STATE OF DELAWARE
STATEWIDE
SELF-ASSESSMENT

2015 CHILD AND FAMILY SERVICES REVIEW

Introduction

The Child and Family Services Reviews (CFSRs), authorized by the 1994 Amendments to the Social Security Act (SSA), are administered by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The goals of the CFSR are to:

- Ensure substantial conformity with title IV-B and IV-E child welfare requirements using a framework focused on assessing seven safety, permanency, and well-being outcomes and seven systemic factors;
- Determine what is happening to children and families as they are engaged in child welfare services; and
- Assist states in helping children and families achieve positive outcomes.

The CFSR is a two-phase process, as described in 45 CFR 1355.33. The first phase is a statewide assessment conducted by staff of the state child welfare agency, representatives selected by the agency who were consulted in the development of the Child and Family Services Plan (CFSP), and other individuals deemed appropriate and agreed upon by the state child welfare agency and the Children's Bureau.

The second phase of the review process is an onsite review. The onsite review process includes case record reviews, case-related interviews for the purpose of determining outcome performance, and, as necessary, stakeholder interviews that further inform the assessment of systemic factors.

Information from both the statewide assessment and the onsite review is used to determine whether the state is in substantial conformity with the seven outcomes and seven systemic factors. States found to be out of substantial conformity are required to develop a Program Improvement Plan (PIP) to address the identified areas out of substantial conformity

Section I: General Information

Name of State Agency: Division of Family Services, Department of Services for Children, Youth and Their Families

CFSR Review Period

CFSR Sample Period: April 1, 2014 to September 30, 2014

Period of AFCARS Data: See attached data profile.

NCANDS Data: See attached data profile

Case Review Period Under Review (PUR): From the beginning of the sample period listed above through the end of case review completion. For Delaware this period begins April 2014 and ends no later than September 2015. The specific PUR varies by site reviewed as approved by the CB.

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Statewide Assessment Participants

State of Delaware Statewide Assessment Participants:

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Susan Radecki, New Castle County Regional Administrator

Linda Shannon, Intake and Investigation Regional Administrator

Joseph Smack, Executive Assistant to the Director

Michael Sullivan, Hotline Assistant Regional Administrator

Susan Taylor-Walls, Sussex County Regional Administrator

Section II: Data profile has been deleted in its entirety.

Section III: Assessment of Child and Family Outcomes and Performance on National Standards

A. Safety

Safety Outcomes 1 and 2

Safety outcomes include: (A) children are first and foremost, protected from abuse and neglect; and (B) children are safely maintained in their own homes whenever possible and appropriate.

- For each of the two safety outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the two federal safety indicators, relevant case record review data, and key available data from the state information system (such as data on timeliness of investigation).

- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Safety Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the safety indicators.

State Response:
Safety Outcomes 1: Children are first and foremost protected from abuse and neglect.

Child safety is analyzed during investigation and treatment using multiple data points such as the timeliness of the initial face to face contact, timeliness of contacts during investigation and treatment, quality assurance reviews, and contract monitoring.

On March 4, 2013, Delaware implemented a contracted Family Assessment and Intervention Response (FAIR) with a teen population as one pathway of its Differential Response System (DRS) that also includes a traditional investigation pathway. The FAIR target population was expanded on July 29, 2014 to include eleven and twelve year olds. FAIR data supporting Safety Outcomes 1 and 2 is also discussed below.

Timeliness of Contacts

SFY	2012	2013	2014
Initial Investigation	**95.12% (N=7,566)**	**97.03% (N=6,838)**	**95.22% (N=6,545)**
Initial Treatment	**91.20% (N=830)**	**93.73% (N=781)**	**90.96% (N=962)**

SFY	2012	2013	2014
Ongoing Treatment	**89.43% (N=15,665)**	**93.49% (N=14,644)**	**91.77% (N=16,965)**

Analysis: DFS' SACWIS system (Family and Child Tracking System or FACTS) measures caseworker contact. As described in prior CFSR national reports, caseworker contact are correlated with child safety, quality case planning and permanency outcomes. For State Fiscal Years 2012 to 2014, performances in three categories are listed in the table above. Automated queries report caseworkers meet initial and ongoing contacts consistently with scores averaging 95.07% for initial investigation, 91.96% for initial treatment and 91.56% for ongoing treatment contacts.

Focus groups with Investigation staff and the DFS Administration about Item 1 indicated that staff is very conscientious about making contacts on time. Challenges to timeliness involve requests from law enforcement to delay contact until after they have conducted interviews, insufficient addresses, unknown parents, families who are out of town, worker illness, and other workload demands.

FAIR	2013 Mar-Dec.	2014 Jan.-Dec.
Percent of families contacted by phone within 24 hours	96% (N=270)	93% (N=362)
Percent of families with face-to-face contact within 48 hours (includes families requiring 24 hour response)	96% (N=248)	91% * (N=224)
Timeliness of Initial Safety Assessment during first face to face contact	90% (N= 231)	92.2% (N=322)

*January – September only - The in-person response time requirement was changed during the fourth quarter to equal the Division's Priority Response times (24 hours, 72 hours, and 10 calendar days).

The initial face to face contact time required for FAIR exceeded the Division's Priority Response times, except for reports requiring a 24 hour response. Although there was a slight decrease in the contact times during 2014, FAIR still maintained very timely contacts. The decrease in 2014 was likely impacted by staff turnover (three of five statewide staff positions responsible for the initial contacts and one of the three positions turned over twice).

FAIR Contract Monitoring

The Contractor maintains comprehensive outcome measures regarding FAIR and issues quarterly reports that are reviewed in routine joint meetings with the Division. DFS also monitored the FAIR contract with Children and Families First during March 24 -26, 2013. In addition, the Annie E. Casey Foundation conducted a one year review of FAIR and issued a report in June 2014. Finally, a follow-up FAIR contract monitoring is in progress during March 2015. The FAIR 2013 and 2014 statistics, 2014 monitoring report, and

AECF one year review are available upon request. (The 2015 monitoring report will not be finalized until June 2015).

Quality Assurance

SFY	2012	2013	2014 (Jan-Aug)
Investigation	**98.15% (N= 108)**	**98.2% (N= 47)**	**94.4% (N=145)**
Treatment	**90.74% (N= 47)**	**93.15% (N= 31)**	**N/A**

The measurement for child safety during Quality Assurance Reviews is a composite of questions in investigation and treatment assessing safety in the child's residence. For the periods 2012 and 2013, Investigation and Treatment reviewers addressed five safety questions, which make up the composite outcome for Safety. QA reviewers are asked to identify the specific safety outcome documented in the assigned case record (Safe, No Plan Needed; Unsafe, Safety Plan Needed; Unsafe and removed from home). Based on the information in the record, indicate if they agree with the selected outcome or not. In addition, if the child was in out-of-home care and returned home, reviewers are asked if a safety assessment and plan (if needed) was completed. Finally, reviewers are asked if safety continued to be assessed throughout the period under review, consistent with policy requirements if circumstances change in the family household or situation.

For the 2014, Treatment QA review system was suspended, due to the adoption of SDM and SOP practice changes. The new instrument will be available in 2015. For 2014, the Investigation QA review instrument was modified to incorporate SDM/ SOP practice items. Reviewers are asked to respond to questions addressing the following six safety assessment and planning areas:

- Completing on appropriate household
- Assessing ALL children in the household
- Identifying safety threats
- Identifying appropriate safety interventions
- Final safety finding appropriate
- Safety agreement, when needed, adequate

The goal is 100% will be assessed as safe. The Family Services' Quality Assurance Case Review measure for assessing child safety in investigation and treatment cases is consistently above 90%.

Safety Outcomes 2: Children Are Safely Maintained In Their Homes Whenever Possible and Appropriate

The online survey indicated that 89.2% of the respondents either agreed or strongly agreed that Family Services helps strengthen families so they can safely care for their children in their own homes.

Item 2 was also discussed with five focus groups: DFS Administration, Investigation, Community Professionals, Clients, and Treatment. The strengths and challenges that were discussed are described below.

Strengths

- We do our best to provide services so that the children are safe while we help the whole family.
- We meet with families to create a plan; we ask questions, look for other relatives and spend time with them.
- TDMs have been very helpful with looking for alternatives to placement, especially finding non-relative placement resources. More service focused culture - Safety Organized Practice.
- We have used prevention placement funds for this. We have offered services such as housing, day care referrals, parent guides, etc. in an effort to meet this goal. Other clusters of services that work well to support at-risk families are: visiting nurses, parent aids, intensive outpatient, one-on-one therapists, and mentors.
- FAIR has effectively prevented foster care entries of teens.
- We have seen a reduction in youth in care and the Outcomes Matter initiatives have been effective with support and services.
- Workers were professional. One woman who has her grandchild reported that DFS does call and check in to see if she needs anything.

Challenges

- Workers are not always aware of services available.
- Services needed - More respite services and crisis intervention services, increased access to mental health treatment and substance abuse treatment. More resources for affordable housing are needed.
- There are also waiting lists or a lack of services at times (especially downstate).
- The Children's Advocacy Center provides services, but often does not communicate with DFS on outcomes.
- In cases of domestic violence, abuse and neglect along with substance abuse, the role of the liaisons can be confusing as the client is unsure as to whether the liaison is working for the client or the state (DFS).
- Trying to plan with non-custodial parents is difficult.
- Courts sometimes place a child with us despite having found other relatives as a resource. Would like DHSS to provide better resources that are safer - not placing at crappy motels that are not safe.
- We need more experienced and effective parent guides.
- Increase Prevention and Behavioral health services.
- We have issues with caregivers not being forthcoming and/or honest.
- There seems to be a lack of understanding of DFS by outside influences.

DFS implemented a new practice model known as Safety Organized Practice (SOP) to engage families better. One of the premises of

this model is to elevate the voice of the family and the child.

The online survey revealed that 91.5% of the respondents thought DFS evaluates the safety of children in their own homes or in foster care and takes action to keep children safe.
DFS implemented Structured Decision-Making® (SDM) Safety Assessment in Investigation and Treatment on February 12, 2013. The Safety Assessment is more balanced because it not only identifies safety threats, but it identifies the protective capacities of the caretakers, too. The SDM® Risk Assessment was also implemented in Investigation on that date. To ensure fidelity to the assessment tools, six case readings have been conducted by the National Council on Crime and Delinquency's (NCCD) Children Research Center (CRC) between March 2013 and January 2015. Furthermore, DFS requested on-site coaching by the CRC staff regarding the tools, as well as our new practice model initiatives known as Outcomes Matter.

Two data indicators that children are being safely maintained in their own homes is the absence of maltreatment recurrence and the number of children that are placed in out-of-home care. A third data indicator is the absence of maltreatment in foster care.

Absence of Maltreatment Recurrence

FFY	2010 (N=934)	2011 (N=1,228)	2012 (N=1,218)	2013 (N=947)
	97.1%	97.8%	97.5%	96.9%

Since FFY 2010, Delaware has consistently exceeded the absence of maltreatment recurrence standard of 94.6% each year through FFY 2013. The new national standards released for the CFSR's third round for recurrence of maltreatment reports, using FFY 2012's NCANDS submission, states Delaware exceeds the 9.0% standard with a Risk-Standardized Performance of 4.9% and an interval of 4.0%-6.0%. This score is at least 3% better than the new 9.0% standard. This includes children from birth to age eighteen.

Data regarding re-reports for FAIR is available for the period March 2013 – March 2014. During this period, approximately 60 youth (16.4%) who had been previously referred to and/or served by CFF (out of a total of 365 youth over the same period) were re-reported to DFS Report Line. Disposition information was available for 50 of the 60 youth and only 4 of the re-reports were substantiated. The substantiation type (abuse, neglect or dependency) was not identified.

Additionally, DFS did an internal review of cases in which a Safety Plan was utilized to help address safety issues while maintaining the child in the home. In SFY14, 1, 928 children were subject of a Safety Plan, but only 45 of those children subsequently entered foster care within 6 months of the plan's implementation.

Children Placed in Out-of-Home Care

SFY	2010	2011	2012	2013	2014
Average # of children in care monthly	**692**	**684**	**739**	**687**	**602**
Children returned home with parental custody	**25.6%**	**25%**	**41.5%**	**38.1%**	**32.7%**

Source: DFS Statistical Fact Sheets

There has been a 13% decrease in the average monthly foster care population since SFY 2010, with the exception of SFY 2012. Conversely, there has been an increase in the number of children returned home with parental custody, with the exception of SFY 2011 which had a 0.6% decrease.

One of the most impactful systemic changes made by DFS to lessen the number of children entering care is Team Decision Making (TDM). These facilitated meetings are mandated during investigation, treatment or FAIR for children at risk of removal or just after entering custody. TDM started August 24, 2013 and through December 31, 2014 there were 381 meetings involving 595 children. Of those, two hundred eighty or 47% of children were diverted from entering foster care.

FAIR comprises a Family Assessment (FA) and Intervention Response (IR) with two levels of services. Level I services utilize Family Keys, Structured Decision-Making® (SDM), and CAFAS assessment tools while Level II provides Functional Family Therapy (FFT). The main goal of Level I services is to decrease out-of-home placement for youth by offering families wraparound services including intensive, short-term crisis intervention and referrals to community-based programs, 24 hours per day, 7 days per week. Families in need of more intensive clinical supports for conflict resolution and relationship repair are tracked to Level II (FFT). FFT is a highly structured, relatively short-term intervention in which most families can effectively be served with 12 to 20 weekly sessions.

Since FAIR began, a total of 607 of 673 families (90%) agreed to participate and were assessed by FAIR. Of these, 71 were returned to DFS because of safety and risk or closed after the assessments indicated there were no safety threats or risk concerns. This left 536 youth who were actually served by FAIR. Of the 607 assessed by FAIR, 26 (4.2%) of the youth entered DFS placement either after being referred back to DFS immediately after assessment or after services provision. Of the 536 youth who actually received services beyond assessment by FAIR, 11 (2.0%) entered placement or were incarcerated at a later date.

Absence of Maltreatment in Foster Care

FFY	2010 (N=1,210)	2011 (N=1,267)	2012 (N=1,306)	2013 (N=1,162)
	99.75%	99.92%	99.85%	99.57%

The national standard for absence of maltreatment in foster care is a goal of 99.68% or higher. Delaware has met the standard of 99.68% in 3 of 4 years, FFY 2010 to 2013. For the 3 years exceeding the standard, the average is .347% above standard. A new national standard began 2014. The measure is expressed as the number of victimizations per 100,000 days in care. Using 2013 and 2014 data, Delaware's Risk-Standardized Performance of 8.88 is within the interval of 5.6-14.09. Overall, Delaware's performance demonstrates a strong safety record in foster care settings.

Focus groups with Division Administration and Community Professionals regarding Item 3 showed the following strengths and weaknesses:

Strengths

- In foster care we do very well.
- This is documented through court proceedings and written reports from DFS. Additionally**,** referrals to DFS, home-based services, in school counseling, school lunch programs and referrals for goods (cribs, car seats etc.) ensure other systems address risk and safety.

Challenges

- We sometime struggle with documenting the strengths of families. This should improve with the new framework (Consultation and Information Framework developed by national consultant, Sue Lohrbach).
- We don't see much of intact families. This question is based on contact schedules but we need more than one or two months.
- Funding is always a challenge.
- First responders are pushing to educate officers on identifying neglect (can be a grey area).
- Some community partners cannot provide the services needed as there are too many in need and not enough assistance.
- We must work to identify gaps or areas of underutilization in services - community, contracted; all services need to be utilized.

Based on information gathered from online surveys, focus groups, and data analysis show that Delaware is in substantial conformity with Safety Outcome Measures 1 and 2. Initial and ongoing contacts are timely. Evidence-based safety and risk assessment tools were implemented to improve decision-making. An array of practice initiatives such as Family Assessment and Intervention Response, Safety Organized Practice, and Team Decision Making were enacted under the umbrella of Outcomes Matter to increase the skills of staff to engage families and to prevent the placement of children.

B. Permanency Outcomes 1 and 2

Delaware's performance on national standards for placement stability, reunification and adoption are mixed. The state's information system provides foster care population attributes, placement stability data and permanency goal measures.

Permanency National Profiles: March 18, 2014 and March 28, 2012

Last FFY available	2009	2010	2011	2012	2013
Of those children in care less than 12 months - % with 2 placements or less. Goal is 86% or higher.	81.5%	84.0%	82.1%	79.4%	83.3%
Of those children in care for 12 but less than 24 months - % with 2 placements or less. Goal is 65.4% or higher.	62.6%	61.3%	62.6%	62.6%	61.3%
Of those children in care 24 or more months - % with 2 placements or less. Goal is 41.8% or higher.	28.2%	26.4%	28.2%	35.5%	33.6%
Reunification within 12 months from the most recent removal from home. Goal is 75.2% or higher.	68.1%	67.9%	76.7%	64.6%	68.2%
Adoption within 24 months from the most recent removal from home. Goal is 36.6% or higher.	35.2%	35.8%	34.7%	31.9%	43.2%

For national standards of placement stability, Delaware has not met the standards for cohorts (in care 0-12 months, 12-24 months, >24 months) for the 5 year period 2009-2013 (National Profiles March 28, 2012 and March 18, 2014). The data demonstrates overall consistent performance and improvement in the >24 month cohort. Additionally, DFS has analyzed this issue extensively and was able to determine that the children who experienced multiple placement changes in the first 100 days in care were those most likely to continue to experience multiple placement changes over their time in care. Consequently, several efforts have been focused on helping to stabilize early placements. These have included behavioral health and trauma screenings for all children and youth entering care. The information gleaned from these screenings is then collated into brief reports that help workers, supervisors, and foster parents better

understand the issues and needs of the children and youth, so that interventions and services can be better tailored to their individual needs. Additional supports for foster parents also have been provided including training on trauma and the implementation of a warm line to help provide immediate guidance and support on de-escalation strategies.

DFS has also implemented an Entry Cohort Longitudinal Database (ECLD) to aide in the assessment of program and practice changes. The national data profile sets utilize aggregate data. Many children and youth in foster care experienced multiple placements prior to the implementation of these supports; consequently, the often large number of those prior placements can skew the data. The ECLD builds statistical case histories for each child who enters care within a specified time frame. This then allows comparisons by disaggregating large child welfare data sets into cohorts of children who entered care before and after specific policies and /or practices were changed. ECLDs are free from the types of biases found in point-in-time data (e.g., which includes all placement histories, including those prior to practice changes) or Exit Cohort data (e.g., which tend to over-represent short stayers in foster care). ECLDs provide the clearest and earliest evidence of how changes in policy and practices can impact child outcome measures. The ECLD reports data measures semi-annually for foster care entries in 2 age categories, teens and younger children, on relative placements, congregate care placements, placement stability, permanency and re-entry. DFS has been able to demonstrate that children entering foster care in the last two years are having fewer placements in the first 100 days. Of the 100 teens age 13 and older entering care during January-June 2011, 64% had 2 or more placements in the first 100 days. For the period July-December 2013, of the 60 teens entering care, only 33% had 2 or more placements in the first 100 days, a 31% improvement.

For the national standard of reunification within 12 months of removal, Delaware met the goal of 75.2% once (2011) over the 5 year national profile reporting periods. The data indicates that Delaware is slower to reunify, however for a comprehensive interpretation of this data, is important to balance it against two other factors. First, to the companion measure for foster care re-entry for these years meets the standard except for 2009. For the 3 federal years, 2011-2013, Delaware has re-entry to foster care rates of 7.3%, 3.5% and 6.8%, respectively. The standard is 9.9% or lower. This suggests strong assessment and service provision to ensure a safe and stable return home. Second, Delaware has a low overall entry rate into foster care, indicating that many children are safely maintained in their families. These two factors together suggest that in Delaware, the children/youth actually in foster care may tend to present with more complex needs. Consequently, the reunification process may be more lengthy than it is in other states with higher entry rates.

For the national standard regarding exiting to adoption within 24 months of the latest entry into foster care, Delaware met the goal of 36.6% once (2013) during the reporting period. Delaware was within 2% for 3 of the remaining 4 years. The 2013 score of 43.2% is the best on record.

Another Planned Permanent Living Arrangement (APPLA) goal choices are evaluated by Quality Assurance Case Reviews conducted by DFS supervisors and management. For calendar year 2012, case reviewers agree 100% with APPLA goal selection and 92.86% for calendar year 2013. Focusing on youth aging out of foster care, the permanency national measure is: Children Emancipated Who Were in Foster Care for 3 Years or More. The standard is lower than 37.5%. For the past 3 federal years, 2012-2014, Delaware has scored 31.1%, 36.8% and 30.8% respectively.

The number of foster children with the goal of APPLA has reduced from 233 in April 2010 to 146 in June 2014. Along with more attention to achieving permanency for teens by DFS and Family Court, the drop in foster care population, reduction in teen entries and increase in kinship initial placements, are all possible factors contributing to the reduction of APPLA permanency goal selection. Focus groups were asked questions about the state's permanency performance. Topics covered included placement stability, establishing permanency goals, efforts to achieve permanency, placement with siblings, visitation with family, preserving connections, kinship care efforts and efforts to promote relationships. Noted strengths include data demonstrating early placement stability for teens within the first 100 days of placement (a 31% improvement). Other common factors contributing to Delaware's positive performance are increased efforts to find and engage relatives (Family Search & Engagement) for placement and social support, and using Team Decision Making before or just after foster care entry to identify needed and available supports. Improved communication among caregivers, youth and caseworkers is also noted as a strength promoting placement stability and permanency planning. Challenges are high caseloads, conducting more pre-removal Team Decision Making meetings, case planning documents not available in FACTS and inadequate guardianship financial assistance. DFS caseworkers noted legal barriers exist when parties or the judge do not agree with agency goals, and delays due to pending criminal proceedings. Youth would like more visits and contacts with their caseworker, family and siblings.

Permanency Item: % Agree_Strongly Agree	Community Professionals	DFS	DSCYF	Legal	Fost/Adopt Pts	Youth
Permanency Outcome 1: Children have permanency and stability in their living situations						
Item 4: Is the child in foster care in a stable placement and were any changes in the child's placement in the best interests of the child and consistent with achieving the child's permanency goal(s)?	76.2	67.3	57.2	70.3	86.9	78.4
Item 5: Did the agency establish appropriate permanency goals for the child in a timely manner?	79.6	88.5		80.4	64.5	
Item 6: Did the agency make concerted efforts to achieve reunification, guardianship, adoption, or other planned permanent living arrangement for the child?	75.9	97.1	76.4	82	83.4	77.5
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.						
Item 7: Did the agency make concerted efforts to ensure that siblings in foster care are placed together unless separation was necessary to meet the needs of one of the siblings?	84.5	96.2	94.4	90.8	90.6	68
Item 8: Did the agency make concerted efforts to ensure that visitation between a child in foster care and his or her mother, father, and s blings was of sufficient frequency and quality to promote continuity in the child's relationships with these close family members?	93.2	96.1	85.4	83.6	94.4	78.9
Item 9: Did the agency make concerted efforts to preserve the child's connections to his or her neighborhood, community, faith, extended family, Tribe, school and friends?	80.3	84.6	83.9	70	86.6	74.7
Item 10: Did the agency make concerted efforts to place the child with relatives when appropriate?	95.7	100	96.7	98.2	94.6	75
Item 11: Did the agency make concerted efforts to promote, support, and/or maintain positive relationships between the child in foster care and his or her mother and father or other primary caregivers from whom the child had been removed through activities other than just arranging for visitation?	63.6	79.2	72.5	53.6	73.1	67.7

Surveys distributed to community professionals, foster/adoptive parents, DSCYF staff, DFS staff, legal and court representatives and youth included permanency items rated on a scale from 'strongly disagree ' to 'strongly agree'. The results for these items are listed below:

Based on data, survey and focus group information, Delaware performs well with placement stability, permanency goal achievement, relative placement, and preserving relationships and connections for youth and families.

C. Well-Being Outcomes 1, 2, and 3

1. Families have enhanced capacity to provide for their children's needs.

QA Data 2013

OUTCOME MEASURES	GOAL	STATEWIDE	Beech	Kent	Sussex	UP
WB1, Item 17: Needs and Services to Children, Parents and Foster Parents*	**75.00%**	**75.51%**	**71.92%**	**73.68%**	**78.76%**	**78.40%**

To determine whether, during the period under review, the agency made concerted efforts to assess the needs of children, parents and foster parents (both at the child's entry into foster care [if the child entered during the period under review] or on an ongoing basis) to identify the services necessary to achieve the case goals and adequately address the issues relevant to the agency's involvement with the family, and provided the appropriate services.

The QA Case Review process was suspended for FY15 due to the extensive trainings on the new practice model, Safety Organized Practice and the implementation of SDM® in Treatment services. During this period, DFS relied on ongoing QA case readings by the Children's Research Center. What this benchmark data from 2013 indicates is that generally DFS met or was relatively close to meeting the goal. Where regions have struggled to meet this goal historically, the primary challenge has been in caseload pressures that have reduced the time workers felt they required for more intense work with families on helping them identify and plan for their needs. The implementation of the SDM® Child and Family Strengths and Needs Assessment, along with the components of Safety Organized Practice, have provided workers with additional skills and strategies to more effectively engage families and deepen the process of assessing and planning for their needs.

Stakeholder feedback has indicated that for children and youth entering foster care, the initial screenings now done by the Screening and Consultation Unit have been extremely helpful in ensuring that plans are comprehensive and appropriate referrals are identified and completed as early as possible in the process. Other feedback has indicated that the STEPS Meetings utilized to help older youth plan for their transition to adulthood have been extremely helpful in ensuring that their needs are addressed in a comprehensive and

collaborative manner. Court staff indicated that there is a significant increase in youth participation in the hearings and these meetings. Client families have indicated that they perceive greater support from their caseworkers—this was true for birth, foster and adoptive families.

2. Children receive appropriate services to meet their educational needs.

QA Case Review Data 2013

OUTCOME MEASURES	GOAL	STATEWIDE	Beech	Kent	Sussex	UP
WB1, Item 21, Education	95%	94.07%	93.18%	93.33%	95.65%	95.24%

To determine if, during the period under review, the agency addressed the educational needs of the child(ren).

DFS has collected qualitative data in case reviews to assess whether children are receiving appropriate services to meet their educational needs. Data from 2013 indicates that regions met or were close to meeting this measure. However, the measure is limited to a general assessment that educational needs are addressed. In addition to this measure, Delaware has utilized other system level data for deeper assessment and monitoring of educational outcomes. One of the efforts that Delaware has undertaken to improve education outcomes was the creation of the Child Protection Accountability Commission's Education Committee, which was formed in 2012. The committee involves multiple system partners in assessing, monitoring and improving education outcomes for children in foster care. This committee receives and analyzes data from DFS and the Department of Education at least semi-annually. For the 2012-2013 school years, data analysis showed that there was very little difference in the attendance rates of foster children (92%) versus all other students (95%). Additional data shows that of all school-aged children, 48% of children in foster care qualify for special education, compared to 20% of all other students. In terms of graduation rates, 57% of all seniors in foster care graduated from high school compared to 87% of all other high school seniors. The data also showed a marked difference in scores on the standardized testing that all Delaware public education students complete. The scores for foster care students were lower than the scores for the general population of students. This discrepancy became more pronounced in the higher grades (7th, 8th, 9th, and 10th).

Proficiency on DCAS	5th Grade	8th Grade	10th grade
Math all Students	74%	68%	70%
Math Students in Foster Care	52%	41%	30%
Lang. Arts all Students	73%	74%	73%
Lang. Arts Students in Foster Care	50%	48%	47%

In assessing and monitoring these outcomes, DFS has worked with its sister Division of Prevention and Behavioral Health Services (DPBHS) to develop additional mentoring and tutoring programs statewide. DPBHS will be bidding their continuum of community-based prevention services in April 2015; the RFP contains specific requirements about including literacy services and tutoring as part of most of the recreation and after-school programs. Additionally, DFS continues to work with the Parent Information Center, which sponsors the Educational Surrogate Parent Program. Given the high number of children in foster care who are eligible for special education services, DFS and the PIC are working collaboratively to increase the number of foster parents who are trained to be Educational Surrogate Parents. Each year at the annual foster parent training conference, there is also a workshop that is focused on helping foster parents learn to collaborate with the schools, use online resources to track student performance, and access supports from the PIC as needed. Lastly, DFS and the CPAC Education Committee have collaborated on bringing training on Trauma-Sensitive Schools to all the school districts in Delaware over the last two years. The impetus for this training was to help school staff better understand the emotional and behavioral issues of children who have experienced trauma, with the hope that this understanding would both increase the schools' sensitivity and supports to these children. While not limited to foster children, a more trauma-sensitive school environment can be a definite support to children in foster care.

The workgroup also analyzed the number of placements youth have during the school year. According to the data, 57% of all children in foster care were able to remain in the same foster home for the entire school year. Assessing this data yearly will help Delaware monitor success in providing Best Interests Meetings for students, develop appropriate transition plans as needed, and better coordinate with the McKinney Vento program managers in the school districts. One of the important policy changes that came through this collaboration was a change in Department of Education Regulations in the summer of 2014, which now allows youth in foster care to be eligible for graduation meeting the minimal core standards. The problem before had been that some of the districts had additional requirements, so that when youth transferred between schools they often had missed opportunities to take required courses, which delayed or deterred their graduation.

Feedback from community professional stakeholders was overwhelmingly positive that the efforts to improve collaboration and coordination between DFS and the school districts are showing progress. Similarly, the client and foster parent focus groups also indicated that they perceive greater supports being available in helping children and youth succeed academically. The challenge identified was that while most school districts have increased their support for children in care, there remain a few schools that have not made these changes. This is an expected result given that there are multiple schools in the 19 districts statewide.

3. Children receive adequate services to meet their physical and mental health needs.

OUTCOME MEASURES	GOAL	STATEWIDE	Beech	Kent	Sussex	UP
WB1, Item 22, Physical Health	**98.00%**	**96.77%**	**97.67%**	**93.55%**	**96.30%**	**100.00%**

To determine if, during the period under review, the agency addressed the physical health needs of the child(ren).

OUTCOME MEASURES	GOAL	STATEWIDE	Beech	Kent	Sussex	UP
WB1, Item 23, Child Mental Health	97.00%	98.43%	100.00%	94.59%	100.00%	100.00%

To determine if, during the period under review, the agency addressed the mental/ behavioral health needs of the child(ren).

This data from 2013 indicates that from general qualitative reviews of case records the DFS regions met or were close to meeting this standard. However, in order to provide more comprehensive assessments of these issues, DFS has utilized other approaches.

From 2012 – 2013, DFS worked with the Health Committee of the Child Death Commission to conduct a review of a randomized sample of files of children in foster care to assess whether their physical health needs were being addressed according to standards of the American Academy of Pediatrics. Dr. Amanda Kay, a pediatrician with Christiana Health Care Systems chaired the group. The sample included a total of 50 cases statewide (10 from the 4 regional offices and an additional 10 selected to review children with known chronic health issues). The report of this committee was approved in the spring of 2015. Major findings included that over 85% of children were getting their initial health screenings according to policy; over 47% had documentation of a current chronic health issue (e.g., asthma, behavioral health disorder); and less than 50% of children were getting timely dental care. In addition to these child-level findings, the report also detailed a number of challenges in the system including the lack of preventive care many of these children received prior to foster care, the lack of understanding among health care providers of the unique challenges in treating children in foster care, and the lack of coordination of health care services. These findings helped create the opportunities for additional review which follow.

Tufts Consultation Project on Psychotropic Medications

Utilization data from Medicaid is being used for system-level monitoring of the prescribing of psychotropic medications for children and youth in foster care. In FY2014, 55.1% of children received no such prescriptions; 11.6% received one (1) prescription; 8.4% received two (2); 6.6% received three (3); and 18.3% received four (4) or more. DFS applied for and was awarded an opportunity to consult with Tufts Medical School, which has led the national effort to raise awareness of the over-use of psychotropic medications both with the Administration for Children and Families/Children's Bureau and the US Congress. As part of the consultation project, DFS and DSCYF are provided several on-site consultation visits, along with monthly teleconferences. The project has brought together key partners such as the State Medicaid Office, Nemours Children's Hospital and psychiatrists from the primary residential treatment centers in the state. The consultation project provides data analysis, as well as ongoing consultation on the development of system- and client-level monitoring and interventions, as well as assistance with the development of policies and procedures.

DFS has developed a contract with a licensed pharmacist for some part-time consultation on case-level monitoring and outreach to prescribers who are prescribing outside of accepted protocols. This pharmacist consultant is also participating in the Tufts Consultation Project. DSCYF has also implemented a trauma-informed approach across the department, which includes increased guidance for ensuring that appropriate psycho-social interventions are identified and implemented for children/youth, as a way of assuring that the

underlying issues of trauma are addressed. Language addressing these expectations were included in all department contracts for FY 2016.

Taskforce on Health Needs of Children in Foster Care

In June 2014, the Delaware General Assembly provided funding to support the Taskforce on Health Care Needs of Foster Children. The Task Force is co-led by Dr. Cathy Zorc of Nemours and Dr. Vicky Kelly of DFS and includes representatives from DFS, Nemours Children's Hospital, Nemours Health and Prevention Services, Controller General's Office, private foster care agencies, Christiana Health Services, Division of Public Health, Office of the Child Advocate, Child Death Commission, DE Chapter of the American Academy of Pediatrics, State Medicaid Office, and several Managed Care Organizations. The initial funding provided comprehensive data analysis of Medicaid claims and utilization data for all children in foster care.

Nemours Children's Hospital provides the Foster Care Clinic service for initial health screenings of children entering foster care. The data has provided a way to geomap all children in foster care by zip codes, to help provide greater coordination of health care services. While foster parents may elect to seek ongoing care management from their preferred pediatricians, DFS is encouraging foster parents to utilize the Foster Care Clinic, which is able to provide continuing coordination of services through their outpatient practice offices.

The utilization data provides system level benchmark data for well-child visits (60%), physician visits (any type) 88%), inpatient hospitalizations (8%), emergency department visits (37%), and behavioral health visits (61%). The data further provides analysis of these types of services by the age of child and by the number of placements. The data also provides a breakdown of the most common high risk diagnoses: behavioral health (61%), asthma (10%), pregnancy (2%), autism (1.4%), diabetes (1%), Hepatitis C (<1%), HIV (<1%). This data helps drive recruitment efforts and training of foster parents.

The data also provides benchmark information on the top diagnoses for emergency department visits: 3% for acute UTI, 2.76 for Depressive Disorder NOS, 2.15% for acute fever NOS, 1.75% for asthma with acute exacerbations, 1.75% abdominal pain NOS; 1.75% lower leg injury; 1.68% Otitis Media NOS and 1.68% constipation NOS. Other data provides top diagnoses for inpatient visits: 11.1% for Failure to Thrive; 6.09% for acute respiratory distress; 4.06% for RSV bronchitis; 2.74% for single lab test in hospital; 2.27% for asthma with acute exacerbation; and 1.55% for obstructive sleep apnea. Also provided are data on the top diagnoses for office visits: 8.97% for ADHD; 7.4% for Adjustment Reaction with Conduct Issues; 6.11% for Adjustment Reaction NOS; 5.14% for prolonged PTSD; 3.22% for prophylactic vaccination and inoculation; 2.86% for Depressive Disorder NOS; 2.09% for Affective Psychosis NOS; 1.97 for Adjustment Reaction with Anxiety; 1.93% for Opposition Defiant Disorder; 1.79% for Adjustment Disorder; 1.08% Lack of normal development unspecified; and 1.01% Otitis Media NOS. This information will be valuable in further assessing and planning for services, especially as behavioral health issues continue to be a significant issue for so many children in foster care.

Section IV: Assessment of Systemic Factors

A. Statewide Information System

The Family and Child Tracking system (FACTS) is the statewide automated case management system used by DSCYF to record detailed client information and, all case work activities involving families and children. The Delaware FACTS Information System is a fully SACWIS compliant operational system. Final notification of this determination was received from ACF on December 7, 2011.
The FACTS system is used by all operating divisions within DSCYF including child welfare, juvenile justice, prevention and behavioral health. All divisions share the collection of client level demographic and residential details, regardless of which division or, program, thus, reducing duplication or redundancy of client records. This process also requires case managers from across the department, to address accuracy of data details and, service panning and permanency goals for clients in common.
FACTS serves multiple purposes:

- FACTS allows DSCYF users to quickly identify the status of every child in foster care, the demographics for every child (date of birth, sex, race, ethnicity, disability, medically diagnosed condition and if the child has ever been adopted), every child's physical location, and the specific permanency goals for every child.
- To provide a single database for all clients served by DSCYF thus, ensuring reduction in duplication of client level data; accuracy and completeness of client detail and; ensuring capacity to quickly identify all family and children services being provided by all divisions and programs.
- To ensure system capacity to document and, make available, all current and historical information regarding children in DSCYF approved or contracted residential services.
- To provide the ability to meet all federal, state and system critical reporting requirements and; the ability to create both standardized and, customized reports using FACTS as the data source.

FACTS became a fully usable application for DFS in 1996. Since that time, all client records, including case management activities and, foster care placement history, has been maintained. In addition, client records are maintained on secure DSCYF servers, with access limited to logon security requirements and, profile access security. The system is available "24-7", to all staff statewide, with appropriate security access. DFS uses the FACTS system to record all programmatic activities including Hotline, Investigation, Treatment, Permanency, Adoption, Independent Living and Interstate Compact. Included in most programmatic activities are the recording of intervention activities, engagement of clients in the assessment processes, engagement of clients in the service planning process, documentation of service delivery activities, foster care placement activities, visitation and, all permanency planning activities and decisions.

DFS practice standards and guidelines require all client level activities and details be entered into the FACTS system within 48 hours after staff have collected or, learned of the information. While this primarily involves staffs direct work with families and children, it does include the receipt of third party documentation such as court orders with permanency goal changes or a child's health record with details that must be recorded in FACTS. The only exception to the requirement involves contracted providers with case management

responsibilities. All contracted providers are prohibited from directly accessing the FACTS information system. Therefore, contract providers managing case planning and activities for children in foster care, must provide DFS with updates every thirty days. The only specific information impacted by this delay is the recording of monthly foster care contacts. However, contractors must notify DFS ahead of time or, within 24 hours, if they plan to move a child between two of their own providers. Access by contracted providers, with appropriate security profiles and settings, to the information system is a planned change in the upcoming FACTS II system.

FACTS information is used to meet the following federal reporting requirements:

- NCANDS
- AFCARS
- NYTD
- Monthly Foster Care Contacts

Data Quality and Reporting

DSCYF utilizes a variety of mechanisms to ensure the information entered into the FACTS system is timely and accurate. The FACTS General User Manual and 'help' guides are available to staff to assist in understanding the structure and data entry requirements for all events. All DSCYF Divisions have 'FACTS Liaisons'; staff specifically trained in the FACTS system and, available to support staff with data entry issues or to assist in correcting or modifying incorrect information. Staffs who are new to the Department participate in FACTS training which addresses login and security access, confidentiality of client records, navigation and, key areas of data entry (i.e. client demographics, placement records, custody records). Refresher training is available to all staff upon request. Prior to any FACTS version, staff is provided training as to the key enhancements included in a version and, implications to workflow's and data entry requirements.

FACTS liaisons are routinely involved in data maintenance activities (i.e. duplicate identification numbers, placement record errors, and request for data correction) and, corrective actions to minimize or eliminate such errors. When such data entry errors are identified, prior to any changes, Liaisons review in detail all information regarding the person and, will address any inaccuracies with staff before making final changes. Staff are monitored for the frequency of entering data errors and when necessary, offered refresher training to address problem areas.

DFS has a Quality Assurance Case Review system, in which cases are randomly selected and assigned to staff for in-depth case reviews. A part of the review process, especially ones addressing children in foster care, is a review of the details identified about a child. This includes a child's demographic information, placement history, current placement location and, permanency goals. When case content details (i.e. interview documentation, birth certificates, court order documents) contradict details recorded, QA reviewers documentation these finding and, communicate to the regional office and supervisors the issues identified.
During CY13 (last available full report), 71 Treatment/ Permanency case reviews were completed, including an assessment of this detail. Between January and June, 2014, 111 Investigation reviews were completed, including an assessment of this detail. [See additional details under Item 25 Quality Assurance System].

Every child who comes into DFS custody and is placed in out-of-home care, must have a 'master client index number' (MCI#) assigned to them. This is a unique identification number assigned by the Department of Health and Social Services (DHSS). DHSS monitor and coordinate such services as TANF, IV-D Child Support and, Medicaid. When DFS conducts a search of the DHSS database for a child, all critical demographic information must match before the MCI link is created. When the information is different, the DFS record is reviewed for accuracy or, DHSS is notified of the differing information for review. When it appears all details regarding a child match between DFS and DHSS, the MCI# is assigned to the child in the DFS FACTS system. During CY14, of the 331 children who had an episode start during this period, required verification in the DHSS system and, assignment of an index.

The majority of children who come into DFS custody and, out-of-home care, must be evaluated for IV-E eligibility. Children, who have been deemed eligible, must also periodically receive a redetermination review. The review process is conducted by a separate unit within DSCYF. The Cost Recovery unit, in addressing the detailed information necessary to make a determination of eligibility, thoroughly reviews all DFS case work activities to validate the critical data. Information reviewed includes the child's name, DOB, the home the child is removed from, current placement setting and citizenship and, custody court orders. In addition, the Cost Recovery unit is able to review child details from other sources, such as, Department of Health and Social Services, Social Security Administration and, Department of Labor. When conducting these reviews, should the data details found in the case record differ from demographic summaries or, other recorded information; staff will contact child welfare staff and review the inconsistencies. As a result, data details may be corrected, if necessary, before completing IV-E determinations. During CY14, of the 331 children who had an episode start during this period, 327 required a IV-E application be completed and a IV-E determination.

As a reflection of the confidence DFS has in the data quality documentation by staff, DFS has two reports used of the state's emergency preparedness plan. The State of Delaware 'Continuity of Operations' Plan (or COOP), ensures that any natural disaster or other significant interruption of state services, a plan is in place to address the citizens of Delaware crisis needs. This includes a plan to address crisis services for children in out-of-home care throughout the state. There are two reports generated weekly: All children in DFS custody (averaging over 650 children point in time), including demographic details pulled from FACTS, as well as, details regarding their current placement setting (i.e. foster home- foster parent name, address; group care- group care address and points of contact).

DFS maintains an inventory of over 100 management reports. These reports are distributed weekly, monthly, quarterly, annually and upon request. Many of these reports are used by operational managers, and staff, as a method of ensuring information recorded in FACTS is accurate. Critical amongst these reports, to ensure continuous review for data quality:

- Weekly custody/ foster care placement report- Management report distributed to supervisors for verification of foster care population. Report details include child name, child ID #, current foster care setting, custody start status, region, supervisor and worker. Supervisors use report to verify details in record and with staff for accuracy.

- Monthly Foster Care Activity Report- details include children entering and exiting residential services by region. This report is shared with external partners Child Placement Review Board (conducts periodic permanency reviews for children), Office of Child Advocate/ CASA Program (maintain an integrated database of children in DFS custody requiring representation of a CASA or GAL). Sharing of this information and feedback from partners, ensures accurate documentation by DFS and stakeholders, of foster children's demographics information, court activity, placement starts and exits, settings and, permanency activities.
- Annual review foster care populations- DFS and the Office of Child Advocate have a 'Memorandum of Understanding' in place, requiring an annual review of the CASA/ GAL database. The CASA/ GAL database has already been built using court orders and, the DFS monthly activity report. The CASEA/ GAL database is provided to DFS who in turn, review and identified all inconsistencies found. This can be missing children or children with inconsistent data details. Both DFS and the OCA /CASA programs review agency records and, interview staff managing the cases. Follow-up communication occurs to address which database requires corrective action. Following the review of 654 records shared between DFS and OCA/ CASA over the FY14 period, there were only 11 records where a discrepancy was identified.
- Delaware prepares the AFCARS submissions twice a year. In doing so, DFS reviews the AFCARS extract details for consistency and accuracy. Prior to any submission, data items believed to contain errors are detailed and, submitted to all regional offices for corrective action. Delaware's AFCAR submissions have consistently met or exceeded the threshold for error of 10% or less for each reportable item. On 11/11/14, DE received the CFSR Round 3 Data Profile. It was noted that DE met all of the 'data quality' standards established, as well as, meeting or exceeding all 'Statewide Data Indicators' As a result, DE is not required to include any corrective actions for these measures in any future CFSR PIP.

Survey and Focus Groups

As part of the CFSR state self-assessment, surveys were distributed to DSCYF/ DFS staff and, a variety of community partners and stakeholders. In addition, the FACTS system was addressed during the DFS Administration focus group. While all participants would not have specific knowledge of the FACTS Information System, there are several groups who use or, are familiar with the system.

- Over 80% of DFS staff indicated a belief that FACTS correctly shows foster children's characteristics, location and permanency goals.
- Over 75% of DSCYF staff indicated a belief that FACTS correctly shows foster children's characteristics, location and permanency goal.
- Focus group discussion points- Most administrators agreed with the survey findings, that child level details are correctly recorded in the FACTS system. Effort to improve data details should focus on timeliness of data entry would enhance this level of detail.

Improvement Opportunities

DSCYF remains committed to the FACTS II project. Beginning in 2012, the FACTS II system was to "Go-Live" on April 1, 2014. However, numerous problems were identified with the system and, to date have not been resolved. While DSCYF and Deloitte Industries continue to resolve the issues delaying a satisfactory implementation, no further details are available, at this time.

Given the current status of the FACTS II project, DSCYF/ DFS are reviewing necessary changes for the current FACTS system. DFS has prioritized the following changes:

- Integration of the SDM assessment instrument and service plan structure.
- Child Support Interface, return file details
- Proposed AFCARS changes.

B. Case Review System

Written Case Plan

On February 3, 2014, DFS initiated the final component of the Structured Decision Making® continuum with the launch of the Family Strengths and Needs Assessment (FSNA) and the Child Strengths and Needs Assessment (CSNA). The FSNA and the CSNA are completed with the parent and the child and help in the development of the written case plan for family members. Case plans written with children in care cover the physical and mental health strengths and struggles and plans for how their on-going medical and mental health needs will be met, including a record of the child's immunizations and medications. The case plans also include educational information including the child's grade level and a summary of his/her school performance. For youth 16 and over, there is a written description of services which will help prepare the youth to transition to independence. For those youth with a permanency plan of adoption or placement in another permanent home, there is a section designated to detailing steps taken/needed to ensure a permanent living situation.

With the launch of the new SDM tools for treatment and permanency staff, the required elements of a service plan are contained in two different locations – the FACTS Plan for Child in Care and the new SDM Case Plan. Caseworkers have been instructed to include the required AFCARS information in the Plan for Child in Care in the current FACTS system. All other information in the case plan is recorded in the new SDM case plan. The SDM Case Plan is a paper document pending the launch of FACTS 2 and therefore is not queriable regarding all of the other required elements of a case plan. Data is only available for those portions of the Plan for Child in Care that have been completed in the current FACTS system. According to DFS's AFCARS submission for the reporting period of Oct 1, 2013 – March 31, 2014, for the data submitted for the 820 children in care, 89% (728) had a case plan goal established, a case plan goal was not yet established for 6% (48) of the children at the time of the query, and 5% (44) did not have a case plan goal. For the reporting period of April 1, 2014 thru September 30, 2014, data for 815 children was submitted in the file. Of those 815 children, 85% (692) had a case plan goal established, a case plan goal had not been established for 5% of the children (44), and 10% (79) did not have a case plan goal.

Prior to the launch of the SDM tools for treatment and permanency cases, DFS conducted monthly quality assurance case reviews. Reviewers looked at whether concerted efforts were made to involve parents and children in the case planning process. According to the DFS Outcome Measures Performance Summary from January 2013 – December 2013, caseworkers involved children in the development of their case plan 71.79% of the time, mothers were involved in the development of their case plan 77.08% of the time, and fathers were involved 55.88% of the time. Because the SDM tools for treatment and permanency cases are completed on paper rather than in the FACTS system, the QA reviews were temporarily suspended in 2014. The QA reviews will begin again after DFS has a computer-based SDM tool. On August 24, 2013, DFS initiated Team Decision Making (TDM) meetings at 2 critical points in a case – either prior to a

child coming into care or within 48 hours after placement occurs. At the conclusion of a TDM meeting, the beginning stages of a plan are crafted. According to data from the TDM database for the period of August 24, 2013 thru June 30, 2014, mothers attended meetings 71% of the time, fathers attended meetings 46% of the time, and youth attended meetings 70% of the time. Our numbers continued to improve for FY2015 YTD: mothers attended 83% of TDM meetings, fathers attended 54% of TDM meetings, youth attended 71% and extended family members attended 74% of meetings. Other service providers attended 84% of TDMs. DFS caseworkers have also begun holding routine family meetings. Family meetings include anyone that is relevant to the family and provides everyone the opportunity to discuss areas of strength as well as areas of struggle. These meetings provide everyone with the opportunity to review the case plan.
Supervisors and caseworkers discuss the development of the case plan during regular Directed Case Conferences (DCC). The DCC provides the structured format for the worker and supervisor to discuss progress on the case plan as well as any areas of concern. Focus groups were conducted with DFS Administration, caseworkers and family members. Administration felt that there are very few instances when a child would not have a case plan. A barrier that was identified is that there are times when the case plan is developed in the office and then taken to the family for review and signature. Caseworkers also stated that due to high caseloads, it is difficult to have sufficient time to plan with families. 15%-20% of foster parents stated they were not involved in the development of the case plan and 80%-85% stated they had been involved. Most have involvement but never see the plan. One foster parent said they must insist on being part of the plan. Lastly, DFS recognizes that due to the delay in the launch of FACTS 2, we are not in compliance with capturing all of the required elements of the case plan. However, when FACTS 2 becomes operational, DFS will be in 100% compliance. DFS ensured that all required elements of the case plan have been included in the system.

Periodic Reviews

Delaware's case review system has judicial and administrative components. The Delaware Family Court issues custody decisions, adjudicates abuse, neglect and dependency findings, and authorizes case plans and permanency goals. The Court Improvement Program (CIP), in consultation with DFS, has established key performance measures for DFS cases. Key measures are reviewed at joint agency and CIP judges meetings where strengths and improvements are discussed. The report states for state fiscal year 2013, Family Court judges averaged 36 children in 31 cases. (See Attachments B: Delaware CIP Final Performance Key Measures Annual Report FY13)
The national profile FFY2013 permanency composites for reunification, adoption and permanency for children in foster care for long periods of time are indicative of court and agency coordination and collaboration. Delaware scores high marks for these composites.
The Child Placement Review Board conducts administrative reviews no less than once during the first year of placement and no less than annually thereafter. During FY2013, the CPRB held 720 individual reviews on 608 unduplicated foster children and held 39 Youth Rehabilitative Services reviews. DFS and Family Court hold local and state level meetings to share information and problem solve. Stakeholder comments note strengths in Guardian ad Litem and CASA representation and a positive court-agency relationship. Improvements to this system are included in the permanency section.

Permanency Hearings

The Permanency Planning Committee (PPC) reviews all children in foster care around the tenth month from the exparte court order and most recent placement episode to make a recommendation for the caseworker to present at the Family Court Permanency Hearing. This issue was discussed at four different focus groups statewide. The groups included caseworkers, supervisors, Assistant Regional

Administrators, Regional Administrators, Central Office staff and adoptive parents. Participants in all of the focus groups stated, this requirement is being met. Children in foster care have a permanency hearing within the first 12 months and annually thereafter. Caseworkers spend a lot of time in court attending hearings and/or reviews. The group stated they do not see any data on this issue.

When asked, how do they know these permanency hearings take place? The caseworkers, caretakers, birth parents, etc. are all invited to participate in these permanency hearings. Also, the court order will record the information discussed at the court hearing, who participated in the court hearing, list the name and dates of all of the previous court hearings and will schedule the date and time for the next permanency hearing or review at that hearing. A permanency hearing is held prior to the 12 month mark and annually for children in foster care until permanency has been established. Also, between the initial permanency hearing and the annual permanency hearing, the court conducts on-going review hearings to determine reasonable efforts and discuss the progress in providing permanency for the child in foster care. The number of additional review hearings varies by county and the assigned Family Court judge. Some of the judge's schedule reviews every three months and this varies by the judge and county. There is no additional data on whether or not a permanency hearing is held within 30 days of a determination that reasonable efforts to return a child home is not required. FACTS does not provide any quantitative data to show the effectiveness of these hearings in moving children through the system to permanency

DFS sent out surveys to the court and legal representatives, DFS staff and to foster/adoptive parents. From the number of surveys completed and returned, for the court and legal surveys, there were 56 surveys returned. There were 40.7% who agreed and 59.3% who strongly agreed that permanency hearings are held at least annually.

From DFS staff, there were 53 responses returned. There were 41.3% who agreed and 58.7% who strongly agreed that permanency hearings are held at least annually. From the foster and adoptive parents, there were 41 responses returned. There were 54.5% who agreed and 42.4 % who strongly agreed that permanency hearings are held at least annually. The responses show that there are permanency hearings held at least annually by the court. The survey does not show if there are compelling reasons that delay the annual permanency hearing for a child in foster care.

The permanency hearings include information such as to why the child entered foster care, whether the agency has reached out and located the birth parents, discusses the case plan and services offered to the birth parents, the services provided to the child in foster care and reasonable efforts made by the agency in moving towards permanency for that child. For those children in foster care who cannot return home and for all subsequent goal changes for the child, these cases are presented to the DFS Permanency Planning Committee for a recommendation to present at the next court hearing or review. For children who are 16 years and older, the services and supports available for the child in preparation for Independent Living are also discussed at this hearing/review and approved by the court. Older youth are invited to participate in and do attend these hearings /reviews.

There is additional information available related to permanency hearings reported in the Family Court CIP database for the Court Improvement Project (CIP) Data Review document dated June 4, 2014. The measures were provided to the state agency from closed cases during the FFY 2013. The information shows that 72% of the child in foster care received an initial permanency hearing within 12

months of placement. There were a number of reasons for the hearing delay for the children who did not have a permanency hearing within 12 months i.e. no calendar time available, related to appointment of counsel, exceptional circumstances found to extend the time, a holiday, no prison transport, child representative, etc. There is no information available from the CIP data base for FFY 2014 at this time. FACTS does not have any additional quantitative data for permanency hearings.

Termination of Parental Rights

The Permanency Planning Committee (PPC) reviews all children in foster care around the tenth month from the most recent placement to make a recommendation for the caseworker to present at the Family Court Permanency Hearing. The timeline of 15 out of 22 months is discussed at the PPC meeting and ASFA date is recorded in the PPC meeting notes. The caseworker also notifies the DFS attorney assigned to the case to request a motion for a goal change needs to be filed at the court prior to the next scheduled hearing/review. When there are exceptions to the termination of parental rights requirement, the exceptions and compelling reasons for determining why a termination of parental rights (TPR) would not be in the child's best interest is recorded in the PPC meeting notes. This information is also presented to the court at the next hearing/review. The filing of the TPR petitions was discussed at three different focus groups statewide. The groups included caseworkers, supervisors, Assistant Regional Administrators, Regional Administrators and Central Office staff. Feedback was that the agency is in compliance with this requirement, but they have not seen any data. The DFS attorney or the courts have not brought the delay in filing termination of parental rights petitions to the attention of the state agency staff for being out of compliance on this item.

DFS sent out surveys to the court and legal representatives and staff. From the number of surveys completed and returned, for the court and legal surveys, there were 56 surveys returned. There were 48.9% who agreed and 36.2% who strongly agreed that TPR petitions are filed timely.

From DFS staff, there were 53 responses returned. There were 55.8% who agreed and 39.5% who strongly agreed that TPR petitions are being filed timely. The responses show that termination of parental rights petitions are being filed timely at DFS. This survey does not show the compelling reasons why a TPR petition is not filed timely for children in foster care for 15 out of 22 months.

The state agency data unit provides a permanency report every 6 months on the children in foster care for tracking information such as placement entries, PPC meetings, petitions filed, decisions, date of the adoption and the total months the child was in foster care. This document is also used to track children who need to be presented to the PPC committee. Upon reviewing the data on this report from October 2014, the information shows that the agency files the TPR petition within the required time frame in 62% of the cases. The report does not show when there are compelling reasons to not to file a TPR petition at 15 out of 22 months in foster care. The adoption Program Manager ensures that DFS documents the exceptions to this requirement in the PPC meeting notes. The exceptions are as follows: 1. the child is placed with a relative, 2. the state documents compelling reasons for not filling a TPR, and 3. the state has not provided services, identified in the case plan, necessary to make the home safe for the child's return within the timeframe specified in the case plan. In some cases, a parent or relative have been identified but the state is waiting for an ICPC approval. Also, there may be compelling reasons for not filing a TPR petition when one of the legal grounds exists such as 1. Adoption is not the appropriate permanency goal for the child, or 2. No grounds exist upon which to file a TPR petition.

There is additional information available related to the filing of termination of parental rights proceedings reported in the Family Court CIP database for the Court Improvement Project (CIP) Data Review document dated June 4, 2014. The measures were provided to the state agency from closed cases during the FFY 2013. The information shows there was a TPR petition filed in Family Court for 79% or 60 cases for the children who were in foster care for 15 out of 22 months. For those cases where a TPR petition was not filed within 15 of out of home placement, there were exceptions documented as to why the TPR petition was not filed or there were compelling reasons why the parents' rights should not be terminated. For this period, there were 76 cases reported and included in the above information. This information was statewide and not broken down by jurisdiction. There is no information available from the CIP data base for FFY 2014 at this time.

Notice of Hearings and Reviews to Caregivers

In anticipation of upcoming court hearings or Child Placement Review Board (CPRB) reviews, the DFS caseworker provides a list of interested parties to the Deputy Attorney General and the administrative office of the CPRB. It is with this list that hearing notifications are sent and/or subpoenas are issued. Foster parents or other placement resources (as well as birth parents) are routinely included in the list. To ensure that all parties are notified of the next hearing date, at the conclusion of the hearing the court schedules the next date. DFS does not have any quantitative data to show how many caregivers/pre-adoptive parents receive notice compared with how many actually attend review hearings. However, in the foster parent focus group, 90% of foster parents stated that they learned about upcoming hearings from the caseworker even before receiving notice from the court or the CPRB. Foster parents receive training on what to say, how to speak and how to dress in court hearings. The majority of foster parents said they feel that they are heard and are allowed to speak in Court rooms as well. A small percentage (20%) of foster parents said they did not receive notifications of Court hearings.

Focus groups composed of adoptive parents felt that they were always included in relevant hearings/reviews for children placed in their homes.

Child Placement Review Board (CPRB) has developed questionnaires to be completed by caregivers who are unable to attend reviews to ensure their opportunity to provide input. The CPRB committee is working on developing questionnaires for Educational Surrogate Parents and other service providers.

Some challenges in this area identified at the community stakeholders' focus group are that court hearing notification processes are sometimes difficult due to not being informed of changes in placements, new addresses for parties or the DFS worker knowing about address changes but the foster care placement agency worker does not.

C. Quality Assurance System

There are several contributing parts to the DFS Continuous Quality Improvement (CQI) system within the Department of Services for Children, Youth and Their Families, Division of Family Services:

- DFS Quality Assurance Case Review System
- Children's Research Center 'case read' reviews
- DFS Management Reports
- Root Cause Analysis

DFS Quality Assurance Case Review System

The primary method utilized by the DFS CQI process is the Quality Assurance Case Review system. Currently there are 5 program specific instruments being used to address outcomes in the following areas:

- Hotline (Screened-In/ Screened-Out)
- IA Investigation
- CAN Investigation
- Treatment Services
- Permanency/ Adoption Services

The Quality Assurance Case Review tools are used to monitor outcomes for children and families active in Delaware's child welfare system. A statewide case review process, in which program specific case, meeting certain criteria, are randomly sampled monthly. DFS uses specifically trained Supervisors, Managers and Administrators to conduct the reviews. Delaware has incorporated most of the Safety, Permanency and Well-being questions found in the Federal OSRI. In addition, questions evaluating the integration of intervention and practice e strategies into case work practice are addressed. Primary focus is the adoption of the SDM Risk Assessment instruments and, Safety Organized Practice activities.

Individual case review results are archived monthly and, made available to the originally assigned worker and supervisor for review. Supervisors have the ability to address any concerned they find with final reviews. Outcome reports are built quarterly, addressing both high level outcome areas and, more detailed information for specific questions.

During Calendar Year 2013, DFS assigned 31 treatment families and 40 foster care cases for review. After modifying the CAN Investigation QA Instrument in 2013, 177 Investigations were assigned for review during 2014.

Individual case review results are archived monthly and, made available to the originally assigned worker and supervisor for review. Outcome reports are built quarterly, addressing both critical benchmarks being specifically monitored over time, and, more detailed information for all questions within critical outcome areas. The results of the QA reviews has been used to inform staff of the overall performance toward achieving positive outcomes for clients on a case specific, regional and statewide basis . They are also used to provide Program Managers with information to support enhancements to DFS policy and procedures, training needs and, evaluation of needed services for specific problem areas statewide or with regional focus. Detailed monitoring and feedback in such areas as 'Efforts to place siblings together'; ' Visiting with parents and siblings in foster care'; "Needs and Services of Children, Parents and Foster Parents' and; 'Assessing [all] well-being needs of children', has resulted in consistent improvements in performance. In addition, results have informed staff of practice areas needing more attention as 'Stability of Foster Care Placements' and 'Child and Family involvement in case planning'. While full outcome reports are generally not shared with stakeholders, many individual performance measures are provided. (See Example of the CY13 'Performance Summary' attached) Note: the Outcome summary includes two additional data items, collected separately but, reported in tandem with QA outcomes. Specifically Safety and Permanency)

Children's Research Center "Quality Assurance Case Readings"

Beginning in 2012, DFS collaborated with the Children's Research Center (CRC) staff, who conducted "case readings". Primary focus of these reviews was the adoption and use of the Structure Decision-Making® instruments, along with Safety-Organized Practice (SOP) practice skills and family engagement techniques. Following each series of reviews, the CRC provided DFS with detailed review outcomes. These reports were used to help strengthen practice and, identify areas for training.

In 2013, the CRC completed 116 reviews on DFS Investigations and, 16 FAIR cases.
In 2014, the CRC completed 37 reviews on DFS Investigation and, 27 FAIR cases.
In 2014, the CRC completed 28 reviews on Treatment cases.

The CRC provided detailed reports addressing their findings, following each of the review periods. Outcome reports provided performance details for the following case review elements:
Solution- focused techniques, Framework with the Family, Reason for Referral, Risk Statements, Safety goals, Techniques to engage children, engaging the safety network.
Following is the outcome grid for the Treatment Case Reviews:

Table 1

Case Review Findings for Engagement Process (Treatment)
(N=28)

Techniques	Working Well		Worries		Both		N/A	
	n	%	n	%	n	%	n	%
Solution-focused questions	5	17.7%	22	78.6%	1	3.6%	0	0.0%
Framework	0	0.0%	28	100%	0	0.0%	0	0.0%
Reason for referral	2	7.1%	26	92.7%	0	0.0%	0	0.0%
Risk statements	12	42.9%	11	39.3%	5	17.9%	0	0.0%
Safety goal	13	46.4%	12	42.9%	3	10.7	0	0.0%
Techniques to engage children	3	10.7%	17	60.7%	4	14.3%	4	14.3%
Engaging the safety network	5	17.9%	20	71.4%	3	10.7%	0	0.0%

This information is then utilized to guide continuing coaching and refresher trainings in the practice model.

Entry Cohort Longitudinal Database (ECLD)

DFS has benefitted from the creation of an Entry Cohort Longitudinal Database (ECLD), which allows comparison of outcomes by segmented groups of children and youth in foster care. It helps build statistical case histories for each child who enters care within a specified time frame. These data bases combine the efficiencies of administrative data with the detail of targeted case reviews. ECLDs provide the clearest and earliest evidence of how changes in policy and practices can impact child outcome measures. These comparisons are made possible by disaggregating large child welfare data sets into cohorts of children who entered care before and after specific policies and/or practices were changed. ECLDs are free from the types of biases found in point-in-time data or Exit Cohort data. ECLDs are sophisticated data sets that can help minimize the investments of staff time and resources in the collection of data and initial analysis for continuous quality improvement (CQI).

The ECLD has provided performance management data on the overall Outcomes Matter Initiative, specifically as strategies were adopted to address preventing unnecessary placements, increasing placements with relatives, and improving placement stability in foster care:

- 45% reduction in all entries into foster care;
- 40% reduction in teen entries;
- 18% reduction of all children in care;
- 66% increase in being able to place teens initially with relatives;
- 38% reduction of children with 2 or more placements in the first 100 days* in care;
- 41% reduction of teens with 2 or more placements in the first 100 days* in care.

(Note: *an analysis of youth with a significant number of multiple placements identified that these youth had experienced 2 or more placements within the first 100 days of entering foster care).

Targeted CQI Efforts

DFS has also initiated a CQI approach focused on strengthening the use of safety plans in investigation and continuing protective services cases. The impetus for this study was recognition that several cases involving serious injury or death of a child, a safety plan had been implemented. DFS had conducted internal reviews of these cases, as had the Child Death, Near Death and Stillborn Commission. DFS, in conjunction with the Department of Justice and the Cabinet Secretary of DSCYF, convened a workgroup to review the issues and develop recommendations. The Office of Children's Services within DFS utilized a segmented sampling approach of 112 randomly selected cases of the 1,843 currently open cases with a Safety Plan. A team of administrative reviewers conducted a structured qualitative review of the pans to assess for appropriateness, completion, and adherence to policy. This review provided baseline data on the percentage of safety plans that conformed to policy versus those in which issues in the assessment or appropriateness did not conform to policy or good practice. Findings included that 20% involved cases in which the Safety Plan was implemented, yet not required, as the Safety Assessment did not indicate the child was unsafe; 22% indicated a need for improvement (e.g., incompleteness of documentation of rationale), and 58% indicated substantial compliance with practice and policy guidelines. This review was completed when the year-long training in Safety Organized Practice was approximately ¾ completed. The plan was for DFS to complete the remaining training modules of which provide additional training on strengthening safety plans and then reassess a sample of Safety Plans early in 2015.DFS is also working with counsel from the Department of Justice to revise the Safety Plan Agreement forms to better guide staff in their use.

Surveys and Focus Groups

- In the Surveys completed by court staff, 82% believes DFS has reports that measure efforts to improve outcomes for children and families.
- In the Surveys completed by community service providers, 89% believe DFS has reports that measure efforts to improve outcomes for children and families.
- In the Surveys completed by DFS staff, 100% believe DFS has reports that measure efforts to improve outcomes for children and families.
- Focus group comments by Community Professionals included receipt of several dashboard reports provided publicly.
- DFS Administration Focus group comments included: 1. Belief DFS does well operating a Statewide CQI system, which has standards and, provides relevant reports; 2. Safety Organized Practice and other Outcomes Matter initiatives reflect improvements to the system; 3. The Entry Cohort Longitudinal Database, helps demonstrates system improvements. This group noted the suspension of the treatment/ permanency QA case review system 18 months ago.
- Investigation Workers focus group comments included a significant number o 'n/a' replies. Investigation staff might note how well service delivery is working if, they are already in place at the beginning of their activity. Many noted that, if the record indicated families had not had success with prior providers, they might review alternatives before referring to the same one.
- Adoption/ Permanency workers focus group comments included awareness that management reports are distributed at the 'Strategic Leadership Team' meetings. However, they also indicated they would like to have more statistical reports shared during unit meetings.

The need for continued improvements to this system exists and, following are items which will be addressed:

- Review the sampling process with a focus on date parameters and, evaluate for 'over-sampling' in all program areas.
- The existing QA system is a FACTS case review only. Evaluate a multi-tiered approach in which a smaller sample of cases are reviewed to include all available information such as: FACTS case record information, hardcopy documents, interviews with supervisors, workers, families, foster care and service providers and other case participants.
- Refresher training with reviewers to further reduce errors and enhance rater reliability.
- QA system is presently maintained in an Access Database. The FACTS II development project includes an integrated QA case review module. Modification of instrument already built in the application is needed. Evaluation of further modification before FACTS II go-live is needed.
- Due to a delay in the FACTS II Go-Live target date, evaluation of restarting the current QA case review system, following the 2014 CFSR case review process.

The need for continued improvements to this system exists and following are items which will be addressed:

- Review the sampling process with a focus on date parameter and, review stratification of regional reviews and, foster care population.

- The existing QA system is a FACTS case review only. Evaluate a multi-tiered approach in which a smaller sample of cases are reviewed to include all available information such as: FACTS case record information, hardcopy documents, interviews with supervisors, workers, families, foster care and service providers and other case participants.
- Refresher training with reviewers to further reduce errors and enhance rater reliability.
- QA system is presently maintained in an Access Database; evaluate opportunities to update the FACTS Information System QA placeholder.

During 2013, DFS modified the Intake and Investigation quality assurance case review instruments having adopted the SDM® report line and risk assessment tools. DFS has also been actively changing many of its practice standards through the Outcomes Matter initiatives, including the incorporation of Safety Organized Practice, Family Search and Engagement, Team Decision Making, as well as, developing a Differential Response System. Modifications to the Intake QA tool focused on adding questions specific to the appropriate use of the SDM® decision making process and, utilization of the decision tree in order to make better initial investigation response recommendations. Changes to the investigation tool included details addressing family engagement, use of the SDM® Risk Assessment and Safety Assessment processes.

Delaware has also adopted additional SDM® tools and intervention strategies when working with intact families or, families with children in foster care. Staff training of these tools was conducted in December 2013 to January 2014, with implementation starting February 2014. As a result of these activities, the treatment and permanency QA case review tools were suspended October 2013. Both instruments are currently being modified in order to incorporate questions regarding the application of the SDM® tools and other critical practice changes occurring under Outcomes Matter. Currently, these tools will be integrated into the FACTS II case management system. Therefore, activating these tools is scheduled to be concurrent to the FACTS II 'Go-Live' date.

D. Staff and Provider Training

The practice of frontline workers is central to DFS achieving identified goals and objectives; therefore training is focused on guiding day-to-day practice and the acquisition of necessary skills of those workers. The Center for Professional Development (CPD) within DSCYF provides competency-based training and professional development opportunities statewide to DFS front line caseworkers, supervisors and managers as well as to DFS contracted in-home service providers, promoting and supporting best practices. A focus on safety, permanency and child/family well-being is thematically integrated in all training.

<u>Pre-service training for DFS Staff and Providers</u>
CPD delivers the training for DFS casework staff in the Family Service Specialist career path and their supports, Family Service Assistants. In addition contracted case managers from two provider agencies, and contracted parent aides from three different contracted agencies attend DFS Core training to understand and implement the DFS evidenced-based practice model. Pre-service training is directed to a level that meets basic knowledge, skills and practices of their job responsibilities as delineated in DFS performance plans or provider contractual specifications. Some contractual agreements stipulate in-home providers like parent aides attend specific DFS trainings while

others, like the new contracted case managers attend the all 12 new worker core trainings in cohorts with DFS staff.

All participants in training including providers must be registered through CPD. Twelve sequenced pre-service core trainings based on standardized child welfare content areas are delivered to cohorts who begin training monthly. New DFS caseworkers most often begin their first days of work during the 4th week of the month. Pre-service training begins the first week of the month. DFS supervisors register their new workers directly by sending an email to CPD. If hired mid-month new caseworkers are oriented to the agency and their job duties by their supervisors and shadow experienced workers in the field until the next monthly cohort begins training. The agency specifies the time frame for the completion of new worker training as four to six months.
New contracted provider staffs with case management responsibilities are registered to attend all core training in sequence along with new DFS casework staff. New contracted provider staffs with parent aide responsibilities are registered for specific core training relevant to their role are enrolled in training as it becomes available. At any given time a training composition may include new DFS case workers, new DFS casework assistants, contracted providers who are case managers and parent aides. This dynamic provides rich ground for engagement, understanding of roles and responsibilities, support and collaboration.

CPD captures training data in Compliance Suite, a training management system (TMS). Quantitative participation metrics are maintained in the database regarding the number of participants scheduled to attend training, the number of participants who attend, their employment status, and the number of participants who complete. Data collected in the database in FY14 indicates 31 new workers and 10 provider agency staff was registered and attended training. Agency supervisory oversight is the control for ensuring new DFS workers. Attendance forms and training records are available for DFS supervisors to oversee the progress of their staff in training online or through training records produced in TMS. Additionally the completion of training is connected to advancement up the career ladder for casework staff. FY2014 Training records indicate 100 % satisfactory completions for DFS new workers for all pre-service training within the agency four to six months. Similarly the supervisors of new providers are the control for ensuring their staff completes training. Certificates of completion and copies of training records are provided to supervisors of provider staff.
Pre-service core curriculum is informed by national competency (knowledge, skills and attitudes) standards in the area of child welfare. Additionally the curricula are informed by current DFS performance plans. A curriculum review process initiated in 2012 is followed whereby content and learning strategies are reviewed and/or reviewed annually and as needed. There is documentation confirming this practice. Current curricula as well as archived training curricula evidence that the content addresses basic skills and knowledge needed by staff to carry out their job duties.

Evaluative data on pre-service trainings are collected from DFS new caseworkers and contracted providers, using a hard copy survey completed immediately following each training event to achieve the highest response rates. This 30 question survey is composed of ordered categories, where course objectives, course content, relevance and understanding, trainer delivery and facilities items are rated either Excellent, Very Good, Good, Fair, or Poor. Also included on the survey is an open-end question under each of the categories listed above requesting ideas on improving that area.

Written responses are read and relevant themes are developed regarding trainee's perception of effectiveness of training content, process, relevance to job, and trainer performance. The participant responses are reviewed immediately following the training and utilized to inform training content, the learning environment, learning strategies, trainer competence and delivery. Tabulation of the survey responses is purely descriptive.
Specific to question at hand, how well initial training in the 12 core content areas address the basic knowledge and skills essential to their jobs duties, participants rated the content for its direct applicability to their job and if their knowledge and skill level increased by the end of the training. A total of eighty one pre-service classes were delivered in FY2014 according to our training database. By reading the hard copy surveys the raw survey data indicates the rating that is observed most frequently from participants across the 12 core pre-service trainings falls into the "very good to good" range.

Additionally, a formative survey, the DFS New Worker Training Survey Mid-Point, is a survey consisting 10 questions using rating scales, multiple choice questions and open ended questions. It is administered to each cohort of new DFS caseworkers in a hard copy format at the mid-point of their pre-service training, month two, during the last day of a training, to gather data relative to the application of what's trained on the job and shadowing experiences completed. It is administered during a training session in an effort to obtain a 100% response rate. The resultant responses are manually entered into survey software for analysis. In addition to the survey an informal focus group format is utilized during that same training session of DFS caseworkers following the administration of the survey to obtain specific feedback about what is working well, what challenges new workers are experiencing in applying their learning to their work and what actions can be taken to improve their training experience during the remaining trainings. This anecdotal information is shared with the training unit and new worker supervisors as needed.

Findings from the FY14 Mid-Point Survey indicate that 100% of the 31 respondents agreed that the skills learned in training are important for successfully performing their job. Ninety seven percent reported that they were applying what they were learning on the job at this midway juncture, with 88% indicating that they began applying the skills within a week to two weeks after a given training. Eighty four percent listed co-worker's assistance, help from a supervisor and their own initiative and creativity as helping them apply what they learned to the job.

The mid-point survey includes a list of 21 required shadowing experiences for DFS caseworkers while in pre-service training. The survey responses indicate that 100% of new caseworkers are shadowing workers in the field in areas associated with training content. The frequency varies related to the specific shadowing experience. The timing of this survey and availability of mentors and experienced workers to shadow a particular event at any given time are factors to consider relative to completing any shadowing experiences. In addition the contents of this list have also changed within FY2014 incorporating Safety Organized Practice shadowing experiences which are still emerging within the population of experienced workers.

To further examine the effectiveness of training, at the conclusion of their pre-service training program one final survey in employed. Summative in nature, both quantitative and qualitative data is captured on the DFS New Worker Training System Survey. Additionally the survey also gathers demographic information on the respondents indicating the participants represent each of the regional sites and

the universe of new hires during a particular time frame. In table form using rating scales the survey directs DFS caseworkers to evaluate their experiences and levels of satisfaction with classroom training, supervision, mentoring, job shadowing and the overall workplace environment categorically as Excellent, Very Good, Good, Fair, or Poor.

Also included on the survey is an open-end question under each of the categories asking for ideas on improving that area. From a list of all agency required job shadowing experiences respondents indicate which they completed. To garner higher response rates the 47 question survey is given to new workers during the final day of the final training in the new worker core curriculum. The survey can be taken online and when possible, access to computers is made available in class during the final training session in the series to facilitate data collection. The other method of data collection utilizes hard copies with responses manually entered into the survey software.

The tabulations were descriptive. Results from the survey in FY14 thirty one respondents indicated that on average 60% agreed that training content was appropriate to orient them to their job. Themes in the comments centered improvement focused on varying learning strategies, upgrading videos, using arrange of learning technology and sequencing of the courses. Another theme focused on having a field experience immediately after getting a training to improve transfer of learning from the classroom to the field.

In the area of supervision respondents agreed that supervision provided them with regular feedback about their job performance. Recommendations focused on improving supervision centered on reducing micromanaging, working more closely with the mentors of new staff and being "more hands on."

In the area of mentoring, the highest rates of agreement from respondents, over 65 %, occurred in the area of mentoring preparing them to do the job. Respondents' comments centered on specific mentors doing 'an awesome job' and on Coaching Supervisors assistance with learning. Two Coaching Supervisors exist in New Castle County. Their job is to oversee the region's new caseworkers ensuring they complete pre-service training, are assigned mentors to shadow job and meet basic performance levels. Themes in the area of needing improvement included not having a mentor assigned and mentors who did not engage and "mentor". A second theme centered on the haphazard nature of shadowing and the lack of structure in counties where there are few designated mentors and no Coaching Supervisors who focus on assisting new workers to complete classroom training and the required experiences.

There are limitations involved in data collection and analysis. The data are purely descriptive. Data quality is determinant upon the accuracy of registration and attendance records, the timeliness of data entry, and the accuracy of manual data input. Also to be considered is administration procedures, survey questions design and the nature of self-reporting. With noted limitations, completion data, formative and summative survey data and informal focused group anecdotal data collected provides a longitudinal evaluative framework with which to demonstrates the level of functioning and the effectiveness of the training system in preparing new staff and providers with the basic knowledge, skills and practices required to effectively fulfill their job duties.

Ongoing Staff Training

In-Service Training

Each year DFS employees are required to complete a minimum of 18 hours of training in areas that build their knowledge, skills and practices that enable them to effectively perform their job duties. There are no licensing requirements for agency staff that deliver services. Continuing education is satisfied through training offered by the agency annually and/or approved training outside of the agency. Agency staff is responsible for updating their in-service training records pertaining to training events outside of the agency such as outside conferences, webinars and workshops by submitting documentation that describes the training and how the training addresses skills and knowledge needed to carry out their job duties. This information is entered into their training record when it is submitted to CPD. Supervisory oversight is the control for the completion of ongoing training requirements. During biannual/annual performance reviews and performance planning ongoing training needs are established and monitored. All levels of staff DFS attend, as appropriate, agency provided in-service training, from senior leadership to supervisors to frontline caseworkers and support staff. Providers participate as appropriate or as stipulated in the contractual agreement with DFS. While no formal comprehensive training needs assessment is carried out, annual training for staff is determined at the end of the calendar year by the Strategic Leadership Team (SLT) composed of the Director, Deputy Director, Family Services Program Support Manager, Regional Administrators, Assistant Regional Administrators, Program Managers, and a Training Administrator from the CPD Unit in the Division of Management Support Services. Drivers such as implementation and sustaining of the new practice model, agency outcomes, departmental goals, best practices, need for refreshers focused on safety, permanency and child well- being are considered in determining annual training plans.

Training for supervisors is referred out to the State of Delaware's Management Development Institute which provides a Supervisory Development Certificate (SDC) program. New supervisors, as well as potential supervisors, received a comprehensive, progressive series of developmental training opportunities to continually improve their performance in areas of educational, administrative and supportive supervision. The agencies' Assistant Regional Administrator (ARA) and/ or Regional Administrator (RA) oversee the skill development of their supervisors.

Additionally, the State of Delaware's Management Development Institute provides a Management Development Certificate (MDC) program offering experienced supervisors and managers a comprehensive, progressive series of developmental training opportunities to continually improve their performance. The program encourages managers to improve individual, team, and organizational performance as related to their specific job duties and responsibilities. The Management Development Certificate program builds on six core competencies necessary for developing effective supervisors, managers, and leaders.

In-service and ongoing training data is captured in the CPD training management system database for all training created therein. Training descriptions and archived class content reflect data regarding what training was delivered and what training content addressed the knowledge and skills needed by ongoing DFS staff and provider staff to carry out their job duties with regard to services as outlined in the CFSP, and what is contained in DFS performance plans.

In FY2014 the data readily available indicate that 25 different in-service trainings were delivered to ongoing DFS staff and contracted

case managers totaling more than 70 days in locations across the state that addressed knowledge and skill areas directly related to staff job duties and service provision pursuant to agency annual continuing education requirements. For trainings where data was submitted and input into the TMS database, the dates of training, the locations, the number of participants registered, the number who attended, and employment status and who completed is retrievable.

To implement and sustain Safety Organized Practice and Family Search and Engagement in FY2014, 26 DFS staff and 10 contracted case managers trained to be trainers of content by the Children's Research Center (CRC) and by the Casey Foundation contract providers delivered in-service training to advance the knowledge and practices in the areas of safety, permanency and well-being. Attendance was required for all staff involved in providing services including caseworkers, their supervisors, ARAs, RA, Program Managers and providers.

Data indicated that between November of 2013 and November of 2014 twenty DFS ongoing staff and seven provider staff each trained every module of 12 Safety Organized Practice modules developed by CRC. Modules, ranging from 3 hours to one day, were trained in each region at a rate of three times a month. Attendance was required for all staff involved in providing services including caseworkers, their supervisors, ARAs, RA, and Program Managers. Metrics indicate a total 150 sessions were ultimately delivered during that 12 month period. Participation rates per training varied from as low as one participant which was very infrequent, to as many as 38 participants per class. A number of trainings were offered in order to facilitate the most attendance. In addition Family Search and Engagement training was offered once in each of the four regions by trained DFS ongoing staff paired with a trained provider. All of the above referenced training was required in-service training for DFS staff. Providers attended these trainings at DFS locations and/or trained providers delivered the content to the own staff. In 2013 & 2014 DFS and provider supervisors were trained by CRC in facilitative supervision and coaching their staff in evidenced based practices to support ongoing practice improvement.

There are limitations regarding participation and analysis. In-service training during FY14 was an enormous undertaking. . Not all ongoing training data is reported to CPD for data entry. Individual program managers may keep separate records of in-service training events specific to their program area that CPD was not involved in developing or delivering. Data quality is determinant upon the accuracy of registration and attendance records, the timeliness of data entry, and the accuracy of manual data input. All available participation metrics have not been categorized and analyzed by CPD as of this writing. The State of Delaware is rolling out a state-of-the-art training management system in 2015. Data in TMS is currently being cleaned up and will be entering into that system by July 1, the "go live" date. It is anticipated that after that time frame a more accurate data analysis can be made.

Hard copies of training evaluations were given out immediately following each training event. Due to the very large number of in-service training events in FY2014 a convenience sample of 143 surveys from 7 of the 12 SOP modules training delivered in centralized Dover DFS office, which was composed of ongoing staff and provider staff from all three counties was analyzed. This 30 question survey is composed of ordered categories, where course objectives, course content, relevance and understanding, trainer delivery and facilities items are rated either Excellent, Very Good, Good, Fair, or Poor. Also included on the survey is an open-end question under each of the categories listed above requesting ideas on improving that area.

From written responses relevant themes were constructed regarding trainee's perception of effectiveness of training content, process, relevance to job, and trainer performance. The participant responses are reviewed immediately following the training and utilized to inform training content, the learning environment, learning strategies, trainer competence and delivery. Tabulation of the survey responses is purely descriptive. The ratings on the categories regarding the relevance of the content, the ready applicability of new skills trained and the perception that these skills enhance services fell in the agreement range of "good". Anecdotal comments from module trainers during train- the- trainer sessions indicated that staff expressed some interest and saw value of the training regarding how it related to effectively carrying out their job duties.
In addition to traditional classroom training, field based learning experiences, such as Family Team Meetings and Team Decision Making meetings were informally observed by workers to build their competence and confidence in family engagement, facilitation, and SOP practices. Similarly coaching was provided by in open forums. At this point workers attended at will. Many of these casework strategies and practices being utilized be ongoing staff are still emerging and not being formally tracked.

The attached training chart provides descriptions of the content and scope of the classroom training experience in both pre-service and in-service areas. The On-The-Job (OJT) training table lists the on-the-job experiences required during the pre-service training period. (See Attachment C: CFSP 2015-2019 Training Plan; See Attachment D: Staff Training Chart 2014-2015; Attachment E: On-The-Job Training Table).

Foster and Adoptive Parent Training

Foster Parent Pre-Service Training
In January 2014, DFS implemented a new foster parent pre-service training curriculum developed by The Institute for Human Services (IHS) in collaboration with the Ohio Welfare Training Program. The 30-hour IHS Pre-Service training includes the following 10 Modules: Orientation to Foster Care, The Child Protection Team, The Effects of Child Abuse or Neglect on Child Development, Attachment, Separation and Placement, Managing Behavior, Preventing and De-escalating Crisis, Cultural Issues in Placement, Understanding the Primary Families, Children Who have been Sexually Abused, and The Effects of Caregiving on the Caregiving family. The first Module "Orientation to Foster Care" is provided by DFS Foster Care Staff as an over view to applicants. The applicants are prescreened and those that are approved are sent to a contracted provider for the other 9 Modules.

The readiness of families to foster is assessed in the context of their ability and willingness to meet 5 essential competencies:

1. Participate as a member of the child protection team
2. Meet developmental needs of children in care
3. Provide safety, well-being and placement stability
4. Work effectively with primary families to promote reunification
5. Promote lifelong connections and permanency

All DFS foster families are required to go through the 30 hours of pre-service training prior to approval. Currently private contract agencies have their individualized designated pre-service hourly requirement; they too are required to complete pre-service training prior to being approved as a foster family. Of the 29 respondents from our bi annual foster parent survey completed in fall 2014, responding to the questions of "I have adequate opportunities to increase my knowledge and skill as foster parent through in-service trainings" 23 answered usually or always, and the question "I take advantage of in-service training opportunities available to foster parents" 20 answered usually or always. The rating scale choices were Never –Seldom –Sometimes – Usually – Always. It is evident that there is room for improvement regarding training and efforts to engage foster families in participating training opportunities to meet their needs. Thirty (32) foster parents who participated in the focus groups, 90% stated they received what they need in regards to training. Initial feedback from the three foster parents who participated in the new IHS pre-service training during the focus groups expressed it as a "great experience and a very supportive trainer"; they expressed it being informative and stated it was helpful to them in preparing for foster children to enter their home. Although the majority of foster parents stated they received the training they needed there were a couple of suggestion to add training on "street drugs" Asperger's, autism and sickle cell. There will be more information about the quality of the new pre-service training forthcoming; we are planning to survey foster parents during the May 27, 2015 foster parent conference. The survey will include questions regarding the new IHS training. This will give us information to better assess the new training as all the contracted private agencies participated and adopted the IHS training curriculum. Foster parents provided positive feedback regarding the varied options to receive in-service training which includes books, on-line training, community offered trainings, college courses, attending and participating in therapy with foster children, and DVD's. All non-traditional trainings must first be approved by foster care staff.

Ongoing Foster Parent Training

In-service training for foster parents was revised to use actual foster parenting experience to facilitate learning. The in-service trainings offered, to matriculate through service levels will include 11 from the IHS curriculum: Primary Families, Attachment, Effect of Abuse and Neglect, Caregivers Voice, Discipline, Healthy Sexual Development, Recognizing Sexual Abuse, Cultural Issues, Foster Families Grow, Defusing Crisis, Roots and Wings. Additional in-service training will include DFS Inappropriate Sexual (ISB) Behavioral Module 1, Teen Training, Foster Care 101, Psychotropic Medications, First Aid and CPR, Depression and Suicide, Trauma, Advanced Attachment, Medication Management, Mental Health Diagnosis, Substance Abuse and Inappropriate Sexual Behavior Offenders. About half of Delaware's 450 foster families are with contracted Child Placing Agencies who operate under licensure and requirements of Delacare Regulations administered by the Office of Child Care Licensing. In the past year, OCCL has promulgated Child Placing Agency Regulations to update requirements for private foster and adoptive home agencies. Items under review include agency licensing, applicant background check references, home approvals, annual reviews, training, service plan requirements, nutrition and tracking of medication and visitation. Once regulations are finalized, DFS will review to ensure our internal policy and procedures for foster home approvals is aligned to standardize practice standards for private and public foster caregivers.

In addition to pre and in-service trainings, the foster care program offers supplemental trainings to foster parents through our contracted training agency and contracted foster care provider agencies, which are listed in our foster parent training newsletters. The newsletters are distributed each year in the spring and fall. A sampling of the supplemental trainings provided are Ice Breaker Meetings, Brain Based

Parenting, What Foster Parents Need to Know about Psychotropic Medications, Stewards of Children, Reaching Out to Law Enforcement: What to Expect and How to Respond, Praising When Praise is Hard, The 357 Model: MY LIFE, Childhood Trauma, How It Impacts Us, Caring for Lesbian, Gay, Bi-sexual, Transgender or Questioning Teen, Fetal Alcohol Syndrome, Inappropriate Sexual Behavior, Teaching Alternatives to Aggressive Behavior, and Developmental Differences and Sensory Integration: Innovative Ways to Help Our Children. For the past three years, DFS and its contracted provider agencies, along with various donors including Family Court's "Court Improvement Program" (CIP) has sponsored a Foster Parent Recognition Conference and Luncheon to recognize our foster parents as well as provide an additional 6 hours of training. This event occurs in May, National Foster Care month and is widely well received. Last year, over two thirds of our foster families, both DFS and its contracted providers, participated in the event. Typically there are 16 trainings given throughout the day with 4 in repetition. The trainings for last year's conference were Each One, Reach One, real life experiences sharing by foster parents; Time In, Not Time Out, child discipline tools for foster parents; Order in the Court, the foster parent's role in the court room; Bouncing Back from Trauma, nurturing strength and resilience; Parents Part I & II: The Key to Getting Through to Youth Who Have Experienced Trauma; Parts I & II: Living with Two Hearts, the explanation of youth relationships to both the birth and foster family; Take Care of Yourself, a training on ways in which foster parents need to take care of themselves as well as their foster youth and families; The Road to Success, a training on academic success for foster youth and educational programs and rights for foster youth; and System Transformation: Efforts at DFS, an overview of the Outcomes Matter initiatives and how these changes are designed to help strengthen the partnership with foster parents and achieve together better outcomes for the children/youth in their homes.

Pre-Adoptive Parent Training

In Delaware, the foster care and adoption agencies must follow the rules and requirements of the Office of Child Care Licensing (OCCL) - Child Placing Regulations. This includes the recruiting and training requirements for the staff working within the agencies in providing the services to the children and families in foster care or children needing permanency. The current OCCL regulations require that private agency staff receive a minimum of 40 hours of training per year. This training must be related to their current position within the agency and related to foster care, adoption, children in out of home placement, children with special needs, etc. When DFS offers training to state staff, the private agency staff is also invited to participate in this training. In the past few years, DFS provided training on Family Search and Engagement and 12 models of training on Safety Organized practice that was also required for the private agency staff. The agency staff working with children with a goal of adoption also received training from Darla Henry on the 3-5-7 model. Delaware took this training and activities one step further and expanded this work by renaming this to MY LIFE - My Young Life in Foster Cara Explained. This work with the children in foster care has been successful to the point where some of the children have worked through the separation and loss from the birth family and are now in a good position to able to move on to developing permanent relationships. Approximately, 300 children in foster care received some level of MY LIFE services to date. All agency staff meets the annual training requirements. There is no quantitative data on how many staff attends the required training.

The OCCL also has a set of requirements for the licensed agencies to follow when working with foster and adoptive families. The OCCL has an annual on-site review with each agency to determine compliance and whether the OCCL state regulations and requirements are being met. DFS contracts out all adoption services statewide to licensed adoption agencies. Currently, there are four licensed adoption

agencies that have been selected through an RFP process to provide these services in Delaware. The contracted services include recruitment, orientation, training, home studies, court reports, MY LIFE and child prep work with the child, Child Specific Recruitment (CSR), Family Search and Engagement (FSE) activities, child profiles, listing the children on local and national adoption exchanges and finalization activities. DFS also has a contract with one of the four licensed adoption agencies to provide post adoption services for children and families touched by adoption and guardianship who are residing in Delaware. The agency has provided post- adoption services to approximately 250 children in the past 7 years.

Also, the adoptive parents and other adult persons in a parenting role residing in the foster home will be required to participate in training that is conducted by the licensed agency. The pre-adoptive parents receive an annual review as long as the family is still active with the agency and during the time a child is placed in the pre-adoptive home. A part of the annual review is to discuss and document the training received and recommendations for additional training needed in the next year. The annual review, the approval letter sent to the family and the annual certificate stating the home is approved for 12 months with an end date is sent to the pre-adoptive family. There is no quantitative data on how many adoptive parents attended the required training each year.

DFS sent out surveys to community partnerships, to the court and legal representatives, to DFS staff and to foster and adoptive families. As of February 18, 2014, there were 100 surveys returned from the community partners. There were 67.5% who agreed and 22.5% who strongly agreed that the training provided the skills and knowledge to care for foster children and youth.

From the 56 surveys returned from the court and legal representatives, there were 56 surveys returned. There were 47.6% who agreed and 28.6% who strongly agreed the foster and adoptive parents were trained to provide care for the children and youth.

From DFS staff, there were 53 responses returned. There were 70.5% who agreed and 22.7% who strongly agreed. For the foster and adoptive parents, there were 41 surveys returned. There were 35.1% who agreed and 59.5% who strongly agreed that the training provided the skills and knowledge to care for foster children and youth. The responses show that the training provided to the foster and adoptive parents was more than adequate at this time.

The adoption agencies track the number of inquiries and the number of families who completed the required training and home study. Survey data indicates the pre-adoptive families believe the training provided them with the knowledge and skills needed to care for the children in their care. This information was gathered from the focus groups for the adoptive families and child welfare staff. Feedback from the adoption agencies was positive as well. In 2014, one adoption agency received 35 inquiries and approved 10 of those families as an adoptive resource. That agency does not require the families to complete a satisfaction survey. Another adoption agency received approximately, 45 inquiries and approved 16 of those families as adoptive families. See Below.

We do have a satisfaction survey after training. In 2014, we trained 60 families and had 106 surveys returned. The comments are generally very supportive. Families particularly like hearing from people who have adopted so our parent panel is very well received. The families stated they appreciate being made to feel very comfortable and accepted. There is always a bit of negativity towards the

video we show regarding transracial adoption. It is a group of young adults who were adopted transracially talking about their experience. It makes some people very uncomfortable and engenders a great deal of good discussion. People also appreciate the information about the way children's brains are changed by trauma and how development is not the same as with children who have not been traumatized. Generally people tell us that although they sometimes think what we are sharing is negative, they are grateful for the information. We tell our families from the beginning that our philosophy is to educate them. We tell them to prepare for the worst and expect the best. One of the kids I saw in therapy said that to me when I asked him what type of advice he would offer to families preparing to adopt. He was placed as an infant and was really challenging as a teenager.

E. Service Array and Resource Development

Supporting family-focused and child-centered interventions, Delaware's child welfare system offers a continuum of services to at-risk families and children from prevention to permanency, provided by public and community based agencies. Evidence of effectiveness of the service array is visible in system measures, quality assurance case reviews and stakeholder comments. Case reviewers agree more than 90% of the time that education, health and mental health needs were identified and services were provided. Reviewers agree with assessment of needs and provision of services to children, parents and foster parents an average of 81% of the time.

Professionals and DFS staff agree the service continuum continues to expand, but note weaknesses in access and capacity of home based treatment and support services, special needs foster care, and independent living services. Other concerns raised are the lack of substance abuse services for teens, community-based domestic violence services, and subsidized child care. Professionals also identified several system issues as concerns, including minority disproportionality in foster care, high rates of school suspension of foster children and the impact on placement stability, and the lack of permanency options for older teens, especially those served in out of state residential facilities.

Prevention Related Services

Home Visiting

The Delaware Maternal and Infant Early Childhood Home Visiting (MIECHV) program provides a broad and expanding array of evidence-based home visiting programs statewide. The Division of Public Health is responsible for administrative and fiscal oversight. It is intended to assure effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to these children and families through home visiting programs. The home visiting program plays a crucial role in the national effort to build quality, comprehensive statewide early childhood systems for pregnant women, parents and caregivers, and children from birth to 8 years of age – and, ultimately, to improve health and development outcomes.

The MIECHV Program in DE has served over 1,000 children and conducted over 6,000 home visits. This program is providing important evidence of being a significant strategy in preventing child maltreatment:

- # of children served by the home visiting program who are reported in a case of suspected maltreatment: 21
- # of children served by the home visiting program who are reported in a case of substantiated maltreatment: 7
- # of children served by the home visiting program who had a maltreatment disposition of "victim" and never had a prior disposition of "victim": 15

Part of the home visiting Program is the Nurse Family Partnership program, which allow nurses to work with young, first- time mothers who are experiencing poverty. DE has two other Evidence-Based home visiting programs, Parents as Teachers and Healthy Families America, which have provided capacity for additional supports and home visits to families who have come to the attention of the child welfare system.

Child Development Watch

Child Development Watch is the statewide early intervention program for children ages birth to 3 that is managed by the Department of Health and Social Services (DHSS)/Division of Public Health (DPH). The program's mission is to enhance the development of infants and toddlers with disabilities or developmental delays and to enhance the capacity of their families to meet the needs of their young children. In FY 14, DFS identified through screenings and referred 26 young children to this program for services. There were 107 children active with both DFS and Child Development Watch this year. DSCYF has two (2) case-managers who are co-located with Child Development Watch to help coordinate collaboration.

Services for Latino Families

The Latin American Community Center (LACC) works with families in Wilmington's Latino community. Provided by bi-lingual staff members, these services target families that are experiencing challenges dealing with their children's behavior issues and/or needing assistance connecting to community resources. La Esperanza is the agency that provides the majority of services to the Latino community in Kent and Sussex Counties. Both agencies have staff now certified in the provision of Parent-Child Interaction Therapy, which is an evidence-based treatment that addresses young children's behavioral issues and strengthens the attachment between the child and parent. Research demonstrates this intervention is very effective in preventing child maltreatment. In addition, La Esperanza provided services to over 900 unaccompanied minors from Latin American countries this year. These services included assistance through the immigration process, referral to health and social services, connection to relatives and other placement resources, and school enrollment and advocacy.

Early Care and Education

Strengthening Families through Parent Provider Partnerships in Child Care – Parent surveys have continued to indicate strong and positive outcomes to questions about their relationships with classroom teachers and their willingness to ask questions when they are worried about their child(ren). Staff surveys have demonstrated a general belief that it is important to share information with parents on a daily basis and that building strong relationships between staff and parents is a priority at their child care center.

The Office of Child Care Licensing's (OCCL's) mission is to ensure the safeguards and enhance the quality for children in out-of-home care. OCCL is responsible for the licensure and regulation of family child care homes, large family child care homes, early care and

education centers, school-age centers, residential child care facilities, day treatment programs, and child placing agencies for programs serving children birth to 18 years of age. For the past six state fiscal years, OCCL has conducted an annual mandated visit to 100% of all licensed facilities.

Early Childhood Mental Health Consultants

The Division of Prevention and Behavioral Health Services (PBHS) has a cadre of seven (7) Early Childhood Mental Health Consultants who provide consultation directly to child care programs to help with identifying and responding to young children with behavioral challenges. In 2007, Delaware was cited as having one of the highest expulsion rates in the country for young children from child care facilities. Such expulsions were major stressors for families and families' inability to deal with young children's behavioral problems can increase the likelihood of maltreatment. Since the implementation of this program in the child care programs, there has been a 97% success rate in stabilizing placements and retaining children in their programs.

Promoting Safe and Stable Families Program

The Promoting Safe and Stable Families Consultation and Support Program (PSSFCS) combined the effort of its family preservation and family support components, thus providing universal/targeted/indicated approaches in the continuum of service that are family focused and child centered. This program consultation process focuses on providing supportive services which are intended to reduce the occurrences of child maltreatment by addressing the four associated risk factors which are: (1) parental characteristics; (2) family coping and isolation; (3) absence of resources and services; and (4) crisis and stress. The PSSFCS program service seeks to prevent families from entering or re-entering services in any division of DSCYF resulting from concerns of neglect, abuse and dependency. The PSSFCS sites are selected based on the geographical locations where child protective services receive the highest number of referrals. PSSF participants are referred to the program services from social service agencies, community organizations, internal/external state departments and self-referrals.

All families who reside in Delaware who have children age birth to 18 years are considered eligible for the Promoting Safe and Stable Family Consultation and Support Program. There are four contract service providers and total of seven sites serving the state of Delaware.

The Intensive Family Consultation Service is a Family Support/Family Preservation Service that uses an interactive "one on one" consultation prevention approach. IFC Services are designed to work with families who are experiencing a multiplicity of complex needs, and exhibiting common risk factors that may contribute to child maltreatment. These risk factors may be limiting the family's ability to successfully work through the challenges that they face; thus limiting their ability to move forward in order to resolve their core concerns. To date, in New Castle County, 49 families and 117 children received services. In Kent and Sussex Counties, 22 families and 67 children received services.

K-5 Early Intervention Program

The K-5 Early Intervention Program (EIP) is an innovative collaboration between the Department of Services for Children, Youth and Their Families (DSCYF) and the Department of Education (DOE). EIP provides services to students displaying behavioral problems which impede their learning processes, or the learning process of others. EIP targets children who exhibit behavioral, academic, social, or mental health problems that, unless appropriately addressed at an early stage, can manifest through early failures in school into other more serious social and/or emotional developmental issues and potentially lead to early onset conduct disorder. Family Crisis Therapists (FCTs) work with a student's entire family, and can address any presenting issue whether behavioral, academic, or emotional. In many instances, FCTs also work with families to address basic needs and/or crisis issues, thus enabling them to focus on the emotional, academic, and social needs of the child (ren). The goals of the EIP are to improve student behavior, strengthen parenting skills, access community resources and reduce the number of families and children needing more intensive services from the Department.
Services provided by the K-5 Early Intervention FCTs include: weekly individual counseling with students at the school, group counseling, weekly consultation with teachers and school administration, monthly family counseling at the home and in the school, home visits, self-advocacy, referral and crisis intervention. In addition, the FCT serves as a Liaison between the family and the school and or community agencies. In FY14, 1,326 children were served in 53 elementary schools statewide.

Behavioral Health Consultants in Middle Schools

Starting FY2014, Delaware now provides interventions to address mental health and substance use issues experienced by middle school students, grades 6-8. Services are provided 12 months a year. The services include: screening for mental health/substance abuse and for trauma, crisis assessment, clinical interventions, psycho-educational groups, and training and consultation for parents, teachers and administrators. The services assist school staff in the development of a positive and productive educational environment. BHCs also assist families and schools to access community mental health, substance abuse and prevention services. As of May 2014, there are 489 active cases in 27 middle schools statewide. In FY14, PBHS implemented a similar program with 29 Behavioral Health Consultants in 31 high need middle schools statewide. In the first half of FY15, these consultants already have provided consultations and assistance to 1,899 students.

Intervention Related Services

Differential Response System

Differential Response System/Family Assessment and Intervention Response (FAIR)
A contract with a community-based provider, Children and Families First (CFF), created the FAIR Program, which launched on March 4, 2013 to provide quick response and support to families struggling with escalating parent-teen conflict. These involved cases that had been screened in by DFS, but were then referred on the alternative pathway of FAIR .By March 31, 2014 (roughly 13 months later), 365 teen youth cases had been referred to FAIR and needed assessments. Of these, 36 families declined FAIR and were returned to DFS. Following assessment, 48 cases were sent back to DFS for safety and/or risk issues or were closed due to lack of safety or risk issues. Overall, 281 teen youth cases were opened and kept beyond assessment. Of these 281 cases, 227 were open in Level One Family Keys only, 47 were open in FFT only and 7 were open in both.

Between 3/4/13 and 3/31/14 (almost 13 months), only 10 youth who had been referred to CFF FAIR eventually entered DFS placements. Seven of these youth were returned the next day or within days because the family refused to work with CFF or there were safety or risk concerns. CFF actually only served three of the youth and families who eventually entered placements.

Between 3/4/13 and 3/31/14, there were approximately 60 re-reports (calls to the DFS hotline) about youth who had been previously referred to and/or served by CFF (a total of 365 youth over the same period). A closer look at 50 of these 60 re-reports shows that 15 of the 50 were made the same day or within a few days of the original referral to CFF and many of these were made by CFF themselves as they re-reported youth whose families refused to participate or whose safety and risk assessments were too high. Only 11 of the 50 had substantiated claims, and of these 11, CFF had served only 4. (The rest were miss-assignments or were returned within days to DFS). Of the 50 re-reports, another 11 had pending investigations as of 3/31/14. The rest were unsubstantiated, erroneous, or no further services required.

DFS Screening and Consultation Unit

All children and youth who now enter foster care are referred for a behavioral health and trauma screening by the DFS Screening and Consultation Unit (SCU). In FY2014, 309 cases were referred to SCU. Infants are not typically screened until at least 6 months of age. Additionally, children/youth confirmed to already be enrolled in behavioral health services do not receive this initial screening. Of the children/youth screened, the following referrals were made: 41 for outpatient behavioral health services; 26 for Child Development Watch/Child Find; 1 for deeper end behavioral health services managed by the Division of Prevention and Behavioral Health Services; and 4 for additional psychological or neuropsychological assessments.

Family Supports

Parent Aide Services

DFS currently contracts with four (4) community-based agencies to provide in-home parent aid and/or in-home counseling services. These services are available to families with an active treatment case. Nine months after the community-based agency has closed out their case, data is reviewed to determine whether the case remained successfully closed. According to that data, in SFY14, 40% of the cases remained closed. However, so far in SFY15 (from July 1, 2014 to present), 50% of the cases were able to remain closed. The improvement in cases remaining closed can be attributed to DFS contracting with a new community-based service provider. It is obvious that DFS and the community-based agencies still have much work to be done to improve the number of cases that are able to remain successfully closed.

Other Family Support Services

DFS also works with several behavioral health providers to obtain psychological and/or psycho-social evaluations to assist in planning for families with complex behavioral health issues. These evaluations help assess a parent's/caregiver's parenting capacities and are not eligible for Medicaid funding. Thus far in FY15, DFS has contracted for 54 evaluations in New Castle County and 50 combined for Kent and Sussex Counties. These evaluations help determination whether and which type of additional individualized supportive services are

indicated.

Family Unification Housing Vouchers

DFS continues to partner with the Delaware State Housing Authority to provide state rental assistance vouchers to families active with DFS. To be eligible for one of the vouchers, lack of housing must be the last barrier preventing reunification; or the lack of housing is likely to result in the imminent placement of children in foster care. The voucher provides rental assistance to qualifying families for two years. During those two years, the family is partnered with the social worker from First State Community Action (FSCA). The FSCA social worker helps the family develop a budget, ensure that they maintain their property in an acceptable manner, and then helps the family prepare to transition out of the voucher program at the end of the two years. To date, 86 families have received a voucher. Of those 86 families, approximately 23% successfully completed the program and were able to be reunified because of the voucher, and DFS was able to prevent placement for the other 66 families

Liaison Services

DFS provides two kinds of Liaison Services. The Alcohol and Drug Liaisons are staff funded by DFS, who work for a community-based substance abuse treatment provider. The liaisons are co-located in DFS regional offices and provide screening, outreach, and consultation services to clients involved with DFS. The liaisons provide consultation to DFS staff in identifying substance use/abuse issues, engaging clients, and linking to community treatment services. In FY14, 2,997 clients had identified issues of substance abuse.

DFS also provides Domestic Violence Liaisons, who are also funded by DFS, work from a community-based domestic violence services provider, and are co-located in the DFS regional offices. These liaisons also provide screening, outreach, and consultation services. They help link clients to domestic violence services and navigate the legal system. In FY14, 1,854 clients had identified issues of domestic violence.

Having these two types of liaisons co-located in the DFS regional offices is a vital resource and helps forge collaboration and coordination of services. In FY14 835 clients had both substance abuse and domestic violence issues, requiring sensitive coordination of services.

Services for Drug Exposed Infants

Delaware has a number of statewide initiatives underway to address the growing epidemic of substance abuse. In part through advocacy provided by DFS in recent years, the Delaware Healthy Mothers and Infants Consortium convened a statewide taskforce to address issues of Neonatal Abstinence Syndrome (NAS). This taskforce is developing consistent protocols for all hospitals about the treatment and discharge of such infants. The result thus far has been that such infants are now receiving longer lengths of stay, which help ensure that they are truly stable for discharge and that their medical needs can appropriately be managed in the community.

Additionally, DFS has helped advocate for additional treatment services for parents. The home visiting programs are now providing on-site parent education and support groups at the substance abuse treatment centers, which helps clients who might otherwise be suspicious of and reluctant to accept these services make connections with the home visiting providers. Delaware previously had one residential program for mothers in treatment for substance abuse to be with their infants, which was the Lighthouse Program by Brandywine Counseling Services and located in Sussex County. In May 2014, Connections opened a second residential program for mothers in

treatment for substance abuse to be with their infants. This program operates in New Castle County and has capacity for 18 mother-infant dyads.

Team Decision Making (TDM) Meetings

DFS utilizes Considered Removal TDM meetings, which are held either whenever DFS is considering removing a child from their home or within 48 hours after placement has occurred. During the program's first10 months of operation (Aug 24, 2013 thru June 30, 2014), 234 TDM meetings were held involving 356 children. Of these, 57 % of referrals occurred pre-removal. From July 1, 2014 through January 20, 2015, 64.7% of TDM meetings were held pre-removal. TDM meetings have involved 265 children and resulted in 54% (165 children) diversion from foster care.

Health Needs of Children in Foster Care

Nemours A. I. DuPont Hospital for Children developed the Foster Care Health Program and has completed a comprehensive health assessment on over 100 children who entered foster care. Nemours offers primary physician care and referral to community medical services. As of last year all children who enter care in New Castle County must have the initial assessment completed at Nemours. The physicians who lead this project have demonstrated outstanding quality of care to and advocacy on behalf of children who use their services. In addition Nemours recently added the Transition of Care Program to support youth ages 18 to 21transition from pediatric care to adult care this services is available for.

Children's Advocacy Center

The Children's Advocacy Center of Delaware (CAC) primarily provides services to children who are victims of child physical and sexual abuse. The CAC provides forensic evaluations and multi-disciplinary team reviews of cases. In FY 2014, the CAC conducted 1,411 forensic interviews of children and 1,556 multi-disciplinary case reviews. Clinical staff of the CAC provided an additional 1,344 post-interview mental health services to child victims. Specialized medical exams were provided to 23 child victims.

Highlights from their 2013 Outcome Measurement System Report, based on survey results from caregivers of children served by the CAC show:

- 95% of caregivers agreed they were referred to services that would help them to support their children and meet their children's needs following the initial visit to the CAC.
- 95% of caregivers agreed, if they knew anyone else dealing with a situation like the one their family faced, they would tell that person about the center.

Services for Runaway Youth

Delaware consistently has an extremely low number of youth in foster care who are missing or on runaway. For FY14 the monthly average was 2.5 youth, with several months there being no youth missing/on runaway. The success in this area is due in large part to the excellent work of the Special Investigator Unit. These investigators utilize social media, interviews with peers, and surveillance to locate youth. Delaware is different from most other jurisdictions in that DFS will send special investigators out-of-state to find and return youth

who have run away. The special investigators work to develop positive relationships with youth and then do follow up with them to support their placement stability. DFS believes this proactive approach is significant in minimizing the risk of these youth becoming vulnerable to sex trafficking, as can happen to foster youth on runaway.

Permanency Supports

MY-LIFE Program

Looking for permanency solutions, DFS contracted with consultant Dr. Darla Henry to provide 3-5-7 Model© training. The 3-5-7 Model© is an evidence-informed relational practice that supports the work of children and youth, individuals and families, in rebuilding their lives after experiencing traumatic events, specifically as they relate to losses. The 3-5-7 Model© provides tools, based on recognized theoretical foundations, in a strengths-based approach that brings continuity to the process for grieving losses and empowering individuals to engage in relationships that are secure and sustainable. Those who received the training were DFS adoption caseworkers, contracted adoption agencies, a few representatives from DFS foster care, CASA program, Attorney Guardian ad Litem (GALS), some supervisors, and court staff. Delaware's adaptation of the 3-5-7© Model is called MY LIFE (My Young Life in Foster Care Explained).

The MY LIFE program is more than adoption preparation; it is readiness for building successful, meaningful relationships. Four contracted adoption agencies provide MY LIFE services.

The first cohort of MY LIFE children were those TPR'd (Termination of Parental Rights) with a status of APPLA started February 2011. Starting October 1, 2013, DFS started providing MY LIFE services to children with a designation of APPLA, whose parents' rights have not been terminated, and some children who have a goal of reunification. Some of these children/youth are 17 years of age and are close to aging out of foster care with no permanent connection. Through March 2014, the four private adoption agencies have provided services to 262 children statewide.

ICPC

In 2013, Delaware Interstate Compact Office (DE ICPC) processed 380 ICPC placement requests for 374 children and 506 placement decisions. Additionally, DE ICPC completed 132 home studies requested via out-of-state ICPCs. Requests were sent for 300 Delaware children for placement out of state ("sending") and received for 74 out-of-state children for placement into Delaware ("receiving"). Delaware children were typically male (66%), ages 11-18 (74%), and nearly evenly distributed racially between African-American (53%) and Caucasian (46%). Out-of-state children were typically younger with the majority aged 1-5 years (39%), but somewhat evenly distributed by race and gender with 55% male, 43% African-American, and 57% Caucasian.

Of 132 home studies completed by DE ICPC, 89% were completed in or under 60 days in compliance with Safe and Timely Interstate Placement of Foster Children Act of 2006. Of total decisions processed, 75% (380) were received for Delaware requests for out-of-state placements ("sending") and 25% (126) were sent for out-of-state requests for placement into Delaware ("receiving"). For sending

requests, DE ICPC received significantly more approvals (79%) for out-of-state placement requests than denials (21%). For receiving requests, DE ICPC sent moderately more approvals (59%) for out-of-state children's placement into Delaware than denials (41%). The continuing challenge to ICPC is in the receiving of home studies and interstate decisions within the expected timeframes. While home studies are mandated to be completed within sixty (60) days, many states are unable to fulfill that regulation.
DFS provides adoption assistance for special needs children and their adoptive families. As of December 31, 2013, there were 410 children receiving adoption assistance (Title IV-E federal financial participation) and 524 children receiving adoption subsidy (non-IV-E). Adoptive families are required to complete annual reviews and Medicaid applications (if they reside in DE). Each year, there are between 50-60 children exiting the program. Most of the children are over 18 years of age and graduate from high school, but some of the children are no longer residing with the adoptive family or may have returned to live with a birth family member. Currently there are 1160 children active in the adoption assistance program.

National research and local experience have demonstrated that at times these families need post-adoption support. When the adoption is finalized, DFS provides information and referral to services and support groups. Yet, adoptions do fail or disrupt. During 2013, there were 12 pre-adoption placement disruptions and 10 adoption dissolutions. Some of the reasons for placement disruptions include the child's behavior or special needs, divorce, adoptive parent health and family relocation. Some of the children where the adoption dissolved include the child's return to their biological family, living with a non-relative, entering long-term treatment facilities and the child's criminal activity.

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Independent Living Services

Independent Living programming is provided through a case management service delivery model which provides youth with assigned case workers to meet their specific needs. Independent living service plans are created collaboratively with the youth in order to promote a unified team approach to goal attainment. This approach also helps create accountability from the youth. Services are provided through contractors who have provided such services for over seven years. This creates consistency within service delivery as well as a strong foundational knowledge of the resources and training needs of the youth served. The effectiveness of the services is further impacted by the significant number of independent living staff that have been maintained (approximately half) over the years. Evidence of effectiveness is reflected in the consistent number of youth ages 18-21 served from 2012 to 2014. Within this time period, on average approximately 100 youth per year have aged out of foster care. During this same time period 293-300 youth in this age range have been served within a calendar year. The continued engagement of youth that have transitioned from foster care speaks to the trust that has been developed and recognition by the youth that the services provided are meaningful and beneficial. Specific services that have shown effectiveness include those related to employment training. Employment programs such as Bright Spot Ventures, Jobs for Delaware Graduates, and Summer Youth Employment have helped to improve the full time employment rate for youth 18 and older from 9% in 2012 to 12% in 2014. The ability for the youth to receive such services while still in foster care is better preparing them for future employment. Additionally, the number of youth that completed Post-Secondary education or training doubled from 2012/2013 to 2014. A contributing factor to the increased number of youth that completed Post-Secondary education can in some respect be attributed to the program developed with Delaware State University. This program allows two youth a year to attend the university essentially free of costs through a combination of financial resources in conjunction with academic supports. Since implementation in 2010, two youth

have graduated with Bachelor degrees. Two additional youth are slated to graduate within the next year. Assisting youth that age out of foster care with affordable housing has been a focus. In 2007, a housing voucher program specific to parenting youth was launched and was expanded each year through 2012. An allotment of 85 vouchers is now available to young adults through both the Family Unification Program and the State Rental Assistance Program. Independent Living programming has been enhanced in order to better prepare youth for the responsibilities of living in a rental unit. Such preparation includes education and training from IL case managers inclusive of daily life skills and financial literacy training. Independent Living skill building begins at age 14 and is built upon as the youth increases in age. By age, 17 the youth participates in a youth driven transition planning meeting where skills needed to effectively transition from care to independent living settings are identified and addressed during the youth's final year in foster care. Evidence of the efforts to better prepare youth for successfully living in a rental unit have been noted in that there has been a decrease in the number of youth that have lost their housing vouchers. An additional resource that has further impacted the reduction in voucher terminations is the implementation of a monthly maintenance stipend program for youth ages 18-21. This financial resource has assisted youth in having financial support to not only help them maintain the monetary responsibilities of a rental unit, but has also allowed more youth to further their education without the added stressors of having to juggle both full time work and school. Since the inception of the program in 2013, participants have higher positive outcome measures than their peers. These comparative outcomes include 51% completion of high school vs. 45% for all youth ages 18-21 receiving IL services. Additionally 42% are employed either part time or full time vs. 37% for all youth ages 18-21 receiving IL services. Independent Living services have been seen to have a positive impact on the youth served and continued efforts to strengthen these services are ongoing.

The community professional focus group felt that there is a need for more transportation, affordable housing, employment, and intensive family preservation programs. They also felt that minority and faith-based representatives were not regularly invited to participate in agency planning and evaluation events.
The adoptive parent focus group felt that there was a need for more mental health services for children. There is a lack of services focusing on fetal alcohol syndrome. They also felt that there needs to be more advocacy in the school system. Schools need more training/services common in adoption – attachment disorder, trauma, and educational disruptions due to multiple placements.

Individualizing Services
DFS strives to ensure that all services available to children and families are individualized to meet the needs of the family. This is most effectively evident in the Division's recent adoption of the new SDM® Child and Family Strengths and Needs Assessment, which help guide the service plan. Staff received extensive training from staff at the Children's Research Center regarding how to develop individualized, culturally sensitive plans with families. Staff have embraced this new way of developing plans and as a result, the quality of plans developed with families has improved significantly. DFS does not have quantitative system data yet; instead, in the first year of implementation, DFS has relied on Quality Assurance case readings from the Children's Research Center.

The DFS leadership focus group felt that services are individualized thru the Division's flexible funding account, the 21st Century Funding account, school meetings, Parent-Child Interaction Therapy and the Placement Resource Team. All of these avenues allow for the customization of services to best meet the needs of children and their families. The community focus group referenced the agency's

new assessment and planning documentation is helpful for individuating care. Adoptive parents would like more services for special needs children and expanded financial assistance for post-secondary education. Surveys covered individualization of services. Youth agreed with the statement "I get services to meet my individual needs", 62.5%. DFS staff, DSCYF staff, community professionals, court and legal representatives and foster/adoptive parents responded to the statement "Services are individualized to meet the needs of children and families." DSCYF staff agreed 57.9%, community professionals agreed 82%, DFS staff agreed 78.5%, foster/adoptive parents agreed 85.3% and court/legal respondents agreed 81.8%.

DFS' Office of Evidence–Based Practice was created to provide an in-house screening and consultation unit and to provide oversight to the various best practice and evidence-based/informed tools and models being implemented division wide. Development and maintenance of a psychotropic medication oversight and monitoring program is also one of our primary program goals. Clinical consultation and monitoring services are provided at both the system and case levels. Currently, OEBP is a small unit with two licensed psychologists and two clinical screeners.

Screening and Consultation Unit

The screening and consultation unit (SCU) provides effective screening for children who enter foster care, and these screenings are scheduled to take place within 4 weeks of entering care. The SCU screenings assist foster families and caseworkers to identify the most appropriate services for children and their families to improve outcomes and promote well-being. The SCU also provides support and follow-up care to caseworkers and children in foster care through ongoing consultation and case related problem-solving.

In terms of specific procedures that are followed by the SCU staff, the following is the general process by which screenings occur. Once a child enters foster care, a Clinical Screener is notified of that child's entry and the screening process begins. The Clinical Screener sends out notification emails to caseworkers, supervisors, and foster care coordinators to alert them to the screening process and request their input. Some children may already be receiving mental health services, or they may have been screened through another resource (e.g., PBH, Outpatient Therapist, CDW, etc.). In these cases, Clinical Screeners will contact treatment provider and foster parent to check-in and ensure that the child's needs are being met. Provided that their needs are being addressed and no additional concerns are raised, no additional screening is required for these children. For all other children, the Clinical Screeners then contact the foster parent to schedule a screening appointment. A variety of screening tools are utilized for the screenings, including developmental screeners, substance abuse screeners, and trauma screeners. Once the screening is complete, the findings and recommendations are shared with the DFS caseworker, supervisor, treatment coordinator, and/or private agency worker involved with the child (via simple 1-2 page summary sheet showing of areas of need). Assistance is provided when needed to aid the child in being connected to the appropriate service and providers in his/her area.

Once findings from the screening process have been shared with the child's treatment team and the appropriate services have been established, the SCU) provides support and follow-up care to caseworkers and children in foster care through ongoing consultation and problem-solving. SCU screeners and psychologists are accessible to staff involved with each child in foster care, as well as available for consultation with providers working with these children. With regards to symptoms of trauma-related anxiety that may be present for children in foster care, the SCU screening protocol includes a screening tool used specifically to identify such symptoms. Should

the child show evidence of trauma-related anxiety, SCU staff immediately refer the child to the trauma program run by the Division of Prevention and Behavioral Health Services. Through this trauma program, the child is connected to a provider who is trained in Trauma-Focused Cognitive Behavioral Therapy for treatment and monitoring. Results from the clinical screeners performed by the SCU are shared with all staff involved with each child, and findings and recommendations are also shared with the child's foster parents. In addition, findings and recommendations are available via the State of Delaware's Family and Child Tracking System (FACTS). The SCU also plays a role in ensuring the continuity of health care services for each child by serving as an access point or point of referral for all types of health care services, including services to address developmental delays in young children, medical concerns raised by foster parents or children, or appropriate mental health services. Obviously, the SCU ensures that services for youth in care are individualized.

Based on survey and focus group information, Delaware performs well meeting individual needs of families and children.

F. Agency Responsiveness to the Community

Several major activities should be recognized in this section as early contributions to the development of the goals and objectives identified in the 2015-2019 Child and Family Services Plan, Section IV. 2015-2019 Strategic Plan. First, the 2010 Child Abuse and Prevention Act reauthorization mandated states provide some type of differential response. This put in motion plans to implement a family assessment track as authorized by Delaware's Child Abuse Prevention Act of 1997. These plans led to DFS receiving technical assistance for planning and implementation from the National Resource Center for In-Home Services. The planning group included representatives from DSCYF, community service provider agencies, the Office of the Child Advocate, Child Death Commission, and the CB-CAP agency of Prevent Child Abuse Delaware, Annie E. Casey Foundation (AECF), DFS front line staff and program staff, and Region III Administration for Children and Families. This planning group developed the plan for Delaware's Differential Response System, which initially included the alternative pathway of the Family Assessment and Intervention Response to address the issue of teen entries into foster care.

Over the last three years, DFS has been involved in a comprehensive system transformation effort, entitled the Outcomes Matter Initiative. The precursor of this initiative occurred in early 2011, when the Child Protection Accountability Commission members sanctioned the adoption of Structured Decision Making® (SDM) at the child abuse report line to improve consistency in accepting and assigning response priorities to abuse and neglect reports using an actuarial risk assessment model. Delaware contracted with the Children's Research Center of the National Council on Crime and Delinquency to implement SDM®. This initial effort grew into adopting a new practice model - Safety Organized Practice. In 2011, Governor Markel and then Department Secretary Rapposelli asked the Child Welfare Strategy Group of the Annie E. Casey Foundation to conduct a child welfare system wide assessment. This assessment used quantitative and qualitative methods to assess the system. Over 100 interviews with DFS staff at all levels statewide, stakeholders, and system partners were conducted as part of that assessment. The compilation of this information helped shape the system transformation efforts. The Casey team was asked to focus its assessment on SDM® implementation, differential response implementation, teens in foster care, emancipation rates, and permanency outcomes. The assessment covered data analysis, policy

review, finance review, business process mapping, observations, case reviews, individual interviews, and surveys. A detailed overview of the assessment methodology, findings and recommendations are attached. (See Attachment A: AECF DE Assessment February 14 2012).

The initial working meeting for the 2015-2019 Child and Family Services Plan was held March 26, 2014 with a group of professional representatives from DFS (policy and operational staff) and its sister agencies within the Children's Department (Division of Youth Rehabilitative Services (DYRS), Division of Prevention and Behavioral Health Services (DPBHS), and the Division of Management and Support Services (DMMS)); the Family Court of Delaware (including the Court Improvement Program and Court Appointed Special Advocate Office); Child Placement Review Board; the Office of the Child Advocate; Delaware Youth Opportunities Initiative, Region III of the Children's Bureau, Administration of Children and Families and several community service agencies representing home-based, foster care, prevention, foster parent training and adoption services. The session began with program updates and a multi-year review of system data and quality assurance results. A draft of goals, objectives and measures was presented as well. The session ended with stakeholders listing strengths and areas needing improvement in child welfare systems. Since the initial planning session, the CFSP coordinator met with DFS managers, supervisors, caseworkers and foster care youth/young adults to identify system strengths and areas needing improvement. Foster parent comments were gathered via survey. Three attempts were made to meet with parents; circumstances prevented accomplishing this activity. DFS will continue to seek parental input at key points in the Child and Family Services Review (CFSR), Annual Progress and Services Report (APSR) process and Continuous Quality Improvement (CQI) process. Approximately 130 stakeholders contributed by focus group or survey. This information contributed to the goals, objectives and measures for the next 2015-2019 CFSP. In summary, over 300 comments were received; the major themes expressed by stakeholders are:

- Maintain strong child safety practices and outcomes
- Complete the set of initiatives to fully engage families and youth in assessment, planning and delivery of child welfare services
- Build capacity for community based out-of-home services within Delaware
- Support the workforce with training and retention initiatives
- Continue collaborative efforts with system partners
- Strengthen service array

Other efforts to involve community stakeholders have also been successful. Two meetings, October 28, 2014 and December 9, 2014, have been held with the Nanticoke Tribal Chief William Daisey, the DFS CFSR/CFSP Coordinator and DFS Sussex regional office staff. These meetings have reestablished points of contact should an Indian child enter foster care. Agreement was also reached to promote foster parenting recruitment at Indian events in the next year such as the annual Powwow which draws approximately 35,000 people. DFS shared the CFSP in hard copy and links to the Annual Progress and Services Report webpage. How the Tribe and agency can collaborate to serve Indian families' needs further exploration. Prevention services are reliant upon community input to define services. Under the Promoting Safe and Stable Family Program (PSSF), the Delaware Fatherhood and Family Coalition (DFFC) was established to create a statewide group of shareholders referred to as the County Leadership Committee (CLC) to embark on broader goals. The collaborative partnership between PSSF and DFFC CLC's effort is to inform and engage the community, informing them of the

importance of re-engagement of fathers into the lives of their children, their family and the community. PSSF family consultants provide support and technical assistance to its statewide coalition of shareholders (CLC) in becoming a driving force behind responsible fatherhood and healthy adult relationships throughout the state of Delaware.

DFS is a member of the Child Protection Accountability Commission (CPAC) responds to recommendations from member agencies. Del. C. Title 16, Chapter 9, §912 sets the Commission's membership as: The Secretary of DSCYF, the Director of DFS, 2 representatives from the Attorney's General Office, 2 members of the Family Court, 1 member of the House of Representatives, 1 member of the Senate, the Chair of the Child Placement Review Board, the Secretary of the Department of Education, the Director of DFS of Prevention and Behavioral Health Services, the Chair of the Domestic Violence Coordinating Council, the Superintendent of the Delaware State Police, the Chair of the Child Death, Near Death and Stillbirth Commission, the Investigation Coordinator, 1 youth or young adult who has experienced foster care in Delaware, 1 representative from the Public Defender's Office, and 7 at-large members (1 person from the medical community, 1 person from the Interagency Committee on Adoption who works with youth engaged in the foster care system, 1 person from a law-enforcement agency other than the State Police, and 4 persons from the child protection community). CPAC provides a formal process for assessing system data, convening system partners, and advocating for policy and legislative changes.

DFS is also represented on the Child Death, Near Death and Stillborn Commission. This commission provides system-level recommendations on cases reviewed. There is a formal process for agencies, including DFS, to respond to recommendations.

DFS also has a Community Advisory Council that reviews agency programming and provides input at quarterly meetings with the Director of DFS Council members represent the following: A Friend of the Family, Inc., Community Legal Aid, Foster Parent, Prevent Child Abuse Delaware, North East Treatment Center, A Better Chance for Our Children, Mt. Pleasant Elementary, Peoples Place II, New Behavioral Network, Red Clay School District, Child Inc., citizen advocate, Grassroots Citizens for Children, Office of the Child Advocate, Wraparound Delaware, Children & Families First, Child Placement Review Board, DE State Housing Authority, DE Coalition Against Domestic Violence, Court Appointed Special Advocate Program, Adoptive Families with Support and Information, A.I. DuPont Hospital and Jewish Family Services. Federal performance measures, state performance measures, and various management reports are reviewed regularly at these meetings, as is the Annual Status and Progress Report, so that members can be informed of the status of the agency's operations and provided an opportunity for feedback and recommendations.

The development of the Annual Progress and Services Reports, coordinated by DFS, credits approximately 25 contributors to the report. Both the annual report and the Child and Family Services Plan are reviewed annually at meetings convened by DFS with representatives from sister Divisions, prevention, family support, foster care and independent living service agencies, Family Court, Office of the Child Advocate, Child Placement Review Board, Delaware Youth Opportunities Initiative, and Region III Administration of Children and Families. Annual reports and CFSPs are posted on the agency's website. (http://kids.delaware.gov/fs/fs_cfs_review_plan.shtml)

Stakeholder input for the CFSR state self-assessment was gathered via a web based surveys and focus groups. (See Focus Group and Survey Summary Attachment for details) The survey statement for community professionals, DSCYF staff and legal partners was "Family Services engages advocates, community professionals and service providers in statewide planning and reporting." The statement for foster and adoptive parents and DFS staff was "I have a voice in statewide agency planning." Youth were asked to rate "I have a say in deciding services for teens and young adults." The results reveal differences between groups. The lowest agreements were 40% of foster and adoptive parents and 58.7% of DFS staff agree they are engaged in agency planning and reporting. Youth agree 76.3% they have a voice in services for teens and young adults. Community professionals agree 86.9%; legal and court representatives agree 89.5% and DSCYF staff agree 74.2%. Overall, all but foster and adoptive parents agree the agency engages partners in planning and reporting.

Comments given at the March 2014 community professionals' meeting to develop the Child and Family Services Plan report collaborations between public and private agencies as a strength. Stakeholders also recognize a strong communication plan, approachable leadership and consistent messaging to community partners as strengths. Stakeholders also say DFS includes family and youth voices more at the case and system level. Stakeholders ask for more data driven, shared decision-making, a stronger family and youth voice, and more communication.

As for focus group comments, there was a mixture of answers directed at the case level and agency planning level, indicating some confusion as to Item 31's purpose. DFS leadership reports community partner engagement with planning and reporting to be a strength, citing a variety of forums where community concerns are addressed such as the Child Protection Accountability Commission, Court Agency meetings, DFS Advisory Council, Youth Advocacy Council, and contracted provider meetings. Community professionals note the agency is challenged to engage minorities, smaller community agencies, and faith based organizations. DFS leaders state engaging parents (clients) as partners is a challenge. At the case level, DFS caseworkers and community professionals state DFS is responsive to community partners involved with specific families. Practices such as Team Decision Making, multi-divisional planning and judicial hearings are noted as case level activities where partner input is visible.

Coordination of CFSP Services With Other Federal Programs

The continuum of services provided by the Title IV-B/IV-E agency is coordinated with a variety of federal, state and local programs. Eligible foster children receive Medicaid benefits. Demonstrating the Agency-Medicaid coordination, of 651 children in a foster care placement February 26th, 646 were Medicaid covered. The remaining five children included two pending eligibility determinations and 3 in ineligible placement settings. Social Security benefits are applied for when eligibility exists. DSCYF contracts to screen children entering foster care for Supplemental Security Income (SSI) disabilities and other Social Security (SSA) benefits. In January 2015, there were 36 foster children receiving SSI benefits and 19 children receiving SSA benefits. DFS coordinates with the Division of Child Support Enforcement (DCSE) to seek child support from non-custodial parents of foster children. For the month of January 2015, there were 125 child support deposits received from DCSE. Promoting Safe and Stable Families services are available to families, including young adults aging out of care with children. Title IV-B Subpart II funding is shared between the Division of Prevention and Behavioral Health Services and DFS. Child care for eligible foster children and intact families is coordinated with the Division of Social Services.

Child Development Watch programming for children age 3 and younger is coordinated with the Division of Public Health. As of March 31, 2014, there were 107 active DFS referred children in Child Development Watch programming. For the 12 month period, April 1, 2013 to March 31, 2014, DFS referred 158 children. Public housing programs, federal and state funded, are offered to DFS families and young adults receiving independent living programming. Social Service Block Grants are shared with DSCYF by the Delaware Department of Health and Social Services. These funds are applied to protective services, foster care services and administrative costs. The agency has Memorandums of Agreement (MOA) with the Department of Education, Law Enforcement Agencies, Division of Developmental Disabilities, Delaware Family Court, Dover Air Force Base, Division of Substance Abuse and Mental Health and the Division of Child Support Enforcement. DSCYF also coordinates placement and supervision of cross-jurisdictional children per Interstate Compact Agreements. The state Health Care Plan for Foster Children is coordinated with the Division of Medicaid and Medical Assistance. DHSS, as lead agency for the Child Care and Development Fund Plan has a MOA with DSCYF to improve the quality of child care. DSCYF is charged with establishing and enforcing the requirements and baseline standards for licensed child care providers in the State. In addition, DSCYF conducts criminal history record (federal and state) and child protection registry checks for license and license exempt providers for the protection of children. The Early Learning Challenge funds from the federal Department of Education are applied to fund DPBHS clinicians serving child care facilities to provide mental health consultation aimed to build the capacity and improve the ability of child care center staff, programs and systems to prevent, identify, treat and reduce the impact of mental health problems.

This item was included in surveys for community professionals, DFS staff and the legal community who responded to this statement "Family Services coordinates with other federal programs such as housing and Medicaid." Court and legal respondents indicated agreement 93.1%, community professionals agreed 92.6% and DFS staff agreed 75.5%. Community professionals and DFS leadership team focus groups addressed this item. DFS notes active MOU's with multiple state and federal entities. Additionally DFS participates in: Multidisciplinary Team meetings through the Children's Advocacy Center, Home Visitation Advisory Board, Fast Track at AI DuPont, Medicaid, Child Development Watch, McKinney/Vento protections with DOE and child care services. Community professionals cite concerns with Medicaid, children served by multiple state agencies, and purchased child care services.

G. Foster and Adoptive Parent Licensing, Recruitment, and Retention

All families, public and private, are required to meet the requirements for criminal background checks that include fingerprinting and the requirement of Adam Walsh Act of 2006. In our survey to foster parents, a question stated "Criminal background checks are done for all adults in my home" of the 37 respondents who had an opinion 36 or 97% agreed or strongly agreed, this is supports evidence that criminal background checks are required for approval and it is known throughout the foster care program it is an non-negotiable requirement.

Requirements for Criminal Background Checks

Last calendar year there were three hundred and sixty eight (368) fingerprint background checks completed on perspective and/or approved foster care families and members of families over twenty one. Four hundred and twenty four (424) fingerprint background checks were completed on adults who had interest in or who adopted children from the foster care system. During our most recent

Federal IV-E review in 2012 with the review of eighty (80) cases, the reviewed found Delaware to be in substantial compliance and cited safety checks and criminal background as a strength and promising practice, all eighty cases had competed approved criminal background checks.

Diligent Recruitment of Foster and Adoptive Homes

DFS hired a contracted statewide recruiter and continued initiatives started as a result of Annie E. Casey Foundation's (AECF's) assessment and recommendations supporting foster family caregiving. AECF's assessment revealed resource gaps for teens and recommended improved recruitment, development, and support for resource families for teens. DFS is responding with an initiative to recruit for targeted populations of teens as well as children with special needs and sibling groups. The needs of these children and youth challenge the current available resources. The statewide recruitment plan maps specific messaging and activities to recruit specific target groups such as teachers, professional organizations and faith-based organizations to fill resource gaps for teens, sibling groups and special needs foster children. During calendar year 2014, we had six hundred and twenty nine (629) inquiries to foster and/or adopt. Of those, ninety four (94) inquired about our targeted population. Of the thirty two (32) families approved in the 2014 only eight (8) were approved to foster our targeted population. As a result, DFS made the decision beginning January 2015 to only accept families who are willing to serve the targeted populations of teen, sibling groups and medical or developmental special needs children. All others inquiries will be directed to private foster care agencies for approval. This is an effort to increase the number of families to care for the targeted populations and will be reassessed halfway thru the 2015 calendar year. Another barrier that was identified in the approval process is the length of time for new foster parents from inquiry (attendance at first informational session) to approval. In some cases this process is as long as six months. Based on this information, all parties involved with this process will come together in April 2015 to review and evaluate the approval process to identify the areas needing improvement to improve the efficiency of this process. Delaware over the last several years has been consistent matching the diverse race and ethnic backgrounds of children in care with foster families. In regards to diversity, general recruitment efforts have produced diverse foster parent homes. We have gone to many faith based organizations who have a diverse congregation and those who do not. We have developed many relationships with diverse faith based organizations; some examples are Bethel A.M.E Church, Perfecting Holiness Ministries, and Church of Jesus Christ of the Latter Day Saints, St. Paul United A.M.E Church, Limestone Presbyterian Church, Sussex County Bible Church, Mt. Olive Brethren Church, St. David's Church, Morning Star Institutional Church, these faith based organization are throughout the state, these and long standing affiliation with the Mid-Atlantic Orphan Care Coalition (MAOCC) 50 Churches/50 Children Initiative and Lt. Governor's Faith, Family, and Foster Care Initiative, this along with our unofficial philosophy that we will go anywhere, speak with anyone, anytime about foster care, we believe have supported our success in having diverse families to meet the diverse needs of children in foster care.

Data, Demographics and Trends

During state fiscal year 2013, 1,153 children were in foster care, which represents a decrease of 11% from fiscal year 2012. Point in time on the last day of fiscal year 2013, there were 648 children in foster care, which is a decrease of 7 % from the end of fiscal year 2012. Foster children in care as of April 1, 2014 are 48% or 280 females and 52% or 305 males. These numbers represent an overall decrease of children in care from April 1, 2013 to April 1, 2014 of 97 children or 11%. With the total number of children in care decreasing, the 2014 numbers represents a slight increase for African American from 54% on April 1, 2013 to 55% and a slight decrease for Caucasians

from 56% on April 1, 2013 to 54 %. Children who were identified as Hispanic/Latino represent 60 children or 9%. Our foster parents' race as of April 1, 2014 is 50% African American and 43% Caucasian. Foster parents are 3% Hispanic. These counts are compatible with the racial population of children in care and have been constant over the last four years. In a recent survey completed January 2015, one questions to foster/adoptive parents ask "Foster and adoptive parents who are recruited reflect the racial and ethnic diversity" of the 32 foster/adoptive parents who had an opinion, 27 or 87% agreed or strongly agreed. Over several years the number of foster children is decreasing, while the percentage of older youth entering care remains stable. Youth initially placed with relatives increased 67% from June 2012 to December 2013.

DFS staff report better coordination of supports for foster parents. Foster parents note training, communication and assistance from Foster Care Coordinators as strengths. Areas identified as needing improvement are training, financial aid and social supports for relative caregivers. DFS staffs recommend support groups for relative caregivers with information and referral (i.e., domestic violence, mental health, substance abuse) resources at those meetings. DFS responds to kinship caregiver concerns with plans to implement kinship care programming with training, case management and financial aid for relative caregivers of children and youth in DFS custody.

State Use of Cross-Jurisdictional Resources for Permanent Placements

DFS continues to recruit adoptive families from all states and has children placed for adoption in 30 different states at this time. DFS uses the local and national adoption exchanges to recruit adoptive families. Children needing permanency can be found on the National Adoption Center and the Adoptuskids websites in addition to the Delaware DSCYF website. Other recruitment activities include the state Deladopt listing, DE Heart Gallery, matching parties at Delaware Valley Adoption Council and Interagency Committee on Adoption, National Adoption month activities which include PSA'S and newspaper articles and reaching out to the local adoption agencies for child specific recruitment activities as needed. These activities are statewide and for all children in foster care needing permanency. Currently, there are 82 children in foster care needing permanency. Fifty two per cent are males; sixty three per cent are African American; sixty three per cent are members of a sibling group and the ages of these children are from 18 months to 17 years of age. This information is gathered from the state Deladopt listing that is updated monthly and sent to agencies in Delaware and the surrounding area. Also, DFS has a contract with the National Adoption Center (NAC) to list all waiting children on their website and on Adoptuskids website. Upon receipt of the adoptive home studies, they are forward to the DFS adoption caseworkers and the Child Specific Recruiters for review. The home studies are then forwarded to the DFS Permanency Planning Committee for approval. The NAC is also responsible for keeping the NAC and Adoptuskids website current and up to date.

DFS sent out surveys to the community partners, to the court and legal representatives and to DFS staff for feedback related to the use of cross-jurisdictional placements. Responses from the 100 community partners showed 37.7 disagree and 34.0% agree as to cross jurisdictional placement. Some of the issues related to the barriers were the delays in the ICPC approval process and connecting children to needed services in the receiving states.

Responses from the 56 court and legal representatives were 42.9% agreed and 34.3 % disagreed to the use of cross jurisdictional placements. DFS has 53 responses where 40.6% disagreed and 34.4% agreed there are no barriers to placing children in homes in other states. The barriers noted were the same for all three areas.

The FY2013 congressional-mandated Annual Report on intercountry adoption from the Bureau of Consular Affairs, U.S. Department of State is available to states. For Delaware, the number of intercountry adoptions for FY 13 involving emigration from the United States regardless of whether or not the adoption occurred under the Hague Convention was 20 adoptions. Fourteen adoptions were finalized abroad and six adoptions were to be finalized in the U.S. There are no other data available related to cross-jurisdictional placements. From my professional judgment and as the program manager who negotiates and develops contracts with adoption agencies in other states and jurisdictions for Delaware children to be placed in permanent homes, the ICPC process has been effective. This issue was discussed at the focus groups with caseworkers, supervisors and administrators. Everyone agreed that DFS continues to look for and place children needing permanency out of state when resources have been identified. The program manager has regular interaction with the adoption caseworkers and participates in adoption work group meetings every six months or as needed and the issue of cross-jurisdictional placements is discussed at each meeting. Feedback has been positive and the child welfare agency staff states the approval process has been timely with no known delays in the ICPC process or cross-jurisdictional placements. Also, there are regular meetings with the contracted adoption agency staff statewide. Since DFS contracts out Child Specific Recruitment (CSR) work to the contracted adoption agencies, this is discussed as well. At this time, there are no known barriers known related to cross jurisdictional placements. There is no data available to confirm the home studies were completed as required within the 60 days.