Administrative Case Review Project
Clark County, Nevada

Report of Data Analysis, Findings And Recommendations

Presented to

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INTRODUCTION

In the spring of 2006 the Clark County Department of Family Services (DFS) had no protocols or processes for conducting comprehensive administrative reviews for open child welfare services cases. Supervisors were required to review only one case per month from each worker's caseload. Judicial reviews were seen as the mechanism to determine whether children were safe and families were making progress toward service goals. County management recognized that an internal case review process is an essential part of a well-functioning child welfare system and requested an administrative review of a sample of open cases that had at least one child under the age of four. For each child, the review was to focus on five areas:

- Can it be reasonably assumed that the child is safe? What is the basis for that assumption?
- Are caseworkers visiting each child a sufficient number of times to accurately assess safety and to ensure that necessary services are provided in order to achieve permanency? Is each child being seen and interviewed (when age appropriate) privately by the caseworker?
- Is the safety assessment protocol being appropriately used to focus on the child's immediate safety? Are safety factors being identified and addressed?
- Is the Family Risk Assessment Protocol being appropriately used to continually assess on-going risk to children on open service cases?
- Is the case plan current? Do the objectives address the risk issues in the family? If the objectives are met, will the child achieve permanency?
- Are there specific types of services that could have made the case plan easier to accomplish, but were unavailable or had long waiting lists?

The review included a random sample of cases from every team in the county, encompassing both intact family and out-of-home placement cases. Each review included reading case file information and interviewing the caseworker. For cases where the worker was on vacation or medical leave, the supervisor was interviewed.

During May and June 135 cases were reviewed. An analysis of results from the first 82 reviews led the DFS to expand the review to include all cases involving families with at least one child under the age of five who was currently a ward of Clark County. Since this task would have taken nearly two years for one reviewer to complete, additional reviewers were brought in from around the country to assist. Each week during July – October 4-8 reviewers were in Clark County reading files and interviewing workers. This resulted in 1352 cases being reviewed from May through October 2006. This report details the results of that project. The specific data and the reviewers' analyses, based upon the case readings and the caseworker interviews, are presented in three sections:

- Safety of the children: This section includes data regarding the use of the Safety Assessment and the Family Risk Assessment Protocol. It also notes the reviewer's determination of the current safety of each child.

- Visitation: The data captured in this area encompasses both the frequency of visits between the caseworker and the child over the past year and documentation of the most recent in-person contact. Additionally, this section provides details regarding whether caseworkers are interviewing or observing children privately. Also included is information regarding caseworker contacts with the child's parent(s).
- Case Planning: The third section provides information regarding the usefulness of the case plan -- whether the plan reflects what the caseworker is currently working on with the family, whether the objectives relate to the identified risk, and whether there was a Family Team Meeting to construct and/or update the case plan.

In all sections, the information presented is broken down into two categories:

- Cases with children in substitute care: This category includes all cases where the child(ren) being reviewed is not in legal placement with his/her parents. It includes children in foster care, residential care, and those placed with relatives.
- Cases with children in intact families: This category includes all cases where the child(ren) being reviewed are living with at least one legal parent (birth or adoptive).

Following the analysis, the report documents major issues identified during the review, including both strengths of the system and problem areas. Recommendations are then offered that focus on addressing these issues. Because many of the recommendations are impacted by more than one of the sections noted above, they are presented as a whole, rather than divided into specific areas.

Finally, caseworkers were asked to identify what services would have made their job easier, both for the particular case and for their caseload as a whole. This question was included to serve as a "needs assessment" from the caseworker's point of view.

CASE SELECTION AND REVIEW PROCESS

A list was generated of all families with open cases that included at least one child who was under six years of age and a ward of Clark County. Administrative staff then provided weekly lists to the project manager of cases identified for review. Reviewers were provided five items from UNITY (the SACWIS computer tracking system) that were read prior to the interviews:

- case notes
- safety assessments
- risk assessments (FRAP)
- case plans
- investigation summaries

The interview was structured in the following way:

1. Caseworkers were asked to give an overview of the case, including: the reason for DFS involvement with the family, demographic information for all family members, current status of the work on the case plan, and the projected date of closure for the case. This information allowed the reviewer to determine the depth of the worker's knowledge about the family and whether the prior case history had been read.
2. Workers were questioned regarding issues that were identified during the case reading, including gaps in contacts and inconsistencies in safety and risk assessments.
3. Specific data questions were posed, including the dates that the children were seen and whether they were interviewed privately.
4. Workers were asked whether there were services that could have made their work with the family more successful, but that such services were either unavailable, unaffordable, or required lengthy waiting lists.

Attachment 1 contains the four forms used by the reviewers as noted below:

- File Review Form: This form was available to the reviewers to help structure their review of the case file prior to interviewing the caseworker. Its use was not mandated, but was presented for reviewers who asked for structural guidelines.
- Case Review Interview Form: This form was designed to keep reviewers focused on the essential elements of the review and ensure that they captured the information needed to complete the data report.
- Review Data Form: This item captured the data elements necessary to evaluate the overall status of the case.
- Safety Determination Form: This forms contains the reviewer's determination regarding the child's safety and the justification for that rating.

DATA RESULTS AND ANALYSIS

SECTION 1 – SAFETY OF CHILDREN

The county child welfare/child protection system exists, first and foremost, to ensure that Clark County children are safe from child abuse and neglect. Even before the first call to the Hotline, the Department of Family Services (DFS) assumes the role of establishing prevention programs to keep children safe in the homes of their parents. Once a call is made and DFS intervenes in a family, this responsibility becomes critical and should be the major driving force for all actions of the agency and its staff. Children who become wards of Clark County are of particular concern since the County has assumed the role of "quasi-parent" for these children, making major decisions impacting their lives. In this role, DFS is obligated to ensure that these children are safe, attain a permanent living arrangement, and have their basic needs met.

This review focused specifically on children who had become wards of the county following an incident (or incidents) of child abuse or neglect. However, because the investigation of the abuse/neglect had a great impact on the type and degree of DFS intervention, some findings and recommendations do reflect issues regarding the investigation rather than after the child became a ward.

In addressing the safety issue, forms documenting the two major protocols designed to keep children safe were analyzed: the Safety Assessment Protocol (SA) and the Family Risk Assessment Protocol (FRAP). In addition to the information gathered from these documents, other information was also taken into account, including:

- Frequency of visitation with the child
- The worker's understanding and accurate perception of the safety and risk elements in the specific case
- The comprehensiveness of the investigation and the information provided to the worker from the investigation
- Private interviews and/or observations of the child
- Use of collateral contacts
- Medical information
- The worker's awareness of the family's history with DFS and its impact on case planning

Considering these elements, along with the SA and FRAP, the reviewer rated the current safety of each child, using one of the three categories noted below. Since this determination is a major concern in evaluating a child welfare system, in addition to these definitions reviewers were provided multiple examples for each category.

1. SAFE: The worker was confident that the child is safe, and the reviewer agreed. Although many factors affected this rating, in general children with this

determination were visitied regularly and recently. Identified risk elements were being addressed and the worker was knowledgeable about the current status of the family regarding child protection issues. For example, the reviewer ensured that the worker knew the reason for DFS involvement, the progress on the case plan objectives, and the plan for the next few months.

2. UNCLEAR, MINOR ISSUES: The caseworker was reasonably confident that the child is safe. The reviewer generally agreed, but felt that some issues needed to be cleared up – an updated safety assessment, more private interviews with the child, unsupervised home visits, historical case information needing addressed that the worker wasn't aware of, etc. A number of cases in this category had no major unaddressed safety factors, but the child hadn't been seen for two months or more and could not be assumed to be safe. Given issues involving kids missing or severely injured in foster homes and/or relative placements, the fact that the child was in such a placement was not seen as guaranteeing safety if no visit had been conducted for months.

3. UNCLEAR, ACTION NEEDED: The caseworker may or may not have felt that the child is safe. The reviewer determined that some type of timely or immediate action was necessary to support the worker's opinion. The worker was informed of the specific actions that the reviewer felt needed to be taken, but was advised to discuss the situation with supervisory staff immediately. The worker was also told that the reviewer would notify the supervisor or management staff of the reviewer's concerns.

The results of the reviewer's determinations are contained in the chart on the next page. Considering all 1352 cases, these determinations were made:

• SAFE	885	(65.4%)
• UNCLEAR, MINOR CONCERNS	381	(28.2%)
• UNCLEAR, ACTION NEEDED	86	(6.4%)

CHILD'S CURRENT SAFETY STATUS

Children in Substitute Care:

	Safe	Unclear With Concerns	Action Needed	Total
South	68 (67.3%)	24 (23.8%)	9 (8.9%)	101
Central	345 (68.9%)	130 (25.9%)	26 (5.2%)	501
North	104 (64.2%)	48 (29.6%)	10 (6.2%)	162
East	80 (77.6%)	23 (22.3%)	0 (0%)	103
West	52 (62.7%)	25 (30.1%)	6 (7.2%)	83
Total	649 (68.3%)	250 (26.3%)	51 (5.4%)	950

Children in Intact Families:

	Safe	Unclear With Concerns	Action Needed	Total
South	37 (62.7%)	19 (32.2%)	3 (5.1%)	59
Central	136 (61.8%)	64 (29.1%)	20 (9.1%)	220
North	32 (54.2%)	22 (37.3%)	5 (8.5%)	59
East	18 (51.4%)	15 (42.9%)	2 (5.7%)	35
West	13 (44.8%)	11 (37.9%)	5 (17.2%)	29
Total	236 (58.7%)	131 (32.6%)	35 (8.7%)	402

Totals for All Children Reviewed:

	Safe	Unclear With Concerns	Action Needed	Total
South	105 (65.6%)	43 (26.9%)	12 (7.5%)	160
Central	481 (66.7%)	194 (26.9%)	46 (6.4%)	721
North	136 (61.5%)	70 (31.7%)	15 (6.8%)	221
East	98 (71.0%)	38 (27.5%)	2 (1.5%)	138
West	65 (58.0%)	35 (32.2%)	11 (9.8%)	112
Total	885 (65.4%)	381 (28.2%)	86 (6.4%)	1352

The "safe" category ranged from a high of 71% in the East Site to a low of 58% in the West Site. The other three Sites ranged from 61.5% to 65.6%. Regarding the "Action Needed" category, the range was from 9.8% in the West Site to 1.5% in the East Site. Other Sites ranged from 6.4% to 7.5%.

Some differences were noted between children living with their parents and those in substitute care. Those in substitute care were determined to be safer -- 68.3% to 58.7%, and less likely to fit into the "action needed" category – 5.4% to 8.7%. This is not surprising, since any decision to leave a child in a home that has been "Substantiated" for abuse or neglect involves some level of risk. The focus of the caseworker and supervisor must be on ensuring that the risk elements are accurately identified and appropriately monitored and managed.

These results reflect a major improvement over the findings from the first 135 cases reviewed. Four factors have had an impact on this enhanced performance:

- New training focusing on the basics of child welfare/protection work, particularly addressing risk and safety issue identification.
- Increased visitation with children, partially due to the requirement that all children be photographed by the caseworkers this summer.
- The review itself; many workers openly stated that they had gone out to see their children and conduct safety assessments when they learned that a review was scheduled. In some cases, these children hadn't been seen for months, so their safety was unclear prior to the recent visit.
- Increased supervisory oversight was apparent. Early in the review process, reviewers rarely saw, or heard about, a supervisory conference on a case; these became much more prevalent near the end of the review.

With few exceptions, workers were very receptive to suggested actions that would make them feel more comfortable about the safety of the children on their caseloads. In fact, three reviewers were asked to review cases not even on the list, as the workers wanted the reviewers' input on how to proceed with the families. However, one particularly disturbing situation was identified and referred to management with a recommendation to review the worker's entire caseload. It should be noted that, for several of the cases that were cited as "action needed", the caseworker agreed with the reviewer that the children were potentially not safe. Two examples that came up a few times: (1) judges returning children to homes in opposition to the worker's recommendations; (2) situations where the caseworker felt that the investigator should have taken protective custody of a child, but didn't. This process gave the workers a forum to get these cases highlighted.

Despite the improvements noted above, the reviewers were unable to state that they were confident that children were safe in over 1/3 of the cases reviewed. It is clear that the protocols and processes in place for ensuring the safety of children on a daily basis are not working as well as they should. The issues of supervisory oversight and the training staff received for identifying risk and safety issues have improved, but need to continue to be a daily focus for supervisors and must be incorporated into ongoing training.

The rest of this section provides information concerning the usage of the protocols that the county has identified as the primary tools for keeping children safe: Safety Assessments and Family Risk Assessment Protocol.

Safety Assessments

Safety assessments were determined to fit into one of three categories:

- Current in UNITY: There was at least one safety assessment that accurately reflected the current safety status of the child. No event (such as return home, case closure, new birth, etc.) had occurred that would require a new safety assessment.
- In UNITY, not current: There were one or more safety assessments in UNITY, but the most recent one did not reflect the current safety status of the child. The safety assessments that were present were either outdated and did not accurately reflect the safety issues identified in the case record and interview.
- Not in UNITY: No safety assessment was in UNITY records.

The chart on the next page reflects the findings for each site regarding the presence of safety assessments in the cases reviewed. For DFS as a whole, there were current safety assessments in 56.8% of the 1352 these cases. Another 37.7% had at least one safety assessment, but the most recent one was not current or was inaccurate. In 5.8% of the cases, there was no safety assessment in UNITY, and the caseworker could not produce documentation of one during the interview.

COMPLETION OF SAFETY ASSESSMENTS

Safety Assessment, Children in Substitute Care:

	Current	Not Current	None	Total
South	67 (66.3%)	33 (32.7%)	1 (1.0%)	101
Central	267 (53.3%)	205 (40.9%)	29 (5.8%)	501
North	98 (60.5%)	50 (30.9%)	14 (8.6%)	162
East	61 (59.2%)	34 (33.0%)	8 (7.8%)	103
West	37 (44.6%)	43 (51.8%)	3 (3.6%)	83
Total	530 (55.8%)	365 (38.4%)	56 (5.8%)	950

Safety Assessment, Children in Intact Families:

	Current	Not Current	None	Total
South	39 (66.1%)	18 (30.5%)	2 (3.4%)	59
Central	134 (60.9%)	81 (36.8%)	5 (2.3%)	220
North	32 (54.2%)	19 (32.2%)	8 (13.6%)	59
East	16 (45.7%)	16 (45.7%)	3 (8.6%)	35
West	17 (58.6%)	11 (37.9%)	1 (3.5%)	29
Total	238 (59.2%)	145 (36.1%)	19 (4.7%)	402

Safety Assessment Totals for All Children Reviewed:

	Current	Not Current	None	Total
South	106 (66.2%)	51 (31.9%)	3 (1.9%)	160
Central	401 (55.6%)	286 (39.7%)	34 (4.7%)	721
North	130 (58.8%)	69 (31.2%)	22 (10.0%)	221
East	77 (55.8%)	50 (36.2%)	11 (8.0%)	138
West	54 (48.2%)	54 (48.2%)	4 (3.6%)	112
Total	768 (56.8%)	510 (37.7%)	74 (5.8%)	1352

In-home cases were more likely to have a current SA (59.2% versus 55.8%), and were slightly less likely to have no SA at all – only 19 of the 405 in-home cases had no SA, while 9.1% of the placement cases had none in UNITY. The presence of a current SA ranged from a high of 66.2% in the South Site to 48.2% in the West Site. The other Sites ranged from 55.6% to 58.8%. The North Site had the highest rate of cases with no SA found at 10%. The West Site had the fewest cases containing no SA – 3.6%. The other Sites percentage of cases missing SAs ranged from 8% in the East to 4.1% and 4.7% in South and Central, respectively. It must be noted that the West Site has by far the highest percentage of SAs that were in the file, but not current, implying that there is a need for information regarding the timelines or milestones that SAs are required.

During the early part of this review there were such major issues regarding safety assessments that the reviewer met with Clark County DFS management staff to assure that he was correctly interpreting the policy for this protocol. Problems included:

- Almost all workers were unclear on the milestones that require a safety assessment. Many children were returned home or began unsupervised visits without a new SA. New babies were born into abusive families, paramours moved in, parents moved into relative placement homes, and cases were closed – SAs on these cases were the exception, not the rule.

- Nearly all the staff viewed the SA as a form that is required prior to completing an investigation or to document some action taken. Very few cases displayed any evidence that the SA was used as a structured decision making device to assist them in determining whether safety issues exist and whether removal of the child was warranted.

- A substantial number of the safety assessments simply were illogical. For example, no factors would be identified, the child would be determined "safe", but protective custody was taken. Another example that occurred frequently is that several factors were checked, but the child was determined to be "safe" and no action was taken. (Similarly, some SAs had no factors checked, but the child was determined to be "unsafe").

- The UNITY system apparently requires that a safety assessment be completed that deems each child named in the file as "safe" before a case can be closed. The problem with this requirement is that many times children are named in the case who have been adopted or placed with relatives out-of-state months or years ago. It is illogical and dangerous for caseworkers to sign a safety assessment certifying that these children are safe when they have never seen or spoken to them. The reviewer advised workers that, if this remains a requirement, they should ensure that a case note is documented to make it clear that they have not seen the child (and they certainly don't know whether the child is safe).

Although the numbers of current Safety Assessments improved during the course of the review, the absence of current SAs in so many cases is a problem that DFS must continue

to aggressively address with caseworkers and supervisors. Safety assessment protocols have been research-validated to be valuable when used appropriately. Retraining regarding safety assessments is vital, particularly focusing on using them to drive decision making. Since nearly 44% of the cases reviewed lack a current safety assessment, caseworkers have not accepted the notion that a properly conducted safety assessment can help them make better, well-supported decisions, thereby making children safer. A second outcome of more competent safety assessments could be that some of the children now spending lengthy periods of time in placement may not have to be removed at all. Research has shown that safety assessments can help workers do a better job of identifying the kids who really are in danger and finding alternative methods to work with those who are not.

Risk Assessments

The Family Risk Assessment Protocol (FRAP) is used by Clark County to determine the ongoing risk to a child. FRAP usage was divided into three categories:

- Current in UNITY: There was a FRAP in UNITY that reflected the current risk status of the child and family.
- In UNITY, not current: There were one or more FRAPs in UNITY, but the most current one did not accurately reflect the current risk or document major changes in the family.
- Not in UNITY: There was no FRAP in UNITY and the worker was not able to provide one during the interview.

The chart on the following page documents the prevalence of the FRAP in the cases reviewed. Countywide, current FRAPs were present in only 29.8% of the cases; 56.8% of the cases reviewed had no FRAP at all.

COMPLETION OF FAMILY RISK ASSESSMENT PROTOCOLS

Family Risk Assessment Protocol, Children in Substitute Care:

	Current	Not Current	None	Total
South	15 (14.9%)	5 (4.9%)	81 (80.2%)	101
Central	158 (31.5%)	75 (15.0%)	268 (53.5%)	501
North	47 (29.0%)	14 (8.6%)	101 (62.4%)	162
East	34 (33.0%)	14 (13.6%)	55 (53.4%)	103
West	21 (25.3%)	16 (19.3%)	46 (55.4%)	83
Total	275 (28.9%)	124 (13.1%)	551 (58.0%)	950

Family Risk Assessment Protocol, Children in Intact Families:

	Current	Not Current	None	Total
South	11 (18.6%)	4 (6.8%)	44 (74.6%)	59
Central	82 (37.3%)	37 (16.8%)	101 (45.9%)	220
North	16 (27.1%)	6 (10.2%)	37 (62.7%)	59
East	6 (17.1%)	4 (11.4%)	25 (71.5%)	35
West	13 (44.8%)	6 (20.7%)	10 (34.5%)	29
Total	128 (31.8%)	57 (14.2%)	217 (54.0%)	402

Family Risk Assessment Protocols for All Children Reviewed:

	Current	Not Current	None	Total
South	26 (16.5%)	9 (5.6%)	125 (78.1%)	160
Central	240 (33.3%)	112 (15.5%)	369 (51.2%)	721
North	63 (28.5%)	20 (9.1%)	138 (62.4%)	221
East	40 (29.0%)	18 (13.0%)	80 (58.0%)	138
West	34 (30.3%)	22 (19.7%)	56 (50.0%)	112
Total	403 (29.8%)	181 (13.4%)	768 (56.8%)	1352

Intact family cases were slightly more likely to have a current FRAP on file (31.8% to 28.9% of placement cases). The South Site had no FRAP in 78.1% of the cases reviewed, while both West and Central had completed at least one FRAP in about half of the cases (50% and 48.8%). Current FRAPs were present in the South Site in only 16.1% of the case files; the rate in the other Sites ranged from 28.5% to 33.3%. Since the current risk assessment process is less than a year old, it may somewhat explain the low compliance rate noted here. However, risk assessment should be on-going, and every case opened prior to the FRAP training should have had a risk assessment by now. As with the Safety Assessment, FRAP compliance clearly improved as the review progressed. The training that occurred clarified some of the confusion caseworkers had, particularly the notion that FRAPs are only for investigators. All reviewers were instructed to review the mandated timelines for FRAP completion with every caseworker.

As noted in the section on safety assessments, there were so many problems identified with the FRAPs that the project manager met with DFS management staff to ensure that he was clear on the protocol and policy. These included:

- Identifying milestones for a FRAP to be completed was confusing for nearly every worker. Some saw it as an investigative process that had nothing to do with them. Others were not clear as to when, or if, they should ever do one.

- FRAPs are confusing because they contain all the safety factors that are in the safety assessment, just organized differently. Of the FRAPs reviewed, many had different responses to the presence of these factors than identified in the safety assessment, even if the two documents were completed on the same day.

- FRAPs were often internally inconsistent. For example, no safety factors were checked, but the conclusion was that the children were unsafe and a case needed to be opened. Or, safety factors were checked, but no case was opened.

- Despite the training that occurred, nearly 10% of the staff interviewed during the first six weeks of the review claimed to have never heard of FRAP. During the latter weeks of the review, this issue seemed to be resolved.

The integration of the FRAP and the safety assessment is vital if either of these protocols are to become valuable tools for workers to accurately identify safety issues and on-going risk to children. Even many of the workers who completed the FRAPs voiced strong opinions that it was "busy work" and did not help them in making critical decisions. Reviewers did not encounter a single worker who stated that the FRAP helped focus case plans or immediate actions to ensure children are not subsequently maltreated. Several supervisors also expressed their opinion that this form is a waste of time and serves no useful purpose.

Child Safety Summary: Clark County DFS caseworkers are not taking full advantage of the safety and risk protocols that have been developed. These protocols are created to structure the decision making processes so that caseworkers are making accurate safety

and risk assessments throughout DFS's involvement with families. Many caseworkers are using them to document decisions after they've been made. As a result, the decision making is based upon each worker's individual experience, training, and education. Since this varies greatly among workers, it leads to inconsistency and decisions not supported by the facts of the case. Retraining must stress the purpose of these protocols, their efficacy, and their interrelatedness. Clark County has begun to retrain caseworkers on these vital protocols, and the positive effects of that training resulted in improved performances late in the review. However, a lot of work remains to be done in this area.

The Family Risk Assessment Protocol is vastly underused by caseworkers. It is a well designed document that can pull together all the elements of a case, providing much detail and connecting all the known facts to potential risk. As noted above, more than half of the cases had no FRAP at all. Many of the others were superficial and did not drive workers' decision-making.

The Safety Assessment, while more widely used, also is often being completed as an "after-the-fact" form, rather than a proactive, prescriptive protocol. The mindset of constantly assessing safety by applying the elements of this protocol is not yet ingrained in the vast majority of caseworkers participating in the review. It has become busy work – that needs to change.

SECTION 2 -- CASEWORKER VISITS

Many studies conducted of recidivism in child abuse/neglect cases have shown that the frequency of caseworker contacts with children and families in open cases is a major factor in keeping children safe from repeat maltreatment. Frequent visits also lead to fewer instances where it becomes necessary to remove children, as developing issues are identified at an earlier time and can be addressed. There is also significant value in talking to children privately in order to establish rapport and gain valuable information. Even children placed with good foster parents may disclose information to a caseworker privately that they are afraid or embarrassed to share with others. Therefore, three areas were reviewed regarding caseworker visits with children:

- When did the last visit occur? This item was categorized into one of three groups: within the past 30 days; 30-60 days; or over 60 days.

- How many times did the caseworker visit the child within the past twelve months? This item was also categorized into three groups: nine or more visits; 6-9 visits; or less than 6 visits. For cases opened less than one year, the number of visits was prorated.

- Is there documentation that the child was interviewed privately within the past 60 days? If the child was very young, this question noted whether the child had been observed privately. This was a "yes" or "no" response.

Because children and parents were not always seen on the same date, there is a separate chart documenting the frequency of caseworker contacts with parents.

Full results are presented in the charts on the following pages for each Site, as well as totals for the entire county. Each area is analyzed separately.

<u>Last visit with children</u>

Overall 45.7% of the children with open cases were seen within the 30 day period preceding the review; 31.3% within the prior 30-60 day period; and 23% had not been seen in more than 60 days. The complete chart for this category follows.

DATE OF LAST WORKER CONTACT WITH CHILD

Children in Substitute Care:

	30 days or less	30-60 days	60 days or more	Total
South	39 (38.6%)	33 (32.7%)	29 (28.7%)	101
Central	241 (48.1%)	152 (30.3%)	108 (21.6%)	501
North	56 (34.6%)	49 (30.2%)	57 (35.2%)	162
East	54 (52.4%)	24 (23.3%)	25 (24.3%)	103
West	31 (37.3%)	30 (36.2%)	22 (26.5%)	83
Total	421 (44.3%)	288 (30.3%)	241 (25.4%)	950

Children in Intact Families:

	30 days or less	30-60 days	60 days or more	Total
South	19 (32.2%)	22 (37.3%)	18 (30.5%)	59
Central	125 (48.1%)	67 (30.5%)	28 (12.7%)	220
North	20 (33.9%)	24 (40.7%)	15 (25.4%)	59
East	19 (54.3%)	11 (31.4%)	5 (14.3%)	35
West	14 (48.3%)	11 (37.9%)	4 (13.8%)	29
Total	197 (49.0%)	135 (33.6%)	70 (17.4%)	402

Totals for all Children Reviewed:

South	58 (36.2%)	55 (34.4%)	47 (29.4%)	160
Central	366 (50.8%)	219 (30.4%)	136 (18.8%)	721
North	76 (34.4%)	73 (33.0%)	72 (32.6%)	221
East	73 (52.9%)	35 (25.4%)	30 (21.7%)	138
West	45 (40.2%)	41 (36.6%)	26 (23.2%)	112
Total	618 (45.7%)	423 (31.3%)	311 (23.0%)	1352

Although children from intact family cases were seen somewhat more frequently in the past 30 days than those in placement, the difference was not huge (49% versus 44.3%).

There was, however, a significant variance from site-to-site. The East and Central Sites had seen slightly more than 50% of these children within the past 30 days (52.9% and 50.8% respectively), while the South (36.2%) and North (34.4%) Sites had conducted visits within 30 days with just over 1/3 of the children on their caseloads. The West Site was in the middle at 40.2%. Two issues may have impacted these results.

- The North Craig Site had two workers leave just before the review started and their cases were assigned to two workers who already had large caseloads, so visitation was a problem.

- The South Site had a supervisor and two workers leave midway through the review; their cases were distributed among other workers, including licensing and other staff..

Most workers attributed the lack of visits to heavy caseloads that forced them to prioritize cases that they felt were the highest risk. This is certainly a major factor, as some workers had more than 50 children on their caseloads, making frequent visits impossible. However, the review identified several cases that were clearly high risk but still had infrequent visits. Another contributing factor is that many workers felt that children in foster homes, at Child Haven, or with relatives were safe and did not need to be seen regularly. Several cases were identified where the caseworker did not see the child until months after being assigned the case because the child was moved from Child Haven to a shelter home to a foster home. These situations were discussed with the workers, with a focus on the need to know the child in order to appropriately assess and service the case. Given the fact that there have been several recent abuse/neglect situations in foster homes and relative placements, the assumption that children in such placements are automatically "safe" is troublesome.

Date of last caseworker contact with parents

Not surprisingly, parents were seen during the month preceding the review at a much lower rate than their children, 31.1% versus 45.7%. The chart on the following page provides both countywide and site specific information regarding caseworker contacts with parents.

DATE OF LAST WORKER CONTACT WITH PARENT(S)

Families with Children in Substitute Care:

	30 days or less	30-60 days	60 days or more	Total
South	17 (16.8%)	23 (22.8%)	61 (60.4%)	101
Central	127 (25.3%)	118 (23.6%)	256 (51.7%)	501
North	42 (25.9%)	31 (19.2%)	89 (54.9%)	162
East	28 (27.2%)	17 (16.5%)	58 (56.3%)	103
West	18 (21.7%)	21 (25.3%)	44 (53.0%)	83
Total	232 (24.4%)	210 (22.1%)	508 (53.5%)	950

Families with Children at Home:

	30 days or less	30-60 days	60 days or more	Total
South	17 (28.8%)	26 (44.1%)	16 (27.1%)	59
Central	122 (55.5%)	61 (27.7%)	37 (16.8%)	220
North	18 (30.5%)	25 (42.4%)	16 (27.1%)	59
East	19 (54.3%)	10 (28.6%)	6 (17.1%)	35
West	13 (44.8%)	10 (34.5%)	6 (20.7%)	29
Total	189 (47.0%)	132 (32.8%)	81 (20.2%)	402

Total for All Families Reviewed:

	30 days or less	30-60 days	60 days or more	Total
South	34 (21.3%)	49 (30.6%)	77 (48.1%)	160
Central	249 (34.5%)	179 (24.8%)	293 (40.7%)	721
North	60 (27.2%)	56 (25.3%)	105 (47.5%)	221
East	47 (34.1%)	27 (19.5%)	64 (46.4%)	138
West	31 (27.7%)	31 (27.7%)	50 (44.6%)	112
Total	421 (31.1%)	342 (25.3%)	589 (43.6%)	1352

As could be expected, parents receiving services while still having their children living at home were seen more recently than parents of children in substitute care, 47% to 24.4%. One major concern is that over 20% of the parents of children in open cases still living at home have not been seen in over 60 days. These are most often the persons identified as being responsible for the abuse/neglect that resulted in wardship of the child. Since permanency requires the parent to complete a case plan, regular visits are necessary both to assist parents with meeting their objectives and to monitor their progress. Also a concern in this area is that over half of the parents with children in out-of-home placements have not been seen for more than 60 days. This fact is somewhat connected to the fact that there are cases where parental rights are in the process of being terminated (or are already terminated) and worker contact may be minimal. However, the overall goal on most case plans is reunification. This cannot be achieved without consistent contact between the caseworker and the parent.

There were significant differences between the Sites in this category. Both Central and East had parental contact in the past 30 days in over 34% of their cases, while South had such contact in only 21.3%. It is also noted that both Central and East had fewer than 1/6 of their cases with no parental contact in the past 60 days for intact family cases. However, all offices had a "60 days or more" rating of over 50% for placement cases. Since Clark County management is committed to involving parents in the case planning process to ensure the safety and permanency of children, this area needs much attention focused on it.

Number of caseworker visits with the child in the past 12 months

The frequency of visitation by caseworkers with children on their caseloads is detailed in the chart on the following page. Overall, slightly over one-third of the children were seen nine or more times during the past year (36.4%). However, a similar number (36.5%) have been seen by the caseworker fewer than six times during the past 12 months. As noted earlier, for cases that have been open less than 12 months, the reviewer pro-rated the number of visits for this data item.

FREQUENCY OF WORKER CONTACT WITH CHILD DURING THE PAST YEAR

Children in Substitute Care:

	9 or more	6-9	Fewer than 6	Total
South	36 (35.6%)	31 (30.7%)	34 (33.7%)	101
Central	190 (37.9%)	139 (27.8%)	172 (34.3%)	501
North	37 (22.8%)	27 (16.7%)	98 (60.5%)	162
East	39 (37.9%)	28 (27.2%)	36 (34.9%)	103
West	19 (22.9%)	30 (36.2%)	34 (40.9%)	83
Total	321 (33.8%)	255 (26.8%)	374 (39.4%)	950

Children in Intact Families:

	9 or more	6-9	Fewer than 6	Total
South	28 (47.5%)	18 (30.5%)	13 (22.0%)	59
Central	102 (46.5%)	60 (27.3%)	58 (26.3%)	220
North	9 (15.3%)	15 (25.4%)	35 (59.3%)	59
East	14 (40.0%)	12 (34.3%)	9 (25.7%)	35
West	18 (62.1%)	6 (20.7%)	5 (17.2%)	29
Total	171 (42.5%)	111 (27.6%)	120 (29.9%)	402

Total for All Children Reviewed:

	9 or more	6-9	Fewer than 6	Total
South	64 (40.0%)	49 (30.6%)	47 (29.4%)	160
Central	292 (40.5%)	199 (27.6%)	230 (31.9%)	721
North	46 (20.8%)	42 (19.0%)	133 (60.2%)	221
East	53 (38.4%)	40 (29.0%)	45 (32.6%)	138
West	37 (33.0%)	36 (32.1%)	39 (34.8%)	112
Total	492 (36.4%)	366 (27.1%)	494 (36.5%)	1352

In this category, there were differences between intact family and placement cases. Children in intact cases were much more likely to have been seen nine or more times than children in placement (42.5% versus 33.8%). They were also less likely to have been visited fewer than six times (29.9% versus 39.4%).

In this area there were also significant differences from site-to-site. While the South, Central and East Sites were in the range of 38.4-40.5% of the children seen at least nine times, the rate for West was 33%, while the North rate was extremely low and cause for concern – 20.8%. The percentage of children seen fewer than six times in the past year is also an critical issue for the North Site -- 60.2%. The other Sites were all in the 29-34% range, which is certainly unacceptable when all these children have been "Substantiated" as victims as abuse and/or neglect.

Documentation that children have been seen privately by the caseworker in the past 60 days

This question was designed to elicit information about whether caseworkers are obtaining information from talking to or observing children rather than simply accepting the caregiver's statements. This is an essential area for both verbal and non-verbal children. Those children old enough to be interviewed will often not contradict or criticize a parent, foster parent, or other adult when they are in the presence of that adult. The DFS caseworker needs to establish a level of trust when each child so that the worker is seen as someone the child can be open and honest when discussing issues in the home. This kind of relationship requires some one-on-one time. For non-verbal children, observing them for bruises, diaper rash, growth and development, and attachment to adults is equally important in ensuring their safety and well-being. This area is one in which DFS caseworker's have not excelled. Overall, only 23.9% of the children have been interviewed or observed privately within the past 60 days. In real numbers, this means that over 1000 of the cases reviewed contained children who had not been seen privately by the caseworker. The chart on the following page provides statistical information for this element.

CHILDREN INTERVIEWED AND/OR SEEN PRIVATELY – PAST 60 DAYS

Children in Substitute Care:

	Yes	No	Total
South	15 (14.9%)	86 (85.1%)	101
Central	121 (24.2%)	380 (75.8%)	501
North	29 (17.9%)	133 (82.1%)	162
East	38 (36.9%)	65 (63.1%)	103
West	17 (20.5%)	66 (79.5%)	83
Total	220 (23.2%)	730 (76.8%)	950

Children in Intact Families:

	Yes	No	Total
South	7 (11.9%)	52 (88.1%)	59
Central	71 (32.3%)	149 (67.7%)	220
North	7 (11.9%)	52 (88.1%)	59
East	12 (34.3%)	23 (65.7%)	35
West	6 (20.7%)	23 (79.3%)	29
Total	103 (25.6%)	299 (74.4%)	402

Total for All Child Reviewed:

	Yes	No	Total
South	22 (13.8%)	138 (86.2%)	160
Central	192 (26.6%)	529 (73.4%)	721
North	36 (16.3%)	185 (83.7%)	221
East	50 (36.2%)	88 (63.8%)	138
West	23 (20.5%)	89 (79.5%)	112
Total	323 (23.9%)	1029 (76.1%)	1352

Children in intact cases were slightly more likely to be seen privately than those in placement (25.6% to 23.2%). There were significant differences in performance by Site. Staff in the East Site had met this criterion 36.2% of the time, while South Site workers had only 13.8% of the children privately. Three items of interest came up during the review:

- Several newer, inexperienced workers expressed that they thought this was a great idea, but that they hadn't been told to do this. They raised many questions about how to do this diplomatically without causing hostility with the parent, relative, or foster parent. After some discussion, most of these workers stated they would begin doing this right away.

- Several workers identified some very thoughtful strategies they used to ensure that they had private time with children, or at least to view them for injuries. (For example -- always changing the baby's diaper while visiting; taking children to wide open spaces so they won't wonder if anyone is listening at the door.)

- The South Site's results were undoubtedly impacted by the sudden departure of a supervisor and some caseworkers. The distribution of their cases to staff with already full workloads made this task more difficult.

Caseworkers who talk to their children privately tend to foresee problems coming and are better able to prevent them from escalating. For school-aged children, it is valuable for them to see the caseworker as someone outside-the-home who is their advocate; this is not possible if they never spend time alone with the worker. For smaller children, private observations will help workers feel more confident that this most vulnerable group is being well cared for.

Child Visitation Summary: The fact that over 23% of the reviewed children had not been seen for more than 60 days and that 36.5% had been seen fewer than 6 times in the past 12 months is cause for alarm. All of these are children who have already been maltreated and are in need of a supportive caseworker. Staff can get assistance from others – foster parents, community members, relatives – to help safeguard these children, but caseworkers must accept the ultimate responsibility to watch over them. When the county takes wardship of children, it assumes the burden of ensuring their safety, permanency, and well being. As an agent of the county, this task falls upon the caseworker. Training and supervisory meetings need to reinforce that this is not the role of the police, the court, or other entities; it is the role of the DFS caseworker. The fact that so few of these children are seen privately supports the notion that acceptance of this mandate and responsibility is often missing.

SECTION 3 – CASE PLANNING

It is crucial for a comprehensive case plan to be constructed with the parents that reflects the objectives, both short term and long term, which must be accomplished to ensure safety and reach permanency. The plan must be current, so that everyone is "on the same page" as to what is expected to be accomplished. The expert panel that reviewed child deaths in Clark County last winter found several cases with goals that were totally out-of-date. For example (not real names):

- Objectives that Johnny would attend day care three times a week when Johnny had been deceased for more than a year.
- Objectives that Billy and Susie would receive weekly counseling with their mother when Billy and Susie had been adopted two years earlier by a relative in Colorado.

Presence of a Current Case Plan

The case plans in UNITY were almost never updated, making it very difficult to determine just what was being worked on. An additional problem is that there was often a disconnect between the safety and risk factors identified and what was in the case plan. For example, a family that had a long history of arrests for various crimes had only one objective in the case plan -- to not commit crimes and to stay out of jail. When the worker was asked if the child be safely returned to the parent if the family accomplished this goal, the answer was a resounding "no", as there were a lot of additional concerns that needed resolution before the child could go home. Realizing that this family could appear in court and say that they had achieved their case plan goal, the worker agreed to quickly revise the plan.

Case plans were determined to fall into one of three categories:

- Current in UNITY: The case plan reflected the appropriate goals that would achieve child safety and permanency.
- In UNITY, but not current: There was a case plan in UNITY, but either the goals were totally outdated and no longer relevant, or they did not address the current risk and safety issues.
- Not in UNITY: No plan could be found in UNITY. Caseworkers were asked during the interview whether they had a signed case plan in their paper file. If they were able to produce one, it was assessed and appropriately categorized.

This review documented that 54.6% of the cases had a current case plan. Case plans were present, but not current, in 35.1% of the cases, while 10.3% had no documented case plan available. The chart on the following page provides data regarding the results of the reviewers' computations in this area.

CASE PLANS

Case Plan, Children in Substitute Care:

	Current	Not Current	None	Total
South	55 (54.5%)	24 (23.7%)	22 (21.8%)	101
Central	259 (51.7%)	193 (38.5%)	49 (9.8%)	501
North	92 (56.8%)	57 (35.2%)	13 (8.0%)	162
East	46 (44.7%)	43 (41.7)	14 (13.6%)	103
West	30 (36.2%)	46 (55.4%)	7 (8.4%)	83
Total	482 (50.7%)	363 (38.2%)	105 (11.1%)	950

Case Plan, Children in Intact Families:

	Current	Not Current	None	Total
South	39 (66.1%)	15 (25.4%)	5 (8.5%)	59
Central	143 (65.0%)	57 (25.9%)	20 (9.1%)	220
North	43 (72.9%)	15 (25.4%)	1 (1.7%)	59
East	17 (48.6%)	12 (34.3%)	6 (17.1%)	35
West	14 (48.3%)	13 (44.8%)	2 (6.9%)	29
Total	256 (63.7%)	112 (27.9%)	34 (8.4%)	402

Case Plan, All Children Reviewed:

	Current	Not Current	None	Total
South	94 (58.7%)	39 (24.4%)	27 (16.9%)	160
Central	402 (55.7%)	250 (34.7%)	69 (9.6%)	721
North	135 (61.1%)	72 (32.6%)	14 (6.3%)	221
East	63 (45.7%)	55 (39.8%)	20 (14.5%)	138
West	44 (39.3%)	59 (52.7%)	9 (8.0%)	112
Total	738 (54.6%)	475 (35.1%)	139 (10.3%)	1352

There were significant differences in the percentages for in-home cases versus placement cases. Intact family cases had current case plans in 63.7% of the cases, while only 50.7% of placement cases had them. Since DFS guidelines note that the parent(s) should participate in the case plan, it is likely that this partially accounts for this difference, since the parents in intact family cases are more readily accessible. The North Site had the best results here, with 61.1% of the cases having a current case plan, and 6.3% of the cases missing the plan entirely. The other sites' percentages of cases with a current plan ranged from 39.3% in the West Site to 58.2% at the South Site. However, the South Site also had the largest percentage of cases without any case plan available -- 16.9%.

Family Team Meetings

A second area analyzed regarding case plans was the prevalence of Family Team Meetings (FTM). This is the process selected by DFS to have caseworkers pull together family members, DFS staff, and relevant collaterals, to help make case decisions and formulate the case plan. These decisions could include: whether the child needs out-of-home placement; which relative is best suited to care for the child; who will monitor compliance with a safety plan, etc. Family Team Meetings are expected to occur whenever a case is passed from investigations to the permanency worker, and at other times when major case decisions need to be made. The chart on the following page provides data regarding the number of cases that have at least one documented Family Team Meeting.

FAMILY TEAM MEETINGS

Family Team Meetings, Children in Substitute Care:

	Within 3 Months	3-6 Months	None	Total
South	21 (20.8%)	17 (16.8%)	63 (62.4%)	101
Central	121 (24.1%)	66 (13.2%)	314 (62.7%)	501
North	29 (17.9%)	24 (14.8%)	109 (67.3%)	162
East	25 (24.3%)	13 (12.6%)	65 (63.1%)	103
West	26 (31.3%)	15 (18.1%)	42 (50.6%)	83
Total	222 (23.4%)	135 (14.2%)	593 (62.4%)	950

Family Team Meetings, Children in Intact Families:

	Within 3 Months	3-6 Months	None	Total
South	13 (22.0%)	11 (18.7%)	35 (59.3%)	59
Central	67 (30.5%)	38 (17.2%)	115 (52.3%)	220
North	9 (15.3%)	18 (30.5%)	32 (54.2%)	59
East	7 (20.0%)	5 (14.3%)	23 (65.7%)	35
West	10 (34.5%)	9 (31.0%)	10 (34.5%)	29
Total	106 (26.4%)	81 (20.1%)	215 (53.5%)	402

Family Team Meetings, All Children Reviewed:

	Within 3 Months	3-6 Months	None	Total
South	34 (21.3%)	28 (17.5%)	98 (61.2%)	160
Central	188 (26.1%)	104 (14.4%)	429 (59.5%)	721
North	38 (17.2%)	42 (19.0%)	141 (63.8%)	221
East	32 (23.2%)	18 (13.0%)	88 (63.8%)	138
West	36 (32.1%)	24 (21.4%)	52 (46.5%)	112
Total	328 (24.2%)	216 (16.0%)	808 (59.8%)	1352

In determining whether a Family Team Meeting occurred, the reviewer used both the UNITY notes and the interview with the caseworker. This distinction is important because UNITY does not have a category in the case notes system titled "family team meeting", so caseworkers used a variety of terms to identify them. After interviewing the caseworker, reviewers used their discretion in determining whether a case note actually referred to an FTM.

Countywide, 328 of the 1352 cases reviewed had documentation that an FTM occurred during the past three months (24.9%). Another 16% had FTMs during the time period of 3-6 months ago. However, that means that 808 of the 1352 cases (59.8%) had no documentation of an FTM during the past six months, despite FTMs being a mandated process in case planning. Intact cases were more likely to have had an FTM than placement cases, particularly when considering any FTMs within the past six months (46.5%-37.6%). Site differences were overwhelmingly significant. West Site had FTMs documented on 53.5% of the cases reviewed, while the other Sites were all in the 35-41% range.

Case Plan Summary: The majority of case plans in UNITY do not reflect the actual goals and objectives that are being addressed by the worker and the family. Some staff noted that the court reports are updated and contain more current information. If so, it is unclear as to the purpose of the case plan in UNITY. At the onset of this review, Family Team Meetings were identified by DFS Management as the "cornerstone" to the child welfare work in Clark County. It was clear that the Director expected an FTM to occur whenever a case was opened and at regular intervals after that. In fact, her presentation to the child death review national expert team stated this fact strongly. This review found that the use of the FTM as a major part of casework is not happening in the majority of cases. One interesting fact that did become apparent – caseworkers who used the family team meeting process at the beginning of a service case generally used it many times after that for the same case. Workers who were knowledgeable about FTM and had time to put them together found them valuable enough to use them repeatedly. It is worthwhile for Clark County management to consider using some of these staff to inform or train other staff on the value of FTMs if DFS is going to continue using this process.

BARRIERS TO PROVIDING OPTIMAL SERVICES/ UNMET NEEDS

During the case reviews, each worker was asked to respond to the following questions:

1. Were there any services that would have enabled you to better meet this family's needs that:

    - Are not available in Clark County?
    - Are available, but funds are not available to purchase them?
    - Are available, but there are lengthy waiting lists?

2. Concerning the other families on your caseload, are there unmet services needs that fit into the categories noted in #1?

Six items were frequently mentioned that are not actually services for families, but do impact the caseworker's ability to implement best practices and provide top notch child welfare casework:

- Caseloads that are too high was an issue raised repeatedly. Many caseworkers reported that they were working with cases involving 50, 60, or even 90 children. Even those staff who believe they have the skills and knowledge to implement best practice standards felt that they could not physically do so with such a high number of cases. Some workers, with no casework experience, reported that they were assigned more than 40 cases within their first week of work. Others reported that, despite having an overwhelming caseload, they were assigned 20 or more new cases due to a vacancy or promotion. It is apparent that Clark County DFS has recognized this issue and is taking steps to address it. A few staff interviewed late in the review stated that they had been given a small number of cases to begin, and that cases were gradually being added to their workload.

- There was a strong consensus among new staff that they were inadequately trained for the job they are expected to do. In fact, many reported that they were assigned cases before getting any training at all. Even veteran workers complained of new policies and practices being implemented with little or no training. Several workers stated that they were sent E-Mails advising them of a practice or policy change, with no opportunity to ask questions for clarification of any issues. Areas mentioned often included: safety assessments, case planning, court procedures and requirements, risk assessment, and direction on dealing with specific types of family situations (domestic violence, substance abuse, mental illness, teen parents, etc.). Staff also requested that specific types of training be developed (possibly on video tape), such as: working with autistic children, issues with premature births, HIV positive kids, etc.

- Staff noted that they are never provided with information on what resources are available for various family needs – for example: housing, WIC, emergency funds, all types of substance abuse treatment, employment training, IEPs, etc. Generally staff felt this is a "learn as you go" environment and that more veteran staff have access to and knowledge of many services that are unknown to newer workers.

- Supervision is problematic. Staff stated that many supervisors have no experience in casework and/or foster care. The expectation that on-the-job-training will occur is not realistic since many supervisors don't know the work, according to several staff. During the reviews, there were very few documented case conferences between caseworkers and supervisors. Also of concern is that the supervisors were invited to sit in on all of the reviews, but very few chose to do so. Obviously, they are extremely busy but their attendance was lower than expected. NOTE: In the final few weeks of the review, substantial improvement was noted in the use of supervisory case consultation. DFS management has recognized the need to improve in this area and begun to move in that direction.

- Policy and Procedures are often communicated through E-Mail. Therefore, there is no guarantee that staff read or understand them.

- A de-briefing should occur quickly when a child dies, and the worker for that child should be evaluated for post traumatic stress.

- Mixed caseloads (i.e., children in the same family assigned to different caseworkers) should be eliminated, as it is confusing to workers and requires a great deal of communication between workers that is not occurring. Although the reviewers were informed by management that no mixed caseloads, every reviewer encountered some of these, and all of them were problematic. In some cases caseworkers were moving in different directions (reunification versus termination of parental rights); in others, caseworkers for some of the children didn't even know the other children existed until informed by the reviewer.

The following is a comprehensive list of service needs and barriers to services that case workers identified. Not all these items are specific services, but they are included to document what workers feel would make the system work better.

- Transportation: Families in the child welfare system are required to complete a variety of activities in order to meet the objectives of their case plans. This includes such things as job hunting, attending employment training, getting substance abuse tests, attending substance abuse classes, receiving anger management or other domestic violence instruction, visitation with their children, and many others. Since many clients do not have cars and Las Vegas does not have a well-developed mass transportation system, this presents a major obstacle.

Although it appears that bus passes are readily available in some offices, other sites often run out of them.

- In-patient substance abuse treatment: Staff identified only one program in Clark County that has an in-patient substance abuse program that allows the parent and child to remain together -- Westcare/Healthy Families. Workers report that there is a waiting list of two months or more at all times. In patient programs that take adults without allowing their children to accompany them are also in short supply and have waiting lists. This item was mentioned by nearly every worker interviewed.

- Housing: Nearly all staff feel that there are many children in Clark County who could return to their parents if the housing issue could be resolved. The lack of section 8 slots and the lack of funds to provide security deposits on apartments were the most often mentioned items. However, many workers also mentioned that families often damage housing that is provided, or allow it to become trash-filled or filthy, then are again homeless. The need for in-home workers to help families learn to take care of their homes is noted below in the "homemakers" section below. The weekly rentals provide a necessary service, but often become overrun with people using drugs, making it difficult for DFS families to stay "clean".

- Homemaker services: Many staff felt that a homemaker program, which provides in-home services to help families learn to manage housekeeping, budgeting, etc., would be a valuable addition.

- Paraprofessional help: According to the caseworkers, there are two Family Support Specialists serving all of Clark County. As described, these are para-professionals who assist with transporting children and/or families for visitation (including sibling), getting families to court, taking children to medical appointments, helping pregnant clients get to pre-natal care, and a variety of other functions. Staff would like to see this program expanded, as the two current specialists are very busy and are not available to most staff (so social workers are doing all these duties).

- Counseling/Treatment programs that provide child care: Parents are required to attend a wide variety of treatment programs; few offer any child care. Parents often use this as an excuse for not attending regularly.

- In-Home Services: This item was mentioned by nearly all caseworkers, and includes many different functions -- parent training that occurs in-home; nutritious meal planning/preparation; child growth and development; disciplinary practices; infant care (including changing diapers regularly); couples counseling; family group work; etc.

- Early Childhood Services: Many of the children on DFS caseloads have various types of developmental delays. Early childhood services are available and are felt to be competent, but there are typically 2-3 month waiting lists. There are also delays in getting IEPs through the schools because there are waiting lists to get the necessary assessments completed to qualify the children for special education services.

- Substance Abuse Assessments: There is usually a 1-2 month waiting time in order to get a substance abuse assessment completed. In addition, some entities who perform these assessments do not accept Medicaid, so funding becomes an issue.

- Interstate Compact Delays: Many clients of DFS often identify relatives who reside in another state as the best living situation for their children while they work on their service plans. There have been great delays in getting background checks and assessments completed through the Interstate Compact. Although much of this delay is beyond the control of DFS because it is dependent upon the response time of other states, there are two issues that can be addressed internally. (1) The communication between the state ICPC unit and the DFS could be improved on both sides. DFS staff are not well-trained on the information that is needed for this process, so often the ICPC referral needs to be returned for additional materials. However, in some cases the ICPC unit took weeks to actually identify that information was missing, so the DFS caseworker thought the other state was working on the assessment when the referral was still sitting in Carson City. It appears that the state needs additional ICPC help, and the county needs an ICPC specialist. (2) The case review identified several cases where the decision to make an ICPC referral had been made several weeks earlier, but the caseworker had not submitted the referral to the state ICPC unit. Because this often meant the children were sitting at Child Haven, there is a need for caseworkers to treat this process as urgent.

- Family Preservation Services: On every case receiving FPS services, the caseworker identified it as a valuable, competent service. But often it took weeks on a waiting list to get FPS in the home. A few staff suggested privatizing this service may make it more available. Several staff noted that there were children on their caseload in foster care who could have been served at home if FPS had been readily available. When a safety factor has been identified, FPS could be an essential part of the safety plan to keep a family intact.

- Transporting kids at Child Haven: Apparently it is policy that, when a child has an off-grounds medical appointment, the caseworker must transport him. Although that may be an important function for serious medical situations, it should not be required for more mundane appointments.

- Medically Fragile Homes: Several staff feel that foster homes for medically fragile children are often not appropriately trained to provide the type of care necessary.

- Halfway Houses: Staff identified this as an issue for young parents who did not have supportive or appropriate families. The choice seems to be "leave them in foster care" or "return them to a risky situation with young parents". The suggestion is that the county could develop some monitored living situations for young parents and their children, which would allow for gradual disengagement.

- Placement Team: The concept of a centralized placement team in Clark County is fairly new. Many workers identified it as a major problem, causing delays in placements (and, therefore, children remaining at Child Haven too long). There are some obvious advantages to the placement team, but since staff see it as a problem, it is imperative that DFS conduct a review of these concerns and make improvements in the process.

- Unit Meetings: Many staff suggested that these meetings with supervisors are not used in the best way. Allegedly they often focus on discussions of vacation requests, use of county cars, and parking. Staff feel the meetings would be of more value if they were used to discuss policy changes, specific cases that are troublesome, and training items.

- Adoption Delays: Although many issues were identified as contributing to the lengthy time it takes to finalize an adoption, three were most frequently mentioned: subsidy negotiations take far too long and are inconsistent and unfair; getting a court date for finalization does not seem to be a priority; and outsourced social summaries take far too long (more contractors are needed).

- Mental Health: A recurring theme among workers is that the MH system is not tied into providing services to DFS families. The MH consortium is not productive – no community system of interconnected care has been developed. There were many other items noted in this area, including: clinical services are focused on the child, not the family; most available services are crisis-driven, with little follow-up; and the system is compartmentalized, with no coordinated system of care.

- County Cars: Either do away with them or make them accessible to all. The consensus is that the distribution/use of county cars is inequitable and that a few staff receive the vast majority of use of the cars. This is a significant morale issue.

- Relinquishment Issues: Because the relinquishment of parental rights can be a complex, difficult process, several staff suggested that a "relinquishment specialist" be hired.

- Domestic Violence Services: Some staff stated that there are 2-3 month waiting lists to get DV services, both for the victim and the perpetrator. However, there was no consensus, as other staff noted that they have no problem getting this service. There was general agreement that better services for children living in DV homes are necessary.

- Volunteers: Staff believe that there are many "busy work" type activities they do that could be handled by volunteers. They suggested that a volunteer coordinator be hired.

- Resource Development: Many staff stated that they did not know who was supposed to be identifying and developing new resources. Therefore, there is no one who is the repository of available services. One office has an intake coordinator, but staff repeatedly stated that they do not know what he does.

- Shelter Homes: Since shelter homes are limited to two special needs kids, they cannot take sibling groups of three or more, so the kids remain at Child Haven.

- Delays in transferring cases to foster care: Several staff felt that the overcrowding at Child Haven could be alleviated if cases were transferred more quickly to foster care. A bigger question is: why can't kids go directly to a foster home rather than Child Haven?

- Clerical shortages: Each unit (supervisor plus workers) should have a clerical person. Workers have to do a multitude of non-professional tasks that could be handled by a clerical. For example -- obtaining copies of birth certificates, tracking down immunization records, etc.

- Post Adoptive Services: These are generally seen as disorganized and available to only a few, resulting in many adoption disruptions.

- "Informal" Service Cases: This term is really a misnomer. In Clark County, when a case is opened for services, even when the children are not removed from their parents, court action is initiated and the children become wards of the county. This means that there is a great deal of extra paper work in writing court reports and a great deal of time spent in court (and waiting in the hall) when there is really no reason for the court to be involved. Additionally, these cases are often kept open longer than necessary while the worker awaits a court date and court approval to close. The apparent reasoning behind this policy was that, with the required court involvement, workers would only open the more serious cases and that caseloads would drop. This has not been the reality. The same cases are being opened, but now require the extra time and work.

STRENGTHS AND ISSUES IDENTIFIED

Strengths Noted

1. Clark County involves the natural fathers in service planning to a greater degree than many jurisdictions.
2. Many workers are enthusiastic about this review and other changes they anticipate coming, particularly new and/or younger workers.
3. Many workers know their cases "inside and out" without even checking notes.
4. Good workers are appalled by the actions of poor workers and not hesitant about citing examples.
5. Some workers expressed great appreciation for their supervisors.
6. Many workers seemed very receptive to learning more about child protection. Many of them felt like the review was somewhat of a training experience.
7. Most workers expressed positive viewpoints about foster parents.
8. There is a realization that this is not a "9 to 5" job and that often evening or weekend work is necessary to ensure good casework occurs.
9. The vast majority of workers expressed very positive attitudes about the children they work with and the goals of the agency.
10. As the review progressed, Clark County management took steps to address several of the issues identified by early review information, most notably: new training to focus on risk and safety elements; improvement and clarification in the role of the frontline supervisors; and requiring that current pictures be taken of every ward, thereby ensuring a home visit.

Issues Identified

1. Investigators and permanency workers often don't meet in a timely manner, and rarely do a "face-to-face" handoff in the presence of the family, even though it's a requirement. Several workers said that, on the few cases this was done, they were able to do a better job with the family.
2. Nearly all workers are confused about the purpose of the Safety Assessment (SA), the Family Risk Assessment Protocol (FRAP), the Case Plan (CP), and safety plans. The majority of cases had no FRAP at all. Many SAs were internally inconsistent (for example – no safety factors checked, child deemed safe, but protective custody was taken). Those who remembered the FRAP training at all mostly felt that the FRAP is just extra work and doesn't serve any useful purpose in serving the family and keeping kids safe – particularly because all the safety factor from the SA are repeated on the FRAP, making the distinction of risk/safety difficult. Also, the SA in UNITY is different than the paper version.
3. There is a major systems problem with the SA. Workers attempting to close a case must do a safety assessment on all children listed, even if they have been out of the family for years (or are dead). This gives the impression that they are

determining children to be safe who died years ago or who they haven't seen for years. The outside death review panel was extremely bothered by this.

4. Many workers are providing services to families that have extensive histories with CPS, but the worker has never read the file. On numerous occasions workers were startled when the reviewer provided case details (from the UNITY casenotes received) that they didn't know about. This included such things as older siblings that the parent was still visiting, previous serious child abuse incidents, and even current investigations that they weren't told about (see the next item).
5. Investigators often do not interview the caseworker when a new CA/N report is received on an open case – sometimes they don't even inform them. One worker was asked about a situation where a 2 y/o was found wandering down a major street twice within a two month period. She believed that there was only one incident that was explained adequately and she had just closed the case. She stated she would not have closed the case had she known of the second incident (it occurred two weeks prior to case closing).
6. There are rarely collateral contacts noted prior to investigators making a finding. In fact, in some incidences, even the child victim is not interviewed – just the parent/perpetrator. (If this is a documentation issue, these contacts should certainly be in UNITY)
7. Although DFS management requires that Child and Family Team Meetings (FTM) occur on all cases, documentation or credible information from the worker was found in only 34.1% of the cases reviewed. In most of those the worker complained that the FTM occurred very near the 45th day, leaving no time to put together a thoughtful case plan. (see next item).
8. Case plans are a problem. The permanency worker is expected to quickly write a case plan immediately after meeting the family. Then the plan is almost never updated. This has resulted in case plans failing to address major issues (and children inappropriately returned home) and case plans identifying goals for dead children.
9. There was a strong consensus among workers that the placement team was has created more problems than it has solved. The centralization of placement has it merits, but workers say it greatly delays placements (adding to Child Haven backlog) and keeps them from placing children in homes that they know are available and appropriate for the involved child.
10. In several cases workers and/or investigators told parents that it's okay for them to hit their kids -- just don't leave marks. In fact, in a few instances, the workers told the children that "your parents can hit you as long as they don't leave marks." This is a philosophical issue that impacts the entire agency and practice model. A CPS agency should not encourage parents to hit kids, nor should its agents imply to children that they are somehow able to stop it (by behaving better?). This attitude is not born out by any studies that this reviewer is aware of.
11. Workers do not conduct a new SA or FRAP when a new baby is born into a family with an open case (policy dictates that major changes require one).
12. Court involvement on intact families should go away. I was told by many workers that, in the past, these cases were not taken to court. Apparently the change was made with the notion that it would reduce caseloads by only serving

the most serious cases. That hasn't happened – instead, caseloads have gone up and now require extra work because of court involvement (or refusal to allow cases to close).

13. The Child Advocacy Center and victim sensitive interviewing is almost never used.
14. On split cases (those where different workers are assigned to different siblings), it is unclear as to who is supposed to work with the parents.
15. A repeated theme is that the worker is only responsible for the child specifically assigned to him/her. There are many cases where other children are in the home, but questions about their safety are not addressed because they are not wards.
16. Several cases involved new babies born and returned to parents while toddlers and older children are in protective custody. This seems contradictory – either the older children should be returned home, or the baby should be removed. It is hard to imagine a situation where a new infant is safe but a two year old is in foster care due to the high-risk home situation, given that the majority of child deaths and critical injuries occur to children under 18 months old.
17. Many staff stated that delays in transferring cases to foster care have contributed to the overcrowding at Child Haven.
18. Roles are unclear when an adoption worker is assigned.
19. The way case notes are structured, it is difficult to determine who was present at a "home visit", where it occurred, and which child said what ("SM" is used without specifying the child).
20. Frequently children at Child Haven or in foster care are not seen by the caseworker for long periods of time. This seems to imply that workers feel that they can assume these kids are safe. Recent events in Clark County should alert workers to the fact that every child on their case load must be constantly assessed for safety issues.
21. Very few of the cases reviewed documented any supervisory consults with the worker. Even inexperienced workers are "own their own" in making case decisions. Several workers were asked if their supervisors would know if they hadn't seen a child in 60 days or more; two out of 10 responded "yes". As noted earlier, this area showed improvement during the final weeks of the review.

RECOMMENDATIONS

1. Training on safety assessment, and risk assessment. Initial and on-going training in these areas is vital. However, this training should not be compartmentalized; it should be presented as an integrated model where each assessment connects with and builds on the others. The underlying philosophy of safety and risk assessments is not apparent to staff. The notion of these being part of a structured decision making process either has not been taught or was not adequately presented. Since workers view these as forms, not protocols, they do not use them to drive decision making. Clark County should consider a scenario-based test for workers to demonstrate proficiency at identifying risk and safety factors in various situations (violence, substance abuse, domestic violence, mental illness, etc.). During the course of this project, DFS began new training in this area that should have a positive effect on the future safety of children who become wards.

2. Supervision. Management must clarify the role of the supervisor, particularly regarding case consultations with caseworkers and oversight of risk and safety decisions. These meetings must occur regularly and be documented. Case notes from these meetings must include any specific directions provided to workers. Supervisors should be trained on new protocols and practices before the caseworkers (or concurrently) so they are able to support and reinforce good practice. The county should also consider a training team for all new workers so they can learn the job at a reasonable pace, under one outstanding supervisor, before transferring to a regular unit and picking up a full caseload.

3. Expansion of in-home services. There are few alternatives to out-of-home placements in Clark County when safety issues are identified. There are no "homemaker" contracts and only two para-professional Family Support Workers for the entire county. Many workers expressed that they often want this type of service, but know that it is unavailable. There are also few, if any, in-home parent training programs – despite the fact that these are generally much more successful than classroom based parent training sessions. Two services that workers identified as valuable in-home aids – Family Preservations Programs and Early Childhood Intervention – both have waiting lists and workers feel like they have to compete to get them involved with their families. In-home substance abuse programs/counseling is non-existent. In somewhat of a "catch 22", paid day care is readily available to foster parents, but often not to birth parents trying to get a job and get substance abuse treatment.

4. Caseload size. Establishing a solid case practice model is a necessity, but it is unrealistic to expect staff to implement it with high caseloads. Realistic caseload sizes, based upon CWLA or other national standards, must be established and sufficient positions funded to maintain these workloads.

5. Accountability. Despite a multitude of situations where county and/or state policies are not being followed, there appears to be little work on corrective plans.

The absence of critical contacts, investigations being "unsubstantiated" without ever seeing the alleged child victim, and inadequate or missing safety assessments demand administrative actions. Many caseworkers have several cases with no documented contacts with the children for months, yet it is apparent that no action was taken. Either the supervision was such that the supervisor didn't know about the issue, or simply did not handle it. One worker was identified by three different reviewers as having major, critical deficiencies in dealing with children and families that any child assigned to her was potentially at risk – it is unclear what action was taken on that situation.

6. Family Team Meetings. If county management believes that this model is the optimal way to implement a strengths-based, family centered system, these meetings need to be mandated and monitored. There are workers who conduct FTMs frequently on their cases and use them as a valuable case planning tool; they could be used in training other staff to incorporate these into everyday practice. Less than 35% of the reviewed cases had even one documented FTM.

7. Case Plans Must Be Updated. There are many reasons why the case plans should be regularly updated, but two stand out. First, workers tend to lose focus as to why DFS got involved with the family to begin with. A well-constructed, current case plan serves as a constant reminder of the risk and permanency issues that requires DFS involvement. Second, there is regular turnover in caseworker positions. A current case plan makes it much easier for the replacement worker to jump into the middle of a case without losing valuable time.

8. Stop filing court petitions on in-home, non-removal cases. Workers spend hundreds of hours preparing court reports, testifying, and sitting in the hallway outside of the courtroom waiting their turn. For placement cases, court action is unavoidable. For non-removal cases, however, court involvement is rarely needed. Well-trained social workers can work with families and accomplish their case plans without ever taking the family to court – it happens hundreds of times a day around the country. Caseworkers can use the extra time to conduct more visits with the children on their caseloads. Keeping these cases out of court also makes it easier to close them when the goals have been accomplished; this is a casework decision, not a legal one.

9. UNITY Review. Nearly every caseworker interviewed described UNITY as a difficult, time consuming system to use. Many of them had specific ideas on how to improve it. Management should convene a committee of users and computer experts to review the system and determine what changes are feasible (both programmatically and fiscally).

10. Agency Philosophy. DFS must play stronger role in gaining community acceptance as the leader in ensuring the safety of children. Too often caseworker contacts are delayed (or never occur) because the police are already involved or some other entity is already working on the situation. That mandate of bearing

the ultimate responsibility for the safety of Nevada children must be instilled in each worker, or they should be encouraged to work elsewhere.

11. Children Placed with Relatives/Parental Involvement. Staff are very unclear as to policy when a child is "removed" from the mother and placed with a relative (usually grandparents) and the mother then moves into grandmother's home. Many workers expressed uneasiness about such arrangements, particularly doubting that the mother is kept from unsupervised contact with the maltreatment victims. However, they are not clear about policy on this issue and are tentative about how to respond to these situations.

12. All the Children in the Family Deserve Protection. There are many cases where some of the children in the home are wards, but not all of them. In many of these situations, when the worker was asked about the welfare of status of one of the non-wards, the response was "he's not mine" or some similar remark indicating that the child is not a ward. Policy must be clear that all the children in the home are DFS's responsibility if there is an open case on the family.

13. Implementing Policy Changes. It cannot be assumed that policy changes sent through E-Mails or memos will be understood and implemented by all workers. Management should require that all new policies be distributed and discussed at team meetings, and that workers sign an acknowledgement that they received a copy.

14. Appealing a Judge's Ruling. If a judge makes a ruling that the worker feels endangers a child, there must be a process for immediately involving a Deputy Attorney General in an appeal. Sitting back and accepting a ruling that will hurt a child is just as problematic as making the ruling in the first place.

15. Hitting Children. DFS management staff should unequivocally take a stand against corporal punishment of children, particularly infants and toddlers. There is an excellent document, created by the National Committee to Prevent Child Abuse, that details 10 reasons why corporal punishment should never be used. Children who are hit as "punishment" are much more likely to end up in jail, become domestic violence perpetrators and victims, become homeless adults, drop out of school, and use drugs and alcohol. This well-documented information should go to all staff.

16. Substance Abuse Treatment. Expand both in-patient and out-patient substance abuse programs. However, since DFS would be a major consumer of these services, management should insist on a lead role in their development so that the needs of DFS families are met. Similarly, more substance abuse assessment programs should be created so that families have immediate access to them.

17. Clerical Help. Each team of five workers and a supervisor should have a clerical person. Caseworkers do many non-social work tasks that prevent them from

spending time with the children on their caseloads; tasks that could be preformed by a clerical. These would include such things as: tracking down birth certificates, filling in the blanks on court petitions, getting immunization records, etc.

18. Monitored Living Situations. A lot of young parents have their children removed because they lack basic parenting and self-management skills. Workers are afraid to leave their children home because of the limited ability to monitor them. Halfway houses would allow the children to stay with their parents while the case plan objectives are being met.

19. Shelter Homes. These are similar to emergency foster homes in other jurisdictions, and they are rapidly disappearing around the country because the built in "automatic move" is not a good experience for children. This process needs a review, including a analyzing the need for kids to go to Child Haven first, rather than directly to a shelter (or foster) home.

20. Resource Directory. A comprehensive resource directory needs to be available to every caseworker in an easy-to-use format. DFS should also have a "resource fair" with providers setting up booths so that caseworkers can meet them and learn about their services.

CONCLUSION

The Clark County child welfare system has clearly been in a crisis situation for a long time. High caseloads, lack of a practice model, inadequate supervision, non-focused training that is not integrated, weak internal communication, and inconsistent accountability have been both symptoms and results of this crisis.

Areas that are most deficient are:

- Irregular visitation with children who are under DFS protection and wardship
- Lack of an understanding of what elements make children safe, and the value of protocols designed to identify risk and safety
- Little supervisory oversight, both in terms of ensuring accountability and providing guidance on cases
- Vague policies that are not consistent with research-based best practice standards

Management at the Department of Family Services has recognized the widespread extent of these problems and has begun to take action to address them. Hiring sufficient staff is a major first step, as workers cannot meet "best practice" standards with caseloads far above the ideal. The current training is a big step forward, as the curriculum focuses on the basics rather than esoteric philosophy. Workers need to know how to delve into family dynamics, to forensically interview children, to understand the effect of domestic violence on children, and to analyze parental use of drugs and its effect on child protection. However, first they must actually go see the children and the parents. They must recognize the value of regular contact and seeing the children privately. Only then can they be effective in the more indepth practices necessary for good child welfare work.

DFS caseworkers must be trained to understand that each of these children is their responsibility for maintaining safety and well being. The police, the courts, the substance abuse agencies and other providers are adjuncts to the work of DFS – not the other way around. These entities have taken on a bigger role because of the vacuum that existed in child welfare. DFS must fill that vacuum with a sufficient number of well-trained, professional caseworkers.

This situation is fixable. Management is moving in the right direction, but must get all staff committed to making these improvements.

DRAFT

ATTACHMENT 1

REVIEWER FORMS

DRAFT

FILE REVIEW FORM

This document is to be used to assist reviewers in documenting pertinent information when reviewing the case notes, case plans, safety assessments, and risk assessments prior to meeting with the caseworkers. It may also be used to help structure the interview. This form is not mandated, as reviewers may wish to utilize another method to take notes while reading the background information.

Case Name: Caseworker:

Names and Birthdates (or ages) of all family members:

Summary of Case Involvement for each year from initial involvement until July 2005 (NOTE: this should include any gaps in contacts, new CPS reports, concerns about past investigations and/or services). It is essential to review this information with the caseworker, as the earlier review noted that many workers had not read the file and were not aware of critical information from earlier involvements. Include why the Department is involved with the family:

Chronology of Contacts since July 2005 (who, when, where, what was discussed)

Current living arrangement for the children; current status of the case

History of Safety Assessments, including identified issues (this should be used as a teaching experience for workers, even if they didn't complete the problem assessments themselves:

History of Risk Assessments, including identified issues (same comment as above:

History of Case Plans – Is the caseworker working from the most recent plan?

0-5 CASE REVIEW PROJECT
INTERVIEW FORM

Case Name: _____ **Date of Review:** _____

Caseworker/Site: _____ **Reviewer:** _____

Case Overview, Including Family Composition and birthdates:

Results of Review

1. Contacts/Visitation

A. Date of Last Visit:

Parent(s): _____ Other Caregiver(s) _____
Involved Child(ren): _____
_____
_____

B. Pattern/Frequency of Visitation over the past 12 months:

Dates Child(ren) seen at home:

Other contacts with child(ren) -- (office/phone/court):

Is there documentation that the children were seen/interviewed privately?

Strengths/Issues Noted for Contacts/Visitation:

2. Safety Assessment

A. Date of Last Safety Assessment _____ Is it current? _____

B. Does the Safety Assessment Accurately Match the Facts of the case as documented in the file?

C. Is the most recent Safety Assessment Internally Consistent?

D. If a Safety Plan is required, is there one? Does it have an adequate monitoring component?

E. Can it be reasonably assumed that the child(ren) is safe? Why or Why not? (It is critical that the reviewer is very specific on this response.)

Strengths/Issues regarding safety assessments:

3. Family Risk Assessment Protocol (FRAP)

   A. Date of the most recent FRAP _____Is it current?_____

   B. Is it accurate/consistent with case notes and facts of the case?

   C. Is it tied to the case plan?

   D. Have events occurred during the past six months that required a new FRAP? (new birth, child returned home, unsupervised visits begun, new CPS report, etc.) If so, was one completed?

Strengths/Issues regarding risk assessments:

4. Case Planning

A. Date of last case plan _____Is it current? _____

B. Date of the most recent Child and Family Team Meeting _____
Were all essential family members and service providers present?

C. Are the primary and concurrent permanency goals clearly identified and made known to the family?

D. Is the service plan reflective of those goals – if the plan's objectives are accomplished, will the permanency goals be met?

E. Does the service plan address the issues noted on the safety and risk assessments?

F. Is there documented progress toward the goals?

G. Is there an expected case closing date identified?

Strengths/Issues regarding the case plan:

H. Do any red flags exist that require immediate supervisory intervention?

I. Is there a need for the children or family to be immediately visited and assessed?

5. Have barriers or unmet service needs been identified? Is there a plan to address or overcome these?

CONCLUSION/OVERALL ASSESSMENT OF THE CASE

REVIEW DATA FORM

This document must be completed for each review:

Case Name: Site: In or out-of-home:

Reviewer: Date of Review:

Last documented in-person contact with the children

Within the past 30 days ___
30-60 days ___
More than 60 days ___

Last documented in-person contact with the parents

Within the past 30 days ___
30-60 days ___
More than 60 days ___

Frequency of in-person contacts with the children over the past 12 months

At least 9 times ___
6-9 times ___
Fewer than 6 times ___

Documentation that the children have been seen/interviewed privately in the past 60 days

Yes ___
No ___

Safety Assessment

Yes, current ___
Yes, not current ___
None ___

Risk Assessment

Yes, current ___
Yes, not current ___
None ___

Case Plan

Yes, current ___
Yes, not current ___
None ___

Family Team Meeting

Within the past 3 months ___
Within the past 6 months ___
None ___

SAFETY DETERMINATION FORM

Each case reviewed must be categorized into one of the options noted below. Specific comments are required to justify the selection.

Case Name:
Reviewer:
Caseworker:

Date of Review:
Site:

SAFE _____
UNCLEAR, SOME CONCERNS _____
UNCLEAR, ACTION NEEDED _____

Justification

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