STATE OF WEST VIRGINIA

PRELIMINARY PERFORMANCE
REVIEW OF THE

CHILD PROTECTIVE SERVICES DIVISION

Children Are at Risk of Abuse When Child Protective Services Does Not Respond to Referrals

OFFICE OF LEGISLATIVE AUDITOR
Performance Evaluation and Research Division
Building 5, Room 751
State Capitol Complex

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September 1996

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Antonio E. Jones, Ph.D.
Director

September 6, 1996

The Honorable A. Keith Wagner
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The Honorable Joe Martin
House of Delegates
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Gentlemen:

Pursuant to the West Virginia Sunset Law, we are transmitting the Performance Evaluation of the Child Protective Services, which will be reported to the Joint Committee on Government Operations on Sunday, September 15, 1996. The issue covered herein is "Children Are at Risk of Abuse When Child Protective Services Does Not Respond to Referrals."

If you have any questions regarding this report, please contact me.

Sincerely,

Antonio E. Jones

AEJ/mba

Enclosure

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Executive Summary

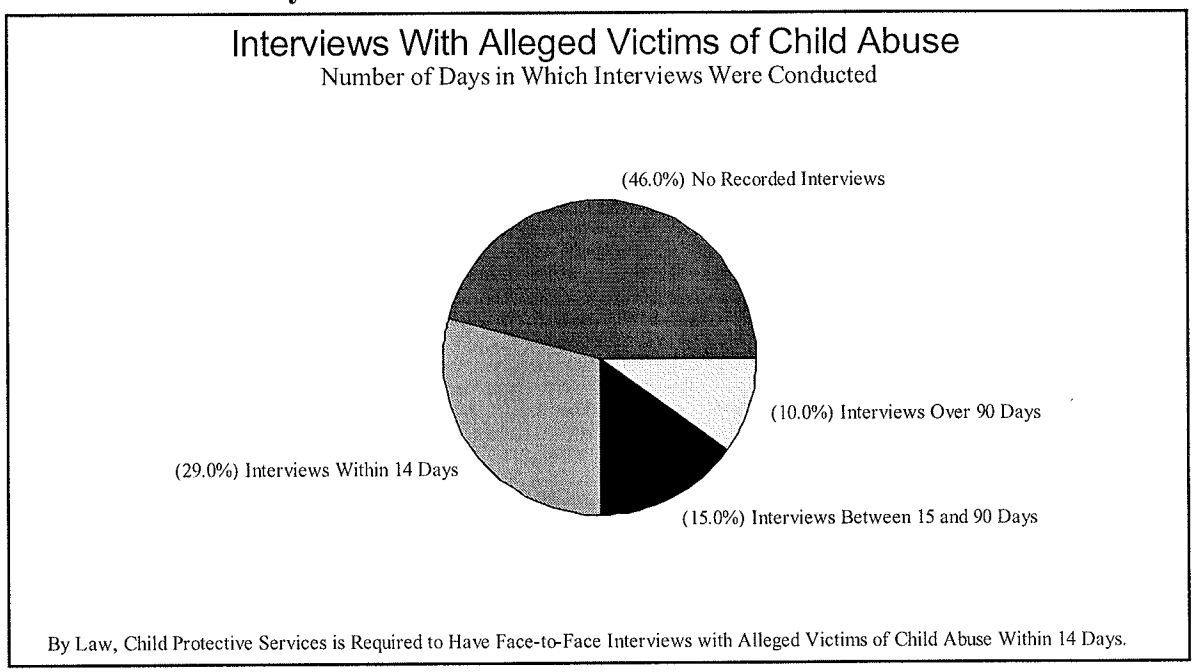
Child Protective Services (CPS) is responsible for protecting the children of the state from abuse and neglect. An important part of that responsibility is investigating every report of child abuse. The issue below describes the agency's performance in investigating cases.

ISSUE AREA 1: Children Are At Risk Of Abuse When Child Protective Services Does Not Respond To Referrals.

According to §49-6A-9, paragraphs (3) and (4) of the West Virginia Code, upon being notified of suspected child abuse or neglect, the Child Protective Services agency is required to begin a thorough investigation of the allegation. As part of the investigation, the agency must have a face-to-face interview with the child or children within 14 days of the report.

PERD's review of 663 CPS child abuse cases for FY 1995 found that **in 46% of the cases, CPS had no record of having a face-to-face interview with alleged victims of child abuse** (see Figure 1). **Furthermore, only 29% of the cases had interviews within 14 days as required by law.** In 15% of cases, CPS took between 15 and 90 days to conduct interviews, and in 10% of cases it took over 90 days to have interviews with alleged victims.

Figure 1
Number of Days From the Referral Date to Have Face-to-Face Interviews



Evidence shows that the cases without recorded interviews were never investigated. Memoranda dating back to 1992 reveal the implementation of a statewide policy that prioritized the investigation of cases based on the initial information received from referrants. Child abuse reports that appeared less serious than others were given lower priority for investigation. The reasons given by the agency for prioritizing investigations were growing caseloads and understaffing in various offices in each of the agency's four geographical regions.

The result of the prioritization policy was that nearly 50% of the cases were held without investigations for **six to 12 months**. The agency made the decision that in those cases, if there was not a second referral on the same case, the case could be "cleared," or closed, **even though they were not investigated.** This procedure violates state law §49-6A-9.

The impact on children from the slow or non response is that children were placed at risk of further abuse. Prioritizing cases based on the initial information received from the referrant is not always indicative of how serious a case may be. Case examples show that serious child abuse cases in which the agency had to intervene went months before the investigation began. During the intervening time these children were at risk of further abuse and neglect.

Review Objective, Scope and Methodology

This preliminary review of the Child Protective Services (CPS) is required and authorized by the West Virginia Sunset Law, Chapter 4, Article 10, Section 11 of the West Virginia Code, as amended. The CPS is mandated to protect the children of the state of child abuse and neglect. The agency protects children from abuse by investigating alleged reports of child abuse, and assessing the child's environment for risk of future child abuse. In cases in which allegations were substantiated, the agency may provide services that can alleviate the risk of future abuse.

The objective of this review was to determine the agency's effectiveness in protecting children. The scope of this report focuses on how responsive the agency is in investigating child abuse cases. This is a critical part of protecting children from abuse. Assessing the risk of future abuse and opening cases for services is equally important. These latter two functions of the agency will be evaluated and reported on in a subsequent report. Also outside of the scope of this review is the issue of whether the agency properly screens out cases. Screened out cases are those referrals which the agency determines do not fit the agency's definition of child abuse or neglect. These referrals are not investigated. Any referral which fits the agency's definition of child abuse must be investigated. These cases are referred to as accepted cases.

The methodology included sampling 663 child abuse cases from 12 counties. The sampling methodology is described in greater detail in Appendix A. Interviews were held with members of the CPS staff and a survey was conducted of staff members of the 12 counties sampled. An evaluation of the Child At Risk Field (CARF) system was performed. This system is used by the agency in administering its function of protecting children. Every aspect of this review complied with **Generally Accepted Government Auditing Standards.**

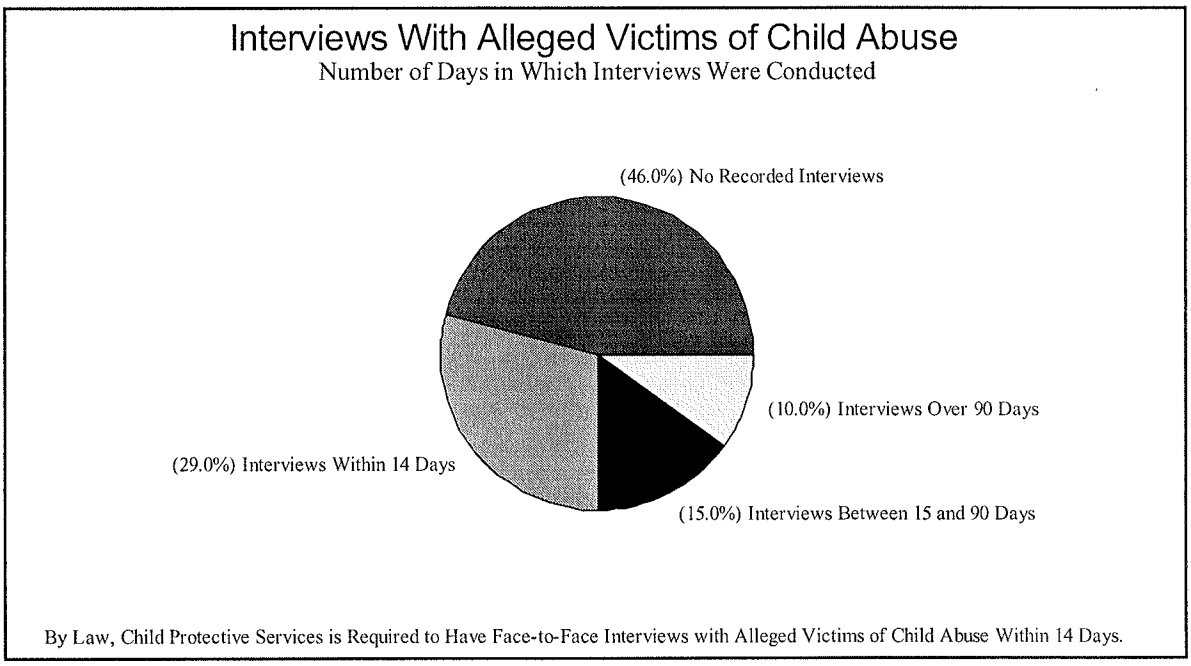
ISSUE AREA 1: Children Are At Risk Of Abuse When Child Protective Services Does Not Respond To Referrals.

To prevent further child abuse, it is important for the Child Protective Services (CPS) agency to have face-to-face interviews with the alleged victims of child abuse or neglect within an appropriate time frame. According to §49-6A-9, paragraphs (3) and (4) of the West Virginia Code,

> Upon notification of suspected child abuse or neglect, commence or cause to be commenced a thorough investigation of the report and the child's environment. As a part of this response, within fourteen days, there shall be: A face-to-face interview with the child or children....(emphasis added)

A survey of 663 cases for FY1995 revealed that in 46% of the cases, CPS had no record of having a face-to-face interview with alleged victims of child abuse (see Figure 1). Furthermore, only 29% of the cases had interviews within 14 days as required by law. In 15% of cases, CPS took between 15 and 90 days to conduct interviews, and in 10% of cases it took over 90 days to have interviews with alleged victims.

Figure 1
Number of Days From the Referral Date to Have Face-to-Face Interviews



In order to evaluate CPS, 12 counties were systematically chosen for a statewide survey. Three were chosen from each of the agency's four geographical districts according to the number of accepted cases that they had during the 1995 fiscal year (see Appendix A for the sampling methodology). Accepted cases are cases which required an investigation of alleged child abuse. The sampling methodology took into consideration that performance may vary by county

according to the number of accepted cases. Therefore, the methodology sampled counties from each region with low, medium, and high numbers of accepted cases, and weighted them accordingly.

Table 1 shows the time it took to have face-to-face interviews for the counties in the sample. In terms of interviews within the mandated 14 days, Gilmer County complied with the mandate in 79% of its accepted cases, while McDowell County had the lowest percent at 13%. In terms of percentages of cases without any record of a face-to-face interview, Ohio County had the lowest percent at 3.6%, while Kanawha County had the highest percent at 77.3%.

Table 1
Time From Referral For CPS to have Face to Face Interviews

Counties with High Accepted Cases				
	Dist I	**Dist II**	**Dist III**	**Dist IV**
	Wood	Kanawha	Berkeley	McDowell
Percentage of Cases without record of Face to Face interviews	25.0%	77.3%	31.9%	41.7%
Interviews within 14 days	25.0%	18.2%	44.7%	13.3%
Interviews in 15 to 90 days	21.7%	1.5%	23.4%	23.3%
Interviews above 90 days	28.3%	3.0%	0.0%	21.7%
Counties with Medium Accepted Cases				
	Ohio	Logan	Jefferson	Wyoming
Percentage of Cases without Record of Face to Face interviews	3.6%	27.7%	31.6%	75.5%
Interviews within 14 days	38.2%	53.2%	57.9%	15.1%
Interviews in 15 to 90 days	54.5%	12.8%	10.5%	3.8%
Interviews above 90 days	3.6%	6.4%	0.0%	5.7%
Counties with Low Accepted Cases				
	Gilmer	Mason	Hardy	Braxton
Percentage of Cases without Record of Face to Face interviews	8.8%	42.9%	41.9%	44.2%
Interviews within 14 days	79.4%	32.1%	38.7%	37.2%
Interviews in 15 to 90 days	11.8%	21.4%	12.9%	18.6%
Interviews above 90 days	0.0%	3.6%	6.5%	0.0%

There is some correlation with respect to response time and the number of accepted cases. For example, the counties with relatively low and medium caseloads in their respective districts had a weighted average of 41% of their cases having interviews within the mandated time. While

the average percent for meeting the mandated time drops to 22% for the four counties with high caseloads. The percent of cases with no recorded interviews also correlates with caseloads. For the counties with high caseloads, the weighted average percent of cases without interviews was 53%; for medium caseload counties the average was 34%; and, for low caseload counties the average was 37%. The correlation is strongest when the high caseload counties are compared to the low and medium caseload counties.

There is abundant evidence that the lack of recorded interviews in nearly half the cases is because they were not investigated. In early 1992, CPS realized that it did not have sufficient staff to investigate all of the incoming referrals. A March 16, 1992 memo from the Director of Family and Children Services to the Regional Administrators, Social Service Coordinators, Family and Children's Services Supervisors and Family and Children's Services Workers presented Revised Interim Measures for CPS case prioritization. The memo acknowledged that a "steady increase in referrals" and a "corresponding reduction in staff" made it difficult to "adequately meet the needs of all its clients." The inadequate staffing also resulted in a growing backlog of cases pending investigation. To address this problem, the revised interim measures included prioritizing the investigation of cases in order that children with the greatest risk of serious harm would be given first priority.

The CPS received some feedback from visits to office sites that resulted in an October 1992 memo that made additional recommendations to address the problem of understaffing and growing caseload. One of the new procedures stated that if a pending report of child abuse was more than six months old, and no subsequent reports had been received, the supervisor may note on a service documentation form that the report is being closed and consider it to be cleared **even though it was not investigated.**

Apparently these new policies and procedures did not work according to the Central Office's intentions. There appeared to be a misunderstanding in many counties on clearing cases that were pending an investigation for six months. A May 5, 1995 memo from the program manager in Social Services stated that the case prioritization policy of 1992 was never intended to allow referrals to be permanently "held," that is, go without investigation. The memo goes on to state that "the expectation was that all referrals would eventually be assigned to a worker" for investigation. However, in some counties a backlog of "held" cases began to build, which means that **a growing number of cases were not being assigned to a worker for investigation.** In fact, the memo stated that some counties were holding referrals that were more than a year old without investigation. In answer to this situation, the memo stated that referrals that were at least a year old and had no additional referrals could be closed and not continue to hold them as pending.

It can be concluded that CPS did not investigate numerous referrals, held them for over a year and, if there were no additional referrals pertaining to a specific family, closed them without investigation. It is apparent from these memoranda that top administrators knew there was not enough staff to handle the number of CPS cases accepted by the agency. However, putting cases on hold potentially increased the chance that a child would be further maltreated.

Effects Of Not Conducting Face-to-Face Interviews In A Timely Manner

If cases are not investigated in a timely manner, children will be at risk of further abuse during the intervening time between when the referral call was made and when CPS began its investigation. To illustrate this point, we examined the length of time to investigate cases that eventually were opened for CPS services. The point being that opening a case is an indication that the case was of a serious nature, considering the agency's limited staff and the small number of cases that were opened for services (9%). Opening a case allows the agency to provide the family with services to alleviate the risk of future child maltreatment. These services generally include counseling for individuals or families, and other forms of assistance.

Below are five case examples in which the agency took considerable time to investigate. Upon investigation, the risk rating of future maltreatment was "significant" according to the risk rating system used by the agency. This is the second highest risk rating under the system. Furthermore, these five case examples show that the child's safety was a concern. Determining the safety of a child is based on the severity of maltreatment, the vulnerability of the child, and how controllable the family situation is. The following case examples show instances of slow response times to referrals that turned out to be serious and had to be opened for services.

> **CASE 1:** *CPS had a face-to-face interview with the child 252 days after the referral date. A risk assessment showed the child's environment had significant risk of future child maltreatment. Neglect did occur and the child's safety was a concern.*
>
> **CASE 2:** *CPS had a face-to-face interview with the child 132 days after the referral. The interview and further examination determined that abuse did occur, and the risk rating of future child abuse was significant. There was also concern over the future safety of the child.*
>
> ***CASE 3:*** *CPS had a face-to-face interview with the child 102 days after the referral. The interview and further examination determined that abuse did occur, and the risk rating of future child abuse was significant. There was also a concern for the future safety of the child.*
>
> ***CASE 4:*** *CPS had a face-to-face interview with the child 55 days after the referral. The interview and further examination determined that neglect did occur, and the risk rating of future child maltreatment was significant. There was also a concern for the future safety of the child.*
>
> ***CASE 5:*** *CPS had a face-to-face interview with the child 20 days after the referral. Maltreatment did occur, and the risk rating of future child abuse was significant. There was also a concern for the future safety of the child.*

The agency's policy of prioritizing the investigation of cases caused some cases to go without investigations or begin investigations months after the initial referral. The prioritization

is based on the initial information received from the referrant over the telephone. However, the initial information often does not adequately determine how serious the situation is until a thorough investigation begins. This is why a thorough investigation of every case should begin within 14 days, which includes a face-to-face interview with the alleged victim. **The agency's investigation prioritization policy resulted in a hit-or-miss approach.** The above case examples show that prioritizing investigations leads to serious cases receiving slow response time. The long intervening time between the referral date and the investigation increases the risk of children being further abused, and even possible death.

Causes Of Not Conducting Face-to-Face Interviews In A Timely Manner

The previously mentioned memoranda dating back to 1992 indicate understaffing as a major cause for many cases not being investigated. The Child At Risk Field (CARF) system used by the agency to investigate child abuse reports specifies a caseload standard of 15 cases per worker. The agency has developed its own caseload standard which requires that intake workers (those who investigate referrals) should have no more than 13 cases a month and that they should clear 13 cases a month. Ongoing workers (those who service opened cases) should have no more than 10 cases each month and should clear 10 cases each month. In either case, CPS workers in the 12 counties sampled indicated that they have caseloads that are twice these standards.

High caseloads have led to the creation of sizeable backlogs leading to controversial agency-wide practices being used to handle this backlog which have caused reports of child maltreatment not to be investigated in a timely manner. This study also shows that interviews conducted with alleged victims of child abuse within the mandated 14 days is correlated to the number of cases each county has. The larger the caseload the smaller the percent of cases which had interviews in the required time.

CARF requires a caseload standard of 15 cases per worker in order for it to be implemented properly. CPS, at the time CARF was implemented, did not have sufficient staff to achieve this caseload standard. CPS tried to implement CARF with its existing staff levels. Instead of getting the additional staff needed to properly administer CARF, CPS modified the system by prioritizing cases and not investigating all referrals.

Recommendation 1

Child Protective Services must comply with WVC §49-6A-9 which stipulates the timeframes for investigating every child abuse case. The Legislature should consider requiring the agency to submit a plan on how it intends to meet the time specifications in the code. This plan should describe the resources needed to accomplish this goal, and the earliest date that timely investigations for every case can be accomplished. This plan should be submitted to the Joint Committee on Government Operations by January 1, 1997.

Recommendation 2

The Child Protective Services agency should routinely monitor the timeliness of investigating cases, and submit quarterly reports on the timeliness of investigations to the Joint Committee on Government Operations, and the Legislative Oversight Commission on Health and Human Resources Accountability.

Appendix A

Child Protective Services
Sampling Methodology

Child Protective Services (CPS) has offices designated for every county in the state, as required by law (§49-6A-9(a)). These offices perform the duties and functions of investigating reports of child abuse. The agency has divided the county offices into four geographical districts. Each district contains between 12 and 16 counties.

In order to arrive at statewide statistics that accurately represent the performance of CPS we sampled child abuse cases from 12 counties, three from each district. The table below shows the 12 counties and the sample size for each county. The total sample size was 663 accepted child abuse cases out of a total population of 16,194 accepted cases for FY 1995. There were 73 cases which the agency could not find or were transferred to another county. These cases were not substituted and thus, were excluded from the sample estimations.

Table 2

Twelve County Sample & Sample Size

District One		District Two		District Three		District Four	
County	Sample Size	County	Sample Size	County	Sample Size	County	Sample Size
Gilmer	39	Mason	57	Hardy	33	Braxton	49
Ohio	58	Logan	63	Jefferson	46	Wyoming	59
Wood	67	Kanawha	70	Berkeley	59	McDowell	63

One objective of the sample was to determine the timeliness of CPS in investigating child abuse allegations. We recognized that caseload would be a factor in any county's ability to respond to child abuse reports. To account for this, we chose to sample cases from three types of counties in each district. The three types of counties are those that had low, medium, and high numbers of accepted cases. A case is accepted for investigation when it is determined by CPS that a report called in fits the description of child abuse. If a report was determined not to be a legitimate case of child abuse it is screened, which means it would not be investigated.

The counties in each district were arranged in ascending order of the number of accepted cases. The total number of counties in each district was divided by three. The result of this division determined which three counties in each district would be selected. For example, regions two and four had 12 counties. Dividing 12 by three equals four. Therefore, counting from the county with the lowest number of accepted cases, every fourth county was selected. District three has 15 counties, therefore, every fifth county was selected. District one had 16 counties resulting in a non-integer value of 5.3 when 16 is divided by three. Therefore, the first county selected in

district one was the sixth county and then every fifth county was selected. The table below illustrates the results of this procedure.

Table 3

Accepted Cases by County and District

District One		District Two		District Three		District Four	
County	Cases	County	Cases	County	Cases	County	Cases
Wirt	0	Clay	132	Pendelton	29	Monroe	28
Doddridge	31	Roane	238	Grant	42	Pocahontas	40
Tyler	40	Jackson	255	Tucker	44	Summers	45
Pleasants	50	**Mason**	**263**	Morgan	46	**Braxton**	**157**
Ritchie	61	Lincoln	304	**Hardy**	**62**	Webster	173
Gilmer	**84**	Boone	339	Mineral	72	Greenbrier	231
Wetzel	120	Putnam	404	Hampshire	97	Nicholas	234
Calhoun	133	**Logan**	**530**	Barbour	105	**Wyoming**	**315**
Brooke	187	Wayne	531	Taylor	126	Fayette	357
Marshall	258	Mingo	709	**Jefferson**	**127**	Raleigh	457
Ohio	**292**	Cabell	1,090	Upshur	148	Mercer	485
Hancock	312	**Kanawha**	**2,506**	Lewis	172	**McDowell**	**515**
Marion	405			Randolph	199		
Harrison	557			Preston	223		
Monongalia	587			**Berkeley**	**316**		
Wood	**931**						

The counties in the bold blocks were the ones selected for the sample. Upon determining the counties, the cases for those counties were placed in chronological order for FY 1995. A set of random number were generated for each county which were used to select the number of cases for each county.

To extrapolate sample estimates to statewide estimates, each county statistic in the stratified sample was weighted. These weights provided that the combined estimates would be representative of statewide population estimates. Weights were calculated for each of the four districts and for each county in the sample. The district weights equaled the number of accepted cases in a district divided by the total number of accepted cases in all four districts. The county weights equaled the number of accepted cases for those counties categorized as low, medium or high caseloads divided by the total number of cases in the respective district. For example, Gilmer County in district one represents the other five counties (Doddridge, Pleasants, Ritchie, Tyler, and Wirt) that were categorized as counties with low caseloads. Therefore, the weight assigned to Gilmer County statistics equaled the sum of accepted cases for Gilmer and the other five counties divided by the total number of cases in district one. This same procedure was followed for medium and high caseload counties. The three county weights for each district sum to equal the value of one, and the four district weights also sum to equal the value of one. Table 4 illustrates the weights associated with each county and each district.

Table 4

County & District Weights							
District One		**District Two**		**District Three**		**District Four**	
County	Weight	County	Weight	County	Weight	County	Weight
Gilmer	0.066	Mason	0.122	Hardy	0.123	Braxton	0.089
Ohio	0.244	Logan	0.216	Jefferson	0.292	Wyoming	0.314
Wood	0.690	Kanawha	0.662	Berkeley	0.585	McDowell	0.597
District 1	0.250	District 2	0.451	District 3	0.112	District 4	0.187

Appendix B

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Secretary
State Capitol Complex, Building 3, Room 206
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Gaston Caperton
Governor

Gretchen O. Lewis
Secretary

September 5, 1996

Aaron Allred, Legislative Auditor
Office of Legislative Auditor
Performance Evaluation & Research Division
Building 5, Room 751
State Capitol Complex
Charleston, West Virginia 25305

Dear Mr. Allred:

Staff from both the field and the State Office of the Bureau for Children and Families have reviewed the preliminary performance review of the Child Protective Services Program conducted by your staff. Based on that review, the following comments were prepared for your consideration.

We are in complete agreement with the correlation between staff capacity and service provision which was one of the central findings of the review. This relationship was also discussed in a report on child welfare services conducted by the federal government. A copy of that report is included for your information.

Despite the lack of adequate resources, this Department has made a concerted effort this year to reduce the backlog of referrals requiring investigation. This effort has included the temporary reassignment of staff, the use of overtime and reallocation of staff from one region to another. The results of that effort can be seen in the two reports on pending referrals.

The problem of the understaffing and underfunding of the CPS system is not new to those familiar with the system. It is no secret that the demands on the system for assistance and services often exceed the capacity of the system to respond. The origins of the imbalance in the system date back to the early 1980's when decreases were made in funding to the states for social services. At the same time, the numbers of children being identified as abused and neglected began to soar (see attachment).

Fiscal belt-tightening led to decreased numbers of staff to provide social services. Increased reporting of abuse and neglect led to higher caseloads. Those working in the field have struggled daily to meet the challenge of doing more with less.

Those struggles have not been ignored. A Child Protective Services State Plan was adopted by the Department in 1990 to provide for strengthening and improving services to abused and neglected children and their families. Part of that plan addresses the need for increased staffing and better workload management. Numerous reports and articles have been written and disseminated regarding the workload and staffing deficit within the child protective services system (see attachments).

In early 1991 former DHHR Secretary Taunja Willis Miller released a public announcement regarding the need to target the limited resources available to the most vulnerable and most at-risk children and the implementation of case prioritization strategies. The Department recognizes that case prioritization is not an ideal method for service delivery, however, there is a need for some process and criteria for establishing priorities for cases until the system develops the capacity to fully respond to all of the current demands.

In 1990 the United States Advisory Board on Child Abuse and Neglect declared that child abuse and neglect represented a national emergency. In 1993 the Board reported that the child protection emergency had clearly deepened in all parts of the nation. The Board further stated that (among other problems) caseloads of local government agencies charged with child protection have soared and that inadequate public resources are still being devoted to child protection.

In July 1994, the West Virginia Supreme Court of Appeals Advisory Committee on Child Abuse and Neglect released their final report in which the committee cites the absence of full and complete staffing of the Department as well as mental health services providers as a barrier to a coordinated effort for resolution of child maltreatment and recommended that legislative action for full staffing be taken.

In October 1994, the Office of Social Services prepared a report regarding caseload standards and staffing and estimated at that time that an additional $7,063,326 in state funds would be needed to reduce caseloads in CPS.

In recent years there has been progress made toward a fully staffed CPS program. The number of CPS workers has increased from just over 100 in 1991 to 252 as of August 1996. This growth in staff resources was made possible by increased appropriations from the Legislature in 1995 and 1996.

Other initiatives are underway to retool and refine CPS in West Virginia such as:

- The Family Options Initiative which is a demonstration project in five counties to explore alternative methods for service delivery in CPS and to expand and improve services to the less intense CPS cases.
- The establishment of a Quality Assurance Division within the Office of Social Services which will develop a system for regular monitoring and evaluation of CPS.
- The current development of FACTS (Family and Children's Tracking System) which is an automated management information system which will provide workload information to local and state managers.
- The development of proposed court rules of procedure for abuse and neglect cases and multidisciplinary team protocol by the Supreme Court Advisory Committee on Child Abuse and Neglect.
- The establishment of the Court Improvement Board by the Supreme Court of Appeals and the subsequent assessment of court performance in child abuse and neglect cases and plan for improvements.
- The implementation of a staff development and training program for all child protective services staff.

In response to the comments about case prioritization, it is clear that the practices arising from these policies must be addressed. Some of the instructions issued in 1992 were intended to be time limited and were designed to address a backlog problem at that time. Those instructions were not intended to remain in effect indefinitely, although some staff appear not to have understood these directions.

The policies on case prioritization which were the subject of the review will be rescinded. A clear set of instructions on how to address all referrals including the statutory response times will be issued by the Office of Social Services.

In conclusion I would like to briefly return to the federal report cited earlier. The report was complimentary in its description of this Department's philosophy, the risk based decision model used in child protective services, and the attitudes as well as many of the practices of staff. Despite all of the positive findings, the report was clear that the safety of children is directly related to staff resources.

It is my intention to use the results of this review to manage our staff resources wisely. It is my hope that your findings will help us to obtain the resources necessary to help protect all children at risk of harm.

Very truly yours,

Gretchen O. Lewis
Secretary

GOL/kc

Enclosures

cc: Sue Sergi, Commissioner
Bureau for Children and Families

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Child Protective Services
JULY 1996

REVISED

County	Referrals Received	Referrals Accepted	Referrals Pending 30+ Days	Total Referrals Pending	Referrals w/out Face to Face w/In 14 Days
STATE TOTAL	**1,939**	**1,475**	**155**	**922**	**158**
Region I	**474**	**380**	**12**	**250**	**17**
Brooke	30	25	2	19	2
Calhoun	9	9	0	0	1
Doddridge	4	4	0	3	0
Gilmer	1	1	0	0	0
Hancock	17	14	1	10	2
Harrison	41	35	0	29	0
Marion	57	35	8	31	5
Marshall	40	33	0	11	0
Monongalia	67	53	0	38	1
Ohio	46	41	0	19	0
Pleasants	3	3	0	2	0
Ritchie	14	8	0	6	5
Tyler	8	3	0	2	0
Wetzel	21	16	0	13	1
Wirt	5	5	1	1	0
Wood	111	95	0	66	0
Region II	**740**	**573**	**0**	**269**	**6**
Boone	35	15	0	5	0
Cabell	142	137	0	100	0
Clay	13	10	0	5	0
Jackson	15	12	0	12	0
Kanawha	227	166	0	43	2
Lincoln	33	22	0	9	0
Logan	66	48	0	10	0
Mason	31	25	0	15	0
Mingo	62	48	0	14	4
Putnam	36	25	0	15	0
Roane	30	28	0	22	0
Wayne	50	37	0	19	0
Region III	**220**	**161**	**29**	**91**	**30**
Barbour	12	11	3	4	0
Berkeley	21	17	0	9	0
Grant	10	2	0	0	0
Hampshire	13	6	1	8	3
Hardy	19	8	1	3	0
Jefferson	10	7	1	6	0
Lewis	21	18	5	5	1
Mineral	16	14	3	14	6
Morgan	4	3	0	1	0
Pendleton	4	3	0	1	0
Preston	22	21	6	14	6
Randolph	40	27	7	19	12
Taylor	7	6	2	4	2
Tucker	3	3	0	3	0
Upshur	18	15	0	0	0
Region IV	**505**	**361**	**114**	**312**	**105**
Braxton	20	16	0	8	1
Fayette	81	40	5	34	7
Greenbrier	45	27	1	20	1
McDowell	70	60	11	29	11
Mercer	82	52	7	39	15
Monroe	3	2	0	0	0
Nicholas	24	24	0	12	0
Pocahontas	10	6	0	2	0
Raleigh	91	61	5	41	0
Summers	10	8	0	8	0
Webster	19	19	0	11	0
Wyoming	50	46	85	108	70

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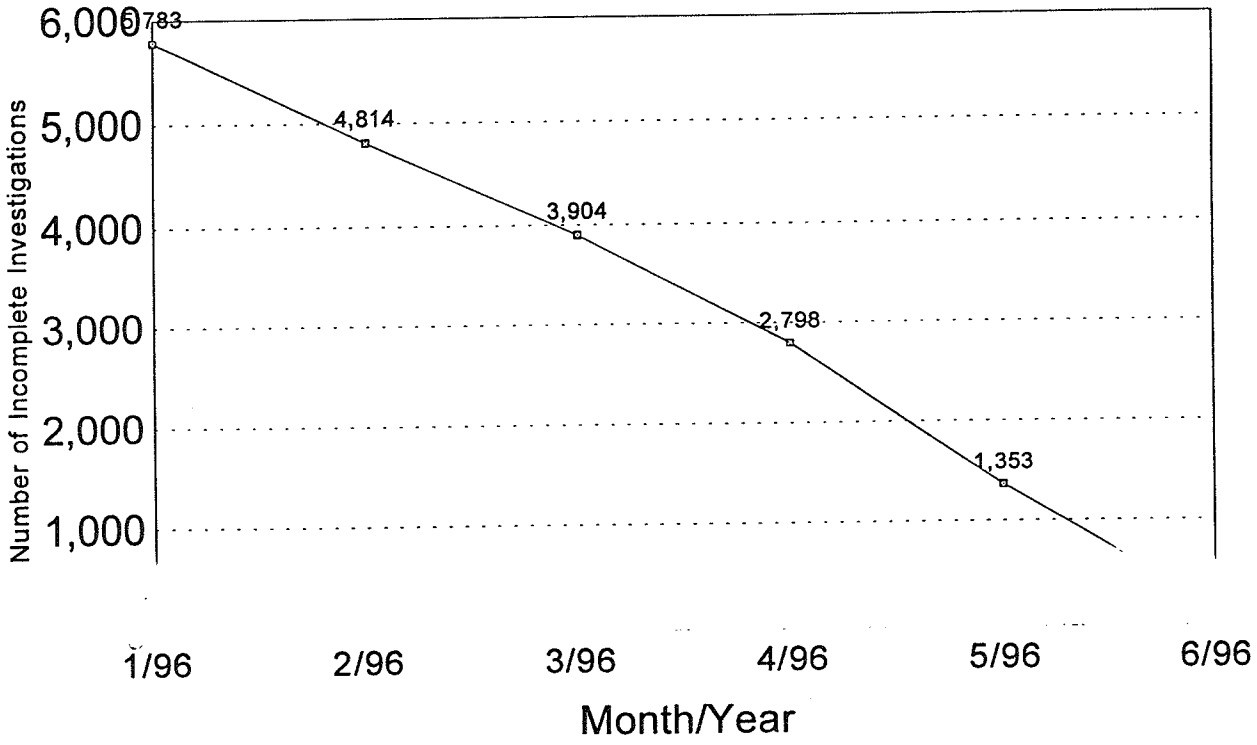
Incomplete Investigations of CPS Referrals Pending Over Thirty Days

Point-in-time For January Through June 1996



Source: West Virginia Department of Health and Human Resources

DEPARTMENT OF HEALTH & HUMAN SERVICES

Administration for Children and Families
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

JAN 1 5 1996

Ms. Gretchen O. Lewis
Secretary
West Virginia Department
of Health and Human Resources
Building 3, Room 206
State Capitol Complex
Charleston, West Virginia 25305

Dear Ms. Lewis:

Enclosed is a copy of the final report to the State of West Virginia, containing the findings and recommendations which were jointly developed by your staff and ours in the conduct of the Pilot Child and Family Services Review. The manner in which our staffs worked jointly has not only increased the opportunities for improved services in West Virginia, but has also provided us with a valuable experience that will continue to guide our work with other States.

Some of the information in the report will not be new to you and your staff since it describes areas previously identified by West Virginia officials as needing improvement. The report moves beyond that, as well, by identifying important strengths in the West Virginia programs and among your staff that will be critical to the success of the State's program improvement efforts. We have also attempted to provide a deeper analysis of the nature of those areas where improvements are needed than may have previously been available to you and to management of the Department of Health and Human Resources.

Please extend my thanks to the State participants in the review, and to Michael O' Farrell, who has demonstrated a commitment to improving child and family services in West Virginia.

Sincerely,

Carol W. Williams, D.S.W.
Associate Commissioner
Children's Bureau

cc: Gary Koch, ACF Region III
Michael O'Farrell
Sue Sergi

WEST VIRGINIA CHILD AND FAMILY SERVICES PILOT REVIEW

FINAL REPORT

December 15, 1995

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Administration on Children, Youth and Families (ACYF) is currently developing a new strategy for reviewing State federally assisted child and family services. The new monitoring strategy will cover the range of federally funded child welfare programs, including child protective services, foster care, adoption, independent living, and family preservation and support services. The reviews are being designed to encourage Federal/State partnerships in identifying and working toward improved outcomes for children and families, promote family-focused practice principles that are likely to lead to improved outcomes, provide opportunities for States to receive technical assistance where needed, and assist States to become self-evaluating over time.

The outcome areas identified for review are safety, permanency and child and family well-being. Within each of these broad domains, more specific outcomes have been developed as follows:

In the area of safety, two outcomes were identified: (1) children are protected from abuse and neglect in their own homes whenever possible and (2) the risk of harm to children is minimized. These outcomes reflect the mission of child protective services programs to protect children from abuse and neglect and promote the value of helping children to live safely with their own families when possible.

Two outcomes also were identified in the area of permanency: (1) children will have permanency and stability in their living situations and (2) the continuity of family relationships, culture and connections will be preserved for children. These describe the primary goals of the foster care system to provide opportunities for children to grow up safely with permanent families while protecting the relationships and connections that are most important to their healthy development.

In the area of child and family well-being, three outcomes were identified that focus on using child welfare services to strengthen the ability of parents to protect their children, and on including the critical areas of education and physical and mental health in the State's efforts to protect and provide permanency for children in its care. They are: (1) families will have enhanced capacity to provide for their children, (2) school-age children will have educational achievements appropriate to their abilities, and (3) children will receive adequate services to meet their physical and mental health needs.

An important component in developing a new monitoring strategy was the series of pilot tests of the self-assessment and on-site review processes. The West Virginia Department of Health and Human Resources (DHHR) volunteered to participate in piloting the proposed review process. This allowed the Federal government the opportunity to join with the State in examining its programs using the new review strategy. The review was structured to provide an assessment of West Virginia's child welfare programs, identify areas where the programs were or were not achieving the

desired outcomes and provide technical assistance in the areas that would be most useful to the State.

As the first step in the review process, the West Virginia DHHR completed an extensive self-assessment instrument that included data on key performance indicators related to the outcome areas. The self-assessment pointed to the safety of children in their own homes and the permanency of children in foster care as the areas most in need of closer examination. The on-site portion of the West Virginia review took place during the week of July 23, 1995. Information was gathered from a variety of sources to determine the extent to which the State's child welfare programs were achieving the outcomes noted above.

During the on-site review, 59 case records of children and families served by the Department throughout the State were reviewed by a team of 20 persons that included Federal ACYF staff, other national and peer State representatives, and staff from all levels of the West Virginia DHHR. Eight local sites, selected from the State's four regions and representing the geographic diversity of the State, were included in the on-site review. These sites included Grantsville and Fairmont in Region I, Charleston and Logan in Region II, Petersburg and Weston in Region III, and Princeton and Sutton in Region IV. In each of these sites, a smaller sample of cases was selected for conducting interviews with the children, parents, foster parents and service providers.

In each of the eight local sites, as well as at the State office in Charleston, stakeholders also were interviewed in an effort to evaluate the current capacity of the West Virginia DHHR to deliver services in accordance with the agency's goals and in a manner leading to satisfactory outcomes for the children and families it serves. The findings of the State self-assessment, the case record review, and interviews were then assembled in this report which addresses each of the key outcome areas. A brief summary of the findings in each outcome area follows below.

Safety. The review found that, in general, children are maintained in their homes, and that they are removed from their homes only when their safety is threatened. The agency recognizes the importance of maintaining children in their own homes whenever possible and uses a variety of approaches and programs to protect children and prevent unnecessary out-of-home placements, but additional services are needed. Multi-disciplinary assessment teams which include broad community representation are working effectively to reduce the risk of harm to children and improve service delivery to children and their families. The agency's use of a systematic initial risk assessment and decision making process provides added assurances that the risk of harm to children is minimized and assessments are conducted consistently throughout the State, but additional training and supervision are needed to increase consistency in the application of the process. The review found that there is a large backlog of child abuse and neglect reports that are pending full investigation. While supervisory screening of all reports is conducted to help assure that reports in which the child's safety is threatened are investigated immediately, there is concern that lower risk families are not provided with needed family preservation/support services to prevent crises from occurring.

Permanency. The agency's designation of adoption specialists in the regions is expediting adoptive placements for a large number of children with adoption as their permanency goal in most locations. However, the number of adoption staff is not sufficient to process all of the children who await permanency through adoption in a timely fashion. In addition, homefinding units are regionally-based, rather than county-based, which limits their capacity to recruit adoptive parents; conduct timely home studies for foster and adoptive families; and address the unique resource needs of individual counties, particularly the smaller rural counties. Consequently, children in foster care

frequently are placed long distances from their families and communities, efforts to promote family and community-based foster care practices are inhibited, the State is spending more on restrictive placements than it would on community-based foster homes, and children are remaining in foster care for longer periods of time that might otherwise be necessary. Movement of children in foster care from one placement setting to another was identified as a major concern, particularly for children moving from one temporary shelter facility to another. The review found that the court system is not functioning in a way that increases opportunities for permanency for children beyond foster care. Judicial reviews are not regularly conducted, and the statutorily mandated pre-adjudicatory improvement periods, at times, impede progress toward permanency goals for children. However, the State recognizes that the Court Improvement Program (CIP) grants provide an opportunity to increase the effectiveness of the courts in promoting permanency for children in foster care. While the agency attempts to place siblings together in foster care whenever possible, the lack of placement options, including foster family homes, therapeutic/specialized foster homes, and specialized shelters also has an impact here. The review also found that the agency is attempting to provide an independent living assessment and appropriate services to all children in foster care who have reached age 16.

Child and Family Well-Being. The review found that the Department promotes a family-focused, community-based approach to guide practice and to increase the family's capability to provide for the needs of their children. The agency makes efforts to meet the educational and medical needs of children in foster care, but the lack of specialized medical services in rural areas limits the agency's ability to provide these services. The Family Resource Centers (FRCs) are a strength of the service array in working with families in some communities to develop strategies to meet their identified needs. Home-based service agencies, as noted, also meet a critical need in this outcome area. However, the inconsistency of available services across communities limits the agency's ability to provide a full range of prevention and support services to low-risk families in need of these services.

State Agency Issues. In addition to the three outcome areas, the review examined the capacity of the Department to carry out its role in the State in the delivery of child welfare services to West Virginia families and children. The review revealed that the agency and staff are well respected and viewed by the community as committed to the protection of children. The Department has developed strong collaborative relationships with community agencies that support its work, and there is a continuing effort to improve services to families and children. However, there are areas that need to be addressed before the Department can move forward in making further improvements in its service provision to children and families. A critical issue that needs to be addressed is staffing. Excessive caseloads make it difficult to provide adequate services to parents and children. The insufficient number of staff affects the safety, permanency, and well-being of children and their families because child protective service staff must focus primarily on responding to emergencies. Low-risk families in need of family preservation/support services are not always afforded the opportunity to access these services, increasing the likelihood that their unmet needs will escalate to the point of requiring more extensive and expensive responses from the Department. Permanency goals of children are delayed because of insufficient homefinding and adoption staff to recruit foster and adoptive parents and process foster home and adoption applications. Excessive caseloads, combined with low salary levels and the absence of a system for acknowledging exemplary work, result in low morale and staff turnover. The agency has updated its policies and procedures for child protective services, adoption, family preservation, and independent living. However, foster care policy has not been updated since 1978, thus the foster care program is not administered uniformly throughout the State because staff are implementing policies and procedures through a variety of program instructions. Furthermore, there is no State monitoring of local program

operations and contracts, which results in inconsistencies in program administration and implementation.

Summary of Recommendations. Based on the findings of the review, the review team compiled a series of recommendations to address the areas in need of improvement. The DHHR should review its levels, patterns and use of staff and develop caseload standards to ensure sufficient staff. The Department also needs to develop a strategy to increase pay scales, recruit and retain talented staff, and provide recognition for State and local staff whose work is exemplary. The agency should implement a statewide monitoring strategy to strengthen accountability and quality assurance of child and family services programs and expedite efforts to develop its management information capacity through Federal funding for development of the Statewide Automated Child Welfare Information System (SACWIS). The DHHR should move forward with its current plans to revise and update its foster care policy manual, implement procedures to ensure timely investigations of all child abuse and/or neglect reports, and provide additional training to workers and supervisors in the provision of family preservation services and consistent use of the agency's risk assessment process. The Department should develop more effective strategies to recruit new foster and adoptive parents, retain existing homes, and process foster home and adoption applications more timely. The Department should work in collaboration with the Family Resource Networks to increase the availability of family support services and collaborate with the FRCs on an alternative service delivery system for children and youth who come into care through the juvenile justice system. In addition, the agency should take the opportunity presented by the CIP grants to increase collaboration with the courts on a training plan for court personnel on permanency planning and child welfare practices, and on the development of guidelines to clearly define the responsibilities of each organization and evaluate current practices to ensure that the needs of children are met in an expeditious manner.

INTRODUCTION

The Administration on Children, Youth and Families (ACYF) is currently developing a new strategy for reviewing State federally assisted child and family services that takes a holistic and comprehensive view of State federally funded public child and family service programs. The new monitoring strategy will cover the range of federally funded child welfare programs, including child protective services, foster care, adoption, independent living and family preservation and support services. The reviews are being designed to encourage Federal/State partnerships in identifying and working toward improved outcomes for children and families, promote family-focused practice principles that are likely to lead to improved outcomes, provide opportunities for States to receive technical assistance where needed, and assist States to become self-evaluating over time.

In contrast to previous Federal reviews of State child welfare programs which focused largely on procedural requirements, the new review process measures the outcomes, or results, of services delivered to children and families in the States. The areas identified for measurement are safety, permanency, and child and family well-being. Within each of these broad domains, more specific outcomes have been developed that reflect the mission of child welfare programs to provide protection for abused and neglected children, permanency for children who must enter foster care and support for families whose children are at risk of abuse or neglect. The specific outcomes being examined in the new review process are as follows:

SAFETY

(1) Children are protected from abuse and neglect in their own homes whenever possible.
(2) The risk of harm to children is minimized.

PERMANENCY

(1) Children will have permanency and stability in their living situations.
(2) The continuity of family relationships, culture and connections will be preserved for children.

CHILD AND FAMILY WELL-BEING

(1) Families will have enhanced capacity to provide for their children's needs.
(2) School-age children will have educational achievements appropriate to their abilities.
(3) Children will receive adequate services to meet their physical and mental health needs.

The West Virginia Department of Health and Human Resources agreed to participate in piloting the new child welfare review process, which allowed ACYF the opportunity to join with the State in examining its programs using the proposed review strategy. The review was structured to provide an assessment of West Virginia's child welfare programs, identify areas where the programs were or were not achieving the desired outcomes and provide technical assistance in the areas that would be most useful to the State.

Key activities in the review process included the following:

- From April to June 1995, State staff completed a State self-assessment of its child welfare programs with consultation from the Administration for Children and Families (ACF) Central and Regional Offices on the programs being assessed.

- Members of the State review team selected eight local sites in West Virginia, two from each of the State's regions, in which to conduct on-site reviews. Sites selected were representative of the diversity within the State. The on-site portion of the West Virginia review took place during the week of July 23, 1995. Three "urban" sites, Charleston, Fairmont, and Princeton, and five rural sites, Grantsville, Logan, Petersburg, Sutton, and Weston, participated in the review.

- A 20-person on-site review team (see Appendix) was divided into 4 regional teams. Review team activities included examining 59 case records (36 foster care and 23 child protective services/in-home services); interviewing local stakeholders in the 8 local sites; interviewing stakeholders at the State office in Charleston; and interviewing family members, social workers and service providers in 8 of the cases examined.

- The results of the State's self-assessment, the on-site record reviews and the interviews were compiled by the review team into this report, along with the team's recommendations for addressing the needs identified in the review.

The following section of this report contains a summary of findings reported in terms of the agency's strengths and areas needing improvement in each of the outcome areas. A summary of key recommendations of the review team is also included. The ACF Regional Office will be working with the Department to determine which of the recommendations can best be addressed through immediate technical assistance and those that will require more extensive planning and commitment of time and resources by the State.

SUMMARY OF KEY FINDINGS

This summary was prepared by integrating the results of the State self-assessment, 59 case record reviews, interviews with key parties of selected cases, interviews with State and local stakeholders, and the preliminary reports of the 4 local on-site review teams. Only the major findings are included in this summary; for example, those that reoccur in the various sources of information that were analyzed or those that pertain to the majority of sites included in the review. In addition, differences between the urban and rural sites are noted.

Safety Outcome #1: Children are protected from abuse and neglect in their own homes whenever possible

Strengths

- **Children are protected in their own homes whenever possible and are removed only when the risk of harm cannot be controlled in the home.**

  The West Virginia Department of Health and Human Resources (DHHR) promotes a family-focused philosophy and approach to working with families and children. The State agency emphasizes the need to maintain children in their homes whenever possible, while protecting them from the harm that led to the agency's involvement with the family. The agency offers a variety of services and approaches to protect children in their own homes such as family preservation, Family Resource Centers (FRCs), the Family Options Initiative, and multi-disciplinary assessment teams. While the availability of in-home and community-based services is inconsistent throughout the State and there are some identified needs in the quality of services provided, local agencies have shown successes in working with families to address needs that impact on the safety of their children. Where in-home and community-based service agencies do exist, DHHR makes extensive use of their services through appropriate referrals.

  The State self-assessment indicated that staff assess whether in-home services are an appropriate alternative to out-of-home placements. Decisions about the removal of children from their homes are based on whether the child is in imminent danger and whether the risk of harm can be controlled in the home.

- Case-specific interviews and interviews with State and local stakeholders confirmed the State's priority of protecting children in their own homes whenever possible. These interviews further validated that family rights, parental rights, and the sanctity of the family are highly regarded and that children are not removed from their homes unnecessarily. Many local stakeholders also expressed high regard for the work of the local agencies and staff in protecting children. There is a close working relationship between many of the local agencies and community agencies. Many mandated reporters readily filed required child abuse and neglect reports because of their confidence in the Department's ability to respond appropriately to these reports.

- **Family preservation and support services are provided to families whose children are at high risk of abuse or neglect in order to protect the children and prevent unnecessary removals from the home.**

  The array of home-based service agencies in the State exemplifies the agency's commitment to keeping the family together whenever possible. Family preservation services are viewed by most communities as a positive approach to working with families.

  The case record review indicated that just over half of the 59 cases reviewed were provided family preservation/family support services. However, a much smaller number of these families actually completed a program. Families receiving child protective services (CPS)/in-home services were provided family preservation/family support services more often than those receiving foster care services. Well over half of the families receiving CPS/in-home services were provided family preservation services.

  The FRCs, which are being expanded through the State's title IV-B, subpart 2 funds, are a strong foundation for family support services in the State. However, there was general consensus that additional services are needed so that more families, including families whose children are not at imminent risk of serious harm but who have needs for services to avoid escalation of the risk can also be served. (See "Areas Needing Improvement" section for a discussion of suggested improvements in this area.)

Areas Needing Improvement

- **The availability and effectiveness of home-based and community-based services are not uniform across the State.**

  There were differences in the availability and perceived effectiveness of home-based and community-based services across counties. Stakeholders in urban areas, where services are readily available, believe that home-based services fill a tremendous need in their communities, and contract staff often provide intensive, high-quality services. In some rural areas, where services have only recently been implemented and are limited, local stakeholders identified the need for more experienced contract staff to improve the effectiveness of these services. In addition, community-based support services for families are limited, particularly in rural areas. (See "Areas Needing Improvement" section for Child and Family Well-Being Outcome #1 for a discussion of this issue.) Reviewers also noted a need to focus on improving the individualization of case planning and the family focus of service delivery in some counties.

Safety Outcome #2: The risk of harm to children is minimized

Strengths

- **The agency uses a systematic initial risk assessment and decision making process to identify reports of child maltreatment where agency intervention is needed to protect children and reduce the of risk of subsequent maltreatment.**

  The agency uses a standardized risk assessment model, the West Virginia Child Protective Services System (WVCPSS), which is based on the Child at Risk Field (CARF) developed by ACTION for Child Protection. The WVCPSS risk assessment instrument is used statewide,

and staff are required to participate in training on its use. This process allows for careful consideration of the child abuse and/or neglect report and screening by the worker and supervisor to determine whether the report meets the State definition of child abuse and neglect and needs to be investigated. For reports requiring investigation, the worker and supervisor determine the urgency of the response needed. This risk assessment model allows a worker to process the information gathered in an objective and organized way in order to make a decision about safety and risk. It promotes staff review of the child's total environment in assessing risk and minimizes the use of subjectivity in assessing the situation. There are some needs associated with the use of this risk assessment process, as noted below.

- **Multi-disciplinary assessment teams are working effectively to reduce the risk of harm to children and improve service delivery to children and families.**

  Some communities already have multi-disciplinary assessment teams operating, and others are in the process of developing these teams, which are mandated by State statute. The review confirmed that these multi-disciplinary teams have broad community participation, and many teams are working well. The multi-disciplinary assessment teams include parents, attorneys, psychologists, child protective services staff, and community service agency representatives. The teams review case situations to determine whether additional services should be provided to keep the family together or whether out-of-home placement is warranted. According to interviews with stakeholders, these efforts have strengthened collaborative efforts in the communities and improved service delivery to children and families.

Areas Needing Improvement

- **There is a large backlog of child abuse and neglect reports that are pending investigation in various parts of the State.**

  State policy requires that all investigations be initiated within 24 hours of the report, but in an emergency, the report must be investigated immediately. Since local agencies do not have sufficient staff to conduct timely investigations of all reports, supervisors review child maltreatment reports to determine the urgency of the response needed and prioritize investigations accordingly. The case record review found that initial face-to-face contact with the child was made within 24 hours of the report in nearly two-thirds of the 46 cases that involved a child abuse and/or neglect report. However, the record review did not include cases that were pending investigation and not opened for services.

  Stakeholders expressed concern over the backlog of cases that are pending full investigation. The case record review showed that in some instances, numerous CPS complaint forms were in the record with no indication that an assessment of risk had been conducted on each complaint. In other instances, an initial assessment was completed on the family which determined low risk to child; however, the worker had not yet officially processed the case. There was concern that, where reports are pending a full investigation for long periods of time, family situations will deteriorate because the families are not afforded the opportunity to participate in family preservation/support services that may be needed to address their needs and, in some cases, prevent out-of-home placement of children.

- **There is a need for additional training and supervision on the use of the agency's risk assessment process in order to increase the consistency of its application statewide.**

  Reviewers found that there is not consistent use of WVCPSS among workers, leading to differences in how the level of risk is assessed and how an agency defines the population of families it serves. While the risk assessment tool seems to help guide workers in considering important safety factors as part of investigations, actual completion of the instrument does not seem consistent among workers. Additionally, some key elements of the investigation were not consistently recorded on the forms, e.g., when children were seen, disposition of reports.

Permanency Outcome #1: Children will have permanency and stability in their living situations

Strengths

- **Designation of adoption specialists in the regions is expediting adoptive placements of many children whose permanency goal is adoption.**

  The State has implemented updated and revised adoption policies and standards to improve practice. Twelve adoption worker positions, with caseloads of 15, have been established in the regions to expedite adoptive placements of children. The top priority has been to finalize adoptions for children whose foster parents intend to adopt them and for whom a family has been identified. The self-assessment shows that 132 children were placed in adoptive homes, and 100 adoptions were finalized in 1994. Stakeholder interviews confirmed that efforts are being made to finalize adoptions for many children with that permanency goal and provide quality adoption services.

  However, the current number of adoption staff remains insufficient to meet the needs of all children whose permanency goal is adoption, and the regional homefinding staff, which are responsible for recruiting adoptive resources and conducting home studies for prospective adoptive parents, do not have sufficient resources.

- **The Court Improvement Program (CIP) grants through title IV-B, subpart 2, provide an opportunity for the State to increase the effectiveness of the courts in promoting permanency for children in foster care.**

  Despite some important needs in which the court system promotes permanency for children in foster care, the State's CIP grants provide a strength to build on in this area. As part of the statewide assessment of the courts' handling of child abuse and neglect cases, State child welfare agency personnel have been involved through a questionnaire designed to assist in planning improvements for abused and neglected children. The West Virginia Supreme Court of Appeals, through the State CIP, is considering the development of uniform case plan formats for court handling of child abuse and neglect cases; development of guides for assisting judges in making "reasonable efforts" determinations regarding the provision of preplacement, preventive services; and an intensive pilot improvement program for courts including monitoring, intensive training and education, and development of a judge's bench guide for hearings and reviews.

- **The DHHR collects and analyzes information on its Independent Living Program so that it can effectively meet the needs of the children in the program.**

  The State is attempting to provide an independent living assessment and appropriate services to all children in foster care who have reached age 16. Services are designed based on an ongoing collection of information about the needs and outcomes of children served in the program, often through direct feedback from the youth themselves.

Areas Needing Improvement

- **The court system in the State is not consistently functioning to promote permanency for children in foster care.**

  Judicial reviews do not always have a clear impact on achieving permanency for children in foster care, as intended in Federal statute requiring these reviews of children in foster care. In some jurisdictions, court reviews occur irregularly, and scheduling these reviews is difficult. County prosecutors have competing demands for representation, and some children do not receive judicial reviews even though they have been in foster care for long periods of time. However, the review team found that the Court-Appointed Special Advocates (CASA) program often works effectively in counties where it operates. CASAs are serving as advocates for the permanency of children and are working in collaboration with local agency staff on permanency planning.

  The State self-assessment and stakeholder interviews noted that provisions in State statute also affect the length of time that a child spends in out-of-home care. State statute allows parents to have 2 improvement periods of up to 18 months each, and if there are court continuances and other legal delays, it may be several years before a final disposition is made in the case. In cases where a petition is filed by a CPS worker, a pre-adjudicatory improvement period, which may be as long as 18 months, is usually granted to determine if the family can change its behavior and provide a safe home for the child. These improvement periods can contribute positively to building parental capacity to care for their children. However, problems arise when repeated pre-adjudicatory improvement periods are ordered without clear indications that progress toward reunification is being made or when routinely ordered without regard to the unique circumstances of the child or family. The child may remain in foster care during the length of several improvement periods without any indications that the home situation is improving.

  The Juvenile Justice system often places children into the Department's custody without advance notice or planning. This poses serious consequences for the family and agency in a number of ways. For the family, the agency's approach to services is often not "family focused." Instead, services are provided to the child, often not involving the family in the service delivery plan or other aspects of planning for the child. For the agency, one area of major concern is that reasonable efforts to prevent placement are not routinely attempted for these children, leaving the State ineligible for Federal title IV-E foster care payments. Additionally, some of these children are inappropriate for regular foster care settings because of the nature of their offenses, yet the agency is held responsible in locating a suitable placement.

- **Many children experience multiple placement settings while in foster care.**

  Children were found to be moving from one placement to another in foster care, often, in the absence of placements designed to meet their needs. The 36 foster care records reviewed indicated that more than one-third of the children had 3 or more placement settings during the most recent removal episode, and almost one-third of the children had 2 placement settings. At times, children were moving from one shelter facility to another and, in one county, from one emergency home to another every 60 days when the time limit for the child's stay lapsed.

Permanency Outcome #2: The continuity of family relationships, culture and connections will be preserved for children

Strengths

- **There is an effort to place siblings together in foster care.**

  The review also focused on efforts to maintain important family ties for children in foster care by placing brothers and sisters together whenever possible. According to the self-assessment, the State is mandated to place siblings together whenever possible. The Department's efforts to comply with this requirement were supported by stakeholder interviews. However, the shortage of foster family homes was noted as a barrier to the State's ability to consistently placing siblings together. The case record review revealed that all or some siblings were placed together in almost half of the foster care cases involving siblings in out-of-home care. Interviews with local staff and individual case records showed that efforts are made to place siblings together, e.g., a local agency was able to place five siblings together in one foster home, and, in another situation, while the local agency was unable to place eight siblings together, two siblings were placed in four foster homes.

Areas Needing Improvement

- **The insufficient array of out-of-home placement options for children in the State is a serious impediment to children in foster care achieving permanency and maintaining critical relationships with their families and communities.**

  Children are routinely placed out of the county or out of the State because of insufficient placement options, including foster family homes, therapeutic homes and specialized care facilities. The lack of foster family homes impacts the agency's ability to meet children's needs for permanency and stability by increasing its reliance on more restrictive and expensive forms of care than the needs of many children require. The lack of foster homes within the counties from which children enter care increases the likelihood that placements will be selected on the basis of availability rather than the individual needs of children, and that the placements selected may be located several counties from the child's home. These placements have the effect of lengthening the time children spend in out-of-home care by reducing the opportunities for visits with family, direct contacts with the agency's social worker, and family-focused service delivery, any of which may expedite the reunification process.

  According to the self-assessment, specialized foster homes are used for children without special needs in some parts of the State, because foster family homes are not available. In

addition, State law requires placement of an adjudicated delinquent in the least restrictive setting available. Furthermore, there is a lack of in-patient beds in the State for children, and foster families are asked to care for children for whom they are poorly trained or equipped to handle. In addition, children with a range of problems, including serious juvenile problems, are placed together in shelters.

The State has created regional homefinding units to recruit and retain foster and adoptive homes, but staff responsibilities are so great that active recruitment is limited. The recruitment issue is being addressed regionally, rather than in the counties and communities from which children in care are coming. Consequently, even if more homes are recruited, they may not be in proximity to the child's county of origin and many of the needs already noted will still exist. The regional based recruitment efforts do not promote the likelihood that the needs and concerns of county staff who have responsibility for the children will be equally shared by the recruitment worker who has responsibility for the homes.

The State foster care payment was increased in July 1995, but many stakeholders believe that this rate is still insufficient to meet the needs of children in foster care. This can be expected to continue impacting the State's ability to recruit and retain foster family homes in sufficient numbers and quality to meet its needs. Interviews with State and local stakeholders confirmed the need for additional foster family homes, therapeutic/specialized foster homes, and specialized shelters.

Child and Family Well-Being Outcome #1: Families will have enhanced capacity to provide for their children's needs

Strengths

- **The agency has adopted a family-focused, community-based approach in its work with children and families.**

  Family assessment and treatment plans are considered an important part of the CPS program. These plans follow initial assessments and require workers to spend time with families to identify strengths in developing treatment plans. Families are involved in case planning, which allows for a greater likelihood that plans will identify the specific needs of families and services to meet their needs, which will lead to goal attainment. An analysis of the 59 case records reviewed during the on-site review revealed that children were provided services that matched their needs in over three-quarters of the cases, and parents were provided services that matched their needs in almost two-thirds of the cases. However, information on the match between the needs and services was missing for children in one-quarter and for parents in one-third of the cases. The emphasis on working with the entire family was also supported by comments provided during State and local stakeholder interviews.

  FRCs are working at the community level and developing strategies, based on the needs of families and the community. Early intervention services provided through the FRCs are working well. In addition, concrete services are being provided to children and their families to prevent removal from the home and to assist with reunification of the family. The State's plan to use a portion of its title IV-B, subpart 2 funds to strengthen and expand Family Resource Networks is a very positive step that builds on an existing strength and recognizes a critical need in the State for family support services.

Areas Needing Improvement

- **The lack of available community-based services limits both the agency's ability to provide prevention services and the family's ability to provide for their children's needs.**

  The review revealed that there is a lack of support services for families whose children are not at imminent risk of harm or removal, but who do have needs for services to prevent their situations from becoming worse and requiring more intensive, long-term services. The services that are primarily limited in the rural areas are: transportation, medical care, substance abuse and sexual abuse treatment, employment, day care, and recreational resources.

  Although some of the FRCs are just beginning to develop their programs, the indications are that they are working effectively at the community level to develop resources, based on the needs identified by the families and communities themselves. There is a strong need to increase available family support services to meet the needs of lower-risk families and the FRCs offer an excellent opportunity and structure to do this in the State.

  The availability of health services is limited in rural areas. Families experience difficulties in accessing medical care and mental health services because of the lack of available doctors, the low State Medicaid rates, and the slow State reimbursement process. In addition, the lack of transportation is a barrier to accessing needed medical care and other services. Families are unable to keep appointments for treatment and services because they do not have a means of transportation, and social workers spend an inordinate amount of time transporting families to service providers. Specialized services, such as treatment for sexual abuse victims and offenders and substance abuse are limited or nonexistent. In many areas of the State, there is a high incidence of sexual abuse, yet these are the very areas where treatment is either limited or not available at all.

  Rural areas have limited resources for employment, day care, and recreation. Parents experience problems with obtaining employment to improve their economic status because of limited employment opportunities. Day care services are available only to families receiving Aid to Families with Dependent Children, and recreational opportunities for youth are minimal.

Child and Family Well-Being Outcome #2: School-age children will have educational achievements appropriate to their abilities

Strengths

- **Some attention is given to the educational needs of children in foster care.**

  Interviews with local stakeholders indicated that agency staff work closely with the schools to help ensure that the educational needs of children are met. In addition, foster parents are attentive to the educational and social development of the child, and the agency, foster parents, and the schools work together to arrange tutoring and other academic services as needed. The case record review showed that child-specific educational information was included in over three-fourths of the cases, and that the majority of these children were at the age-appropriate grade level.

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

Strengths

- **The medical needs for a majority of children in foster care are identified, and services are provided to meet their needs.**

  The State self-assessment reported that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is the primary provider of medical services to children in the agency's care. Foster care providers and adoptive parents are provided information on EPSDT examinations and the individual child's health needs by agency workers. Local stakeholders reported that children undergo psychological evaluations and health screenings routinely. In addition, efforts are made to meet special medical needs of children, although resources, especially mental health services are limited.

  The 36 foster care case records reviewed indicated that the child's medical history was included in the majority of the records. According to the case record review only, immunizations were current in over two-thirds of the cases and the child's medical needs were met in well over two-thirds of the cases. The health information is based on case record documentation, thus these numbers may not accurately reflect the health status of the children reviewed as there was a fair amount of missing information.

Areas Needing Improvement

- **The unavailability of specialized medical services in many rural areas prevents children from receiving needed medical services.**

  Rural areas do not have adequate mental health, sexual abuse, and substance abuse treatment resources to meet the needs of children who receive child welfare services. In some instances, children must wait for as long as six months for psychological examinations and then often must be transported long distances for the appointments. Limited therapeutic and counseling services are available for children while they are in foster care and often, there are no follow-up services provided when they return home. In addition, few doctors in rural areas have experience in screening for sexual abuse, and substance abuse treatment services are limited.

State Agency System

Strengths

- **The State has updated Child Protective Services, Adoption, Family Preservation, and Independent Living policies and procedures to guide workers at the practice level.**

  The DHHR makes an effort to maintain updated policies and procedures for its line workers and supervisors in the program areas of: Child Protective Services, Adoption, Family Preservation, and Independent Living. This serves to keep the field abreast of changes in a

timely way and helps to ensure consistent application of policy and procedures in these areas.

Areas Needing Improvement

- **Excessive caseloads make it difficult to provide adequate services to parents and children.**

  The DHHR is understaffed, staff turnover is a problem in some areas, and local agency staff spend inordinate amounts of time in activities related to the lack of resources, e.g., transporting children to distant placements, arranging visits over long distances. Employees are not well compensated, and staff morale is low. In addition, there is a lack of recognition of the achievement of workers by the State agency. All of these factors contribute to the agency's capacity to achieve desired outcomes with the families it serves. Specifically, there is insufficient staff to investigate reports of child abuse and/or neglect promptly, recruit foster and adoptive parents, and process foster home and adoption applications.

- **The foster care program is not uniformly administered throughout the State.**

  Foster care policy has not been updated since 1978, and local staff operate the foster care program in accordance with a variety of program instructions. The absence of a current foster care policy manual has resulted in inconsistencies in program administration among local agencies and workers.

- **There is no State monitoring of local program operations and contracts.**

  The State agency has no monitoring system to ensure consistent application of program policy and operations. This results in inconsistencies in program administration among local offices, an inability to identify areas of strength and need within the agency, and limited opportunities to track progress or key indicators over time. In addition, State contracted family preservation services are not monitored. While these agencies provide needed in-home services to families and children, there is inconsistency across the State in meeting contract requirements, such as providing regular progress reports on families being served.

- **An inadequate management information system limits the capacity of the State to produce data needed for management and decision making purposes, to identify program needs and monitor progress.**

  Data was provided for this pilot review from several special studies and inventories because the State's information system was unable to produce data for most of the performance indicators in the self-assessment. The data submitted gave some indication of basic program needs and the extent to which current populations were being served. Data are not widely available on key program areas needed to inform management and local staff about needs, progress and monitoring of the agency's clientele and services provided. Currently, the State is developing a Child Welfare Information System through enhanced funding available SACWIS that will produce needed data for management and decision making purposes and will identify program needs and monitor progress.

SUMMARY OF KEY RECOMMENDATIONS

Based on existing strengths and the findings of the review, the review team recommends that the Department address the identified needs in the following ways:

Administration/Management

- The West Virginia Department of Health and Human Resources (DHHR) should examine its existing levels, patterns and use of staff in relation to its system of conducting investigations of child abuse and neglect reports, recruiting foster and adoptive parents, placing children in foster care settings, and processing adoptions. Based on these findings, the Department should develop and implement a statewide staffing plan than follows the caseload standards recommended by the Child At Risk Field committee; a strategy to increase pay scales so that salaries are comparable to staff in other States and competitive with the local market; a plan to effectively recruit and retain talented staff; and a system to provide recognition for State and local staff whose work is exemplary.

- The Department should implement a statewide monitoring strategy to strengthen accountability and quality assurance of child and family services programs throughout the State.

- The DHHR should move forward with its current plans to revise and update its foster care policy manual and disseminate it statewide. The policy manual should clearly define the agency's missions in terms of a family-focused, community-based child welfare system and provide guidance on how day-to-day work activities support the mission, e.g., recruitment and support of foster family homes in the communities where the children and families served by the agency live, matching placements to the needs of children and supporting timely reunification or other permanency outcomes for children in care.

- The Department should develop procedures to eliminate the backlog of child abuse and neglect reports pending investigation and to ensure that all investigations are initiated within 24 hours or immediately in emergencies.

- The DHHR should expedite efforts to develop its management information capacity through Federal funding for development of the Statewide Automated Child Welfare Information System. The State should focus on complying with Adoption and Foster Care Analysis and Reporting System reporting requirements which should significantly improve its capacity to inform management on key decision making and monitoring processes and assist staff at the local level to manage their work on an ongoing basis.

Training and Public Education

- The DHHR should develop and implement a training strategy for the courts to promote a clearer understanding among court personnel around the issues of permanency goals, matching needs to services and overall child welfare practices.

- Additional training for workers and supervisors are needed in the provision of family preservation services and consistent use of the agency's risk assessment process.

Program Development

- The DHHR should develop more effective strategies to recruit and retain foster and adoptive parents and implement procedures to ensure timely processing of foster home and adoption applications. This includes specialized foster family homes to care for children with serious behavioral and emotional needs. The agency should consider placing recruitment responsibility within the counties, as opposed to regions, in order to address the unique needs of each county.

- The DHHR should work with the Family Resource Networks on the development of family support services to meet the needs of low-risk families who are not currently served. In addition, the Department should work in collaboration with the Family Resource Centers on an alternative service delivery system for children and youth who come into care through the juvenile justice system for reasons such as incorrigibility and truancy.

- The DHHR should work in collaboration with the courts to develop clear guidelines on respective responsibilities for scheduling and conducting judicial reviews, providing options for legal representation of DHHR in situations where the county prosecutor's time is limited, and assessing the productivity of pre-adjudicatory improvement periods and establish guidelines based on these findings. Title IV-B, subpart 2 Court Improvement Program grants are in place in the State and present a good opportunity to focus on improving the reliability and effectiveness of judicial reviews and training court personnel on permanency and other child welfare issues.

APPENDIX

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