SENATE OF PENNSYLVANIA
DEMOCRATIC POLICY COMMITTEE

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CHILDREN AND YOUTH SERVICES & CHILD CARE ROOM

Testimony of
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The Support Center for Child Advocates is Philadelphia's lawyer pro bono program for abused and neglected children. We offer the skills and dedication of lawyer-social worker teams, and we represent more than 1,000 children each year. *Child Advocates'* legal and social services are offered to child victims through **Direct Representation Services** and **Child Advocacy Leadership and Training**. For more than 45 years, we have served as a resource to this Legislature and its staff, and I thank you for the invitation to serve in this role once again. When asked, we attempt to offer to you a balanced, candid and constructive assessment of what our children need and how we are all doing for our kids.

Today we consider the need for emergency placements of children out of their own homes as facilitated by the Philadelphia Department of Human Services ("Phila-DHS" or "DHS") and the short-term overnight facility known as the Child Care Room ("CCR"). The Child Care Room is actually a set of rooms and other spaces located on the first floor of DHS in their main headquarters building at 1515 Arch Street.

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What should happen when a child comes into care on very short notice? One should know that historically, across the nation, there are countless stories of children sleeping "in the hallways" of public child welfare agencies, while waiting for a "bed" to be identified for them in a foster home, relative's home, a shelter, hospital or other institution. To its credit, DHS has never had this problem! Twenty-plus years ago, there was a cadre of emergency foster homes developed and designated for short-term placements -- these were homemakers and families who made themselves available to take a child NOW – on a phone call, and generally for just a few days or so. There were also numerous institutional settings, like St. Vincent's Home in Tacony and St. Joseph's Home in Northeast Philadelphia, and others, where a social worker could likely find a bed. Now those emergency homes are mostly gone and those institutions are closed, all for good reasons as the system purposely moves away from the use of congregate care facilities.

The companion problem to a child or youth coming <u>into</u> care for the first time, is the one who is already in out-of-home placement, but <u>needs a new placement</u>. Like a child in a psychiatric hospital or Residential Treatment Facility (RTF) who is ready for discharge to a foster family. Or a youth whose caregiver has "given notice" that 'time-is-up-and-I-want-this-child-out-of-my-home'. The hospitalized child stays in the hospital, unable to leave. The ambulatory child often ends up in the Childcare Room!

And so it should come as no surprise that children will wait … somewhere, while DHS searches for an appropriate placement. Sitting around in the Child Care Room or in a hospital. Out of school. Decompensating. Acting out. Some getting into trouble. This is our responsibility, not theirs.

What are the problems? The Philadelphia child welfare system lacks placement options and fails to prepare for known needs. Breakdowns occur throughout the process, and the gaps in service and staffing are everywhere. Staff who mean well but are not up to the task of care in a challenging environment. Insufficient accountability and creative approaches that will increase stability of child placements and reduce the need for emergency overnight stays. We offer details below.

What solutions? What we really are more beds and a streamlined placement process to get kids in and out faster! Children should always be placed in the least restrictive setting, which means creating placement resources that are not restrictive AND that work to meet their needs. We need better-supported foster homes and respite caregivers, with timely access to therapeutic supports, and other resources/supports. We must advance thoughtful, research-based creative alternatives like professional foster homes and community engagement. Children and youth who experience placement disruptions and require time in the CCR, generally those with more specific behavioral needs, need trauma-informed staff to support them during this transitional period.

And of course, stepping back, our entire community knows that we are not sufficiently supporting children and families in their own homes – certainly some children need to be removed, but many others could stay at home, were there a fundamentally different approach. Rather than blaming the kids or their families or their depth of need, we should be taking them as we find them, and serving them as they need and deserve. That is our shared mission and goal.

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Lack of Placement Options and Failing to Prepare: Throughout human services, we have become an on-demand manufacturing and delivery system, trying to behave like Amazon or industrial America: no excess capacity. Manufacturers only order the number of parts they will need in the coming days or weeks, and work hard to not keep unused components or finished product on their shelves. We do the same thing in our supply chain. We fail to prepare, to get out in front, concerned that we will "buy" empty beds, and out of fear that we will fill them. We continue to do so without the necessary and entirely predictable preparation that comes with knowing that WE WILL NEED BEDS TONIGHT, AND TOMORROW, AND NEXT MONTH. Ask DHS, or any CUA or provider, how many open beds they have waiting. Then you will know what the "bench" looks like.

Private Community Umbrella Agencies, or "CUAs", and "provider" social service agencies create or "develop" their foster homes and provide supports for kinship caregivers. Many work hard at recruitment, and societal shifts seem to have changed the landscape of who may be willing to serve as caregivers. The agencies do not hold beds, at least not for very long. They are not required to have excess unused capacity of homes – a "bench" – waiting to be filled by a referral that-has-not-yet-come. And they are not paid or reimbursed for such an expense if they wanted to maintain a "bench."

Either an empty bed will wait for a child. Or a child will wait until a bed is found. Make your choice. This waiting is happening all the time.

The lack of placement options is even more challenging and damaging for children with complex medical or behavioral health needs, leading to extended stays at the CCR, Juvenile Justice Services Center ("JJSC"), and hospitals. In the last two years our office has brought at least 12 youths to the attention of DHS leadership – youths with special needs who had been waiting for their next placement for months or even years.

Cumbersome and Broken Bureaucracy: The DHS "Central Referral Unit" (CRU) is, as its name suggests, the singular place to look for placement options. When the new Improving Outcomes for Children program was designed, referrals happened by each CUA looking for its own placement options. But this became cumbersome, duplicative and ineffective; as the resource pool of homes diminished for each CUA agency, many cases were inevitably referred to the CRU for a system-wide search after a few days of the child waiting for placement. And so DHS "took back" and centralized the referral/placement process. Now, the CUA Case Manager makes the referral to the CRU, requesting a search for a placement option. The CRU circulates a "Referral Packet" to its list of potential providers. While the CRU is charged with looking for available placement options, the CRU does not itself develop the placement resources, i.e., the "beds."

Breakdowns occur throughout the multi-step process, and the gaps in service and staffing are everywhere. Referrals sometimes do not get made by CUA, as high caseworker workloads and lack of support results in high turnover and things seemingly falling through the cracks, constantly. With limited resources parents and beds, providers either fail to respond or decline to accept a child who may seem "difficult." When a child has been missing from a placement, the CRU won't look for a new placement unless the child is physically at the CCR, despite the child having access to another place where they feel safe at the time. Child advocacy teams find it difficult to obtain information from CRU to collaborate in the process; instead we are left to pry open the information-door with lawyers at court.

We have seen unnecessary delays in kinship placement, for which the law allows placement of a child with "kin" while the certification process of the caregiver ensues (that is, after passing child abuse clearances and home assessment). We have frequently had cases in which a child is held in the CCR or placed in group homes and other non-kinship placements while an identified caregiver is completing certification.

What is happening in the foster home that too often results in a child being disrupted? Are disruptions on the rise, as they seem to be? What trainings and services are currently available for parents and kinship supporters to care for these children with complex needs? With critical appraisal, we ought to know these answers.

Need Trauma-Informed Staff Practice: Trauma-informed practice requires practitioners who can create spaces for healing, rather than escalate difficult situations. The mere fact that a child is in the CCR indicates a removal from their home of origin or foster home was determined to be necessary, and sometimes, in addition, the child has been rejected from other placement(s) – these are all traumas. Emergency placements are always difficult, and working with a child or youth who is in some form of emotional breakdown is most challenging. Too often, staff at CCR do not act in a trauma-informed manner when interacting with children awaiting placement.

Behavior of staff in the CCR has a direct correlation to the child's behavior during a time of crisis when a child feels powerless and more likely to push back in an effort to regain control over the situation. Our own staff have observed incidents include: staff exacerbating a child's behavior by talking to them in a derogatory way; responding to a child's behavior with name-calling about and toward children; rolling their eyes when certain youth are mentioned; talking about fighting youth; physically getting "in the space" of a child who is visibly agitated; and escalating already-sensitive situations.

Staff specializing in behavioral health are not available at all times. Currently, children are separated into two rooms; as though one room can service a 1-year-old as well as an 11-year-old with age-

appropriate activities. Children should be separated into more than two age categories. Cell phones are taken away from children when they are brought to the CCR – with competing concerns of child safety v. child empowerment/sense of control. Without cell phones, youth are bored. The CCR offers no programming for children and youth who are spending time there. While CUA agencies are responsible for children in the CCR during the day, requiring them to transport them to school or to their agency for the day, children are returned to the CCR before 5 p.m. until the next morning and often remain there all weekend.

Insufficient accountability for CCR overuse and overcrowding: CCR usage and other problems were recently revealed in two compelling *Inquirer* reports [1] – but we shouldn't have had to hear in this way. While DHS leadership commitment to resolving problems with CCR is commendable, there remains a lack of transparency on daily usage data. Census and usage data should be shared with PA-DHS, with local advocates and community members, and with the Child Welfare Oversight Board (CWOB). Phila-DHS has been collecting this data for more than five years; for example, compare August 2017 DHS-CCR Utilization Report and October 2022 CWOB presentation (attached).

Clearly there has been a tremendous spike in overnight stays in the CCR, from 95 children in FY18 and 60 children in FY19, to 301 different children in FY22. We reference the Quarterly Indicators Report recently posted on the DHS website and presented to a recent CWOB session, including a special presentation with data presented on the use of the Child Care Room. DHS data show that the number of children and youth using CCR is greater than ever in 2022, and the greatest number are between 11-17 years, slightly more female than male, and significantly greater numbers of black children and youth in 2022. The greatest numbers result from foster care disruptions, runaway from placements, or not receiving any service.

Importantly, however, we do not know how many total nights, nor the length of stays of these many children. Data that would help to better understand the scope of the problem include:

a) Overnight population (day-by-day).
b) Age breakdown.
c) Length of stay (i.e., number of overnights) per child.
d) Length of stay (hours per day).
e) Reasons for overnight stays.
f) Length of wait for placement by CUA and CRU.

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In addition to the recommendations noted above, we respectfully offer the following suggestions for improvement:

1. We agree with this key DHS-presented solution: increase emergency resources, kin in particular, and select foster care providers for "professional resource parents for older youth and behavioral needs" and develop a 'personalized plan" with youth who remain in CCR after 1 day.

2. Allow CRU to make placement referrals for youth who are in touch with CUA and who have confirmed they will come to DHS or CUA when placement is located.

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[1] See Samantha Melamed, "Here's how Philly kids ended up sleeping in a DHS conference room for weeks on end," *The Philadelphia Inquirer*, Aug. 4, 2022; and Samantha Melamed, "Missing kids, illicit activity: Staff warn of chaos at Philly DHS office that houses stranded kids," *The Philadelphia Inquirer*, Aug. 4, 2022 (attached).

3. Referral packet and social summary needs to be updated and current.

4. Executive Teaming meeting should occur for any child for whom CRU is still searching for placement after 30 days.

5. Open communication with CRU and child/parent advocates should occur, including the sharing of referral documents and search efforts.

6. At CCR, consider a check-in process where a youth can check-in during the morning and placement will be searched for 24 hours until child checks in again.

7. Child Care Room practice, facility management and staffing should include:
   a. Reduce daily instability of a child's experience (i.e., to and from CUA, by day and night).
   b. Improve staffing and supervisory support, especially for appropriate response to children in crisis and acting-out behaviors.
   c. Introduce [additional] activities for younger children such as tablets with educational apps, music therapy, art program, tutors
   d. Assign additional staff tasked with providing activities and monitoring younger children; allow staff to take children outside to park or playground while awaiting placement.
   e. Assign Achieving Independence Center (AIC) staff present in CCR to assist older youth with connecting with a coach, providing tablet or laptop during stay so that child can work on an AIC course. (Note: AIC is the well-regarded Phila-DHS program for older youth).
   f. Separate children into at least 3 age groups (i.e., young child; adolescent; teen).
   g. Explore reasonable alternatives to cell phone possession and use by children while at CCR.
   h. Stop labeling children as being "AWOL" from the CCR; CCR is not a placement.

8. Improve foster home/resource home recruitment. Consider creative alternative models such as the Mockingbird model to better support Resource Parents.

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