child upon discharge.

The foster home case brought to the attention of one Region as a Critical Issue was related to concerns regarding the indoor temperature being very warm, the foster parent “hovering” over the children when the case manager was attempting to talk with them privately, the children appearing to be coached in their answers, the five oldest children sharing the same room, and the home not being in approved status since 5/31/15 due to needing required information. In addition, there were a total of seven children residing in the unapproved home.

The four cases identified as Administrative Concerns were from the Permanency program. The cases involved: a child who has been allowed to linger in foster care although he has been free for adoption since December 2013; a case in which a report to Adult Protective Services was required to ensure the disabled mother of a child in care was not being abused and exploited by her paramour; and a case in which a child was returned to her father without the agency ensuring the family was fully advised of the child’s needs and linked with needed services. The final case was one in which the agency did not fully investigate reported maltreatment allegations. Although allegations were not fully assessed, the case was ultimately not deemed a safety issue due to the children being in foster care and not having contact with the alleged maltreator.

Upon receipt of an Area of Concern, Critical Issue or Administrative Concern, all Regions provided follow-up documentation to support that concerns had been addressed or that a plan of action was in place to address identified concerns. For one Family Preservation and two Family Support cases brought to the Regions’ attention, all three were reopened for investigation in order to provide further assessment.

**VI. Stakeholder Feedback**

The input of 247 stakeholders was incorporated from April 2015 through September 2015. Case specific interviews and/or surveys were conducted in counties and at the region level with community partners, including foster parents, service providers, court personnel, attorneys and school personnel.

**General Information**:

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While the majority (**75%**) of stakeholders interviewed reported satisfaction (rating Excellent or Good) with staff accessibility, many stakeholders throughout the state reported a failure by the agency to return phone calls. This issue was reported to mainly relate to case managers, and stakeholders attributed this to staff turnover and/or high caseloads. It was also reported that supervisors and administrators are generally more accessible than case managers. Stakeholders also attributed the lack of timely service provision to staff turnover.

**Eighty seven percent** **(87%)** of stakeholders interviewed indicated that the agency provides adequate services to ensure children are safe and protected from abuse and neglect. Some stakeholders reported that a lack of quality services available in the area negatively impacted the agency’s ability to provide the needed services.

**Foster Parents:**



Foster Parents interviewed included both Division Foster Parents and Child Placing Agency (CPA) Foster Parents, although only Division Foster Parents were interviewed regarding training provided. Comments provided about trainings included that more training is often needed when special needs children or children with mental/behavioral health needs are placed in the home. Other needs identified regarding training included refresher courses throughout the year or better pacing for trainings rather than trying to fit the required annual hours in all at once. Foster Parents did indicate that there has been an improvement in the availability of local trainings.

Regarding timely notification of court hearings to Foster Parents, **77%** of DFCS Foster Parents reported being notified timely (a rating of Excellent or Good) while **75%** of CPA Foster Parents reported timely notification of court proceedings.

Regarding Foster Parents being allowed input at court proceedings, including panel reviews, **75%** of DFCS Foster Parents interviewed indicated that their input was allowed (rating Excellent or Good) while **90%** of CPA Foster Parents interviewed indicated being allowed to provide their input during these proceedings.

While most Foster Parents indicated that the agency did provide needed services, some Foster Parents reported issues with receiving timely per diem payments, assistance with transportation for foster children to appointments, and mental health services to foster children.

**Legal Providers/Court Personnel:**



Many of the legal stakeholders interviewed indicated that staff turnover and/or high caseloads negatively impacted the agency’s preparedness for court, knowledge of cases, timely achievement of permanency for children in foster care, and collaboration/ communication with GAL/CASA staff. New case managers were reported to be more open to collaboration with GAL/CASA.

It was recommended by stakeholders that regular staffings with Special Assistant Attorney Generals (SAAGs) could improve timeliness of court actions as well as preparedness for court for Division staff.

Another concern noted by court personnel was that case plans are not regularly updated to reflect correct information, such as comprehensive service needs of the family, children’s updated medical/educational information, current written Transitional Living Plans, etc.

**Service Providers:**



This group of stakeholders interviewed reported that the agency needs to provide more information when making referrals to them for service provision, including details of case circumstances, needs of the family, and correct or current contact information for the family and assigned case manager. One recommendation made by these stakeholders included the need for timely service authorizations and payments to providers to prevent service disruption to families.

Only **57%** of stakeholders interviewed reported that the agency informs them of changes in mutual cases. Noted concerns included stakeholders not being notified when there is a change in case managers or when mutual cases are closed by the agency.

Stakeholders also attributed the agency’s high staff turnover to the lack of adequate information provided in referrals, the lack of timely notification of changes in mutual cases, and the failure to involve stakeholders in decision making.

# VII. Continuous Quality Improvement

The overall vision for Continuous Quality Improvement (which encompasses Quality Assurance activities) is for it to be the catalyst that enables the Division to become the best child welfare agency in the world. The Division has completed the on-site review portion of the third round of the CFSR and will now begin the development and implementation of a Performance Improvement Plan (PIP). Over the next three years, implementation of the CFSR PIP will flow through the state and local CQI teams. As discussed during the last trend report released earlier in 2015, the purpose for the CWCQI Unit Plan was to improve both the health and function of all CQI teams so that they are prepared to implement the PIP and drive continual practice improvement within the agency. Below is a brief status report on the achievement of Unit Plan goals.

**2015 Child Welfare Continuous Quality Improvement (CQI) Unit Plan:**

***Goal 1: Increase the capacity of the CWCQI Unit to support statewide continuous quality improvement efforts by ensuring that all CQI Specialists are providing appropriate support to the CQI teams.***

***Intervention 1:*** Develop formal structures and processes for the CWCQI Unit.

***Outcome:*** As of 12/31/15, a set of structures and processes have been created for the CWCQI Unit, including an updated job description. The Unit, with the assistance of the CQI Implementation Team, is in the process of formalizing these structures and processes in a procedural manual. The final version of the manual will be completed by March 2016.

***Intervention 2:*** Develop a formal training and professional development plan for the CQI Specialists.

***Outcome:*** A formal training and professional development plan was created for the CWCQI Unit, and to date monthly trainings have been held since February 2015. Training topics were specifically chosen to align with federal guidance related to a strong state CQI system and process, and were designed to increase the capacity of the CQI Specialists to work with their assigned regions and CQI teams. These trainings will continue in Calendar Year 2016.

***Goal 2: To increase the capacity of the CQI Specialist role in order to enable all CQI teams to become fully functional by November 1, 2015.***

***Intervention 1:*** Develop and implement a formal plan to regularly engage county, regional and state level leadership.

***Outcome:*** As of 12/31/15, the CWCQI Unit along with Quality Management Section leadership has provided regular communication to and engagement with all levels of leadership and staff regarding statewide CQI efforts. This has occurred through a variety of methods, including (but not limited to) agency newsletter publications, presentations at meetings and conferences, and individual meetings with local and state leadership. By July 1, 2015, individual meetings had been held with all of the Regional Directors throughout the state in order to assess local CQI team function and establish partnerships for ensuring the progression of CQI efforts. Periodic follow-up meetings will be conducted over the next few years during implementation of the CFSR PIP.

***Intervention 2:*** Develop a revised process for completing targeted reviews.

***Outcome:*** As of 12/31/15 a draft process for targeted reviews has been created but not yet implemented. Quality Management Section leadership will continue to discuss and evaluate if and when this particular intervention will proceed with full implementation.

***Goal 3: To enhance statewide communication efforts related to CQI in order to increase the quality of communications related to CQI.***

***Intervention 1:*** Develop and implement a formal communication plan.

***Outcome:*** As of 12/31/15, the CWCQI Unit along with Quality Management Section leadership has provided regular communication to all levels of leadership and staff regarding statewide CQI and C3 efforts. This has occurred through a variety of methods, including (but not limited to) agency newsletter publications, presentations at meetings and conferences, and individual meetings with local and state leadership. This provision of regular communication, (including the use of multiple methods), will continue in Calendar Year 2016.

***Intervention 2:*** Develop a process for obtaining regular feedback from both internal and external stakeholders regarding statewide CQI efforts.

***Outcome:*** As of November 2015, a feedback survey had been developed and distributed to the Statewide CQI Team Facilitators. The purpose of the survey was to gain an understanding of how the Facilitators assessed their own capacity to lead CQI teams, as well as allow them an opportunity to identify what resources they need in order to increase their capacity to lead teams. Results from the survey are being used to guide conversations with leadership about how to appropriately support staff so that they are able to successfully implement CQI activities (including those related to the CFSR PIP). A similar feedback survey has also been developed for CWCQI Unit staff but has not yet been distributed.

***Goal 4: To increase the capacity of all CQI teams to support continual practice improvement so that all teams will be fully functional by November 1, 2015.***

***Intervention 1:*** Develop formal structures and processes for CQI teams, including a defined set of outcome measures to identify CQI team functioning.

***Outcome:*** As of December 2015, a set of structures and processes have been created for the state and local CQI teams, including a defined set of outcome measures. The CWCQI Unit, with the assistance of the CQI Implementation Team, is in the process of formalizing these structures and processes in a procedural manual. The final version of the manual will be completed by March 2016. Currently, the outcome measures developed are informally being used to assess the individual function of the 16 CQI teams within the Division.

***Intervention 2:*** Develop a formal training and technical assistance plan for the CQI Facilitators.

***Outcome:*** A formal training and technical assistance development plan was created for the Statewide CQI Team Facilitators, and to date quarterly trainings have been held since March 2015. Training topics were specifically chosen to align with federal guidance related to a strong CQI system and process, and were designed to increase the capacity of the Facilitators to work with their CQI teams and help drive continuous improvement efforts on the local level. In addition, all Regional CQI teams were provided the opportunity in Calendar Year 2015 to have their team members receive the Performance Improvement Training – the formal two-day training on the CQI process itself. All trainings for Facilitators and team members will continue in Calendar Year 2016.

***Intervention 3:*** Develop a formal structure and process for the State Office CQI team, including a defined role for the team as it relates to all other CQI teams.

***Outcome:*** As of 12/31/15 the State Office CQI team has an established set of by-laws which will guide how membership is managed, meetings are conducted and decisions are made. These by-laws were finalized and adopted in October 2015. With the development and implementation of the CFSR PIP on the horizon, the State Office team will serve as a central entity for the monitoring and implementation of PIP-related activities. An informational session is being held in January 2016 to bring together both internal and external stakeholders to learn about CQI in child welfare, the role of the State Office Team, and how specific individuals, sections and stakeholders can contribute to Georgia's CQI system through participation on the State Office team. The goal of the session is to increase team membership.

# VIII. Appendix

The following charts and tables provide a further breakdown of the CFSR Outcomes and results discussed in this report.

**FFY 2011 to FFY 2014 Outcome Comparisons to 2015 CFSR Review (April 2015-September 2015)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | FFY 2011 | FFY 2012 | FFY 2013 | FFY 2014 | FFY 2015\* |
| Safety 1 | 84% | 86% | 83% | 74% | 67% |
| Safety 2 | 59% | 56% | 59% | 41% | 52% |
| Permanency 1 | 41% | 46% | 35% | 18% | 13% |
| Permanency 2 | 65% | 67% | 59% | 43% | 73% |
| Well-Being 1 | 45% | 49% | 44% | 26% | 38% |
| Well-Being 2 | 74% | 80% | 82% | 45% | 65% |
| Well-Being 3 | 57% | 65% | 60% | 30% | 44% |

**CFSR (April 2015- September 2015) Regional Safety Outcomes Achievement**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **REGION**  **01** | **REGION 02** | **REGION**  **03** | **REGION 04** | **REGION**  **05** | **REGION**  **06** | **REGION**  **07** | **REGION 08** | **REGION**  **09** | **REGION 10** | **REGION 11** | **REGION 12** | **REGION 13** | **REGION 14** |
| **Outcome S1:** | **73%** | **100%** | **20%** | **80%** | **57%** | **33%** | **100%** | **50%** | **80%** | **100%** | **67%** | **57%** | **67%** | **71%** |
| Item 1: | **73%** | **100%** | **20%** | **80%** | **57%** | **33%** | **100%** | **50%** | **80%** | **100%** | **67%** | **57%** | **67%** | **71%** |
| **Outcome S2:** | **13%** | **80%** | **70%** | **27%** | **58%** | **17%** | **40%** | **38%** | **86%** | **100%** | **63%** | **21%** | **21%** | **50%** |
| Item 2: | **43%** | **100%** | **100%** | **33%** | **50%** | **67%** | **NA** | **100%** | **100%** | **100%** | **67%** | **43%** | **50%** | **63%** |
| Item 3: | **13%** | **80%** | **70%** | **27%** | **58%** | **17%** | **40%** | **38%** | **86%** | **100%** | **63%** | **21%** | **21%** | **50%** |

Substantial Conformity for Outcomes: 95% or above; 94%- 80%; Below 80%

Substantial Conformity for Items: 90% or above; 89%- 80%; Below 80%

**CFSR (April 2015- September 2015) Regional Permanency Outcomes Achievement**

Substantial Conformity for Outcomes: 95% or above; 94%- 80%; Below 80%

Substantial Conformity for Items: 90% or above; 89%- 80%; Below 80%

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **REGION**  **01** | **REGION 02** | **REGION**  **03** | **REGION 04** | **REGION**  **05** | **REGION**  **06** | **REGION**  **07** | **REGION 08** | **REGION**  **09** | **REGION 10** | **REGION 11** | **REGION 12** | **REGION 13** | **REGION 14** |
| **Outcome P1:** | **50%** | **14%** | **14%** | **14%** | **14%** | **33%** | **0%** | **17%** | **50%** | **50%** | **0%** | **0%** | **0%** | **7%** |
| Item 4: | **100%** | **71%** | **86%** | **57%** | **71%** | **100%** | **80%** | **83%** | **100%** | **50%** | **83%** | **57%** | **22%** | **50%** |
| Item 5: | **71%** | **57%** | **43%** | **17%** | **43%** | **100%** | **40%** | **67%** | **50%** | **50%** | **17%** | **14%** | **33%** | **38%** |
| Item 6: | **50%** | **14%** | **29%** | **43%** | **29%** | **33%** | **0%** | **17%** | **50%** | **50%** | **33%** | **14%** | **22%** | **21%** |
| **Outcome P2:** | **50%** | **29%** | **29%** | **14%** | **57%** | **67%** | **60%** | **67%** | **0%** | **50%** | **33%** | **14%** | **11%** | **14%** |
| Item 7: | **100%** | **100%** | **83%** | **75%** | **50%** | **67%** | **100%** | **100%** | **100%** | **100%** | **100%** | **75%** | **50%** | **37%** |
| Item 8: | **71%** | **33%** | **43%** | **33%** | **40%** | **50%** | **25%** | **25%** | **50%** | **50%** | **40%** | **50%** | **29%** | **64%** |
| Item 9: | **71%** | **14%** | **29%** | **17%** | **57%** | **33%** | **60%** | **60%** | **50%** | **50%** | **67%** | **0%** | **22%** | **43%** |
| Item 10: | **43%** | **43%** | **86%** | **29%** | **67%** | **67%** | **80%** | **50%** | **100%** | **100%** | **67%** | **14%** | **11%** | **29%** |
| Item 11: | **57%** | **50%** | **33%** | **20%** | **60%** | **0%** | **33%** | **25%** | **0%** | **0%** | **40%** | **0%** | **0%** | **60%** |

**CFSR (April 2015-September 2015) Regional Wellbeing Outcomes Achievement**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **REGION**  **01** | **REGION 02** | **REGION**  **03** | **REGION 04** | **REGION**  **05** | **REGION 06** | **REGION**  **07** | **REGION 08** | **REGION**  **09** | **REGION 10** | **REGION 11** | **REGION 12** | **REGION 13** | **REGION 14** |
| **Outcome WB1:** | **20%** | **50%** | **40%** | **19%** | **50%** | **33%** | **0%** | **37%** | **57%** | **0%** | **50%** | **14%** | **5%** | **14%** |
| Item 12: | **27%** | **44%** | **33%** | **18%** | **40%** | **50%** | **0%** | **38%** | **40%** | **0%** | **50%** | **21%** | **0%** | **14%** |
| Item 13: | **33%** | **44%** | **44%** | **45%** | **60%** | **83%** | **50%** | **57%** | **60%** | **33%** | **63%** | **36%** | **7%** | **33%** |
| Item 14: | **40%** | **80%** | **80%** | **55%** | **75%** | **50%** | **40%** | **63%** | **86%** | **100%** | **88%** | **43%** | **26%** | **68%** |
| Item 15: | **29%** | **43%** | **44%** | **40%** | **45%** | **50%** | **33%** | **33%** | **57%** | **0%** | **43%** | **17%** | **6%** | **25%** |
| **Outcome WB2:** | **73%** | **63%** | **43%** | **44%** | **78%** | **80%** | **25%** | **29%** | **100%** | **33%** | **60%** | **78%** | **17%** | **58%** |
| Item 16: | **73%** | **63%** | **43%** | **44%** | **78%** | **80%** | **25%** | **29%** | **100%** | **33%** | **60%** | **78%** | **17%** | **58%** |
| **Outcome WB3:** | **27%** | **12%** | **38%** | **20%** | **20%** | **50%** | **20%** | **12%** | **67%** | **0%** | **37%** | **14%** | **12%** | **40%** |
| Item 17: | **33%** | **56%** | **50%** | **38%** | **40%** | **50%** | **60%** | **29%** | **67%** | **50%** | **75%** | **42%** | **29%** | **80%** |
| Item 18: | **40%** | **13%** | **50%** | **29%** | **43%** | **100%** | **0%** | **17%** | **100%** | **0%** | **20%** | **17%** | **17%** | **35%** |

Substantial Conformity for Outcomes: 95% or above; 94%- 80%; Below 80%

Substantial Conformity for Items: 90% or above; 89%- 80%; Below 80%

**District Comparisons 2015**

**North District (Regions 1-5) -58 applicable cases**

**Urban District (Regions 13 and 14) - 41 applicable cases**

**South District (Regions 6-12) – 51 applicable cases**

**Safety 1 and 2**

**Permanency 1**

**Permanency 2**

**Well Being 1**

**Well Being 2 and 3**