



***West Virginia
Department of Health and Human Resources
Bureau for Children and Families***



Strategic Plan

*Reduction of Dependence on
Out-of-State Placement of Youth*

July 2004



Strategic Plan

Reduction of Dependence on Out-of-State Placement of Youth

Executive Summary

Purpose

- Develop a strategic plan containing specific strategies and time frames to significantly reduce the dependence on out-of-state placement of West Virginia youth.
- Establish a committee that is representative of family members and stakeholders serving our children and families.

Parameters Established by Stakeholders

- Decisions will be made based on what is in the best interest of the children being served. The decisions must meet individualized needs and best practice through evidence based approaches.
- The plan is a “working” document. Continuous monitoring will occur as it relates to the effectiveness of what is implemented and/or changes made in practice.
- Direct practitioners, systems analysts shall review the plan throughout the two years. Children and families shall likewise be involved in the community review.
- Reviews of national trends which concentrate on community based, child centered, family focused program models shall occur as part of the plan review.
- A definition of out-of-state placements in relationship to the border counties has been established.
 - Community based refers to a facility, program or service located within fifty miles radius of the youth’s home or family/involves community participation in planning

Data Analysis

- A point-in-time review of children/youth in out-of-state placements excluding foster care, trial adoptions and kinship care was conducted. March 31, 2004 was randomly selected.
- 369 out of 3,268 children/youth (11%) in care of the WVDHHR were in out-of-state placements.
- 60 youth were being served in Psychiatric Residential Treatment Facilities (PRTF). Of these, 25 of the youth were identified with sexually reactive/offending behaviors.

- 309 children/youth in out-of-state placements were authorized or reviewed by APS Healthcare, Inc. More than 30 percent have substance abuse issues; 83 percent were males, and 17 percent were females.
- The regional breakdown of the 369 was:
 - Region I accounted for 141 or 38 %
 - Region II accounted for 58 or 16%
 - Region III accounted for 127 or 34 %
 - Region IV accounted for 43 or 12 %
- 15 of the 55 counties have ten or more in out-of-state placement
- Further evaluation will occur to determine the caseload number of children/youth in custody compared to the number of children/youth in out-of-state placements.
- The plan initially focuses on the implementation of the identified system changes with two populations: substance abuse and sexually reactive/offending behaviors.

New Initiatives

- **New Initiatives focus on Child Protective Services (CPS) and Youth Services (YS) populations within the Bureau for Children and Families.**
- **Comprehensive Assessment and Planning System (CAPS) July 2004**
 - CAPS focuses on safety/risk issues for children/youth that put them at risk of out-of-home placement.
 - CAPS systematically approaches the assessment of children and families to meet DHHR goals for the federal outcomes for safety, permanency and well-being.
 - CAPS will expand to include all appropriate child welfare cases.
 - CAPS will meet the mandate incorporated into legislation (HB 4649).
- **Socially Necessary Services (SNS) July 2004**
 - SNS are interventions necessary to improve relationships and social functioning with the goal of preserving the individual's tenure in the community and family.
 - The Administrative Service Organization (ASO), APS Healthcare, process is to insure that families and children receive the most appropriate services in the most cost effective manner.
 - ASO will provide retrospective quality reviews of services and trainings.
 - Availability of services when needed as part of child welfare case planning will be assured.
- **Community Based Team (CBT) July 2004**
 - Intensive family reunification/preservation community based teams reunify youth returning from out of state/special needs placements that require multi-agency involvement.
 - Provide for the collaboration of local community based providers willing to work together in the best interest of children and families.

Future Directions - July 2004 to July 2006

- Increase statewide clinical capacity for both populations while continuing to assess the remaining population.
- Train clinical staff in the quality/evidenced based practices.
- Broker professional consultative relationships in the community to provide technical assistance.
- Develop community service capacity in the area of outpatient services including assessments and interventions.
- Expand foster family care and step down programs to address both the substance abuse issues and sexually re-active/offending behaviors.
- Formalize practice protocols and training for assessments, case consultations, MDTs, reunifications and linking with appropriate child serving systems.
- Establish statewide oversight and monitoring of the recommendations of the MDT, the number of court orders complying with the MDT legislation.

Outcomes

- Historical data shows the following number of children in the custody of the Department placed in out-of-state residential facilities. March 31st was selected as a random point-in-time date.

3/31/2000	315 Youth
3/31/2001	366 Youth
3/31/2002	368 Youth
3/31/2003	358 Youth

- Ability to track and capture the number of children and families served within the Child Welfare Services, the service utilization and the funds expended for each service area.
- By July 2006 the percent of children in the custody of the Department placed in out of state residential facilities will be reduced from 11 percent (11%) to three percent (3%).
- The quarterly benchmarks based upon the March 31, 2004 data will result in:

10/2004	11%	369 youth
01/2005	10%	327 youth
04/2005	9%	294 youth
07/2005	8%	261 youth
10/2005	6%	196 youth
01/2006	4%	130 youth
07/2006	3%	98 youth

“Continued development and refinement of the full service delivery system must continue. It must be based on the assessment of service needs at the community level including services which provide supports, prevention, intervention and treatment. These must be based on quality and be accessible and appropriate to our children and families within Child Welfare. To accomplish this will require a reinvestment of those dollars which are currently funding the placement of our children and youth in out-of-state facilities and out-of-home care.”

STRATEGIC PLAN

REDUCTION OF DEPENDENCE ON OUT-OF-STATE PLACEMENT OF YOUTH

NARRATIVE

Charge/Purpose

The West Virginia Department of Health and Human Resources has developed a strategic plan containing specific strategies and time frames to reduce the reliance on out-of-state resources to care for children and youth in the custody of the Department. A committee was established with representatives and stakeholders from the many disciplines currently serving our children and families both directly and systematically. The following stakeholders participated (for a specific list of representatives (see appendix A):

- Department of Health and Human Resources-
 - Bureau for Children and Families (BCF)
 - Bureau for Behavioral Health and Health Facilities (BHBF)
 - Bureau for Medical Services (BMS)
- Department of Education
 - Office of Institutional Education
 - Office of Special Education Programs and Services
- Department of Military Affairs and Public Safety
 - Division of Juvenile Services
- Supreme Court of Appeals
 - Probation Services
- APS Healthcare Inc.
- Alliance for Children, Inc.
- Kids First Network
- River Park Hospital
- Stepping Stones Inc.

Youth Academy

Braley and Thompson
Comprehensive Behavioral Health Facilities
Prevention Resource Center

Parameters

These stakeholders established several key parameters. First and foremost, every decision made will consider what is in the best interest of the children served. This allows for quality services that will meet their individualized needs utilizing best practice through evidence based approaches. Long-term, effective outcomes must not be lost in this process.

Secondly, the plan will remain a “working” document during the entire development and implementation period. Continuous monitoring of progress and effectiveness will allow for the strategies to be refined and/or altered as data and outcomes are analyzed. As past programs and services were reviewed by the committee, it became clear that no single initiative had provided the solution to prevent children/youth from being placed out-of-state.

Review of the plan by stakeholders will be solicited throughout the process. This will include direct practitioners, systems analysts and most importantly the involvement of children/youth and families. A review of national trends will be included in this process concentrating on community based, child centered and family focused program models.

These actions will be consistent with core values and principles of systems of care.

A definition for out-of-state placements in relationship to the border counties was established. Considering the geographical arrangement of West Virginia, there are areas where a community may encompass multiple states. Maintaining a child's ties to the community is just one means in which safety, permanency and well-being are established. "Community based" treatment has repeatedly proven to evoke the most effective outcomes for child welfare recipients. The definition is as follows:

"Community Based," when referring to a facility, program, or service, means located near, within a fifty (50) mile radius, of the youth's home or family and involving community participation in planning, operation, and evaluation, and which may include, but is not limited to, medical, educational, vocational, social and psychological guidance, training, special education, counseling, alcoholism and any treatment, and other rehabilitation services. Additionally, an available in-state provider that is located within 50 miles of a youth's home or family, but may be further in distance than an out-of-state provider, the in-state providers receives priority. Lastly, an in-state provider shall receive priority in instances where the referral is going to exceed the fifty (50) mile radius, but is still closer than an out-of-state provider.

A sample of out-of-state placements was chosen using data from the Bureau for Children and Families' Family and Children Tracking System (FACTS) reflecting data from March 31, 2004 was reviewed for distance from the family home to the out-of-state provider location. Of the 224 cases reviewed less than 1% was found to be within a 50 mile radius of their family home.

System Barriers

An overall look at the current system of care in West Virginia and reasons for out of state placements revealed several barriers to the effectiveness of care. When children are placed outside the West Virginia border, they are subject to different placement licensures. While each placement is approved through an Interstate Compact Placement of Children (ICPC) agreement, childcare licensing regulations are different from state to state. The ICPC process certifies that the out of state facility has met that individual state's licensing standards. However, childcare-licensing regulations being different from state to state does not guarantee that West Virginia's expectations are being met. The same issue holds true of abuse/neglect standards. For example, the statute defining abuse/neglect in the state of Pennsylvania is more lenient. What would be construed as abuse in a West Virginia licensed facility is not in Pennsylvania. These differences can drastically effect the achievement of safety, permanency and well-being. Another licensing barrier affecting out-of-state placements relates to age. There are few residential based treatment beds for those under the age of 12 for situations when clinical treatment needs cannot be met in the community. On the other extreme, West Virginia's residential licensing ends at age 18. If a youth remains in care past their 18th birthday and still requires a residential placement, an out -of- state placement is the only option.

New Initiatives

In addition to evaluating system barriers, it was also noted there are several other collaborative initiatives taking place to reduce out-of-state placements that will affect our purpose. The WV DHHR has contracts with two healthcare organizations to assist in determining if placements out of state are medically necessary. West Virginia Medical Institute (WVMI) is charged with determining medical necessity for the youth placed in Medicaid funded Psychiatric Residential Treatment Facilities (PRTF's) both in and out-of-state. APS Healthcare authorizes, reviews and/or tracks out of state placements that are funded through the Bureau for Children and Families. These agencies work with BCF to keep officials informed of the clinical status of children in out of state placements.

The Department piloted a program for youth services cases called CAPS or Comprehensive Assessment and Planning System. It was implemented statewide in July 2004. The youth services program serves children and youth at risk of being or currently involved with the legal system because of status offence behaviors and/or delinquent offences. CAPS focuses on youth where safety/risk factors may put them at risk of out-of-home placement. These youth generally have multiple problems and are involved with many systems. The CAPS project is a systematic approach to the assessment of those children and families who are

receiving child welfare services from the Department. The goal of CAPS is to assist Department staff in meeting the federal outcomes for safety, permanency and well-being by assuring that children/youth and family receive a comprehensive assessment that results in the development of a thorough and appropriate treatment plan. The CAPS assessment provides a comprehensive, standardized assessment of the youth as well as the family's needs for both behavioral health treatment and social interventions. The multi-dimensional assessment process culminates in a Comprehensive Assessment Report (CAR) that provides recommendations for services to meet the family's individual needs at the least restrictive level of care. This project is paid for by Medicaid and Social Services funding. It is also a collaborative effort with the Department and Licensed Behavioral Health providers within the state. While this program currently only focuses on the Youth Services population, it will expand to encompass the child protective services population. This assessment process was recently incorporated into legislation with the passage of HB 4649 (see attached appendix B). The CAPS program will have established outcomes for the Department as well as the providers.

In conjunction with the CAPS program, the department has implemented the provision of socially necessary services. Socially necessary services are interventions necessary to improve relationships

and social functioning with the goal of preserving the individual's tenure in the community or the integrity of the family or social system. Socially necessary services are essential in achieving child welfare goals of safety, permanency and well-being. The designation "socially necessary" is used to distinguish these services from other services that have been determined to be medically necessary and can be obtained through Medicaid. The goals of the ASO process are to ensure that families and children served by the Department receive the most appropriate services in the most cost effective manner. The effective management of resources in order to ensure the availability of services when needed is as much a part of child welfare as case planning. The keys to the success of the ASO process are the consistent application of the current policy rules for assessment, case planning and case review by Department staff and the consistent application of the current policy rules governing the ASO process for Socially Necessary Services by providers. These are designed to increase community services to support the youth and their families thereby reducing out-of-home placements.

Another initiative in cooperation with the Department is CBT or Community Based Team. This is an intensive family reunification/preservation community based team designed to reunify those youth returning from out of state/special needs placements that require multi-agency involvement. The team is a catalyst for creativity, collaboration,

and an innovative multi-agency coordination of services. This collaboration will not only ensure the practice of inclusive service delivery but will also provide for the collaboration of local community based providers willing to work together in the best interest of children and families. This initiative targets youth in the custody of DHHR residing in out-of-state placements, those returning to a family setting or transitioning via specialized step-down placements as well as those who are risk of being placed in one of the previous settings. To be eligible for services, imminent danger must not be an issue. This program will initially target one hundred children/youth. Some of the services provided are family team meetings, family engagement, transition visits, family support/preservation services, a mobile crisis team and mentoring.

Also, the Bureau for Behavior Health and Health Facilities (BHHF) is currently working on its three-year plan to improve children's mental health and substance abuse services. This addresses the fiscal year 2005 Block Grant Plans for Children's Mental Health and Substance Abuse. BHHF will be prioritizing the following areas: community integration, provider workforce development, transitioning issues, basic needs in a rehabilitation model, intervention, prevention and access to services. The grant will center on researched based strategies that show outcomes at the community level. They will also be submitting an application for funds for the Strategic Prevention Framework State Incentive Grants (SPF SIGs).

These funds are to be used to build a solid foundation for delivering and sustaining effective substance abuse and/or mental health services. The Strategic Prevention Framework is built on community-based risk and protective factors approach to prevention and a series of guiding principles that can be operationalized at the Federal, State and community levels. It is implemented through partnerships between the State and the communities.

The Bureau for Children and Families (BCF) and Bureau of Behavioral Health and Health Facilities (BHFF) continue to discuss the sustainability and replication throughout the state of the system of care known as Mountain State Family Alliance (MSFA) in Region II. In October of 1999, West Virginia received a five year system of care grant focusing on the twelve southwestern counties of the state. The original purpose was to enable funds to be used as seed money to develop least restrictive community based alternatives thus bolstering the effort to keep children in their community, return children from out-of-home placement and reunify families. MSFA has become a practical mechanism for families and children to navigate the myriad of available service and to coordinate services designed to meet the needs of the individual child and families.

Education is a considerable factor in children achieving safety, permanency and well-being. An Out-of-home Care Education Task Force has been established to address the educational needs of the 3,000

children in out-of-home care. In general, there are a number of core issues that have been raised over the years regarding those children in out-of-home care as it relates to public school settings. From funding to policy, from standardization to consistency, collaborative study and action to improve the present approaches/outcomes of out-of-home care education is needed. There appears merit in using a future oriented, problem-solving approach involving key leadership to identify issues, analyze them and offer possible solutions in a set of priority recommendations. The task force was brought together to address ways to ensure that all students, no matter the setting in which they may be placed or their learning environment, will achieve a high quality education program.

The Division of Juvenile Services has expanded its diagnostic beds in which they will be implementing more individual assessments that mirror a CAPS assessment. A multi-disciplinary team process is being utilized on every diagnostic youth prior to making recommendations to the court. As DJS develops their three, twenty-four bed staff-secured, community based residential programs they will incorporate community providers who will reinforce the community-based concept.

The Alliance for Children has obtained a grant in which they have provided four Access Coordinators for the state. A coordinator is assigned to each of the four DHHR regions with the goal of assisting DHHR workers in

locating beds for residential placements and specialized/therapeutic foster care. The team provides a weekly report of available beds to stakeholders as well as provides individual assistance to DHHR workers.

As a result of the Federal Child and Family Service Review, the Bureau for Children and Families has implemented a Program Improvement Plan (PIP). Safety, permanency and well-being are the three goals of the plan. The PIP addresses many areas of practice related to out of state placements. The Bureau for Children and Families has implemented a continuous quality improvement process according to the Council on Accreditation standards and guidelines. In order to measure improvement and quantify progress towards achieving Bureau goals and outcomes, the Bureau has implemented a case review process consisting of peer reviews and reviews completed by the Office of Planning Improvement staff which mimics the Child and Family Services Review process. In addition, the Office of Planning and Quality Improvement has developed local, regional and state Quality Improvement Councils as the mechanism for feedback and corrective action. The completed implementation of the continuous quality improvement process will not only allow us to measure the effectiveness of the strategies identified for program improvement around the outcomes of safety, permanency, and well being for children and families but also, it allows us to utilize information collected and modify strategies based upon empirical data.

The PIP has goals and objectives that specify workers and management attend additional training on adoption, permanency, concurrent planning and MDTs. Other goals and objectives address involving parents, children, foster parents and important stakeholders in the MDT process. Preserving connections and supporting the parent-child relationship are also addressed within the PIP. Family-Centered Practice, domestic violence and substance abuse training is also required for child welfare staff. The strengthening of these core child welfare practices will enhance the community based service delivery system.

Addressing issues on the direct practice/provider side as well as those related to policy implementation must occur in all areas of practice. Systems level practice requires as much consideration in this plan as does the individuals served. This will have an impact on reducing/eliminating the reliance on out-of-state placements.

Data Analysis

Further, shared data sources between the Department and it's contracted agencies has assisted in being able to delineate trends for those being placed in out of state facilities. A specific timeframe was chosen to review data of those children/youth in out of state placements excluding foster care, trial adoption and kinship care as of March 31, 2004.

There were sixty (60) youth being served in Psychiatric Residential Treatment Facilities (PRTF's) out-of-state. These facilities accept West Virginia Medicaid and require authorization through WVMI. Within the sample twenty-five (25) children/youth of the sixty (60) were identified with sexually reactive/offending behaviors. Of this number, six were under the age of 13 and seven had deficits in mental functioning. Twenty-one (21) of sixty are under the age of thirteen. Borderline Intellectual Functioning or a diagnosis of Mental Retardation (at various severities) was noted in eighteen of the sixty children/youth in the sample. Substance abuse issues were identified within six members of the sample. One youth out of the sample of sixty, was identified as a fire starter.

There were 309 children/youth authorized or reviewed by APS Healthcare, Inc. in out-of-state placements in Children's Residential Level I, II, and III, non-clinical alternatives, decertified PRTF placements, Mental Retardation/Developmentally Disability programs, and review only placements. A non-clinical alternative residential placement is one in which no medically necessary behavioral health services are provided. The environment is highly structured, regulated and intensively supervised. It is designed to provide intervention and support for youth who exhibit behavior problems, not related to a behavioral health diagnosis, which may endanger the community at large. Goals for the program are to develop acceptable social behaviors through skill development, take

responsibility for their behavior, and increase personal accountability. Some programs may also include restitution and community service. Decertified/certified PRTF placements, mental retardation/developmentally disability programs and review only placements are out-of-state residential placements in which the child/youth is in one or both of the following situations:

- The consumer no longer meets medical necessity for behavioral health services at the level of intensity that is being provided.
- The consumer requires residential services not currently available within the WV Medicaid Rehabilitation or Clinic Manuals.

Of this population eighty-three percent (256) are males and seventeen percent (53) are females. For this population children ranged in age from 0-19; however, children who were less than ten years old and greater than eighteen years old comprised less than one percent of the entire group. Using in ranges of 10-12 years, 13-15 years, and 16-18 years for both males and females

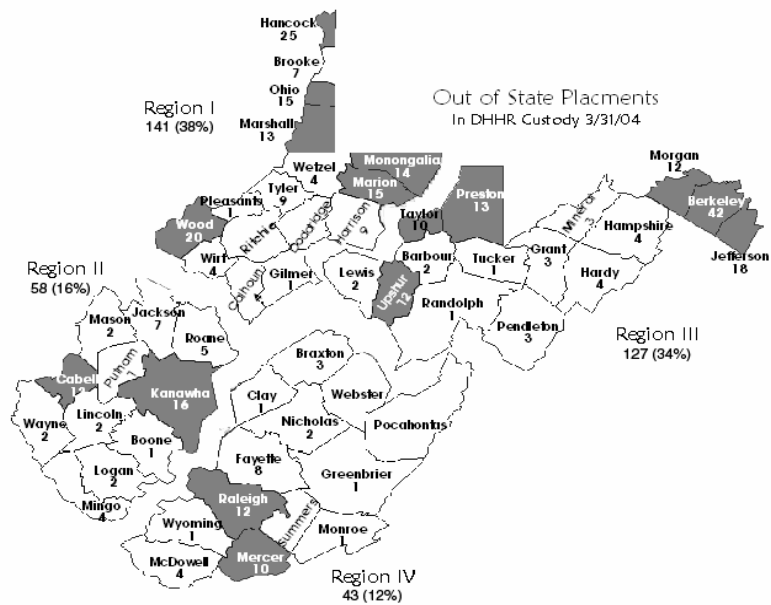
- 7% (22) are between 10 and 12 years old
- 47% (145) are between 13 and 15 years old
- 46% (142) are between 16 and 18 years old

Of the same sample 67% (207) were adjudicated delinquent, 5% (15) were adjudicated status offenders, 15% (46) were dependent, 9% (28) were non-adjudicated delinquents or non-status offenders and 5% (15) had no

legal problems. One hundred nine of the three hundred nine in the sample 37% were identified with substance abuse issues ranging from dependence to use. Twenty-two of the three hundred nine (7%) in out of state placements are identified with sexually reactive/offending behaviors. Sixteen percent (49) were placed in non-clinical alternatives.

Data from the Bureau for Children and Families FACTS reflecting a March 31, 2004 date indicated a total of 369 out of state placements (excluding foster family care, trial adoptions and kinship care). Region I accounted for 141 of 369 or 38% of out of state placements. Region II has 58 of 369 or 16% of the out of state population. 127 of 369 of children/youth or 34% were from Region III. Region IV totaled 43 of 369 or 12% of the out of state placements. Fifteen of the fifty-five counties have ten or more youth in out of state placement. These are as follows:

Berkeley	42	Marshall	13
Hancock	25	Preston	12
Wood	20	Morgan	12
Jefferson	18	Upshur	12
Kanawha	17	Raleigh	12
Marion	15	Cabell	12
Ohio	15	Mercer	10
Monongalia	14	Taylor	10



When looking at the counties where children are placed out of state, further evaluation is needed to determine the caseload number of children in custody compared to the number of those youth/children in out of state placements.

A further evaluation of a representative sample of 224 cases from those counties with ten or more youth in out-of-state placement is currently being done. Cases are being reviewed for MDT timeliness, attendance by significant and/or mandated representatives as well as recommendations to the court.

	All 0-9 Population: Total	All 10 to 17 Population: Total	All 0 to 17 Population: Total	DHHR Custody Caseload 3/31/04	% of Population	Out-of- State 3/31/04	% of Caseload
WV	213367	187774	401141	3298	0.82%	369	11.19%
Barbour	1826	1758	3584	52	1.45%	2	3.85%
Berkeley	10532	8880	19412	157	0.81%	42	26.75%
Boone	3289	2648	5937	38	0.64%	1	2.63%
Braxton	1685	1638	3323	31	0.93%	3	9.68%
Brooke	2739	2452	5191	23	0.44%	7	30.43%
Cabell	10621	8596	19217	211	1.10%	12	5.69%
Calhoun	866	821	1687	24	1.42%	4	16.67%
Clay	1404	1230	2634	48	1.82%	1	2.08%
Doddridge	867	1012	1879	4	0.21%		0.00%
Fayette	5540	4775	10315	66	0.64%	8	12.12%
Gilmer	757	692	1449	11	0.76%	1	9.09%
Grant	1393	1168	2561	16	0.62%	3	18.75%
Greenbrier	3813	3606	7419	63	0.85%	1	1.59%
Hampshire	2752	2281	5033	52	1.03%	4	7.69%
Hancock	3676	3166	6842	40	0.58%	25	62.50%
Hardy	1668	1294	2962	20	0.68%	4	20.00%
Harrison	8424	7407	15831	66	0.42%	9	13.64%
Jackson	3609	3117	6726	44	0.65%	7	15.91%
Jefferson	5390	4530	9920	59	0.59%	18	30.51%
Kanawha	23025	19358	42383	232	0.55%	16	6.90%
Lewis	2093	1651	3744	50	1.34%	2	4.00%
Lincoln	2670	2498	5168	58	1.12%	2	3.45%
Logan	4479	3839	8318	77	0.93%	6	7.79%
McDowell	3140	3214	6354	56	0.88%	4	7.14%
Marion	6026	5591	11617	135	1.16%	15	11.11%
Marshall	4333	3784	8117	73	0.90%	13	17.81%
Mason	3210	2660	5870	18	0.31%	2	11.11%
Mercer	7209	6059	13268	139	1.05%	10	7.19%
Mineral	3254	3076	6330	48	0.76%	3	6.25%
Mingo	3546	3306	6852	71	1.04%	4	5.63%
Monongalia	8111	6690	14801	98	0.66%	14	14.29%
Monroe	1473	1454	2927	10	0.34%	1	10.00%

Morgan	1897	1442	3339	25	0.75%	12	48.00%
Nicholas	2989	3202	6191	52	0.84%	2	3.85%
Ohio	5384	4712	10096	110	1.09%	15	13.64%
Pendleton	922	861	1783	12	0.67%	3	25.00%
Pleasants	978	822	1800	1	0.06%	1	100.00%
Pocahontas	961	957	1918	11	0.57%		0.00%
Preston	3410	3532	6942	79	1.14%	13	16.46%
Putnam	6915	5918	12833	27	0.21%	1	3.70%
Raleigh	8960	8082	17042	113	0.66%	12	10.62%
Randolph	3317	2983	6300	75	1.19%	1	1.33%
Ritchie	1257	1115	2372	13	0.55%		0.00%
Roane	1775	1822	3597	59	1.64%	5	8.47%
Summers	1468	1188	2656	24	0.90%		0.00%
Taylor	1981	1712	3693	67	1.81%	10	14.93%
Tucker	848	707	1555	13	0.84%	1	7.69%
Tyler	1103	1120	2223	22	0.99%	9	40.91%
Upshur	2763	2498	5261	77	1.46%	12	15.58%
Wayne	5267	4722	9989	55	0.55%	2	3.64%
Webster	1156	1080	2236	40	1.79%		0.00%
Wetzel	2163	2036	4199	36	0.86%	4	11.11%
Wirt	693	788	1481	10	0.68%		0.00%
Wood	10842	9362	20204	149	0.74%	20	13.42%
Wyoming	2898	2862	5760	96	1.67%	1	1.04%

Based upon the discussion and data reviewed, this plan will initially focus on the implementation of the identified system changes and two populations: those youth with substance abuse issues and youth identified with sexually re-active/offending behaviors. Based on the March 31, 2004 data, 369 of 3,268 children/youth (11%) in care of the WVDHHR were in out of state placements. By July 2006 the percent of children in the custody of the Department placed in out of state residential facilities will be reduced to three percent (3%). The quarterly benchmarks are as follows;

10/2004	11%	(369)
01/2005	10%	(327)
04/2005	9%	(294)
07/2005	8%	(261)

10/2005	6%	(196)
01/2006	4%	(130)
07/2006	3%	(98)

The overall basic needs of children are the same regardless of their specific location in West Virginia, just as the goals for both the sexually reactive/offending population and those with substance abuse issues are very similar after evaluating the current system and youth's traits. In order for both populations to be served appropriately in state, increased statewide clinical capacity is needed, as well as training of clinical staff in the best quality/evidenced based practices, including assessment and intervention. Professional consultative relationships need to be brokered in the community to provide technical assistance to those who are working to expand the systems capacity to address these issues in a community based fashion. Community service capacity also needs to be developed in the area of outpatient services including the assessments and interventions. Foster family care providers and step down programs also need to be developed to address both the substance abuse issues and sexually re-active/offending behaviors. Distinct clinical protocols need to be developed for assessments, case consultations, MDT's, reunifications and linking with appropriate child serving systems for these targeted populations. All these issues need to be incorporated in the other system movements such as CAPS. Attached is the specific West Virginia Department of Health and Human Resources, Bureau for Children

and Families, Strategic Plan Regarding out of State Placement of Children and Youth. It incorporates the specific strategies and interventions that will be implemented to reach the previously stated goal. Monitoring practices will be finalized as feedback is obtained and the strategies and interventions are completed.

STRATEGIC PLAN ACTION STEPS

Strategies	Target	Activities	Responsible/	Date Complete
A-To improve education & awareness	-Community -Workers -Court system	A1-Provider survey to identify current capacity, needs, gaps and barriers in the service delivery system A2-Decision-maker survey (probation, judges, DHHR workers), Regional Summits and Community Collaboratives to identify current capacity needs, gaps and barriers in the service delivery system A-3 Comparison of A1 and A2. A4-Information Sharing & Training through Community Collaborative, Regional Summits, Provider Associations, Networks and Community Organizations.	A1-DHHR/OOS Work group/Providers A2-DHHR/OOS Work Group/Providers A3-DHHR-BHHF and BCF through community partnerships A-4-DHHR – BHHF and BCF through community partnerships	
B-To increase statewide clinical service capacity	-All clinical staff/providers -State staff and facilities	B1-Train clinical staff on sexually reactive and substance abuse issues <ul style="list-style-type: none"> • Explore possibility, cost, resources and logistics of certifying at minimum 5 Sex Offender Treatment Specialist per Region in order to provide local community based expertise & resources. • Repeat Co-Occurring Treatment Training and Certification and ensure at minimum 5 representatives from each Region participate in order to provide 	B1- DHHR in conjunction with River Park and other providers to be identified <ul style="list-style-type: none"> • Ohio University and other resources to be identified. • DHHR 	

		<p>for community based expertise and resources.</p> <p>B2-Contract with the designated Sex Offender Treatment Specialist, Co-Occurring Trained individuals, and local Sex Offender & Substance Abuse Treatment Facilities to provide the necessary training, consultation and support to local providers/clinicians in order to provide the clinical expertise to ensure there are enough qualified clinicians to participate in MDT's, treatment planning and interventions to the target populations</p> <p>B3-Provide a comprehensive, standardized assessment process for all children and youth identified as at risk of being placed out of their home by utilizing the West Virginia Comprehensive Assessment and Planning System (CAPS).</p> <p>B4-Based on actual data analysis of the needs of youth traditionally necessitating out of state placement ensure for an adequate number of these identified services for youth with substance abuse issues and/or sexually re-active/offending behaviors in WV.</p>	<p>B2- - DHHR in conjunction with River Park and other providers to be identified</p> <p>B3- DHHR and CAPS providers</p> <p>B4-DHHR/DJS/OOS Workgroup/Providers</p>	
C-To increase community service capacity	-Community service providers	C1-Increase and improve out-patient services, in the existing continuum of care. Utilize Provider Survey results of barriers to provide for the necessary regulatory, funding, policy	C1-- DHHR in conjunction with other providers to be identified	

		<p>changes, and cross agency collaboration to make this increase in services possible.</p> <p>C2-Increase the availability of foster family’s as well as residential capacity with both the willingness and expertise to care for sexually reactive, sex offending, and co-occurring youth, as well as other high need youth who traditionally have been sent out of state for Treatment.</p> <ul style="list-style-type: none"> • Explore the levels of Foster Family Care and convene a task team to explore evidence based models of Foster Family Care Delivery (such as behavioral FC, TX, and Specialized), and how these models are implemented nationwide with an analysis of model outcomes and applicability to the state of West Virginia. <p>C3-Increase the availability of step-down programs (aftercare, small group homes, groups, evening report centers, intensive in-home services) This can be accomplished by convening a task team to gather data on existing models, evidence based models, outcomes, national implementation as well as WV applicability.</p>	<p>C2-- DHHR in conjunction with other providers to be identified</p> <p>C3- DHHR in conjunction with other providers such as those involved with the CBT model</p>	
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		<p>C4-Increase the cooperation between service providers</p> <p>C5-Make the necessary changes to the Certificate of Need process to allow those agencies willing to reconfigure their programs creatively and innovatively to do so without huge cost and time constraints to their agencies if such configuration is not increasing beds.</p> <p>C6-Develop a model of mobile response, crisis respite, and community stabilization to ensure the ability to provide these youth's needs, while preventing unnecessary hospitalization and multiple foster home or residential moves. This can be best accomplished by developing a model, providing for uniform training and researching other states who have addressed high risk youth needs in this manner such as New Jersey, Tennessee, Florida, and Wisconsin.</p> <p>C-7 – Collaborate with other planning efforts as it relates to early intervention/prevention resources, clinical capacity, other resource development.</p>	<p>C4- DHHR, Community Collaborative and Regional Summits</p> <p>C5-DHHR-Legislature-Providers</p> <p>C6-DHHR-Providers-BMS-APS</p> <p>C-7 – DHHR – BCF & BHHF, DJS, other providers, MSFA</p>	
D-1 To develop and implement system improvements	-State government	D1-Improve the appropriate placement of youth by implementing protocols that provide for the oversight and clinical review of all out of state placements. Many groups/models are available	D1-DHHR staff, Probation, DJS, Providers and CAPS	

		<p>for review to address this issue. Revamping of MDT oversight groups, modeling Kids Care, and utilizing an already existing statewide oversight group for state level review. Collaborate with MSFA as to “lessons learned” regarding these issues.</p> <p>D2-MDT issues. Explore all available models of multi-disciplinary planning that are based on family centered practice and utilize these models to further refine the West Virginia MDT Process. Enhance the process to be more uniform, consistent and accountable process through the development of protocols, training, etc. Ensure the MDT process is utilized to ensure family driven planning process’ that provide for the well being, safety and permanency of children. Expand the CAPS Family Conference to incorporate a Family Team Meeting that occurs prior to the actual MDT so that all families at risk of or in out of home placements have developed a family plan draft that they have ownership in prior to utilize as a starting point in the actual MDT.</p> <p>D3-Improve discharge planning from out-of-state placement. Replicate models such as the CBT that provide for at least 30 days of pre-reunification services to both the youth and their family to ensure a positive transition back to WV. Define in writing, Protocols that define</p>	<p>D2-DHHR staff- PIP/Providers</p> <p>D3-DHHR, MDTs and service providers</p>	
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		<p>the difference between behavioral and treatment issues that can be addressed instate versus those that necessitate the child MUST remain out of state as many youth linger out of state after they have completed OOS level of TX due to issues that can be addressed by instate agencies once they return. Train the courts, DHHR field staff and OOS providers on these protocols.</p> <p>D4-Agree on best quality/ evidence based/promising practices and develop a system to recognize and replicate effective programs.</p> <p>D5-Develop internal monitoring system of DHHR policies that inhibit staying in-state</p> <p>D6-Develop a model for substance abusing child welfare and juvenile justice kids. (Research what are the components to do effective substance abuse treatment in the community for this population)</p> <p>D7-Implement best practices model for sexually reactive child welfare and juvenile justice kids, one for Sex Offender TX, and one for Sex Offender Step Down. (Research what are the</p>	<p>D4-DHHR BCF/BHHF & WVPRC for substance abuse/Providers</p> <p>D5- BCF Office of Planning and Quality Improvement /Providers</p> <p>D6- DHHR, WVPRC, PROVIDERS</p> <p>D7- DHHR BCF/BHHF & WVPRC/PROVIDERS</p>	
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		<p>components to do effective treatment in the community for this population)</p> <p>D8-Improve education of children in state custody and an out of home placement</p>	<p>D8- DHHR, DJS and DOE & the Out-of-Home Education Task Force</p>	
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**STRATEGIC PLAN WORKGROUP
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(9-24-04)**

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ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 4649

(By Delegates Amores, Fleischauer,

Craig and Schadler)

[Passed March 11, 2004; in effect ninety days from passage.]

AN ACT to amend and reenact §49-5D-2, §49-5D-3 and §49-5D-3a of the code of West Virginia, 1931, as amended, all relating to child welfare; providing for a child advocacy center participation in multidisciplinary investigative teams; providing for uniform comprehensive assessments of children; preference to instate placement; including in team, child, the juvenile's attorney, appropriate school official, court-appointed special advocate when available, and a representative from the licensed domestic violence program serving the county, when appropriate and available; requiring team preference of in- state placement; requiring court preference of instate placement; and requiring that reasons for out-of-state placement be in order.

Be it enacted by the Legislature of West Virginia:

That §49-5D-2, §49-5D-3 and §49-5D-3a of the code of West Virginia, 1931, as amended, be amended and reenacted, all to read as follows:

ARTICLE 5D. MULTIDISCIPLINARY TEAMS.

§49-5D-2. Multidisciplinary investigative teams; establishment; procedures; coordination between agencies.

(a) The prosecuting attorney shall establish a multidisciplinary investigative team in each county. The multidisciplinary team shall be headed and directed by the prosecuting attorney and shall include as permanent members the prosecuting attorney or his or her designee, a local child protective services caseworker from the department of health and human resources, a local law-enforcement officer employed by a law- enforcement agency in the county and, where appropriate to the particular case under consideration and available, a child advocacy center representative, and a representative from the licensed domestic violence program serving the county. The department of health and human resources and any local law-enforcement agency or agencies selected by the prosecuting attorney shall appoint their representatives to the team by submitting a written designation of the team to the prosecuting attorney of each county within thirty days of the prosecutor's request that the appointment be made. Within fifteen days of the appointment, the prosecuting attorney shall notify the chief judge of each circuit within which the county is situated of the names of the representatives so appointed. Any other person or any

other appointee of an agency who may contribute to the team's efforts to assist a minor child as may be determined by the permanent members of the team may also be appointed as a member of the team by the prosecutor with notification to the chief judge.

(b) Any permanent member of the multidisciplinary investigative team shall refer all cases of accidental death of any child reported to their agency and all cases when a child dies while in the custody of the state for investigation and review by the team. The multidisciplinary investigative team shall meet at regular intervals at least once every calendar month.

(c) The investigative team shall be responsible for coordinating or cooperating in the initial and ongoing investigation of all civil and criminal allegations pertinent to cases involving child sexual assault, child sexual abuse, child abuse and neglect, and shall make a recommendation to the county prosecuting attorney as to the initiation or commencement of a civil petition and/or criminal prosecution.

(d) State, county and local agencies shall provide the multidisciplinary investigative team with any information requested in writing by the team as allowable by law or upon receipt of a certified copy of the circuit court's order directing said agencies to release information in its possession relating to the child. The team shall assure that all information received and developed in connection with the provisions of this article remains confidential. For purposes of this section, the term "confidential" shall be construed in accordance with the provisions of section one, article seven of this chapter.

§49-5D-3. Multidisciplinary treatment planning process.

(a)(1) A multidisciplinary treatment planning process shall be established within each county of the state, either separately or in conjunction with a contiguous county by the secretary of the department with advice and assistance from the prosecutor's advisory council as set forth in section four, article four, chapter seven of this code.

(2) Treatment teams shall assess, plan and implement a comprehensive, individualized service plan for children who are victims of abuse or neglect and their families when a judicial proceeding has been initiated involving the child or children for juveniles and their families involved in status offense or delinquency proceedings when, in a status offense proceeding, the court refers the juvenile for services pursuant to sections eleven and eleven-a, article five of this chapter and when, in a delinquency proceeding, the court is considering placing the juvenile in the department's custody or placing the juvenile out-of-home at the department's expense pursuant to the provisions of section thirteen of said article. In any such status offense or delinquency case, the juvenile probation officer shall notify the local office of the department of health and human resources and the division of juvenile services at least five working days before the court proceeding in order to allow the multidisciplinary treatment team to convene and develop a comprehensive individualized service plan for the child: *Provided*, That such notice is not required in cases where the child is already in state custody or there exist exigent circumstances which justify taking the child immediately into custody without a judicial proceeding. In developing an individualized service plan for a child, the team shall utilize a uniform comprehensive assessment of the child. The department shall adopt a standard uniform comprehensive assessment instrument or protocol to be used by treatment teams.

(3) Prior to disposition, in each case in which a treatment planning team has been convened, the team shall advise the court as to the types of services the team has determined are needed and the type of placement, if any, which will best serve the needs of the child. If the team determines that an out-of-home placement will best serve the needs of the child, the team shall first consider placement at facilities or programs located within the state. The team may only

recommend placement in an out-of-state facility if it concludes, after considering the best interests and overall needs of the child, that there are no available and suitable in-state facilities which can satisfactorily meet the specific needs of the child.

(b) Each treatment team shall be convened and directed by the child's or family's case manager. The treatment team shall consist of the child's custodial parent or parents, guardian or guardians, other immediate family members, the attorney or attorneys representing the child, the parent or parents of the child, the child's attorney, the guardian ad litem, if any, the prosecuting attorney or his or her designee and where appropriate to the particular case under consideration and available, a court- appointed special advocate, an appropriate school official and any other person or an agency representative who may assist in providing recommendations for the particular needs of the child and family. The child may participate in multidisciplinary treatment team meetings if such is deemed appropriate by the multidisciplinary treatment team. For purposes of delinquency proceedings, the juvenile probation officer shall be a member of the treatment team.

(c) The treatment team shall coordinate its activities and membership with local family resource networks and coordinate with other local and regional child and family service planning committees to assure the efficient planning and delivery of child and family services on a local and regional level.

(d) State, county and local agencies shall provide the multidisciplinary treatment teams with any information requested in writing by the team as allowable by law or upon receipt of a certified copy of the circuit court's order directing said agencies to release information in its possession relating to the child. The team shall assure that all information received and developed in connection with the provisions of this article remain confidential. For purposes of this section, the term "confidential" shall be construed in accordance with the provisions of section one, article seven of this chapter.

§49-5D-3a. Recommendation of team to the court; hearing requirement; required findings.

(a) In any case in which a multidisciplinary treatment team develops an individualized service plan for a child pursuant to the provisions of section three of this article, the court shall review the proposed service plan to determine if implementation of the plan is in the child's best interests. If the multidisciplinary team cannot agree on a plan or if the court determines not to adopt the team's recommendations, it shall, upon motion or sua sponte, schedule and hold within ten days of such determination, and prior to the entry of an order placing the child in the custody of the department or in an out-of-home setting, a hearing to consider evidence from the team as to its rationale for the proposed service plan. If, after a hearing held pursuant to the provisions of this section, the court does not adopt the teams's recommended service plan, it shall make specific written findings as to why the team's recommended service plan was not adopted.

(b) In any case in which the court decides to order the child placed in an out-of-state facility or program it shall set forth in the order directing the placement the reasons why the child was not placed in an in-state facility or program.