CUSTODY, BUT NO CARE:  
A REVIEW OF CHILDREN’S EXPERIENCES IN MDHS CUSTODY

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Executive Summary

This report focuses on the custodial experiences of a representative sample of 286 Mississippi foster children over a two-year period, June 1, 2003 through June 1, 2005. Dr. Peg Hess, most recently Professor of Social Work and Director of Doctoral Studies at the University of South Carolina, designed and directed this project and authored this report. Information about the children’s experiences was derived from their Mississippi Department of Human Services (MDHS) case records. The review was conducted at the request of Plaintiffs’ attorneys and took place on-site in nine county offices of the MDHS, Division of Family and Children Services (DFCS) from June 27, 2005 through August 26, 2005. This report provides expert opinions concerning the adequacy of the casework practice and placement services provided to children in MDHS custody as measured against minimum acceptable professional standards, including federal and Mississippi state law and policies, and published and recognized national practice standards.

The review documented pervasive failure by MDHS to protect and serve the children in its custody as follows:

Safety. MDHS repeatedly has failed to fulfill its legal mandate to report and investigate documented instances of suspected foster caregiver maltreatment of children while in MDHS custody, resulting in substantial preventable harm. Because of MDHS’ failure to maintain face-to-face contact as required with the majority of children in custody and their foster caregivers, assure continuity of social work services by trained professional staff, and document children’s needs and experiences, children are inevitably endangered. Their safety while in MDHS custody has not been, and cannot be, monitored and assured due to multiple ongoing MDHS failures.

- ONE IN TWENTY (4.9%) children in MDHS custody had substantiated maltreatment in their placements; a majority of those children were maltreated since January 1, 2004.
- ONE IN TEN children in MDHS custody (11.8%) had indications of their maltreatment in care or the maltreatment of another foster child in their placement that was either substantiated or considered serious enough to warrant a placement move.
- ONE IN EIGHT children in MDHS custody (12%) had at least one incident of suspected maltreatment in their placement that was not investigated. 7.4% had at least one incident of maltreatment in their placement that was documented but never formally reported for investigation by MDHS.
- ONE IN FOUR children in MDHS custody (24%) had some documentation (reports, investigations, or case notes) in their records indicating their
maltreatment in care or the maltreatment of another foster child in their placement.

- In the majority of incidents (54.1%) of substantiated maltreatment in the children’s placement, the children were not moved.
- 87.6% of the children in MDHS custody were not seen at least monthly by their social worker or supervisor, as required, during the one-year period prior to June 1, 2005.
- 13.5% of the children had no face-to-face contact with their assigned social worker/supervisor during this same 12-month period. 8.4% were not visited once by any MDHS staff during this one-year period.
- In 97.1% of the children’s cases, the MDHS social worker or supervisor failed to see their foster parents at least monthly in the 12-month period prior to June 1, 2005. For one third of the children (32.6%), the MDHS social worker/supervisor failed to visit the foster parents’ home even once during the year prior to June 1, 2005.

**Placement services and children’s well-being.** Due to its failure to identify and evaluate children’s health, mental health, and educational needs, MDHS has failed to determine and appropriately respond to children’s placement and service needs. As a result of this and other failures, the overwhelming majority of children have experienced profound instability while in MDHS custody.

**Placements:**

- **FOUR OUT OF FIVE** children in MDHS custody (82.7%) were moved at least once from their original placement and up to 57 times.
- **ONE IN TEN** children in MDHS custody (11.3%) were moved ten or more times.
- Of the children who were moved, infants under the age of one (4.1 average moves per year) and three-year olds (4.3 average moves per year) had the highest average number of moves of any age group.
- Despite MDHS policy that acknowledges that a “foster child who moves many times . . . can suffer devastating effects on his/her emotional health,” more than 90.0% of the time, MDHS failed to offer or provide services to foster children or their caregivers to prevent placements from disrupting.
- **ALMOST TWO OUT OF THREE** children in MDHS custody (63.8%) were placed at least once in an emergency shelter facility or emergency foster home since their most recent entry into custody.
- 45.1% of the children who were placed in an emergency shelter facility/home were placed in such an emergency placement more than once and up to 15 times.
• 29.5% of the children had an emergency placement stay of more than 45 days within a six-month period during the two-year period prior to June 1, 2005; the majority (51.9%) had such stays without the required written extension approval. The average total length of time spent in emergency placements during the children’s most recent stay in custody was almost 3 months (11.4 weeks).
• More than one-half of the children ages 0-5 who were placed in emergency placements were placed there for a total of more than six weeks.
• 44.7% of children were placed separately from one or more of their siblings in MDHS custody. For 72.3% of these children, MDHS failed to document any efforts to find or develop a placement for the sibling group.
• ALL (100%) of the children placed separately from siblings failed to be provided by MDHS the twice monthly sibling visits required by agency policy during the entire 12-month period prior to June 1, 2005. 60.1% of the children placed separately from siblings in MDHS custody were not provided even one sibling visit during the same one-year period.

Physical, Dental and Mental Health Evaluations and Services:

• MDHS failed to provide the overwhelming majority (84.1%) of children a physical exam within 7 days of placement as required.
• MDHS failed to provide any annual physical exam for 28.2% of the children during the two years prior to June 1, 2005.
• Almost one-third (32.4%) of the youngest foster children (ages 0-5) in custody for at least one year - those for whom multiple immunizations are required, numerous developmental milestones occur, and medical problems can be particularly serious - failed to receive even one physical exam during the two years prior to June 1, 2005.
• MDHS failed to maintain immunization records for 17.4% of children ages 0-5 years old.
• MDHS failed to provide even one dental exam for 42.2% of the children ages 3 and older in custody at least one year during the two-year period prior to June 1, 2005.
• For 89.4% of children entering custody on or after June 1, 2003, MDHS failed to provide the child’s health records to the child’s caregiver at that time.
• 57.7% of the children ages 4 and older entering custody on or after June 1, 2003, were not provided a psychological assessment as required within 90 days; 35.5% were never evaluated for mental illness or developmental disorders.
• 69.1% of the 4 and 5 year olds were not provided any evaluation for mental illness or developmental disorders while in MDHS custody.
• For 50% of the children whose case files documented the identification of a mental illness or developmental disorder for which further assessment was recommended by a mental health provider, MDHS failed to provide any further assessment.

• In 21% of the instances in which inpatient treatment was specifically recommended for a child, such treatment was not provided during the 24-month period prior to June 1, 2005.

• 83.4% of the children with a diagnosed mental illness or developmental disorder who were placed with foster families were placed in a non-therapeutic foster home placement as of June 1, 2005.

**Educational Services:**

• ONE OUT OF FIVE school-age children in MDHS custody (22%) had *no* educational records in their case files; 63.6% of the children who had to switch schools at the time of entry into MDHS custody had *no* information in their files about their subsequent school enrollment; for 29.2% of the children receiving special education services, MDHS did not maintain a copy of the child’s current Individualized Education Plan (IEP) as required.

• Of the school-age children entering custody on or after June 1, 2003, who had documentation about their enrollment in a new school at the time of their entry into custody, 40.4% were not enrolled in school for between 10 and 90 days.

• Of the school-age children entering custody on or after June 1, 2003, 61.9% with documentation had to change schools at least once during their most recent stay in custody; of those children 9.1% had to switch schools at least four times. The vast majority of the school changes while in custody were due to MDHS moving the child to another placement with delays in enrollment ranging from 2 to 90 days.

• 60.2% of the adolescents in MDHS custody whose case file contained an independent living plan had plans that failed to address how they could obtain further education or vocational training as required; for 76.9% of adolescents with an independent living plan, MDHS failed to even address in the plan the youth’s anticipated housing needs at the time of discharge from custody.

**Permanency.** For the majority of children in custody MDHS has also failed to provide mandated services to achieve permanent homes for children and timely discharge from custody.
Planning for Children:

- Children in MDHS custody at least 60 days as of June 1, 2005, had an average length of stay of 2.8 years. 29.8% had been in custody three or more years. 8.8% had been in custody for more than five years.
- ONE IN FIVE children (20.9%) have spent half or more of their lives in MDHS custody.
- 66.7% of the children entering MDHS custody on or after June 1, 2003, had no Individualized Service Plan (ISP) within 30 days as required by federal law and MDHS policy; 40% did not have this critical case planning document completed within the first three months of entering custody.
- 9.6% of all children in custody had no ISP for the two-year period prior to June 1, 2005.
- The accuracy of the historical information in completed ISPs is compromised by a programming error in MDHS’s computer system (MACWIS) that automatically deletes and updates information on ISPs as of the date they are printed out from the system.
- For 56.1% of the children entering custody on or after June 1, 2003, MDHS failed to complete the required ISP for either parent within 30 days.
- For 94.5% of the children who entered custody on or after June 1, 2003, MDHS failed to convene even one conference with family members (Family Group Conference) to make plans for the child.
- For 85.5% of the children in MDHS custody over one year, MDHS failed to secure for them at least one 12-month judicial permanency review during the two-year period prior to June 1, 2005.

Reunification Services:

- As of June 1, 2005, 16.1% of children in MDHS custody with a goal of reunification were placed in a non-adjacent Mississippi County (12.3%) or another state (3.8%).
- For 95.2% of the children with a primary or concurrent goal of reunification, the social worker or supervisor failed to meet with the mother at least monthly during the 12-month period prior to June 1, 2005. For 45.5% of the children with a goal of reunification, the social worker/supervisor failed to meet with the mother even once during this same one-year period.
- MDHS failed to have face-to-face contact with the children’s fathers monthly for 92.1%, or at all for 58.5%, of the children with the goal of reunification during the same period.
- 90.5% of the children with a primary or concurrent goal of reunification were not provided at least a monthly visit with their mother as required in
the 12 months prior to June 1, 2005. 51% of the children with a goal of reunification were not provided with any visit with their mother during the same year period.

- MDHS failed to provide monthly visits to the children with their fathers as required for 95.8%, or at all for 85.2%, of the children with the goal of reunification during the same period.

Adoption Services:

- 79.7% of the children had been in MDHS custody for at least 17 months, yet MDHS failed to file a petition to free them for adoption or document a compelling reason for not filing a petition for the termination of parental rights (TPR).
- 24.1% of the children for whom a TPR petition was filed spent another two years or more waiting for it to be granted.
- As of June 1, 2005, 51.0% of the children with a goal of adoption had been in MDHS custody for a total of 3 years or more; 20.7% had been in custody for a total of between 5 and 17.9 years.
- 26.2% of the children legally free for adoption spent another 3 years or more in MDHS custody since being legally freed, up to as much as 11 years.
- For 34.1% of the children with the primary goal of placement or adoption with a relative, MDHS had failed to identify any relative with whom the child could be placed or adopted.
- As of June 1, 2005, MDHS had failed to place 36.9% of the children with the goal of adoption in an adoptive home; for 85.5% of these children MDHS had made no efforts to identify an adoptive family for them in the two years prior to June 1, 2005.

It must be emphasized that in every area, great variability is found in the placement services provided by the nine counties selected for the study. Although children have dramatically different placement experiences depending upon the county of responsibility through which they enter MDHS custody, foster children in all nine counties are being deprived of minimally adequate placement services. Thus, MDHS fails to assure basic safety, well-being, and permanency to the children in its custody. In discussions regarding foster children, the phrase “in care” is often used interchangeably with “in custody.” The findings confirm that the children and youth in MDHS custody receive little “care.”
In March 2004 6-month-old Eric had his arm broken in 3 places while in an MDHS foster home. The homemaker (an untrained MDHS staff position with no social work qualifications) who transported Eric to the doctor neither questioned the doctor regarding possible child abuse nor recorded concerns about further risk to the child, even though an investigation of physical neglect regarding another child in the placement had occurred two months earlier. During a follow-up medical visit, a specialist specifically expressed concern regarding Eric’s placement. When questioned by the homemaker whether the child should be removed, the doctor responded “Questionable, very questionable.” The homemaker did not document discussions with any other agency staff regarding risk to the child, “a report was not made and the agency did not conduct an investigation.” The following month, there was an investigation regarding yet a third child in the home, and Eric was moved to an emergency shelter. Information separately produced by DHS confirms that physical abuse of the third child by the foster mother was substantiated, but no licensing action was taken.
I. Introduction

The Project

This case reading and analysis of information contained in the original case files of a representative sample of 286 Mississippi foster children was conducted at the request of Plaintiffs’ attorneys. Dr. Peg Hess, most recently Professor of Social Work and Director of Doctoral Studies at the University of South Carolina, designed and directed this project and authored this report. A copy of Dr. Hess’ *curriculum vitae* is attached as Appendix A. Dr. Peter Jones, Vice Provost of Undergraduate Studies at Temple University, assisted with the development of the protocol, sample design and selection, data entry and computer generated aggregate data, and data analysis. A copy of Dr. Jones’ *curriculum vitae* is attached as Appendix B. Ten case readers and one supervisor were hired for the project. The case readings took place on-site in nine county offices of the Mississippi Department of Human Services (MDHS), Division of Family and Children Services (DFCS) throughout the State from June 27, 2005 through August 26, 2005.

The Report

This report presents and evaluates information and data derived from the case record review. It focuses principally on the custodial experiences of the sample children over a two-year period, June 1, 2003 through June 1, 2005. The report further provides expert opinions concerning the adequacy of the casework practice and services provided to foster children in MDHS custody. As indicated throughout the report, the casework practice and services documented in the children’s case files were measured against minimum acceptable professional standards, including federal and Mississippi state law and policies, and published and recognized national practice standards.

Sample Selection Process

The sample of children whose case files were reviewed was selected from a computer-generated (MACWIS)\(^1\) list provided by MDHS of the 3,183 foster children who were in the Agency’s custody as of June 10, 2005. The initial sampling process was based upon the need to balance several requirements, including MDHS’s refusal to make case files available for review anywhere but in the 84 county offices across the state where the children’s files are maintained. The overall strategy involved a two-stage cluster sampling design in which a sample of counties was first selected, and then individual cases were randomly

\(^{1}\) Mississippi Automated Child Welfare Information System
selected from within those counties. This clustering strategy was required in order to meet the available time and resource constraints.

The first stage of sampling was a purposive selection of counties stratified by region. One county was selected from each of the nine MDHS regions (see Table 1 below) to provide geographic representation. Using definitions from the urban-rural continuum guidelines developed by the Economic Research Service (2005), each Mississippi county was classified with a code that represented county population size, ranging from 1 (counties in metro areas of 1 million population or more) to 9 (completely rural or less than 2,500 urban population, not adjacent to a metro area). Applying the following criteria, one county was tentatively selected from each region: the county in each region with the largest population of children in MDHS custody, and at least one rural and one urban county from each of the state’s three adoption regions. Counties that had been tentatively selected were adjusted to assure a sufficient number of rural counties, each with a sufficient number of children for review and easily accessible to at least one other selected county. The target number for the sample was 10% of the total population of children in MDHS custody.

Table 1. Selected Sample Counties

<table>
<thead>
<tr>
<th>County Type²</th>
<th>Region</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban-1</td>
<td>1W</td>
<td>Desoto</td>
</tr>
<tr>
<td>Urban-2</td>
<td>7</td>
<td>Hinds</td>
</tr>
<tr>
<td>Urban-3</td>
<td>6N</td>
<td>Forrest</td>
</tr>
<tr>
<td>Urban-3</td>
<td>6S</td>
<td>Harrison</td>
</tr>
<tr>
<td>Rural-6</td>
<td>3</td>
<td>Yazoo</td>
</tr>
<tr>
<td>Rural-7</td>
<td>1E</td>
<td>Pontotoc</td>
</tr>
<tr>
<td>Rural-7</td>
<td>2</td>
<td>Humphreys</td>
</tr>
<tr>
<td>Rural-7</td>
<td>5</td>
<td>Jefferson</td>
</tr>
<tr>
<td>Rural-9</td>
<td>4</td>
<td>Clarke</td>
</tr>
</tbody>
</table>

Within each of the selected counties, all cases with less than 60 days in custody as of June 1, 2005, were removed from the sample frame so that at least 60 days of MDHS services could be reviewed for all selected cases. The remaining cases were then stratified by time in custody and sampled systematically so that the final sample of cases best replicated the distribution of the entire sample frame as to the length of time in care.

² “Type” is the rural-urban county continuum code for Metro and Nonmetro counties as presented in ERS/UDSDA Briefing Room – Measuring Rurality: Rural-Urban Continuum Codes (2005), p. 2. Codes range from 1 to 9.
The selection of individual cases involved a disproportionate sampling strategy. In the five rural counties the number of eligible cases was relatively small, and a sampling strategy was considered inappropriate both from the perspective of sampling efficiency and sampling error. Given the fixed costs of moving a coding team to each county, the optimal solution in each rural county was to collect data from all eligible cases (thereby assigning each case a probability of selection of 1.0).

In the four urban counties it was not possible to collect data from all cases because of the large number of cases in these counties. The sampling strategy employed involved systematic random sampling with a sampling ratio of approximately twenty percent from a sample frame of 766 eligible cases.

Because the overall sampling strategy was disproportionate (urban cases were under-represented in the final sample compared to rural cases) each urban case was weighted for purposes of data analysis. Weighting involves each case in the sample being weighted by the inverse of its probability of selection. Cases in the five rural counties have a weight of 1 (148/148). Cases in the four urban counties have a weight of 5.55 (766/138).

Accordingly, the analysis reports weighted results that combine the actual 148 cases from rural counties with a weighted 766 cases from urban counties (138 actual urban cases x 5.55 individual case weight) for a total of 914 cases. The use of weighted results is especially important to analyses that combine all counties or subsets of urban/rural data. Failure to use weighted results in such situations would produce a disproportionately lower impact of urban county data on all complete sample results since rural cases are represented at a level that is approximately five times higher than that of their urban counterparts.

The census of eligible cases from the five rural counties yields population parameters with no associated sample error as all eligible cases were reviewed in those counties. In the four urban counties the maximum sample error is +/- 7.4%. For the total combined samples the maximum sample error is therefore +/- 4.9%.

A total of nine selected children’s case files had to be replaced. Eight children selected for the sample upon review were determined not to have been in custody as of June 1, 2005, as represented in the computer-generated list provided by defendants, and one child was one of the named plaintiff children. In instances where case data proved to be ineligible a replacement case was selected randomly from the same time-in-custody stratum. Two replacement cases were not reviewed

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3 This figure represents the nine county total of 914 minus the 148 rural cases.
due to delays in their production and the events of Hurricane Katrina at the end of the study period.

The overall sampling approach maximizes sampling efficiency given the constraints of county-based data availability and the realities of moving teams of coders around the state. The 286 cases surveyed comprise a probability-based sample of the nine-county total of 914 eligible cases. The counties themselves were selected to represent each of the nine geographic regions as well as multiple levels of the urban-rural continuum. Given that the 914 cases represented by the sample comprise almost one third\(^4\) of all eligible cases in the state it is reasonable to conclude that the survey results are highly generalizable to the entire state.

**Design of the Protocol**

A protocol was used to collect data and information from the selected case files. Questions in the protocol involved the following areas: demographic information; case planning; visits; services; judicial reviews; and foster placement services. All information needed to answer questions in the protocol is required to be maintained in the public agency case record, including both the paper and MACWIS case file records. A copy of the protocol is attached as Appendix C to this report.

Guidelines for the Case Reading Protocol were developed, including references to documents likely to include information needed to answer protocol questions. A copy of the Protocol Guidelines is attached as Appendix D to this report.

**Training and Supervision of Case Readers**

Prior to initiating the case record review, Dr. Hess conducted five days of training for the case readers. On the first day, Dr. Hess provided an overview of child welfare policies and practices. On the second day she reviewed each section of the protocol in detail, clarifying how each category of information related to child welfare policy and practice, and all questions were answered. On the afternoon of the second day, each reader was provided a copy of an actual case record and asked to individually complete the Protocol in sections, interspersed with question and answer periods with Dr. Hess. On the third day, readers continued to individually complete the protocol, with periods in which readers compared and discussed their responses on the Protocol with the entire group.

\(^4\) Of the 1,021 cases in the nine counties 107 (10.5%) were ineligible because the child spent less than 60 days in custody as of June 1, 2005. Applying the same estimate of ineligibility to the state total of 3,183 cases yields an eligible population of 2,849. The nine county total of 914 thus represents 32.1% of the state population in care at least 60 days as of June 1, 2005.
During the fourth and fifth days, this process of protocol completion, comparison, and clarification was also completed with a second actual case.

Throughout the case reading, Dr. Hess was available on site to supervise the case readers. She also regularly reviewed completed protocols, comparing the readers’ responses with documents copied from the case record, and reviewed numerous case records, both paper files and MACWIS information. She met regularly with the case readers individually and as a group and with the supervisor, who, in addition to reading case records, handled administrative details and assisted in reviewing completed protocols. During the limited time when Dr. Hess was not on-site, she was available to the supervisor and case readers by telephone and email.

**Pilot Testing of the Protocols**

Prior to the training period, the protocol was pilot tested with two actual case record files by Dr. Hess and another experienced case reviewer. In addition, during the training period, the ten case readers and supervisor piloted the protocol with the same two case files. All necessary clarifications identified through pilot testing were addressed through revision of the protocol prior to the beginning of the case record review.

**Reliability Testing**

During data collection approximately ten percent of the coded cases were randomly selected for replication coding by a second coder. Both the original and the replicate cases were entered into a separate database and subjected to an itemized comparison. Results from the comparison of each paired case were sent to Dr. Hess for review and continued training of coders. In every instance where the two coded forms (original and replicate) differed, Dr. Hess provided a final confirmatory protocol that represented the final version of the case data to be entered into the database.

Discrepancies between the original and the replicate coded protocol were of two main types. The first represented actual coding error – where two different responses were provided to the same question. The second represented only differences in the ordering of responses – where multiple response sections allowed raters to code protocols in such a way that the ordering of the results differed even though the content remained the same (e.g. in section IV the listing of mental illnesses in Grid 4A).

If one combines all sources of discrepancy the average rate was below 4%. If one counts only actual coding errors then the rate is less than 2%, with many of
those being relatively minor differences in dates. Overall, these reliability statistics are exceptionally high and reflect a very rigorous data collection process incorporating a highly structured protocol, selective hiring of coders, good quality training, and development of a reliability monitoring system with direct feedback to coders and supervisors for in-service development.

Data Entry and Analysis

A database was created using Statistical Package for Social Sciences (SPSS) software. The database contained a total of 1,149 originally coded variables. Data entry was conducted by two experienced coders (both previously employed by Dr. Jones on large scale social survey research projects). The accuracy of data entry was continuously reviewed through frequency counts, cross-tabulations, and logical variable associations (such as the chronology of dates) designed to identify possible coding or data entry errors.

Dr. Jones performed all data analyses. The initial production of basic frequency counts and crosstabulations was followed by a series of specific analytic requests generated by Dr. Hess. All requests were translated into SPSS syntax programs that were written and applied by Dr. Jones. The results were reviewed by Dr. Jones before being sent to Dr. Hess.

Organization of this Report

The remainder of this report is divided into nine sections. All of the findings presented are taken or derived from the information in the reviewed files of foster children in the custody of Mississippi Department of Human Services. Section II provides a general overview of child welfare practice as it concerns foster children in government custody. Section III addresses demographic and other basic information concerning foster children in the study. Section IV addresses placement practices harmful to children in the custody of the Mississippi Department of Human Services, including a range of health and safety incidents. Section V addresses the physical and mental health needs of foster children in MDHS custody and the failure of the agency to address those needs. Section VI addresses the agency’s failure to meet the basic educational needs of foster children in its custody. Section VII addresses the lack of services provided by MDHS to support the reunification of foster children with their biological families or other legal caregivers, as well as the agency’s failure to allow foster children to maintain relationships with and contact with their parents and siblings while in foster care. Section VIII addresses the agency’s lack of efforts toward permanency planning for MDHS foster children and failure to deliver services to achieve children’s goals for permanency. Section IX addresses the agency’s failure to achieve the goal of adoption for foster children who should be adopted.
Throughout the report, examples drawn from the children’s case records are used to illustrate the study findings. Case examples have been drawn from the nine counties selected for the study; however, the examples frequently describe practice by additional counties involved in the children’s placement services. The names of foster children, those serving them, and community agencies have been changed or omitted to provide anonymity.
II. Child Welfare: Goals and Processes

In this section, the goals and processes of the child welfare system are described.\textsuperscript{5} This description provides the context within which the findings of the review of the case records of children in the custody of the Mississippi Department of Human Services must be placed.

All children need a stable, nurturing, enduring relationship with at least one adult who assures that their physical, emotional, educational, and social needs are met and protects them from harm. Unfortunately, each day the public child welfare system receives many reports about children who allegedly are not receiving adequate care and protection from their parents or other permanent caregivers. The service system’s legally mandated first response is to immediately and thoroughly investigate the nature and degree of harm experienced by the child. This first response is crucial. In addition, agency staff must determine whether the child can safely remain at home if supportive services are provided to improve the parents’ level of care. If so, child welfare agency staff must develop an appropriate service plan with the goal of preventing out-of-home placement and monitor both its implementation and the child’s continuing safety in the home. This entire process must be focused upon the safety and the well-being of the child.

When agency staff determines that the child cannot safely remain in his or her own home, the child welfare agency is required to provide for the child’s welfare and protection by taking legal and physical custody of the child. In doing so, the public child welfare agency accepts the critical responsibility of functioning as the child’s parent or caregiver and consequently is expected to provide care and protection at a level fully adequate to meet each child’s basic and individualized special needs.

Federal laws specifically mandate that states and local child welfare agencies take full responsibility for the children in their custody. Such responsibility includes assuring that 1) the child is safe and protected from further harm; 2) the child’s physical, emotional, educational, social and special needs are met; and 3) a plan is developed and implemented to provide a safe, nurturing, and permanent home for the child in a timely manner.

Placement of a child in foster care is intended to be a temporary measure. Children should be placed in out-of-home care only when a careful assessment determines that the child’s safety and well-being cannot be ensured even with the provision of intensive services to the family. In those instances, out-of-home family placement with relatives or others or in a group care setting,

\textsuperscript{5} To improve readability, references are not cited in this section. The ideas contained in this section are cited extensively throughout this report.
depending upon the child’s special needs, is a time-limited measure, taken to protect the child until the child can be safely returned to his or her home. When the preferred placement outcome of family reunification cannot be achieved, placement then is necessarily extended. But placement remains a temporary measure, taken until the child can be permanently and legally placed with another family, either relatives or an adoptive family. In only a few instances should children be required to stay for longer periods in custody, including those in which the child’s special needs require treatment that cannot be provided in a family setting. The child welfare system is not intended to serve as a replacement for the families that children need and deserve. However, when the child welfare system fails to follow the legally mandated processes outlined above, it will inevitably fail to achieve the goals for permanency it is mandated to accomplish. As a consequence, children will predictably spend longer periods in custody than is necessary or acceptable.

For more than forty years, research has consistently found that the longer children are permitted to remain in care, the greater the likelihood that they will never return to their own families or move into another stable permanent home. And during lengthy stays in custody, if they are exposed to multiple placement changes and/or to other harms in care, including caregiver neglect and abuse, their emotional, physical, social, and educational status will deteriorate, often markedly. Young children, particularly, who rely on a stable, continuous nurturing adult relationship to develop the capacity for healthy human attachments, are often irreparably harmed by multiple placement changes and neglect and abuse in care. Practice standards and federal and state legislation have been devised to prevent such harms to already vulnerable children.

Providing a safe and nurturing placement. A child’s family is at the center of his or her world. Therefore, for almost all children, the experience of being removed from their family is extremely traumatic. No matter what harms children have experienced, they are attached to their parents/caregivers and thus experience profound loss and fear at being taken to live with strangers. Therefore, the public agency must be prepared to immediately provide the child a safe, nurturing placement and assure that in every way possible, the child is afforded support and stability. For example, every effort must be made to place children with caring relatives and with all siblings also in custody, which provides reassurance and comfort to them, and to place school-aged children near their own school, thus preventing the loss of familiar teachers and friends. These important efforts reduce the negative impact of removal upon the child.

Further, within days of placement, the public agency must provide children contact with their parents/caregivers, preferably in-person. This contact reassures children that they have not been abandoned and that the adults responsible for
their care understand their deep need to maintain a relationship with their parents and other family members.

If it is determined that children cannot safely be placed with a relative or other familiar person, the public agency is responsible for identifying a placement with caregivers that are fully prepared to meet not only the child’s basic needs but also his or her special needs. For example, a child who has been chronically neglected may have severe developmental delays or medical needs; a child who has been repeatedly abused and lived in a violent household may be withdrawn and uncommunicative or aggressive and unresponsive to typical household rules. A child who has been sexually abused may relate to adults and other children in ways that place him or her at further risk for exploitation. Depending on the nature and extent of children’s special needs, their needs may be met through placement in a relative or non-relative foster family home or may require more specialized services, such as a therapeutic foster home or medical foster home. Some children’s special needs, including diagnosed mental illness, require the intensive services and structure provided in a group or residential treatment setting.

Therefore, at the time of placement, an accurate and full assessment must be made regarding the level of caregiver training and competence, placement structure, and medical, mental health, and educational services that are required to assure that the child’s special needs are met while in custody. Otherwise, children continue to be subjected to repeated traumatic events at a time of already heightened vulnerability.

When public agencies fail to make an immediate, accurate determination of the level of care and services that are required to meet the needs of children for whom they have accepted legal responsibility, vulnerable children are inevitably further harmed. For example, when a child is placed in a setting that cannot meet his or her particular needs, the child’s troublesome behaviors typically either begin or escalate, anxiety increases, and educational performance deteriorates. Sometimes inadequately trained or frustrated caregivers resort to destructive interactions with the child, including abusive and neglectful behaviors. Very often the placement disrupts, and the child experiences one or more placement moves and additional separations. As a consequence, the child’s already damaged trust in adults to provide care and protection is further betrayed and the child’s fragile ability to form attachments and relationships further deteriorates. A downward spiral often sets in.

In order to address all these issues, the child’s public agency social worker is charged with coordinating an assessment and service planning process. Through this process, the child’s service and placement needs are determined, an appropriate placement setting is selected, and a plan for delivery of needed service
is developed. The child’s plan for services (the case plan or Individualized Service Plan) is developed in partnership with the child’s family, monitored through court and other reviews every six months at a minimum, and revised as indicated by the parent’s use of services and the child’s needs. In addition, throughout the child’s placement the public agency social worker is responsible for maintaining regular contact with the child, the child’s parents, and the child’s caregiver to assure that the child is safe, that caregivers have the information and support necessary to provide for the child’s care, that the continuity of family relationships and connections is preserved for children, and that progress toward the permanent plan is occurring.

**Family reunification as a permanency goal.** Because children want to live with their families and because, both legally and morally, parents and other legal permanent caregivers have a right to raise their children when they can do so safely, the public agency is required to make reasonable efforts to provide services that enhance the family’s capacities and facilitate the child’s safe return home. This placement outcome is called family reunification; the goal is to achieve this outcome within 12-15 months of the child’s entry into custody.

To achieve reunification, services must be individualized to address a family’s particular needs, be accessible, and be provided in a timely manner by competent professionals. Thus, it is the public agency’s responsibility to assure, that at or immediately following the child’s placement, the family’s service needs are identified, appropriate services are offered, and obstacles to service provision are addressed. Such services necessarily include frequent, regular parent-child (and when, placed separately, sibling-sibling) visits and other contacts. Without frequent contact, already fragile family relationships cannot be maintained and children inevitably experience abandonment and deep loss. Without frequent contact, family reunification is much less likely to occur and to occur successfully. Again, the child’s well-being and safety are at stake.

When it has been determined that a child may safely be returned to his or her home, an assessment must be made of the follow-up services required to support the family in this often difficult transition. Simply returning a child who has lived out of the home back into the family unit without services to support changes in the parents’ behaviors predictably can result in further harm to the child due to neglect and abuse.

**Adoption and other permanency goals.** In some instances, due to the severity of the neglect and/or abuse, a parent’s diagnosed condition, or a family’s history, it can be determined at the time of placement that family reunification cannot safely be achieved. In other instances, such a determination is made after reunification services have been provided and it becomes clear, based on the
parent’s inability or unwillingness to make the changes required for the child’s safe return to his or her care, that reunification will not be achieved.

In either case, under timetables mandated by federal law, the public agency is responsible for identifying another viable plan for the child’s future that provides the child stability and a sense of permanence. The agency must determine what plan is appropriate for the child, i.e., permanent placement with relatives, adoption, or, for older children, preparation for independent living. Steps to achieve this permanent plan must be identified, taken in a timely manner, and documented fully in the case record. For example, achieving the goal of adoption typically requires the legal termination of the parent’s rights, recruitment of an appropriate adoptive family, and preparation of the adoptive family and the child for adoption.

In all instances, achieving permanency for the child through means other than family reunification will require services that support the child in working through the realization that he will not be returning to his parent’s care. In all instances, achieving permanency for the child requires that the potential permanent caregiver is fully informed of the child’s basic and special needs and is willing and able to meet those needs. And once the child is placed with the potential permanent caregiver, services that support the child’s integration into the caregiver’s family are essential.

Children in custody necessarily rely on others to document their needs and experiences. In order to provide for children’s care and development, parents rely on their records and their memories to inform others of their children’s needs. If a child is allergic to penicillin, a good parent makes sure that those to whom the child is entrusted, such as the child’s health care providers, have this information to prevent the child from being injected with penicillin. If the child has special education needs, the parent makes sure that the child’s school is informed. When an agency assumes the custody of a child, it also assumes the full responsibility to maintain an accurate and complete record of the child’s needs and experiences – to maintain the child’s health, educational, and psychological records and to assure that these are immediately available to caregivers and others responsible for the child’s care and services; to maintain an accurate record of the child’s whereabouts and changes in the child’s whereabouts; and to maintain an accurate record of the child’s experiences, both positive and negative, while the child is in the agency’s custody.

The child’s public agency case record is the repository of all observations, decisions, and actions taken on the child’s and family’s behalf by the public agency and all others to whom some aspect of care and services has been referred or delegated. Social workers, supervisors, and others who are responsible for many
different children and families cannot trust that they will be able to later recall even one day’s multiple observations and decisions. Therefore, all case information must be documented both quickly and thoroughly to avoid the errors and gaps in information that inevitably result from delays in recording. If observations, decisions, agreements, and actions are not documented immediately, subsequent decisions that rely on information in the record may be in grave error. Professionals in the child welfare system understand that if it is not written down, it is as if it never happened. Without a full and accurate record of the child’s needs and experiences, the child’s well-being and safety are in constant jeopardy. Given the life-altering nature of the decisions made within the child protection and permanency planning process, decisions based upon incomplete or inaccurate documentation not only are likely to be unwise, but also seriously harmful and even life-threatening to a child.

In addition, without timely, accurate, and thorough documentation of the child’s experiences while in care, critical aspects of the child’s history will be lost. The agency will then be unable to fully and accurately inform others, such as placement caregivers or service providers, about children’s needs while in care or to inform children’s birth or adoptive families about their needs upon discharge from custody. Judicial decision makers will also be deprived of critical information affecting the custodial status and best interests of the child.

Finally, when an agency assumes custody of a child, it also assumes full responsibility to provide services to the child and the child’s family as described above. Accurate and complete documentation assures that the decisions made about the child and the child’s future are fully informed and based upon the best possible information. Decisions made without documented information regarding the needs, efforts, and experiences of children and their families are inevitably influenced by the decision-makers’ own assumptions and biases. As indicated above, such decisions also may be dangerous or destructive to the child and to others.

At every stage and for every child and family, the cornerstone of effective child welfare is formed by comprehensive and ongoing assessment, the competent and timely provision of appropriate services, and the complete and accurate documentation of service provision and outcomes.
III. Demographic Composition of Sample

This section presents basic data concerning the 286 children whose case files were reviewed in this study. All children included in the study were in the custody of the Mississippi Department of Human Services on June 1, 2005 and had also been in foster care for at least the preceding 60 days. As described in Section I, findings are presented in weighted percentages. All percents are calculated to a weighted base sample of 914 cases. This comprises 148 rural county cases (all with a probability of selection of 1.0) and the 138 urban county cases, each weighted as the inverse of their probability of selection (5.55 or 766/138). Use of the weighted data in the analyses adjusts for the disproportionate sampling and differential probability of selection in rural and urban counties. Identified differences between urban and rural cases found through data analysis are therefore not artifacts of a disproportionate sampling rate. Basic statistical information is presented in this section; more detailed breakdowns of data are presented throughout this report.

**Gender and race.** As presented in Figures 1 and 2, the majority of children were female and Black Non-Hispanic.

![Figure 1. Gender](image)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>56.0%</td>
</tr>
<tr>
<td>Male</td>
<td>44.0%</td>
</tr>
</tbody>
</table>

![Figure 2. Race](image)

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>42.3%</td>
</tr>
<tr>
<td>Black Non-Hispanic</td>
<td>53.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.1%</td>
</tr>
<tr>
<td>Bi-racial</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

**Age of foster children.** As of June 1, 2005, the children’s mean age was 9.8, ranging from 0 to 19. Figure 3 presents the children’s ages as of June 1, 2005, broken down from 0-5 years, 6-12 years, and 13+ years. The pre-school (0-5), school-aged (6-12), and teen-aged (13+) groupings were selected for analysis because of the shared developmental issues and experiences within each of these age groups; these groupings are used throughout the report.
Reasons for most recent entry into MDHS custody. Information was collected to determine the reason for the child’s most recent entry into MDHS custody as indicated by the original court order as well as other documents in children’s case files. The original court order was missing from 7.2% of the case files; 2.7% had an order, but no reason for entry was cited. Therefore, information regarding reasons for most recent entry was collected for the children for whom documents were available and a reason given. In the majority of orders, the language identifying the reason for placement was general, i.e. neglect (not specified), or abuse/neglect (not specified). Table 1 depicts this information.

Table 2. Reasons for Children’s Most Recent Entry into Custody As Stated in Original Court Order

<table>
<thead>
<tr>
<th>Reason for Most Recent Entry into Custody</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>51.0</td>
</tr>
<tr>
<td>Abuse/neglect</td>
<td>13.0</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>10.3</td>
</tr>
<tr>
<td>Parental substance abuse or misuse</td>
<td>6.9</td>
</tr>
<tr>
<td>Inadequate supervision/failure to supervise</td>
<td>5.7</td>
</tr>
<tr>
<td>Abandonment</td>
<td>4.6</td>
</tr>
<tr>
<td>Sexual abuse or exploitation</td>
<td>4.5</td>
</tr>
<tr>
<td>Environmental neglect</td>
<td>3.8</td>
</tr>
<tr>
<td>Substance exposed infant or child</td>
<td>2.1</td>
</tr>
<tr>
<td>Delinquent child</td>
<td>1.3</td>
</tr>
<tr>
<td>Medical neglect</td>
<td>1.0</td>
</tr>
<tr>
<td>Educational neglect</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td>4.1</td>
</tr>
</tbody>
</table>

*More than one reason was identified for entry into custody for some children. Percentages are weighted.

Information was also collected concerning the reason for entry from any document dated within 90 days of the child’s most recent entry into custody that
specifically identified the reason(s) for placement. Additional reasons for the child’s placement included domestic violence, inadequate housing, lack of childcare, children’s disabilities, children’s behavior problems, children’s drug/alcohol use, and unaccompanied minor refugee status.

Reports of maltreatment prior to most recent entry into custody. Information was collected to determine the number of reports of child maltreatment that were documented in the child’s case file prior to the report that resulted in the child’s most recent entry into custody. For 38.8% of the children, the CPS report/investigation that resulted in the child’s most recent entry was the only one documented in the child’s case record. The other 61.2% of the children had a mean of 3.2 reports prior to the report that resulted in the child’s placement. The number of prior reports ranged from 1 (34.4% of those with reports) to 8 prior reports (8.4% of those with reports).

Of the children with reports documented in the child’s file prior to the most recent entry, 54.2% had a mean number of 1.7 prior reports that were evidenced, ranging from 1 (58.1% of those with reports) to 5 (4.0%).

Re-entries into care. Information was collected regarding the percentage of children in the study sample that had experienced at least one discharge and re-entry into MDHS custody since the child’s first entry into care. As depicted in Figure 4 below, almost one-quarter (24.3%) of the children had experienced at least one such re-entry.

Figure 4. Re-entries into MDHS Custody

Placements. Information was collected on the type of foster care placement for children in the study. Placement information as of June 1, 2005, indicated that each of the children in the sample lived in one of twelve types of placements. These included: (1) foster family home with relative, (2) foster family home with non-relative, (3) adoptive home before finalization, (4) residential treatment center, (5) group home, (6) home of parents, on trial reunification visit, (7) therapeutic (family based treatment home), (8) emergency shelter facility, (9) runaway, (10) out-of-state foster care home, (11) independent living program, and
(12) other. Table 3 presents the complete breakdown of the placement setting for children in the study.

**Table 3. Children’s Placement Settings as of June 1, 2005**

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster family home with relative</td>
<td>27.8</td>
</tr>
<tr>
<td>Foster family home with non-relative</td>
<td>20.5</td>
</tr>
<tr>
<td>Adoptive home before finalization</td>
<td>11.5</td>
</tr>
<tr>
<td>Residential treatment center</td>
<td>8.3</td>
</tr>
<tr>
<td>Group home</td>
<td>7.0</td>
</tr>
<tr>
<td>Home of parents, on trial reunification visit</td>
<td>7.0</td>
</tr>
<tr>
<td>Therapeutic (family based treatment home)</td>
<td>5.0</td>
</tr>
<tr>
<td>Emergency shelter facility</td>
<td>3.5</td>
</tr>
<tr>
<td>Runaway</td>
<td>2.5</td>
</tr>
<tr>
<td>Out-of-state foster care home</td>
<td>1.9</td>
</tr>
<tr>
<td>Independent living program</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>3.8</td>
</tr>
</tbody>
</table>

*Percentages are weighted.

Figure 5 presents placement types in terms of family-based foster homes vs. congregate or group care facilities.6

**Figure 5. Foster Care Placements for Children as of June 1, 2005**

- **Types of family-based foster homes.** The family foster home category, which encompasses 73.6% of the total sample placements as indicated above, can be broken down further to specify treatment level of foster home placements.

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6 Children whose placement settings were either Runaway or Home of parents were excluded from this analysis. Children whose placement setting was Independent Living program were included with Other.
Figure 6. Types of Family Foster Home Placements

![Pie chart showing types of family foster home placements]

- Regular Non-Relative: 30.7%
- Regular Relative: 41.7%
- Adoptive Pre-Finalization: 17.2%
- Therapeutic: 7.6%
- Out of State: 2.8%
- Regular Non-Relative: 30.7%

Permanency goals. Data were collected regarding the children’s primary and concurrent permanency goals as of June 1, 2005, as indicated in the most recent Individualized Service Plan (ISP) completed within the 24 months prior to June 1, 2005. Ten percent (9.6%) of the children had no ISP in the case record during this two-year period; 4.4% had an ISP, but no primary permanency goal was identified in the ISP. The most frequent plan (29.0%) was adoption, followed by reunification (26.9%). The children’s primary permanency goals are presented in Figure 7.

Figure 7. Primary Permanency Goals of Children in MDHS Custody

![Pie chart showing primary permanency goals]

- Adoption: 29.0%
- Reunification: 26.9%
- Relative Placement/Adoption: 5.3%
- Long-Term Foster Care: 1.4%
- Relative Placement/Durable Legal Custody: 7.1%
- Emancipation: 13.7%
- No plan identified: 4.4%
- Other: 2.6%
- No ISP in Record: 9.6%

In addition, 53.7% of the children had a concurrent permanency goal on the most recent ISP in their case record. Of those with a concurrent permanency goal,
the most frequently identified was relative placement (44.8%). The children’s concurrent permanency goals are presented in Figure 8.

Figure 8. Concurrent Permanency Goals as Identified in Children’s Most Recent ISP Prior to June 1, 2005

![Chart showing concurrent permanency goals]

**Length of time in care.** The total length of time the children had been in MDHS custody as of June 1, 2005, ranged from less than 1 year to 17.9 years. Thirty percent (29.8%) had been in custody 3 or more years; 8.8% had been in custody for more than 5 years. The breakdown is presented in Figure 9.

Figure 9. Length of Time in Care as of June 1, 2005

![Chart showing length of time in care]

**Number of moves while in care.** Information was also collected concerning the number of times a child was moved from one foster home or facility to another during his or her most recent stay in custody. The vast

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7Temporary changes with a planned return to a specific placement, such as respite care or hospitalization, are not included as “moves” in this study; neither are periods during which the child had run away.
majority of the children (82.7%) experienced at least one move from their original placement during their most recent stay in custody, ranging from 1 to 57 moves. Notably, almost two-thirds (62.9%) of the entire sample of children in the study were moved two or more times; one-half (49.7%) were moved 3 or more times; and 39.9% were moved 4 or more times. Children who were moved at least once were moved a mean of 5.8 times.

Figure 10 presents the number of moves children experienced.

Figure 10. Number of Placement Moves

As depicted, almost one-third of the children (31.0%) were moved 5 or more times, and more than one in ten (11.3%) were moved 10 or more times. Four percent (3.8%) of the children were moved 16-25 times, and 3.0% were moved more than 25 times.

As depicted in Figure 11, during their most recent stay in MDHS custody at least one-third of the children in each age group were moved the equivalent of every 4 months, i.e., an average of 3 or more times per year.

Figure 11. % of Children by Age Group Who Were Moved an Average of 3 or More Times Per Year (on Average at Least Every 4 Months) During Most Recent Stay in Custody

Examination of children within each age group reveals that infants less than 1 year of age (mean average moves 4.1 per year) and children age 3 (mean average 4.3 moves per year) were moved on average more frequently than children of
every other age; the closest mean number of moves per year was 3.9 for 16 year olds.

Children with serious behavioral problems and/or a diagnosis of mental illness/developmental disorder. The majority of children had serious emotional and behavioral problems. Information in children’s case files was collected to determine the presence of “serious behavioral problems” (e.g., child hurts other children), whether or not coupled with a diagnosis of a mental illness or developmental disorder (e.g., anxiety disorder or depression). Figure 12 presents children in the study with no such issues indicated in their case files, and those with serious behavioral problems and/or a diagnosis of a mental illness/developmental disorder.

Figure 12. Children with Either a Serious Behavioral Problem and/or a Diagnosed Mental Illness/Developmental Disorder
IV. Harmful Placement Practices

Key findings:

- MDHS fails to provide stability to children in custody, subjecting them to an unreasonably high number of moves from one foster home or facility to another.

- MDHS subjects children to multiple and very lengthy stays in emergency placements.

- MDHS fails to assure that the child’s assigned social worker maintains required minimum face-to-face contacts.

- MDHS fails to maintain continuity of social workers and social work services for foster children.

- MDHS fails to prevent frequent and extensive gaps in case records reflecting periods of no social work or case management services or monitoring of foster children.

- MDHS fails to protect children from further abuse or neglect while in custody.

- MDHS fails to protect foster children from corporal punishment.

- MDHS often fails to follow up on reports or other indications of maltreatment of children in MDHS custody.

- MDHS fails to protect children from further abuse or neglect while on trial reunification visits while still in custody and from re-entry into custody due to further abuse or neglect after being discharged from custody.

Federal mandates, MDHS policy, and national practice standards prohibit subjecting children in legal custody to harm. Therefore, agency social workers are responsible to provide services that afford foster children appropriate placements, stability of care, and continuity of services, and to monitor children’s safety and well-being while in custody.
A. MDHS Fails to Provide Stability to Children in Custody, Subjecting Them to an Unreasonably High Number of Moves from One Foster Home or Facility to Another

Changes in placement may create severe disruption in children’s lives. The traumatic after-effects of the initial entry into placement and of subsequent moves led Littner (1975) to assert that “An important rule of placement is that the first placement should also be the last one – unless it is otherwise deliberately planned” (p. 24). He outlined numerous consequences for children of separation experiences, including increased sensitivity to later separation experiences and fear of emotional closeness. Similarly, Bowlby (1969) and Goldstein, Freud, and Solnit (1973) warn about the negative and often long-lasting consequences of separating children from their caregivers. Particularly for young children, the loss of yet another caregiver caused by each placement change creates feelings of rejection, grief, and confusion, and may complicate their capacity to form future attachments. In addition to the change in foster family constellation and routines, most moves for school-aged children also involve a school change (see Section VI). Because of the negative impact on children of multiple moves from one foster home or facility to another, the agency must assure that the decisions made regarding children’s placement and services do not create further instability in their lives.

Agency policy8 (3262) stresses that “since a child’s ability to bond and trust is damaged by each placement change, any break in continuity and stability should be avoided as much as possible. The more children experience a change in placement, the more that damage is inflicted deepens [sic]. A foster child who moves many times, or who constantly fears that he/she may have to move, can suffer devastating effects on his/her emotional health.” Reflecting the harm to children that placement changes cause, MDHS policy (p. 3243) further states that “once a child is placed in a foster home, or group home the child cannot be moved unless the division of Family and Children Services specifically documented to the court that the current placement is unsafe or unsuitable or that another placement is in the child’s best interest or unless the new placement is in an adoptive home or other permanent placement.”

In addition, policy (3210) specifically states “MDHS policy requires approval by the Area Social Work Supervisor for placement, replacement and removal of a child in foster care. A Youth Court Judge must authorize all

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8 References to “agency policy” in this report refer to the MDHS Policy Manual unless otherwise specified.
placements, replacements, moves, and removals of a child in foster care” (emphasis in original).

Although agency policy provides direction for choosing the most suitable placement at the time of the child’s entry (3231), preparing the child and the placement setting for a child’s initial placement (3231-3238), and limiting the use of emergency placements (3216-3217, 6133), no specific directives are provided regarding the specific efforts that should be made by social workers and other staff to prevent abrupt or unnecessary moves of a child while in custody or to mitigate the potential harmful effects of placement changes. This omission in MDHS policy occurs despite the explicit recognition by the agency cited above (3262) of the serious harms to children associated with multiple moves.

Consistent with the recognized harms associated with frequent and unnecessary placement changes, national practice standards9 (Child Welfare League of America (CWLA) FC 2.46 and Council on Accreditation (COA) 21.3.06) emphasize that all involved in serving the child in placement should work actively to achieve stability of care with the foster family. COA standards specifically direct that an assessment and justification that each placement change is made in the child’s best interest be included in the child’s record and that each party (agency staff and caregivers) provide at least 14 days’ formal notice when a change will occur to allow for a minimally disruptive transition whenever possible.

Information was collected concerning the number of times a child was moved from one foster home or facility to another10 during his or her most recent stay in custody.

- The vast majority (82.7%) of the children experienced at least one move from their original placement during their most recent stay in custody, ranging from one to 57 moves. Thus,

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**Case Example #1**

Fourteen-year-old Mary spent her first five months in MDHS custody in a Salvation Army Shelter and spent a total of 350 days in emergency placements during her first 2.5 years in custody. There is no documentation of any MDHS efforts to determine the level of care that Mary needed. In January 2005, Mary’s MDHS social worker visited Mary in her 16th placement: “[Mary] was afraid worker was there to remove her. Worker stated that she was just there to check on her.” Mary was moved again in April 2005.

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9 All practice standards cited throughout the remainder of the report will be referred to either by the acronym “CWLA” followed by the acronym for the standard subject area, e.g. “KIN” referring to the practice standards for kinship care, or by the acronym “COA,” followed by either G7 (Standards for Training and Supervision), S5 (Case Management Services), S14 (Adoption Services), or S21 (Foster and Kinship Care Services) and the specific cite.

10 Temporary changes with a planned return to a specific placement, such as respite care or a medical hospitalization, are not included as “moves” in this study; neither are periods during which the child had run away.
82.7% of the children were placed by MDHS in at least two placement settings.

- Children who were moved at least once were moved a mean of 5.8 times during their most recent stay in MDHS custody. As presented in Table 4 below, the mean number of moves for children ranged widely by county.

- By age group, the mean number of moves for children who were moved at least once during their most recent stay in custody was 2.7 for children ages 0-5; 4.1 for children 6-12; and 9.4 for adolescents.

- Almost two-thirds (62.9%) of the children were moved two or more times during their most recent stay in custody; one-half (49.7%) were moved 3 or more times; and 39.9% were moved 4 or more times.

- Almost one-third (31.0%) were moved 5 or more times, and more than one in ten (11.3%) were moved 10 or more times. Four percent (3.8%) were moved 16-25 times, and 3.0% were moved more than 25 times.

Table 4. By County, Minimum, Maximum, Mean Number of Moves, and Mean Number of Moves Per Year, for Children Moved at Least Once in Most Recent Stay in Custody

<table>
<thead>
<tr>
<th>County</th>
<th>Minimum Moves in Most Recent Stay</th>
<th>Maximum Moves in Most Recent Stay</th>
<th>Mean* Number of Moves in Most Recent Stay</th>
<th>Mean* Number of Moves Per Year in Most Recent Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeSoto</td>
<td>1</td>
<td>57</td>
<td>6.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Clarke</td>
<td>1</td>
<td>8</td>
<td>3.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Forrest</td>
<td>1</td>
<td>30</td>
<td>7.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Harrison</td>
<td>1</td>
<td>40</td>
<td>6.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Hinds</td>
<td>1</td>
<td>19</td>
<td>4.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Humphreys</td>
<td>1</td>
<td>23</td>
<td>10.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Jefferson</td>
<td>1</td>
<td>21</td>
<td>5.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Pontotoc</td>
<td>1</td>
<td>8</td>
<td>3.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Yazoo</td>
<td>1</td>
<td>23</td>
<td>5.7</td>
<td>2.3</td>
</tr>
</tbody>
</table>

*Means are weighted numbers.

**Frequency of moves per year.** By examining the number of moves for each child and the length of the child’s most recent stay in MDHS custody, the frequency of moves per year was calculated.
At least 33.0% of the children in each age group who were moved at least once during their most recent stay in MDHS custody were moved an average of 3 or more times per year – the equivalent of every 4 months or more: 34.9% of those ages 0-5 years; 35.1% of those 6-12; and 33.0% of those 13 and older.

The mean number of moves per year during their most recent stay in custody for children moved at least once ranged from 3.5 (Forrest, Jefferson) to 1.9 (Clarke).

Children ages 0-5 who were moved at least one time were moved an average of 2.8 times per year, ranging from a minimum of .3 to a maximum of 8.7 average moves per year. Children ages 6-12 were moved an average of 2.8 moves per year, ranging from a minimum of .08 to a maximum of 10.1 times per year. Adolescents (13+) were moved an average of 2.9 times per year, ranging from a minimum of .08 to a maximum of 11.8 times per year.

**Frequency of moves per year for the youngest children.** Even the youngest children (ages 0-5) in MDHS custody have been moved multiple times:

- Almost three-quarters (72.3%) of the children ages 0-5 had been moved from their original placement, ranging from 1 to 8 times.
- Two-thirds (66.5%) of the youngest children (ages 0-5) who had been moved had been moved two or more times.

The average moves per year for children who were moved at least once is as high for the youngest group of children (ages 0-5) as it is for children six and older. When examined by age within the youngest group,

- 71.0% of the infants less than 1 year of age who were moved at least once were moved an average of three times per year or more; 35.5% were moved an average 5 times per year or more, with a maximum of 7.2 average moves per year.
- Of those moved at least once, infants less than 1 year of age (mean average moves 4.1 per year) and children age 3 (4.3 moves per year) were moved on average more frequently than children of every other age; the next highest mean number of moves per year is 3.9 for 16 year olds.

**Lack of MDHS services to prevent unnecessary moves.** For each placement change, information was collected to determine whether the social worker offered or provided services to the caregiver and/or to the child to maintain
the placement. Placement changes for which efforts to prevent the placement change would not have been applicable, such as a move from an emergency shelter to a foster family home, were excluded from this analysis. In addition, information was collected to determine whether the child’s social worker obtained approval from the Area Social Work Supervisor and obtained authorization from the Youth Court for the placement change as required by agency policy (3210).

Despite the admonition in MDHS policy (3262) that a “foster child who moves many times, or who constantly fears that he/she may have to move, can suffer devastating effects on his/her emotional health,” in the overwhelming majority of children’s placement changes MDHS social workers failed to take actions to prevent the move and to secure approval for the move as required by national practice standards and by agency policy as presented in Table 5.

Table 5. % of Children’s Moves in which MDHS Failed to Make Efforts to Prevent Children’s Placement Changes and to Secure Required Approval for Children’s Placement Changes

<table>
<thead>
<tr>
<th>MDHS Failures to Make Efforts to Prevent Placement Changes and to Secure Approval for Placement Changes</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to offer/provide services to caregiver to maintain placement</td>
<td>91.6</td>
</tr>
<tr>
<td>Failed to offer/provide services to child to maintain placement</td>
<td>90.5</td>
</tr>
<tr>
<td>Failed to obtain Area Social Work Supervisor’s approval for move</td>
<td>92.0</td>
</tr>
<tr>
<td>Failed to obtain authorization of the Youth court for the move</td>
<td>88.4</td>
</tr>
</tbody>
</table>

*Percentages are weighted.

Information was also collected to determine the reason(s) for all placement moves for children during their most recent stay in MDHS custody. Case reviewers could record as many as two reasons found for the move in the child’s case record.

- For 23.5% of the children’s moves during their most recent stay in custody, no reason for the placement change could be located in the child’s case record.

Table 6 depicts the most common reasons identified.
Table 6. Most Common Reasons Identified for Children’s Placement Moves

<table>
<thead>
<tr>
<th>Reasons for Placement Moves</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reason for move found in child’s record</td>
<td>23.5</td>
</tr>
<tr>
<td>Non-emergency placement available</td>
<td>21.3</td>
</tr>
<tr>
<td>Medical/mental health provider recommended move or child needed diagnostic evaluation</td>
<td>13.0</td>
</tr>
<tr>
<td>Child needs different level of care</td>
<td>12.9</td>
</tr>
<tr>
<td>Caregiver requests move due to child’s behavior</td>
<td>12.6</td>
</tr>
<tr>
<td>Moved to relative placement/sibling reunification</td>
<td>9.7</td>
</tr>
<tr>
<td>Child’s behavior presents danger to self or others</td>
<td>7.2</td>
</tr>
<tr>
<td>Suspected abuse/neglect, home closed, home exceeded number of children for license</td>
<td>3.1</td>
</tr>
<tr>
<td>Moved to parents’ home for trial reunification</td>
<td>3.1</td>
</tr>
<tr>
<td>Other</td>
<td>13.5</td>
</tr>
</tbody>
</table>

*Percentages are weighted.

Notably, the most common reason (21.3%) identified for a child’s placement change was that a non-emergency placement was available. (The overuse of emergency placements is discussed below.) This reason was followed in frequency by three reasons related to children’s need for a different level of care. Reasons for placement changes related to children’s mental health and/or behavioral needs or difficulties, or children’s unmet need for a different level of care combine to total 45.7%.

In October 2001, 14-year-old Tom was placed in MDHS custody due to neglect. In 2003 and early 2004, Tom attended dialysis three times per week. In February 2004, Tom’s therapists reported that Tom “is getting sicker everyday.” April 2004 case notes document that Tom “is not receiving the best care” and that his placement in the Jarvis Home for Boys “is not suitable for his medical needs.” MDHS then failed to move Tom into a medical foster home for an additional fourteen days. A March 2005 supervisor’s review documented that medical, dental, and psychological status and care information were missing from this medically fragile child’s case record.

Case Example #2

B. MDHS Subjects Children to Multiple and Very Lengthy Stays in Emergency Placements

At the time of placement, an accurate and full assessment must be made regarding the level of caregiver training and competence, placement structure, and medical, mental health, and educational services that are required to assure that the
child’s needs are met while in custody. Both agency policy and national practice standards provide for the temporary placement of children entering custody in emergency placements while such an assessment is made or at a time of crisis, such as when a child’s placement disrupts.

By definition, placement of a child in an emergency shelter, whether an emergency facility or emergency foster home, is intended to be for a very brief period of time. MDHS policy (3216) states “Emergency Shelters for children are short term interim placement resources. The brief time in the shelter (45 [days] maximum) gives the Social Worker time to further evaluate the home situation and to work with the family and those designated as part of the family group for the immediate return of the child, to identify and evaluate relative resources, and gather information about the child to ensure a more appropriate foster care placement if this becomes necessary” (emphasis in original). State policy (3217, 6133) requires that the maximum stay in either an emergency shelter or an emergency foster home shall be 45 days, unless written extension is given by the Regional Director in the county of responsibility. Policy (6133) further mandates “Extensions granted by the Regional Directors will only be allowed for up to 90 days from the date of placement.”

Practice standards (CLWA FC 1.11) emphasize that emergency shelter foster care can offer a protective setting when a child is in “imminent danger, pending resolution of the crisis.” Standards (CWLA ANC&F 1.28) further stress that emergency shelter placement services should “be used on a time-limited basis (i.e., less than 14 to 21 days) to allow for careful exploration of the possibility of family reunification.” The reference to family reunification in this standard conveys the implicit assumption that emergency shelter care is used primarily at the time of a child’s entry into custody.

Information was collected to identify the extent to which MDHS used emergency placements for foster children during their most recent stay in custody and to determine whether the agency was adhering to its policy prohibiting the use of emergency placements for extended stays without documented written permission by the Regional Director in the county of responsibility.

- 63.8% of children in MDHS custody were placed at least once in an emergency shelter facility or emergency foster home since their most recent entry into custody, ranging from 90.0% (Jefferson) to 21.4% (Yazoo).

- 45.1% of the children who were placed in an emergency shelter facility/home were so placed more than once during their most recent stay in custody, ranging from 2 (all counties) to 15 times (Harrison County).
• The average total length of time spent in emergency placements during the children’s most recent stay in custody was almost 3 months (11.4 weeks).

• During their most recent stay in custody, the total time spent by children in an emergency placement ranged from one day to one year and 15 weeks. Figure 13 depicts the total amount of time spent in emergency placements by the children placed at least once in such placements.

Figure 13. % of Children Spending Lengths of Time in Emergency Shelter Facilities/Homes During Most Recent Stay in Custody

• Thirty-nine percent (39.2%) of those placed in emergency placements were thirteen or older. More than one-third (34.9%) of these youth spent more than 90 days in shelter care; 16.5% spent more than 6 months. Their mean length of time in such placements was 15.6 weeks, or almost four months.

• Slightly more than one-third (34.6%) of those with emergency placements were 6-12 years old; their mean time in such placements was more than two months (9.4 weeks), ranging from less than one week to slightly more than one year.
Even the youngest children spent lengthy periods of time in emergency placements: 26.0% of the children placed in emergency placements during their most recent entry in custody were between the ages of 0 and 5. Their mean time in such placements was almost two months (7.7 weeks).

More than one-half (50.7%) of the 0-5 year-olds who were placed in emergency placements were placed in such placements for a total of more than six weeks; only 15.3% who were so placed were in such placements for less than 7 days. Several in the youngest age group (4.2%) were so placed for almost six months (as many as 24 weeks).

When the mean length of stay in emergency placements is examined by county, the 0-5 year olds’ mean length of stay ranged from more than 3 months (13.0 weeks, DeSoto) to 1.1 weeks (Clarke). Mean stays for children 6-12 ranged from 3.5 months (14.2 weeks, Forrest) to .1 week (Humphreys). For adolescents, the mean length of stay in emergency placements ranged from 5.7 months (22.8 weeks, DeSoto) to 1.2 weeks (Clarke).

Permission documented for stay longer than 45 days in emergency placement. As cited above, MDHS policy (3216-3219, 6133) requires that the maximum stay in an emergency foster home or shelter shall be 45 days, unless written extension is given by the Regional Director in the county of responsibility. Policy further mandates “Extensions granted by the Regional Directors will only be allowed for up to 90 days from the date of placement” (6133).

Information was collected to determine whether in the 24-month period prior to June 1, 2005, the child stayed in an emergency shelter more than 45 days within a 6 month period, and if so, whether written permission for an extension

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**Case Example #3**

In December 2003, Rachal, John, and Suzie, then 3 years, 2 years, and 10 months old, entered MDHS custody due to their parent’s failure to provide housing, clothing, and food. All three pre-school age children were placed in an emergency shelter, and extensions were twice approved, allowing the children to remain in the shelter until early May 2004. After a 150-day stay at the emergency shelter, the three children were sent home for a trial reunification with their parents, which lasted until November, when they were removed again for physical neglect.

All three were placed again in the same emergency shelter. In January 2005, a 30-day shelter extension was approved; the extension request noted that the County of Responsibility had no available homes capable of meeting the children’s needs. In February 2005, after a 106-day stay in the emergency shelter, the children were again returned to their parents on a trial basis.
from the Regional Director was documented in the child’s record. Where more than one such stay had occurred, the most recent stay was used for data collection.

- Thirty percent (29.5%) of the children had an emergency placement stay of more than 45 days within a 6-month period during the 24 months prior to June 1, 2005.

- For the majority (51.9%) of these children, no written permission for an extension was contained in the child’s case record.

- When examined by age, 23.5% of the children 0-5 had such a stay; of these, 56.7% had no documented permission for an extension. One-quarter (25.5%) of the 6-12 year olds had such a stay; 43.9% had no documented permission for an extension. Of those 13+, 37.6% had such a stay; 54.3% had no documented permission for an extension.

- Counties’ percentage of children with emergency placement stays of more than 45 days within a 6-month period during the 24 months prior to June 1, 2005, ranged from 61.0% (Forrest) to none (0.0% Clarke).

- In five counties, the percentage of children with such stays whose case records contained no permission for an extension was either more than or close to 50.0%: Harrison, 100.0%; Hinds, 66.7%; Humphreys and Yazoo, 50.0%; and Forrest, 47.9%.

C. MDHS Fails to Assure that the Child’s Assigned Social Worker Maintains Required Minimum Face-to-face Contacts

Frequent face-to-face contact between public agency social workers and the children and foster care caregivers they serve is an essential component of service (Maluccio, Fine, & Olmstead 1986) and is mandated by both agency policy and national practice standards. The expectation that social workers assess whether or not foster children are safe and are faring well in their placements necessarily requires that they frequently and directly observe and interact with children as well as with the children’s foster caregivers.

When frequent face-to-face contact does not occur between social workers and both the children assigned to them and the children’s caregivers, the agency cannot assure that children are safe and are receiving necessary services. Under such conditions, the agency also cannot assure that caregivers have the information, skills, and support necessary to provide for the child’s care or that children’s placements are providing the appropriate level of care.
1. Social worker-child contacts

Contacts during the first 30 days of placement. The first days and weeks of placement can be traumatic for both foster children and their foster caregivers. A “fundamental readjustment” (Triseliotis, Sellick, & Short 1995:129) is required when children are separated from their families and enter a new living situation. Children may express their feelings of anxiety, fear, confusion, guilt, anger, and sadness by a range of behaviors, including withdrawal, regression, acting out or testing, and clinging. The agency social worker must be available to children during this difficult transition not only to help them cope with the placement experience, but also to assess children’s needs and adjustment as well as the service and informational needs of the foster caregivers.

Consistent with the heightened nature of children’s needs during this period, MDHS policy (3239) states, “The MDHS/MDHS Social Worker shall maintain weekly contacts (either face to face or by telephone) with the child during the first 30 days of placement.” National practice standards (CLWA FC 2.37) state that the agency social worker and foster parents should be available to “help the children in their care cope with the effects of separation from their parents and other family members . . . Dealing with separation and loss is pivotal to the casework help that children in placement must receive to counter the trauma of separation . . . children who are unable to express their feelings about separation and loss often act out their pain through problematic behaviors and/or physical symptoms and ailments.”

National practice standards (CWLA FC 2.35) also direct social workers to provide information to children about the move, including “an emergency plan with the child in the event the child should need the immediate help of the social worker.” COA standards (S21.4.02) require that the agency social worker meet “privately with the child to conduct a preliminary assessment within the first 72 hours of the child’s initial placement or any subsequent re-placements; [and] conducts a complete assessment within 45 days.”

For children whose most recent entry into custody occurred on or after June 1, 2003, information was collected to determine whether, as required by MDHS policy, the child’s social worker maintained weekly contact with the child during the first 30 days of placement, either face-to-face or by telephone.

- For three-quarters (75.1%) of the children whose most recent entry began on or after June 1, 2003, MDHS failed to maintain the required weekly contact during the first 30 days of placement.
Very young children are the most vulnerable during the days and weeks following placement; they are unable to initiate contact with the social worker should they experience difficulties in the placement. Therefore, very frequent contact with them during the first 30 days of placement is particularly important. Despite this, during the first month of placement,

- MDHS social workers/supervisors failed to maintain weekly contact with 70.2% of infants less than one year old and with 74.5% of the children who were 1 year old.

- During the first month of the child’s placement, the MDHS social worker/supervisor failed to maintain weekly contact with almost all (95.2%) of the 4 year olds.

- When examined by county, the percentage of children with whom the child’s social worker/supervisor failed to maintain weekly contacts during the first 30 days of placement ranged from 88.0% (DeSoto 87.8%, Yazoo 87.9%) to none (0.0% Humphreys).

**Required monthly social worker-child contacts.** Agency social workers’ frequent, direct observation of and interaction with foster children is necessary in order to accomplish the multiple responsibilities they carry for children’s care and services, including the ongoing assessment of children’s safety and well-being as well as of children’s health, mental health, educational, and other service needs. Moreover, without in-person contact, children have no basis for an ongoing relationship with the social worker; such a relationship is critical in helping children feel sufficiently safe with the social worker to disclose difficulties they are experiencing in placement, including maltreatment in the placement setting.

MDHS policy (3239) requires that “Face to face contact shall be maintained with all foster children, regardless of their placement type every 30 days thereafter [after the first 30 days of the child’s placement]. This could require a County of Service Social Worker to make the face to face contact.”

National practice standards (CWLA FC 2.55) also require that the social worker “meet face-to-face with the child at least monthly” to “ensure the child’s continuing safety and to ensure that developmental needs are being met in the family foster home and that the child is maintaining optimal connections with his or her parents.” This standard directs that in meetings with the child, the social worker should give the child information about whatever affects the child’s life, communicate that the child can contact the social worker between scheduled meetings, listen to the child’s view of how well the service plan is working and observe the child’s reactions to the plan, be aware of any evidence of maltreatment
or failure of the child to develop, and determine when a modification in the child’s plan is needed. COA standards (S21.4.02) also require social worker-child contact at least once a month, and, for special needs children, (S21.4.03) private face-to-face contact at least twice a month.

Information was collected to determine whether children in MDHS custody were provided the required minimum of one face-to-face contact per month with their assigned social worker or supervisor (either County of Responsibility or County of Service) during the 12-month period prior to June 1, 2005. The protocol was designed to collect information regarding social worker or supervisor in-person contact with the child during each month of the 12-month period prior to June 1, 2005. When the child was not in custody for an entire month during this period, “not applicable” was entered in the appropriate month or months; these months were then excluded from this analysis. The proportion of possible months that each child could have been visited during the 12-month period was determined, and the proportion of those months the child was actually visited as required, i.e. at least one visit per month, was calculated. This analysis was completed for social worker contacts with children, foster parents, and children’s parents.

- 87.6% of the children did not receive the required minimum of at least one face-to-face contact per month from their social worker/supervisor during the one-year period prior to June 1, 2005.

- 13.5% of the children had no face-to-face contact with their assigned social worker/supervisor during this same 12-month period.

In the 12 months prior to June 1, 2005, social workers/supervisors made only an average of 49.2% of the required monthly contacts with children. Figure 14 presents the percentage of minimum required contact MDHS provided to children.
For 79.7% of the youngest children (ages 0-5), MDHS failed to achieve the required minimum of at least one face-to-face contact per month by a social worker with the child during the 12 months prior to June 1, 2005. Only slightly over half (54.7%) of the required minimum monthly contacts, on average, were provided to the youngest children.

Eleven percent (10.8%) of the children ages 0-5 had no face-to-face contact with their assigned social worker/supervisor during the one-year period prior to June 1, 2005.

For 91.1% of the children ages 6-12, MDHS failed to achieve the required minimum of one face-to-face social worker contact per month. The average percent of the required monthly contacts provided to these children was less than one half (47.0%).

Twelve percent (11.8%) of the children ages 6-12 had no contact during this same one-year period with their assigned social worker/supervisor.

For 90.4% of the children ages 13 and older, MDHS failed to meet the required minimum of at least one face-to-face contact per month by a social worker during the 12 months prior to June 1, 2005. On average, these children received only 47.0% of the required monthly contacts during same 12-month period.

Fourteen percent (14.2%) of the adolescents had no social worker-child contact during the one year prior to June 1, 2005.
When examined by county, the mean percent of the required monthly contacts with children made by social workers/supervisors in the 12 months prior to June 1, 2005 ranged from only 38.8% (Harrison) to only 82.2% (Jefferson). During the same 12-month period, the mean aggregate number of actual contacts per child ranged from 4.0 (Forrest) to 12.6 (Jefferson).

Case Example #4

“Tobie, a 16 year old in DHS custody...was here for about 90 days...During that time she periodically decompensated because she knew she was ready to go and felt abandoned by her DHS social worker, who did not respond to her [psychiatric facility] social worker’s calls after a time and did not bring the clothes she needed. Tobie suffered a lot of anxiety about her length of stay and the uncertainty about placement.” “[She] was here far longer than [she] should have been because the DHS social workers would not come to get [her].” “...in situations such as these, the children suffer and may place our other patients at risk.”

Face-to-face contact with children by any MDHS staff. Despite the agency requirement that the child’s assigned social worker (County of Responsibility or County of Service) maintain face-to-face contact with children in custody, children are frequently visited instead by other staff members through a statewide waiver (MDHS Bulletin No. 5692 2000). Therefore, information was also collected to determine the number of face-to-face contacts conducted by a MDHS staff member other than the child’s social worker or supervisor (including MDHS social work aides, homemakers, and clerical staff) with the child during the 12 months prior to June 1, 2005.

- The majority (58.3%) of children either received none (23.2%), only one (20.9%) or only two (14.2%) additional visits from staff members other than their social worker/supervisor during this one-year period.

- Even when visits by all MDHS staff (including social workers, supervisors, social work aides, homemakers, and clerks) are included, in the 12 months prior to June 1, 2005, 8.4% of the children were not visited once by any MDHS staff member.

- The percentage of children by age group visited either not at all or fewer than 6 times in the 12-month period by any MDHS staff member were:
  - 31.3% of the children 0-5 years old
  - 25.2% of the children 6-12 years old
  - 30.2% of the children 13+
When face-to-face contacts by any MDHS staff member are combined, the mean number of total face-to-face contacts per child for the 12-month period is 9.9. When examined by county, the mean number of total face-to-face contacts made by MDHS staff per child for the 12-month period ranged from 7.9 (Harrison) to 22.9 (Jefferson).

2. Social worker-foster parent contacts

Children’s foster parents also need and deserve frequent face-to-face contact with an agency social worker. Such contact is essential to “keep one another informed about the child’s adjustment and development in the foster family; to support one another in carrying out their responsibilities for the child; and to identify and plan for additional services necessary to achieve permanency for the child” (CWLA FC 2.54).

MDHS policy (6018) implicitly identifies a specific minimum requirement of once a month face-to-face contact with the child’s foster parents as they provide monthly supervision of the child placed in the home and support caregivers in providing quality care for the child. Agency policy (6018) states: “Once a child or children are placed in the licensed foster family home, the child’s assigned Social Worker will be responsible for providing monthly supervision of the child placed in the licensed foster home. The child’s Social Worker shall maintain continuing supervision of the child while in the foster home. The child’s Social Worker will be responsible for providing reports regarding the monthly supervision on children in MDHS foster home placements in the child’s case record and shall provide a copy of same reports to the Licensing Specialist or designated Social Worker so they shall have knowledge of the situation as to be assured that the child is receiving care in accordance with licensing requirement and in relation to his/her specific needs . . . The Licensing Specialist or designated Social Worker shall assume responsibility for strengthening the capacity of the foster parents to provide quality care for the child or children in their care. . . [and] shall help the foster parents increase their understanding of the child’s behavior and help deal as effectively as possible with whatever problems arise in the course of care (6018).”

National practice standards (CWLA FC 2.54, 2.55; COA S21.4.02, S21.8.05a) require that the agency social worker meet face-to-face at least monthly with the child’s foster caregivers. CWLA (FC 1.7) further requires that the monthly meetings with the caregiver must occur in the foster home. Practice standards (CWLA FC 2.54) state that the agency social worker and the foster parents “should work as partners for the safety and welfare of the children in care and as partners in assisting parents to meet the objectives in their service plans.” Social workers and foster parents should meet regularly “to review and assess the
needs of children and the services that they are receiving” (CWLA FC 2.54) and to provide support to foster parents (COA 21.8.06).

The COA standard (S21.8.06) for contact is more stringent when a child with special needs or problems is placed in foster and/or kinship care homes. Its standard states that an agency that places “children with special needs or emotional or behavioral problems in foster and/or kinship care homes supports the foster and kinship parents of these children through: a. weekly contacts by the assigned worker; b. twice monthly in-person visits by the assigned worker; 24 hour a day/seven day a week availability of personnel via pager.”

Information was collected regarding social worker/supervisor contacts with the caregivers of children who were placed in foster family care during the 12 months prior to June 1, 2005. Months during which the child was not in foster family care were excluded from the analysis.

- In 91.7% of the children’s cases, the MDHS social worker or supervisor failed to meet the national practice standard of at least one monthly face-to-face contact with the foster parents during the 12-month period prior to June 1, 2005.
- More than one-fourth (26.0%) of the children had caregivers who were not visited even once during the 12-month period prior to June 1, 2005.
- The mean percent of required monthly contacts with children’s foster family caregivers made by social workers/supervisors in the 12 months prior to June 1, 2005 was 33.4%, an average of one visit every four months.
- When examined by county, the mean average percentage of required monthly contact with children’s foster family caregivers provided by the child’s social worker/supervisor ranged from only 24.2% (DeSoto) to only 67.1% (Jefferson).

Contacts in caregiver’s home. As noted above, practice standards (CWLA FC 1.7) require that the agency “maintain ongoing communication with the foster family by visiting the foster home at least monthly.” Information was collected to determine whether MDHS provided monthly in-home face-to-face contacts.

In September 2004 an MDHS supervisor asked a homemaker to contact the foster mother of a child who had not been seen as required: “The foster mother was very upset, she states that no one from [County of Responsibility] has been to see this child, and that her phone calls are never returned. That the child is in need of clothing, no one ever address her issues [sic].”
D. MDHS Fails to Maintain Continuity of Social Workers and Social Work Services for Foster Children

Stable relationships with adults are critical for foster children, whose trust in adults has often already been extremely compromised due to the reasons that resulted in their removal from their parents (Remkus 1991; Webb 1996). As such, it is critical that the agency maintain continuity of social work services and of social workers.

It is widely recognized that high caseloads contribute to discontinuity of social workers and social services for foster children. High caseloads result in uncovered or partially covered tasks, inadequate decision making, and social worker turnover. Therefore, practice standards emphasize the maintenance of a caseload size that permits adequate provision of all required services (CWLA FC 3.48, AD 7.19, KIN 4.19-4.20; COA S21.11.03-S21.11.04, S21.15.03, S21.26.04, S21.29.03-S21.29.04).

Frequent changes or turnover in children’s social workers result in inadequate documentation and transfer of critical case information; inadequate time for reading records and becoming familiar with children’s extensive case records; and often lengthy time periods in which no services are provided to families, children, or foster parents. Frequent changes in social workers inevitably
lead to ineffective case planning, poor case decisions, and poor placement outcomes.

### Case Example #6

“This case was recently assigned to my workload in February 2004. However since that time no one has staffed this case with me or given me any information regarding the involved children. As is evidenced by the previous narrative entries this case has for the most part been handled by ASWS.” The case was being transferred to yet another worker in March 2004.

Frequent changes in the child’s social worker also affect the nature of the relationship between the social worker and the children for whom they have responsibility. For example, children tire of telling their stories over and over to strangers, and thus, over time, may cease to answer a second, or third, or fourth social worker’s questions. Effective casework practice requires that changes in the child’s social worker must be avoided whenever possible. When changes cannot be avoided, the negative effects of change must be mitigated by a well-planned transition.

### Number of social workers assigned to children

Information was collected to determine the number of social workers assigned to children during the 24-month period prior to June 1, 2005. Information was available regarding assigned social workers for 98.6% of the children. Additional assigned workers in a County of Service were included in the count. It should be noted, however, that missing and/or confusing documentation of who the assigned social worker was at any point in time as well as the gaps in case notes described later in this section most likely resulted in an undercount of the number of different social workers assigned to children.

- During the 24 months prior to June 1, 2005, the majority (58.3%) of the children in MDHS custody had more than one social worker; 11.0% had 3 social workers. Ten percent (10.4%) had 4 or more social workers during that 24-month period.

- Almost two-thirds (62.7%) of the adolescents were assigned more than one worker during the 24 months prior to June 1, 2005, as were more than one-half of both the 6-12 year olds (56.5%) and the 0-5 year olds (54.7%).

- When examined by county, the percentage of children who had more than one social worker ranged from 84.1% (Yazoo) to 30.8% (Humphreys). The percentage having 4 or more social workers during the 24-month period ranged from 52.2% (Yazoo) to 0.0% (DeSoto, Harrison, Humphreys, Jefferson, and Pontotoc).
Numerous problems associated with social worker discontinuity were identified throughout the review of children’s case records. These include lack of appropriate transition planning when social workers change, and often lengthy gaps in services to children, their foster caregivers, and their families.

**Case Example #7**

In November 2003, 4-year-old Jon entered MDHS custody due to his mother’s inability to supervise him. Under the category “Current emotional behavioral issues,” Jon’s August 2004 ISP states: “The child has been subjected to different people in and out of his life on a daily basis. There is no stability for this child.” MDHS then provided a total of six different adults—two social workers, three social work aides, and one YMCA worker—to maintain face-to-face contact with Jon during the 12 months prior to June 1, 2005. These adults met with Jon in a haphazard and unpredictable manner, and contact with Jon occurred variously at a day care center, at kindergarten, and at court. During this same 12-month period, there were no MDHS visits to the foster caregiver’s home, except for the initial home study visit. A contact note states: “child did not remember worker.”

**Case Example #8**

Jeffrey entered custody in April 2002 when he was 3.5 years old. No MDHS staff member made face-to-face contact with Jeffrey in 17 of the 24 months between June 1, 2003 and June 1, 2005, and Jeffrey’s record contains no case notes for a total of 10 months during the same two-year period. After no contact had been made with either the child or the caregiver for months, in July 2004 a social work aide visited the caregiver’s workplace and learned that Jeffrey had been admitted to a psychiatric facility for 2 weeks. The aide conveyed this information to a “new worker” and suggested that she schedule a face-to-face contact with the caregiver. Contact with the child was not made until one month later, and case notes fail to document any further telephone or face-to-face discussion with the foster caregiver in the 10 months between July 2004 and June 1, 2005. No explanation is documented regarding the reason for the child’s two-week stay in a psychiatric facility.

**Additional sources of service discontinuity.** The review of the children’s records identified additional sources of discontinuity of social workers for children in MDHS custody. First, as identified in MDHS policy (3248), children and their families may be served by a County of Responsibility (COR), a County of Service (COS), and a County of Residence (COR) social worker. During the 12-month period prior to June 1, 2005, some children had one or more face-to-face contacts with social workers from multiple counties. Particularly for very young children, who cannot conceptualize a change in the social worker who visits them as related to “distinct differences in the roles” (3248) of the multiple counties providing aspects of their care and service, contacts most likely are perceived as being made by strangers, particularly when months have passed since the most recent contact occurred.
Another source of discontinuity in social work services to children in custody is caused by the MDHS practice of assigning responsibility for children’s face-to-face contact to other agency personnel in addition to the child’s social worker. In order to address a shortage of social workers, a statewide waiver of agency policy (Bulletin No. 5692, dated December 4, 2000) allows monthly face-to-face contact with foster children “to be made by agency Homemakers and Social Work Aides as well as Social Workers.”

- The review of children’s records documented that personnel assigned responsibility for children’s face-to-face contact included not only social workers, ASWSs, program specialists, social work aides, and homemakers, but also clerical staff. In one county (Harrison), several children were visited by a “YMCA social worker,” and case notes regarding these contacts were entered under the name of an agency staff member.

Although authorized by the 2000 state waiver, the MDHS approach to providing casework services is not supported by national practice standards. These (CWLA FC 3.45, 3.52; COA S21.11.1-S21.11.02) stress the importance of relevant education and training for the social workers who provide direct services to foster children and families.

Information was collected to determine the total number of different MDHS staff members (including social workers, supervisors, social work aides, homemakers, clerical staff, and others) who had face-to-face contact with children during the 12-month period prior to June 1, 2005.

- More than half (51.2%) of the children were visited by 3-5 different staff members during the 12 months prior to June 1, 2005; 11.1% were visited by between 6 and 13 different staff members.

- When examined by county, the percentage of children who were visited by 6 or more different staff members during the same 12-month period ranged from 30.0% (Jefferson) to none (0.0% DeSoto).
A number of problems were documented through the record review as associated with the MDHS practice of using multiple staff members to maintain face-to-face contact with children in custody. First, homemakers, social work aides, clerks, and even county of service social workers do not have the authority to act on many of children’s questions and requests, e.g., requests for a placement change, visits with family members, and clarification of the child’s permanent plan. In many children’s case records, staff notes repeatedly documented a common MDHS staff member response to children “You have to talk with your social worker about that.” When the MDHS staff members assigned to maintain face-to-face contact with children continually defer or delay responses to children’s requests and questions, children are likely to conclude that no one really cares about them and their situation and as a consequence cease to voice their needs and questions.

The greater the number of staff members involved in serving children and their foster caregivers, the more difficult it is to clarify who is responsible to respond to specific needs and concerns and to transfer information in a timely and accurate manner. Both the lack of clarity regarding responsibility for specific case activities and incomplete, delayed, or inaccurate transfer of case information cause discontinuity in social work services.

In August 2004, 16-year-old Tommy was removed from his grandmother’s custody due to medical neglect and placed 90 miles away in a different county. In conversations with at least 4 different MDHS workers, Tommy begs to visit with his grandmother, be moved to his aunt’s home, be moved back home or be moved to the town where his grandmother lives. The social work aide “told him he would have to ask his SW;” the County of Service social worker “explained he would have to express these concerns to his COR [County of Responsibility social worker];” “[unidentified MDHS staff] stated she will pass this information on to his SW.” In the 19 months prior to June 1, 2005, there is no indication that any MDHS staff ever attempted to arrange a visit for Tommy with his grandmother, to locate his aunt, or to explore the possibility of his being moved closer to his family.

In the 7 months between October 2004 and May 2005, Megan’s facility houseparent made repeated requests regarding the child’s need for clothing to the MDHS County of Service social worker, who noted: “CHILD NEEDS CLOTHING BADLY AND SHE HAS STILL NOT RECEIVED ANY MONEY FOR CLOTHES” (emphasis in original). In January 2005 a houseparent called the MDHS supervisor to report the lack of response, and a check was finally mailed that month. Clothing requests for the child, however, were again made in March, April, and May of 2005 without a response from the County of Responsibility.
A third problem created by permitting monthly face-to-face contact with foster children to be made by homemakers, social work aides, and clerks as a substitute for contact by the children’s assigned social worker is that children are served by persons who do not possess the knowledge and skill required to effectively serve foster children. Social work aides, homemakers, and clerical staff are ill-prepared to conduct the professional tasks associated with the required social worker-child face-to-face contacts. For example, staff assigned to monitor children’s well-being and safety must be trained to convey to the child that they are trustworthy, to understand children and their experiences from a developmental perspective, to relate to the child in an age-appropriate manner, and to appropriately interpret their direct observations of the child and the child’s responses to their questions. Consistently, case notes entered by untrained social work aides, homemakers, and clerical staff primarily contained superficial accounts of their face-to-face contacts, describing only what the child was wearing and a statement that the child reports that everything is fine. Such notes also often conveyed little or no understanding of the need to interview children separately from their caregivers or the fact that children’s need for adult approval may affect their responses in conversations with agency staff.

**Case Example #11**

In September 2004, 6-year-old Sara entered custody due to abandonment. A clerk was assigned to provide MDHS-mandated face-to-face contact with Sara. The clerk noted that things were going well in the foster home, and she reported after her fourth monthly visit that Sara appeared to be “very happy and adjusted.” She did not document any private conversations with Sara, and only one week later, in December 2004, allegations of emotional abuse and neglect of foster children in the home were reported. Six-year-old Sara confirmed that she was punished by having to take cold showers with her clothes on and stand in front of the mirror and repeat statements like, “I will not lie,” for an hour or longer. Several children described a foster family member as grabbing Sara’s arm “everyday,” leaving red marks.

The maltreatment was evidenced, and the investigator recommended to “possibly close this home as this is the second report of allegations regarding this foster home and the foster parents’ caretaker” and “there are several children relating the same information.” Although two of the other foster children were moved as a result of the investigation, the home was not closed. Sara remained there until May 2005, at which point she was moved three times, ending up in an emergency shelter as of June 1, 2005.
Unfortunately, case notes also documented serious errors made by MDHS staff whose lack of knowledge regarding indicators of child abuse and neglect and of agency policy regarding child abuse reporting placed children at serious risk.

Case Example #12

In September 2001, Casey was placed in MDHS custody due to neglect at the age of six. In August 2002, her mother expressed concern that the relative foster parent’s son might be mistreating her daughter. The social worker discounted the mother’s concern, asking whether she had taught “her daughters about good touches and bad touches.” When the mother stated that she had, the social worker “advised [Casey’s mother] that if anything had happen [sic] that I’m sure that your child would tell you.”

In March 2003, a school counselor reported sexual abuse of 7-year-old Casey and her 11-year-old sister by a friend of the foster mother. The relative foster parent “explained to this SW that these are the same allegation [sic] that she told this [same] SW about when it occurred and the children stated to her that nothing happen [sic] and that [male friend of foster parent] was barred from her home or being around her children.” The social worker did not interview either of the foster children who were the alleged victims as part of the investigation, and the allegation was not evidenced.

In June 2004, the foster parent herself reported sexual abuse of Casey and her sister by the relative foster parent’s son and requested that Casey be moved. After the girls were interviewed, sexual abuse was confirmed.

Case Example #13

Tammy and four siblings entered MDHS custody in August 2001 due to chronic neglect. In March 2005, a social worker received a call from 17-year-old Tammy, who was pregnant. Tammy revealed that she was living with her mother and father, who had previously surrendered their parental rights, and that her uncle, with whom Tammy was placed, was living in another county. Tammy said to the worker “can’t you just keep it a secret for two more months, like [the previous MDHS social worker] did?”

The worker and ASWS immediately went to the home to remove Tammy and place her at a shelter. Tammy’s father informed them that Tammy had been with them for approximately nine months and that the previous MDHS social worker had known. The uncle with whom Tammy had been placed later stated that “he was not aware of any problems with her being with her parents because [the prior MDHS social worker] knew the entire time, so why was DHS all of a sudden picking Tammy up from that home?”

When Tammy was brought to the shelter, she stated that she would not be alive in the morning. Tammy had to be taken to a psychiatric facility for an emergency assessment.

Each change in the social worker or other staff member who maintains face-to-face contact with children interrupts the relationship that the child is developing with the social worker and potentially affects the degree of disclosure.
and accuracy of information achieved in worker-child conversations. When the safety and well-being of children in care are monitored either sequentially or concurrently by numerous social workers and other MDHS staff with multiple levels of authority and varied degrees of training (including no training), the information collected from face-to-face contacts with children is likely to be superficial. Under such conditions, the agency’s ability to provide care and services that meet children’s needs is predictably greatly undermined.

E. MDHS Fails to Prevent Frequent and Extensive Gaps in Case Records Reflecting Periods of No Social Work or Case Management Services or Monitoring of Foster Children

An accurate and timely record of all contacts, observations, decisions, agreements, and actions related to the child’s care and services is essential. Without such a record, the child’s well-being and safety are in constant jeopardy. Therefore, the accurate and timely recording in the foster child’s case record of all contacts, observations, decisions, agreements, and actions related to the child’s care and services is a basic tenet of minimally acceptable social work practice. The occurrence and specific nature of all telephone and in-person contacts with children, their parents, foster caregivers, and others involved in the child’s care and services should be documented.

Agency staff should also document information shared with other agency staff and with other parties to the child’s case; agreements made; questions addressed; concerns expressed, etc. Further, all such information must be documented quickly to avoid the errors and gaps in information that inevitably result from delays in recording.

Given the life-altering nature of the decisions made within the child protection and permanency planning process, decisions based upon incomplete or inaccurate documentation are likely to be arbitrary, unwise and even life-threatening to the child. The potential dangers to foster children due to uninformed, incorrect, or irrational decision making caused by the failure to thoroughly and accurately record events in their lives are only further compounded when foster children experience the multiple changes in their assigned social workers described above.

A complete and accurate case record is also necessary for legal purposes. For example, case notes may become evidence in meeting the agency’s legal requirement to show that it has made reasonable efforts either to prevent unnecessary placement of a child through services or to reunify a foster child with his or her family through services: “These efforts should be clearly documented in
the agency file” (Fiermonte & Renne 2002). Professionals in the child welfare system thus understand that if it is not written down, it is as if it never happened.

In addition to completing the protocol for each case, case reviewers documented any information missing from the case file, such as legal documents, medical records, etc., during the 24-month period prior to June 1, 2005. In many case files, information of some type, such as the child’s medical or educational information or legal documents, was missing for this entire 24-month period. In others, case notes referenced information that was not explained or documented elsewhere in the file.

To quantitatively measure the presence of case notes in children’s case files, reviewers identified case notes recorded by any MDHS staff member during the 24-month period prior to June 1, 2005. Recorded information concerning the child, the child’s parents, and the child’s caregivers, no matter how limited, was counted as a case note for any given month. If the child was not in custody for an entire month, the month was excluded from the analysis.

- For 3.9% of the children, MDHS staff failed to record any case notes in the record over the two-year period prior to June 1, 2005.
- For almost one-third (31.3%), MDHS staff failed to provide even one case note that documented social work or other MDHS activity for one out of every five (20.0%) months the child was in custody in the two years prior to June 1, 2005.
- When examined by county, the mean percentage of months that MDHS failed to include any case notes in all children’s files during the 24 months prior to June 1, 2005, ranged from 17.8% (Hinds) to 4.8% (Jefferson).

F. MDHS Fails to Protect Children From Further Abuse or Neglect While in Custody

Because of the impact of the maltreatment they experienced prior to placement on children’s ongoing development and well-being, foster children are particularly vulnerable to the negative effects of further maltreatment. Thus, the agency responsible for the child while in care must assure that children’s foster caregivers do not inflict further harm on them while they are in custody.

Federal mandates, national practice standards, and agency policy are unequivocal in prohibiting that children in legal custody be subjected to harm. Consistent with these expectations, a state’s conformity with federal child welfare
requirements is measured by whether “[c]hildren are, first and foremost, protected from abuse and neglect.” 45 C.F.R. § 1355.34(b)(i)(A).

MDHS policy explicitly prohibits any physical or emotional punishment or threats of punishment to a child. Agency policy (6108) states that to qualify for and maintain licensure as a foster parent, a person must demonstrate the “willingness and ability to protect children from harm”. Policy (6119) further specifically mandates that “a foster parent shall not use corporal punishment or maltreat a foster child, and shall not allow any other person to do so.” Corporal punishment or maltreatment are defined by MDHS (6119-6120) to include any type of physical hitting, striking, spanking, switching, and slapping inflicted in any manner; verbal abuse, including arbitrary threats of removal from the foster home; disparaging remarks about a foster child or a child’s family members; deprivation of meals, clothing, bedding, shelter, or sleep; denial of visitation or communication with a foster child’s family and significant persons when such denial is inconsistent with the child’s case plan; cruel, severe, depraved, or humiliating actions; locking a foster child in a room or confined area inside or outside of the foster home; and requiring a foster child to remain silent or be isolated for unreasonable periods of time.

National practice standards (CWLA CAN 6.3, FC 1.4, 2.69, 2.70; COA S21.4.04, S21.8.04, S21.9.04c, S21.10.01) also explicitly prohibit any physical or emotional punishment or threats of punishment to a child and assert that all children in out-of-home care have a right to safety and protection.

Case records were reviewed for documentation of reports, investigations, or other indications of maltreatment of foster children while in MDHS custody. The following findings represent an unduplicated count of children’s experiences as these relate to suspected caregiver maltreatment while in MDHS custody:

- 24.0% of the children had documentation of child abuse or neglect reports, investigations, or other indications of maltreatment of themselves or of another foster child in their placement at least once while in MDHS custody.
  - 27.1% of these children had 2 or more such documented indications of maltreatment of themselves or of another child in their placement while in MDHS custody; 17.2% had 3 or more.
  - Those children with at least one documented indication of maltreatment of themselves or of another child in their placement while in MDHS custody had an average of 1.5 such documented indications.
• In one of the counties selected for the study (Yazoo), 50.0% of the children had documented indications of maltreatment of themselves or of another child in their placement while in MDHS custody.

Of the 24.0% of children who had documentation of child abuse or neglect reports, investigations, or other indications of maltreatment of themselves or of another foster child in their placement at least once while in MDHS custody,

• 1.3% of the children’s case files documented that while in MDHS custody the child had been placed in a foster home or facility in which an allegation had been investigated and found Not Evidenced; all of these children were identified as victims in the investigation. However, in all of these cases corporal punishment of the child was documented as part of the investigation.

• 1.9% of the children’s case files documented that while in MDHS custody the child had been placed in a foster home or facility in which an allegation of foster caregiver abuse and/or neglect had been investigated and found Not Evidenced. One percent (1.4%) of these children were identified as victims in the investigation.

• Five percent (4.9%) of the children were specifically identified as victims in substantiated foster caregiver abuse/and or neglect incidents. The majority of these children (73.3%) were subjected to these incidents of substantiated maltreatment after January 1, 2004.

• Six percent (5.6%) of the children had documented incidents of Evidenced (substantiated) foster caregiver abuse and/or neglect of themselves or of another foster child in their placement. More than three-quarters of these incidents (76.5%) of substantiated maltreatment occurred after January 1, 2004.
  o The sample child was not moved in the majority (54.1%) of the incidents of suspected caregiver maltreatment that were investigated and found to be Evidenced.

• Case records documented that 6.2% of the children had to be moved from their homes or facilities due to suspected foster caregiver abuse or neglect. Six percent (6.1%) of the children were specifically identified as victims of the foster caregiver abuse/and or neglect incidents directly related to the move.
• For 9.1% of the children, MDHS failed to complete an investigation and the child was not moved from the foster placement. These children’s experiences are discussed in sub-section G. below.

A January 2004 report of abuse and neglect in a foster home, licensed for 4 but with 11 foster children, alleged that one of four Smith siblings was “whipped to the point that she was limping. All of the children have head lice...so bad that they have caused sores in the children [sic] head.” The children reported to the investigator that the foster mother’s boyfriend threatened the boys, stepped on one child’s back and made him cry, and pulled one child’s fingers back until he cried and that the foster mother whips them with a fly swatter. One of the Smith children stressed that he “could not take it much longer in the foster home...there were too many people to live in a trailer...[including] 2 babies [ages 1 month and 5 months] in [foster parent’s] room.” The worker found “no evidence to support the allegations of abuse/neglect” and expressed only “concern” about the number of children (9) who were left in the home.

When all incidents documented in children’s case records of suspected foster caregiver maltreatment of children while in MDHS custody are examined:

• 18.7% of the documented suspected incidents of caregiver abuse and/or neglect of children in MDHS custody were investigated and found Evidenced.

• In 27.8% of the documented suspected incidents of caregiver abuse and/or neglect of children in MDHS custody, the child was moved by MDHS to another placement due to suspected foster caregiver abuse and/or neglect of the child or another child in the placement.

• 7.6% of the documented suspected incidents of caregiver abuse and/or neglect of children while in MDHS custody were investigated and found Not Evidenced, but corporal punishment of children in the placement was documented as part of the investigation.

• Fifteen percent (15.4%) of the documented suspected incidents of foster caregiver abuse and/or neglect of children while in MDHS custody were investigated and found Not Evidenced.

It must be emphasized that due to the gaps in information in children’s case records reported earlier in this section and MDHS’ failure to follow up on reports or other indications of maltreatment of foster children in MDHS custody reported later in this section, the percentages of maltreatment reported above are almost certainly an undercount.
G. MDHS Often Fails to Follow Up on Reports or Other Indications of Maltreatment of Foster Children in MDHS Custody

When all incidents documented in children’s case records of suspected foster caregiver maltreatment of children while in MDHS custody are examined:

- Twelve percent (12.0%) of the children in MDHS custody had at least one incident of suspected maltreatment while the child was in MDHS custody that was not investigated. This represents fifty percent (49.8%) of the children with at least one documented incident of suspected foster caregiver maltreatment while in MDHS custody.

- Seven percent (7.4%) of the children in MDHS custody had at least one incident that was not reported. This represents 30.8% of the children with at least one documented incident of suspected foster caregiver maltreatment while in MDHS custody.

- Four percent (4.3%) of the children in MDHS custody had at least one incident in which MDHS had begun an investigation but failed to complete it; no finding was documented in the child’s record. This represents 17.6% of the children with at least one documented incident of suspected foster caregiver maltreatment while in MDHS custody.
• 68.9% of the documented incidents of suspected caregiver maltreatment while the child was in MDHS custody occurred after January 1, 2004.

• Although almost all counties selected for the study failed to investigate the majority of documented incidents of suspected foster caregiver maltreatment either not at all or incompletely, apparent patterns of response were found. For example, in one county (Harrison), the majority (76.3%) of such incidents were either not reported (40.9%) or the investigation was not begun (23.6%) or not completed (11.8%); however, in all completed investigations, the allegations were Evidenced (23.7% of the documented incidents). In another county (Pontotoc), almost all (94.0%) documented incidents of suspected foster caregiver maltreatment of children were either not reported (41.1%) or not investigated (52.9%); when an incident was investigated it was found Not Evidenced (5.9%). In a third county (Yazoo), the majority of incidents (56.3%) were investigated; however, upon investigation, all but one were found to be Not Evidenced.

For 9.1% of the 24.0% of children in MDHS custody who had documentation of child abuse or neglect reports, investigations, or other indications of maltreatment of themselves or of another foster child in their placement at least once as reported above (unduplicated count), MDHS failed to complete an investigation and the child was not moved from the placement. For these children, records revealed that MDHS failed to take mandated steps to determine whether children were safe as presented in Table 7.

Table 7. MDHS Failure to Take or Document Actions To Investigate Allegations of Child Abuse and Neglect in Placement

<table>
<thead>
<tr>
<th>MDHS Failures to Take or Document Actions</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected abuse/neglect incident was documented, but was not formally reported or investigated</td>
<td>3.1</td>
</tr>
<tr>
<td>Suspected abuse/neglect incident was formally reported, but an investigation was not opened</td>
<td>4.8</td>
</tr>
<tr>
<td>An investigation was opened, but was not completed and no finding was filed in the child’s record</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>9.1</td>
</tr>
</tbody>
</table>

*Percentages are weighted.
H. MDHS Fails to Protect Foster Children from Corporal Punishment

As Gershoff (2002) states in a review of research about corporal punishment, “The defining aspect of corporal punishment, and indeed the key to its potential for securing short-term compliance, is that it involves inflicting pain on children.” Corporal punishment of foster children in MDHS custody is expressly prohibited by agency policy (6119-6120): “a foster parent shall not use corporal punishment or maltreat a foster child, and shall not allow any other person to do so.”

National practice standards (CWLA FC 2.70; COA S21.9.04c) also specifically prohibit corporal punishment of children in placement and state that compliance with this prohibition should be a condition for foster parent licensing and re-licensing.

Case records were reviewed to determine whether during the child’s entire stay in the custody of MDHS there was documentation in the child’s record that corporal punishment had been used on the child or another foster child in the child’s placement by a foster caregiver.

- The case records of 6.2% of the children included indications of corporal punishment by a foster caregiver used in dealing with the child or another foster child in the child’s placement while the child was in MDHS custody.

- In the seven counties in which the use of corporal punishment had been documented in the child’s record, the percentage of children in whose placement the foster caregivers used corporal punishment with the child or another foster child ranged from 4.9% (Forrest) to 21.4% (Yazoo and Humphreys).

In October 2003, 5-year-old Becca was placed in MDHS custody due to neglect. In June 2005, the Foster Care Reviewer “notes that the following statement was documented in the MACWIS system on 04/26/05. ‘[Becca] said she gets whipped with an extension cord and SW examined her for injury.’ This will be discussed with her grandmother. She said she has not received a whipping in a while.’” (emphasis in original). “FCR notes SW indicates that she examined child, but she did not document her findings nor is there any indication that these allegations were investigated further. FCR suggest [sic] that County follow up on these allegations as soon as possible and advised [sic] the grandmother regarding agency policy on corporal [sic] punishment.” (emphasis in original). As of June 1, 2005, MDHS failed to document any follow up on either the allegations or on reviewing with the grandmother agency policy forbidding corporal punishment.
I. MDHS Fails to Protect Children from Further Abuse or Neglect while on Trial Reunification Visits While Still in Custody and From Re-entry into Foster Care Due to Further Abuse or Neglect after Being Discharged from Foster Care.

The trauma children suffer as a result of being removed from their homes due to abuse and neglect occurs again, and is exacerbated, if while still in custody a child is placed with his or her family for a trial reunification visit and is further abused and/or neglected and then returned to placement, or if a child is discharged from custody to his or her family, is further abused and/or neglected, and subsequently re-enters foster care one or more times. Therefore, the literature (Davis, English, & Landsverk 1993; Festinger 1994; Hess, Folaron, & Jefferson 1992; Pine, Warsh, & Maluccio 1993) documents the great care with which family reunification and placement discharge to other permanent caregivers must be planned, implemented, monitored, and supported through appropriate services. Although all unsuccessful trial reunification visits and re-entries cannot be predicted or prevented, many occur due to poor assessment regarding the parent’s and the child’s readiness for a trial reunification visit or for the child’s discharge, and/or due to agency failure to provide adequate monitoring and supportive services (Festinger 1994; Hess, Folaron, & Jefferson 1992).

Information was collected concerning placement changes for children who were moved at least once during their most recent stay in custody.

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**Case Example #18**

In March 2002, 12-year-old Sheri entered MDHS custody due to sexual abuse. Following a failed trial reunification with her mother and placement in an emergency shelter, she was moved to a foster home in September 2002. Within three months, Sheri was one of three foster children named as victims in an investigation of alleged emotional abuse/neglect in the home; a fourth foster child, Peter, was alleged to have been physically abused.

Separate interviews with each foster parent, with the principal at Peter’s school, and with Peter’s grandmother all confirmed that a MDHS Lamar County social worker had approved corporal punishment as a discipline method for Peter: “Just don’t leave anyu [sic] bruises.” After the foster parents agreed to stop using corporal punishment on the foster children in their home, the foster mother left Peter at the DHS office in February 2003 saying “Here he is, take him.” Sheri was left in the home.
5.0% of these children in MDHS custody had at least one placement change that occurred when the child was returned to placement from an unsuccessful trial reunification visit due to abuse and/or neglect that occurred during the extended visit.

Case Example #19

In December 2001, 14-year-old Shanika was placed in MHDS custody after refusing to return to her grandparents’ home—where she lived due to her father’s incarceration and her mother’s lack of involvement—stating that her grandfather frequently yelled at her. With the goal of reunification, her grandparents agreed in January 2002 to twice-monthly family counseling, but by early May they missed a required session. Shortly thereafter, Shanika expressed “mixed feelings” about returning to her grandparents’ home, yet no attempt to discuss Shanika’s concerns was documented. Even after the grandparents then missed a second counseling appointment, the social worker recommended that Shanika be returned to her grandparents’ home for a three-month-long trial reunification. No visit was documented either to the grandparents’ home or to Shanika’s placement to assess readiness for reunification, and no service other than sporadic counseling was set up to support reunification, during the entire five months prior to the trial reunification.

Once the trial reunification began in May 2002, MDHS again failed to provide even minimal services to Shanika and her grandparents and, in so doing, failed to identify a number of obvious risks to Shanika’s safety. In the first seven weeks of the trial reunification visit, the MDHS social worker had no contact with Shanika’s grandfather and only one phone call, and one brief office visit with Shanika’s grandmother. In the first fourteen weeks, the MDHS worker had no private contact with Shanika to assess her safety, well-being, and service needs, even after a call from Shanika’s counselor alerting the worker to Shanika’s “very unsafe working conditions.” In late August, Shanika disclosed several violent incidents in which the grandfather physically abused the girls and threatened to kill Shanika, as well as the fact that her grandfather had required her to continue working in an unsafe factory even after the grandmother had promised MDHS that such work would stop. Following these alarming disclosures, Shanika was required by MDHS to remain in this volatile and dangerous situation for six more days before being moved: “[Shanika] agreed to not say anything [about the impending move] and make it through the weekend.” Shanika remains in custody, no investigation was ever conducted, and her social worker has only visited her once in the two-year period prior to June 1, 2005.

Documentation in children’s case records also indicated that some children who were abused and/or neglected while on a trial reunification visit continued to be placed there by MDHS.
In addition, information collected regarding children’s re-entries into custody following discharge from custody reveals that:

- 24.3% of the children in MDHS custody had experienced at least one previous discharge and re-entry into custody after further abuse and/or neglect.

Discussion

According to Roget’s Thesaurus (1978), the word custody has a number of synonyms, among them detention, incarceration, guardianship, care, safekeeping, and protection. Custody and care can be synonymous. In discussions regarding foster children, the phrase “in care” is often used interchangeably with “in custody.” An agency that actually provides care to foster children gives planful consistent attention to their basic and special needs, and the agency’s staff members go to great lengths to maintain stability in the children’s placements, to assure continuity in the children’s relationships with caregivers and social workers, to protect the children from further harm, and to document all of the children’s needs, services, and experiences. The findings regarding MDHS’s harmful placement practices confirm that the children and youth in MDHS custody are not “in care;” rather, the findings indicate that the children in MDHS custody receive little care. Instead, their months, years, and, in many instances, lifetimes in custody are marked by instability, discontinuity, arbitrariness, and maltreatment.

Instability. The overwhelming majority of children in this study have experienced unimaginable instability while in MDHS custody. It would be harmful enough to children if they were spending lengthy periods of time in custody living continuously in one stable foster family home while separated from
their families. However, the experience of the overwhelming majority of children in MDHS custody is anything but stable. The unconscionable number of placement changes that children are subjected to while in MDHS custody is inherently destructive. Children have been required to re-adjust to different placements on average almost 3 times per year – every four months – and as many as 57 times. As a consequence, large numbers of children have had repeated instability in their living situations and repeated separations in their relationships with their foster caregivers as well as in other significant relationships, such as those with teachers and friends.

**Discontinuity.** It is likely that children’s very frequent and numerous moves, lengthy stays in emergency placements, and other harms that occur in MDHS placements are exacerbated by the discontinuity of MDHS social workers and social work services. To illustrate, for social workers to effectively offer and provide services to prevent unnecessary placement changes and other harms in placement, they must be accessible to the children and caregivers assigned to them and current in their knowledge about them. Such current knowledge on the part of the child’s social worker is derived from regular frequent face-to-face contact with the child and the child’s caregivers. When MDHS staff members’ relationships with foster children and their caregivers are characterized by frequent turnover and coverage of caseloads by multiple and often untrained staff members, the necessary current familiarity with the needs and experiences of foster children and their caregivers cannot be achieved.

Continuity in social workers and in social work services is a prerequisite to providing care to children in custody – to monitoring children’s safety and well-being, intervening to prevent unnecessary moves, assessing and responding to children’s needs, supporting children’s caregivers in providing stable and appropriate placement services, steadily progressing toward permanency, and documenting fully the child’s needs, services, and experiences. When foster children’s relationships with the adults responsible for their service and protection are consistently characterized by discontinuity, children are inevitably endangered. Such is the case for the children in MDHS custody.

*It must be emphasized that when the MDHS social worker/supervisor -- the person(s) whose position is pivotal to the child’s protection and services -- fails to see children and their caregivers for months at a time or at all, children not only fail to be, but simply cannot be, protected and served. Face-to-face contacts with children and caregivers were made by constantly changing and frequently untrained MDHS staff members, creating confusion regarding which staff member has authority and responsibility for decisions regarding the child; superficial, erroneous, and often no communication; and lengthy delays as well as serious errors in the agency’s responses to children’s and caregiver’s needs, questions, and
requests. The multiple problems associated with MDHS staffing patterns inevitably result in arbitrary and harmful decisions regarding children’s services, placements, and permanency. It is abundantly evident that under these circumstances basic minimum social work responsibilities are not being effectively completed if at all.

**Arbitrariness.** According to the Child Welfare League of America practice standards (FC 1.1), foster care “should be a *planned, goal-directed service* in which the temporary protection and nurturing of children take place in the homes of agency-approved foster families” (emphasis added). Planned, goal-directed service requires accurate, timely, and complete information readily available to agency staff, court personnel, children’s caregivers, and community service providers. As documented in this section and throughout this report, children’s case records very frequently do not contain documentation regarding the reason for the child’s entry into custody, children’s service and placement needs, children’s placement changes, children’s permanency goals, and other essential information. Missing, incomplete, and inaccurate information in children’s case records inevitably results in decision-making that is arbitrary, and as a consequence flawed and potentially life-threatening to children.

Another finding regarding harmful placement practices is the extreme variability in services associated with the child’s county of responsibility. There are clearly patterns of placement services or lack of such services that vary by county; these variations result in much greater lengths of stay for children in some counties than in others; greater likelihood of experiencing child abuse, child neglect, and/or corporal punishment in some counties than in others; greater likelihood of frequent placement changes in some counties than in others; and other extreme variations documented throughout this report. Unfortunately, the findings indicate that *not one* of the nine counties selected for inclusion in this study provides adequate placement services to children in MDHS custody.

**Maltreatment.** Federal mandates, MDHS policy, and national practice standards are unequivocal in prohibiting that children in legal custody be subjected to harm. Therefore, it is of the utmost concern that many children have been maltreated while in MDHS custody, some of them repeatedly. For the majority of documented incidents of suspected foster caregiver maltreatment of children in MDHS custody, MDHS has failed to complete an investigation as mandated. In failing to do so, as well as in failing to change children’s placements when allegations of foster caregiver maltreatment are found to be Evidenced, MDHS has required that children remain essentially captive in harmful situations. In its consistent indifference to children’s and others’ documented allegations of maltreatment of foster children, MDHS has failed to protect the children in its custody from further *preventable* harms.
Corporal punishment is also against agency policy. As Gershoff (2002) stresses, corporal punishment is intended to cause children pain; therefore, the use of corporal punishment on children who have been maltreated prior to their entry into custody is rightly prohibited by MDHS. However, time and time again, case records document that MDHS social workers and other staff were aware that children were being subjected to the pain of corporal punishment and discounted this information.

Subjecting children who enter legal custody for their protection to caregiver maltreatment, including corporal punishment, is not only contrary to the law and agency policy, it is also inexcusable and inhumane. It is inexcusable because it is almost always preventable. It is inhumane because the damaging consequences of these experiences will affect children throughout their and their children’s lifetimes. Foster parents and placement facility staff can be carefully screened, trained, supported, and monitored closely by agency staff. MDHS must assure that, at the time of licensing and with each subsequent placement, caregivers have the temperament, knowledge, and skills to provide adequate safe care for the children placed with them. If children’s needs and caregivers’ capacities are assessed, children can be placed with caregivers who are willing and able to provide the appropriate level of care and manage their behaviors without resorting to maltreatment.

While the extent of maltreatment, including corporal punishment, in MDHS custody is of serious concern, it must be emphasized that it is reasonable to assume that due to the lack of documentation in children’s records, the lack of consistent and in some instances any face-to-face contact with children during the two year period prior to the case review, and the superficial or non-existent relationships between MDHS staff and the children assigned to them, many additional children maltreated by their foster caregivers while in MDHS custody were not so identified in this review.
V. Medical and Mental Health Needs and Services

Key findings:

- MDHS fails to provide and document required medical, dental, and mental health evaluations and care.

- MDHS fails to provide children’s health information to their foster caregivers.

- MDHS fails to provide reasonable and appropriate mental health services, including appropriate placements, to foster children with mental health conditions.

Foster children are placed at particular and serious risk to their health and development by the maltreatment that brings them into out-of-home placement, the experience of separation from family while in custody, and the often multiple placement changes that they are subjected to while in custody (Dore 2005; McCarthy & Woolverton 2005). Therefore, it is essential that foster children be provided timely and appropriate medical and mental health evaluations and treatment.

A. MDHS Fails to Provide and Document Required Medical, Dental, and Mental Health Evaluations and Care

Federal law requires states to ensure that foster children receive adequate services to meet their physical and mental health needs (45 C.F.R. § 1355.34(b)(iii)(C)) and to maintain children’s health records in the child’s agency file (42 U.S.C. § 675(1)). State policy (3216, 3350) is consistent with these mandates in its requirements concerning medical and mental health services at the time of entry, requiring a physical exam within 7 days of the child’s entry into custody; a dental exam for children ages 3 and older within 90 days of placement; and a psychological assessment within 90 days of custody for children ages 4 and older.

Although agency policy (3351-3355) provides specific directives regarding medical, dental, and mental health exams/evaluations at the time of entry, infant medical check-ups, early intervention services for infants and toddlers with special needs, and the schedule for children’s immunizations, agency policy regarding foster children’s ongoing health, dental, and mental health care lacks sufficient specific directives, stating (3350) only that when a child is placed in custody, the agency “assumes the responsibility for securing the child’s access to medical, dental, psychological and educational services” and (3350) that “documentation of
For all children entering foster care, national practice standards (COA S21.5.01, S21.5.02; CWLA FC 263, HC 2.6) require that comprehensive medical, dental, mental health, and developmental assessments are to take place within 30 days of placement. CWLA standards (FC 2.63) direct that in such assessments “Specific attention should be given to [the child’s] general health status, immunizations, mental health and emotional well-being, alcohol and substance use/abuse, and developmental delays and disabilities.” COA standards (S21.5.01) also direct that an assessment of the need for age-appropriate immunizations as well as “hearing, vision, and lead-exposure screenings” be completed within 30 days. With regard to ongoing health care, the protocols of the American Academy of Pediatrics should be followed (CWLA HC 2.6), including at minimum an annual physical exam.

Practice standards also require that the agency “ensures that the child receives all necessary mental and physical health services” (COA S21.5) and that social workers “collaborate with the foster family to arrange for and use available resources and advocate for additional resources, when necessary, so that the children in family foster care receive the medical, dental, psychological, developmental, and educational services they need” (CWLA FC 2.64). These services should include preventive health services (CWLA HC 3.1); routine dental, eye, and ear exams and treatment (CWLA HC 3.2); psychiatric and psychological services (CWLA HC 3.3, 3.4); emergency and specialized health care (CWLA HC 3.5, 3.6, 3.7); and specialized health and mental health services for adolescents and for children who are chronically ill or who have special needs (CWLA HC 3.8, 3.9).

Health Information in the Child’s Individualized Service Plan (ISP). Federal law mandates that, for a state to be eligible to receive federal foster care funds, the state must ensure that all foster children on whose behalf the state receives such funds has an individualized case plan. (42 U.S.C. § 671(a)(16)). Among other items, the case plan must include “the health records of the child, including immunizations, medications....” (42 U.S.C. § 675(1)). Agency policy (3288, 9007) similarly requires that the child’s Individualized Service Plan (ISP) must include the child’s health record (including the most recent psychological evaluation and results) and immunization record. Practice standards also require the agency to maintain well-documented records on the health status and health care of all children in its care (CWLA FC 2.66; COA S21.5.03).

For all children whose files were reviewed, due to serious problems with
the MACWIS\textsuperscript{11} printing of child’s ISPs as described in Section VII, the ISPs provided by MDHS for the case review failed to contain reliable information regarding children’s health and emotional/psychological status and services. Therefore, the degree to which children’s health and emotional/psychological information was included in the children’s ISPs could not be determined.

For 40.0% of the children, no health or mental health information was included on the child’s initial ISP because such an ISP was not completed within 90 days of placement.

**Physical exam within 7 days of placement.** Information was collected to determine the provision of physical exams at the time of entry for children who entered custody on or after June 1, 2003. Such an exam is critical to immediately identify the health needs of the child and to document the status of his or her health at the time of entry.

- MDHS failed to provide the overwhelming majority (84.1%) of children a physical exam as required within 7 days of placement.

- MDHS failed to provide such an exam to 90.8% of the children ages 6-12 and 84.9% of those ages 13 and older.

- More than three-quarters (76.5%) of the youngest group, infants to children 5 years old, failed to receive the required physical exam within 7 days of entering custody.

- 71.5% of the infants less than one year of age failed to receive a medical exam within 7 days of placement.

- When examined by county, wide variation was found in the provision of children’s physical exams as required at time of entry. Harrison County provided only 4.0% of its children entering custody on or after June 1, 2003, the required exam within 7 days, while Humphreys County provided all (100.0%) such children a physical exam within 7 days.

**Annual physical exam.** The American Academy of Pediatrics (2002) standard is for foster children to receive physical exams at least every 6 months through adolescence. For children who had been in custody at least one year as of June 1, 2005, information was collected to determine whether at least an annual physical examination was documented in the child’s case record in the 24 months prior to June 1, 2005.

\textsuperscript{11} Mississippi Automated Child Welfare Information System
• MHDS failed to provide any annual physical exam for 28.2% of the children during the two years prior to June 1, 2005.

• For those children who were provided an exam during this two-year period, almost two-thirds (63.0%) received only one. Two exams were received by 28.3%, and 8.5% received 3 or more exams.

• Almost one-third (32.4%) of the youngest foster children (ages 0-5) in custody for at least one year—those for whom multiple immunizations are required, numerous developmental milestones occur, and medical problems can be particularly serious—failed to receive even one physical exam during the two years prior to June 1, 2005.

• MDHS failed to provide more than one quarter (26.1%) of the children 6-12 and 29.5% of those 13+ a physical exam during the 24 months prior to June 1, 2005.

• When examined by county, during the 24 months prior to June 1, 2005, the mean percentage of children in custody for at least one year for whom MDHS provided at least one physical exam ranged from less than one-half (49.1% Yazoo) to 92.9% (Humphreys).

**Case Example #21**

Two-year-old Charlie was placed in MDHS custody in March 2004 due to medical neglect. Despite unmet medical needs sufficiently grave to warrant Charlie’s entry into custody, MDHS failed to provide him with either a physical or dental exam during his 15 months in custody as of June 1, 2005.

**Dental exams within 90 days of placement.** For children ages 3 and older who entered custody on or after June 1, 2003, information was also collected to determine the provision of dental exams within 90 days of entry as required by the agency.

• Eighty-one percent (80.8%) of the children for whom this requirement was applicable were not provided the required dental exam within 90 days of placement.

• When the findings are examined by age group, 79.5% of the youngest age group (3 to 5 years) failed to receive such an exam.

• Not one of the three year olds was provided the required dental exam within 90 days of placement; 90.0% of the four year olds failed to receive such an
exam.

• MDHS failed to provide a dental exam as required within 3 months of entry for 79.0% of 6-12 year olds and for 83.9% of the children ages 13 and older.

• When examined by county, wide variation was found in the provision of the required dental exams to children within 90 days of placement entry, ranging from only one child in twenty or fewer (5.1%, Harrison; 3.7%, Yazoo) to only two-thirds (66.7%, Jefferson).

**Annual dental exam.** Current dental healthcare standards are for dental exams to be provided two times a year beginning at age one (American Academy of Pediatric Dentistry, 2006; Green & Palfrey, 2002). Information was collected for children ages 3 and older who had been in custody at least one year as of June 1, 2005, to determine whether at least one dental examination was documented in the 24 months prior to June 1, 2005.

• MHDS failed to provide even one dental exam for 42.2% of the children ages 3 and older during the two-year period prior to June 1, 2005.

• MDHS failed to provide even one dental exam to 62.2% of the foster children ages 3-5 in custody one year or more—those for whom early childhood neglect greatly affects dental health—during the two years prior to June 1, 2005

• MDHS failed to provide even one dental exam to more than one-third (35.1%) of the 6-12 year olds and 47.8% of the adolescents during the 24 months prior to June 1, 2005.

• When examined by county, the percentage of children ages 3 and older who had been in custody for at least one year for whom MDHS provided at least one exam during the 24 months prior to June 1, 2005, ranged from only 42.0% (Yazoo) to 100.0% (Jefferson).

**Immunizations.** MDHS policy (3355) also requires that immunization records must be kept in the child’s file. Information was collected to determine

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**Case Example #22**

In December 2004, fifteen-year-old Marina was placed in MDHS custody due to evidenced sexual and emotional abuse. There are no case notes for her first 3 months in custody, and there is no documentation of either a medical or dental exam in the six months between her entrance into custody and June 1, 2005.
whether any record of immunizations was contained in the children’s case files.

- The case files of 13.7% of the children failed to contain any record of immunizations.

  Case Example #23
  
  A letter dated February 2005 from an emergency shelter to a MDHS County of Responsibility lists four foster children in the shelter, each of whom is missing immunization records and a court order; in addition, for each child either an insurance card, social security card, and/or a signature on an application was also missing.

- When examined by age group, MDHS’ failure to maintain immunization records in the child’s record is greatest for the youngest children, ages 0-5 (17.4%) as compared with those 6-12 (12.1%) or those 13+ (11.8%).

- Within the 0-5 age group, 33.6% of the 2 year olds failed to have immunization records in their case files.

- When examined by county, the percentage of children with immunization records in their files ranged from only 57.1% in Yazoo County to all of the children (100.0%) in DeSoto, Humphreys, Jefferson, and Pontotoc counties.

B. MDHS Fails to Provide Children’s Health Information to their Foster Caregivers

In accordance with federal law, agency policy requires that information about the child’s health and medical needs be provided to the child’s caregiver at the time of placement. (42 U.S.C. § 675(5)(D)). MDHS policy (3234) requires that prior to placement, the social worker should provide foster parents or licensed child caring facility staff the child’s current medical, dental health, educational, and psychological information. Agency policy (3238) requires the social worker to take a copy of the child’s Medicaid card to the child’s caregiver on the actual date of placement.

Information was collected for children entering MDHS custody on or after June 1, 2003, to determine whether at the time of entry the child’s health records and the child’s Medicaid card were given to the family or facility with whom the child was placed.

- For 89.4% of the children entering custody on or after June 1, 2003, MDHS failed to provide the child’s health records to the child’s caregiver (family or facility) at that time.
• For 88.1% of the youngest children (ages 0-5), those almost wholly unable to provide health care information themselves to their caregivers, MDHS failed to provide health records to their caregivers.

• MDHS failed to provide health records to caregivers of 87.2% of the children ages 6-12 and to almost all (95.0%) caregivers of adolescents (13+).

• The counties’ provision of health care records to caregivers ranged from only 6.0% or fewer (Yazoo 6.1%; Forrest 4.3%; Harrison 3.8%) to only one-half (50.0% Clarke).

For 84.9% of the children who entered custody on or after June 1, 2003, the child’s Medicaid card was not provided to the foster caregiver (family or facility) at the time of entry.

• Counties’ provision of children’s Medicaid cards to caregivers at entry ranged from none (0.0% DeSoto) to only 70.0% (Clarke).

C. MDHS Fails to Provide Reasonable and Appropriate Mental Health Services, Including Appropriate Placements, to Foster Children with Mental Health Conditions.

Psychological assessment within 90 days of entering custody. Children who enter foster care are at particularly high risk for mental health problems associated with the neglect and/or abuse to which they have been subjected (Dore 2005:150). A psychological evaluation that permits early identification of these problems is essential to assure that foster children are provided the appropriate level of placement and needed mental health treatment.

MDHS policy (3350) requires that all children ages 4 and older should have a psychological assessment within 90 days of entering custody. The American Academy of Pediatrics (2002) standard is for foster children to receive reassessments of their development and emotional status at least every 6 months through adolescence. National practice standards (CWLA HC 2.6) require that a standardized diagnostic mental health assessment be completed within 30 days of placement by a qualified mental health practitioner (CWLA HC 2.7). COA
(S21.5.02) standards require a mental health assessment within 30 days after entry.

- For more than one-half (57.7%) of the children ages 4 and older entering custody on or after June 1, 2003, MDHS failed to provide a psychological assessment as required within 90 days of entering custody.

- MDHS failed to provide any of the 4 and 5 year olds a psychological assessment within the required time frame.

- More than one-half (56.6%) of the 6-12 year old children and 50.6% of the adolescents (13+) were not provided such an assessment within 90 days of placement.

- When examined by county, provision of a psychological assessment within 90 days of placement as required ranged from only 25.0% (Clarke) to provision to all children to whom the requirement applied (100.0% Jefferson).

**Evaluation for mental illnesses or developmental disorders while in MDHS custody.** Less than two-thirds (64.5%) of all children had documentation of an evaluation for mental illnesses or developmental disorders while in MDHS custody.

- No evaluation for mental illnesses or developmental disorders while in MDHS custody was found for 69.1% of the children ages 4 and 5; in two counties (DeSoto and Harrison), none of the 4 and 5 years olds had been provided such evaluations.

- No evaluation for mental illnesses or development disorders while in MDHS custody was found for 21.8% of the children ages 6-12 and for 14.6% of those 13 and older.

**Diagnosed mental illness or developmental disorder requiring further assessment.** For those children for whom an evaluation for mental illness or developmental disorders had been provided while in MDHS custody, information was collected to determine whether a medical or mental health provider had identified a mental illness or developmental disorder that required further assessment.

The case files of 9.5% of the children documented the identification of a mental illness or developmental disorder for which further assessment was recommended. The developmental disorders most frequently identified were
mental retardation, borderline MR, ADHD, depression/mood disorder, oppositional defiant disorder, and adjustment disorder. Almost one-half (48.2%) of the children for whom further assessment was recommended were 0-5 years of age; 17.9% were 6-12; and 32.4% were 13 or older.

- For 50.0% of the children whose case files documented the identification of a mental illness or developmental disorder for which further assessment was recommended, MDHS failed to provide further assessment as recommended.

**Mental illness or developmental disorder diagnosed.** Eighty percent (80.3%) of the children whose files documented that an evaluation for mental illness or developmental disorder had been provided were diagnosed with such an illness or disorder. Of these, 7.4% were ages 0-5; 39.9% ages 6-12; and 52.7% 13+.

The most frequently diagnosed conditions are listed in Table 8 below.

Table 8. Most Frequent Conditions for Children with Diagnosed Mental Illness and/or Developmental Disorder and % of Children So Diagnosed

<table>
<thead>
<tr>
<th>Mental Illness / Developmental Disorder</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression or mood disorder</td>
<td>43.9</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>40.9</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>31.6</td>
</tr>
<tr>
<td>ADHD</td>
<td>28.7</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>20.0</td>
</tr>
<tr>
<td>Disruptive behavior/conduct disorder</td>
<td>18.1</td>
</tr>
<tr>
<td>Developmental disability/Mental retardation</td>
<td>16.5</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>13.9</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>8.0</td>
</tr>
</tbody>
</table>

*Percentages weighted. Many children had multiple diagnoses; therefore totals do not equal 100.0%.

**Diagnosed mental illness or developmental disorder requiring treatment and MDHS provision of treatment.** For 81.0% of those diagnosed with a mental illness or developmental disorder, a medical or mental health provider recommended a specific treatment other than medication\(^\text{12}\) for at least one diagnosis. For 61.1%, treatment was recommended for at least two diagnosed conditions.

\(^\text{12}\) Information collected regarding children’s treatment for mental illness/developmental disorders did not include treatment with psychotropic medication as this was not a medical review.
The mean number of diagnosed mental illnesses or developmental disorders per child for which treatment was recommended was 3.3, ranging from 1 to 12.

The specific mental health treatments that were most frequently recommended for the children varied by diagnosis, and included inpatient treatment, individual psychotherapy/clinical services/play therapy, family therapy, group psychotherapy, and others.

Information was collected to determine whether the specific treatment recommended for the child’s condition was ever provided during the 24-month period prior to June 1, 2005. Those children for whom a medical/mental health provider determined that treatment was no longer needed were excluded from the analysis. Table 9 presents the percentage of children with each diagnosed condition for whom treatment was recommended but MDHS failed to provide it during the 24-month period prior to June 1, 2005.

Table 9. Most Frequently Diagnosed Mental Illnesses and Developmental Disorders and % of Children for whom MDHS Failed to Provide Recommended Treatment during 24-Month Period Prior to June 1, 2005

<table>
<thead>
<tr>
<th>Mental Illness / Developmental Disorder for which Treatment Was Recommended</th>
<th>%* of Children for whom Treatment Was Recommended for whom MDHS Failed to Provide Recommended Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>72.0</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>50.0</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>43.8</td>
</tr>
<tr>
<td>Developmental disability/Mental retardation/borderline MR</td>
<td>36.9</td>
</tr>
<tr>
<td>Depression or mood disorder</td>
<td>36.6</td>
</tr>
<tr>
<td>ADHD</td>
<td>31.0</td>
</tr>
<tr>
<td>Disruptive behavior/conduct disorder</td>
<td>23.3</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>15.5</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>5.4</td>
</tr>
</tbody>
</table>

*Percentages weighted. Many children had multiple diagnoses; therefore, totals do not equal 100%.
For the majority of diagnostic categories, more than one-third (ranging from 36.6% to 72.0%) of the children diagnosed with mental illnesses or developmental disorders were never provided the recommended treatment during this 24-month period prior to June 1, 2005.

In 21.0% of the instances in which inpatient treatment was specifically recommended for a child, such treatment was not provided during the 24-month period prior to June 1, 2005.

Information was also collected to determine whether as of June 1, 2005, children who continued to need the specific recommended treatment were receiving it. Those for whom a medical/mental health provider determined that treatment for the condition was no longer needed were excluded from the analysis. Table 10 presents the most frequently diagnosed mental illnesses and developmental disorders for which children continued to need the recommended treatment for the condition as of June 1, 2005, and the percentage of children for whom, as of the same date, MDHS was failing to provide the recommended and needed services for the conditions.

Table 10. Most Frequently Diagnosed Mental Illness and/or Developmental Disorder for which Specific Treatment Still Recommended and Needed and % of Children MDHS Was Failing to Provide Recommended Treatment as of June 1, 2005

<table>
<thead>
<tr>
<th>Mental Illness/Developmental Disorder for which recommended treatment still needed as of June 1, 2005</th>
<th>%* of children for whom treatment recommended and needed but MDHS failing to provide rec. treatment as of June 1, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>92.3</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>69.2</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>60.8</td>
</tr>
<tr>
<td>Disruptive behavior/conduct disorder</td>
<td>58.3</td>
</tr>
<tr>
<td>Developmental disability/Mental retardation/borderline MR</td>
<td>54.0</td>
</tr>
<tr>
<td>Depression or mood disorder</td>
<td>52.3</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>51.9</td>
</tr>
<tr>
<td>ADHD</td>
<td>39.4</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>38.1</td>
</tr>
</tbody>
</table>

*Percentages weighted. Many children had multiple diagnoses; therefore, totals do not equal 100%.
In seven of the nine diagnostic categories, more than one-half (ranging from 51.9% to 92.3%) of the children with diagnosed mental illness(es) or developmental disorder(s) for whom treatment was recommended and still needed, were not being provided the recommended treatment as of June 1, 2005.

Children with behavioral problems. In addition to data on children with mental illnesses or diagnosed developmental disorders documented in their files, information was collected regarding children identified as having specific behaviors of concern to the social worker and/or caregiver (e.g., the child hurting other children, hurting her or himself, perpetrating sexual abuse, damaging or destroying property, carrying a weapon) within the two-year period prior to June 1, 2005.

- Forty percent (39.6%) of the children were identified in the child’s record as having behaviors of concern during the two-year period prior to June 1, 2005.
  - Of those, 14.8% had never been provided an evaluation for mental illness or developmental disorders while in MDHS custody despite the very serious nature of the concerns identified in those cases, including hurting other children, perpetrating sex abuse, damaging or destroying property, attempting suicide, carrying a weapon, masturbating in public, stealing property and/or food, and having serious emotional or behavior problems in school.

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**Case Example #25**

Margot was 13 and the mother of a 6-month old infant when she entered MDHS custody in 2000 after she was released from a treatment facility and her adoptive mother refused to take her back. Her history included sexual abuse at age 4, multiple psychiatric hospitalizations for serious mental illness, and a lack of supervision by her adoptive mother. Her court treatment referral by a psychiatrist recommended that Margot “be placed, as soon as possible into a long-term care setting.” Instead, Margot has been shuffled through 35 to 40 placements since entering custody, including at least 7 emergency shelters and other revolving-door placements in state and private psychiatric hospitals and residential treatment centers, detention centers, and foster family homes.

Although a July 2004 psychological evaluation recommended that Margot be placed in “a stable living environment, possibly a therapeutic group home placement,” MDHS staff members have clearly abdicated decision-making about Margot’s placements. October 2004 documentation states: “Worker asked where she was staying... [Margot responds] with Mimi and Gail Smith.” Seventeen days later, a case note reports that “Margot is now living with Ms. Jasper.” In January 2005, Margot called the worker to give her the name and address of her current residence; in April 2005, the file documents that Margot is living in a trailer park with a friend. As of June 1, 2005, Margot appears to be living with her sister.
Twenty-nine percent (29.3%) of the children had both one or more serious behavioral problems and one or more diagnosed mental health and/or developmental disorder identified in their record; 33.3% had either one or more serious behavioral problems or a diagnosis of a mental illness/developmental disorder; only 37.3% had neither.

**Foster care experiences of children with serious mental health needs.**

As indicated above, children with diagnosed mental illnesses or developmental disorders have special placement and treatment needs that should be addressed while in custody. They are also among the children most likely to be negatively affected by stresses within a foster home or placement facility and by placement instability.

Despite their vulnerability,

- A higher proportion (91.4%) of the sub-sample of children with diagnosed mental illness(es) and/or developmental disorder(s) were moved at least once during their most recent stay than were children generally (82.7%).

- Moreover, for children moved at least once, the sub-sample of children with these diagnosed conditions was subjected to an higher mean number of moves, 8.1, than were children generally, 5.8.

CASE EXAMPLE #26

Since her entry into MDHS custody in 1998, Tobie has endured more than 50 placements, including 5 placements totaling 161 days in the county jail. A January 2004 Notice of Change form states that Tobie was moved to the “jail to await bed for [the state hospital’s short-term psychiatric treatment facility].” Tobie stayed in jail for 18 days while waiting to be placed for treatment at the state hospital.

- A higher proportion (78.1%) of the children with a diagnosed mental illness or developmental disorder were placed in emergency placements than were children generally (62.6%).
In September 2003, 14-year-old Edward entered MDHS custody from the care of a relative due to Edward’s behavior. His April 2004 ISP documents that “Edward presents a number of mental problems. He is threatened [sic] and violent . . . Edward has a lot of issues with being present when his father shot his step mother that he is not dealing with...” A doctor concluded that Edward “need[s]...long term residential treatment.” Instead, MDHS shuffled this child with mental illness through 19 different placements in the 20 months between his entry into MDHS custody and June 1, 2005, including placements totally inappropriate to his serious mental health needs, such as county shelters, detention centers, and relative and non-relative foster homes.

Case notes from 2004 document MDHS’s chaotic placement process:

**May 14:** ASWS and I went to [county DHS] to pick Edward from hospital and transported him back to Jefferson County. We were unable to find a placement [sic] for him, [sheriff] transported him to detention in [another county].

**May 17:** I assist SWA in picked up Edward from [county detention center] and placed him with his aunt.

**June 2:** Worker stated she received a call from [contract agency]. They want her to bring Edward to TN. Good but we don’t know where he is . . . He is not on his medication and who knows what he is doing in the streets . . .

On his supervisor’s instructions, Edward’s caseworker then asked the judge to relieve MDHS of custody of the child “because we do not know where this child is and something may happen to him or he may do something and we will be held liable for him.” A later case note indicates “[detention center] could not hold him no longer than 6 hours...we had ran out of placement...I was very desperate because I knew that there was no place for us to place Edward so I asked [the judge] if he could call the shelter and see if they would keep Edward until morning and he told [me] that he could not do that because the judge is firm on the rules...Someone from the detention center called me to tell me that Edward wanted to know if I had forgotten him. I told him to tell Edward that we was looking for a place for him to go.” (emphasis added).

Placement in settings that do not correspond with the level of care required by the child’s special needs. When children enter out-of-home care, the public agency is responsible for identifying a placement with caregivers that are fully prepared to meet not only the child’s basic needs but also his or her special needs. Depending on the nature and extent of children’s special needs, their needs may be met through placement in a relative or non-relative foster family home. Some children’s special needs, including diagnosed mental illness, may require more specialized foster family placements, such as a therapeutic or medical foster family home, or the intensive services and structure provided by a group home or residential treatment setting.

To determine the level of care provided in children’s placements as of May 1, 2005, information was collected regarding the child’s Notice of Change Form. A thirty-day period prior to June 1, 2005, was selected to provide adequate time for the form’s completion and inclusion in the child’s case record. For 44.2% of the children, the case record failed to contain this required form. Of the children
Ten-year-old Owen was placed in custody in December 2002 due to physical abuse. He had at least nine placements prior to June 1, 2005, including an emergency psychiatric admission, several emergency shelter placements, and a placement in detention following his out-of-control behaviors in an emergency shelter. A January 2003 psychological evaluation conducted following an emergency psychiatric admission confirms a prior evaluator’s conclusion that an “emergent psychosis is a strong possibility,” with a primary treatment recommendation of “long-term psychiatric residential placement.” Only one Notice of Change Form was found in his record. That form, which was signed by a social worker, indicated that he was removed from MDHS custody in December 2004, even though Owen’s January 2005 ISP confirms that he remains in MDHS custody at home on a trial reunification visit.

For those children with identified board rates on the Notice of Change Form, almost two-thirds (63.7%) had a regular board rate; 11.4% had an emergency shelter rate. Only 24.9% had a therapeutic/medical/emergency foster home rate, which (due to missing forms and board rate information) is only 5.4% of the children.

Thus, despite the behavioral, developmental, and emotional problems documented in this section for the majority of the children, only 5.4% of the children were placed in settings with a documented therapeutic/medical/emergency foster home rate as of May 1, 2005.

A similarly low percentage of placements in therapeutic settings is documented as of June 1, 2005:

- Despite their diagnosed conditions, 83.4% of the children with mental illness or developmental disorder(s) who were placed with foster families were placed in a non-specialized foster home placement as of June 1, 2005.

- More than one-quarter (25.7%) of the children with these diagnosed conditions who were placed with foster families as of June 1, 2005, were placed with non-licensed relatives.
The consistent failure to place children in settings that correspond with the level of care required by the child’s special needs is further confirmed by the high percentage of placement changes for which the documented reason for the change related to the child’s mental health or behavioral needs/difficulties and/or the unmet need for a different level of care. As reported in Section IV,

- For 45.7% of the children’s placement moves, a documented reason included behavioral, emotional, or developmental problems that could not be managed in the child’s placement as follows: In 13.0% a medical/mental health provider recommended the move and/or the child needed a diagnostic evaluation; in 12.9% the child needed a different level of care; in 12.6% the child’s caregiver requested the move due to the child’s behavior; and in 7.2%, the placement change occurred because the child’s behavior presented a danger to the child or to others.

Discussion

Federal law, agency policy, and national practice standards stress the importance of determining and documenting children’s medical, dental, and psychological status at the time of placement in order to identify the appropriate level of care for the child’s placement and the health and mental health services needed by the child. For the overwhelming majority of children who entered custody on or after June 1, 2003, MDHS failed to adhere to these very basic standards of care.

The extent of the indifference to children’s health and mental health needs at the critical point of entry into custody is staggering. National practice standards require dental and psychological assessments within 30 days of placement; even with the additional 60 days permitted by MDHS policy to complete these assessments, the agency was either unwilling or unable to comply with this very basic directive. Without such assessments, children’s health and mental health needs cannot be addressed by their caregivers or considered in selecting the appropriate level of care for children’s placements.

Such failure is similarly found with regard to MDHS’ provision of ongoing health care for children in custody. As noted previously, agency policy regarding foster children’s ongoing health and dental care lacks sufficient specific directives. However, the minimum level of care expected of a child’s parents to such vulnerable children might be applicable: at least one physical and one dental exam annually, which MDHS did not consistently provide.

It is particularly alarming that the very youngest children in MDHS custody, those whose growth and development is most vulnerable to the effects of
undiagnosed and untreated medical problems, are as, and in some instances more, neglected than are the older children in custody. It is critical that the agency responsible for children in custody assures that throughout children’s stay in custody their placement and service needs are fully identified, understood, and immediately addressed. Therefore, neglecting to obtain medical and health care information for these very young children not only within the first 30 days in placement but for periods as long as two years is serious and potentially life-threatening.

MDHS has also significantly failed the children in its custody in the area of mental health services, even when children were diagnosed with a mental illness or developmental disorder. In addition, children in MDHS custody who were diagnosed with mental illness(es) and/or developmental disorder(s) were much more frequently subjected to multiple harms in placement than children not so diagnosed, including frequent placement changes and lengthy and repeated stays in emergency placements. That as of May 1, 2005, the overwhelming majority of children so diagnosed (94.6%) were placed in non-specialized placements is likely a major contributing factor to the children’s placement instability. The study findings clearly indicate that many of these children either are not placed in an appropriate level of care and/or that the children and their caregivers are not receiving adequate services to support the placement. Neither is acceptable.

The difficulties of caring for children with special needs can only be addressed by caregivers who have the temperament, knowledge, skills, and agency support to provide the appropriate level of care. MDHS, however, fails to regularly visit children and their caretakers as reported in section IV. It is evident that MDHS has not only failed to identify or develop sufficient appropriate placements with varying levels of care for children with diagnosed mental illness and/or developmental disorders, but it has also failed to support foster caregivers in caring for children with complicated and demanding special needs.

**Case Example #29**

4-year-old Louise and her 6-year-old brother Chris were placed together in May 2003 due to neglect. Shortly after placement, the foster parent stated that “Louise and Chris act out inappropriately by touching... one another.” Soon thereafter Chris was placed in a psychiatric unit for an evaluation. Two weeks later he was returned to the same foster home, and “was caught in a sexual position with his sister.” Four months later Chris was still sexually aggressive towards his sister, and the foster parent reported that she “cannot leave him unattended anytime his sister is around. [She] says she is ready to let someone else take on Chris.” Twenty months later, MDHS has failed to place Chris elsewhere, and his history of sexual assaults on his sister has not been addressed.
VI. Education and Schooling of Foster Children While in MDHS Custody

Key findings:

- MDHS fails to include basic educational information in foster children’s case files.
- MDHS fails to provide foster children’s school records to their foster parents or other caregivers.
- MDHS fails to ensure that children are enrolled in school when they enter custody.
- MDHS forces children to change schools frequently due to multiple moves among foster care placements.
- MDHS fails to provide access to special education services for foster children with special education needs.
- MDHS fails to identify further education in the plans for older teens in custody.

Even for children growing up in supportive families and communities, the transition to adult roles and responsibilities can be challenging. Educational attainment is a strong predictor of adolescent well-being and adult functioning and self-sufficiency (Elze, Auslander, Stiffman, & McMillen 2005:186). Therefore it is critical that foster children and youth be provided support and services to complete high school and continue their education or training to prepare for a competitive job market.

A. MDHS Fails to Include Basic Educational Information in Foster Children’s Case Files

Federal regulations require that states assure that “Children [in state custody] receive appropriate services to meet their educational needs” (45 C.F.R. § 1355.34(a)(iii)(B)) and further require that the child’s educational records and extensive educational information be included in the case plan (42 U.S.C. § 675(1)(C)). Consistent with federal law, agency policy (3288) requires that the child’s case plan (ISP) include “Educational Information” and that MACWIS (3356) include “Information of schools attended, grade level achieved, IEP rulings and other educational information.”

The protocol was designed to collect information from the case files of the
school-aged children to determine the inclusion of educational information in the child’s ISP. However, for all children whose files were reviewed, due to serious problems with the MACWIS printing of children’s ISPs as described in Section VII, the ISPs provided by MDHS for the case review failed to contain reliable information regarding children’s educational status and school attendance. Therefore, information regarding the degree to which children’s educational information was included in the children’s ISPs could not be collected and analyzed.

However, for all children who entered placement on or after June 1, 2003, information was available to determine whether the child’s initial ISP was completed within 90 days of placement. For 48.1% of the school-aged children who entered custody on or after June 1, 2003, no educational information was included within 90 days of placement on the child’s initial ISP because such an ISP was not completed.

For school-aged (6 years through 17) children whose most recent entry into custody was on or after June 1, 2003, information was collected to determine the child’s educational status at the time of the most recent entry. Of these school-aged children, 90.9% were enrolled in kindergarten through high school. The children’s educational status is presented in Figure 15.

Figure 15. Educational Status of School-aged Children in MDHS Custody

![Educational Status of School-aged Children in MDHS Custody](image)

Information was collected regarding children’s school and school attendance during their most recent entry for children entering custody on or after June 1, 2003 who were ages 6-17 at the time of their most recent entry into MDHS
custody or who attained ages 6-17 during the 24 months prior to June 1, 2003.

- For 22.0%, the children’s file failed to contain any information regarding the child’s school and/or school attendance. For the majority of children whose files contained any information about children’s school enrollment and attendance, the information was very incomplete.

B. MDHS Fails to Provide Foster Children’s School Records to their Foster Parents or Other Caregivers

In order for foster caregivers to provide for children’s educational needs, they need accurate information regarding the children’s educational status. Agency policy (3234) requires that information about “education (grade level, past grades, attendance patterns, tutoring needs, educational expectations, achievements)” be provided to foster parents and other caregivers prior to the child’s placement. Practice standards (COAS21.4.05; CWLA FC 2.64) require that the agency and foster family collaborate to meet children’s educational needs.

Information was collected for the school-aged children whose most recent entry occurred on or after June 1, 2003 to determine whether the agency provided the child’s school records to the family or facility with whom the child was placed.

- For 78.8% of the school-aged children who entered custody on or after June 1, 2003, MDHS failed to provide school records to their foster caregiver (family or facility) at the time of placement.

- When examined by county, the percentage of children’s caregivers who were provided school records ranged from only 3.8% (Yazoo) to only 80.0% (Clarke).

C. MDHS Fails to Ensure That Children Are Enrolled in School when They Enter Custody

Federal regulations require that states assure that “Children [in state custody] receive appropriate services to meet their educational needs” (45 C.F.R. § 1355.34(a)(iii)(B)). MDHS policy (3355-3356) requires that the educational needs of children in custody are met as follows: All school-aged children shall have educational achievements appropriate to their abilities and must be enrolled in an accredited school or an approved educational program. The Social Worker shall keep current documentation on the child’s grade level and areas of achievement and areas of improvement; obtain needed tutorial programs and other enrichment programs based on the child’s educational needs; shall make sure that the child’s school records follow the child to the appropriate school as placements change;
shall attend and actively participate in IEP meetings and advocate for appropriate services for the child. Copies of report cards, IEP rulings, and current information on school enrollment and attendance and grade level achievement must be kept in the case record of the child.

National practice standards (CWLA FC 2.71; COA S21.4.04.c) require that school-age foster children be enrolled in school. Standards (CWLA FC 2.71-2.73, 2.63-2.64) further require that all children in care be provided educational assessments and services, receive the education most appropriate to their needs, including special education, attend school full-time, receive supplementary educational support as necessary, and be helped to achieve the maximum level of formal education they are capable of attaining. COA standards (S21.4.05) require that the agency work with caregivers, schools, and other relevant stakeholders to “help the child achieve his/her full educational potential.”

For school-aged children who entered custody on or after June 1, 2003, information was collected to determine school enrollment and attendance for the 24 months prior to June 1, 2005.

- 58.4% of the children did not remain in the school they attended prior to their most recent entry into MDHS custody.
- Of the children who changed schools at the time of entry into MDHS custody, 63.6% had no information in their files regarding school enrollment following entry into custody.
- Of the children who changed schools at entry into custody with information in their files regarding school enrollment following entry, 40.4% missed more than one week of school because they were not enrolled in school after entry into MHDS custody, ranging from 10 to 90 days.

**D. MDHS Forces Children to Change Schools Frequently Due to Multiple Moves among Foster Care Placements**

Federal law requires that children’s foster care placement take into account proximity to the school in which the child is enrolled at the time of placement (42 U.S.C. § 675(1)(C)(iv)). Mississippi policy (3231) is more general, stating that in selecting the most suitable placement “among the child related factors often considered are . . . the medical, education and developmental needs of the child.”

Information was collected from the files of school age foster children in the study whose most recent entry occurred between June 1, 2003 and June 1, 2005, and whose files contained any information regarding movement from one school
to another while in custody. Of those with such information,

- 61.9% of the children did not remain in the same school from the date of entry into custody (on or after June 1, 2003) through May 31, 2005.

For those with school changes and for whom information was available, information regarding school changes was collected for up to four school changes per child. As depicted in Table 11,

- 9.1% of the school-aged foster children entering custody on or after June 1, 2003, changed schools at least four times during their most recent stay in custody.

Table 11. For Children Entering Custody on or after June 1, 2003 and Changing Schools at Least One Time, % of Children with Number of School Changes

<table>
<thead>
<tr>
<th>Number of School Changes</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>67.2</td>
</tr>
<tr>
<td>2</td>
<td>23.2</td>
</tr>
<tr>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>4</td>
<td>9.1</td>
</tr>
</tbody>
</table>

*Percentages weighted.

- For 9.0% of the children’s documented school changes during their most recent stay in MDHS custody, no reason was documented in the case record.

- Notably, 78.3% of the children’s documented school changes while in custody were due to MDHS moving the child to another out-of-home placement; 3.7% occurred when the child completed the last grade in the school in which he or she was enrolled. Two percent (2.0%) of the documented school changes were due to the child’s request for the change, and other reasons were identified for 6.7%.

- For three-quarters (74.6%) of the children’s documented school changes while in MDHS custody,

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Case Example #30

Tobie entered MDHS custody in April 1998 due to physical and sexual abuse by her father. As of June 1, 2005, Tobie has been subjected to an average of slightly more than 8 moves per year. An ISP states: “Child is losing ground with her progress in her education due to being constantly moved from one treatment center to another in the last two years. . . . she is not in the proper grade for her age.”
no information was available in the child’s case record regarding school enrollment following the change.

- In 42.1% of the documented school changes for which information regarding enrollment was available, delays in the children’s enrollment in the new school ranged from 2 to 90 days.

### E. MDHS Fails to Provide Access to Special Education Services for Foster Children with Special Education Needs

Research indicates that a substantial proportion of foster children have special education needs. Studies suggest that between 30% and 41% of foster children qualify for special education services (Elze, Auslander, Stiffman, & McMillen 2005; Goerge, Voorhis, Grant, Casey & Robinson, 1992; Edmund S. Muskie School of Public Service & the National Resource Center for Youth Services, 1998; Yu, Day & Williams, 2002).

During the child’s most recent stay in custody, the case files contained information indicating that 24.5% of the school aged children had been referred to special education; 75.9% of those referred were in special education as of June 1, 2005.

- Only 18.2% of the school-aged children were in special education as of June 1, 2005.

Of those children in special education as of June 1, 2005, 79.2% had been diagnosed with a mental illness or a developmental disorder. However,

- 80.0% of those children who had been diagnosed with mental illness or a developmental disorder were not currently receiving special education services.

For children who receive special education, the most critical guide to their educational needs is their Individualized Education Plan, or IEP, required by federal law (20 U.S.C. § 1414). Practice standards (CWLA FC 2.73) require that the “agency should review the IEP within one month of the child’s placement.” This would require that the agency have a copy of the IEP.

- The case files of 29.2% of the children receiving special education services failed to include a copy of the current Individualized Education Plan (IEP).
F. MDHS Fails to Identify Further Education in the Plans for Older Teens in Custody

It is recognized that transition, independent living, and self-sufficiency services cannot take the place of permanency and family relationships. However, youth in out-of-home care “may need additional support to learn life skills, achieve educational and career goals, build a network of social support, and development the confidence and resilience to achieve optimum positive development” (Nixon 2005:579).

MDHS policy (3417) requires that “Independent Living Program Services are provided to all youth in custody age 16-20 . . . All youth, no matter what their permanent plan, must have an opportunity to participate in a plan for independent living preparation.” The social worker (3417-3418) coordinates preparation for independent living, including preparation for the adolescent “educationally to be on his or her own” and “training and experience with tasks associated with independent living, such as locating and maintaining housing.” An MDHS Policy Bulletin updated this policy in 2002 to require such services for all children in custody 14 year old and above. (8/1/02 Policy Bulletin No. 5742).

Due to the difficulties of foster children and youth in the area of educational achievement, among other things an independent living plan should include educational services (CWLA ILS 2.3). “Educational services begin with informal and formal assessments of skills, learning styles, aptitudes, and abilities. The comprehensive educational assessment should lead the adolescent to the appropriate resource. . .” (Id.) Additionally, the agency should help youth access training programs for future employment (CWLA ILS 2.4). For youth in residential programs, the agency should provide vocational training and assistance in job preparation (CWLA ILS 5.14).

Information was collected to determine whether MDHS had completed a plan for independent living services for youth 14 years or age or older.

- Of the youth who were 14 years of age or older and eligible for independent living services, the case records of almost two-thirds (65.6%) failed to include an independent living plan during for their most recent stay in custody.

- Of the youth with an independent living plan in their case file, 60.2% had plans that failed to address ways in which the youth could obtain further education, such as college or specialized vocational training.

Information was also collected to determine whether the youth’s MDHS
social worker provided or arranged for the provision of support in the development of educational/vocational training with the youth during his or her most recent stay in custody.

- Of the youth 14 or older, more than two-thirds (69.4%) had social workers that failed either to provide or to arrange for the provision of support in the development of educational/vocational training.

Another area of particular concern for youth in custody is instruction regarding locating and maintaining housing. For example, one recent study of former foster youth 6 months to 3 years after discharge found that 36.0% indicated that there were times when they had no place to live (Reilly 2003).

- For 76.9% of the youth whose case file contained an independent living plan, MDHS failed to address the youth’s anticipated housing needs at the time of discharge from custody in the plan.

Discussion

Unfortunately, the findings regarding the education and schooling of children in MDHS custody are consistent with other findings reported thus far in this report. First, disregarding federal and state policy requirements and national practice standards regarding the inclusion of children’s educational information in their records, in the majority of cases MDHS failed to include in children’s files basic information essential to assessment and planning for children’s education and schooling.

Where information was available, the documented educational experiences of children were negatively affected by changes and delays in school enrollment. Only 41.6% of those with such information available remained in the school they attended prior to their most recent entry into MDHS custody. The majority of children experienced multiple school changes and many experienced enrollment delays while in MDHS custody due to agency changes, often frequent, to their placements. Serious harms to children’s education occurred due to the children’s placement instability.

Because of the special needs of many foster children, placement in special education may be appropriate. Yet only 18.2% of the school-aged children and only 20.0% of those who had been diagnosed with mental illness or a developmental disorder were receiving special education services as of June 1, 2005. When compared with the percentages (30-41%) of foster children in other localities who qualify for special education services, it would appear that many children in MDHS custody were not receiving needed special education services.
In addition, of the youth 14 years of age and older and who had an independent living plan in their file (only 34.4%), 60.2% had plans that failed to address ways in which the youth could obtain further education. Thus MDHS also failed to assure that the adolescents in custody received the necessary education and training required to secure future employment.

Therefore, in the critical area of education and schooling, MDHS failed to adhere to federal and state policy mandates and national practice standards to secure and maintain appropriate documentation regarding children’s educational needs and schooling, maintain school stability for children, and ensure that appropriate educational services were provided.
VII. Lack of Services to Support Reunification and Maintain Family Relationships

Key findings:

- MDHS fails to place children with the goal of reunification in close proximity to parents or other caregivers.
- MDHS fails to prepare children’s initial Individualized Service Plans.
- MDHS fails to complete the initial Individual Service Plan for Parents.
- MDHS fails to convene family conferences.
- MDHS fails to offer and provide appropriate services to allow foster children to be safely reunified with their parents or other caregivers from whom they were removed.
- MDHS fails to assure that the child’s social worker maintains minimum face-to-face contact with the child’s parents.
- MDHS fails to facilitate visits between foster children and their parents or other caregivers with whom reunification is planned.
- MDHS fails to place foster children with siblings who are also in foster care.
- MDHS fails to facilitate visits between foster children and their siblings who are also in foster care.
- MDHS fails to prevent unreasonably long stays in foster care for children with goals of reunification without achieving or changing their goals.

A child’s family is at the center of his or her world. Therefore, whenever a child must be removed from his or her family and placed into foster care, providing services to the family that facilitate the child’s safe return home is the first priority. Both public policy and national practice standards recognize children’s rights to know and be with their families when it is safe for them to do so and, as a consequence, mandate that priority be given to making reasonable
efforts to reunify children with their families.

As identified in the professional literature (Hess, Folaron, & Jefferson 1992; Pike et al 1977; Pine, Spath, & Gosteli 2005; Maluccio, Fine, & Olmstead 1986; Stein & Rzepnicki 1983), critical steps in facilitating family reunification include: placing children in close proximity to their families; completing case plans that identify services to address the foster child’s needs as well as family services specifically targeted to address the reason(s) why the child was placed in custody; offering and providing services to allow foster children to be safely reunified with their parents or other caregivers from whom they were removed; monitoring and evaluating families’ progress toward reunification; and, while the child is in custody, supporting the maintenance of family relationships, including sibling relationships, through frequent visits and other contacts. When it becomes clear that reunification cannot safely occur, priority must be given to establishing another permanency goal for the child with other family members or through another caregiver, usually through adoption (Maluccio, Fine, & Olmstead 1986; Pike et al 1977).

Typically, when children enter custody, reunification is the initial permanency goal. For 82.9% of the children who entered MDHS custody on or after June 1, 2003, and for whom an initial ISP was completed within 90 days of placement and a permanency goal was identified on the ISP, the primary permanency goal identified on the ISP was reunification. As of June 1, 2005, reunification was the primary or concurrent permanency goal for 36.9% of the children.

A. MDHS Fails to Place Children with the Goal of Reunification in Close Proximity to Parents or Other Caregivers.

Federal law requires that children be placed in close proximity to their parents. (42 U.S.C. § 675(5)(A)). MDHS policy (3291) states that to achieve reunification, the child should be placed “in the same county as the birth parents if possible.” Policy further elaborates (3232) that “the child should be placed in close geographical proximity to his parent’s home, consistent with the child’s best interest and special needs,” and that consideration should be given to “the ease with which the child, his parents, and family may visit each other, and the availability of services the child may require.”

National practice standards (CWLA FC 2.29) state that in selecting the most appropriate foster family for a given child “Placement with foster families who live outside of the child’s community should be avoided. Geographic closeness promotes continuity for the child and family.”
For those children whose primary or concurrent permanency goal as of June 1, 2005, was reunification with the child’s parents or other caregiver prior to entering custody, information was collected to determine the proximity of the child’s placement as of that same date to the parent’s or previous caregiver’s home.

- For those children, MDHS failed to document the placement location of 4.7% of the children in the child’s case record (ranging as high as 12.5% for the children with the goal of reunification in Yazoo County).

- Of the children with the goal of reunification with placement information available, 72.5% were placed in the same county as their parent or previous caregiver as of June 1, 2005; 13.0% were placed in an adjacent county; 12.3% were placed in a non-adjacent Mississippi County; and 3.8% were placed in another state.

- In three counties, children with the goal of reunification were placed out of state as of June 1, 2005: Hinds 11.1%; Pontotoc 5.0%; and Harrison 4.9%.

- In four counties, more than one-third of the children with the goal of reunification were not placed in the same county as their parent or caregiver: Pontotoc 55.0%; Forrest 46.2%; DeSoto 40.7%; and Clarke 37.5%. In three of these, more than 20.0% of the children were placed in neither the same nor an adjacent county: Pontotoc 45.0%; Clarke 37.5%; and Forrest 23.1%.

- In 86.8% of the cases in which the child was placed in neither the same nor the adjacent county as the child’s parent/caregiver, MDHS failed to document efforts to place the child in the same county as the child’s parent or caregiver.

**B. MDHS Fails to Prepare Children’s Individualized Service Plans**

Upon a child’s entry into foster care, the preparation of a case plan for the child is a critical and indispensable process for social workers and families to establish goals for the child and document target appropriate services to meet
those goals (Pike, Downs, Emlen, Downs, & Case 1977; Fiermonte & Renne 2002; Maluccio, Fine, & Olmstead 1986; Seabury 1985; Stein & Rzepnicki 1983; Wiltse 1985). It is essential that clear and explicit service goals and objectives are identified in the foster child’s plan for services to guide all those who are involved in serving the child and his or her family and to measure progress toward achieving permanency.

Federal law mandates that, for a state to be eligible to receive federal foster care funds, the state must ensure that each foster child on whose behalf the state receives such funds has an individualized case plan. (42 U.S.C. § 671(a)(16)). Federal law also requires that the case plan be reviewed at least every six months, either judicially or administratively. (42 U.S.C. §§ 671(a)(16); 675(5)).

Federal law further requires that the case plan must include a description of the child’s placement, including its safety and appropriateness; a description of the services to be provided to the parents and child in order to achieve the permanency goal and to address the needs of the child while in foster care; the health and education records of the child, including immunizations, medications, and school reports; the independent living plan for children over the age of 16; and the steps the agency is taking to achieve any non-reunification permanency goal. (42 U.S.C. § 675(1)).

MDHS policy (3287-3290, 9007-9008) similarly requires that for each child in custody, an Individualized Service Plan (ISP)/Custody Case Plan for Children is developed by the child’s social worker in partnership with the child’s family within thirty (30) calendar days of the initial date of custody. The plan must be monitored through court and other reviews every six months at a minimum, and revised as is indicated by the child’s needs and the parent’s use of services. The agency form (3288-3290) for the ISP addresses the federally mandated components of the permanency plan for the child in custody.

National practice standards (CWLA FC 2.5, 2.85, 2.86, 2.87, 2.91, 2.94, 2.95, 2.96, 2.97, 2.101, 2.102, 2.103; COA S21.1.02, S21.2, S21.2.02-S21.2.06, S21.3.03-S21.3.07, S21.4.02-S21.4.03) also emphasize the agency social worker’s role in providing and coordinating services to achieve the child’s permanent plan, including the early development and regular review of the child’s case plan.

**Completion of ISP within 30 days of entry.** Information regarding MDHS compliance with federal and state requirements concerning the development of a case plan (ISP) for children was collected from the records of the children whose most recent entry into custody occurred on or after June 1, 2003.
• For two-thirds (66.7%) of the children, MDHS failed to complete the child’s ISP within 30 days of removal.

• In five counties, the percentage of children for whom MDHS failed to complete the ISP for the child within 30 days of removal was two-thirds or higher: 100.0% Clarke; 87.8% DeSoto; 87.1% Forrest; 67.9% Pontotoc; and 66.7% Jefferson.

• For 40.0% of the children entering MDHS custody on or since June 1, 2003, the primary case planning document required by federal law and state policy was not even completed within the first three months of the child’s entry into MDHS custody.

Information contained in the initial ISP. The protocol was designed to collect information concerning the inclusion of critical information\textsuperscript{13} in the child’s

\textsuperscript{13} According to agency policy (3288-2390), the Individualized Service Plan Custody Case Plan for Children must include the following elements:

(1) The purpose for which the child was placed in custody, including a statement of the reasons why it was necessary to place the child to ensure the child’s safety and well-being;

(2) A description of the initial services needed and offered and the services provided to ensure safety of the child, and prevent removal of the child from the home;

(3) A discussion of the safety, restrictiveness, and appropriateness of the placement to ensure the child’s safety and well-being and how the agency plans to carry out the judicial determination made with respect to the child; a description of the type of home/facility in which the child has been/is to be placed to ensure the child’s safety and well-being.; further, a statement regarding the nearness of the placement to the parent’s location, discussion of why the child was not placed closer to the parent’s home, and reasons why such a placement is consistent with and in the best interest and special needs of the child.

(4) A discussion of the strengths and needs of the child while in foster care and the agency’s plan to assure that the child receives proper care and services in placement, including appropriateness of services provided to the child, parents, and foster parents to facilitate reunification or another permanent plan;

(5) The child’s health and educational records, and, for children over 16, a description of independent living services;

(6) A visitation plan, specifying the frequency, time, and location for visits, and including visits between siblings and/or relatives;

(7) Documentation of the steps the agency is taking to find an adoptive permanent home, place the child with an adoptive family, durable legal custody or other permanent home, and finalize the adoption if child cannot return safely to parents/relatives within the legal time frame or if reasonable efforts are not required;

(8) The child’s financial plan, estimating potential expenditures for the child for the next 6 months;

(9) The name of the social worker who responsible for ensuring that the plan is implemented;

(10) The name of the ASWS who reviews the child’s plan.

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Case Example #32

The four Warren siblings entered MDHS custody January 20, 2005, after four separate investigations in the span of six months, the last of which evidenced medical and physical neglect by the mother and physical abuse by the father. MDHS failed to complete an ISP for any of the children by June 1, 2005. By the time an initial ISP was completed on July 22, 2005, with a primary permanency goal of reunification, the entire six-month timeframe within which the parents were required by policy to complete the tasks in the service agreement and to achieve reunification had already passed.
initial ISP for children whose most recent entry occurred on or after June 1, 2003. In addition, for all children regardless of date of entry, information was collected concerning information contained in the ISP most recently completed or updated prior to June 1, 2005 (see Section XIII). Information to be collected included the child’s primary and concurrent permanency goals, the names of the social worker responsible for implementing the permanency plan and the ASWS reviewing the plan, the child’s health and educational records, the child’s psychological status/mental health services, services provided to prevent the initial removal of the child, services being provided to the child, parents, and foster parents, and a schedule for parent-child visitation.

Initially in the MACWIS printouts provided from the children’s electronic case records, only one ISP -- the child’s most recent ISP-- was included. When additional ISPs were subsequently requested and reviewed, it was determined that only the child’s most recent ISP contained information that appeared accurate as of the ISP completion date. For prior ISPs, with the exception of the child’s primary and concurrent permanency plans, the social worker’s and Area Social Work Supervisor’s (ASWS) names, and the date(s) of plan completion and review, it became clear that information had been electronically over-written by more recent information. Thus, most information on previous ISPs had been deleted and replaced with information subsequently entered concerning events that had not yet occurred at the time the ISP was originally completed. To illustrate, ISPs dated in 2001, 2002, 2003, and 2004 contained information from 2005. Therefore, most of the critical historical information contained in prior ISPs was not reliable and could not be collected and reported.

Case Example #33
Jerry had five ISPs printed out from his MACWIS record, each dated with a different “approval date.” Even though two of the ISPs were dated 2002 and two were dated 2003, each of the five ISPs contain an identical statement referencing a physical Jerry did not have until March 17, 2005.
Table 12. Comparison of Excerpted Information from three ISPs Contained in Child’s Paper File and ISPs Printed Out from MACWIS August 4, 2005 and Provided for Case Review by MDHS

<table>
<thead>
<tr>
<th>Excerpt from ISP in Paper File</th>
<th>Excerpt from ISP from MACWIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/30/2003 submitted 11/14/2003 approval Printed January 07, 2004 1:39PM Name and type of setting: Blank Appropriateness of placement: Blank Visitation plan: Blank</td>
<td>10/30/2003 submitted 11/14/2003 approval Printed August 04, 2005 3:28PM Name and type of setting: W.B. Child-specific Appropriateness of placement: Sally is placed with her sister Laura. This is the most family like setting for child. Child is placed in same county as his [sic] family. Visitation plan: There is no further vistaitation [sic] per court order from Judge [name].</td>
</tr>
<tr>
<td>01/16/04 submitted 02/25/04 approval Printed February 25, 2004 11:29AM Visitation plan: All visitation is under the department of Human Services.</td>
<td>01/16/04 submitted 02/25/04 approval Printed August 04, 2005 3:28PM Visitation plan: There is no further vistaitation [sic] per court order from Judge [name].</td>
</tr>
<tr>
<td>08-02-04 submitted 08-02-04 approval Printed August 02, 2004 11:25AM Immunization record: Blank</td>
<td>08-02-04 submitted 08-02-04 approval Printed August 04, 2005 3:28PM Immunization record: 7 entries with dates</td>
</tr>
</tbody>
</table>

This apparent systemic programming error in MACWIS means that if a paper copy of the ISP is not printed out at the time it is completed and filed in the child’s paper record, the history of needs, services, and decisions contained in the ISP, intended by federal law to be the record of the child’s service plan and its achievement, cannot be accurately re-created or replaced. The inability of MACWIS to document a child’s previous ISPs with information accurate as of the date of ISP completion prevents social workers, ASWSs, foster care reviewers, judicial decision makers, and others from identifying change and evaluating progress over time. The same kind of problems were found with the MACWIS Youth Court Hearing and Review Summary used by MDHS to document the six-month County Conferences as discussed in Section VIII(C) below. This is a very serious casework practice and legal problem for all children in MDHS custody.

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14 The paper record for most of the children did not include a hard copy of the ISP for the most recent 24-month period prior to June 1, 2005.
Given these very serious problems in the reliability of the critical historical information in the ISPs generated by MACWIS, information collected from ISPs and analyzed had to be limited to the primary and concurrent permanency plans, the electronic signatures (identities) of the social worker completing the plan and the ASWS reviewing the plan, and the date(s) of plan completion and review.

MDHS policy (3289) requires that the initial ISP include “the initial permanency plan for the child and an alternate plan [concurrent plan] in case it is needed.” For children whose most recent entry into custody occurred on or after June 1, 2003, 21.8% had an initial ISP completed in 90 days but the plan failed to contain the child’s primary permanency plan; 26.1% had an initial plan completed within 90 days, but the plan failed to contain the child’s concurrent permanency plan. As reported previously, 40.0% of the children entering on or after June 1, 2003, failed to have an initial ISP in their case records. Therefore,

- 61.8% of the children failed to have an initial ISP in the file with an identified primary permanency plan for the child within 90 days of placement, either because the ISP was not completed or because the ISP failed to contain this essential information.

- 66.1% of the children failed to have an initial ISP in the file with an identified concurrent permanency plan for the child within 90 days of placement, either because the ISP was not completed or because the ISP failed to contain this essential information.

Information was also collected to determine whether the initial ISP completed within 90 days of custody contained the electronic signatures (the only source of identity) of the social worker responsible for plan implementation and the ASWS reviewing the plan. In more than one-half (52.3%) of the children’s cases, the social worker responsible for plan implementation either failed to complete the initial ISP within 90 days or failed to provide his/her electronic signature on the plan. Virtually all of the case plans missing a social worker signature were signed by an ASWS, suggesting that many ISPs (12.1%) were in fact completed by the ASWS.

C. MDHS Fails to Complete the Initial Individual Service Plan for Parents

To facilitate the timely identification and provision of services to address the factors that resulted in the child’s placement, agency policy (3283) requires that an Individual Service Plan (ISP)/Service Agreement for Parents “must be completed on all cases within 30 days of the child’s placement in agency custody.” Policy (3283) further requires that the ISP for parents address “the target
problems, the assigned tasks to be accomplished, and time frames of all parties, and what may be expected upon completion of non-completion of the assigned tasks.” Because policy requires that parents accomplish the tasks outlined in the ISP within six months unless “extraordinary and compelling reasons(s) for extending the time period” (3282) are documented, the timely completion of the service plan is critical.

For children whose most recent entry into MDHS custody began on or after June 1, 2003, information was collected to determine whether the ISP for parents was completed as required within 30 days of the child’s placement in agency custody.

- MDHS failed to complete the ISP for either parent within 30 days as required for 56.1% of the children; for 36.0% of the children, the ISP was completed for only one of two applicable parents.

- In seven of the nine counties, MDHS failed to complete the ISP for either parent within 30 days of the child’s placement for 50.0% or more of the children: Hinds 78.6%; Clarke 70.0%; Yazoo 72.7%; Harrison 57.7%; DeSoto 55.0%; Humphreys and Pontotoc, 50.0%.

- In only five counties and for only a small percentage of children did MDHS complete an ISP for both of a child’s parents: Pontotoc 3.6% of the children; Forrest, 5.0%; Hinds 5.1%; Harrison 11.5%; and DeSoto, 22.4% of the children.

MDHS did not place 9-year-old Karen and her two siblings in custody until 2.5 months after sexual abuse was evidenced in 2003. The foster care reviewer documented in mid-May 2005 that reunification was still the goal, even though the mother had not yet completed a parental ISP, and the children had been in custody for 15 months. As noted by the reviewer, the children’s ISP was 5 months overdue, there was no documentation of a Permanency Hearing in the paper case file or MACWIS, and there was no 15 month Permanency Planning Review by the Supervisor in the paper case file. In addition, invitation letters for the mid-May 2005 County Conference were not sent to all the required participants nor were they sent within the timeframes mandated by policy. Neither the assigned SW nor ASWS were present for the County Conference, so another social worker “with only limited knowledge of the case” participated instead.

D. MDHS Fails to Convene Family Conferences

MDHS policy (3242) states that parents of children in custody have “the right to request/participate in Family Group Conferences.” Policy further states (3265-3266) that family-centered concurrent permanency planning involves
“Family Group Conferences/Kinship Assessment” and requires (3211) that “Family Group Conference meetings shall be held within the first thirty days of custody in order to make appropriate plans for the child. The parents shall be given the opportunity to decide who will be part of the Group.” Consistent with the emphasis on family-agency partnerships, national practice standards (CWLA FC 1.5, 1.7; COA S21.2.05, S21.2.02c) require that children in care and their families be encouraged to participate in determining and achieving their service plan objectives and be included in a team that implements the service plan.

The literature regarding the achievement of permanency for children in placement emphasizes the importance of the partnership that is ideally created between the agency social worker and the child’s parents (Altman 2005; Fiermonte & Renne 2002; Maluccio, Fine & Olmstead 1986; Pike et al 1977; Pine, Warsh, & Maluccio 1993; Seabury 1985). This partnership involves regular family conferences and joint planning among parents, the agency, and others responsible for the child’s placement and services.

Information regarding whether a Family Group Conference was held within 30 days of the child’s most recent entry into MDHS custody was collected for the children who entered custody on or after June 1, 2003.

- MDHS failed to convene any family conference within 30 days of placement for 97.5% of the children.

In addition, information was collected for all children to determine whether at least one Family Group Conference was held during the 24-month period prior to June 1, 2005. At least one such conference was documented for only 5.5% of the children. Thus,

- MDHS failed to convene even one Family Group Conference for 94.5% of the children during the two years prior to June 1, 2005.

E. MDHS Fails to Offer and Provide Appropriate Services to Allow Foster Children to be Safely Returned Home to their Parents or Other Caregivers from whom They Were Removed

MDHS policy (3271) states that reasonable efforts to reunify the child and family can include “providing support services” and “making referrals in community resources and other social service agency.” To facilitate the timely identification and provision of services to address the factors that resulted in the child’s placement, agency policy (3291, 3286) requires that the social worker must “complete an Individualized Service Plan/Service Agreement for parents within 30 calendar days of the child’s entry into custody . . . The ISP/Service Agreement is
not to exceed a six month period of time [to meet the goal of reunification] unless the Department has documented extraordinary and compelling reason(s) for extending the time period.” Policy (3282) further states that if the service agreement has not been satisfactorily met, “simultaneously the child will be referred to the appropriate court for termination of parental rights and placement in a permanent relative’s home, adoptive home, or foster/adoptive home within six (6) months thereafter.”

National practice standards (CWLA FC 1.5, 2.90, 2.91, 2.92) dictate that the child’s mother, father, and other relatives are to be given priority as potential resources for the child’s permanent placement upon discharge and thus should be provided appropriate services to that end. Standards emphasize (CWLA FC 2.5) that the service plan developed with the child’s family should be based on a thorough assessment and should identify services targeted to improve the family’s capacity to care for the child in those specific areas in which failures have occurred. Similarly, COA standards (S21.7, S21.26, S21.7.04) state that either directly or through arrangement, the agency should provide intensive services to biological parents to facilitate the child’s return home and strengthen family functioning.

As agency policy and practice standards emphasize, the service plan developed with the child’s family should be based on a thorough assessment and should identify services specifically targeted to improve the family’s capacity to care for the child in those specific areas in which failures have occurred. For example, parents or caregivers who fail to adequately supervise their children present a range of different problems and needs. Many may lack information or knowledge about children’s needs and about appropriate child-rearing practices; others may need short-term in-home intensive assistance to provide on-site support to parents and to model and teach appropriate parenting. Therefore, appropriate services for such parents would include parent-skills training (Dore & Lee 1999; Pike et al 1977; Stein & Rzepnicki 1983) and intensive short-term in-home treatment (Lindblad-Goldberg, Dore & Stern 1998).

When a parent’s or legal caregiver’s alcohol and substance abuse contribute to the child’s entry into care, the identification of the need for alcohol and substance abuse treatment and the provision of such services to the parent or caregiver are essential to determining whether or not the child and parent/caregiver could be safely reunified (Fenster 2005; Pike et al 1977; Semidei, Radel, & Nolan 2001; Smith 2003). Similarly, mental health disabilities that incapacitate parents require an expert diagnosis in order to treat the condition, determine how long the condition is likely to last, and determine whether it will improve with treatment (Pike et al 1977).
For children whose primary or concurrent permanency goal as of June 1, 2005, was reunification, using information in children’s case files regarding the reason(s) for the most recent entry, information was collected to determine the efforts of MDHS staff to offer within 60 days of the child’s placement to children’s mothers and fathers services that targeted those problems that would necessarily need to be resolved in order for children to return home safely. In addition, information was also collected to determine the status of services provided to mothers and fathers as of May 31, 2005.

- It should be noted that whether services were offered, refused, or provided that addressed the reason(s) for the out-of-home placement could only be evaluated for 43.0% of the mothers and 16.6% of the fathers of the children with the goal of reunification as of June 1, 2005, due to information missing from the children’s case records regarding the specific reason(s) for the child’s most recent entry into custody and/or regarding specific services offered and/or provided to the children’s parents.

As presented in Table 13, eight different categories of problems that typically contribute to placement of children in out-of-home care were used in the protocol to collect service information. Information regarding services offered and provided to children’s mothers is also presented.

Table 13. For Children with Goal of Reunification as of June 1, 2005, Services Offered and Provided to Mothers

<table>
<thead>
<tr>
<th>Problem Requiring Child’s Entry Into Most Recent Stay in Custody</th>
<th>%* of Mothers to Whom MDHS Failed to Offer Relevant Service Within 60 Days</th>
<th>%* of Mothers for Whom Service Still Needed Who Failed to Receive Service As of May 31, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>90.4</td>
<td>100</td>
</tr>
<tr>
<td>Failure to supervise</td>
<td>57.7</td>
<td>92.0</td>
</tr>
<tr>
<td>Physical abuse of child</td>
<td>41.3</td>
<td>41.3</td>
</tr>
<tr>
<td>Environmental neglect</td>
<td>35.1</td>
<td>38.4</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>25.5</td>
<td>54.5</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>15.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Medical/educational neglect</td>
<td>7.8</td>
<td>52.0</td>
</tr>
<tr>
<td>Sexual abuse of child</td>
<td>0</td>
<td>28.6</td>
</tr>
</tbody>
</table>

*Percentages are weighted. Some mothers needed service in more than one problem/service category.

Variations in service offering and provision were found between the problem/service categories. For example, MDHS failed to offer services within 60
days to almost all (90.4%) of the mothers with mental illness. Similarly, services were not offered to the majority (57.7%) of mothers who had inadequately supervised their children.

- In only one of the problem/service categories (sexual abuse of child) did MDHS staff offer all mothers whose children entered care for this reason the relevant services within 60 days.

- Excluding from the analysis mothers who as of May 31, 2005 had either refused the service or resolved the problem preventing the child’s return home, 100.0% of the mothers with mental illness, 92.0% of those who failed to supervise their children, 54.5% with substance abuse problems, and 52.0% of those who had medically or educationally neglected their children were not receiving relevant services despite a continued need for services and the agency’s documented plan to reunify their children with them.

Table 14 presents the picture concerning the offering and provision of services to children’s fathers to support reunification.

Table 14. For Children with Goal of Reunification as of June 1, 2005, Services Offered and Provided to Fathers

<table>
<thead>
<tr>
<th>Problem Requiring Child’s Entry Into Most Recent Stay in Custody</th>
<th>%* of Fathers to whom MDHS Failed to Offer Relevant Service Within 60 Days</th>
<th>%* of Fathers for Whom Service Still Needed Who Failed to Receive Service As of May 31, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse of child</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Environmental neglect</td>
<td>47.5</td>
<td>47.5</td>
</tr>
<tr>
<td>Failure to supervise</td>
<td>42.2</td>
<td>84.4</td>
</tr>
<tr>
<td>Sexual abuse of child</td>
<td>35.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>23.4</td>
<td>23.4</td>
</tr>
<tr>
<td>Medical/educational neglect</td>
<td>0</td>
<td>67.2</td>
</tr>
<tr>
<td>Mental illness</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Percentages are weighted. Some fathers needed service in more than one problem/service category.

- In five problem/service categories, MDHS failed to offer relevant services to more than one-third of the children’s fathers within 60 days of the child’s placement.
In two problem/service categories—domestic violence and physical abuse—MDHS failed to offer or provide relevant services to any of the children’s fathers.

Excluding from the analysis fathers who as of May 31, 2005 had either refused the service or resolved the problem preventing the child’s return home, not one of the fathers with a continued need for service in three categories was receiving services: domestic violence, physical abuse, and sexual abuse.

The majority of fathers were not receiving services in two additional categories: failure to supervise (84.4%) and medical or educational neglect (67.2%). In the area of environmental neglect, 47.5% were not receiving services.

F. MDHS Fails to Assure that the Child’s Social Worker Maintains Minimum Face-to-Face Contact with the Child’s Parents

When family reunification is the permanency plan, frequent face-to-face contact with a child’s parents is essential to coordinate services provided to the family and assess progress toward the goal of returning the child to the parents. MDHS policy states that parents have “the right to assistance from the Social Worker to help them alleviate the problems which caused removal from the home” (3242). Policy does not, however, specify a minimum contact requirement.

COA standards (S21.7.05) require that the social worker have “a private, face-to-face meeting with the child’s biological parents within the first two weeks of placement, and at least every month thereafter for children in short-term foster or kinship care [i.e., with a goal of family reunification], according to the service plan and the child’s strengths and changing needs.” A required frequency for social worker contacts with parents is not specified in CWLA standards; however, regular contact is implicit in the requirement that the family’s service plan is “case managed on an ongoing basis” (FC 2.51).

Information regarding face-to-face social worker-parent contact was collected in those cases (36.9%) in which the child’s primary or concurrent permanency goal was reunification with the child’s parents or previous caregivers as of June 1, 2005. As described in Section IV, the protocol was designed to collect information regarding the number of times the social worker or supervisor had contact with the child’s parents during each month of the 12-month period prior to June 1, 2005. When the child was not in custody for an entire month during this period, “not applicable” was entered in the appropriate month or months; these months were then excluded from this analysis. The proportion of
possible months that each parent could have been visited during the 12-month period was determined, and the proportion of those months the parent was actually visited as required, i.e. at least one visit per month, was calculated.

**Contact with the child’s mother.** Information was collected to determine the extent of face-to-face contact by the MDHS social worker or supervisor with the child’s mother in those cases in which the child’s primary or concurrent permanency goal as of June 1, 2005, was reunification and in those months in which contact information was applicable.

- For 95.2% of the children with a primary or concurrent goal of reunification, the MDHS social worker/supervisor failed to meet with the mother at least once a month as required by practice standards during the 12-month period prior to June 1, 2005.

- For 45.5% of the children with a goal of reunification, the MHDS social worker/supervisor failed to meet with the child’s mother even once in the 12 months prior to June 1, 2005.

- The mean percent of monthly contacts with children’s mothers made by social workers/supervisors in the 12 months prior to June 1, 2005, was 21.3%, on average a visit in only 2.5 of the 12 months.

- When examined by county, the mean percent of monthly face-to-face contacts with mothers for whom reunification is the child’s goal ranged from only 12.9% (Yazoo) to only 80.2% (Humphreys).

**Contacts with the child’s father.** Information was also collected to determine the extent of face-to-face contact by the MDHS social worker or supervisor with the child’s father in those cases in which the child’s primary or concurrent permanency goal as of June 1, 2005 was reunification and in those months in which contact information was applicable.

- For 92.1% of the children with the primary or concurrent permanency goal of reunification, MDHS social workers/supervisors failed to have face-to-face contact with the children’s fathers at least once a month as required by practice standards during the 12 months prior to June 1, 2005.

- For the majority (58.5%) of the children with the goal of reunification, the MDHS social worker/supervisor failed to have any face-to-face contact with the child’s father during this same 12-month period.
• The mean percent of monthly face-to-face contacts with children’s fathers made by social workers/supervisors in the 12 months prior to June 1, 2005, was 19.4%, on average a visit in only 2.3 of the 12 months.

• When examined by county, the mean percent of monthly social worker/supervisor contacts with fathers during the same period ranged from none (0.0% Hinds, Humphreys) to only 68.0% (Clarke).

G. MDHS Fails to Facilitate Visits Between Foster Children and their Parents or Other Caregivers with whom Reunification is Planned

For children who will return home, visiting is the primary mechanism through which family relationships are maintained (Haight, Kagle, & Black 2003; Hess & Proch 1993; Maluccio, Fine, & Olmstead 1986; Pine, Warsh, & Maluccio 1993) and through which parents’ and children’s readiness for reunification is assessed (Hess & Proch 1993; Pine, Warsh, & Maluccio 1993). Research has consistently found that children who are more frequently visited by their parents while in foster care are more likely to be successfully discharged from foster care (Davis, Lansverk, Newton, & Ganger 1996; Fanshel & Shinn 1978; Kuehnle & Ellis 2002; Lawder, Poulin, & Andrews 1984; Milner 1987; Sherman, Neuman & Shyne 1973) and are more likely to experience shorter placement time in months (Mech 1985). To illustrate, Davis et al (1996) found that in a sample of children 12 years old or younger, after up to 18 months in care, 66% were reunified with their families. The researchers found that “when the mother visited as recommended the child was approximately 10 times more likely to be reunified” (p. 375). Visiting has also been found to be associated with children’s positive well-being while in care (Borgman, 1985; Fanshel & Shinn 1978; Weinstein 1960).

MDHS policies outline a number of requirements concerning parent-child visiting:

• (3239) “It is imperative that contact between the child and his family be arranged immediately (within 24 hours) after placement unless there are documented reasons why this should not occur . . . A visit with his family immediately after placement assures him that his family has not disappeared or died, they know how to reach him, and that he is not being hidden from them by the agency. He is better able to accept his foster care status because of the continuing relationship with his family.” Elsewhere (3286), agency policy states that visitation between the child, parents, sibling, relatives and any other significant individuals should occur within 48 hours;
• (3240-3241) “Parents have a right to visit with their children. The agency has the responsibility of informing them of this right, encouraging visits, and arranging visits that are convenient for both the birth family and the foster family... Visitation should be a required element in every Parent’s Individualized Service Plan and Service Agreement... At the time of placement, as part of the case plan, a plan should be developed specifying the time and location for visits. Frequent visitation has a direct and positive effect in aiding the return of the child to his family;”

• (3290) “[The visitation] plan should include a minimum of one visit per month (unless ordered otherwise by the court). Family Centered Permanency Planning encourages more frequent visitation to maintain and establish attachment and achieve reunification;”

• (3292) “[The social worker is responsible to] develop with the parent, child, foster parents, and other involved parties, a visitation plan. All visitation during a child’s stay in foster care should be held in the most natural setting possible (birth family’s home, home of a relative, foster home). The visitation schedule must be clearly specified on the ISP for parents and the ISP for children.”

Plans for parent-child visiting are recognized by national practice standards as essential to achieving the permanency goal of reunification. Standards (COA S21.3.03, S21.3.05) stress the importance of visiting to achieving permanency and helping “children to sustain an emotional connection to their families;” standards (CWLA FC 2.42, 2.44, 2.88) also identify visiting as “a critical determinant of parent-child reunification.” Specifically, practice standards (CWLA FC 2.88) emphasize that that agency social worker should “[w]ith the parents and the child whenever possible, create a written visiting plan, with a copy for all parties involved, that clarifies the roles and responsibilities of all the participants in the visit, and the frequency, duration, and location of the visits” and should “use the visits to assess parental readiness and capacity for reunification.” COA standards (S21.2.03d, S21.3.03d, S21.3.07b, S21.7.06, S21.25a, S21.26.01c) emphasize the importance of frequent parent-child visiting for children’s well-being and the maintenance of the parent-child relationship as well as the usefulness of visits for assessment of a family’s readiness for reunification.

**Required visits within 48 hours of placement.** Information was collected from the records of children who entered MDHS custody on or after June 1, 2003, to determine whether MDHS provided the required parent-child visit within 48 hours of the child’s placement.

• MDHS failed to provide this required visit for 81.9% of the children whose
most recent entry occurred on or after June 1, 2003.

- For 73.2% of the youngest children (ages 0-5), those most affected by separation from their parents/caregivers, MDHS failed to provide a visit within 48 hours of entering custody.

- Three counties failed to provide a parent-child visit within 48 hours of the child’s entry into foster care to 100.0% of their children: Clarke, Jefferson, and Yazoo. Forrest failed to provide such visits to 93.9%.

- Such a family visit was not provided to 51.9% of the infants less than one year old; 96.4% of those one year of age; and any of the 2 year olds.

- MDHS failed to provide a family visit within 48 hours of entry for 84.8% of the 6-12 year olds and for almost all (93.3%) of the adolescents.

**Required monthly parent-child visits.** For children whose primary or concurrent permanency goal was reunification as of June 1, 2005, information was collected for the 12-month period prior to that date to determine whether the minimum required number of face-to-face visits between the child and the child’s mother and father – one visit per month – was provided by MDHS. If the child was not in custody for the entire month or was placed with his/her mother/father during a month, the month was excluded from the analysis. Table 15 below reports the frequency of visits between children and their biological parents as documented in case records.

<table>
<thead>
<tr>
<th>Frequency of Parent-child Visits Provided by MDHS</th>
<th>%* of Mothers</th>
<th>%* of Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum requirement of at least one visit each month was not met</td>
<td>90.5%</td>
<td>95.8%</td>
</tr>
<tr>
<td>No visit provided in half of applicable months</td>
<td>78.6%</td>
<td>91.7%</td>
</tr>
<tr>
<td>No visits provided during the 12-month period</td>
<td>51.0%</td>
<td>85.2%</td>
</tr>
</tbody>
</table>

* Percentages are weighted.

- Notably, for the entire 12-month period, no parent-child visits were provided by MDHS for the majority (51.0%) of the mothers of children for whom the permanency goal was reunification, ranging by county from more than two-thirds (69.1% Harrison; 68.8% DeSoto; 67.3% Hinds) to
Visits to prepare for reunification. Practice standards (Allen & Hamilton 2001; Hess & Proch 1988; Maluccio, Fine, and Olmstead 1986; Haight, Black, Workman, & Tata 2001) require that over time and as family reunification or placement with a relative nears, visits between children and parents/caregivers should increase in frequency and in length, including overnight and weekend visits, and be unsupervised. For the children with a primary or concurrent goal of reunification as of June 1, 2005, in the 6 months prior to that date

- 84.3% failed to have weekend overnight visits at the parent’s or former caregiver’s home
- 82.5% failed to have unsupervised daytime visits
- 82.5% failed to have overnight visits at parent’s or former caregiver’s home

H. MDHS Fails to Place Foster Children with Siblings who are also in Foster Care

Sibling relationships are widely recognized as very important to children’s emotional support and self-esteem and are often stronger for children in dysfunctional homes (Elstein 1999; Schuerger 2002). For most foster children, sibling relationships provide comfort while they are separated from their parents. As Hegar stressed “most often, these [foster] children belong to sibling groups over which an agency has significant decisionmaking control. Unfortunately, the sibling group is sometimes the only part of a foster child’s family that a child welfare agency has a chance of preserving” (2005:543).

Agency policy (3232) states that “Every effort should be made to place siblings together. If siblings are not placed together initially, diligent efforts must be made to place them together as expeditiously as possible. The child’s case record and case plan (ISP) must contain justification for the separation of

0.0% (all mothers had at least one visit, Humphreys).

- No parent-child visits were provided for 85.2% of the fathers, ranging by county from none of the fathers (100.0% Hinds, Jefferson) to only 50.0% of the fathers (Clarke).
siblings.” MDHS policy (3291) states that when siblings are not placed together, social workers are required to “document reasons why and efforts made to keep the siblings together [and] consider placements which are geographically close together.”

National practice standards (CWLA FC 2.30) also strongly stress the importance of placing siblings together: “The foster family agency should recognize the right of siblings to be placed together while in family foster care. Placement of siblings separate from each other should take place very rarely and should be an exception to agency policy. Siblings should be placed separately only if placement together would be contrary to the developmental, treatment, and safety needs of a given child.” COA standards similarly emphasize that agencies should give priority to placing children with the sibling group (S21.2.01a, S21.10.02).

Information was collected to identify the percentage of children with siblings also in custody and to determine whether MDHS had placed siblings together. At the time of their most recent entry into MDHS custody, 73.7% of the children had a sibling already in custody or coming into custody with them. For 2.3% of the children, information regarding siblings could not be located in the file.

- Of the children known to have one or more siblings in custody, 44.7% were placed separately from one or more of their siblings.

  Case Example #36
  "Mary is very emotionally attached to her younger siblings and feels like she must protect adn [sic] care for them. This has become an increasingly difficult problem to deal with because Mary purposely [sic] blows any new placements we obtain for her in foster homes in order to stay with her younger siblings at the [shelter] . . . Since it very likely that the Permanent [sic] plan for the two younger children will eventually be adoption SW does not fell [sic] like this is the best of the children[sic] for them to be so dependant on each other. This continued dependency will make any adjustment periods regarding adoption [sic] extremely hard on the younger children."

- Twenty-two percent (21.9%) of the children were placed separately from all of their siblings.

- Despite the MDHS requirement that social workers document why siblings are not placed together, whether efforts were made to keep the siblings together, and/or to placement them in geographically close placements, social workers failed to record this information for 28.1% of the children not placed with their sibling group.
For 71.9% of the children, the case record contained at least one reason why the child was not placed with all of his or her siblings. The reason(s) documented are presented below in Table 16.

Table 16. Reason(s) Documented for the Separation of Sibling Groups while in Foster Care

<table>
<thead>
<tr>
<th>Reason for Placing Siblings Separately</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/sibling has medical/mental health needs requiring special level of care</td>
<td>28.6</td>
</tr>
<tr>
<td>No reason documented</td>
<td>28.1</td>
</tr>
<tr>
<td>Agency unable to find caregiver to accommodate sibling group</td>
<td>24.3</td>
</tr>
<tr>
<td>Other</td>
<td>21.9</td>
</tr>
<tr>
<td>Child or sibling has behavior problems that pose a safety risk</td>
<td>19.0</td>
</tr>
<tr>
<td>Child’s sibling(s) previously in custody; sibling’s caregiver will not care for child coming into custody and move of sibling already in custody not in sibling’s interest</td>
<td>16.7</td>
</tr>
</tbody>
</table>

*Percentages are weighted. Totals exceed 100% due to documentation of more than one reason for some children.

Accepted practice further requires that social workers document efforts to find or develop a placement that would accept a sibling group in all cases in which a sibling is not placed with his or her sibling group.

- For almost three-quarters (72.3%) of the children whose sibling group was not placed together, the agency failed to document efforts to find or develop a placement for the complete sibling group.

  Documented efforts were limited to asking relatives (20.2%) and/or foster parents (9.6%) to care for the siblings who were ultimately placed separately. No recruitment efforts through media and community contacts or other efforts were documented.

- In the majority (55.1%) of the cases in which MDHS failed to place siblings together, the agency failed to document the required efforts to place siblings in the same county.

1. MDHS Fails to Facilitate Visits for Foster Children and their Siblings who are also in Foster Care

When siblings in custody are not placed together as a group, visits provide the primary means for maintaining the relationship. MDHS policy (3233) mandates that “when siblings are not placed together, they must be allowed frequent contact, including visitation with one another” and specifically requires
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(3240) that “it is very important that regular visitation at least twice a month be maintained among siblings if they are not placed together, unless the child’s case record justifies that this is impossible.”

National practice standards and increasingly, state policies (Hegar 2005; Hess 2003, 2005; Schuerger 2002) require that siblings placed separately be provided visits while in care. CWLA standards (FC 2.30) state that “If siblings must be placed with separate foster families, frequent and regular ongoing contact between the children should be maintained.” COA standards similarly emphasize that wherever possible agencies should maintain relationships among siblings placed separately “through visits and shared activities.” (S21.25d, S21.3.05b).

As reported above, 44.7% of the children with siblings had at least one sibling in custody with whom they were not placed. Information regarding sibling visits during the 12-month period prior to June 1, 2005 was applicable (i.e. siblings remained in custody for the month and had not been reunified in the same placement) for 97.9% of the children not placed with siblings as a group.

- MDHS failed to provide all (100.0%) of the children placed separately from their siblings a visit twice monthly as required by agency policy in the year prior to June 1, 2005.

- 60.1% of the children placed separately from siblings were not afforded even one sibling visit during the entire 12-month period prior to June 1, 2005.

- By age group, MDHS failed to provide any sibling visits to 56.9% of the children ages 0-5 placed separately from siblings; 59.3% of the children ages 6-12; and 64.4% of the adolescents during the 12 months prior to June 1, 2005.

- When examined by county, the percentage of children for whom MDHS failed to provide the required two visits per month with siblings in even one of the 12 months prior to June 1, 2005, ranged from all (100% DeSoto, Harrison, Jefferson, Pontotoc, Yazoo) to 28.6% (Humphreys).
J. MDHS Fails to Prevent Unreasonably Long Stays in Foster Care for Children with Goals of Reunification without Achieving or Changing their Goals

Under federal law, the permanency goal of reunification is to be achieved within 12 to 15 months; if a child has been in custody for 15 of the prior 22 months, the agency must file a petition to terminate the parents’ rights (so that the child can be freed for adoption) or document compelling reasons why termination of parental rights should not occur. (42 U.S.C. § 675(5)(E)).

Mississippi law provides parents with a six-month period in which to meet the service agreement for reunification. As stated in agency policy (3285, 3286) if the service agreement has not been satisfied within the six months, “and there are not extraordinary and compelling circumstances for extending that agreement, the department will institute parental rights termination action within six months. For children under 3, TPR will be made within two months after the six month period” (3286). “Extraordinary and compelling reasons” (3282) can include that parents are visiting regularly; are unable due to no fault of their own to enter treatment; are making diligent efforts and progressing toward completion of the service agreement; have a diagnosed illness that hinders compliance with the service agreement; or the services needed to reunite the family are not available.

Using the primary permanency goal on the children’s most recent ISP as of June 1, 2005, the mean length of stay for children with the goal of reunification was 1.2 years, ranging from a mean of 3.4 years (Humphreys) to a mean of .8 years (Hinds).

- Thus the mean length of stay in custody (1.2 years) for children with the permanency goal of reunification is more than two times the six months required by MDHS policy (3282, 3333) unless “extraordinary and compelling reasons for extending the time period” are documented.

- Four counties had an average length of stay of more than 15 months for children with a goal of reunification: Humphreys 3.4 years; Pontotoc 1.7 years; Clarke 1.6 years; and Forrest 1.4 years. Each of these counties had exceeded the federal guideline of 12-15 months for either achieving reunification or establishing another permanency goal for the child. (42 U.S.C. § 675(5)(C), (E)).
Discussion

Because children want to live with their families and because, both legally and morally, parents and other legal permanent caregivers have a right to raise their children when they can do so safely, with very limited exceptions public child welfare agencies are required to make reasonable efforts to provide services that enhance the family’s capacities and facilitate the child’s safe return home. Federal law mandates the achievement of this outcome within 12-15 months of the child’s entry into custody; Mississippi state law mandates its achievement within 6 months.

Research has established that achieving the outcome of family reunification is associated with the development of an explicit time-limited service agreement or case plan for the child and family that outlines specific services targeted to address the family problems that caused the child to be placed in custody; with the timely provision of such targeted services to the family; and with frequent parent-child visiting while the child is in custody. Research has also found that to facilitate the ease of visiting, children must be placed in close proximity geographically to their parents or other legal caregivers with whom reunification is planned.

MDHS policy states “The parents will have a six-month period of time in which to meet the Service Agreement with the Department for the benefit of the child” unless extraordinary and compelling reason(s) for extending the time period are documented. The findings reported in this section document that meeting the Service Agreement within six months of the child’s entry into custody is nearly impossible for parents because MDHS has almost fully abdicated its responsibility to provide to children’s parents the services that are essential to achieving reunification.

It must be emphasized that families cannot usually themselves resolve the issues that caused the placement of their children. Services, often multiple and intensive services, are needed. Unless the agency places children in geographic proximity to parents’ homes, provides a Service Agreement (Individual Service Plan) completed in a timely manner, offers and provides targeted services, maintains frequent regular contact with the agency social worker/ supervisor, and provides frequent regular parent-child visits, families cannot be expected to achieve reunification. MDHS failed to provide these services to children’s families.

Research has repeatedly documented that unvisited children are almost always sentenced to lose the option of family reunification. Thus, in failing to provide the majority of children with the goal of reunification even one visit with
their parents for a full year, MDHS is not only disregarding children’s needs for and rights to a relationship with their parents, the agency is also failing to support parents and children in achieving family reunification.

MDHS also failed to ensure that children were able to maintain relationships with siblings from whom they were placed separately. Given the failure to place siblings together, one would have hoped that MDHS would then have made strong efforts to ensure that siblings who were placed separately had regular contact; yet in the year prior to June 1, 2005, 60.1% of the children placed separately from their siblings were not afforded one single visit with a sibling.

No matter what internal or resource issues a public child welfare agency is confronting, it cannot be absolved from harms to children caused by ignoring their needs for and rights to relationships with their parents and siblings. In denying children these relationships, MDHS causes irreparable harm. Clearly, MDHS dramatically fails to make reasonable efforts to reunify children and families and to maintain children’s relationships with their families.

Moreover, one must have grave concern, even alarm, for the safety and well-being of children whom MDHS does reunify with their families. Simply returning a child who has lived out of the home back into the family unit without providing services to support changes in parents’ behaviors and without providing frequent visits to maintain often fragile family relationships predictably results in further harm to the child due to maltreatment.
VIII. Lack of Permanency Planning and Case Management Services

Key findings:

- MDHS fails to identify the whereabouts of family members when children enter custody.
- MDHS fails to update children’s Individualized Service Plans.
- MDHS fails to conduct required judicial annual reviews of the status of foster children.
- MDHS fails to make reasonable progress toward permanency goals and thus subjects children to unreasonably long stays in custody.

Permanency planning requires that the agency that is granted protective custody of children who have been removed from their own homes must systematically provide appropriate services either to facilitate the child’s safe and timely return home (reunification) or to provide the child with a legally protected stable relationship with another caregiver(s), usually through adoption. The public agency social worker’s role is pivotal with regard to accomplishing the tasks and services necessary to achieve permanency for foster children.

Pike et al (1977) clarify the meaning of permanence as it applies to permanency planning for children in foster care:

Permanence describes intent. A permanent home is not one that is guaranteed to last forever, but one that is intended to exist indefinitely. When the expectation of permanence is lacking, a child experiences doubt, uncertainty, and hesitancy. Permanency planning means clarifying the intent of the placement, and, during temporary care, keeping alive a plan for permanency. When a temporary placement is prolonged, foster care may have the appearance of permanency, but it lacks the element of intent that is critical to permanence. (p. 1)

In the process of achieving permanency for children, the public agency social worker has been identified as having “the central and indispensable role of coordinating the activities of these people [foster parents, parents, and others involved in the child’s daily care] and service agencies” (Pike et al 1977:6).
A. MDHS Fails to Identify the Whereabouts of Family Members when Children Enter Custody

In order to determine the services needed by children’s parents and the potential roles that parents and other family members may play in a child’s life both while the child is in foster care and after his or her discharge from custody, family members and their whereabouts must be identified either prior to or at the time of the child’s entry into custody. This basic step is necessary to determine whether a non-custodial parent or relative can be a resource for the child’s placement and/or permanency. Even when children are not expected to return to their parents, an exhaustive search to determine each parent’s whereabouts is required in order to terminate parental rights (Pike et al 1977).

Regardless of the child’s residence prior to entering custody, immediately prior to or following the child’s entry into MDHS custody, Mississippi law (Section 43-15-13 of the Mississippi Code of 1972) and agency policy (3244, 3333) require that social workers shall document diligent efforts to locate parents or guardians if their whereabouts are unknown at the time of placement and the outcomes of such efforts. MDHS policy (3273, 3322) specifically mandates that “The agency must conduct diligent searches for both birth parents and relatives. These searches must be conducted within the first two months of the child’s entry in the foster care system.” Agency policy further clarifies “Failure to conduct diligent searches and inquiries may result in both the TPR Judgement and any subsequent adoption decree to be vacated and set aside for jurisdictional defects” (3274).

National practice standards also stress the importance of locating children’s family members either before or at the time of placement. CWLA standards (FC 0.11) urge that “When it has been determined that a child cannot remain safely with his or her own parents . . . placement with kin should be the first arrangement considered for the child’s care and protection.” Even when family members cannot be a placement resource, they may be able to identify potential living arrangements for the child (CWLA KIN 2.8) and visit with the child while the child is in foster care (CWLA FC 2.44). Similarly, COA standards (S21.1.04) stress that kinship resources should be explored and assessed “prior to non-relative placement.”

Information was collected from the children’s case records to determine agency efforts to identify family members’ identities and whereabouts at the time of the child’s most recent placement. At the time of the most recent entry, the identity of the child’s mother was known in 98.8% of the cases in which it was applicable. In 87.5%, her whereabouts were also known.
In 42.7% of the cases in which the mother’s identity and/or whereabouts were unknown at the time of the most recent entry, the social worker failed to document any efforts to identify and locate the child’s mother within 2 months of the child’s entry into custody.

The identity of the child’s father was known for 81.1% of the children at the time of the child's most recent entry into MDHS custody; his whereabouts were known for only slightly more than one-half (56.8%).

In 72.7% of the cases in which the father’s identity and/or whereabouts were unknown at the time of the child’s most recent entry, the social worker failed to document any efforts to identify the father and/or his whereabouts within 2 months of the child’s entry into custody.

For the majority of children (91.9%), the identity of relatives was known at the time of the most recent entry into custody; for 88.2% the relatives’ whereabouts were known.

For 77.0% of the children for whom the identity and/or whereabouts of relatives were unknown at the time of the child’s most recent entry, the social worker failed to document any efforts to identify relatives and/or their whereabouts within 2 months of the child’s placement.

B. MDHS Fails to Update Children’s Individualized Service Plans

Federal law (42 U.S.C. §§ 671(a)(16); 675(5)) and state policy (3290) require that the child’s case plan be reviewed at least every six months, either judicially or administratively. In order to determine the currency of the ISPs contained in children’s case records, information was collected to determine the most recent ISP completed or updated during the 24-month period prior to June 1, 2005. This information was collected for all children regardless of the date of the child’s most recent entry into custody.

The case records of 9.6% of the children failed to contain even one ISP for the most recent 24-month period. An additional 13.9% failed to contain a plan completed or updated within the 6 months prior to June 1, 2005. Therefore,

MDHS failed to update or complete a case plan for 23.5% of the children during the six months prior to June 1, 2005.
Information contained in most recent ISP. For all children regardless of the date of their most entry into custody, information was collected regarding information contained in the most recent ISP completed or updated during the 24-month period prior to June 1, 2005.

As discussed in Section VIII, given the very serious problems in the reliability of the critical historical information in the ISPs generated by MACWIS, information collected from ISPs and analyzed had to be limited to the primary and concurrent permanency plans, the electronic signatures (identities) of the social worker completing the plan and the ASWS reviewing the plan, and the date(s) of plan completion and review.

Table 17 depicts information that MDHS failed to include in the most recent ISP because either no ISP was found in the child’s file for the most recent 24-month period or MDHS staff failed to include information on the most recent ISP. As reported above, the case records of 9.6% of the children failed to contain even one ISP for the most recent 24-month period.

Table 17. Information Missing from Most Recent ISP Prior to June 1, 2005 for Children Because MDHS Failed Either to Complete ISP During 24-month period Prior to June 1, 2005 or to Include Information in Most Recent ISP

<table>
<thead>
<tr>
<th>Information Missing from Most Recent ISP</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary permanency goal</td>
<td>14.0</td>
</tr>
<tr>
<td>Concurrent permanency goal</td>
<td>46.3</td>
</tr>
<tr>
<td>Electronic signature of social worker responsible to assure plan implementation</td>
<td>42.0</td>
</tr>
<tr>
<td>Electronic signature of ASWS reviewing child’s ISP</td>
<td>28.6</td>
</tr>
</tbody>
</table>

*Percentages are weighted.

C. MDHS Fails to Conduct Required Judicial Annual Reviews of the Status of Foster Children

Permanency reviews are required to assure that progress toward the child’s permanent plan is monitored and that the appropriateness of the plan is periodically assessed. As a requirement of the Adoption and Safe Families Act (ASFA), within 12 months of the child’s entry into foster care, a permanency hearing must be held, open to the participation of the parent, foster parents, pre-adoptive parents and child (Fiermonte & Renne 2002). MDHS policy (3446) states that “a court review, which may be called review, dispositional or permanency hearing must be held within twelve (12) months of initial placement, and annually thereafter.”
Information was collected to identify cases in which annual judicial permanency reviews were conducted in the 24-month period prior to June 1, 2005. Children who had been in MDHS custody less than one year were excluded from this analysis.

- MDHS failed to secure for 85.5% of the children a 12-month permanency review by the court in the 24 months prior to June 1, 2005, ranging by county from 90.0% or more of the children (100.0% Clarke, 94.0% Yazoo, and 90.0% DeSoto) to 57.1% of the children (Humphreys).

Information was also collected to determine whether during the same 24-month period at least one formal 6-month review (County Conference facilitated by a Foster Care Reviewer or court review) was held for children whose most recent stay in custody was longer than 6 months.

- For 5.0% of the children, MDHS failed to provide at least one formal 6-month review during the 24 months prior to June 1, 2005.

As discussed in section VII.B above, there is an apparent systemic programming error in MACWIS that precludes reproducing historical documents that are accurate as of the date of completion. The following table 18 illustrates this problem as it relates to the Youth Court Hearing and Review Summary.
Table 18. Comparison of Excerpted Information from Youth Court Hearing and Review Summaries Contained in Paper File and Those Printed Out from MACWIS and Provided for Case Review

<table>
<thead>
<tr>
<th>Conference Date: 06/03/2004</th>
<th>Conference Date: 06/03/2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong></td>
<td><strong>Part A</strong></td>
</tr>
<tr>
<td>The compelling reason(s) for the identified Permanency Plan and why TPR is not in the best interests of the child, if applicable:</td>
<td>The compelling reason(s) for the identified Permanency Plan and why TPR is not in the best interests of the child, if applicable:</td>
</tr>
<tr>
<td>Sally is placed in DHS custody due to mother being unable to provide for child.</td>
<td>Sally is placed due to mother not being able to care for child.</td>
</tr>
<tr>
<td><strong>Permanency Plan:</strong> (Sally)</td>
<td><strong>Permanency Plan:</strong> (Sally)</td>
</tr>
<tr>
<td>Reunification 08/21/2003</td>
<td>Adoption 08/02/2004</td>
</tr>
<tr>
<td><strong>Concurrent Plan:</strong></td>
<td><strong>Concurrent Plan:</strong></td>
</tr>
<tr>
<td>Durable legal Custody Non Rel</td>
<td>Durable Legal Custody Non Rel</td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td><strong>Part B</strong></td>
</tr>
<tr>
<td>Lists names for Foster Care Reviewer and Social Worker</td>
<td>No names listed for Foster Care Reviewer and Social Worker</td>
</tr>
<tr>
<td><strong>Part C</strong></td>
<td><strong>Part C</strong></td>
</tr>
<tr>
<td>Appears to be identical except that signatures and dates are filled in.</td>
<td>Appears to be identical except that signatures and dates are blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conference Date: 04/26/2005</th>
<th>Conference Date: 04/26/2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong></td>
<td><strong>Part A</strong></td>
</tr>
<tr>
<td>The compelling reason(s) for the identified Permanency Plan and why TPR is not in the best interests of the child, if applicable:</td>
<td>The compelling reason(s) for the identified Permanency Plan and why TPR is not in the best interests of the child, if applicable:</td>
</tr>
<tr>
<td>Sally is placed due to mother not being able to care for child.</td>
<td>Sally is placed due to mother not being able to care for child.</td>
</tr>
<tr>
<td></td>
<td>TPR has been sent to AG’s office and is being processed.</td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td><strong>Part B</strong></td>
</tr>
<tr>
<td>Appears to be identical</td>
<td>Appears to be identical</td>
</tr>
<tr>
<td><strong>Part C</strong></td>
<td><strong>Part C</strong></td>
</tr>
<tr>
<td>Appears to be identical except that signatures and dates are filled in.</td>
<td>Appears to be identical except that signatures and dates are blank.</td>
</tr>
</tbody>
</table>

D. MDHS Fails to Make Reasonable Progress Toward Permanency Goals and Thus Subjects Children to Unreasonably Long Stays in Custody

Agencies are responsible to provide permanency planning and other services in a timely manner in order to avoid subjecting foster children to
unnecessarily lengthy periods of time in custody. As discussed previously, the child welfare system is not intended to serve as a replacement for the families that children need and deserve. Rather foster care is intended to be a temporary solution that has as its outcome the timely and safe achievement of permanency for children. The minimal expectation of social work practice and of agency policy in the area of permanency planning is that reasonable efforts will be made to provide appropriate services either to facilitate the child's safe and timely return home or, if that cannot be accomplished, efforts will be taken to provide the child with a permanent, stable relationship with another caregiver, usually through adoption.

MDHS policy (3248-3249, 3273-3274, 3277-3285, 3287-3307, 3319, 3322-3326, 3328, 3333-3334, 3350-68, 3419-3420) mandates that the child’s social worker is responsible to complete the activities required to achieve permanency for the child. When these social work activities and tasks are not completed, or are not completed in a timely way, children move toward permanency very slowly, if at all.

As is discussed throughout this report, numerous systemic failures deny children the opportunity to proceed toward their permanency goals. The most frequent result of such failures is that foster children in MDHS custody simply get "stuck" in the system without timely progress toward their goals and without efforts taken on their behalf to change their goals when necessary. Being stuck in the system results in lengthy stays in custody that can cause significant harm.

- As of June 1, 2005, the total length of time the children had been in MDHS custody as of June 1, 2005, ranged from less than 1 year to 17.9 years, with a mean length of stay of 2.8 years.

- Thirty percent (29.8%) of the children had been in custody 3 or more years; 8.8% had been in custody for more than 5 years.

**Percentage of the children’s lives spent in custody.** One way to present the harm of long lengths of stay in custody is to portray length of stay as a percentage of a child’s lifetime. Taking into account the children’s age as of June 1, 2005 and the total length of time children had been in MDHS custody,

- 20.9% of the children had spent 50% or more of their lives in MDHS custody.

**Percentage of lifetime spent in custody by children ages six and older.** Spending 50% or more of one’s life in custody presents particularly egregious harm for children ages six and older – children for whom the length of stay in
custody is greater than three years.

Children ages 6-12 had spent a mean of 22.6% of their lives in MDHS custody; 5.3% had spent 50% or more of their lives in custody. When examined by county, the mean, minimum, and maximum percentages of lifetimes that children 6-12 had spent in custody range dramatically:

- For children 6-12, the mean percentage of the child’s life spent in MDHS custody ranged from 40.3% (Humphreys) to 14.3% (Jefferson). The minimum percentage of the child’s life spent in custody ranged from more than one-third (34.0% Humphreys) to 2.1% (Clarke); the maximum percentage ranged from the child’s entire life (99.9% Clarke) to 18.3% (Jefferson).

Adolescents had spent a mean of 23.3% of their lives in MDHS custody; 9.8% had spent 50% or more of their lives in custody. For youth 13 years of age and older, the mean, minimum, and maximum percentages of lifetimes spent in custody also range widely when examined by county:

- The mean percentage of the adolescents’ life spent in MDHS custody ranged from more than 60.0% (60.3% Clarke and 61.0% Humphreys) to 12.5% (Jefferson). The minimum percentage of the adolescent’s life spent in custody ranged from 29.1% (Humphreys) to 1.2% (Yazoo); the maximum percentage ranged from almost the youth’s entire life (97.1% Humphreys) to 20.7% (Jefferson).

**Length of time in custody by permanency goal.** As presented in Table 19, when children’s mean length of time in MDHS custody is examined by the primary permanency goal identified in their most recent ISP, differences range from a mean of 1.2 years for children with the primary goal of reunification to a mean of 5.5 for those with the goal of emancipation.

- Moreover, marked differences in children’s mean length of stay are observed related to children’s County of Responsibility. For example, for children in DeSoto County with the permanency goal of adoption, the mean length of stay is 1.2 years; for children in Humphreys County with the same permanency goal, the mean length of stay is 8.5 years.
### Table 19. Length of Stay by Primary Permanency Goal in Most Recent ISP

<table>
<thead>
<tr>
<th>Primary Permanency Goal from Most to Least Frequent</th>
<th>%* of Children with Goal</th>
<th>Mean Length* of Stay in Years</th>
<th>Mean Length* of Stay in Years (Low County)</th>
<th>Mean Length* of Stay in Years (High County)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption</td>
<td>29.0</td>
<td>3.1</td>
<td>1.2 (DeSoto)</td>
<td>8.5 (Humphreys)</td>
</tr>
<tr>
<td>Reunification</td>
<td>26.9</td>
<td>1.2</td>
<td>.8 (Hinds)</td>
<td>3.4 (Humphreys)</td>
</tr>
<tr>
<td>Emancipation</td>
<td>13.7</td>
<td>5.5</td>
<td>2.8 (Jefferson)</td>
<td>13.3 (Humphreys)</td>
</tr>
<tr>
<td>Relative Placement/Durable Legal Custody</td>
<td>7.1</td>
<td>1.9</td>
<td>.9 (Hinds)</td>
<td>2.8 (Yazoo)</td>
</tr>
<tr>
<td>Relative Placement/Adoption</td>
<td>5.3</td>
<td>3.4</td>
<td>2.1 (Hinds)</td>
<td>7.1 (Yazoo)</td>
</tr>
<tr>
<td>Relative Placement</td>
<td>2.5</td>
<td>2.4</td>
<td>1.0 (Hinds)</td>
<td>3.9 (Humphreys)</td>
</tr>
<tr>
<td>Formalized Long Term Foster Care</td>
<td>1.4</td>
<td>2.7</td>
<td>2.2 (Forrest)</td>
<td>3.5 (Pontotoc)</td>
</tr>
<tr>
<td>No Permanency Plan Identified in ISP</td>
<td>4.4</td>
<td>2.5</td>
<td>.2 (Yazoo)</td>
<td>2.7 (Harrison)</td>
</tr>
<tr>
<td>No ISP in Record in 2 Years Prior to June 1, 2005</td>
<td>9.6</td>
<td>.8</td>
<td>.2 (Forrest)</td>
<td>3.2 (Yazoo)</td>
</tr>
</tbody>
</table>

*Percentages and mean length of stay are weighted.

Information was also collected to determine the progress toward permanency made by MDHS for children with a range of permanency goals. Findings regarding progress toward several permanency goals are reported below. Sections VII and IX contain discussions of the progress toward permanency for children with the permanency goals of reunification and adoption.

**Progress towards permanency for children with primary permanency goals of relative placement, relative placement/adoption, or relative placement/durable legal custody.** Information was collected to determine the progress toward permanency made by MDHS as of June 1, 2005, for children whose primary permanency goal depended upon the identification of the children’s relatives. The most recent primary permanency goal identified for 15.1% of the children in a formal foster care or a court review, whichever occurred closer to June 1, 2005, was either relative placement, relative placement/adoption, or relative placement/durable legal custody.
• For more than one-third (34.1%) of the children with the primary permanency goal of relative placement, relative placement/adoption, or relative placement/durable legal custody, MDHS had failed to identify any relative by whom the child could be adopted or with whom the child could be permanently placed as of June 1, 2005.

• MDHS’ failure to identify any relative with whom the child’s primary permanency goal could be achieved ranged from to 100.0% (Humphreys and Jefferson) to none (0.0% Harrison).

• For 91.5% of those children for whom no relative had been identified, in the 12 months prior to June 1, 2005, MDHS failed to document diligent efforts to locate the child’s relatives.

Progress for children with a concurrent permanency goal of relative placement, relative placement/adoption, or relative placement/durable legal custody. The most recent concurrent permanency goal identified for 36.9% of the children in a formal foster care or court review, whichever occurred closer to June 1, 2005, was either relative placement, relative placement/adoption, or relative placement/durable legal custody.

• Of the children with one of these concurrent permanency goals, for 53.3% MDHS had failed to identify any relative by whom the child could be adopted or with whom the child could be permanently placed as of June 1, 2005.

• MDHS’ failure to identify any relative with whom the child’s concurrent permanency goal could be achieved ranged from more than 80.0% of the children (Jefferson 100.0%; Humphreys 87.5%; Forrest 87.1%; Hinds 86.8%) to none (0.0% Harrison).

• For 50.3% of the children with the concurrent permanency goal of relative placement, relative placement/adoption, or relative placement/durable legal custody for whom no relative had been identified, MDHS failed to document diligent efforts to locate the child’s relatives in the 12 months prior to June 1, 2005.

Progress for youth towards independent living and emancipation. Policy (3417; 8/1/02 Policy Bulletin No. 5742) requires that all youth ages 14-20, including those with the permanency goal of emancipation, “must have an opportunity to participate in a plan for independent living preparation.”
• Of the youth who were 14 years of age or older and eligible for independent living services, the case records of almost two-thirds (65.6%) failed to include an independent living plan for their most recent stay in custody.

**Discussion**

The *Child Welfare League of America Standards of Excellence for Family Foster Care Services* states (0.4):

All children should be part of, or have connection with, families intended to be permanent. Families offer children and young people opportunities for permanence and family relationships intended to last a lifetime. Permanency affords the stability and security that children must have for building competence and self-reliance and for maximizing their physical, emotional, social, educational, cultural, and spiritual growth. Most children’s need for permanency is best met by family relationships.

Federal and agency policy and national practice standards in the areas of permanency planning and case management are based in large part upon research findings documenting the harms to children who “drift” in foster care without permanency (e.g., Fanshel & Shinn 1978; Maas & Engler 1959). In addition, standards and policies are grounded in research conducted in public agency child welfare settings regarding the positive permanency outcomes that can be safely achieved for children when services are intentionally provided by well trained caseworkers using systematic case management and case planning procedures (e.g., Pike et al 1977; Stein, Gambrill, & Wiltse 1978). However, when basic permanency planning and case management practices and policies are not followed, the logical steps of case planning, provision of appropriate and timely services to caregivers and children, review of progress toward the child’s established permanency goal and change in the child’s goal when indicated, and timely reunification or the achievement of another permanency goal, including adoption, cannot occur.

Given MDHS’ failures in permanency planning and case management reported in this section and summarized below, one can predict with reasonable certainty that children will be “stuck” in MDHS custody with little or no movement toward permanency because the required permanency planning and case management services are not being provided. The length of time children are “stuck” in custody appears to be the result of MDHS’ apparent system-wide lack of clarity about permanency goals and their importance, lack of follow through to achieve goals in a timely fashion, and failure to change the child’s goal when it becomes clear that the goal cannot be achieved and to make efforts to achieve another goal. Moreover, it appears that the particular permanency goal with which
children wait in custody and the length of time that they wait with that particular goal arbitrarily depends on the County of Responsibility in which children enter custody and that county’s assignment of permanency goals.

Thus, some counties appear to arbitrarily prefer to keep children waiting while hoping for adoption; yet as reported in Section IX, most of the children in this study who are waiting for adoption have not yet even been legally freed for adoption. Other counties prefer to keep children waiting while hoping for relative placement, relative placement/adoption, or relative placement/durable legal custody; yet for many of the children in this study MDHS has not yet even identified a relative with whom this permanency goal might realistically be achieved, as reported above. Still others keep children waiting without any goal for their permanency. Sadly, in all nine counties the majority of children appear to be waiting for permanence with false hope. Measuring the findings in this section against the requirements for minimally adequate professional practice, MDHS completely fails to meet these requirements.
IX. Lack of Services to Support Adoption

Key Findings:

- MDHS subjects children with a goal of adoption to unreasonable lengths of time in custody waiting to be adopted
- MDHS fails to take mandated steps toward placing foster children in adoptive homes
- MDHS fails to identify the special needs of children with the goal of adoption in order to make reasonable efforts to provide them appropriate adoption recruitment and adoption assistance services

A. MDHS Subjects Children with a Goal of Adoption to Unreasonable Lengths of Time in Custody Waiting to be Adopted

Appropriate foster care practice requires that if a child cannot be returned safely to his or her parents or other family caregivers, then reasonable steps must be taken to move that child toward another permanent home, usually through adoption (Groza, Houlihan, & Wood 2005; Maluccio, Fine, & Olmstead 1986; McFadden 1985; Pike et al 1977). Adoption is defined as “the social, emotional, and legal process through which children who will not be raised by their birth parents become full and permanent legal members of another family while maintaining genetic and psychological connections to their birth family” (CWLA AD 1.1). Because foster care is temporary and by definition not a place for children to grow up, both public policy and national practice standards encourage agencies to “engage in concurrent planning – working simultaneously toward family reunification and adoption or another permanent alternative – for all children in care” (Groza, Houlihan, & Wood 2005:434).

Underscoring the importance of achieving permanency for all foster children as quickly as is safely possible, federal law requires that when a child has been in foster care for 15 of the most recent 22 months, efforts for permanency must shift from reunification to adoption by the filing of termination of parental rights petitions unless an allowable compelling reason not to file has been established. (42 U.S.C. § 675 (5)(E)). Consistent with federal mandates (42 U.S.C. § 675(5)(C)), MDHS policy requires (3297) that “if reunification or Durable Legal Custody cannot be accomplished, then the family situation must be evaluated regarding legal grounds for termination of parents rights [and adoption].”

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15Durable legal custody (3295-3297) is achieved when a relative or non-relative has custody and MDHS is relieved of custody and supervision of the case; the child’s parents, however, maintain their parental rights.
further states “Reasonable effort to place a child for adoption or through Durable Legal Custody should be made concurrently with reasonable efforts to reunify.”

According to MDHS policy (3285-3287, 3332-3333) Mississippi law specifically mandates a more stringent timetable for achieving family reunification than is required by federal law: “[State law] provides that policy of the Department of Human Services shall be to return a child in its custody to the natural parents, or place the child for adoption within six months of the child’s entry into foster care” (3332). Policy (3332) states “The parents will have a six-month period of time in which to meet the Service Agreement with the Department for the benefit of the child. If the agreement has not been satisfied within six months, the Department will initiate parental rights termination action within six months following the six months’ time limitation of the Services Agreement.” Both federal law and state policy as cited above require that when family reunification cannot be achieved within 12-15 months (6 months by Mississippi law), efforts for permanency must shift from reunification to adoption by filing a petition to terminate parental rights petitions unless an allowable compelling reason not to file has been established.

Information was collected to determine the total length of stay in MDHS custody for those children for whom adoption was established as their primary permanency goal at some point during their most recent stay; the length of the children’s most recent stay was also determined. In addition, information was collected to determine the time spent in the child’s most recent stay prior to and since establishment of adoption as the goal; the length of time spent in custody waiting to be freed for adoption; the length of time spent in custody since being legally freed for adoption; and the time spent in custody since placement in an adoptive home.

For 37.6% of the children, adoption was established as the primary permanency goal at some point during their most recent stay in MDHS custody. As of June 1, 2005, the children’s mean age was 9.0, ranging from less than 1 year to 19 years old. Their mean age when the goal of adoption was established was 6.9, ranging from less than one year to 17 years old. Adoption was first

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16 This percentage is higher than the 29.0% reported for children for whom adoption was identified as the primary permanency goal in the most recent ISP in the 24-month period prior to June 1, 2005; however, 29.0% is likely an undercount since it cannot include the permanency goal of 14.0% of children who either had no ISP in the file during the most recent 24 months (9.6%) or who had an ISP, but it did not identify the child’s permanency goal (4.4%). This percentage (37.6%) is also higher than that (28.5%) reported for children whose most recent foster care or court review prior to June 1, 2005, identified adoption as the primary permanency goal; 28.5% is also likely an undercount, as it cannot include the 8.4% of the children who were either excluded from that analysis because they had been in custody for 6 months or less (6.6%) or because they had no permanency plan identified in their most recent foster care or court review (1.8%).
documented as the primary permanency goal for these children as long ago as April 1993, and as recently as November 2004.

The mean length of the most recent stay in custody for children with the permanency goal of adoption surpasses by more than two years the point in time when efforts for permanency should have shifted to adoption:

- The mean length of the *most recent stay* in MDHS custody for children for whom adoption was established as their primary permanency goal during their most recent stay was 3.4 years, ranging from 4.3 months (17 weeks) to 17.9 years.

- The mean *total length of stay* in MDHS custody of children with the goal of adoption was 3.8 years, ranging by county from a mean of 13.8 years (Humphreys) to a mean of 1.1 years (Jefferson).

- As of June 1, 2005, 51.0% of the children with a goal of adoption had been in MDHS custody for a *total* of 3 years or more; 20.7% had been in custody for a *total* of between 5 and 17.9 years.

**Time spent in the most recent entry into MDHS custody prior to the establishment of adoption as goal.** Information was collected to determine the length of time children with a goal of adoption spent in MDHS custody *prior* to the goal of adoption being established during their most recent entry.

- For 59.0% of the children, the goal of adoption was established within the first year of the child’s most recent stay.

- For 31.1%, adoption was established as the permanency goal between either the first and second years of custody (16.9%) or the second and third years of custody in the child’s most recent stay (14.2%).

- For 9.2% of the children, adoption was established as the permanency goal after the child had been in custody for three years or more in his or her most recent stay, ranging as high as

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**Case Example #39**

Four-year-old Sissy entered MDHS custody in December 1993, and her biological mother died in 1996. An ISP 11.5 years later, dated May 2005, includes the following statements: “There is no need for adoption at this time. 07-29-03 The foster parent had mention [sic] they are interested in adopting Sissy and Sissy is agreeable with this. 05/03/05, THE PLAN IS FOR CHILD TO BE ADOPTED.” (emphasis in original). As of June 1, 2005, TPR had still not been filed. Despite Sissy’s permanency goal of adoption, MDHS has failed to move Sissy, now 15 ½ years old, toward permanency.
10.6 years.

**Time spent in MDHS custody since the establishment of adoption as goal.** Using the date on which adoption was first documented in either the child’s ISP or a foster care or court review as the child’s primary goal, information was also collected to determine the length of time children had spent in MDHS custody since the goal of adoption was established.

- Children had spent a mean of 2.1 years in custody since adoption was established as their permanency goal, ranging from 2 weeks to 12.2 years.

- By county, the mean length of time for children since adoption was established as their permanency goal ranged from 3.6 months (Jefferson) to 8.6 years (Humphreys) as of June 1, 2005.

- Almost one-third of the children (32.0%) had spent either 3 to 4 years (18.9%) or 4 or more years (13.1%) in custody during their most recent stay since adoption was established as their primary permanency goal.

**Length of time spent in MDHS custody waiting to be legally freed for adoption.** Information was collected to determine whether MDHS had filed a petition to terminate the parental rights (TPR) of children who had been in custody for more than 15 of 22 months or more, and if not, whether MDHS had documented compelling reasons in their case records for not filing such a petition. Children whose parents were deceased or had surrendered their rights were excluded from this analysis.

- MDHS had not filed a petition to terminate the parental rights (TPR) of 90.9% of the children who had been in MDHS custody longer than 15 of 22 consecutive months (i.e. had entered custody prior to January 2004, see footnote 3).

- For 79.7% of the children who had been in MDHS custody longer than 15 of 22 consecutive months and for whom a petition for the termination of parental rights had not been filed, MDHS failed to document a compelling reason for not filing for TPR.

- For only 4.7% of the children who had been in MDHS custody longer than 15 of 22 consecutive months and for whom a Termination of Parental Rights petition had not been filed with the court was documentation of a

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17 Compliance with this federal standard (42 U.S.C. § 675(5)(E)) was calculated after 17 months in custody (children in custody since before January 1, 2004).
referral for TPR to the State Office Placement Unit found in the child’s record.

MDHS policy (3298) requires social workers to “prepare and submit a complete Termination of Parental Rights (TPR) referral within 30 calendar days after adoption becomes the permanent plan through the county’s decision, order of the court, or recommendation of the Dispositional FCRB” (emphasis in the original). Despite this requirement,

- No logical sequence could be found in the steps of the documented establishment of adoption as the child’s primary permanency goal and the granting of termination of parental rights. For some children, the TPR was granted as many as 1.4 years prior to the establishment of the goal of adoption; for others TPR was granted more than 3 years after the goal of adoption was established.

Information was also collected to determine whether children with the primary goal of adoption during their most recent stay in custody had been legally freed for adoption.

- As of June 1, 2005, MDHS had failed to legally free for adoption 65.7% of the children for whom adoption had been established as the primary permanency goal during their most recent stay in custody.

- In Jefferson and Yazoo counties, not one of the children with the primary goal of adoption had been legally freed for adoption.

- In five counties, more than one-half had not yet been legally freed: Hinds 76.3%; Harrison 68.2%; DeSoto 57.9%; Pontotoc 55.6%; and Forrest 50.0%.

- Twenty-nine percent (28.9%) of the children not yet legally freed were ages 0-5; 45.6% were ages 6-12; and 25.4% were adolescents.

**Time spent in MDHS custody since the child was legally freed for adoption.** Information was also collected to determine the length of time children who had been legally freed by MDHS for adoption spent in custody after they
were legally freed.

- Using the date the child became legally freed from both parents, the mean time children had been in custody since being legally freed for adoption was 2.2 years.

- When examined by county, the mean length of stay for children since becoming legally freed for adoption ranged from .4 years (Pontotoc) to 9.4 years (Clarke).

- 40.2% of the children legally freed for adoption had spent either between 1 and 3 years in custody since they were legally freed for adoption (14.1%) or 3 years or more, ranging as high as 11 years, in MDHS custody since they were legally freed (26.1%).

- Adolescents who had been legally freed for adoption had spent a mean of 4.2 years in custody since becoming legally freed, ranging from 15 weeks to 11 years.

Information collected from children’s records indicates that for some children the process of being freed for adoption may account in part for the excessively long lengths of time they spend in custody waiting to be adopted.

- Almost one-quarter (24.1%) of the TPR petitions were granted either between 2 and 3 years (18.1%) or more than 3 years (6.0%) after the petition was filed. Twenty-one percent (20.5%) were granted within 6 months of filing; 52.4% between 6 months and 1 year of filing; and 3.0% within 1 to 2 years of filing.

B. MDHS Fails to Take Mandated Steps Toward Placing Foster Children in Adoptive Homes

Federal law mandates that the agency document “the steps the agency is taking to find an adoptive family...to place the child with an adoptive family...and to finalize the adoption...At a minimum, such documentation shall include child specific recruitment efforts such as the use of State, regional, and national adoption exchanges including electronic exchange systems” (42 U.S.C. § 675(1)(E), 45 C.F.R. § 1356.21(g)(5)).

Consistent with federal mandates, MDHS policy states that if the child cannot be safely reunified with his or her parents/relatives within the legal time frame or if reasonable efforts to reunify are not required, the child’s ISP must include “documentation of the steps the agency is taking to find an adoptive
permanent home, place the child with an adoptive family, durable legal custody or other permanent home and finalize the adoption” (3289). Policy also states (3298) “For every child whose permanency plan is adoption or another permanent placement, the Department is required to document the steps taken to find an adoptive family or permanent home.” Documentation must include (3298) “child specific recruitment efforts such as Adoption Resource Exchange, Internet, newspaper, picnic, media and/or other activities to identify an adoptive family for a child.”

National practice standards for adoption services emphasize that the agency should frame adoption services “in terms of the resources needed to find, prepare, and support an adoptive family for a child” (CWLA AD 1.12). Emphasis is given to aggressive child-specific recruitment (CWLA AD 3.16, 3.18), promptness of placement with adoptive appropriate families (CWLA AD 1.11, 3.1), and extensive services (CWLA AD 1.22, 3.23, 3.24, 5.5, 5.6) to support what is called the adoptive triad – the child, the child’s birth family, and the adoptive family. Similarly COA standards (S14.1) require that the agency provide “child-focused services, either directly or through arrangement, to all parties involved in the adoption, including the child, the adoptive applicants/parents, and the birth parents, as appropriate, and in accordance with the Interstate Compact on Placement of children or Canadian equivalent, including provisions related to medical and adoption assistance.” COA standards emphasize that the agency must initiate “an orderly adoption process” (S14.3.01).

As reported earlier in this section, for 37.6% of the children, adoption was established as the primary permanency goal at some point during their most recent stay in MDHS custody. For those children for whom adoption was indicated as the primary permanency goal during their most recent stay in custody, information was collected from children’s case records to determine the minimum actions that MDHS took to move the children toward adoptive placements, including exploring the children’s foster parents’ interest in adopting them; referring foster children to the Adoption Specialist; and other efforts made to identify and recruit adoptive homes for children with the goal of adoption and to place children in adoptive homes. Separate adoption files were not always provided for review.

**Failure to progress with foster parents as a resource for adoption.** It is widely accepted that children’s foster parents are a significant source of adoptive parents (Cole 1985; Barbell & Freundlich 2005:508). MDHS policy (3298) requires that social workers’ reasonable efforts to place a child for adoption should occur concurrently with reasonable efforts to reunify and that social workers’ responsibilities include to “Discuss the plan of adoption with the child, parents, and foster parents [and] Ascertain whether or not the foster parents are interested in adopting the child.” Policy (4582) requires that “the County Worker should
encourage application for adoption of the foster child only in those situations where the County Worker, and the Area Social Worker Supervisor(s) are in agreement that the child’s best interest would be served through adoption by foster parents. The case discussion and recommendations of the County Staff should be recorded in the case record.” According to policy (4584-4586), an Adoption Study following the procedures under Foster Home Adoption Study is to be completed by the Adoption Specialist when the foster parents’ application to adopt has been received by the Adoption Unit. Policy (4588) provides that if the child’s foster parents are approved as adoptive parents, “there will be no additional supervisory period prior to the finalization of the adoption. The time the child has been in the Foster Home under the supervision of the county Social Worker will count as the supervisory period.”

MDHS policy (6139-6141) also provides for Foster/Adopt Foster Homes “that have been studied and approved for licensure by meeting the requirements for both foster home licensure and adoption approval” and are used as a placement option “for a child who has been assessed as at high risk for adoption becoming the permanent plan.”

- In 33.3% of the cases in which adoption was the goal and in which it was applicable (i.e., the child was placed in foster family placement and not yet moved to an adoptive home), the foster family with whom the child was placed was not identified as an adoptive resource for the child.
  - In 36.3% of these cases, no reason was given in the child’s record for not considering the family as an adoptive resource.
  - In 31.7% of the cases in which the foster family with whom the child was placed was not identified as an adoptive resource for the child the foster parents did not want to adopt the child; in 7.9% the foster child did not want to be adopted by the foster parents. In 6.4%, the agency did not approve the family for adoption, and in 17.7%, other reasons were documented.

- In 92.4% of the cases in which the foster family with whom the child resided was identified as an adoptive resource, MDHS had discussed adoption with the family.

- Ninety percent (90.3%) of the foster parents with whom adoption was discussed by MDHS expressed an interest in pursuing adoption of the foster child residing in their home.
  - For more than two-thirds (69.1%) of the foster parents who expressed to MDHS interest in adopting the foster child placed in their home, no referral for an adoptive home study or any other information was
documented by MDHS concerning the foster parents’ status as potential adoptive parents as of June 1, 2005.

- Of the 30.9% of foster parents who had expressed an interest in adopting the foster child who resided with them and had been referred for an adoptive home study as of June 1, 2005,
  - An adoptive study had been completed for only 52.9% as of June 1, 2005; all had been approved as adoptive families.
  - For more than a quarter (26.5%), the study had either not yet begun (5.7%) or had not yet been completed (20.8%).
  - For 20.8%, no further information was documented by MDHS as to their status as potential adoptive parents as of June 1, 2005.

**Failure to place the child in an adoptive home.** According to agency policy (4501), “Actual placement of foster children in an adoptive home will not be made until the child is legally free for adoption” unless “a legal risk placement is granted by the Placement Director and cleared through the Attorney General’s Office.”

- As of June 1, 2005, MDHS failed to place 36.9% of the children with adoption as their goal in an adoptive home; children who had been placed in adoptive homes had been placed there for a mean of 4.2 years, ranging from 6.6 months to 13.2 years.

- In six counties, MDHS failed to place one-third or more of the children with the goal of adoption in an adoptive home: Jefferson 83.3%; Humphreys 50.0%; Forrest 49.4%; Yazoo 44.0%; Hinds 37.5%; and Pontotoc 33.3%.

- Moreover, for 85.5% of the children who were not placed in an adoptive home, MDHS failed to document any child-specific recruitment efforts to locate an adoptive family during the two years prior to June 1, 2005.

- In six counties (DeSoto, Clarke, Hinds, Jefferson, Pontotoc, and Yazoo) MDHS failed to document any efforts within this two-year period to locate an adoptive family for all (100.0%) of the children with the goal of adoption who were not yet placed in an adoptive home.

National practice standards (CWLA AD 1.13, 3.7, 3.8) emphasize the
importance of placing siblings together in an adoptive home, stating that “The agency providing adoption services should place siblings together in adoption unless serious reasons have been specifically identified that necessitate their separation” and that siblings relationships are “a powerful source of constancy for a child.” MDHS does not even mention placement of siblings together in its policies regarding the selection of adoptive homes for children (4560-4563). Information was collected to determine whether siblings had been placed together in adoptive homes.

- More than one-half (54.2%) of the children placed in an adoptive home were not placed with their entire sibling group.

- MDHS failed to place 60.0% or more of the children in adoptive homes with their entire sibling group in six counties: Jefferson, Clarke, and Yazoo, 100.0%; Hinds 81.8%; Harrison and Pontotoc, 60.0%.

- Moreover, MDHS failed to document any efforts to place siblings together in an adoptive home for 51.4% of the children placed separately from their sibling group.

- The percentage of children for whom MDHS failed to document why siblings were not placed together in an adoptive home ranged from 40.0% (Hinds) to 100.0% (Jefferson, Pontotoc).

For 9.0% of the children, the most recent concurrent permanency plan identified in a formal foster care or court review, whichever occurred closer to June 1, 2005, was adoption.

- For 75.6% of these children, as of June 1, 2005, MDHS had failed to place them with a foster family identified as willing to adopt, ranging from 100.0% (DeSoto, Clarke, Forrest, and Humphreys) to none (0.0% Yazoo).

**Failure to refer the child to an Adoption Specialist.** As cited above, MDHS policy (3298) states “Reasonable effort to place a child for adoption or through Durable Legal Custody should be made concurrently with reasonable efforts to reunify.” Policy (3298) further states that child specific recruitment for an adoptive family must be done for every child whose permanency plan is adoption (emphasis added). However, somewhat inconsistently with these mandates, policy requires only that for “any child freed for adoption” (4510), the Adoption Unit will immediately send notification to the Adoption Specialist/Adoption Worker.
• MDHS failed to assign an Adoption Specialist for 73.8% of the children for whom adoption was the goal during the child’s most recent stay in custody as of June 1, 2005.

• Of those children for whom an Adoption Specialist had been assigned, almost one-third (30.2%) had either been assigned between 1 and 2 years (15.4%) or three or more years (14.8%) after the establishment of the goal.

• Only 47.3% of the children had been assigned to an Adoption Specialist within 6 months of the establishment of the goal of adoption; 22.4% had been assigned between 6 months to a year.

失败 to place children legally freed for adoption in adoptive homes. For the 34.3% of the children with adoption as the permanency goal who were legally freed for adoption,18 information was collected to determine the actions MDHS took to achieve this permanency goal.

MDHS policy (4509, 4510) specifically requires “When a child becomes free for adoption, the child’s social worker will immediately begin the preparation for adoption process with the child . . . The Adoption Unit will immediately send notification of any child freed for adoption to the Adoption Specialist/Adoption Worker.” Other policies require that MDHS staff “coordinate child specific recruitment activities” (4528) to identify an adoptive home for children legally freed for adoption. As cited previously in this section, both federal law and agency policy require documentation of child-specific efforts to identify and recruit adoptive families for foster children.

• Despite the policy requirement that legally freed children be immediately referred to the Adoption Specialist, 36.8% of the legally freed children with the goal of adoption had not been referred to an Adoption Specialist as of June 1, 2005.

• As of June 1, 2005, MDHS failed to place 17.2% of the legally freed children with the goal of adoption in an adoptive home.
  o For 66.1% of the legally freed children not placed in an adoptive home, MDHS failed to document any child-specific recruitment efforts to locate an adoptive family in the 24 months prior to June 1, 2005.
  o Four counties were responsible for all of the children who were legally

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18 Legally freed children included those for whom TPR had been granted as well as children legally freed as a result of the death of the child’s mother and/or the father and/or as a result of the voluntary surrender of a parent’s legal rights.
free but not yet placed in an adoptive home (17.2% of the legally freed children). No efforts were documented in the two years prior to this date to recruit an adoptive family for any of the children in three of these counties: DeSoto, Clarke, and Pontotoc. In the fourth, Forrest County, efforts were made to recruit adoptive homes for only 50.0% of the children not yet placed with an adoptive family.

As discussed previously in this section, national practice standards urge the placement with siblings together as a group for adoption (CLWA AD 1.13, 3.7, 3.8). However,

- 52.1% of the legally freed children placed in an adoptive home were not placed with their entire sibling group.

- MDHS failed to document any efforts to place siblings together for 42.6% of the children placed in adoptive homes separately from siblings.

**Time in MDHS custody since the placement of legally freed children in an adoptive home.** As of June 1, 2005, 82.8% of the legally freed children with the goal of adoption were living in adoptive homes pending finalization.

- The mean length of time since the date legally freed children had been placed in an adoptive home was 3.3 years, ranging from 6 weeks to 12.6 years.

- 44.3% of the legally freed children had been living in an adoptive home and awaiting adoption for more than 2 years.

- 17.5% of the legally freed children had been living in an adoptive home and awaiting adoption for more than 4 years.

C. MDHS Fails to Identify the Special Needs of Children with the Goal of Adoption In Order to Make Reasonable Efforts To Provide Them Appropriate Adoption Recruitment and Adoption Assistance Services

In the past 25 years, adoption has been redefined as a service that seeks permanent homes for every child (Hartman 1985), recognizing that some children’s “special needs” require additional efforts to recruit and support adoptive homes that will meet their needs. Several characteristics qualify a child as a “child with special needs” for the purposes of recruitment, assessment, and/or Adoption Assistance. MDHS policy defines special needs children as including those “where one of the following circumstances present a [an adoption] placement barrier: Older children, in the six to eighteen age range; membership in a family
group of brothers and/or sisters of two or more; emotionally handicapped; mentally and/or physically handicapped; medical conditions (4539).”

The formal identification and documentation of a foster child as a “child with special needs” is critical; policy (4539) states that “families who express interest in adopting a ‘special needs’ child are given priority in the acceptance of applications.” MDHS policy further states (4600) “Adoption Assistance is designed as a supplemental financial benefit to assist families adopting an eligible child with special needs who would be unlikely to be adopted otherwise. The purpose of Adoption Assistance is to reduce financial barriers that may impede the special needs child’s opportunity for adoption. Authorization of Adoption assistance is based upon the needs of the child (emphasize in the original).” Policy (4602) states that when children are free for adoption, “The Adoption Unit Staff is responsible for compiling the information needed to determine a child’s eligibility for IV-E Adoption Assistance. The Child must be determined eligible for Adoption Assistance by the Adoption Assistance Program specialist and approved by the administrator of the Adoption Unit as requiring Adoption Assistance to assure adoption.”

National practice standards (CWLA AD 1.22) state that “To be effective and have the capacity to place children with a wide range of needs into adoptive families without delay, the agency providing adoption services should have available a core of essential services, including counseling; adoptive parent recruitment, assessment, preparation and training; and financial and supportive services.” COA practice standards (S14.3.07) stress that an agency “that has assumed responsibility for placing a child with special needs uses concentrated efforts to conduct and stabilize the [adoptive] placement such as intensive recruitment of adoptive parents, the use of an adoption resource exchange, or subsidized adoption, as appropriate.”

Information was collected to determine whether the child was identified in the case record as having at least one of the “special needs” characteristics identified in MDHS policy as of the date that adoption was established as the child’s primary permanency goal. Also presented is the percentage of children with the goal of adoption for whom each characteristic of “special needs” applied and the percentage of children with each characteristic who were formally identified by MDHS as a “special needs” child.
Table 20. % of Children with Goal of Adoption Who Had Special Needs Characteristic Identified in MDHS Policy and were Formally Identified by MDHS as “Special Needs” Child

<table>
<thead>
<tr>
<th>Characteristics Identified in MDHS Policy as “Special Needs” Characteristics for Purpose of Adoption Recruitment and Adoption Assistance</th>
<th>%* of Children with the Goal of Adoption Whose Case Records Identified That They Had This Characteristic</th>
<th>% of Children With Goal of Adoption and This Characteristic and Who Were Identified by MDHS as “Special Needs” Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally, mentally, and/or physically handicapped</td>
<td>25.7</td>
<td>19.3</td>
</tr>
<tr>
<td>Older children, in the six to eighteen age range</td>
<td>58.7</td>
<td>11.7</td>
</tr>
<tr>
<td>Membership in a family group of brothers and/or sisters of two or more</td>
<td>55.5</td>
<td>5.8</td>
</tr>
<tr>
<td>Medical conditions</td>
<td>8.2</td>
<td>3.6</td>
</tr>
</tbody>
</table>

*Percentages weighted. Many children had more than one of these characteristics.

- 96.5% of the children with the goal of adoption had at least one of the characteristics identified by MDHS in policy as qualifying them as a child with “special needs” for the purposes of recruitment or adoption assistance; 50.6% of the children with the goal of adoption had more than one of these characteristics.

- Only 7.2% of the children who qualified under MDHS policy as a child with “special needs” were formally designated by MDHS as having “special needs” for the purposes of recruitment or adoption assistance.

- In five counties (DeSoto, Clarke, Forrest, Jefferson, and Pontotoc) not one (0.0%) of the children who qualified under MDHS policy as a child “with special needs” in any category were formally designated by MDHS as having “special needs” for the purposes of recruitment or adoption assistance.

- Of the children who were legally freed for adoption, 85.5% had information in their case records indicating that they had one or more of the above characteristics that would qualify them as a child with special needs. However, MDHS had designated only 5.6% of the legally freed children as “child[ren] with special needs” for the purpose of recruitment or adoption assistance.
Discussion

Case Example #41

Cherese, Chuck, Josh, and Bob Matthews, age 5 months to 5 years, entered MDHS custody due to sexual abuse in May 1992. TPR was granted in 1995 but was appealed. According to a January 2003 case note, the Supreme Court remanded the case back to the lower court for rehearing in 2000. As of June 1, 2005—ten years after TPR was first granted—that hearing had not been scheduled. As a consequence, none of these four siblings—each of whom has been in MDHS custody for thirteen years—has yet achieved permanency.

In late 1995, Josh’s foster parents, with whom he has lived for his entire stay in custody, completed an application to adopt him. Also in 1995, Cherese and Bob’s foster parents, the Chesnutts, completed an application to adopt them; Cherese and Bob had lived with the Chesnutts since 1993. In 2000, their brother Chuck was moved to the Chesnutt’s home, and, though Chuck is not even mentioned in the MDHS adoption file, he has stated to his psychologist that he too hopes to be adopted by the family before entering the armed services. However, as of June 1, 2005, there is no documentation that, for either family, an adoptive study has even been completed.

In the five years prior to June 1, 2005, MDHS repeatedly failed for extended periods to provide any documentation of contact or other services. The children’s files contain reprimands of MDHS staff for failure to include any documentation in the children’s records for periods as long as nine months. Cherese, Bob, and Chuck have not had face-to-face contact with their social worker for at least two years. Moreover, Josh has rarely been provided contact with his three siblings from whom he was separated at entry into custody.

The children’s files contain numerous letters to the judge with statements such as “I wanted to be adopted NOW!” (Emphasis in original.) A January 2005 evaluation of one of the children states that failure to complete the adoption soon is likely to “so strongly destabilize” the child that the child’s “adolescence will become a tragedy.” The evaluator continues: “All sources of help in Mississippi, including high ranking DHS personnel, the State Supreme court, and the State Attorney General’s Office, should be solicited by DHS to settle any issues blocking [the child’s] adoption.”

Should family reunification not be achieved for children with that permanency goal, the goal of adoption may provide an alternative opportunity for permanency. However, children with adoption as their goal are running out of permanency options.

At first glance, it might appear that a large proportion (37.6%) of the children in this study are moving toward permanent homes with an adoptive family given MDHS’s designation of adoption as the children’s permanency goal. What the findings presented in this section make clear, however, is that these children have not, and most likely will not, be moving anywhere. More than one-third (34.3%) of these children are legally orphans since MDHS has petitioned for and been granted the termination of the children’s parents’ rights. And yet these children continue to wait for a permanent home for up to 11 years.

If adoption is not achieved for them, these children will most likely live out
the rest of their childhoods in MDHS custody. If the current MDHS practices continue, it is highly unlikely, even impossible, that adoption will be achieved for most of the children for whom adoption was established as their primary permanency goal during their most recent stay in custody.

Clearly, MDHS has not made reasonable minimum efforts, and in many instances any efforts, to achieve adoption for the children in its custody. The agency has failed to achieve the major milestones for children with the permanency goal of adoption – petitioning to free the child for adoption, legally freeing the child, moving the child into an adoptive placement, and finalizing the adoption. Moreover, those children with special needs with the goal of adoption were treated by MDHS as anything but special.
X. Recommendations

The following actions are recommended to immediately address the documented ongoing harms to children in MDHS custody.

Emergency actions needed:

- Every child in MDHS custody should immediately be provided face-to-face contact with independent professionals to determine his or her safety as well as to identify the immediate need for the child to be provided physical, dental, and psychological evaluations.

- The placement history of every child in MDHS custody should immediately be reviewed by independent professionals to determine whether the child’s current placement provides the level of care appropriate to meet the child’s basic and special needs, and, if not, to identify the steps needed to determine the type of placement needed and to achieve an appropriate placement for the child.

- All MDHS staff involved in face-to-face contact monitoring children’s safety and well-being while in custody should immediately be provided training that specifically addresses communicating with, interviewing, and observing foster children.

Immediate actions needed:

Mechanisms are clearly needed to assure statewide compliance with federal and state policy and to assure that counties conduct ongoing reviews of children’s safety, placement services, and progress toward permanence.

Statewide and County Mechanisms should be developed to:

- Monitor all placement changes for infants and children 5 and under, including changes to and from emergency placements.

- Monitor the use of emergency placements for all children and develop plans to decrease over-use of emergency placements at children’s entry into custody as well as throughout children’s stays in custody.

- Review the frequent use of time-limited assessment and treatment placement programs for children and determine 1) the degree to which the use of these time limited placements creates “revolving door” placement...
experiences for children and 2) in what instances resources in the community in which the child is placed could be used to provide assessment and treatment services and thus avoid placement changes.

• Review statewide and county placement capacity for 1) children with diagnosed/documented special medical, educational, and mental health needs; 2) very young children; 3) adolescents; and 4) sibling groups. Develop a short- and long-term plan for targeted recruitment and development of a range of family and facility placements that will adequately meet the needs of these populations.

• Monitor the status of and support provision of placement services, including:
  o services to children with the permanent goal of family reunification, including provision of services to the child’s parents, adequacy and implementation of the parent-child visiting plan, identification of a concurrent permanent goal for the child, and timetable for goal change if reunification not achieved.

  o services to children with the permanent goal of adoption, including filing of petitions for termination of parental rights, identification and recruitment of adoptive homes, and placement of children in adoptive homes. Particular attention should be given to identifying children with special needs and recruiting adoptive families for these children.

  o services to children with permanent goals dependent upon identification of relatives, including diligent efforts to identify relatives and recruit relatives for goal achievement, and a timetable for goal change if a willing and able relative cannot be located.

To address serious staffing problems:

• Evaluate the training and support needs of foster caregivers and develop concrete plans and programs to provide ongoing services and training for foster caregivers, including relative foster parents.

• The state should immediately discontinue its waiver permitting MDHS staff other than trained professional social workers and supervisors to meet the face-to-face contact requirements with children and foster caregivers.

• Sufficient trained professional social work staff should be employed to assure that MDHS provides minimum required face-to-face contact with children, caregivers, and children’s parents, and provides continuity of
social workers and social work services.

- Sufficient trained social work supervisors should be employed to monitor social work services, including face-to-face contact with children, families, and foster caregivers; reporting, investigation, and follow-up of documented suspected caregiver maltreatment; decisions regarding children’s placement and placement changes; and MDHS efforts to achieve children’s permanency.

**Policy is needed in the areas of:**

- A specific standard for face-to-face contact with foster caregivers in their homes for purposes of support, monitoring children’s safety, monitoring foster caregivers’ training needs, and identifying suspected maltreatment of children.

- The identification, reporting, and investigation of suspected maltreatment in children’s foster homes and facilities, including guidelines for monitoring and assuring children’s safety while investigations are underway, such as the use of temporary placement of children, and guidelines for assuring children’s safety when investigations have been completed, such as implementing, monitoring, and evaluating the achievement of corrective action plans.

- Required agency services to children and caregivers to prevent unnecessary placement disruptions and the over-use of emergency placements.

- The ongoing medical, dental, and psychological evaluations and services to children in custody.
Sources Cited


________. (1999). *Child Welfare League of America standards of excellence for services*


**Federal Statutes**

45 C.F.R. § 1355.34(a)(iii)(B)
45 C.F.R. § 1355.34(b)(i)(A)

20 U.S.C. § 1414

42 U.S.C. § 671(a)(16)

42 U.S.C. § 675(1)

42 U.S.C. § 675(1)(C)

42 U.S.C. § 675(1)(C)(iv)

42 U.S.C. § 675(1)(E)

42 U.S.C. § 675(5)(A)

42 U.S.C. § 675(5)(C)

42 U.S.C. § 675(5)(D)

42 U.S.C. § 675(5)(E)

**Mississippi State Policies**

February 7, 2006
Appendix A
CURRICULUM VITAE

PEG McCARTT HESS
1108 Meadow Lane
Kingsport, TN 37663
(423) 239-6104
peghess@charter.net

EDUCATION

1987       Ph.D., University of Illinois at Urbana-Champaign, School of Social Work
Dissertation: What caseworkers consider in developing visiting plans for children
in foster care

1970       M.A., University of Chicago, School of Social Service Administration, with
honors

1968       B.A., Duke University

ACADEMIC APPOINTMENTS

2003-2005  University of South Carolina - Columbia, College of Social Work:
Professor; Director of Doctoral Studies, 2003-2004; tenured 2003; on leave 2004-2005

2001-2005  University of South Carolina - Columbia, Institute for Families in Society:
Research Professor and Associate Director for Research and Scholarship, 2001-2003;
Faculty Affiliate 2003-2005

2001-2002  University of South Carolina - Columbia, College of Education: Adjunct
Professor

and Professor, 1998-2003; Associate Professor, 1992-1998; tenured, 1994

1994-2003  Faculty, Columbia University Graduate School of Arts and Sciences

tenured 1987; Assistant Professor 1982-87; Teacher Practitioner, 1981-82

1979-1981  University of Tennessee School of Social Work, Memphis: Assistant Professor

1977-1979  University of Alabama School of Social Work: Assistant Professor, 1978-1979;
Faculty Field Instructor, 1977-1978

1974-1977  University of Chicago, School of Social Service Administration: Field Instructor
PUBLICATIONS

Books and Monographs


Book Chapters


Journal Articles


**Research and Policy Reports, Training Manuals, and Other Publications**


**RESEARCH AND TRAINING GRANTS AND PROJECTS**


*Co-Principal Investigator.* (2002-2003). The Relationship Between Childhood Sexual Abuse and Adult Sexual Assault. With Vicki Flerx. Funded by the University of South Carolina Office of Research Support Programs.


SOCIAL WORK EDUCATION

Courses Taught

- Qualitative research methods
- Monitoring and evaluating clinical practice (developed and taught)
- Social service delivery systems: Child and family welfare
- Foundations of social work practice
- Advocacy in social work practice
- Direct social work practice
- Advanced clinical practice with families with children
Social work practice with children (developed and taught)  
Values and ethics in social work practice (developed and taught)  
Addressing ethical dilemmas in advanced clinical practice (developed and taught)  
Principles of field instruction (developed and taught)  
Generalist social work practice (BSW)  

**Dissertation Committee and Research Practicum Supervision**

*Columbia University School of Social Work:*

Jeanne Finch “ A Study of Drug Involved Mothers” DSW granted May 2000  
Mary Banach “In Whose Best Interest: Decision Making in Child Welfare” DSW granted May 1995  

Research practicum supervision:  
Michael Powell (1996-97)  
Ernst VanBergijk (1996-97)  

**LEGISLATIVE/LEGAL TESTIMONY AND CONSULTATION**

Prepared for expert testimony, Michael H. v. Giuliani (Superior Court, NY County), 1994-1996  
Testimony before the Indiana Commission on Abused and Neglected Children, June, 1992.  
Testimony re: Senate Bill 238, Indiana Senate Health and Human Services Committee, January 12, 1990.  
SELECTED CHILD WELFARE CURRICULUM DEVELOPMENT, TRAINING, AND CONSULTATION

2006-current  Casey Family Programs, Washington, DC. Consultant.
2005  Tennessee Department of Children’s Services, Nashville, TN. Consultant.
2003-2004  Northwest Crescent Child Development and Family Services Center, Greenville, SC. Consultant


PROFESSIONAL PRACTICE

1984-1992  Children’s Bureau of Indianapolis. Child welfare clinical and program consultation, supervision, and staff development

1987-1991  Visiting Nurse Association of Indianapolis. Child welfare clinical and program consultation and staff development


1975-1977  Independent social work practice, Lake Forest, Illinois

1970-1972  Special Education District of Lake County, Illinois. School social worker (K-12)

PROFESSIONAL PUBLICATIONS, REVIEWER

Faculty Editorial Committee, Columbia University Press, 2001-2003
Consulting Editor, *Marriage and Family Review*, 24, Special Issue: The Methods and Methodologies of Qualitative Family Research, 1996

SELECTED ACADEMIC AND PROFESSIONAL PRESENTATIONS


“Becoming a Professional.” Commencement speech, University of Illinois Urbana-Champaign, School of Social Work. May 1999

“Self Awareness for Multicultural Practice.” Faculty Development Institute, CSWE Annual Program. With C. Franks, E. Sheiman, K. Walters, & D. Wheeler. San Francisco, 1999


"Court Ordered Supervised Visitation: Documenting an Unmet Need." Association of the Bar of the City of New York, Committee on Family Court and Family Law, 1994


"Reunification in the Context of Permanency Planning." International Reunification Symposium, Charleston, S.C., 1992

"Evaluating Effectiveness of Family Reunification Services." With G. Folaron & R. Kinnear. 5th National Assoc. for Family-Based Services Empowering Families Conf, St. Louis, 1991

"The Challenges of Permanency." Ohio Assoc. of Child Caring Agencies, Columbus, 1991


PROFESSIONAL ORGANIZATIONS AND SELECTED COMMUNITY SERVICE ACTIVITIES

The Children’s Advocacy Center, Sullivan County, TN. board member, 2004-current
Wellmont Hospice, 2004-current volunteer bereavement counselor
National Association of Social Workers, 1970-current
Supervised Visitation Network, 1992-2002
New York City National Association of Social Workers (NASW) School Social Work
Columbia University Rape Crisis Center, Volunteer Supervisor, Fall 1992-1994
Coalition for Children's Access to Parents, Founding Board Member, Indiana, 1989-1994
Indiana Chapter for the Prevention of Child Abuse, Executive Com.of the Board 1991-1992

PROFESSIONAL CERTIFICATION

NASW, Academy of Certified Social Workers (ACSW) (entry date 1975)
Appendix B
CURRICULUM VITAE

Peter R. Jones
Acting Vice Provost for Undergraduate Studies
5th Floor Conwell Hall, Temple University
Philadelphia, Pennsylvania 19122

Home:       Work:
Tel: (610) 446-3060   (215) 204-2044
Fax: (610) 789-9065   (215) 204-3175
E-Mail:  prjones@temple.edu

Personal Information:
Date of Birth:   September 17, 1954 (Wales)
Marital Status:  Married with four children
Home Address:  219 Sagamore Road, Havertown, Pennsylvania 19083

Education:
• Ph.D. (Geography), 1981 University College of Wales, Aberystwyth
  (Thesis: The Decline of Community in the Modern City.)
• B. A. (Geography), 1976 University College of Wales, Aberystwyth

Professional Organizations:
• American Society of Criminology
• Academy of Criminal Justice Sciences
• American Probation and Parole Association
• American Association of Colleges and Universities

Professional Experience:
2004-  Acting Vice Provost for Undergraduate Studies, Temple University, Philadelphia
2001-2004 Principal, Crime and Justice Research Center, Temple University, Philadelphia
1991-  Associate Professor, Department of Criminal Justice, Temple University, Philadelphia
1989-2001 Principal, Crime and Justice Research Institute, Philadelphia
1985-91 Assistant Professor, Department of Criminal Justice, Temple University, Philadelphia
1979-85 Senior Research Officer, Home Office Research and Planning Unit, London, England

Professional Activities (last 5 years):
• Board Member American Association of Community Justice Professionals (AACJP) 2005-
• Board Member, National Community Corrections Victim Services Association, 2005-
• Board Member Awareness of Teaching & Teaching Improvement Center (ATTIC) Temple University, 2001-
• National Institute of Justice Consultant (2004-)
• University Learning Communities Research Fellow, Temple University (2001-)
• Graduate Chair, Department of Criminal Justice, Temple University (2000-2003)
• Member, University Task Force on Course & Teaching Assessment (2001)
• Member, College of Liberal Arts Committee on Course & Teaching Assessment (2001)
• Member, University Committee on Assessment of Teaching (2001)
• Member, University Committee on Teaching Evaluation (2000)
• Member, Distinguished Teacher Award Committee, College of Liberal Arts, Temple University (2000)
• Student Mentor for Project PUMP Mentoring Program, Temple University, (1999-2000)
• Student Mentor, Temple University (1999-2000)
• Board Member, Awareness of Teaching and Teaching Improvement Center (ATTIC) Committee, College of Liberal Arts, Temple University (1998-)
• Board Member, Social Sciences Data Library, College of Liberal Arts, Temple University (1998-)
• Member, Ruth Shonle Cavan Young Scholars Award Committee, American Society of Criminology, (1998-99)
• Member, Undergraduate Committee, Department of Criminal Justice, Temple University (1997-99)
• Member of Planning Group, Center for Public Policy, College of Arts & Sciences, Temple University, (1997-99)
• Member of Steering Committee of University Community Collaborative of Philadelphia Project (UCCP), (1997-99)
• Associate Editor, The Prison Journal, Sage Publications (1993-99)
• Member, Student Awards Committee, American Society of Criminology, (1994-95)
• Chair, Merit Committee, Department of Criminal Justice, Temple University (1993-94; 1994-95)
• Youth Aid Panelist, Haverford Township, PA. (1995-2000)
• Chair, Committee on the Quality of Instruction, Department of Criminal Justice, Temple University (1996-00)
• Chair, Committee on Instruction, Department of Criminal Justice, Temple University (1992-94)
• Chair, Undergraduate Curriculum Committee, Department of Criminal Justice, Temple University (1993-96)
• Chair, Search Committee, Department of Criminal Justice, Temple University (1987/88 and 1988/89)
• Member, Departmental Personnel Committee (since 1993)
• Member, Departmental Technology Committee 1997/98
• Member, Social Science Data Library Advisory Committee 1997/98
• Program Co-Chair, American Society of Criminology, Annual Conference, Montreal (1986-87)
• Program Committee Member, American Society of Criminology Annual Conference, Reno (1988-89)
• Member, Committee on Instruction, Department of Criminal Justice, Temple University (1990-92)
• Member, Research Development Committee, Department of Criminal Justice, Temple University (1990-92)
• Member, Search Committee, Department of Criminal Justice, Temple University (1985/86, 1986/87 and 1989/90)
• Coordinator of Faculty Evaluation, Department of Criminal Justice, Temple University (1985-2000)
• Member, Undergraduate Curriculum Committee, Department of Criminal Justice, Temple University (1986-1990)

Undergraduate teaching:
• Introduction to Criminal Justice
• Criminal Courts/Criminal Justice
• Research Methods in Criminal Justice
• Introduction to Law Enforcement
• Urban Crime Patterns
• Criminal Justice Practicum (Internship program)

Graduate teaching:
• Criminal Courts (Masters)
• Advanced Statistics (Ph.D.)
• Advanced Research Methods (Ph.D.)
• Graduate Teaching Seminar (Ph.D.)

Graduate dissertations/theses:
• Dissertation Committee Chair/Member for doctoral students in Criminal Justice
• Dissertation Committee Member for doctoral students in Political Science, Psychology and Sociology

Honors:
• Temple University, **Lindback Foundation Great Teacher Award Winner**, April 2004.
• Selected as **Finalist** (25 programs selected from over 1,700 applicants) in the **1999 Innovations in American Government Awards Program** for the development of the ProDES information system. The competition is funded by the **Ford Foundation and administered by the John F. Kennedy School of Government**, Harvard University, 1999.
• Nominee for the ‘**Temple University Great Teacher Award**’ 1999.
• **Recipient of American Correctional Association ‘Best Practices’ Award** for the development of the ProDES information system, 1998.
• Temple University, Study Leave Awarded -- Spring Semesters 1994 and 2004.
• Temple University Increased Compensation Award 'For excellence in Research, Teaching and Service' 1987-88, 1989-90
• Temple University Merit Award Winner (Research, Teaching and Service) each year from 1985 to 1996, 1998-2003.
• Selected faculty mentor of undergraduate Alumni Award Association prize winner and Criminal Justice Faculty Award prize winner (Temple University Baccalaureate Awards), May, 1990.
• Selected faculty mentor of Department of Criminal Justice Grabowski Award prize winner (Temple University Baccalaureate Awards), May, 1991.

Research Grants and Sponsored Research:

**Co-Principal Investigator** with Philip Harris, **Evaluating Services for Delinquent Youths: A Continuation**, 2003/2004, $890,000 Philadelphia Department of Human Services.


**Co-Principal Investigator** with Philip Harris, **Evaluating Services for Delinquent Youths: A Continuation**, 2002/2003, $890,000 Philadelphia Department of Human Services.

**Co-Principal Investigator** with Philip Harris, **Evaluating Services for Delinquent Youths: A Continuation 2001/2002**, $895,000 Philadelphia Department of Human Services.

**Co-Principal Investigator** with Philip Harris, **Evaluating Services for Delinquent Youths**, 2000/2001, $894,000 Philadelphia Department of Human Services.

**Co-Principal Investigator**, **Evaluation of Juvenile Programs**, 2000, $60,939 Bureau of State Children and Youth Programs, Pennsylvania Department of Public Welfare.
Co-Principal Investigator with Philip Harris, Evaluating Services for Delinquent Youths, 1999/2000, $890,000, Philadelphia Department of Human Services.

Co-Principal Investigator with Philip Harris, Evaluating Services for Delinquent Youths, 1998/99, $750,000, Philadelphia Department of Human Services.


Co-Principal Investigator with Eric Gross, An Evaluation and Review of the Peacemaker Court of the Navajo Nation, 1997, $38,700, National Institute of Justice, Graduate Student Fellowship.

Co-Principal Investigator with Philip Harris, Evaluating Services for Delinquent Youths, 1997/98, $895,000, Philadelphia Department of Human Services.

Co-Principal Investigator with Philip Harris and the American Humane Association, Developing and Implementing an Outcome Measurement Program, 1997/98, $225,000, City of Philadelphia, Dept. of Human Services, Children and Youth Division.

Co-Principal Investigator with Philip Harris, Evaluating Services for Delinquent Youths, 1996/97, $900,000, Philadelphia Department of Human Services.

Principal Investigator, Developing a Risk Instrument for Juvenile Delinquents, 1996, $55,000, Sub-contract from Pennsylvania Commission on Crime and Delinquency and Philadelphia Family Court.

Principal Investigator, An Evaluability Assessment of the Peacemaker Court of the Navajo Nation, 1996, $2,100, Temple University Research Incentive Fund.

Co-Principal Investigator with Philip Harris, Evaluating Services for Delinquent Youths, 1995/96, $900,000, Philadelphia Department of Human Services.


Co-Principal Investigator with Philip Harris, Evaluating Services for Delinquent Youths, 1994/95, $782,391, Philadelphia Department of Human Services.

Co-Principal Investigator with Philip Harris, Evaluating Services For Delinquent Youth; A Continuation, 1993/94, $175,000, Philadelphia Department of Human Services.

Principal Investigator, Juvenile Intensive Supervision Probation: A Program Evaluation, 1993, $10,000 New York City Department of Probation.

Principal Investigator, Development of Risk-Instrument for Probation Revocation Population, New York City, 1992, $9,758, New York City Department of Probation Research Contract (#3P00306).

Co-Principal Investigator with Philip Harris, Evaluating Services For Delinquent Youth, 1992, $100,000, Philadelphia Department of Human Services.

Principal Investigator, Estimating Philadelphia's Caseloads in the Year 2000, Crime and Justice Research Institute, 1992, $10,000.

Co-Principal Investigator with Philip Harris, An Evaluability Assessment and Preliminary Evaluation of Philadelphia's Community-Based Services for Delinquent Youths, 1992, $78,496, Philadelphia Department of Human Services.
Co-Principal Investigator with John Goldkamp, Issues in Managing the Drug Involved Offender in the Community: Findings from a National Survey of Probation/Parole and Drug Abuse Treatment Agencies, 1992, $10,000, U.S. Department of Health and Human Services, Alcohol, Drug Abuse and Mental Health Administration National Institute on Drug Abuse, Purchase Order #91MF23452401D.

Principal Investigator, Probation revocation and recidivism: a study in New York City, 1991, $9,626, New York City Department of Probation Research Contract, Purchase Order No.2P00155.

Co-Principal Investigator with Philip Harris, An Evaluability assessment of the 'Women at Risk' Program, Asheville, North Carolina, 1991, $12,000, National Institute of Corrections, Technical Assistance Grant No. 91-C-1060.


Co-Principal Investigator with John S. Goldkamp, and Michael. R. Gottfredson, Assessing the Impact of Drug Cases on Community Safety, Court Delay and Jail Overcrowding, 1988-89, $300,000 Bureau of Justice Assistance Grant No. 88-DD-CX-K002.

Co-Principal Investigator with John S. Goldkamp, and Michael. R. Gottfredson, Assessing the Utility of Bail Guidelines, 1987-88, $888,000, National Institute of Justice Grant No. 84-IJ-CX-0056.

Co-Principal Investigator with M. K. Harris, Evaluating Community Corrections in Kansas, Edna McConnell Clark Foundation, 1985-87 $167,500.

Principal Investigator, Bail Decisions in England and Wales, Sponsored by Home Office Criminal Division (C3), 1985

Co-Principal Investigator with Roger Tarling and David D. Moxon, Sentencing Patterns in Magistrates' Courts, Sponsored by Home Office Criminal Division (C3), 1985

Principal Investigator, Committal proceedings as a filter in the criminal justice system, Sponsored by Home Office Criminal Division (C3), 1984

Principal Investigator, The Vietnamese Refugee Reception and Resettlement Program: An Evaluation, Sponsored by Home Office Immigration and Race Relations Division (F1) and the Joint Committee for Refugees from Vietnam, 1983-4

Principal Investigator, Patterns of immigration into Britain, Sponsored by Home Office Immigration and Race Relations Division (F1), 1981.

Principal Investigator, Ethnic Intermarriage in Britain, Sponsored by Home Office Immigration and Race Relations Division (F1), 1981.

Principal Investigator, Arranged Marriages and Asian Immigration Patterns, Sponsored by Home Office Immigration and Race Relations Division (F1), 1980.

Research Consulting:

Consultant, Foster Care Custody in Mississippi, 2005-06, Children’s Rights, New York.


Consultant, Assessing the Impact of Day Treatment Programs, 2002, Community Services Foundation, PA (July).


Consultant, Developing Outcomes Measures – An Evaluability Assessment 1999, National Institute of Corrections and the Oregon Department of Corrections, Grant No. 00-C-1018, November 1999 – March 2000.

Consultant, Developing an Evaluation Strategy for Senate Bill 1145, 2001, National Institute of Corrections and the Oregon Department of Corrections, Grant No. 01-C-1049, April 2001.


Consultant, Developing Outcomes Measures For Gender Specific Programs: Cook County, Illinois 2000, National Institute of Corrections and the Department of Women's Justice Services in the Cook County Sheriff's Office, Grant No. 00-C-2013.

Consultant, Developing Outcomes Measures – An Evaluability Assessment 1999, National Institute of Corrections and the Oregon Department of Corrections, Grant No. 00-C-1018, November 1999 – March 2000.


Consultant, Risk Prediction and Classification 1999, Utah Department of Juvenile Justice, March.

Consultant, Planning For an Outcomes Based Information System 1998, National Institute of Corrections and the York County (PA) Department of Probation, Grant No. 99-C-1024.

Consultant, Development of a Juvenile Evaluation and Information System 1998, Community Services Foundation.


Consultant, Developing an Outcome-based Information System through Evaluability Assessments, 1997, National Institute of Corrections and Travis County (Austin), Texas, Grant No. 97-C-1159.


Consultant, Developing Outcome Based Measures for Community Corrections, Ramsey County (St. Paul), Minnesota, 1996, National Institute of Corrections and Ramsey County Dept. of Corrections, the Grant No. 96-C-10.

Consultant, Assessing the Integration of Criminal Justice Initiative in Travis County, Texas, 1996, National Institute of Corrections and Travis County (Austin),Grant No. 96-C-1016.
Consultant, Improving the Statistical Capacity of the Pennsylvania Board of Probation and Parole, 1996, National Institute of Corrections and the Pennsylvania Board of Probation and Parole Grant No. 96-C-1066.


Consultant, Retained by New York City, Department of Probation, for consulting on study of revocation procedures (1995).

Consultant, Developing performance Based Indicators For Community Corrections And Parole in Kansas, 1994, National Institute of Corrections and Kansas State Dept. of Corrections. Grant No. 94-C-1130.

Consultant, Evaluability Assessments and the ProDES information System, Ohio Department of Youth Services, 1994.

Consultant, to Ohio Department of Rehabilitation and Corrections, for National Institute of Corrections, 1994.

Consultant, with South Carolina Department of Probation, Parole and Pardons for National Institute of Corrections, 1994.

Consultant, An Evaluability Assessment of Project HOPE (Women in Prison), Minneapolis, 1994, for National Institute of Corrections.


Consultant, for National Institute of Corrections, National Academy, Program Design Workshop I for Community Correction Practitioners, 1993.

Consultant, for National Institute of Corrections, National Academy, Program Design Workshop II for Community Correction Practitioners, 1993.

Consultant, Commissioned by International Association of Residential and Community Alternatives (IARCA) to prepare research paper on risk prediction, 1993

Consultant (Project Director, Alan Harland) Program Development Training and Technical Assistance Project, 1992, assist in running a $150,000 program development grant for National Institute of Corrections.


Consultant, retained by New York City, Department of Probation, for research program development, 1991-1994.

Consultant, Evaluation Research Design and Development for the Edgecombe Day Treatment Center, New York, 1991, for National Institute of Corrections and New York City Dept. of Probation, Grant No. 91-C-1209.
Consultant, Research, Policy and Program Development for Edgecombe Day Treatment Center, New York, 1991, for National Institute of Corrections and New York City Dept. of Probation, Grant No. 91-C-1178.

Senior Research Consultant, to ‘The Response Center’ (Market Research), Philadelphia, (analyzed, written and presented over twenty major research reports for corporate clients), 1989-1995.

Published Research:

Peer Reviewed Journals


**Book Chapters**


**Books**


**Non-peer reviewed articles, reports and manuscripts**


Other Documents:

Journal Referee:
Crime, Law and Social Change (since 2004)
Criminology and Public Policy (since 2004)
Journal of Criminal Justice Education (since 1988)
Journal of Research in Crime and Delinquency (since 1989)
Journal of Criminal Justice (since 1989)
The Justice System Journal (since 1992)
Journal of Quantitative Criminology (since 1999)
Journal of Social Problems (since 1985)
The Prison Journal (Associate Editor 1991-99)
**Book Reviews**

**Presentations:**


41. Jones, P. R., Risk Assessment: History and Etiology, Utah Division of Youth Corrections, Salt Lake City, UT, April 1999.

42. Jones, P. R., ProDES and Juvenile Justice Evaluation, Utah Division of Youth Corrections, Salt Lake City, UT, April 1999.

43. Jones, P. R., Chronic Offenders: Identification and Prediction, Utah Division of Youth Corrections, Salt Lake City, UT, April 1999.


52. Harris, P. W. and Jones, P. R. Developing and empirically based typology of juvenile delinquents, Academy of Criminal Justice Sciences, Annual Conference, Albuquerque, NM, March 1998.


60. Jones, P. R. and Harris, P. W., Getting Beyond the Rhetoric: Matching Treatment Needs With Program Services, American Society of Criminology Conference, Chicago, November 1996.


63. Harris, P. and Jones, P. R. Defining Relevant Outcomes for Juvenile Correctional Programs, Academy of Criminal Justice Sciences Conference, Las Vegas, March, 1996.

64. Robert, L. and Jones, P. R., Testing Assumptions About Sex Offenders, Academy of Criminal Justice Sciences Conference, Las Vegas, March, 1996.


73. **Jones, P. R.**, *Evaluation and Accountability in Community Based Corrections*, National Institute of Corrections Seminar, Ohio Department of Rehabilitation and Correction; Columbus, Ohio, April, 1994.

74. **Jones, P. R.**, *Integrity in the Evaluation Process*, National Institute of Corrections Seminar, Ohio Department of Rehabilitation and Correction; Columbus, Ohio, April, 1994.


77. **Jones, P. R.**, *The Day Treatment Center as an Alternative to Incarceration*, American Society of Criminology Conference, Phoenix, October, 1993.


82. **Jones, P. R.**, *The Development and Validation of a Risk Classification Instrument For Probation Violators*, New York City Department of Probation Research and Administration Officials, New York, March 1993.


86. **Jones, P. R.** Measuring the impact of drug testing at the pretrial release stage: experimental findings from Prince George's County and Milwaukee County, Annual Conference of the National Association of Pretrial Services Agencies, Lexington, Kentucky, October 1991.

87. **Jones, P. R.** The effectiveness of community based sanctions, National Institute of Corrections Program Design Workshop, Boulder, April 1991

88. **Jones, P. R.** Evaluating community based sanctions - the question of design, National Institute of Corrections Program Design Workshop, Boulder, April, 1991


92. **Jones, P. R.** Community Corrections in Kansas: Extending Community Based Corrections Or Widening The Net? Annual Conference of the American Society of Criminology, Montreal, Canada, November 1987.

93. **Jones, P. R.** Evaluating Community Corrections in Kansas, Annual Conference of the American Society of Criminology, Atlanta, Georgia, November 1986.


Appendix C
OLIVIA Y. V. BARBOUR CASE RECORD PROTOCOL
(7/6/05)

COVER SHEET – PROTOCOL

Case Identification:

C1. Case number

C2. Person ID number

C3. Client Date of Birth

C4. Client Name

Case Reader:

C5. Name (print)

Signature

C6. Date Instrument Completed

Quality Control Reviewer:

C7. Name (print)

Signature

C8. Date Review Completed

Case Determination:

C9. As of June 1, 2005, was the child in the custody of MDHS?

1 = Yes   2 = No

If NO, sign and date above and return protocol to Case Reading Supervisor.

If YES:

C10. As of June 1, 2005, has the child been in the custody of MDHS for more than 60 days (since on or before April 2, 2005)?

1 = Yes   2 = No

If NO, sign and date above and return protocol to Case Reading Supervisor.

C11. As of June 1, 2005, which County has responsibility for the child’s case?

1 = DeSoto   4 = Harrison   7 = Jefferson
2 = Clarke   5 = Hinds   8 = Pontotoc
3 = Forrest   6 = Humphreys   9 = Yazoo

C12. As of June 1, 2005, what is the child’s primary permanency goal?

1 = Adoption   2 = Other
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A. Child and Family Characteristics

1.1. Case number

1.2. Person ID number

1.3. County:  
1 = DeSoto  
2 = Clarke  
3 = Forrest  
4 = Harrison  
5 = Hinds  
6 = Humphreys  
7 = Jefferson  
8 = Pontotoc  
9 = Yazoo

1.4. Child’s date of birth

1.5. Child’s sex:  
1 = male  
2 = female

1.6. Child’s race/ethnicity:* (select only one)

*NOTE: Using AFCARS and U.S. Bureau of the Census standards, children of Hispanic origin may be of any race

1 = White Non-Hispanic  
2 = Black Non-Hispanic  
3 = Hispanic  
4 = Native American Non-Hispanic  
5 = Asian or Pacific Island Non-Hispanic  
6 = Bi-racial  
7 = NI

1.7. Is the date of the child’s most recent (current) entry into MDHS custody documented in the case record?  
1 = Yes  
2 = No

If NO, go to Question 1.9.
If YES:

1.8. What was the date of the child’s most recent entry into MDHS custody?

1.9. Did the child have one or more previous entries into the MDHS custody documented in the case record?  
1 = Yes  
2 = No

If NO, go to Question 1.18.
If YES, please list the dates of all of the child’s entries and discharges from DHS custody below:

<table>
<thead>
<tr>
<th>Entry date</th>
<th>Discharge date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10. M</td>
<td>D</td>
</tr>
<tr>
<td>1.16. M</td>
<td>D</td>
</tr>
</tbody>
</table>

At the time of the child’s most recent entry into the custody of MDHS,

1.18. Was the identity of the child’s mother known?  
1 = Yes  
2 = No  
3 = NA

1.19. Were the whereabouts of the child’s mother known?  
1 = Yes  
2 = No  
3 = NA
If YES or NA to both 1.18 and 1.19, go to Question 1.21.
If NO to either 1.18 or 1.19:

☐ □ 1.20. Within 2 months of the child’s most recent entry, did the case manager document in the file a completed diligent search to identify the mother and/or her whereabouts? 1 = Yes 2 = No

At the time of the child’s most recent entry into custody of MDHS,
☐ □ 1.21. Was the identity of the child’s father known? 1 = Yes 2 = No 3 = NA
☐ □ 1.22. Were the whereabouts of the child’s father known? 1 = Yes 2 = No 3 = NA

If YES or NA to both 1.21 and 1.22, go to Question 1.24.
If NO to either 1.21 or 1.22:

☐ □ 1.23. Within 2 months of the child’s most recent entry, did the case manager document in the file a completed diligent search to identify the father and/or his whereabouts? 1 = Yes 2 = No

At the time of the child’s most recent entry into custody of MDHS,
☐ □ 1.24. Was the identity of any of the child’s relatives known? 1 = Yes 2 = No
☐ □ 1.25. Was the address of any of the child’s relatives known? 1 = Yes 2 = No

If YES or NA to both 1.24 and 1.25, go to Question 1.27.
If NO to either 1.24 or 1.25:

☐ □ 1.26. Within 2 months of the child’s most recent entry, did the case manager document in the file a completed diligent search to identify the child’s relatives and/or their addresses? 1 = Yes 2 = No
### B. Most Recent Care Setting

1.27. As of June 1, 2005 what is the child's current Placement Setting Type?

- 1 = MDHS Relative (kinship) foster home
- 2 = MDHS non-relative foster home
- 3 = Contract agency placement
- 4 = Other

1.28. Locate the column for the child’s current Placement Setting Type (answer to 1.27.). Scanning down the column, enter the number that corresponds most accurately to the child’s specific placement. If “18 Other” is entered, be sure to specify placement.

<table>
<thead>
<tr>
<th>Specific placement</th>
<th>1 MDHS Relative</th>
<th>2 MDHS Non-relative</th>
<th>3 Contract</th>
<th>4 Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Adoptive home (before finalization)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Emergency foster family home</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Emergency shelter facility</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 MDHS Licensed foster family home with relative</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5 Licensed foster family home with non-relative</td>
<td></td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6 Relative placement, not licensed</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>7 Therapeutic Foster Home</td>
<td></td>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>8 Medical Treatment Foster Home</td>
<td></td>
<td></td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>9 Group Home</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10 Residential Treatment Center</td>
<td></td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11 Out-of-state foster family home</td>
<td></td>
<td></td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>12 Out-of-state Residential Treatment Center</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>13 Home of parents; on trial visit</td>
<td></td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Runaway</td>
<td></td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15 NI</td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16 Other (specify)</td>
<td></td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17 Juvenile Detention Center</td>
<td></td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18 Out-of-state foster home with relative</td>
<td></td>
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<td>18</td>
<td></td>
</tr>
<tr>
<td>19 Government-run hospital (for temporary medical care)</td>
<td></td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20 Government-run hospital (for mental health or other needs)</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 private hospital (for temporary medical care)</td>
<td></td>
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<td>21</td>
<td></td>
</tr>
<tr>
<td>22 Private hospital (for mental health or other needs)</td>
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<td>22</td>
<td></td>
</tr>
<tr>
<td>23 Respite Foster Home</td>
<td></td>
<td></td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>24 Independent Living Placement</td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>25 Bethel Boys Academy / Eagle Point Christian Academy</td>
<td></td>
<td></td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26 Bethel Girls Academy</td>
<td></td>
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<td>26</td>
<td></td>
</tr>
<tr>
<td>27 Blue Mountain Children's Home</td>
<td></td>
<td></td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28 Day Star Women's Ministries</td>
<td></td>
<td></td>
<td>28</td>
<td></td>
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<tr>
<td>29 French Camp Academy</td>
<td></td>
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<td>29</td>
<td></td>
</tr>
<tr>
<td>30 Chamberlain-Hunt Academy</td>
<td></td>
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<td>30</td>
<td></td>
</tr>
<tr>
<td>31 Happiness Hills Christian Home</td>
<td></td>
<td></td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>32 Hope Christian Home / Hope Children's Academy</td>
<td></td>
<td></td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>33 Light the Fire Ministries / Accendo Christian Home / Accendo Christian Boys' Home</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34 Lighthouse Children's Home</td>
<td></td>
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<td>34</td>
<td></td>
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<tr>
<td>35 Mississippi Baptist Children's Home</td>
<td></td>
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<td>35</td>
<td></td>
</tr>
<tr>
<td>36 Palmer Home for Children</td>
<td></td>
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<td>36</td>
<td></td>
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<tr>
<td>37 Sunbelt Christian Youth Ranch</td>
<td></td>
<td></td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>38 Tupelo Children's Mansion</td>
<td></td>
<td></td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>
C. Reason for Child's Most Recent Entry Into Custody of MDHS

☐ 1.29. Does the case file contain a copy of the original court order (emergency or temporary custody order, shelter hearing order) for the child's most recent entry into custody of MDHS?  1 = Yes  2 = No

If NO, go to Subsection D.

If YES, indicate the reason(s) listed in the court order for the child's most recent entry into custody by entering "1" for all that apply:

☐ 1.30. Child - physical injury or maltreatment; includes injuries resulting from corporal punishment
☐ 1.31. Child - sexual abuse or exploitation
☐ 1.32. Child - mental injury or emotional abuse; includes confinement and bizarre treatment
☐ 1.33. Child - environmental neglect: conditions hazardous to health; inadequate shelter, food, clothing
☐ 1.34. Child - lack of health care or medical neglect, failure to thrive
☐ 1.35. Child - educational neglect
☐ 1.36. Parent - failure to protect child from injury
☐ 1.37. Parent - other child dead or near fatality due to child abuse or neglect
☐ 1.38. Parent - inadequate supervision or failure to supervise
☐ 1.39. Parent abandoned child
☐ 1.40. Parent - mental illness
☐ 1.41. Parent - substance exposed infant or child (poisoning, positive drug toxicology infant)
☐ 1.42. Parent - family violence
☐ 1.43. Parent - developmental disability
☐ 1.44. Parent - hospitalized
☐ 1.45. Parent - incarcerated
☐ 1.46. Parent - deceased
☐ 1.47. Parent - substance abuse or misuse
☐ 1.48. Parent - unknown
☐ 1.49. No reason cited
☐ 1.50. Other (specify)
☐ 1.51. Parental Request for Placement

D. Initial Agency Actions

If the child's most recent entry into custody occurred on or after June 1, 2003, answer the following questions. If the most recent entry was before June 1, 2003, go to Question 1.65.

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1.52. At the time of entry, did the agency give the child's health</td>
</tr>
<tr>
<td>records to the caregiver (family or facility) with whom the child</td>
</tr>
<tr>
<td>was placed?  1 = Yes  2 = No</td>
</tr>
<tr>
<td>☐ 1.53. At the time of entry, did the agency give the child's Medicaid</td>
</tr>
<tr>
<td>card to the caregiver (family or facility) with whom the child was</td>
</tr>
<tr>
<td>placed?  1 = Yes  2 = No</td>
</tr>
</tbody>
</table>
### SECTION I: DEMOGRAPHIC INFORMATION & CURRENT STATUS

(7/6/05) Page 5

<table>
<thead>
<tr>
<th>Question</th>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.54. At the time of entry, did the agency give the child's school records to the caregiver (family or facility) with whom the child was placed? (use NA if child under age of 6)</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td>3 = NA</td>
</tr>
<tr>
<td>1.55. At the time of entry, did the agency provide a copy of the court order to the foster family or licensed child care facility with whom the child was first placed?</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td></td>
</tr>
<tr>
<td>1.56. Within 48 hours of the child's entering custody, did the agency arrange for a visit between the child and family (use NA if there are documented reasons a visit should not occur)</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td>3 = NA</td>
</tr>
<tr>
<td>1.57. Within 7 days of the day the child entered custody, did the agency provide a medical exam for the child?</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td></td>
</tr>
<tr>
<td>1.58. During the first 30 days of placement, did the child's case manager maintain weekly contacts with the child (face to face or telephone)?</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td></td>
</tr>
<tr>
<td>1.59. Within the first 30 days of custody, did the agency hold a Family Group Conference meeting to make appropriate plans for the child?</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td></td>
</tr>
<tr>
<td>1.60. Within 30 days of the initial date of custody, did the agency complete the Individual Service Plan (ISP)/Custody Case Plan (MDHS-SS-405) for the child?</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td></td>
</tr>
<tr>
<td>1.61. Within 30 days of the initial date of custody, did the agency complete the Individual Service Plan for Parents (MDHS-SS-406)?</td>
<td>1 = Yes for both parents</td>
<td>2 = Yes for only one of two applicable parents</td>
<td>3 = No for both parents</td>
</tr>
<tr>
<td></td>
<td>4 = NA (child abandoned, parents' identities unknown)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.62. Within 90 days of the initial date of custody, did the Area Social Work Supervisor conduct an initial Review of the child's plan and the individual service plans to assess progress towards permanency? (Use NA if child not in custody for 90 days)</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td>3 = NA</td>
</tr>
<tr>
<td>1.63. Within 90 days of placement, did the agency provide a dental exam for the child? (Use NA if child younger than 3 or child not in custody for 90 days)</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td>3 = NA</td>
</tr>
<tr>
<td>1.64. Within 90 days of entering custody, did the agency provide a psychological assessment for the child? (use NA if child younger than 4 or child not in custody for 90 days)</td>
<td>1 = Yes</td>
<td>2 = No</td>
<td>3 = NA</td>
</tr>
</tbody>
</table>

Has a court of competent jurisdiction ever determined that (enter “1” for all that apply)

- **1.65.** the parent subjected the child to aggravated circumstances which may include but are not limited to, abandonment, torture, chronic abuse and/or sexual abuse.

  If yes, enter date: **1.66.** M[ ] D[ ] Y[ ]

- **1.67.** the parent has committed murder or manslaughter of another child of the parent or has aided or abetted, attempted, conspired or solicited to commit such a murder or such voluntary manslaughter.

  If yes, enter date: **1.68.** M[ ] D[ ] Y[ ]

- **1.69.** the parent has committed a felony assault that results in serious bodily injury to the child or another child of the parent.

  If yes, enter date: **1.70.** M[ ] D[ ] Y[ ]
1.71. the parental rights of the parent to a sibling have been terminated involuntarily.

If YES, enter date: 1.72. M [ ] D [ ] Y [ ] [ ] [ ]

1.73. Is there at least one document dated within 90 days of the child’s most recent entry into custody of MDHS that specifically identifies the reason(s) for the child’s placement?

1 = Yes  2 = No

If NO, go to Question 1.96.

If YES, indicate the reason(s) for the child’s most recent entry into custody by entering “1” for all that apply:

1.74. Child - physical injury or maltreatment; includes injuries resulting from corporal punishment
1.75. Child - sexual abuse or exploitation
1.76. Child - mental injury or emotional abuse; includes confinement and bizarre treatment
1.77. Child - environmental neglect; conditions hazardous to health; inadequate shelter, food, clothing
1.78. Child - lack of health care or medical neglect, failure to thrive
1.79. Child - educational neglect
1.80. Parent - failure to protect child from injury
1.81. Parent - other child dead or near fatality due to child abuse or neglect
1.82. Parent - inadequate supervision or failure to supervise
1.83. Parent abandoned child
1.84. Parent - mental illness
1.85. Parent - substance exposed infant or child (poisoning, positive drug toxicology infant)
1.86. Parent - family violence
1.87. Parent - developmental disability
1.88. Parent - hospitalized
1.89. Parent - incarcerated
1.90. Parent - deceased
1.91. Parent - substance abuse or misuse
1.92. Parent - unknown
1.93. No reason cited
1.94. Other (specify)________________________________________
1.95. Parental Request for Placement
1.96. Is the CPS report/investigation that resulted in the child's most recent entry the only report/investigation documented in the child's case record? 1 = Yes  2 = No

If YES, go to Section II.

If NO, list below the dates of all separate prior reports/investigations (subsequent to any previous stays in custody).

If the report was investigated and evidenced, enter "1" for all that apply:

<table>
<thead>
<tr>
<th>Evidenced</th>
<th>Prior Report Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1.97</td>
<td>1.98 M</td>
</tr>
<tr>
<td>1.99</td>
<td>1.100 M</td>
</tr>
<tr>
<td>1.101</td>
<td>1.102 M</td>
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<td>1.103</td>
<td>1.104 M</td>
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<td>1.105</td>
<td>1.106 M</td>
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<td>1.107</td>
<td>1.108 M</td>
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<td>1.109</td>
<td>1.110 M</td>
</tr>
<tr>
<td>1.111</td>
<td>1.112 M</td>
</tr>
</tbody>
</table>

1.113. Comments:
A. Individual Service Plans (ISPs)

2.1. During the 24-month period June 1, 2003 through May 31, 2005, does the child's case record include at least one Individual Service Plan (ISP)/Custody Case Plan MDHS-SS-405 completed for the child during his or her most recent entry into custody?  Yes = 1  No = 2

If NO, go to Question 2.42 (page 10).
If YES, what are the dates of each Individual Service Plan (ISP)/Custody Case Plan MDHS-SS-405 completed for the child during his or her most recent entry into custody during the 24-month period June 1, 2003 through May 31, 2005?

2.2. M ______ D ______ Y _______ _______ ISP 1
2.3. M ______ D ______ Y _______ _______ ISP 2
2.4. M ______ D ______ Y _______ _______ ISP 3
2.5. M ______ D ______ Y _______ _______ ISP 4
2.6. M ______ D ______ Y _______ _______ ISP 5

Note: Make a copy of each ISP found in the child's record for the 24-month period June 1, 2003 through May 31, 2005.

B. Initial Case Planning for Children Whose Most Recent Entry into Custody Occurred June 1, 2003 through May 31, 2005

If the child's most recent entry into MDHS custody occurred on or after June 1, 2003 through May 31, 2005, answer the following questions.

If the child's most recent entry into custody occurred prior to June 1, 2003, go to Question 2.25.

2.7. Was an initial Individual Service Plan (ISP)/Custody Case Plan MDHS-SS-405 completed for the child within 90 days after his or her most recent entry into MDHS custody?  1 = Yes  2 = No

If NO, go to Question 2.25.
If YES:

2.8. What is the date of the plan?
M ______ D ______ Y _______ _______

2.9. Which primary permanency plan is identified for the child in the initial ISP?

1 = Reunification
2 = Relative Placement
3 = Relative Placement/Adoption
4 = Relative Placement/Durable Legal Custody
5 = Durable Legal Custody (Non-Relative)
6 = Adoption
7 = Emancipation
8 = Formalized Foster Care/Long Term Foster Care
9 = No primary permanency plan is identified in the ISP
10 = Other, (specify) __________________________

2.10. Which concurrent permanency plan is identified for the child in the initial ISP?

1 = Reunification
2 = Relative Placement
3 = Relative Placement/Adoption
4 = Relative Placement/Durable Legal Custody
5 = Durable Legal Custody (Non-Relative)
6 = Adoption
7 = Emancipation
8 = Formalized Foster Care/Long Term Foster Care
9 = No concurrent permanency plan is identified in the ISP
10 = Other, (specify) __________________________
SECTION II: CASE PLANNING
(7/6/05) Page 9

Which of the following information does the child's initial ISP contain? (enter “1” for all that apply)

- 2.11. Discussion of reasonable efforts to prevent removal
- 2.12. Proximity of child’s placement to parent’s home
- 2.13. Strengths and needs of the child
- 2.14. Plan for assuring that child receives proper care and services
- 2.15. Services being provided to the child
- 2.16. Services being provided to the parents to improve the condition in the home to facilitate reunification or another identified plan
- 2.17. Services being provided to the foster parents
- 2.18. Steps agency is taking to find an adoptive permanent home, place the child with an adoptive family in durable legal custody or other permanent home
- 2.19. Visitation plan, including frequency of visits
- 2.20. Child’s health record
- 2.21. Child’s educational record
- 2.22. Psychological evaluation/mental health services
- 2.23. Social worker’s name
- 2.24. Name of ASWS reviewing plan

If the initial ISP is the only plan contained in the child's record for the 24-month period June 1, 2003 through May 31, 2005, go to Question 2.42.

C. Most Recent Individual Service Plan (ISP) for the Child for the Most Recent Entry

2.25. During the 24-month period June 1, 2003 through May 31, 2005, what is the date of the most recent updated/created Individual Service Plan (ISP)/Custody Case Plan MDHS-SS-405 in the child’s case record for the child’s most recent entry? [ ]

2.26. In the most recent ISP, which primary permanency plan is identified for the child? [ ]

- 1 = Reunification
- 2 = Relative Placement
- 3 = Relative Placement/Adoption
- 4 = Relative Placement/Durable Legal Custody
- 5 = Durable Legal Custody (Non-Relative)
- 6 = Adoption
- 7 = Emancipation
- 8 = Formalized Foster Care/Long Term Foster Care
- 9 = No primary permanency plan is identified in the ISP
- 10 = Other, (specify) ____________________________

2.27. In the most recent ISP, which concurrent permanency plan is identified for the child? [ ]

- 1 = Reunification
- 2 = Relative Placement
- 3 = Relative Placement/Adoption
- 4 = Relative Placement/Durable Legal Custody
- 5 = Durable Legal Custody (Non-Relative)
- 6 = Adoption
- 7 = Emancipation
- 8 = Formalized Foster Care/Long Term Foster Care
- 9 = No concurrent permanency plan is identified in the ISP
- 10 = Other, (specify) ____________________________
SECTION II: CASE PLANNING
(7/6/05) Page 10

Which of the following information does the child's most recent ISP contain? (enter "1" for all that apply):

- 2.28. Discussion of reasonable efforts to prevent removal
- 2.29. Proximity of child's placement to parent's home
- 2.30. Strengths and needs of the child
- 2.31. Plan for assuring that child receives proper care and services
- 2.32. Services being provided to the child
- 2.33. Services being provided to the parents to improve the condition in the home to facilitate reunification or another identified plan
- 2.34. Services being provided to the foster parents
- 2.35. Steps agency is taking to find an adoptive permanent home, place the child with an adoptive family in durable legal custody or other permanent home
- 2.36. Visitation plan, including frequency of visits
- 2.37. Child's health record
- 2.38. Child's educational record
- 2.39. Psychological evaluation/mental health services
- 2.40. Social worker's name
- 2.41. Name of ASWS reviewing plan

D. Family Group Conferences

Answer the following question for all children:

- 2.42. During the 24-month period June 1, 2003 through May 31, 2005 does the child's case record document at least one Family Group Conference?  1 = Yes  2 = No

If NO, go to Question 2.44.
If YES:

- 2.43. How many total Family Group Conferences were held during this 24-month period?
E. Case Manager’s Assignment to Case / Contacts with Child

☐ 144. Were any case notes recorded either in the case file or in the narrative section of the MACWIS during the 24-month period June 1, 2003 through May 31, 2005?  
1 = Yes 2 = No

If NO, go to Question 2.69.  
If YES, provide information in Grid 2A below. For each month, if the child was not in the custody for the entire month, indicate “NA.”

**GRID 2A.**

<table>
<thead>
<tr>
<th>Months</th>
<th>Case notes found in case records?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 = Yes 2 = No 3 = NA</td>
</tr>
<tr>
<td>5/05</td>
<td>2.45</td>
</tr>
<tr>
<td>4/05</td>
<td>2.46</td>
</tr>
<tr>
<td>3/05</td>
<td>2.47</td>
</tr>
<tr>
<td>2/05</td>
<td>2.48</td>
</tr>
<tr>
<td>1/05</td>
<td>2.49</td>
</tr>
<tr>
<td>12/04</td>
<td>2.50</td>
</tr>
<tr>
<td>11/04</td>
<td>2.51</td>
</tr>
<tr>
<td>10/04</td>
<td>2.52</td>
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<tr>
<td>9/04</td>
<td>2.53</td>
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<tr>
<td>8/04</td>
<td>2.54</td>
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<tr>
<td>7/04</td>
<td>2.55</td>
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<tr>
<td>6/04</td>
<td>2.56</td>
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<tr>
<td>5/04</td>
<td>2.57</td>
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<tr>
<td>4/04</td>
<td>2.58</td>
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<td>3/04</td>
<td>2.59</td>
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<td>2/04</td>
<td>2.60</td>
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<td>1/04</td>
<td>2.61</td>
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<tr>
<td>12/03</td>
<td>2.62</td>
</tr>
<tr>
<td>11/03</td>
<td>2.63</td>
</tr>
<tr>
<td>10/03</td>
<td>2.64</td>
</tr>
<tr>
<td>9/03</td>
<td>2.65</td>
</tr>
<tr>
<td>8/03</td>
<td>2.66</td>
</tr>
<tr>
<td>7/03</td>
<td>2.67</td>
</tr>
<tr>
<td>6/03</td>
<td>2.68</td>
</tr>
</tbody>
</table>
2.69. During the 24-month period June 1, 2003 through May 31, 2005, what was the total number of MDHS case managers assigned to the child?

GRID 2B. During the 12-month period June 1, 2004 through May 31, 2005, in the grid below list the total number of times a MDHS case manager/supervisor had face-to-face contact with the child within the month. If a case manager/supervisor did not see the child during a month, using the key, insert the reason for the lack of a visit in the corresponding box for the month. **Enter “98” for NA if child is not in custody for the entire month.**

<table>
<thead>
<tr>
<th>Months</th>
<th># of times case manager or supervisor had contact with the child (Enter 98 for NA)</th>
<th>Reason child was not seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/05</td>
<td>2.70.</td>
<td>2.71.</td>
</tr>
<tr>
<td>4/05</td>
<td>2.72.</td>
<td>2.73.</td>
</tr>
<tr>
<td>3/05</td>
<td>2.74.</td>
<td>2.75.</td>
</tr>
<tr>
<td>2/05</td>
<td>2.76.</td>
<td>2.77.</td>
</tr>
<tr>
<td>1/05</td>
<td>2.78.</td>
<td>2.79.</td>
</tr>
<tr>
<td>12/04</td>
<td>2.80.</td>
<td>2.81.</td>
</tr>
<tr>
<td>11/04</td>
<td>2.82.</td>
<td>2.83.</td>
</tr>
<tr>
<td>10/04</td>
<td>2.84.</td>
<td>2.85.</td>
</tr>
<tr>
<td>9/04</td>
<td>2.86.</td>
<td>2.87.</td>
</tr>
<tr>
<td>8/04</td>
<td>2.88.</td>
<td>2.89.</td>
</tr>
<tr>
<td>7/04</td>
<td>2.90.</td>
<td>2.91.</td>
</tr>
<tr>
<td>6/04</td>
<td>2.92.</td>
<td>2.93.</td>
</tr>
</tbody>
</table>

**Key:** Reason for Lack of Face-to Face Contact (select only one)
1 = Child in care out-of-state
2 = Case manager/supervisor left agency
3 = Foster caregiver canceled visit
4 = Foster caregiver failed to cooperate for visit
5 = Visit attempted, child not at location
6 = Other (specify in grid)
7 = Child runaway
8 = No indication in the record that the case manager/supervisor arranged to visit
9 = No reason documented in record
98 = NA

2.94. During the 12-month period June 1, 2004 through May 31, 2005, what is the total number of different MDHS staff members (including case managers, supervisors, social work assistants, homemakers, and clerical) who had at least one face-to-face contact with the child?

2.95. During the 12-month period June 1, 2004 through May 31, 2005, what is the total number of face-to-face contacts with the child conducted by a MDHS staff member other than a case manager or supervisor (including social work assistants, homemakers, and clerical)?
If as of June 1, 2005 the child's primary or concurrent permanency goal is reunification with either the child's parent or the legal custodian prior to the child's most recent entry into care, answer the following question. If reunification is not a primary or concurrent permanency goal, go to Subsection G.

**GRID 2C.** In the grid below, list the total number of times the MDHS case manager/supervisor had face-to-face contact with the parent/custodian within the month during the 12-month period June 1, 2004 through May 31, 2005. Enter NA if child is not in MDHS custody for the entire month, goal is not reunification for that month or if parent could not be located, was deceased, had surrendered his/her rights, or his/her rights were terminated involuntarily.

<table>
<thead>
<tr>
<th>Months</th>
<th>Visits</th>
<th>Visits</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1). Was there a visit between case manager/sup and <strong>mother</strong> (birth or prior legal cust.) with whom reunification is planned? 1=Yes 2=No 3=NA</td>
<td>(2). # of times case manager/sup saw <strong>mother</strong> (birth or prior custodian)</td>
<td>(3). Was there a visit between case manager/sup and <strong>father</strong> (birth or prior custodian) with whom reunification is planned? 1=Yes 2=No 3=NA</td>
</tr>
<tr>
<td>5/O5</td>
<td>2.96.</td>
<td>2.97.</td>
<td>2.98.</td>
</tr>
<tr>
<td>4/O5</td>
<td>2.100.</td>
<td>2.101.</td>
<td>2.102.</td>
</tr>
<tr>
<td>3/O5</td>
<td>2.104.</td>
<td>2.105.</td>
<td>2.106.</td>
</tr>
<tr>
<td>2/O5</td>
<td>2.108.</td>
<td>2.109.</td>
<td>2.110.</td>
</tr>
<tr>
<td>1/O5</td>
<td>2.112.</td>
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<td>2.114.</td>
</tr>
<tr>
<td>12/04</td>
<td>2.116.</td>
<td>2.117.</td>
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<tr>
<td>11/04</td>
<td>2.120.</td>
<td>2.121.</td>
<td>2.122.</td>
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<tr>
<td>10/04</td>
<td>2.124.</td>
<td>2.125.</td>
<td>2.126.</td>
</tr>
<tr>
<td>9/04</td>
<td>2.128.</td>
<td>2.129.</td>
<td>2.130.</td>
</tr>
<tr>
<td>8/04</td>
<td>2.132.</td>
<td>2.133.</td>
<td>2.134.</td>
</tr>
<tr>
<td>7/04</td>
<td>2.136.</td>
<td>2.137.</td>
<td>2.138.</td>
</tr>
<tr>
<td>6/04</td>
<td>2.140.</td>
<td>2.141.</td>
<td>2.142.</td>
</tr>
</tbody>
</table>
G. MDHS Case Manager's Contacts with Foster Caregiver

If the child was placed in a relative or non-relative foster family home during the 12-month period June 1, 2004 through May 31, 2005, answer the following question. If the child was placed in a facility during this 12-month period, go to Question 3.1.

**GRI02D.** During the 12-month period June 1, 2004 through May 31, 2005, list the total number of times a MDHS case manager/supervisor had face-to-face contact with the foster caregiver within the month. If a case manager/supervisor did not see the foster caregiver during a month, using the key, insert the reason for the lack of a visit. Enter NA if the child is not in custody for the entire month or is not placed in a foster family home for the entire month.

<table>
<thead>
<tr>
<th>Month</th>
<th>VISITS</th>
<th>If YES to (1.), answer (2)-(3).</th>
<th>If NO to (1.), answer (4).</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.144</td>
<td></td>
<td>2.145</td>
<td>2.146.</td>
</tr>
<tr>
<td>4/05</td>
<td></td>
<td>2.149.</td>
<td>2.150.</td>
</tr>
<tr>
<td>3/05</td>
<td></td>
<td>2.153.</td>
<td>2.154.</td>
</tr>
<tr>
<td>2/05</td>
<td></td>
<td>2.157.</td>
<td>2.158.</td>
</tr>
<tr>
<td>1/05</td>
<td></td>
<td>2.161.</td>
<td>2.162.</td>
</tr>
<tr>
<td>12/04</td>
<td></td>
<td>2.165.</td>
<td>2.166.</td>
</tr>
<tr>
<td>11/04</td>
<td></td>
<td>2.169.</td>
<td>2.170.</td>
</tr>
<tr>
<td>10/04</td>
<td></td>
<td>2.173.</td>
<td>2.174.</td>
</tr>
<tr>
<td>9/04</td>
<td></td>
<td>2.177.</td>
<td>2.178.</td>
</tr>
<tr>
<td>8/04</td>
<td></td>
<td>2.181.</td>
<td>2.182.</td>
</tr>
<tr>
<td>7/04</td>
<td></td>
<td>2.185.</td>
<td>2.186.</td>
</tr>
<tr>
<td>6/04</td>
<td></td>
<td>2.189.</td>
<td>2.190.</td>
</tr>
</tbody>
</table>

**Key:** Reason for Lack of Face-to-Face Contact (select only one)
1 = Child in care out-of-state
2 = Case manager/supervisor left agency
3 = Foster caregiver canceled visit
4 = Foster caregiver failed to cooperate
5 = Visit attempted, foster caregiver not at location
6 = Other (specify in grid)
7 = No indication in the case record that case manager/supervisor arranged to visit
8 = No reason documented in record
A. Child-Sibling Visits for Siblings in MDHS Custody Placed Separately

Answer the questions in this section for the child's most recent entry into the custody of MDHS. NOT: These questions are for ALL children in the sample irrespective of permanency goal.

☐ 1.1. At the time of his or her **most recent entry** into custody of MDHS, did the child have a sibling in the custody of MDHS or coming into MDHS custody simultaneously?  1 = Yes  2 = No  3 = NI

If NO or NI, go to Question 3.29.
If YES:

☐ 3.2. Was the child placed with his or her sibling(s)? 1 = Yes, all  2 = No  3 = NI  4 = Some but not all

If YES, all or NI, go to Question 3.29.
If SOME but not all or NO:

What justification is given in the case record for not placing the siblings together? (enter “1” for all that apply)

☐ 3.3. Child or one or more sibling(s) has special medical or mental health needs that require special level of care and assistance.

☐ 3.4. Child or one or more sibling(s) has behavior problems that pose a safety risk, and placing the child with the sibling(s) is not in her or his best interest.

☐ 3.5. One or more sibling(s) is in the custody of MDHS for a long period of time, the foster caregiver will not care for other sibling(s), and moving the other sibling(s) is not in her or his best interest.

☐ 3.6. Agency unable to find caregiver able to accommodate the entire sibling group.

☐ 3.7. Other (specify) ____________________________________________

☐ 3.8. No justification documented

☐ 3.9. Were efforts to find or develop a placement that would accept the entire sibling group documented in the case file?  Yes = 1  No = 2

If NO, go to question 3.14.
If YES:

What efforts were documented? (enter “1” for all that apply)

☐ 3.10. Asked foster parents whether they would care for the siblings

☐ 3.11. Asked relative(s) whether they would care for the siblings

☐ 3.12. Recruitment efforts through media and community contacts

☐ 3.13. Other (specify) ____________________________________________

☐ 3.14. Were efforts documented to place the child in the same county as siblings?  1 = Yes  2 = No

☐ 3.15. Is a sibling visiting plan included in the child’s Individual Service Plan (ISP)/Custody Case Plan (Form MDHS-SS-405)?  1 = Yes  2 = No

☐ 3.16. Is there one or more of the child’s siblings in MDHS custody in a different placement who is not included in the child’s sibling visiting plan or in visits with the child?  1 = Yes  2 = No

If YES, please describe the circumstances: ____________________________________________
GRID 3A. Using the grid below, list the total number of times the child had visits with any of his or her siblings in MDHS custody in a different placement within a month during the 12-month time period **June 1, 2004 through May 31, 2005**. Enter “98” (NA) if during the month the child and his or her sibling(s) were all placed together or the child and/or the child’s sibling(s) were not in MDHS custody during the entire month.

<table>
<thead>
<tr>
<th>Months</th>
<th># of face-to-face visits with any sibling in MDHS custody (Enter “98” if NA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/05</td>
<td>3.17.</td>
</tr>
<tr>
<td>4/05</td>
<td>3.18.</td>
</tr>
<tr>
<td>3/05</td>
<td>3.19.</td>
</tr>
<tr>
<td>2/05</td>
<td>3.20.</td>
</tr>
<tr>
<td>1/05</td>
<td>3.21.</td>
</tr>
<tr>
<td>12/04</td>
<td>3.22.</td>
</tr>
<tr>
<td>11/04</td>
<td>3.23.</td>
</tr>
<tr>
<td>10/04</td>
<td>3.24.</td>
</tr>
<tr>
<td>9/04</td>
<td>3.25.</td>
</tr>
<tr>
<td>7/04</td>
<td>3.27.</td>
</tr>
<tr>
<td>6/04</td>
<td>3.28.</td>
</tr>
</tbody>
</table>

**B. Child-Parent Visits**

☐ **3.29.** As of June 1, 2005, is the child’s current primary or concurrent permanency plan reunification with the child’s parents or with the child’s legal custodians prior to the child’s most recent entry into care?

1 = Yes  
2 = No

If NO, go to Question 4.1 (page 16).

IF YES:

☐ **3.30.** What is the proximity of the child’s current placement to the parent’s/previous custodian’s home?

1 = Child’s placement is in same county
2 = Child’s placement is in adjacent county
3 = Child’s placement is in Mississippi but not in same or adjacent county
4 = Child’s placement is in another state
5 = Location of child’s placement or parent’s/previous custodian’s home not included in file

☐ **3.31.** If child is not placed either in same or adjacent county to parent’s or previous custodian’s home, were efforts documented to place the child in the same county as parent/previous custodian?  
1 = Yes  
2 = No
During the 6-month period **December 1, 2004 through May 31, 2005**, have visit arrangements for the child and parent/previous custodian included:  **(enter “1” for all that apply)**

- 3.32. Unsupervised daytime visits
- 3.33. Overnight visits at child’s parent’s / previous custodian’s home
- 3.34. Weekend overnight visits at child’s parent’s / previous custodian’s home
- 3.35. Visits longer than a weekend at child’s parent’s / previous custodian’s home

**GRID 3B.** In the grid below, list the total number of times the parent(s) / previous custodian(s) had visits with the child within a month during the 12-month period **June 1, 2004 through May 31, 2005**. Enter “98” (NA) if during the month the child was home on trial reunification visit, the child’s parent(s) / previous custodian(s) were deceased, the child was not in custody of MDHS during the entire month, or the goal was not reunification for that month.

<table>
<thead>
<tr>
<th>Months</th>
<th># of face-to-face visits with mother (birth/prior custodian) (Enter “98” if NA)</th>
<th># of face-to-face visits with father (birth/prior custodian) (Enter “98” if NA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/05</td>
<td>3.36.</td>
<td>3.37.</td>
</tr>
<tr>
<td>4/05</td>
<td>3.38.</td>
<td>3.39.</td>
</tr>
<tr>
<td>3/05</td>
<td>3.40.</td>
<td>3.41.</td>
</tr>
<tr>
<td>2/05</td>
<td>3.42.</td>
<td>3.43.</td>
</tr>
<tr>
<td>1/05</td>
<td>3.44.</td>
<td>3.45.</td>
</tr>
<tr>
<td>12/04</td>
<td>3.46.</td>
<td>3.47.</td>
</tr>
<tr>
<td>11/04</td>
<td>3.48.</td>
<td>3.49.</td>
</tr>
<tr>
<td>10/04</td>
<td>3.50.</td>
<td>3.51.</td>
</tr>
<tr>
<td>9/04</td>
<td>3.52.</td>
<td>3.53.</td>
</tr>
<tr>
<td>8/04</td>
<td>3.54.</td>
<td>3.55.</td>
</tr>
<tr>
<td>7/04</td>
<td>3.56.</td>
<td>3.57.</td>
</tr>
<tr>
<td>6/04</td>
<td>3.58.</td>
<td>3.59.</td>
</tr>
</tbody>
</table>
## A. Mental Health Issues

### 4.1. Is there documentation in the child’s case file that during any stay in MDHS custody the child was ever evaluated for mental illnesses or developmental disorders?  
1 = Yes  2 = No

If NO, go to Subsection B (page 20).  
If YES:

### 4.2. Is there documentation in the child’s case file that in any stay in MDHS custody a medical or mental health provider diagnosed or identified a mental illness or developmental disorder that required further assessment?  
1 = Yes  2 = No

If NO, go to Question 4.68.  
If YES, please answer the questions in GRID 4A for EACH mental illness or developmental disorder requiring further assessment.

GRID 4A. Indicate whether there is documentation in the case file that each illness or disorder received further assessment. To identify the illness or disorder in the “Mental Illness or Developmental Disorder” column, use KEY 1. If NO (a), identify reason(s) why assessment was not provided (b).

| Mental Illness or Developmental Disorder (use KEY 1) | (a). Received further assessment?  
1 = Yes  2 = No | (b). If NO, Reason(s) Assessment Not Provided (Enter “1” for all that apply) |
|-----------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------|
| 4.3.                                                | 4.4                                             | 4.5. Service was not available or waitlist for the service  
4.6. Eligibility requirements not met  
4.7. Problems in scheduling times or no transportation available  
4.8. Medical provider did not make referral  
4.9. Parent or child did not consent or cooperate  
4.10. Caregiver did not cooperate and case manager/supervisor did not make other arrangements  
4.11. Service provider refused to provide service to eligible child  
4.12. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service  
4.13. Other (specify)________________________  
4.14. Need for assessment identified after April 30, 2005  
4.15. No reason documented in record |
| 4.16.                                               | 4.17.                                           | 4.18. Service was not available or waitlist for the service  
4.19. Eligibility requirements not met  
4.20. Problems in scheduling times or no transportation available  
4.21. Medical provider did not make referral  
4.22. Parent or child did not consent or cooperate  
4.23. Caregiver did not cooperate and case manager/supervisor did not make other arrangements  
4.24. Service provider refused to provide service to eligible child  
4.25. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service  
4.26. Other (specify)________________________  
4.27. Need for assessment identified after April 30, 2005  
4.28. No reason documented in record |
| 4.29.                                               | 4.30.                                           | 4.31. Service was not available or waitlist for the service  
4.32. Eligibility requirements not met  
4.33. Problems in scheduling times or no transportation available |
| 4.42. | 4.43. | 4.44. Service was not available or waitlist for the service | 4.45. Eligibility requirements not met | 4.46. Problems in scheduling times or no transportation available |
| | | | | |
| 4.47. Medical provider did not make referral | 4.48. Parent or child did not consent or cooperate | 4.49. Caregiver did not cooperate and case manager/supervisor did not make other arrangements |
| 4.50. Service provider refused to provide service to eligible child | 4.51. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service |
| 4.52. Other (specify) | 4.53. Need for assessment identified after April 30, 2005 | 4.54. No reason documented in record |

| 4.55. | 4.56. | 4.57. Service was not available or waitlist for the service | 4.58. Eligibility requirements not met | 4.59. Problems in scheduling times or no transportation available |
| | | | | |
| 4.60. Medical provider did not make referral | 4.61. Parent or child did not consent or cooperate | 4.62. Caregiver did not cooperate and case manager/supervisor did not make other arrangements |
| 4.63. Service provider refused to provide service to eligible child | 4.64. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service |
| 4.65. Other (specify) | 4.66. Need for assessment identified after April 30, 2005 | 4.67. No reason documented in record |

**KEY1: Mental Illnesses or Developmental Disorders**

1 = Depression or mood disorder
2 = Tic disorders or Tourette's disorder
3 = Disruptive behavior or conduct disorder
4 = Anxiety disorder
5 = Psychotic disorder
6 = Schizophrenia
7 = Autism
8 = Substance-induced mental disorder
9 = Post-traumatic stress disorder
10 = Eating disorder
11 = Borderline personality disorder
12 = Adjustment disorder
13 = Developmental Disability/Mental Retardation/Borderline MR
14 = Other diagnosis of mental illness or developmental disorder (specify) 
15 = Oppositional defiant disorder (ODD)
16 = Impulse control disorder
17 = Attention deficit disorder (ADD)
18 = Pervasive developmental disorder (PDD)
19 = Mathematics disorder
20 = Impulse control disorder
21 = Fetal alcohol syndrome
22 = Language disorder
23 = Emotional behavioral disorder (EBD)
24 = Reactive attachment disorder
25 = Antisocial personality disorder
26 = ADHD
468. Is there documentation in the child’s case file that a medical or mental health provider ever diagnosed the child as having at least one of the mental illnesses or development disorders listed in KEY 1 above? 1 = Yes 2 = No

If NO, go to Subsection B.
If YES, fill in GRID 4B below for each illness/disorder:

<table>
<thead>
<tr>
<th>Mental Health Illness or Developmental Disorder</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a). What type of illness or disorder? USE KEY 1 above (on p.17)</td>
<td>4.69</td>
<td>4.70</td>
<td>4.71</td>
<td>4.72</td>
<td>4.73</td>
<td>4.74</td>
</tr>
<tr>
<td>(b). Did a medical or mental health provider recommend a specific treatment for the diagnosis (other than medication)? If NO, skip remaining questions in the table for this illness/disorder.</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
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<td>4.75</td>
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<td>4.78</td>
<td>4.79</td>
<td>4.80</td>
</tr>
<tr>
<td>i. What specific treatment was recommended? USE KEY 2 below</td>
<td>4.81</td>
<td>4.82</td>
<td>4.83</td>
<td>4.84</td>
<td>4.85</td>
<td>4.86</td>
</tr>
<tr>
<td>ii. Does the case record indicate that this specific treatment was provided during the 24-month period June 1, 2003 through May 31, 2005? (NA=determined by medical/mental health provider that treatment no longer needed) If NO or NA, skip iii. for this illness/disorder.</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
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<td>4.87</td>
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<td>4.89</td>
<td>4.90</td>
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</tr>
<tr>
<td>iii. As of June 1, 2005, was the child currently receiving the specific treatment? (NA=determined by medical/mental health provider that treatment no longer needed)</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
<td>1 = Yes 2 = No 3 = NA</td>
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<td></td>
<td>4.93</td>
<td>4.94</td>
<td>4.95</td>
<td>4.96</td>
<td>4.97</td>
<td>4.98</td>
</tr>
</tbody>
</table>

KEY? (If more than one specific treatment was recommended, select first applicable code listed in the key):
1 = Inpatient services 5 = Other (specify in grid)
2 = Individual psychotherapy/clinical services/play therapy 4 = Group psychotherapy
3 = Family therapy

B. Child Medical Health Services

In the questions below, report information on child health examinations. The time period is the child’s most recent entry into MDHS custody. If child’s most recent stay in care has been longer than 24 months, use only the 24-month period June 1, 2003 through May 31, 2005.

If the child’s most recent stay in MDHS custody is less than 12 months (as of May 31, 2005), go to Question 4.103.

4.99. Is an annual comprehensive unclothed physical examination documented in the child’s case record? 1 = Yes 2 = No  If NO, go to Question 4.101.

4.100. If YES, enter total # of annual comprehensive unclothed physical exams documented between June 1, 2003 and May 31, 2005.

4.101. Is an annual dental exam documented in the child’s case record? 1 = Yes 2 = No 3 = NA (child under age of 3)  If NO, go to Question 4.103.
4.102. If YES, enter total # of dental exams documented between June 1, 2003 and May 31, 2005.

4.103. Are there any immunization records in the child’s case file?  
1 = Yes  
2 = No

4.104. During the child’s most recent stay in MDHS custody, is there documentation in the case file that a medical provider diagnosed or identified a physical condition (excluding mental illness and developmental disorders) requiring further assessment? If the child’s most recent stay has been longer than 24 months, use only the 24-month period June 1, 2003 through May 31, 2005.  
1 = Yes  
2 = No

If NO, go to Question 4.170.  
If YES, please indicate in GRID 4C below whether there is documentation in the case file that each physical condition received further assessment. Write a description of the physical condition in the “Physical Condition” column. If NO (a), identify reason(s) why assessment was not provided (b).

| Physical Condition | (a). Received further assessment  
1 = Yes  2 = No | (b). IF NO, Reason(s) Assessment Not Provided  
(Enter “1” for all that apply) |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>4.105.</td>
<td></td>
<td>4.107. Service was not available or waitlist for the service</td>
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<td></td>
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<td>4.108. Eligibility requirements not met</td>
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<td>4.109. Problems in scheduling times or no transportation available</td>
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<td>4.110. Medical provider did not make referral</td>
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<td>4.111. Parent or child did not consent or cooperate</td>
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<td>4.112. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.113. Service provider refused to provide service to eligible child</td>
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<td>4.114. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.115. Other (specify)</td>
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<td>4.116. Need for assessment identified after April 30, 2005</td>
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<td>4.117. No reason documented in record</td>
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<td>4.118.</td>
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<td>4.120. Service was not available or waitlist for the service</td>
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<td>4.121. Eligibility requirements not met</td>
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<td>4.122. Problems in scheduling times or no transportation available</td>
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<td>4.123. Medical provider did not make referral</td>
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<td>4.124. Parent or child did not consent or cooperate</td>
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<td>4.125. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.126. Service provider refused to provide service to eligible child</td>
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<td>4.127. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.128. Other (specify)</td>
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<td>4.129. Need for assessment identified after April 30, 2005</td>
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<td>4.130. No reason documented in record</td>
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<td>4.131.</td>
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<td>4.133. Service was not available or waitlist for the service</td>
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<td>4.134. Eligibility requirements not met</td>
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<td>4.135. Problems in scheduling times or no transportation available</td>
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<td>4.136. Medical provider did not make referral</td>
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<td>4.138. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.139. Service provider refused to provide service to eligible child</td>
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<td>4.140. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.141. Other (specify)</td>
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<td></td>
<td>4.142. Need for assessment identified after April 30, 2005</td>
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</tbody>
</table>
4.143. No reason documented in record

4.144.  
- 4.145.
  - 4.146. Service was not available or waitlist for the service
  - 4.147. Eligibility requirements not met
  - 4.148. Problems in scheduling times or no transportation available
  - 4.149. Medical provider did not make referral
  - 4.150. Parent or child did not consent or cooperate
  - 4.151. Caregiver did not cooperate and case manager/supervisor did not make other arrangements
  - 4.152. Service provider refused to provide service to eligible child
  - 4.153. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service
  - 4.154. Other (specify)
  - 4.155. Need for assessment identified after April 30, 2005
  - 4.156. No reason documented in record

4.157.  
- 4.158.
  - 4.159. Service was not available or waitlist for the service
  - 4.160. Eligibility requirements not met
  - 4.161. Problems in scheduling times or no transportation available
  - 4.162. Medical provider did not make referral
  - 4.163. Parent or child did not consent or cooperate
  - 4.164. Caregiver did not cooperate and case manager/supervisor did not make other arrangements
  - 4.165. Service provider refused to provide service to eligible child
  - 4.166. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service
  - 4.167. Other (specify)
  - 4.168. Need for assessment identified after April 30, 2005
  - 4.169. No reason documented in record

4.170. During the child's most recent stay in MDHS custody, is there documentation in the case file that a medical provider diagnosed or identified a physical condition (excluding mental illness and developmental disorders) requiring treatment? If the child's most recent stay has been longer than 24 months, use only the 24-month period June 1, 2003 through May 31, 2005.  

IF YES, please indicate in GRID 4D below whether there is documentation in the case file that each physical condition received treatment. Write a description of the physical condition in the "Physical Condition" column. IF NO (a), identify reason(s) why treatment was not provided (b).

GRID 4D.

<table>
<thead>
<tr>
<th>Physical Condition</th>
<th>(a). Received treatment</th>
<th>(b). If NO, Reason(s) Treatment Not Provided (Enter “1” for all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.171.</td>
<td>4.172.</td>
<td>4.173. Service was not available or waitlist for the service</td>
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<tr>
<td></td>
<td></td>
<td>4.174. Eligibility requirements not met</td>
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<td>4.175. Problems in scheduling times or no transportation available</td>
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<td>4.176. Medical provider did not make referral</td>
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<td>4.177. Parent or child did not consent or cooperate</td>
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<td>4.178. Caregiver did not cooperate and case manager/supervisor did not</td>
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<td>make other arrangements</td>
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<td>4.179. Service provider refused to provide service to eligible child</td>
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<td>4.180. Case manager/supervisor did not make final arrangements for service</td>
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<td>or case manager did not inform caregiver how to access service</td>
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<td></td>
<td>4.181. Other (specify)</td>
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<td></td>
<td></td>
<td>4.182. Condition diagnosed/identified after April 30, 2005</td>
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<tr>
<td></td>
<td></td>
<td>4.183. No reason documented in record</td>
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<tr>
<td>4.184.</td>
<td>4.185.</td>
<td>4.186. Service was not available or waitlist for the service</td>
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<td></td>
<td>4.187. Eligibility requirements not met</td>
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<td>4.188. Problems in scheduling times or no transportation available</td>
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<td></td>
<td>4.190. Parent or child did not consent or cooperate</td>
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<td></td>
<td>4.191. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.192. Service provider refused to provide service to eligible child</td>
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<td>4.193. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.194. Other (specify)</td>
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<td>4.195. Condition diagnosed/identified after April 30, 2005</td>
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<td>4.198. Service was not available or waitlist for the service</td>
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<td>4.201. Problems in scheduling times or no transportation available</td>
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<td>4.203. Parent or child did not consent or cooperate</td>
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<td>4.204. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.205. Service provider refused to provide service to eligible child</td>
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<td>4.206. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.207. Other (specify)</td>
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<td>4.208. Condition diagnosed/identified after April 30, 2005</td>
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<td>4.209. No reason documented in record</td>
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<td>4.211. Service was not available or waitlist for the service</td>
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<td>4.213. Eligibility requirements not met</td>
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<td>4.214. Problems in scheduling times or no transportation available</td>
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<td>4.215. Medical provider did not make referral</td>
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<td>4.216. Parent or child did not consent or cooperate</td>
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<td>4.217. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.218. Service provider refused to provide service to eligible child</td>
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<td>4.219. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.220. Other (specify)</td>
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<td>4.221. Condition diagnosed/identified after April 30, 2005</td>
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<td></td>
<td>4.222. No reason documented in record</td>
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</tr>
</tbody>
</table>

4.223. Service was not available or waitlist for the service

4.225. Service was not available or waitlist for the service

4.226. Eligibility requirements not met

4.227. Problems in scheduling times or no transportation available

4.228. Medical provider did not make referral

4.229. Parent or child did not consent or cooperate

4.230. Caregiver did not cooperate and case manager/supervisor did not make other arrangements

4.231. Service provider refused to provide service to eligible child

4.232. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service

4.233. Other (specify)

4.234. Condition diagnosed/identified after April 30, 2005

4.235. No reason documented in record

4.236. During the child’s most recent stay in MDHS custody, is there documentation in the case file that a medical provider diagnosed or identified a dental condition requiring further assessment? If the child’s most recent stay has been longer than 24 months, use only the 24-month period June 1, 2003 through May 31, 2005. 1 =Yes  2 = No  If NO, go to Question 4.302.

If YES, please indicate in GRID 4E below whether there is documentation in the case file that each dental condition received further assessment. Write a description of the dental condition in the "Dental Condition" column. If NO (a), identify reason(s) why assessment was not provided (b).
### SECTION IV: SERVICES

(7/6/05) Page 24

**GRID 4E.**

<table>
<thead>
<tr>
<th>Dental Condition</th>
<th>(a) Received further assessment 1 = Yes 2 = No</th>
<th>(b) If NO, Reason(s) Assessment Not Provided (Enter &quot;1&quot; for all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.237.</td>
<td>[ ] 4.238.</td>
<td>4.239. Service was not available or waitlist for the service</td>
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<td>4.240. Eligibility requirements not met</td>
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<td>4.241. Problems in scheduling times or no transportation available</td>
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<td>4.242. Medical provider did not make referral</td>
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<td>4.243. Parent or child did not consent or cooperate</td>
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<td>4.244. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.245. Service provider refused to provide service to eligible child</td>
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<td>4.250.</td>
<td>[ ] 4.251.</td>
<td>4.246. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td></td>
<td>4.247. Other (specify)</td>
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<tr>
<td></td>
<td></td>
<td>4.248. Need for assessment identified after April 30, 2005</td>
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<td>4.249. No reason documented in record</td>
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<td>4.263.</td>
<td>[ ] 4.264.</td>
<td>4.252. Service was not available or waitlist for the service</td>
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<td>4.253. Eligibility requirements not met</td>
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<td>4.254. Problems in scheduling times or no transportation available</td>
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<td>4.255. Medical provider did not make referral</td>
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<td>4.256. Parent or child did not consent or cooperate</td>
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<td>4.257. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.258. Service provider refused to provide service to eligible child</td>
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<td>4.259. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.260. Other (specify)</td>
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<td>4.261. Need for assessment identified after April 30, 2005</td>
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<td>4.262. No reason documented in record</td>
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<td>4.276</td>
<td>[ ] 4.277.</td>
<td>4.265. Service was not available or waitlist for the service</td>
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<td>4.266. Eligibility requirements not met</td>
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<td>4.268. Medical provider did not make referral</td>
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<td>4.273. Other (specify)</td>
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<td>4.274. Need for assessment identified after April 30, 2005</td>
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<td>4.275. No reason documented in record</td>
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<td>4.289.</td>
<td>[ ] 4.290.</td>
<td>4.278. Service was not available or waitlist for the service</td>
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<td>4.279. Eligibility requirements not met</td>
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<td>4.280. Problems in scheduling times or no transportation available</td>
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<td>4.282. Parent or child did not consent or cooperate</td>
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<td>4.283. Caregiver did not cooperate and case manager/supervisor did not make other arrangements</td>
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<td>4.284. Service provider refused to provide service to eligible child</td>
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<td>4.285. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service</td>
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<td>4.286. Other (specify)</td>
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<td>4.287. Need for assessment identified after April 30, 2005</td>
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<td>4.288. No reason documented in record</td>
</tr>
</tbody>
</table>

4.291. Service was not available or waitlist for the service
4.292. Eligibility requirements not met
4.302. During the child’s **most recent stay** in MDHS custody, is there documentation in the case file that a medical provider diagnosed or identified a **dental condition requiring treatment**? If the child’s **most recent stay** has been longer than 24 months, use only the 24-month period June 1, 2003 through May 31, 2005.

1 = Yes  2 = No  If NO, go to Question 4.368.

If YES, please indicate in GRID 4F below whether there is documentation in the case file that each dental condition received **treatment**. Write a description of the dental condition in the “Dental Condition” column. If NO (a), identify reason(s) why treatment was not provided (b).

<table>
<thead>
<tr>
<th>Dental Condition</th>
<th>(a). Received treatment? 1 = Yes  2 = No</th>
<th>(b). If NO, Reason(s) Treatment Not Provided (Enter “1” for all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.303.</td>
<td>[ ]</td>
<td>4.305. Service was not available or waitlist for the service 4.306. Eligibility requirements not met 4.307. Problems in scheduling times or no transportation available 4.308. Medical provider did not make referral 4.309. Parent or child did not consent or cooperate 4.310. Caregiver did not cooperate and case manager/supervisor did not make other arrangements 4.311. Service provider refused to provide service to eligible child 4.312. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service 4.313. Other (specify) 4.314. Condition diagnosed/identified after April 30, 2005 4.315. No reason documented in record</td>
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<tr>
<td>4.316.</td>
<td>[ ]</td>
<td>4.317. Service was not available or waitlist for the service 4.318. Eligibility requirements not met 4.319. Problems in scheduling times or no transportation available 4.320. Medical provider did not make referral 4.321. Parent or child did not consent or cooperate 4.322. Caregiver did not cooperate and case manager/supervisor did not make other arrangements 4.323. Service provider refused to provide service to eligible child 4.324. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service 4.325. Other (specify) 4.326. Condition diagnosed/identified after April 30, 2005 4.327. No reason documented in record</td>
</tr>
<tr>
<td>4.329.</td>
<td>[ ]</td>
<td>4.330. Service was not available or waitlist for the service 4.331. Eligibility requirements not met 4.332. Problems in scheduling times or no transportation available 4.333. Medical provider did not make referral 4.334. Parent or child did not consent or cooperate 4.335. Caregiver did not cooperate and case manager/supervisor did not make other arrangements 4.336. Service provider refused to provide service to eligible child 4.337. Case manager/supervisor did not make final arrangements for service or case manager did not inform caregiver how to access service 4.338. Other (specify) 4.339. Condition diagnosed/identified after April 30, 2005 4.340. No reason documented in record</td>
</tr>
</tbody>
</table>
### C. Child's Educational Services

#### 4.368. During the period of the child’s **entire most recent stay** in MDHS custody, does the child’s case records include a formal determination regarding special education eligibility or ineligibility?  
1 = Yes  2 = No  3 = NA (as of June 1, 2005, child is less than 6 years of age)

If NA, go to Subsection E. **If YES,** go to Question 4.371.  
If NO:

#### 4.369. Is there a recommendation in the file that the child be assessed for eligibility for special education?  
1 = Yes  2 = No  **If NO,** go to Question 4.377.

**If YES:**

<table>
<thead>
<tr>
<th>M</th>
<th>D</th>
<th>Y</th>
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<tr>
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</table>

#### 4.370. Date of recommendation

#### 4.371. Has the child been referred to special education?  
1 = Yes  2 = No  3 = NI

If NO or NI, go to Question 4.377.  
If YES:

<table>
<thead>
<tr>
<th>M</th>
<th>D</th>
<th>Y</th>
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<tbody>
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</table>

#### 4.372. Date of referral
4.373. Disability area

4.374. Is the child currently in special education? 1 = Yes 2 = No 3 = NI
   If NI, go to Question 4.377.

   If YES: 4.375. Is a copy of the current Individualized Education Plan (IEP) in the child's case
   record? 1 = Yes 2 = No

   If NO: 4.367. Has the child previously been in special education, but is no longer eligible? 1 = Yes
   2 = No 3 = NI

   If the child's most recent entry into MDHS custody occurred on or after June 1, 2003 through May 31,
   2005, answer the following questions. If the child's most recent entry was prior to June 1, 2003, go to
   Subsection D.

   4.378. What was the child's educational level or status at the time of the child's most recent entry
   into MDHS custody of MDHS? (select only one)
   1 = Kindergarten
   2 = Elementary through high school
   3 = Post high school program leading to degree or certification
   4 = Not in school, but of school age
   5 = Other (specify) __________________________
   6 = NI
   7 = Not in school, not of school age (18 years of age or older)

   Answer the following questions a) for children ages 6 to 17 at the time of their most recent entry into
   MDHS custody and b) for children who attained ages 6 to 17 during the period June 1, 2003 through May
   31, 2005. If the child's age did not fall between 6 to 17 years during these periods, go to Subsection D.

   4.379. After the most recent entry, did the child remain in the school he or she attended prior to the
   most recent entry into MDHS custody? 1 = Yes 2 = No 3 = NI 4 = NA
   If YES, NI, or NA, go to Question 4.382.
   If NO:

   4.380. Did the child miss more than one week of school because the child was not enrolled
   in school immediately after entry into MDHS custody? 1 = Yes 2 = No 3 = NI
   If YES:

   4.381. How many days of school were missed?

   4.382. Did the child remain enrolled in the same school from the date of entry into custody through
   May 31, 2005? 1 = Yes 2 = No 3 = NI
   If YES, go to Subsection D.
   If NO, in Grid 4G below, report information on changes in the child's enrollment in school. Using
   the key, insert the reason the child changed schools, and insert the number of days missed.
   Insert NI if the information for any item is missing. The time period is the child's most recent
   entry through May 31, 2005.
### SECTION IV: SERVICES

(7/6/05) Page 28

<table>
<thead>
<tr>
<th>GRD 4G.</th>
<th>(1). First Change While in Care</th>
<th>(2). Subsequent Change</th>
<th>(3). Subsequent Change</th>
<th>(4). Subsequent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reason for change with care</td>
<td>4.383.</td>
<td>4.384.</td>
<td>4.385.</td>
<td>4.386.</td>
</tr>
<tr>
<td>b. Enrollment delayed</td>
<td>4.387.</td>
<td>4.388.</td>
<td>4.389.</td>
<td>4.390.</td>
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<tr>
<td>c. Number of missed days</td>
<td>4.391.</td>
<td>4.392.</td>
<td>4.393.</td>
<td>4.394.</td>
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</table>

**Key: Reason for Change (select only one)**

1 = Child completed last grade in enrolled school
2 = School staff recommended change
3 = Birth parent requested change
4 = Child requested change
5 = Foster parent moved
6 = No reason documented in record
7 = Other (specify in grid)
8 = Child’s placement was changed
9 = Child was moved either due to allegations of abuse/neglect, or home closed by agency, or home not re-licensed by agency

---

**D. Youth Services: Independent Living Services**

Complete the section below only for children who are 14 years of age or older as of May 31, 2005, i.e., born in or before calendar year 1991. For children born after calendar year 1991, go to Subsection E.

☐ 4.395. What is the youth’s current educational status as of May 31, 2005?

1 = Enrolled in high school
2 = Enrolled in program leading to a high school equivalency diploma (GED)
3 = Enrolled in career or specialized job training program leading to a certificate or license
4 = Enrolled in a two-year or four-year college or educational institution granting a degree
5 = Not in school
6 = Other (specify)

If NO, go to Question 4.399.

If YES:

☐ 4.397. Does the independent living plan (ILP) address ways the youth can obtain further education such as college or specialized vocational training? Consider the most recent ILP prepared between June 1, 2003 and May 31, 2005 in the youth’s most recent stay in MDHS custody. 1 = Yes 2 = No

☐ 4.398. Does the independent living plan (ILP) address the youth’s anticipated housing needs at the time of discharge from custody? Consider the most recent ILP prepared between June 1, 2003 and May 31, 2005 in the youth’s most recent stay in MDHS custody. 1 = Yes 2 = No

☐ 4.399. Did the case manager provide, or arrange for the provision of, support in the development of educational / vocational training with the youth during his or her most recent stay in MDHS custody? 1 = Yes 2 = No

---

**E. Services to Birth Parents and Caregivers**

If the answer to question 3.29 (Page 16) in Section III was YES, (the child’s most recent primary or concurrent permanency plan was reunification) answer questions below. If the answer was NO, go to Section V.
**SECTION IV: SERVICES**

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**GRI04H.** For the child's most recent entry, for each parent/previous legal custodian problem identified in the original court order (emergency or temporary custody order, shelter hearing order) and/or in the MACWIS AFCIRS reasons, indicate whether specific services were offered following the child's placement by the case manager to address this problem and if documentation in the case record indicated that services were being provided as of May 31, 2005. For the problem of mental illness only, indicate whether an evaluation can be found in the case record. **IF EITHER THE COURT ORDER WAS NOT IN THE FILE OR THE COURT ORDER DID NOT IDENTIFY ONE OF THE REASONS LISTED BELOW OR THERE IS NO INFORMATION ON THE AFCIRS REPORT, please skip this question and go to Section V.**

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<table>
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<tr>
<td><strong>GRI04H.</strong></td>
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<tr>
<td><strong>(a). Parent/Prior Custodian Problem (see p. 4: questions 1.30, 1.31, 1.33, 1.34, 1.35, 1.38, 1.40, 1.41, 1.42, 1.47) (also see p.6, questions 1.74, 1.75, 1.77, 1.78, 1.79, 1.82, 1.84, 1.85, 1.86, 1.91) Enter &quot;1&quot; for all that apply. If applies, answer (b)-(e).</strong></td>
<td><strong>(b). Is there a mental health evaluation in the case record? 1 = Yes 2 = No</strong></td>
<td><strong>(c). Is there documentation in the case record that specific services to address this problem/condition were offered by the MDHS case manager within 60 days of child's entry into care? 1 = Yes 2 = No</strong></td>
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<tr>
<td>□ 4.00. Mo / substance abuse</td>
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<td>□ 4.08. Mo / mental illness</td>
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<td>4.409.</td>
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<td>□ 4.17. Fa / domestic violence</td>
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<td>□ 4.21. Fa / mental illness</td>
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<td>4.422.</td>
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<td>□ 4.30. Fa / Physical injury or maltreatment</td>
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<td>□ 4.34. Mo / Sexual abuse of child</td>
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<td>□ 4.38. Fa / Sexual abuse of child</td>
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<td>□ 4.42. Mo / Environmental neglect</td>
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<td>□ 4.46. Fa / Environmental neglect</td>
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<td>□ 4.50. Mo / Medical or educational neglect</td>
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<tr>
<td>□ 4.54. Fa / Medical or educational neglect</td>
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<tr>
<td>□ 4.58. Mo / Inadequate supervision or failed to supervise</td>
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<tr>
<td>□ 4.62. Fa / Inadequate supervision or failed to supervise</td>
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</table>
1. During the child's most recent stay in MDHS custody, was a formal 6-month review of the child's case conducted? (If the child's most recent stay in custody has been longer than 24 months, include only the 24-month period from June 1, 2003 through May 31, 2005.)
1 = Yes  2 = No  3 = NA  (Use NA if the child has been in care 6 months or less)

If NO or NA, go to Section VI.
If YES, indicate in Grid 5A below the date of the formal review and, using the key, the type of formal review to which the case was subjected.

**GRID 5A.**

<table>
<thead>
<tr>
<th>Date(s) of Formal 6-Month Review</th>
<th>(a). Type of Formal 6-Month Review USE KEY</th>
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<tbody>
<tr>
<td>5.2. M   D   Y</td>
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<td>5.4. M   D   Y</td>
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<td>5.6. M   D   Y</td>
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<tr>
<td>5.8. M   D   Y</td>
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**KEY: Type of Formal 6-Month Review**
1 = County Conference (facilitated by Foster Care Reviewer)
2 = Permanency hearing before a judge
3 = Other court review
### A. Movements

1. During the child’s most recent stay in custody, does the case file include documentation that the child was moved by the agency from his or her original placement to another placement?

   - **1 = Yes**
   - **2 = No**

   If **NO**, go to Question 6.47.

   If **YES**, in GRID 6A below, report information on the child’s movements. Write in the dates of the child’s moves in the row below the main heading. Using the keys, insert the type of sending facility or foster caregiver, the reason for the move, and the type of receiving facility or foster caregiver. Report on all movements including moves to/from an adoptive placement. Also include moves to and from an emergency shelter and/or emergency foster family home.

   **Dates of Movements**

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<td>6.3</td>
<td>D</td>
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<td>D</td>
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<tr>
<td>6.4</td>
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   **GRID 6A.**

   - **(a).** What was the type of caregiver or facility sending the child? **USE KEY 1 CODES**
   - **(b).** What was the reason(s) for moving the child? **USE KEY 2 CODES to identify up to two reasons**
   - **(c).** What was the type of caregiver or facility receiving the child? **USE KEY 1 CODES**
   - **(d).** Prior to the move, does the case file document that the case manager obtained approval from the Area Social Work Supervisor for the move?
   - **(e).** Prior to the move, does the case file document that the case manager offered or provided services to the caregiver to maintain the placement? (NA = Effort to maintain placement not appropriate)
   - **(f).** Prior to the move, does the case file document that the case manager offered or provided services to the child to maintain the placement? (NA = Effort to maintain placement not appropriate and/or child is an infant)
   - **(g).** Does the case file document that the Youth Court authorized the move?

   **KEY 1: Type of Caregiver or Facility (select only one)**

   - **1 = Adoptive home (before finalization)**
   - **2 = Emergency foster family home**
   - **3 = Emergency shelter facility**
   - **21 = private hospital (for temporary medical care)**
   - **22 = Private hospital (for mental health or other needs)**
   - **23 = Respite Foster Home**
SECTION VI: PLACEMENT SERVICES
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4 = MDHS Licensed foster family home with relative
5 = Licensed foster family home with non-relative
6 = Relative placement, not licensed
7 = Therapeutic Foster Home
8 = Medical Treatment Foster Home
9 = Group Home
10 = Residential Treatment Center
11 = Out-of-state foster family home
12 = Out-of-state Residential Treatment Center
13 = Home of parents; on trial visit
14 = Runaway
15 = NIL
16 = Other (specify in grid)
17 = Juvenile Detention Center
18 = Out-of-state foster home with relative
19 = Government-run hospital (for temporary medical care)
20 = Government-run hospital (for mental health or other needs)
21 = Independent Living Placement
22 = Bethel Boys Academy / Eagle Point Christian Academy
23 = Bethel Girls Academy
24 = Blue Mountain Children's Home
25 = Day Star Women's Ministries
26 = French Camp Academy
27 = Chamberlain-Hunt Academy
28 = Happiness Hills Christian Home
29 = Hope Christian Home / Hope Children's Academy
30 = Light the Fire Ministries / Accendo Christian Home / Accendo Christian Boys' Home
31 = Lighthouse Children's Home
32 = Mississippi Baptist Children's Home
33 = Palmer Home for Children
34 = Sunbelt Christian Youth Ranch
35 = Tupelo Children's Mansion
36 = 36 = Tupelo Children's Mansion
37 = 37 = Tupelo Children's Mansion
38 = 38 = Tupelo Children's Mansion
39 = Licensed child placing agency foster family home with non-relative

KEY: Reason Documented for Moving Child (select up to two reasons)
1 = Child's request
2 = Sibling reunification
3 = Birth family request
4 = Child placed in adoptive home
5 = Placement together of teen parent in custody of DHS and child
6 = Child needs diagnostic evaluation
7 = Child arrested
8 = Child's behavior presents a serious danger to self or others
9 = Child ran away
10 = Medical/mental health provider recommended child be moved to a new setting
11 = Foster caregiver suspected of child abuse or neglect
12 = Foster caregiver requests that child be moved due to child's behavior
13 = Foster caregiver is incapacitated by own illness or that of family member
14 = Foster caregiver does not want to adopt or commit to child on long-term basis
15 = Foster caregiver did not provide adequate care
16 = Foster home has exceeded its maximum number of children
17 = Agency did not issue new license to foster caregiver
18 = Moved to foster caregiver of same ethnicity
19 = Moved to adoptive parent of same ethnicity
20 = NIL
21 = Other (specify in grid)
22 = Child moved to parents' home for reunification or trial reunification
23 = Child moved to parents' home for reunification or trial reunification
24 = Trial reunification not successful
25 = Foster home closed by agency
26 = Foster caregiver requests that child be moved due to lack of DHS support
27 = Moved to relative placement
28 = Non-emergency placement available

☐ §47. Does the file indicate that the caregivers in the child's current placement have expressed concern about their ability to handle the needs of the child?  1 = Yes  2 = No

☐ §48. During the 24-month period June 1, 2003 through May 31, 2005, if the child stayed in an emergency shelter more than 45 days within a 6-month period, is written permission for an extension from the Regional Director documented in the case record? (If there is more than one stay of more than 45 days in 24-month period, answer question for most recent stay)  1 = Yes  2 = No  3 = NA (Use NA if no such stay)

☐ §49. For each placement during the child's most recent stay in MDHS custody, is there documentation of the child's board rate in the case file?  1 = Yes  2 = No  3 = Some, but not all

If YES, or SOME, attach copy(ies) of documentation.
6.50. Is there a MDHS-SS-444A Notice of Change Form in the child’s case file concerning the child’s current placement as of May 1, 2005?  
1 = Yes  2 = No  If NO, go to Question 6.52.

6.51. If YES, is the board rate identified (select only one):
1 = Regular  6 = Emergency Group Shelter
2 = Special Needs I  7 = Therapeutic Group Home
3 = Special Needs II  8 = Emergency Shelter (contractual)
4 = Therapeutic/Medical/Treatment/  9 = Comprehensive Therapeutic Services
   Emergency Foster Home  (contractual)
5 = Foster Teen Parent  10 = No rate identified

B. Permanency Goals/Changes in Permanency Goals

6.52. What is the most recent primary permanency plan set for the child as stated in a formal review (either a foster care review or court review), whichever occurred the latest? (select only one)
1 = Reunification
2 = Relative Placement
3 = Relative Placement/Adoption
4 = Relative Placement/Durable Legal Custody
5 = Durable Legal Custody (Non-Relative)
6 = Adoption
7 = Emancipation
8 = Formalized Foster Care/Long Term Foster Care
9 = Other, specify
10 = No permanency plan is identified
11 = NA (use NA if the child has been in care 6 months or less)  If NA, go to Subsection C.

6.53. Is the child’s most recent primary permanency plan relative placement, relative placement/adoption or relative placement/durable legal custody?  
1 = Yes  2 = No  If NO, go to Question 6.56.

If YES:

6.54. Has the agency identified a relative by whom the child could be adopted or with whom the child could be permanently placed?  
1 = Yes  2 = No

If NO:

6.55. Has the agency documented diligent efforts to locate the child’s relatives in the past 12 months (since June 1, 2004)?  
1 = Yes  2 = No

6.56. What is the most recent concurrent permanency plan set for the child as stated in a formal review (either a foster care review or court review), whichever occurred the latest? (select only one)
1 = Reunification
2 = Relative Placement
3 = Relative Placement/Adoption
4 = Relative Placement/Durable Legal Custody
5 = Durable Legal Custody (Non-Relative)
6 = Adoption
7 = Emancipation
8 = Formalized Foster Care/Long Term Foster Care
9 = Other, specify
10 = No concurrent permanency plan is identified

6.57. Is the child’s most recent concurrent permanency plan relative placement, relative placement/adoption or relative placement/durable legal custody?  
1 = Yes  2 = No  If NO, go to Question 6.60.

If YES:
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6.58. Has the agency identified a relative by whom the child could be adopted or with whom the child could be placed?  
1 = Yes    2 = No

If NO:
6.59. Has the agency documented diligent efforts to locate the child’s relatives in the past 12 months (since June 1, 2004)?  
1 = Yes    2 = No

6.60. Is the child’s most recent concurrent permanency plan adoption?  
1 = Yes    2 = No

If NO, go to Subsection C.
If YES:
6.61. Is the child’s current placement with a foster family identified as willing to adopt? 1 = Yes  2 = No

C. Health and Safety Incidents in MDHS custody

GRID 6B. Answer the following questions regarding child behaviors for the period of the child’s most recent entry during the 24-month period June 1, 2003 through May 31, 2005. Using the keys, insert the date the behavior was identified, the person who identified the behavior, up to three behaviors identified as an area of concern, and up to three primary actions taken by the agency.

<table>
<thead>
<tr>
<th>Child Behavior</th>
<th>(1).</th>
<th>(2).</th>
<th>(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is there documentation in the child’s record that someone identified a child behavior as an area of concern?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If NO, go to Question 6.89.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Who identified the behavior? USE KEY 1 CODES (select one)</td>
<td>6.62.</td>
<td>6.63.</td>
<td>6.64.</td>
</tr>
<tr>
<td>c. What behavior(s) was identified? USE KEY 2 CODES to identify up to 3 most serious behaviors</td>
<td>6.71</td>
<td>6.72</td>
<td>6.73</td>
</tr>
<tr>
<td>d. What behavior(s) was identified? USE KEY 2 CODES to identify up to 3 most serious behaviors</td>
<td>6.74</td>
<td>6.75</td>
<td>6.76</td>
</tr>
<tr>
<td>e. What actions were taken by the agency within 60 days of the behavior being identified? USE KEY 3 CODES to identify up to 3 primary actions</td>
<td>6.80</td>
<td>6.81</td>
<td>6.82</td>
</tr>
</tbody>
</table>

KEY 1: Person Who Identified the Behavior (select one)  
1 = Agency    4 = Placement facility staff    7 = Education professional
2 = Foster Caregiver    5 = Child    8 = Other (specify in grid)
3 = Other household member    6 = Medical or mental health professional    9 = NI

KEY 2: Child’s Behavior Identified as Areas of Concern (select up to 3 most serious)  
1 = The child has tried alcohol or other drugs    15 = The child has attempted suicide
2 = The child plays with matches or sets fires    16 = The child perpetrates sexual abuse
3 = The child is intentionally cruel to animals    17 = The child has been suspended or expelled from school
4 = The child hurts other children    18 = The child refuses to go to school
5 = The child hurts herself or himself    19 = The child has serious emotional or behavioral problems in school
6 = The child talks about hurting her or himself    20 = The child has run away
7 = The child has sleeping or eating problems    21 = The child steals property or food
8 = The child has bedwetting problems
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10 = The child purposely destroys things
11 = The child is withdrawn or seems depressed
12 = The child is hyperactive or agitated
13 = The child is socially withdrawn and has difficulty in communicating
14 = The child has other unusual or unexplained behaviors

KEY: Actions Taken (select up to 3 primary actions)
1 = Police called
2 = Investigation initiated
3 = Information gathered
4 = Child removed and replaced temporarily
5 = Child removed and replaced permanently
6 = Foster home closed
7 = Health or mental health assessment arranged for the child
8 = Health or mental health assessment arranged for the caregiver
9 = Counseling provided to child
10 = Counseling provided to the caregiver
11 = Child behavior management training arranged for the caregiver
12 = Corrective actions taken to assure compliance with health, fire and safety requirements
13 = Follow-up corrective action planned but not taken
14 = No follow-up action documented
15 = Other (specify in grid)
16 = Special education or other educational assessment arranged for the child
22 = The child has hallucinations or delusions
23 = The child has other behaviors that the foster caregiver has concerns about
24 = The child engages in prostitution
25 = The child damages or destroys property
26 = The child carries a weapon
27 = Other (specify in grid)

GRID6C. Answer the following questions about concerns regarding caregiver, household member, or facility staff member's behavior or conditions in the home/facility of placement for the entire period of the child's most recent entry. Using the keys, insert the person who identified the behavior, up to three behaviors or conditions identified as areas of concern, and up to three primary actions taken by the agency.

Case Reader Note: If documentation is included in the case file regarding concerns about caregiver’s, household member’s, or facility staff member’s behavior or conditions in the home/facility, describe in Section VII and attach copies for each behavior/condition of concern.

<table>
<thead>
<tr>
<th>Caregiver, Household Member, or Facility Staff Member's Behavior and Conditions in the Home/Facility</th>
<th>(1).</th>
<th>(2).</th>
<th>(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.89.</td>
<td>6.90.</td>
<td>6.91</td>
</tr>
<tr>
<td>M</td>
<td>D</td>
<td>Y</td>
<td>M</td>
</tr>
<tr>
<td>1. Is there documentation in the child's record that someone identified a caregiver's, household member's or placement facility staff member's behavior, or condition in the home or facility as an area of concern? If NO, go to Question 6.116.</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
<td>1 = Yes 2 = No</td>
</tr>
<tr>
<td></td>
<td>6.92.</td>
<td>6.93.</td>
<td>6.94.</td>
</tr>
<tr>
<td>2. Who identified the behavior/condition? USE KEY 1 CODES (select one)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.95.</td>
<td>6.96.</td>
<td>6.97.</td>
</tr>
<tr>
<td>3. What behavior(s) or condition(s) in the home/facility was identified? USE KEY 2 CODES to identify up to 3 most serious behavior(s) or condition(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What actions were taken by the agency within 60 days of the behavior/condition being identified? USE KEY 3 CODES to identify up to 3 primary actions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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KEY 1: Person Who Identified the Behavior (select only one)
1 = Agency
2 = Foster Caregiver
3 = Other household member
4 = Placement facility staff
5 = Child
6 = Medical or mental health professional
7 = Education professional
8 = Other (specify in grid)
9 = NI

KEY 2: Caregiver’s/Other’s Behavior or Condition in Home/Facility (select up to 3 most serious)
1 = Caregiver/other misuses alcohol or other substances
2 = Caregiver/other does not provide adequate supervision
3 = Caregiver/other does not clothe child properly or fails to assure that child is clean and well groomed
4 = Caregiver/other does not provide nutritionally balanced meals or age appropriate snacks
5 = Caregiver/other does not provide child with a place to store personal belongings
6 = There is inadequate living or sleeping space in the home/facility
7 = There are unsanitary conditions in home/facility
8 = There are hazardous conditions in the home/facility
9 = There are conditions in violation of fire safety standards
10 = Other (specify in grid)
11 = Physical injury or maltreatment of child; includes injuries resulting from excessive corporal punishment
12 = Sexual abuse or exploitation of child
13 = Derogatory remarks or threats of removal from the home
14 = Withholds meals, clothing, or locks the child out of home as a form of punishment
15 = Denies the child contact or visits with his or her family as punishment
16 = Assigns chores that are excessive or potentially harmful to the child
17 = Mental injury or emotional abuse of child; includes confinement and bizarre injuries
18 = Lack of health care or medical neglect of child
19 = Educational neglect of child
20 = Other (specify in grid)

KEY 3: Action Taken (select up to 3 primary actions)
1 = Police called
2 = Investigation initiated
3 = Information gathered
4 = Child removed and replaced temporarily
5 = Child removed and replaced permanently
6 = Foster home closed
7 = Health or mental health assessment arranged for the child
8 = Health or mental health assessment arranged for the caregiver
9 = Counseling provided to child
10 = Counseling provided to the caregiver
11 = Child behavior management training arranged for the caregiver
12 = Corrective actions taken to assure compliance with health, fire and safety requirements
13 = Follow-up corrective action planned but not taken
14 = No follow-up action documented
15 = Other (specify in grid)

6.116. During any of the child’s stay(s) in MDHS custody, does the case file indicate that a foster family caregiver, other foster care provider, or other staff member or other person affiliated with a placement facility has used corporal punishment in dealing with the child or another child in the child’s placement? 1 = Yes 2 = No

Case Reader Note: If documentation is included in the case file regarding corporal punishment being used by a foster family caregiver, other foster care provider, or other staff person or other person affiliated with a placement, describe in Section VII and attach copy(ies) for each incident.

If NO, go to Question 6.133.
If YES: (Enter “1” for all that apply and indicate date(s) of documentation of corporal punishment)

6.117. Foster family caregiver

Date(s): 6.118. 6.119. 6.120.
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☐ 6.121. Foster family household member
Date(s): 6.122. M D Y
6.123. M D Y
6.124. M D Y

☐ 6.125. Staff member of a placement facility
Date(s): 6.126. M D Y
6.127. M D Y
6.128. M D Y

☐ 6.129. Other person affiliated with a placement
Date(s): 6.130. M D Y
6.131. M D Y
6.132. M D Y

☐ 6.133. Is there any indication in the case file that, during any of the child’s stays in MDHS custody, a foster family caregiver, other person in the foster family home, staff member, or other person affiliated with placement facility allegedly abused or neglected the child or another child in the child’s placement?
1 = Yes  2 = No

Reader note: Attach copies of all documents related to all parts of Questions 6.133 – 6.201

If NO, go to Subsection D (page 40).
If YES:

☐ 6.134. Were there any incidents of suspected abuse/neglect incidents that were NOT formally reported (i.e., there are informal indications in the case record of suspected abuse or neglect including case manager case notes, psychological evaluations, therapist progress notes, private agency case manager case notes, etc.)?
1 = Yes  2 = No

If NO, go to Question 6.162 where formally reported incidents are documented.
If YES, for each abuse or neglect incident that was not formally reported, fill in GRID 6D below. One column should be used for each separate incident. There may be several types of abuse/neglect identified in the case record. The time period is the length of any stay(s) in MDHS custody.

<table>
<thead>
<tr>
<th>Date that suspected abuse or neglect was documented in the child's record</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M D Y</td>
<td>M D Y</td>
<td>M D Y</td>
<td></td>
</tr>
<tr>
<td>(a). What type(s) of abuse or neglect was(are) informally documented? USE KEY 1 to identify up to 3 primary types</td>
<td>6.135.</td>
<td>6.136.</td>
<td>6.137.</td>
</tr>
<tr>
<td>(b). In regard to informal documentation of abuse or neglect in the case file, was there any documentation of agency follow-up? 1 = Yes 2 = No</td>
<td>6.147.</td>
<td>6.148.</td>
<td>6.149.</td>
</tr>
<tr>
<td>(c). What actions were taken by the agency following the finding within 60 days of identifying the incident? USE KEY 2 to identify up to 3 primary actions</td>
<td>6.150 6.155 6.158</td>
<td>6.151 6.154 6.155</td>
<td>6.152 6.155 6.158</td>
</tr>
</tbody>
</table>
### SECTION VI: PLACEMENT SERVICES

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<table>
<thead>
<tr>
<th>(d). Does the file indicate that the incident(s) of abuse/neglect was(ere) communicated to a supervisor? (i.e., a case manager supervisor, a county director or other higher level official)</th>
</tr>
</thead>
</table>

#### KEY 1: Types of Abuse or Neglect (select up to 3 primary types)
1 = Physical injury or maltreatment of child; includes injuries resulting from excessive corporal punishment
2 = Sexual abuse or exploitation of child
3 = Derogatory remarks or threats of removal from the home
4 = Withholds meals, clothing, or locks the child out of home as a form of punishment
5 = Denies the child contact or visits with his or her family as punishment
6 = Assigns chores that are excessive or potentially harmful to the child
7 = Mental injury or emotional abuse of child; includes confinement and bizarre injuries
8 = Environmental neglect of child: conditions hazardous to health; inadequate shelter, food, clothing
9 = Lack of health care or medical neglect of child
10 = Inadequate supervision or failure to supervise by parent/caregiver
11 = Educational neglect of child
12 = Child-on-child sexual abuse due to failure of caregiver to supervise
13 = Death of child
14 = Other (specify other in appropriate grids below)

#### KEY 2: Action of Agency Following Verified or Indicated Report (select up to 3 primary actions)
1 = Police called
2 = Information gathered
3 = Child removed and replaced temporarily
4 = Child removed and replaced permanently
5 = All children in home removed
6 = Further use of foster home "on hold"
7 = Foster home license suspended
8 = Health or mental health assessment arranged for the child
9 = Health or mental health assessment arranged for the caregiver
10 = Counseling provided to the child
11 = Counseling provided to the caregiver
12 = Child behavior management training for the caregiver
13 = Corrective actions to assure compliance with health, fire and safety requirements
14 = No corrective action taken
15 = Other (specify in grid)

[ ] 6.162. Were there any suspected abuse/neglect incidents that were formally reported (i.e., there is documentation in the case file of a formal report to the child abuse hotline, DHS county intake or a Regional Director)?
1 = Yes  
2 = No

If **NO**, go to Subsection D (page 40).
If **YES**, for each suspected abuse or neglect incident that was formally reported, fill in GRID 6E below. Write in the date of each incident of reported suspected child abuse or neglect in the top row. One column should be used for each separate incident. There may be more than one incident, or type of abuse or neglect, that occurred on a particular date. The time period is the length of any stay(s) in MDHS custody.
### SECTION VI: PLACEMENT SERVICES

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<table>
<thead>
<tr>
<th>Date of suspected child abuse or neglect incident</th>
<th>(1).</th>
<th>(2).</th>
<th>(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td>M[ ] D[ ] Y[ ]</td>
<td>6.163.</td>
<td>6.164.</td>
<td>6.165.</td>
</tr>
<tr>
<td>6.166.</td>
<td>6.167.</td>
<td>6.168.</td>
<td></td>
</tr>
<tr>
<td>6.169.</td>
<td>6.170.</td>
<td>6.171.</td>
<td></td>
</tr>
</tbody>
</table>

(a). What type(s) of abuse or neglect was(were) formally reported? USE KEY 1 to identify up to 3 primary types:

- 6.175. 1=Yes 2=No
- 6.176. 1=Yes 2=No
- 6.177. 1=Yes 2=No

If NO, answer (h)-(j) below in this grid.

(c). Does the file indicate the investigation has been completed?

- 6.178. 1=Yes 2=No
- 6.179. 1=Yes 2=No
- 6.180. 1=Yes 2=No

If NO, answer (h)-(j) below in this grid.

(d). Date investigation was completed

- 6.181. M[ ] D[ ] Y[ ]
- 6.182. M[ ] D[ ] Y[ ]
- 6.183. M[ ] D[ ] Y[ ]

(e). What was the finding?

- 6.184. 1 = substantiated / evidenced
- 6.185. 1 = substantiated / evidenced
- 6.186. 1 = substantiated / evidenced

(f). Is the investigation report filed in the child's record?

- 6.187. 1=Yes 2=No
- 6.188. 1=Yes 2=No
- 6.189. 1=Yes 2=No

(g). Was there a corrective action plan?

- 6.190. 1=Yes 2=No
- 6.191. 1=Yes 2=No
- 6.192. 1=Yes 2=No

(h). Did the child remain in the home?

- 6.193. 1=Yes 2=No
- 6.194. 1=Yes 2=No
- 6.195. 1=Yes 2=No

(i). If the child was removed or the foster home was closed, when?

- 6.196. M[ ] D[ ] Y[ ]
- 6.197. M[ ] D[ ] Y[ ]
- 6.198. M[ ] D[ ] Y[ ]

(j). Did DHS report allegations to the DA?

- 6.199. 1=Yes 2=No
- 6.200. 1=Yes 2=No
- 6.201. 1=Yes 2=No

**KEY 1: Types of Abuse or Neglect (select up to 3 primary types)**

1 = Physical injury or maltreatment of child; includes injuries resulting from excessive corporal punishment
2 = Sexual abuse or exploitation of child
3 = Derogatory remarks or threats of removal from the home
4 = Withholds meals, clothing, or locks the child out of home as a form of punishment
5 = Denies the child contact or visits with his or her family as punishment
6 = Assigns chores that are excessive or potentially harmful to the child
7 = Mental injury or emotional abuse of child; includes confinement and bizarre injuries
8 = Environmental neglect of child: conditions hazardous to health; inadequate shelter, food, clothing
9 = Lack of health care or medical neglect of child
10 = Inadequate supervision or failure to supervise by parent/caregiver
11 = Educational neglect of child
12 = Child-on-child sexual abuse due to failure of caregiver to supervise
13 = Death of child
14 = Other (specify other in appropriate grids below)

**Case Reader Note:** If documentation is included in the case file regarding suspected abuse or neglect incidents while in MDHS custody, describe in Section VII and attach copy, or if multiple times, attach copies.
**D. Adoption**

GRID 6F. Complete the grid below indicating if the agency has ever taken steps to legally free the child for adoption through termination of parental rights or as a result of voluntary surrender and/or death of parent(s).

<table>
<thead>
<tr>
<th></th>
<th>a. Mother</th>
<th>b. Father (if more than one, answer for individual most recently regarded by DHS as the father/putative father)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Petition filed for Termination of parental rights</td>
<td>6.202. 1 = Yes  2 = No</td>
<td>6.203. 1 = Yes  2 = No</td>
</tr>
<tr>
<td>If YES,</td>
<td>6.204. Give date termination petition filed</td>
<td>6.205. Give date termination petition filed</td>
</tr>
<tr>
<td></td>
<td>M:  D:  Y:</td>
<td>M:  D:  Y:</td>
</tr>
<tr>
<td></td>
<td>6.206. Give date termination petition granted</td>
<td>6.207. Give date termination petition granted</td>
</tr>
<tr>
<td></td>
<td>M:  D:  Y:</td>
<td>M:  D:  Y:</td>
</tr>
<tr>
<td>(2) Voluntary surrender</td>
<td>6.208. 1 = Yes  2 = No</td>
<td>6.209. 1 = Yes  2 = No</td>
</tr>
<tr>
<td>If YES,</td>
<td>6.210. Give date Court approved surrender</td>
<td>6.211. Give date Court approved surrender</td>
</tr>
<tr>
<td></td>
<td>M:  D:  Y:</td>
<td>M:  D:  Y:</td>
</tr>
<tr>
<td>(3) Death of a parent</td>
<td>1 = Yes  2 = No</td>
<td>1 = Yes  2 = No</td>
</tr>
<tr>
<td></td>
<td>6.212.</td>
<td>6.213.</td>
</tr>
<tr>
<td></td>
<td>M:  D:  Y:</td>
<td>M:  D:  Y:</td>
</tr>
</tbody>
</table>

If the child's most recent stay in MDHS custody began before January 1, 2004, and a Termination of Parental Rights (TPR) has not been filed with the court, answer the following questions: (If a termination of parental rights was filed, go to Question 6.221.)

- ✓ 6.216. Is there a documented reason in the child's individual service plan (ISP) or a court finding that filing a TPR petition would not be in the best interests of the child or the child's family was not provided necessary reunification services?  1 = Yes  2 = No

- ✓ 6.217. Is there documentation in the child's case record that a referral for TPR was made to the State Office Placement Unit?  1 = Yes  2 = No

  IF NO, go to Question 6.221.

  If YES:

  M:  D:  Y:  6.218. Indicate the date the referral for TPR was made to the State Office Placement Unit.

- ✓ 6.219. Is there documentation in the child's case record that a referral for TPR was made by the State Office Placement Unit to the Attorney General's Office?  1 = Yes  2 = No

  If NO, go to Question 6.221.

  If YES:

  M:  D:  Y:  6.220. Indicate the date the referral for TPR was made by the State Office Placement Unit to the Attorney General's Office.
§221. During the child's most recent stay in MDHS custody, did the agency ever establish adoption as the primary permanency goal for the child?  
1 = Yes  
2 = No

If NO, go to Section VII (page 44).
If YES:

M D Y 6.222. On what date was the plan for adoption as the primary permanency goal first documented in either the child's individual service plan (ISP) or a formal review (either a foster care review or court review)?

On that date, was the child:  (Enter "1" for all that apply)

6.223. Six (6) years of age or older
6.224. Member of a sibling group of two (2) or more to be placed together
6.225. Had documented physical, emotional, or mental handicap
6.226. Had documented medical conditions
6.227. None of the above
6.228. NI

6.229. On that date, was there an identified adoptive family?  
1 = Yes  
2 = No

6.230. Was the child's case ever assigned to an Adoption Specialist?  
1 = Yes  
2 = No

If YES:  
M D Y 6.231. Date case assigned

6.232. Was the child ever freed for adoption?  
1 = Yes  
2 = No

6.233. Was the child in an adoptive home at any time while the child was in MDHS custody?  
1 = Yes  
2 = No

If NO to 6.233, go to Question 6.237.

If YES to Question 6.233:

M D Y 6.234. What was the earliest date that the child was in an adoptive home?

6.235. Were the child's siblings placed together in the same pre-adoptive or adoptive family?  
1 = Yes, All  
2 = No  
3 = Some, but not all  
4 = NA (no siblings)

If YES or NA, go to Question 6.245:
If NO or SOME, BUT NOT ALL:

6.236. Is there documentation in the child's record of the justification for placing siblings separately rather than together in the same pre-adoptive or adoptive family?  
1 = Yes  
2 = No
If either YES or NO, go to Question 6.245.
If NO to Question 6.233:

☐ 6.237. Is there documentation during the period June 1, 2003 through May 31, 2005 of child-specific recruitment efforts to locate an adoptive family? 1 = Yes 2 = No

If NO, go to Question 6.245.
If YES:

M D Y 6.238. What is the most recent date before June 1, 2005 of such documented efforts?

Which of the following child-specific recruitment efforts were documented? (Enter “1” for all that apply)

☐ 6.239. Local foster family resource recruitment
☐ 6.240. Local adoptive family resource recruitment
☐ 6.241. Refer to State Adoption Exchange
☐ 6.242. Refer to Southeast Regional or National Adoption Exchange
☐ 6.243. Referred to a private agency for the purpose of adoption recruitment/placement
☐ 6.244. Other (specify)

☐ 6.245. Was the foster family with whom the child currently resides identified by MDHS as an adoptive resource for the child? 1 = Yes 2 = No 3 = NA (use NA if child not placed in foster family placement or if child has been moved to an adoptive home in which he or she is currently placed)

If NA, go to Question 6.266.

If NO, what was the reason? (Enter “1” for all that apply)

☐ 6.246. Foster child does not want to be adopted by foster caregiver
☐ 6.247. Foster caregiver does not want to adopt
☐ 6.248. Foster caregiver does not want to adopt child's siblings who are free for adoption
☐ 6.249. A relative wants to adopt
☐ 6.250. Foster caregiver has health problems
☐ 6.251. Agency did not approve the caregiver as an adoptive resource
☐ 6.252. Child abuse or neglect is verified or some indicator exists
☐ 6.253. Home conditions pose health or safety risk
☐ 6.254. No documentation in the case file that the current foster caregiver was considered as an adoptive resource for the child
☐ 6.255. Other (specify)

If YES:

☐ 6.256. Does the case file show that adoption was discussed with the child's foster parents? 1 = Yes 2 = No

If NO, go to Question 6.266.

If YES:
6.257. Did the foster parents express an interest in pursuing adoption?
1 = Yes  2 = No  3 = NI

If NO or NI, go to Question 6.266.
If YES:

6.258. Were the foster parents referred for an adoptive home study?
1 = Yes  2 = No

If NO, go to Question 6.266.
If YES:

6.259. M || D || Y || || On what date was this family referred for an adoption home study?

6.260. Was an adoption home study completed?
1 = Yes  2 = No  3 = NI  4 = study not yet begun

If YES:
6.261. M || D || Y || || Date adoption study completed

6.262. Is adoption planned with this family?  1 = Yes  2 = No  3 = NI

If NI, go to Question 6.266.
If NO:

6.263. Are reasons why not stated in the case file?  1 = Yes  2 = No

If YES:

6.264. Have they been approved as an adoptive family?
1 = Yes  2 = No  3 = NI  4 = study not yet begun  5 = study not completed

If YES:

6.265. Date of Approval

6.266. Did the agency ever determine that the child was a "special needs" child for the purpose of adoption maintenance subsidy or for payment of a non-recurring adoption expense?  1 = Yes  2 = No
SECTION VII: ADDITIONAL DOCUMENTATION
(7/6/05) Page 44

Case Identification:

7.1. Case number

7.2. Person ID number

7.3. Client Date of Birth

7.4. Client Name___________________________

ADDITIONAL DOCUMENTATION

7.5. Please attach copies of ALL of the child’s case plans for the period June 1, 2003 through May 31, 2005. (See Questions 2.1-2.6)

7.6. Description and documentation regarding concerns about caregiver’s, household member’s, or facility staff member’s behavior and/or conditions in the home/facility (attach copy(ies) of documentation). (See Questions 6.89-6.115)

7.7. Description and documentation regarding indications of corporal punishment (attach copy(ies) of documentation). (See Question 6.116)

7.8. Description and documentation regarding abuse or neglect incidents while the child was in MDHS custody. (attach copy(ies) of documentation). (See Questions 6.133-6.201)

7.9. Attach copy(ies) of documentation of child’s board rate found in the case file. (See Question 6.49)

7.10. Attach copy of each MDHS-SS-444A Notice of Change Form found in the file. (See Question 6.50)

7.11. Specifically describe any information missing from the case file such as legal documents, case notes, etc. during the 24-month period from June 1, 2003 through May 31, 2005. Please use extra sheets of paper if necessary. Be sure to note the period of time during which the information is missing.
7.12. Please describe any information of concern regarding this child's case that is not captured through the questions on the protocol. Attach copy(ies) of documentation.

7.13. Please list the first date of each placement during the child's most recent entry and the names of the foster parent or facility for each placement.

<table>
<thead>
<tr>
<th>First Day of Placement</th>
<th>Name of Foster Parent or Facility</th>
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Enter the date the protocol of protocol completion on the cover sheet and submit the completed protocol.
GUIDELINES REGARDING THE OLIVIA Y. V. BARBOUR
CASE RECORD READING PROCESS AND PROTOCOL

Case Record Reading Process

1. Based on documentation found in the case record, each case that is read must meet the criteria listed on the cover sheet of the protocol, including:
   - As of June 1, 2005 the child was in the custody of MDHS.
   - As of June 1, 2005, the child had been in the custody of MDHS for more than 60 days (since on or before April 2, 2005)
   - As of June 1, 2005, the county of responsibility for the child’s case is one of the sample counties.
If a case does not meet these criteria, inform Peg or Carolyn.

2. If a case record cannot be read for any reason (including it does not meet the criteria listed on the cover page), Peg or Carolyn will select a replacement case from the approved replacement list. Such replacements must be selected in the sequential order in which they are listed. When a case is not read and another case is selected in its place, the reason the case is not read must be indicated on the cover page of the protocol. In addition, the number of the replacement case must be documented on the master sample case list.

3. When each case is signed out by a case record reader, the case number and person ID number on the master sample case list must be recorded on the cover page of the protocol. If you are concerned that the child whose case record you have may not be the same child listed on the approved random sample case list, inform Peg or Carolyn.

4. When each case is signed out and back in by a case record reader, the master sample case list must be initialed by both the case reader and either Peg or Carolyn.

5. Upon completion of a protocol, check that copies of all required case documents have been made as directed in the protocol and are paper clipped (not stapled) to the protocol. Write the question number, case number, person ID number, and client name on the right hand corner of the first page of each separate document and clip the pages of each separate document together.

6. Upon completion of a protocol, have the protocol reviewed by either Peg or Carolyn. Document the transfer of the case record back to the state (see #4 above). Save all notes made while reading the case and completing the protocol.

7. If for a specific question the number of responses exceeds the available space on the protocol,
   a. Next to the question, directly on the protocol, clearly indicate that an additional sheet(s) is being attached.
   b. Make a Xerox copy of the question.
   c. Use the Xerox copy of the question to record the additional information.
d. Attach the extra sheet(s) to the protocol behind the page where the question is.

8. When contradictory or inconsistent information is found in the case records, regard information contained in legal documents – if available -- as definitive. If legal documents are not available, regard information contained in the greatest number of documents as definitive.

9. If you find information in the case record that appears to have been altered, discuss with Peg or Carolyn before answering relevant questions.

10. If you find case notes or summaries for different dates that are exact duplicates, i.e. word for word, discuss with Peg or Carolyn before answering relevant questions.

**General Guidelines for Reading a Case and Taking Notes**

When you read a case, start out by making a **time line**, including dates of entry in MDHS custody, placement locations and caregivers, and all moves and changes in custody. This will help you know at a glance where the child was on a certain date, how long the child was there, and who the child was with. This information is used for the “moves” question as well as in tracking what information may apply for questions related to “the most recent entry” or “most recent stay in custody.” Whenever you read in the narrative about a move, tab the page and write the information on your time line. If that date comes up again, refer to your time line – you already know that it has been recorded so look for an earlier or later date for another possible move in the time frame you are dealing with. As you read through the file you may find inconsistent dates for a particular placement or move, see # 8 above.

As you read the case use stickys as **tabs** to mark information related to the protocol. You may want to develop a system, e.g. blue for court documents, green for moves, yellow for Individual Service Plans, red for abuse in care, etc. Always tab court documents – Permanency hearings, Adjudicatory or Dispositional hearings; Family Conferences; ISPs; and mental health, health, and educational documents. When you find diagnoses, write the diagnosis on the tab. You do not have to read them all in their entirety at first, but tab them so that when you get to that particular section in the protocol you will be able to go back. Make sure Court documents and ISPs are signed and dated. If an ISP has been generated in MACWIS, it must include the worker’s name and date printed electronically. If the form was not generated in MACWIS, it must include a dated worker signature.

Locating and recording information regarding case manager/supervisor **face-to-face visits/contacts** can be challenging. It may be useful to make a list on a separate sheet, e.g. CM/Child visits, CM/foster caregiver visits, etc. Make a list of the dates a MDHS staff member saw the child every time it is mentioned, the name of the person who visited the child, and if it is recorded, the position of the person (i.e. case manager, supervisor, homemaker, etc.), and maintain in the list dates of visits scheduled and not made and reason not made. Sometimes there are duplications of the same visit in the record, especially in the narrative print. When dealing with the CM/ FP visits, always write the date seen as well as whether the caregiver was seen in the foster home. Look for this information right away – in
home or not - so that you will not have to re-visit the same question just for that part. The narrative will typically identify where the visit took place and will often have a reason for lack of visit.

A similar process should be used for recording information regarding mother/father visits with child and regarding sibling visits. Make a list for each separate parent with dates of visits. Always use dates to keep track of the months and the years. This also makes duplicate dates more obvious.

In many records, the education documents will be together, e.g. special education and school records. Look for that section and tab it so that you can refer to it when answering questions in the education section of the protocol.

The child’s primary and concurrent permanency plans should be on the ISPs. Pay careful attention to the dates on the ISPs to see if there are subsequent changes to the permanency plans. Also look at the Youth Court Hearing and Review Summary Reports for permanency plans.

For Board rates look for the “Social Service Report of Children Taken into Custody.”

The Youth Court Case Summaries (for the county) have information on the hearings and dates and whether they were continued or took place. Use these to cross reference with the actual court documents.

**Specific Protocol Guidelines**

You must answer every question on the protocol unless the instructions tell you to skip certain questions or parts of questions.

All sections of the protocol contain a number of questions that ask for dates. If you can locate a year but cannot locate either the day and/or month, always use the following: 06 if month is missing, 15 for missing day.

A number of questions on the protocol ask that you report information for specific time frames. Be very careful to adhere to the directions regarding time periods for each question. June 1, 2005 is the date selected after which no information is taken from the case records. Therefore, all questions relate to the period of time prior to June 1, 2005. Many questions ask you to identify activities for a specific period prior to this date, such as the 12 months prior to June 1, 2005. Other time periods referred to in the protocol include: 1) the original entry into MDHS custody, which is the date on which the child first came into MDHS custody; 2) the most recent stay in MDHS custody, which is the current stay if the child has never been in custody prior to this stay or the date of entry into MDHS custody closest to the date of June 1, 2005 if the child had been in custody previously, discharged, and had re-entered custody – this may in fact have occurred several times. In questions that require an answer for each month during a specific time period, i.e. 12 months, dates are provided in a grid for your answers.
Cover Sheet
As noted above, the cover sheet documents that a specific case does or does not meet the criteria for inclusion in the study sample. Questions C1-C4 and C9-C11 should be answered before you begin working on the case and complete the protocol. If the case does not meet the criteria, the cover sheet and protocol are turned in for review by Peg or Carolyn.

Section I

1.6 gives you the option of NI. NI means no information and is an option on many but not all questions throughout the protocol. NI is not provided as an option on questions for which you should use NO when you are not able to locate information in the case file

1.7 asks for the child’s most recent entry. The child’s most recent entry is the most recent date that the child was placed in MDHS custody. This date might be as recent as April 2, 2005 or several years ago.

1.18-1.22, use NA if mother or father is deceased. Use the child’s legal mother and father; this may be biological parents or adoptive parents. Father may be putative father.

Section D Initial Agency Actions is to be answered only for children whose most recent entry into custody occurred on or after June 1, 2003, i.e. in the 24 months prior to June 1, 2005.

Section II

When answering the questions about a child’s Individual Service Plan (ISP), use the “date submitted” to answer the question about date.

2.10 “c permanency plan” may be used by MDHS to designate concurrent permanency plan.

2.24 ASWS is Area Social Work Supervisor.

GRID 2B. Face-to-face contact with the child means that the case manager talked privately with the child about his or her status/experiences. Privately means with the child away from the foster parents and other children. If the child is too young to speak, the case manager’s notes regarding direct face-to-face observation qualify as a face-to-face contact.

Subsection F. Previous custodian includes the person(s) who had legal custody of the child prior to the child’s entry into MDHS custody if the child was not with his or her mother/father. May be relatives, adoptive parents, or others who have been granted legal custody of the child.

Subsection G. Do not answer the questions in this subsection if the child was placed in a facility during the 12 months prior to June 1, 2005. Note that GRID 2D, 3 asks about contacts located in the foster home.
Section III
Watch for changing time periods throughout this section. Include half-sibling in the definition of sibling.

Section IV
Subsection A. Information related to mental health issues may be found anywhere in the child’s case record. Note that 4.1, 4.2, GRID 4A, 4.68, and GRID 4B ask about any stay in MDHS custody; ii and iii in GRID 4B, however ask about specific time periods.

Subsection B. Note that in contrast to the questions in Subsection A, the questions in Subsection B relate to the child’s most recent stay in custody, and if the child’s most recent stay has been longer than 24 months, only the 24-month period June 1, 2003 through May 31, 2005.

Subsection E. Note that the parent/problem identified in GRID 4H must correspond with specific questions on page 4.

Section V
Note that 5.1-5.9 ask about the child’s most recent stay in MDHS custody, and if the most recent stay has been longer than 24 months, use only the 24-month period prior to June 1, 2005.

Section VI
Note that 6.1 – 6.46 ask about the child’s most recent stay in custody.

Subsection C. Health and Safety Incidents in MDHS Custody. Note the changes in time period covered in the questions in this section. Information useful in answering these questions may be found anywhere in the child’s case record.

Note that if the answer to 6.221 is NO, you go to Section VII.

Section VII
This section serves as a reminder to attach copies related to specific questions throughout the protocol and also asks in 7.11 that you describe information missing from the case from June 1, 2003 through May 31, 2005 and in 7.12 that you describe any information of concern not captured through the protocol questions.