

# DEPARTMENT OF SOCIAL AND HEALTH SERVICES



## THE CHILDREN'S ADMINISTRATION CENTRAL CASE REVIEW

2011  
Annual Report



*The Children's Administration is committed to ongoing quality assurance activities as part of a proactive process to assist social workers, supervisors and managers to improve outcomes for children and families.*

# Central Case Review 2011 Children's Administration Annual Report

## Executive Summary

Central Case Reviews are part of the Children's Administration's (CA) quality assurance process to improve quality and consistency of social work practice in every area of the state and promote accountability and improved outcomes for children and families. Central Case Reviews evaluate the compliance and quality of practice through a review of the case record and FamLink, and include interviews with parents.

A guiding principle of Central Case Review is that reviews are designed to support the professional development of staff and assist social workers, supervisors and managers to improve outcomes for children and families. Central Case Reviews are designed to improve practice through:

- Individual feedback to social workers, supervisors, the area administrator and the regional administrator on each case reviewed.
- An exit meeting with managers and social workers to discuss preliminary practice trends, policy and practice clarification.
- Detailed office reports that identify practice trends including strengths and areas needing improvement. Reports also include recommendations based on strategically selected practice areas needing improvement.
- Collaboration with office and regional management to develop an Action Plan designed to address recommendations identified in the report, and target areas of practice identified for improvement.
- Tracking of quarterly progress to complete practice improvement activities included in the Action Plan.

When present danger is identified for a child during a case review, this concern is immediately discussed with the supervisor. If after discussion with the supervisor, there remains a concern of present danger for a child, a memo outlining the safety threat is immediately sent to the supervisor, Area Administrator (AA) and Regional Administrator (RA). The RA or designee provides follow up to the Central Case Review Team lead and supervisor on what follow up actions were taken.

Beginning in January to November 2011, there were 15 offices reviewed using the 2011 Case Review Tool. In December 2011, a new tool was designed and implemented that includes eight practice areas of the Washington State Practice Improvement Plan (PIP) and compliance and quality with the child Safety Framework which became effective November 2011. The data in this report represents summary of the 15 offices reviewed from January – November 2011, a total of 326 cases.

Office	# of Cases Reviewed
White Center	25
Shelton	23
Moses Lake	25
Omak	17
Forks	17
Newport	16
Stevenson	16
Centralia	25
Everett	41
Clarkston	17
Kelso	24
Colfax	16
Smokey Point	32
Long Beach	16
South Bend	16
<b>TOTAL</b>	<b>326</b>

Cases included in the review were from the following categories:

- **CPS investigation only cases:** The case did not remain open for services or monitoring of child safety beyond the CPS investigation.
- **In-home service cases:** The case remained open for in-home service provision and/or child safety monitoring. The child has remained in the home during the last 12 months.
- **Out-of-home cases:** The child was placed in out-of-home care through court action or a Voluntary Placement Agreement (VPA) during the last 12 months.

CPS Investigation Only Cases	In-home Service Cases	Placement Cases	Total Cases
96	63	167	326

Cases were reviewed in the program areas of Child Protective Services (CPS), Family Voluntary Services (FVS) and Child Family Welfare Services (CFWS). Some cases were reviewed in more than one program area when the case was open to multiple programs during the last six months. Cases were reviewed in the following program areas.

CPS	FVS	CFWS
213	65	166

## 2011 State Practice Trends

The practice areas below were identified as a strength when the result was 80% or above, or as a area needing improvement when result was below 80%.

### 1. Strengths

#### ***Indian Child Welfare (ICW) Practice; Inquiry with the Family of Possible Indian Ancestry and Collaboration with Tribes in Case Planning***

- In 85% (270 out of 319) of the cases, inquiry occurred with both parents or both sides of the family when available, regarding possible Native American ancestry. An additional 11% (36 cases) were partially achieved because inquiry was made with one side of the family, but not both.
- In 82% (23 out of 28) of the cases of Indian children, there was documentation of ongoing communication and collaboration with the child's Tribe in case planning.

#### ***Assessing and Addressing Safety Threats***

- In 87% (283 out of 324) of the cases, safety threats to the child were adequately assessed and addressed during the last year. Addressing safety threats was a strength in CPS cases at 87% (186 out of 213), FVS cases at 89% (58 out of 65), and in CFWS cases at 91% (151 out of 166).
- In 82% (27 out of 33) of the cases, when there were possible safety threats regarding out-of-home caregivers there was documentation that the threats were adequately assessed and addressed.
- In 83% (63 out of 76) of the cases, all background clearances were completed for unlicensed caregivers within required timeframes. This included National Crime Information Center (NCIC) checks prior to placement and Background Check Central Unit (BCCU) checks and fingerprints within ten days of placement.
- In 94% (225 out of 239) of the cases, the Child Protective Services (CPS) decision to close the case, transfer the case to Family Voluntary Services (FVS), or initiate court action met the child's safety and protection needs.

#### ***Shared Planning Meetings***

- In 85% (162 out of 190) of the cases, Shared Planning Meetings were utilized at critical points for case planning, and in 93% (150 out of 162) of the cases, there was documentation that family members and other persons who had relevant case information were invited to the meeting.

#### ***Meeting the Well Being Needs of Children***

- In 91% (146 out of 161) of the cases, there was documentation that the educational needs of the child were assessed and addressed.
- In 88% (177 out of 201) of the cases, there was documentation that the physical health needs of the child were assessed and addressed.
- In 80% (96 out of 120) of the cases, there was documentation that the mental/behavioral health needs of the child were assessed and addressed.

### ***Monthly Visits with the Child by the CA Social Worker***

- In 91% (200 out of 220) of the cases, there was documentation that monthly visits occurred with the child during the most recent six months. Monthly visits occurred for in-home cases 74% (42 out of 57) of the time and for placement cases 96% (157 out of 163) of the time.
- In 95% (190 out of 200) of the cases, there was adequate documentation of a conversation with the child for ongoing assessment of safety, well being, and permanency, or an adequate observation of the child, when the child was non-verbal.

### ***Efforts towards Timely Reunification, Filing Termination Petitions Timely and Achieving Stable and Lasting Living Arrangement for Youth Who were in Long Term Foster Care.***

- In 87% (62 out of 71) of the cases with a permanent plan of reunification, actions were taken to achieve timely reunification with the family.
- In 81% (59 out of 73) of the cases of children who had been in care 15 of the most recent 22 months, a petition to terminate parental rights was filed timely or compelling reasons not to file a petition were documented in the Individual Services and Safety Plan (ISSP).
- In 100% (14) of the cases of youth 14 years or older for whom all other permanency goals had been ruled out and Long Term Foster Care or Independent Living was the permanency goal, there was documentation that actions were taken to achieve a stable and lasting living arrangement for the youth.

### ***Child Protective Services (CPS); Timeliness and Quality of Investigative Child Interviews***

- In 95% (145 out of 152) of the CPS cases, there was documentation that an initial face-to-face contact (IFF) was made with all alleged child victims within 24 and 72 hour timeframes.
- In 84% (38 out of 45) of the CPS cases with a supervisory extension or exception to the IFF, the extension or exception was supported by policy and timely follow up efforts were made to see the children.
- In 81% (146 out of 181) of the CPS cases, comprehensive investigative interviews were documented with all alleged child victims, which addressed all allegations of child abuse and neglect and safety threats. When children were non-verbal there was a comprehensive observation of the child including injuries when applicable.

## **2. Areas Needing Improvement**

### ***Child Protective Services (CPS); Quality of Subject Interviews, Collateral Contacts, Safety Plans, Structured Decision Making (SDM), Timeliness of the Investigative Assessment (IA).***

- In 28% (48 out of 171) of the CPS cases, the subject interviews did not comprehensively address all of the allegations of child abuse and neglect and safety threats.
- In 26% (45 out of 176) of the CPS cases, documentation of collateral contacts with all important individuals who may have relevant information to identify or verify safety threats was not located.
- In 34% (12 out of 35) of the CPS cases with serious and immediate safety threats to a child, a Safety Plan was not documented.
- In 48% (82 out of 172) of the CPS cases, there was not documentation that sufficient information was gathered to answer each of the Structured Decision Making (SDM) questions. In 32% (54 out of 171) of the cases, the SDM questions were not answered accurately according to definitions.

- In 43% (76 out of 177) of the CPS cases, the Investigative Assessment was not completed and submitted for supervisory approval within 45 days, or 60 days after November 14, 2011.

#### ***Compliance with Child Protection Team (CPT) Staffings***

- In 32% (23 out of 73) of the cases, a Child Protection Team (CPT) staffing was not completed when required by Executive Order and policy. This included staffing cases of children ages six years or younger prior to return home or prior to case closure when the child remained in the home, and the risk to the child was moderate high or high.

#### ***Compliance with Monthly Supervisory Reviews***

- In 25% (80 out of 314) of the cases, monthly supervisory reviews were not documented in the most recent six month period.

#### ***Indian Child Welfare (ICW); Inquiry to all Tribes to Determine Indian Status***

- In 27% (18 out of 97) of the cases, documentation was not located that inquiry was made with all Tribes to determine Indian status. In an additional 8% (8 cases), contact was made with some but not all Tribes.

#### ***Translation and Interpretive Services***

- In 45% (9 out of 20) of the cases, there was not documentation that all of translation and/or interpretive services required by the family were offered or provided to meet their communication needs. In an additional 35% (7 cases) translation and/or interpretive services were provided to meet at least half, but not all, of the communication needs of the family.

#### ***Assessing the Needs of the Parents, Providing Services and Parental Engagement***

- In 21% (71 out of 345) of the cases, there was a lack of documentation that the parent's needs were adequately assessed and services were offered to address their needs:
  - Mothers: In 14% (27 out of 191) of the cases, the mother's needs were not assessed or services were not provided to her.
  - Fathers: In 29% (44 out of 154) of the cases, the father's needs were not assessed or services were not provided to him.
- In 24% (83 out of 339) of the cases, there was a lack of documentation of ongoing efforts to involve the parents in the case planning process:
  - Mothers: In 17% (32 out of 191) of the cases, there were not ongoing efforts to engage the mother.
  - Fathers: In 34% (51 out of 148) of the cases, there were not ongoing efforts to engage the father.

#### ***Timeliness of Adoption and Guardianships***

- In 32% (23 out of 73) of the cases with adoption as the permanent plan, actions were not taken to finalize the adoption within 24 to 30 months from the date of the child's placement.
- In 71% (12 out of 17) of the cases with a permanent plan of 3<sup>rd</sup> party custody or guardianship, actions were not taken to achieve the plan timely.

#### ***Providing Independent Living Services for Youth 15 Years and Older***

- In 28% (7 out of 25) of the cases with a child 15 years and older in out-of-home care, documentation was not located that independent living services were offered to successfully transition youth from out-of-home care to adulthood in a developmentally appropriate way.

## Recommendations

The results included in this report provide a comprehensive assessment of CA practice trends including strengths and areas needing improvement for the 15 offices that were reviewed in 2011. It is recommended the following four practice areas be prioritized for practice improvement:

### **1. Improve the Quality of Child Protective Services (CPS) Investigations**

There was inconsistent practice in the overall comprehensiveness of CPS investigations. This occurred most notably in the areas of quality of subject interviews, gathering additional information from collateral contacts, developing Safety Plans when safety threats were identified, gathering sufficient information to answer the Structured Decision Making (SDM) questions, and completing the Investigative Assessment (IA) timely to close or transfer the case.

Recommendations:

- Development and delivery of in-service training for CPS supervisors and social workers on the elements to complete a comprehensive CPS investigation to identify safety threats to children using real case scenarios. Identify and prioritize offices for training with “quality of CPS investigations” identified as a practice trend needing improvement identified in the Central Case Review.
- Development of a Quality Assurance (QA) process at the office level to increase Area Administrator (AA) and supervisory oversight on the quality of CPS investigations. The QA plan should include a review of a random selection of CPS investigations from each social worker assigned CPS intakes to evaluate the quality of practice.

### **2. Increase Compliance with Monthly Supervisory Reviews**

There was inconsistent practice in compliance of monthly supervisory reviews in the most recent six months.

Recommendations:

- Development and delivery of in-service training for supervisors of case carrying units on the purpose and elements that should be documented in supervisory reviews. Identify offices with “compliance with supervisory reviews” identified as a practice trend needing improvement in the Central Case Review and prioritize training for those offices.
- Development of a QA process that includes reviews by the AA of a random sample of cases for compliance, content and quality of supervisory reviews.

### **3. Improve Documentation of Assessing Parent’s Needs, Provision of Services and Ongoing Parental Engagement**

There was inconsistent practice in adequately assessing the parent’s needs, providing services to meet their needs and ongoing engagement of the parents in the case plan. Most frequently there were gaps in time when there was little or no contact with the parent and in some cases there were insufficient efforts to locate an absent parent. In most offices, efforts were greater to maintain regular contact, assess needs and provide services to the mother than to the father.

Recommendations:

- Implement policy requiring monthly visits/contact with parents in FVS and CFWS cases by April 1, 2012.

- Require monthly supervisory reviews to include verification of documentation for the last in-person visit and/or phone contact with each parent, including efforts to locate absent fathers, and efforts to engage the parents in the case planning process each month.
- Continue the statewide quality assurance review activity for Area Administrators to review a sample of ISSPs each month that have been approved by the supervisor. The quality assurance review includes assessment of the ongoing engagement of the parents, including a focus on fathers in the case planning process.

**4. Improve Indian Child Welfare (ICW) Compliance; Inquiry to all Tribes to Determine Indian Status**

There was inconsistent practice in completing inquiry efforts with all Tribes to determine the child's Indian status. This included both telephone contact with the Tribes or sending inquiry letters to all Tribes identified by the parents or family members.

**Recommendations:**

- Conduct the statewide 2012 ICW Case Review in collaboration with Washington State Tribes for a comprehensive review of ICW practice and to identify future ICW quality assurance activities.

## Central Case Review 2011 Results

### I. Native American Inquiry and Tribal Involvement

#### A. Inquiry with the Parents

**Inquiry was made with both sides of the family to discover if the child had American Indian/Alaska Native/Canadian Indian status.**

85% fully achieved  
(270 out of 319 cases)

Cases were fully achieved when documentation of the child's Indian status was made through inquiry with both sides of the family by asking all available parents, and/or relatives, if the parent was unavailable.

An additional 11% (36 cases) was partially achieved because inquiry was done with one side of the family, by asking one available parent and/or relative, but not both available parents and/or relatives.

#### B. Contacting the Tribe(s) to Determine Indian Status

**The Tribe(s) or the Bureau of Indian Affairs (BIA) was contacted to determine the child's Indian status.**

73% fully achieved  
(71 out of 97 cases)

Cases were fully achieved when inquiry letters were sent to all Tribes, or there was other case record documentation that indicated all Tribes were contacted to determine the child's Indian status.

An additional 8% (8) of the cases was partially achieved because there was more than one Tribe and not all of the identified Tribes were contacted to determine the child's Indian status.

### C.. Active Efforts to include the Tribe in Case Planning

**There were ongoing active efforts to include the child's Tribe(s) in case planning.**

82% fully achieved  
(23 out of 28 cases)

Cases were fully achieved when there were ongoing active efforts to include the child's Tribe(s) in case planning, for example:

- Identification of services to prevent placement
- Safety planning
- Placement decision and placement recommendations
- Maintaining cultural connections
- Permanency planning goals

## II. Translation and Interpretive Services

**Translation and/or interpretive services were provided to families who were Limited English Proficiency (LEP) or used American Sign Language (ASL).**

55% fully achieved  
(11 out of 20 cases)

Cases were fully achieved when translation and/or interpretive services were provided to meet the communication requirements needed by the family.

An additional 35% (7 cases) was partially achieved because translation and interpretive services were provided to meet at least half of the communication requirements needed by the family.

### III. Safety

#### A. Assessing and Addressing Safety Threats to Children

All cases were reviewed to the practice area of comprehensively assessing and addressing safety threats to children. The review period was the last twelve months, and some cases were open in more than one program; Child Protective Services (CPS), Family Voluntary Services (FVS) and/or Child and Family Welfare Services (CFWS) during that time.

The overall office performance is not an average, but represents the percentage of cases in which safety was managed for the child during the last twelve months in all programs.

When present danger was identified for a child during a case review, a memo outlining the safety threat was immediately sent to the supervisor, Area Administrator (AA) and Regional Administrator (RA) and follow up to the concern was tracked by the Central Case Review Team. Cases that were rated not achieved for adequately assessing and addressing safety threats were brought to the attention of the AA for further review.

#### **Safety threats were adequately assessed and addressed for child(ren).**

Overall statewide performance was 87%  
(283 out of 324 cases)

CPS was 87%  
(186 out of 213 cases)

FVS was 89%  
(58 out of 65 cases)

CFWS was 91%  
(151 out of 166 cases)

The following practice trends were noted for the 41 cases that were not achieved:

#### **Cases open to Child Protective Services (CPS)**

- In eleven cases, comprehensive CPS investigative activities were not documented to identify and assess safety threats to the child. Missing information included comprehensive interviews with alleged child victims, comprehensive interviews with parents and adequate collateral contacts with professionals and other persons who may have had firsthand knowledge of the incident, the injury or the family's circumstance. In some cases, the alleged child victims were interviewed in the presence of the alleged subject.
- In ten cases adequate safety planning was not located in cases with identified safety threats. Some cases did not have a safety plan and in other cases the safety plan did not include outside eyes on the child to monitor the child's safety and were based on the parent's ability to monitor their compliance.
- In four cases, there was not an adequate assessment of individuals who resided in the child's home in a caregiver role and an assessment of this person was relevant to determine if there were safety threats.
- In two cases, a transfer to FVS occurred when court intervention was indicated.

### **Cases open to Family Voluntary Services (FVS)**

- In five cases, child safety was not assessed and addressed through safety planning on an ongoing basis and as family circumstances changed.
- In two cases, there was not an adequate assessment of adults who resided in the child's home in a caregiver role and assessment of this person was relevant to determine if there were safety threats.

### **Cases open to Child and Family Welfare Services (CFWS)**

- In nine cases, the child returned home and safety threats were not adequately addressed through safety planning and monitoring after the trial return home. In four of these cases there were new intakes accepted for CPS investigation and adequate investigative activities or safety planning regarding the threats to the child was not documented.
- In two cases, the child was in a relative placement and concerns regarding the relative were not assessed and addressed timely.
- In two cases, the child was transitioning home including overnight visits and adults residing in the home were not adequately assessed to determine if there were safety threats to the child.
- In the two remaining cases, there was a sibling group and at least one child was placed in out-of-home care and one remained in the home. An assessment of the safety threats to the child remaining in the home was not comprehensive. In one of these cases there was a birth of a baby who remained in the home without an adequate safety assessment.

## **B. Assessing and Addressing Safety Threats in the Home of the Out-of-home Caregiver**

**All safety threats regarding the child's out-of-home caregiver were adequately assessed and addressed.**

82% fully achieved  
(27 out of 33 cases)

The following practice trends were noted for the six cases that were not achieved:

- In three cases, the child was placed with a relative, and there was no assessment of all adults in the home who were in a caregiver role. In some cases it was not clearly specified who lived in the home and who were caregivers.
- In one case, the child resided in the home of the maternal grandmother, and the mother moved into the home. There was no safety planning related supervision of the child and mother's interaction.
- In one case, the child was placed in licensed foster care. The mother reported two incidents of bruising on the child, and the intake was not accepted for investigation.
- In one case, concerns regarding the foster mother's mental health and leaving the child in the care of unauthorized caregivers during the time she was psychiatrically hospitalized was not addressed timely.

### C. Completion of Background Clearances for Unlicensed Caregivers

**All required background clearances were completed for unlicensed caregivers within required timeframes.**

83% fully achieved  
(63 out of 76 cases)

Cases were fully achieved when all required background clearances were completed in accordance with Adam Walsh legislation that became effective in July 2007. A review of the Background clearance Liaison (BCL) log was completed to determine compliance.

Required background clearances included:

*Prior to Placement*

- National Crime Information Center (NCIC) check
- FamLink check

*Within 10 calendar days of placement*

- Background check Central Unit (BCCU) check
- Fingerprints
- Out of state Child Abuse and Neglect (CA/N) registry if someone lived out of Washington in the past five years
- For youth 16 and 17 residing in the home, and foster youth over 18, a FamLink check and BCCU check

An additional 12% (9 cases) was partially achieved because all required background clearances were completed; however the submission of the BCCU checks and/or fingerprints was completed but it was after the 10 calendar day requirement.

### D. Child Protection Team (CPT) Staffing

A CPT was utilized for consultation to assist in the assessment of future risk of Child Abuse and Neglect (CA/N), and the need to place children in out-of-home care as outlined in Executive Order and CA policy.

**A CPT staffing was completed when required.**

Statewide performance was 69%  
(50 out of 73 cases)

The following practice trends were noted for the 23 cases that were not achieved:

- In 18 cases, the risk level was moderately high or high on the Structured Decision making (SDM) risk assessment, and the child was age six or younger and a CPT staffing was not held prior to case closure.
- In three cases, the child was age six or younger, had been in out-of-home placement over 60 days, was returned home on a trial home visit, and a CPT staffing was not held.
- In two cases, CPT consultation was needed on a complex case of a child age six or younger for consultation regarding safety threats and placement decisions.

## **E. Child Protective Services (CPS) case disposition; meeting the child's safety and protection needs**

All cases that were open to CPS in the last twelve months were reviewed to determine if the appropriate CPS case disposition was made, e.g. at the time there was a decision made to close the case, provide voluntary services or to initiate court action. Some cases were rated to more than one of the following three areas if there were multiple case openings, and different case dispositions were made.

### **1. CPS Decision to Close**

**The decision to close the case met the safety needs of the child.**

Statewide performance was 91% (91 out of 100 cases)

### **2. CPS Decision to Provide Voluntary Services**

**The decision to provide voluntary services met the safety needs of the child.**

Statewide performance was 94% (58 out of 62 cases)

### **3. CPS Decision to Initiate Court Action**

**A dependency petition filed when needed to ensure the child's safety and protection.**

Statewide performance was 99% (76 out of 77 cases)

## **IV. Family Engagement and Service Planning**

Family engagement and service planning applied to all cases that remained open beyond the Child Protective Services (CPS) investigation for service delivery, safety monitoring or placement. This included all mothers and fathers as follows:

- Placement cases: all parents who were identified and located
- In-home cases: all parents who were identified and involved in the child's life.

### **A. Assessing Parental Needs and Offering Services**

The overall office performance is the average for assessing the needs of the mother and the needs of the father(s). This included:

- Actions to assess the parent's needs at the initial contact and on an ongoing basis
- Offering appropriate services to meet the parent's identified needs related to safely parenting their children.

**The parent's needs were assessed and services were offered to address their needs.**

Overall office performance was 79%

Mothers were 86% (164 out of 191 cases)

Fathers were 71% (110 out of 154 cases)

## **B. Engagement of parents in the case plan**

The overall office performance is the average for ongoing efforts to involve the mother and the father(s) in the case planning process. This included:

- Offering the parent an opportunity to have a voice in the case plan
- Inviting the parents to participate in shared planning meetings
- Maintaining frequent ongoing contact with the parents to discuss the case plan by phone and in person when geographically available.

### **There were ongoing efforts to involve the parents in the case planning process.**

Overall office performance was 76%

Mothers were 83% (159 out of 191 cases)

Fathers were 66% (97 out of 148 cases)

## **C. Shared Planning Meetings**

Shared planning meetings, including Family Team Decision-Making meetings (FTDM), occurred when a placement or a placement change was being considered, and every 12 months thereafter.

### **Shared planning meetings were utilized at critical points for case planning.**

Office performance was 85% (162 out of 190 cases)

### **Family members and other persons who had relevant information were included in the shared planning meeting.**

Office performance was 93% (150 out of 162 cases)

## **V. Well Being Needs of the Child**

Meeting the well being needs of the child applied to all cases that remained open beyond the CPS investigation for service delivery, safety monitoring or placement.

### **A. Education**

#### **The child's education needs were assessed and addressed**

Office performance was 91%

In-home cases were 92% (22 out of 24 cases)

Placement cases were 91% (124 out of 137 cases)

The following trends were noted on the cases that were not achieved:

- In eleven placement cases, educational needs were identified for the child but there was minimal documentation of follow up as to how the child's needs were being met by the caregiver or the school.
- In two placement cases, there was little documentation of the child's current educational status.

- In two in-home cases, there was no documentation of follow up to meet the identified educational needs of the child.

## B. Physical Health

### The child's physical health needs were assessed and addressed

Office performance was 88%  
 In-home cases were 97% (36 out of 37 cases)  
 Placement cases were 86% (141 out of 164 cases)

The following trends were noted on cases that were not achieved:

- In twelve placement cases, there was no documentation that the child had routine health and dental checks during the last year.
- In seven cases, the child had received a well child check during the last year, but there was no documentation that a routine dental check occurred or was scheduled.
- In three cases, a specialized physical health need was identified for the child and follow up care was not documented. This included on-going ear infections, chronic skin rashes, placement of tubes in ears, and hearing evaluations.
- In one in-home case, a specialized health need was identified and follow up with the parent or doctor was not located to ensure the child's health need was met.

## C. Mental/behavioral Health

### The child's mental/behavioral health needs were assessed and addressed

Office performance was 80%  
 In-home cases were 77% (20 out of 26 cases)  
 Placement cases were 81% (76 out of 94 cases)

The following trends were noted on cases that were not achieved:

- In three in-home cases, mental health services were indicated for the child. There was no documentation of a referral for an assessment or counseling services, or a discussion with the parent(s) related to the child's need for mental health services.
- In three in-home cases, the child had identified substance abuse or sexualized behaviors and follow up to address the child's needs were not located.
- In six placement cases, there were indicators the child needed a mental health assessment or counseling but follow up was not located.
- In five placement cases, a referral for mental health services was made, but there was no documentation if the child was receiving services or no contact with the child's therapist was made to determine progress.
- In five placement cases, substance abuse services were indicated for the youth and a referral for services was not documented.
- In two placement cases, it was documented that the youth did not wish to participate in mental health treatment, but efforts to encourage the youth to engage in needed services was not located.

## VI. Monthly Visits with the Child by the CA Social Worker

Monthly visits with the child applied to cases that remained open beyond the CPS investigation. The review period was the last six full months the case was open prior to the review. Cases were rated achieved when the child was seen in each full month the case was open.

When monthly visits with the child occurred, the quality of the visit was also reviewed. Cases were rated as achieved when during visits, the following activities occurred when applicable:

### *Observation of the child*

- How the child appeared developmentally, physically and emotionally
- How the parent/caregivers respond to each other
- The child's attachment to the parent/caregiver
- The home environment

*Discussion or an attempt to have a discussion with the verbal child in a separate location from the parent, foster parent or relative:*

- Inquiry as to whether the child felt safe
- Inquiry about the child's needs, wants and progress
- Visits with siblings and parents
- Case activities and planning

### **Monthly visits occurred with the child.**

Office performance was 91% (200 out of 220 cases)

In-home cases were 74% (42 out of 57 cases)

Placement cases were 96% (157 out of 163 cases)

### **The quality of visits was sufficient for ongoing assessment of the safety, well being and permanency of the child.**

Office performance was 95% (190 out of 200 cases)

In the 20 cases that were not achieved for monthly visits, the visits with the child occurred with the following frequency:

<b>Visits with Child</b>	<b># of Cases</b>
5 out of 6 months	2
4 out of 6 months	2
2 out of 6 months	1
4 out of 5 months	2
3 out of 5 months	1
2 out of 5 months	1
1 out of 5 months	1
3 out of 4 months	2
2 out of 4 months	1
1 out of 4 months	1

0 out of 4 months	1
2 out of 3 months	2
1 of 3 months	2
1 out of 2 months	1

## VII. Monthly Supervisory Reviews

Monthly supervisory reviews applied to cases that stayed open for a full calendar month or longer. The review period was the last six full months the case was open prior to the review. Cases were rated achieved when supervisory reviews occurred in each of the full months the case was open.

When monthly supervisory reviews occurred, the quality of the supervisory review was also reviewed. Cases were rated as achieved when during supervisory reviews the child's safety, permanency and well being were addressed.

### Monthly supervisory reviews occurred.

Office performance was 75% (234 out of 314 cases)

**The quality of the monthly supervisory reviews was sufficient to address the safety, well being and permanency of the child.**

Office performance was 80% (187 out of 234 cases)

In the 80 cases that were not achieved for monthly supervisory reviews, reviews occurred with the following frequency:

Supervisory Reviews	# of Cases
5 out of 6 months	19
4 out of 6 months	14
3 out of 6 months	9
1 out of 6 months	1
4 out of 5 months	2
3 out of 5 months	7
2 out of 5 months	1
3 out of 4 months	5
2 out of 4 months	2
2 out of 3 months	8
1 out of 3 months	3
1 out of 2 months	7
0 out of 1	2

## VIII. Permanency

Permanency applied if the child was in placement through court order or Voluntary Placement Agreement (VPA) during the last 12 months.

### A. Reunification

Cases were reviewed to timely efforts to achieve reunification when reunification was the primary permanency goal. Timely efforts to achieve reunification included:

- Return home (trial home visit) within 12 months of the Original Placement Date (OPD)
- Active efforts to achieve reunification when the child was in care less than 12 months
- The child was in care over 12 months, however the parent was making significant progress and an additional six months was indicated to achieve reunification within 18 months.

**Actions were taken to achieve the permanency goal of reunification timely.**

Office performance was 87% (62 out of 71 cases)

In nine cases that were not achieved for timely reunification efforts, the length of stay for the child was the following:

Length of Stay	# of Cases
18 to 24 months	4
24 to 36 months	4
36 to 48 months	1

### B. Adoption

Cases were reviewed to timely efforts to achieve adoption when adoption was the primary permanency goal. Timely efforts to achieve adoption included:

- Finalization of adoption occurred within 24 months of the Original Placement Date (OPD).
- The child entered care less than 24 months ago and actions were taken to complete the adoption within 24 month.
- The child entered care over 24 months ago and actions were taken to finalize the adoption within 24 months, however there were circumstances beyond CA's control regarding the child, the pre-adoptive parents or court that justified the delay, and the adoption was completed or scheduled to be completed within 30 months of OPD.

**Actions were taken to achieve the permanency goal of adoption timely.**

Office performance was 68% (50 out of 73 cases)

In the 23 cases that were not achieved for timely adoption efforts, the length of stay for the child was the following:

Length of Stay	# of Cases
24 to 36 months	7
36 to 48 months	7
Over 48 months	9

**C. Filing a Timely Termination Petition or Documenting Compelling Reasons**

To calculate if the child was in care 15 of the most recent 22 months, the date the child entered care was not the OPD, but was the earlier of the following options: (1) the date of an order of dependency or (2) 60 calendar days after OPD.

Timely efforts included:

- A termination petition was filed by the 15<sup>th</sup> month (see calculation above).
- The child had been in care beyond 15 months, but the termination petition was filed prior to the last 12 months.
- Compelling reasons were documented in the most recent ISSP why termination was not in the best interest of the child.

**A petition to terminate parental rights was filed timely or compelling reasons were documented.**

Office performance was 81% (59 out of 73 cases)

**D. Third Party Custody and Guardianship**

Cases were reviewed to timely efforts to achieve third party custody or guardianship when these were indicated as the primary permanency goal. Timely efforts to achieve third party custody or guardianship included:

- Third party custody or guardianship occurred within 12 months of the Original Placement Date (OPD).
- Actions were taken to achieve the goal within 12 months but the circumstances of the case justified the delay and the goal was achieved or was scheduled to occur within 18 months of OPD. Efforts to achieve the goal included:
  1. The initial goals of reunification and adoption were ruled out.
  2. The proposed caregiver was identified as having a significant relationship with the child and the ability to meet the child's needs without support from CA.
  3. An agreement was reached with all parties (including the child when age appropriate) that third party custody or relative guardianship was in the best interest of the child.

**Actions were taken to achieve the permanency goal of third party custody or guardianship timely.**

Office performance was 29% (5 out of 17 cases)

In the 12 cases that were not achieved for timely efforts to achieve third party custody or guardianship, the length of stay for the child was the following:

Length of Stay	# of Cases
18 to 24 months	4
24 to 36 months	3
Over 36 months	5

## II. Transitioning Youth to Adulthood

Transitioning youth to adulthood applied when the youth was 14 years or older and resided in out-of-home care during the last 12 months.

### A. Actions to Achieve a Stable and Lasting Living Arrangement

Actions to achieve a stable and lasting living arrangement for youth 14 years and older when all other permanency goals had been ruled out, was evidenced by one of the following:

- The youth was in a stable and lasting living arrangement with a caregiver, and there had been a commitment by all parties involved (signing a long term care agreement), that the youth would remain with the caregiver until age 18, or 21.
- The youth had a significant connection to the caregiver, and there was discussion with the youth and caregiver regarding the future development of a long term care agreement.
- The youth was not in a stable and lasting living arrangement with a caregiver, but there were actions taken to locate a stable and lasting living arrangement including a discussion with the current caregiver (if not in group care placement) regarding willingness to consider a long term care agreement.
- The youth had high-level service needs, and actions were taken to stabilize and transition the youth to a less restrictive family environment.

**Actions were taken to achieve a stable and lasting living arrangement.**

Office performance was 100% (14 cases)

### B. Services to transition youth to adulthood

Services to transition youth to adulthood applied when the youth was 15 years or older and in out-of-home care. Services were developmentally appropriate and included the following when applicable:

- Referring the youth for an independent living assessment and/or transitional living services
- Developing an Independent Living/Learning Plan
- Coordinating with the school district when developing an independent living plan for youth receiving special education services

- Completing a life skills assessment and developing a plan to address the youth's needs in the areas of career planning, daily living, home life, housing and money management, self care, social relationships and work life
- Collaborating with DDD to develop a transition plan for youth 17.5 years old who are eligible for DDD services
- Coordinating a Youth Exiting Care staffing at least six months prior to a youth exiting care to share information (e.g. housing resources, Medicaid to 21 Foster Care to 21 program) and important documents (e.g. birth certificate, education/health records, social security card, state identification card or driver's license).

**Services were offered to successfully transition the youth from out-of-home care to adulthood in a developmentally appropriate way.**

Office performance was 72% (18 out of 25 cases)

## IX. Quality of Child Protective Services (CPS)

The following questions applied when the case was open for a CPS investigation during the last six months. The question numbers for this section correlate to the question numbers in the Central Case Review Tool.

Question	Full Compliance	Partial Compliance	Non Compliance	Number of cases
27. Was an initial face-to-face contact (IFF) made with all alleged child victim(s) within required timeframes?	95%	3%	2%	152
28. If there was a supervisory extension or exception to the IFF, was the decision supported by policy, and did timely efforts to see the child(ren) occur?	84%	-	16%	45
29. Were the investigative interviews with child victims comprehensive, and were all safety threats and risk concerns thoroughly addressed?	81%	9%	10%	181
30. Were all subjects interviewed face to face?	89%	9%	2%	182
31. Did the subject interviews comprehensively address all safety threats and risk concerns?	72%	21%	7%	171
32. Was information gathered from medical professionals to assist in the evaluation of suspected child abuse and neglect (CA/N), or to determine the need for medical treatment?	86%	-	14%	69
33. Were adequate collateral contacts made during the investigation to gather sufficient information regarding safety threats and risk concerns?	74%	16%	10%	176
34. Did the Safety Assessment accurately indicate all safety threats and serious and immediate harm to the child(ren)?	90%	-	10%	169
35. If there were serious and immediate safety threats to the child(ren), was a Safety Plan developed? )	66%	-	34%	35
36. If a Safety Plan was developed due to serious and immediate safety threats, did the plan address the ongoing safety of the child(ren)?	87%	-	13%	23

Question	Full Compliance	Partial Compliance	Non-Compliance	Number of cases
37. Was sufficient information gathered to answer each of the Structured Decision Making (SDM) questions?	52%	22%	26%	172
38. Were the Structured Decision Making (SDM) questions answered accurately according to the SDM definitions?	69%	19%	12%	171
39. Was the Investigative Assessment(s) (IA) completed and submitted for supervisory approval within 45 days?	57%	6%	37%	177
40. Was the finding supported by the evidence or information gathered in the investigation?	96%	2%	2%	155

## X. Family Voluntary Services (FVS)

The following questions applied when the case was open for FVS or the child was placed on a Voluntary Placement Agreement (VPA) during the last six months. The question numbers for this section correlate to the question numbers in the Central Case Review Tool.

Question	Full Compliance	Partial Compliance	Non-Compliance	Number of cases
41. Was a Family Assessment completed within 30 days of the case being open for services in FVS?	26%	-	74%	54
42. Did the Family Assessment comprehensively assess the family's strengths and needs?	90%	-	10%	29
43. Were actions taken to provide or arrange appropriate services to the family targeted at the safety threats and risk concerns to the child(ren)?	80%	9%	11%	56
44. If the child was placed through a Voluntary Placement Agreement, (VPA) did the decision to place the child on a VPA meet the needs of the child?	-	-	-	0
45. Was there adequate monitoring to ensure the child's safety and support the family during the time the case was open to FVS?	95%	-	5%	57

Question	Full Compliance	Partial Compliance	Non-Compliance	Number of cases
46. Was an Assessment of Progress completed every 90 days and at case closure?	39%	-	61%	23
47. Did the Assessment of Progress and Compliance accurately indicate parental progress and compliance to reduce safety threats and risk concerns?	100%	-	-	11

## XI. Child Family Welfare Services (CFWS)

The following questions applied when the case was open for CFWS during the last six months. The question numbers for this section correlate to the question numbers in the Central Case Review Tool.

Question	Full Compliance	Partial Compliance	Non Compliance	Number of cases
48. Were the visits between the child and the parents of sufficient frequency and quality to maintain the child and parent relationship?	93%	2%	5%	124
49. Were the visits between the child and all siblings of adequate frequency and quality to maintain the continuity of the sibling relationship?	52%	-	48%	25
50. Were there actions taken to identify relatives as a placement resource?	93%	1%	6%	150
51. Were all identified relatives considered and evaluated as to their appropriateness as a placement resource?	90%	-	10%	140
52. If a child(ren) returned home, or remained in the home, were services offered or provided?	93%	-	7%	41
53. Was a Reunification Assessment completed prior to overnight visits or a trial home visit?	65%	-	35%	23
54. Did the Reunification Assessment comprehensively assess the risk to the child and support the recommendation?	75%	-	25%	16
55. If the child returned to their parent(s), was a Transition and Safety Plan (T&SP) completed?	79%	-	21%	24
56. Did the Transition and Safety Plan (T&SP) adequately address the child's safety and the steps for transitioning the child to the parent(s) care?	80%	-	20%	20

## XII. Parent Interviews

Case reviews included interviews with parents on cases that remained open beyond the Child Protective Services (CPS) investigation. Standardized interview questions were designed to assist the office to improve practice through understanding the parent's perspective. For each of the eleven questions that are discussed in this report, additional questions were asked to gather background information from the parents and to ensure the parents understood the intent of the question.

There were attempts to interview parents on all cases reviewed that were open beyond the CPS investigation. Interviews were completed by phone with parents who were available and willing to participate in interviews. There were interviews with parents on 91 cases. A total of 110 parents were interviewed: 72 mothers and 38 fathers.

### A. Safety

*Parents with children in-the-home reported:*

**The CA social worker assisted them to ensure the safety needs of their child were met.**

Overall parental response was 88%

90% of the mothers (43 out of 48)

90% of the fathers (17 out of 19)

*Parents with children in-placement reported:*

**Their child's safety needs were met in their out-of-home placement.**

Overall parental response was 95%

96% of the mothers (52 out of 54)

93% of the fathers (27 out of 29)

#### Mothers

Mothers of children in-the-home reported:

- The majority of mothers stated that they understood what safety threats existed for their children as the social worker explained this to them, and they received assistance to keep their children safe in their care.
- Three mothers indicated they did not believe there were safety concerns regarding their children even though they agreed to have their case remain open for in-home voluntary services, and they did not think this was helpful to them.
- Two mothers stated they did not receive the assistance they needed prior to the placement of their children in out-of-home care.

Mothers of children who were placed reported:

- All but two mothers were satisfied that their children were safe in their foster home or with their relative caregiver.
- Two mothers reported concerns regarding their child's out-of-home caregiver. In one case, the mother reported concerns regarding the foster parent which was investigated, and the child was no longer in the care of the foster parent. In another case, the mother reported

concerns for her child who was placed with grandparents but she was unable to articulate why she felt there was a safety threat.

### **Fathers**

Fathers of children in-the-home reported:

- The majority of fathers stated that they understood what safety threats existed for their children as the social worker explained this to them, and they received assistance to keep their children safe in their care.
- Two fathers stated they had concerns regarding the safety of their children who were in the care of their mothers. The fathers had reported these concerns to the social worker but were not satisfied.

Fathers of children who were placed reported:

- All but two fathers were satisfied that their children were safe in their foster home or with their relative caregiver.
- One father stated he reported to the social worker that there was physical abuse to his child by the foster parent and was not satisfied by the follow up. At the time of the interview, the child was in his care.
- One father stated he had concerns regarding the level of supervision provided to his children by the caregiver who was fictive kin.

### **B. Social worker Contact with the Parents**

*The parents reported:*

#### **They had monthly contact with their social worker.**

Overall parental response was 78%

86% of the mothers (69 out of 80)

64% of the fathers (25 out of 39)

#### **The contact with the social worker was helpful related to parenting their children.**

Overall parental response was 68%

71% of the mothers (57 out of 80)

67% of the fathers (24 out of 36)

### **Mothers**

- The majority of mothers reported they had monthly contact with their social worker including frequent telephone contact and regular face to face contact. The contact with the social worker was helpful to them.
- There were eleven mothers who reported contact with the social worker was not monthly. Some of the mothers reported they felt ignored by the social worker, that contact only occurred when the mother initiated it, or that contact was frequent with one social worker assigned to the case but had not been frequent when a different social worker was assigned to the case.

## Fathers

- The majority of fathers reported they had monthly contact with their social worker including frequent telephone contact and regular face to face contact. The contact with the social worker was helpful to them.
- There were fourteen fathers who reported contact with the social worker was not monthly. One father reported he had no contact with the social worker during the last year, and another father stated he had been contacted only once during the last eleven months. Other fathers stated they have infrequent contact, and social workers do not return their phone calls. Several fathers stated that they had not been contacted by a social worker for a long time, but since a new social worker was assigned, they began having regular social worker contact.

## C. Parent Engagement

*The parents reported:*

### **They were included in the case planning process.**

Overall parental response was 68%

72% of the mothers (57 out of 79)

64% of the fathers (25 out of 39)

### **They were invited to a shared planning meeting regarding their family.**

Overall parental response was 81%

90% of the mothers (62 out of 69)

68% of the fathers (23 out of 34)

### **They participated in a shared planning meeting and their input was valued.**

Overall parental response was 77%

81% of the mothers (50 out of 62)

74% of the fathers (17 out of 23)

## Mothers

- The majority of mothers were satisfied regarding their involvement in the case planning process.
- Mothers who indicated they were not involved in case planning and decision making for their children reported: they had agreed to a case plan which was developed without their input, there was some “bias” against them and they were not given a chance, they had not been treated with respect when they had participated in a shared planning meeting or they were not invited to any meetings regarding their children.

## Fathers

- Fewer fathers reported being satisfied regarding their involvement in the case planning process. Fathers stated the focus of the case was for the mother to parent the children, and that minimal efforts were made to involve them. .
- Eleven fathers reported not being invited to shared planning meetings and when they were invited, they did not get the notice in time to attend. Two fathers who participated in shared planning meetings thought the decisions regarding their family were made

before the meeting started. Two fathers reported they had not been treated with respect when they participated in shared planning meetings, and one father said he had been treated rudely.

## **D. Services**

*The parents reported:*

### **Services were offered that were helpful related to safely parenting their children.**

Overall parental response was 80%

84% of the mothers (65 out of 77)

73% of the fathers (24 out of 33)

### **Services were provided that met their individual and cultural needs.**

Overall parental response was 96%

95% of the mothers (56 out of 59)

96% of the fathers (24 out of 25)

### **Mothers**

- The majority of mothers reported they were offered services related to parenting their children. Services included parenting classes, domestic violence services, Family Preservation Services, chemical dependency assessments and services, drug court, Family Reconciliation Services, life skills classes, housing, and mental health services. Some mothers felt the services were “very” helpful to them and assisted them to have their children returned to their care.
- Twelve mothers reported: they completed required services which were not helpful to them, they had not been referred to services, or they had requested assistance that was not provided (e.g. daycare and housing).
- Two Native American mothers stated that services did not meet their cultural needs. One of the mothers was upset that her child’s hair had been cut during the time the child was in care.

### **Fathers**

- The majority of the fathers reported they were offered services related to parenting their children. Services included domestic violence services, parenting classes, chemical dependency assessments, life skills classes, and mental health services. Several fathers also mentioned that having visitation with their children was very helpful to them.
- Nine fathers reported they had not been referred to services or the services were not needed or helpful. One father stated he was having financial difficulty, which prevented him from being able to complete a parenting plan, and he received no support from the social worker.