2015

Annual Progress Report

Advancing New Outcomes

Findings, Recommendations, and Actions

of the West Virginia Commission to Study

Residential Placement of Children

WEST VIRGINIA
Department of
Health & Human Resources

Bureau for Children and Families
350 Capitol Street, Suite 730
Charleston, WV 25301

Earl Ray Tomblin, Governor
Karen L. Bowling, Cabinet Secretary

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Office of the Secretary
One Davis Square, Suite 100 East
Charleston, West Virginia 25301
Telephone: (304) 558-0684 Fax: (304) 558-1130

Karen L. Bowling
Cabinet Secretary

As Cabinet Secretary of the West Virginia Department of Health and Human Resources, and on behalf of the Commission to Study Residential Placement of Children, I am pleased to submit the annual summary report, *Advancing New Outcomes: Findings, Recommendations, and Actions of the West Virginia Commission to Study Residential Placement of Children.*

Over the years, the Commission has established both a foundation and greater understanding of what is needed to reduce the number of children in out-of-state placement and out-of-home care.

While we are making steady progress, there is more work to be done. We will continue to work collaboratively and cooperatively, making informed decisions that will improve the quality of life for West Virginia's children.

Sincerely,

Karen L. Bowling
Cabinet Secretary

2015 COMMISSION MEMBERS

Commission to Study Residential Placement of Children
Karen L. Bowling, Chair
Cabinet Secretary

The Honorable Jack Alsop
Circuit Court Judge
Webster County

Cindy L. Beane
Acting Commissioner
Bureau for Medical Services
WV Department of Health and Human Resources

Stephanie Bond
Director
Division of Juvenile Services
WV Department of Military Affairs & Public Safety

Steve Canterbury
Administrative Director
WV Supreme Court of Appeals

The Honorable Scott Elswick
Family Court Judge
Lincoln County

Nancy Exline
Commissioner
Bureau for Children and Families
WV Department of Health and Human Resources

Susan Fry
Director
Stepping Stones
(Group Residential)

Jessica Ritchie-Gibson
Family Representative

Jacob Green
Superintendent of Institutional Education
WV Department of Education

Rahul Gupta, M.D.
Commissioner
Bureau for Public Health
WV Department of Health and Human Resources

Sue Hage
Deputy Commissioner
Bureau for Children and Families
WV Department of Health and Human Resources

Pat Homberg
Executive Director
Office of Special Education
WV Department of Education

The Honorable David W. Hummel, Jr
Circuit Court Judge
Wetzel and Tyler Counties

The Honorable Gary Johnson
Circuit Court Judge
Nicholas County

Vickie Jones
Commissioner
Bureau for Behavioral Health and Health Facilities
WV Department of Health and Human Resources

Mike Lacy
Director
Probation Services
WV Supreme Court of Appeals

Michael Martirano
State Superintendent of Schools
WV Department of Education

Rhonda McCormick-Hayes
Parent/Family Representative

Philip W. Morrison II
Executive Director
WV Prosecuting Attorneys

The Honorable Phillip M. Stowers
Circuit Court Judge
Putnam County

Nikki Tennis
Director, Division of Children's Services
WV Supreme Court of Appeals

Steve Tuck
Director
Children's Home Society
(Foster Care)

<u>Staff to Commission</u>
Linda Dalyai
Health and Human Resource Specialist, Senior
Bureau for Children and Families
WV Department of Health and Human Resources

PREFACE

The Commission to Study Residential Placement of Children was created by an act of the 2005 Legislature (HB 2334) to achieve systematic reform for youth at risk of out-of-home residential placement and to establish an integrated system of care for these youth and their families (see Appendix A for "The System of Care Principles Guiding Effective Care for Children, Youth & Families" that guide this work).

The bill's original topics of study included placement practices with special emphasis on out-of-state placements, as well as ways to ensure that children who must be placed out-of-state receive high quality services consistent with West Virginia's standards of care. This focus was broadened with several recommendations made by the Commission in its May 2006 report *Advancing New Outcomes* that include all children and their families in out-of-home placement and those at risk of out-of-home placement.

Since that time, the Commission has continued to monitor the status of each of its recommendations. In 2010, the Legislature passed SB 636 to reconstitute the Commission. The focus was expanded to address additional issues relative to foster care placement, as well as reduction in out-of-state placements.

During 2012, the Commission took a hard look at progress on its original thirteen recommendations from the 2006 summary report. This involved analyzing all the work done to date by Commission work groups as well as various other collaborations among the state's public and private entities. The Commission then prioritized ten goals that will make the most significant difference in improving outcomes for children, youth and families. This report reflects these overarching priorities and shows annual progress toward their implementation.

West Virginia Department of Health and Human Resources, Bureau for Children and Families received a federal IV-E waiver in fall 2014. The IV-E waiver, which echoes the Commission to Study the Residential Placement of Children's Priority Goals for Implementation, will allow West Virginia to improve our child welfare system and serve children in their home communities through the Safe at Home WV demonstration project. As a partner in the Safe at Home WV project, the Commission's members will participate on the cross-discipline workgroups specific to the Safe at Home WV project.

For More Information

There is a large body of background information, including studies, reports, data analyses and minutes of Commission meetings, available online: http://www.wvdhhr.org/oos_comm/. Additional inquiries may be addressed to Linda Watts, Deputy Commissioner for Programs, Bureau for Children and Families, West Virginia Department of Health and Human Resources, 350 Capitol Street, Room 730, Charleston, WV 25301 (304.356.4527) or Linda.M.Watts@wv.gov).

TABLE OF CONTENTS

FOUNDATIONS OF CHANGE

The Critical Issue

> Difficult and 'hard-to-place' children are frequently placed in multiple foster homes, multiple potential adoptive homes, and multiple residential treatment facilities. Because these placements are often in different counties in different areas of the State, the child is treated by multiple providers. For these frequently placed children, treatment is not consistent, nor are services uniform. A good program for the child while in foster care in Kanawha County may not be available when the child is placed in Wayne County.
>
> With each new placement, a new counselor, therapist, psychiatrist and psychologist begins treatment. These persons may have different treatment protocols than the previous providers. Medications are frequently changed when a new psychiatrist is involved and new 'trusts' for the child and the providers must be developed; treatment begins anew, time is lost, and progress starts all over. This cycle is then repeated again when the child regresses and the new foster/adoptive parents give up, and the child is again placed in another geographical area. The new placement is often too distant from the old placement, so another set of providers commences again. This lack of continuity and level of services hampers the child's progress. The Commission finds this frequent occurrence a significant barrier that must be addressed in all possible ways. The Commission advocates, throughout its work, that viable solutions should always strive to minimize the disruptions of the child as much as possible.
>
> From *Advancing New Outcomes, 2006*

The Commission's prime charge is to safely, and within a quality framework, reduce the number of children in out-of-home care who are placed outside their West Virginia community of residence—and out of proximity of their families, neighborhood schools, health care providers and support networks.

The Commission recognizes that this effort involves a wide variety of programs and services across a number of child-serving agencies and organizations, both public and private. There are a number of initiatives and activities, from policy to specific programs that can improve outcomes for West Virginia children in out-of-home care.

Principle-Based Collaboration

Bringing together a diverse group of individuals representing the many facets of the system is a necessary step for meaningful improvement. The Commission carries out its work with strong collaborative participation from all of West Virginia's child and family serving systems. Open discussion, research and materials presented at quarterly meetings reflect the day-to-day experiences and voices of field staff members, families and youth from all areas.

From its inception, the Commission has relied on both standing and ad hoc collaborative bodies and work groups that bring multiple perspectives and expertise to focus on specific recommendations. The Service Development and Delivery Work Group, as well as the System of Care, Out-of-State Provider Certification and Multidisciplinary Treatment work groups are among those specifically formed through the original recommendations of the Commission to Study Residential Placement of Children.

The Commission works in collaboration with other projects/initiatives including the Safe at Home WV, Education of Children in Out-of-Home Care Advisory Committee, National Governor's Association Three-Branch Institute, and West Virginia Court Improvement Program, as well as additional programs, to support its goals in the study of the residential placement of children.

Outside of the formal Commission meetings, members and many other stakeholders have collaborated to provide key background information, data analysis and suggested recommendations. This continuing effort draws on the positive work taking place in our state, as well as research on promising solutions from outside of West Virginia.

All parties participating in the Commission agree the goal is to do everything possible to ensure that needed quality services are provided in, or as close as possible to, the community in which each child resides. At the same time, members respect the mission, roles and expertise of each entity within the system.

Given this overall goal, Commission members from their respective agencies and organizations will champion the recommendations and intent of the Commission to improve the state's internal systems of care for all out-of-home children.

Definition of System

For the purpose of the Commission's work, the use of the word *system* refers to the total combination of policies, processes and people, including families, which constitute the entire focus along a full continuum of care (programs and services) for working with the out-of-home child population, and preventing children from being placed in out-of-home settings.

Defining the Population of Focus

From the Commission's inception, defining and developing the most appropriate benchmarks has been challenging, requiring appropriate definitions, accurate facility information and timely data. The Commission moved to specify ways to define and report placements, and agreed to the following:

- To report on children in West Virginia custody (through the West Virginia Department of Health and Human Resources).
- To include three state custody populations:
    1. Group Residential Care
    2. Psychiatric Facility (long term)
    3. Psychiatric Hospital (short term)
- To base all information and analysis on data extracted from the West Virginia Department of Health and Human Resources Families and Children Tracking System (FACTS).
- To use placement population definitions established by the Commission for performance outcomes metrics.

The ultimate goal is to have all of these children served closer to their home communities.

Data is extracted each month based on updated information in FACTS to provide a point-in-time analysis referred to as the Performance Scorecard (the final Scorecard for 2015 can be found in Appendix D). Though the population of young people being monitored by the Commission is necessarily limited, it should be stressed that the ongoing work of this body has continued to improve the quality of care and increase the treatment options for all of West Virginia's children at risk of out-of-home care.

Pivotal Accomplishments from 2006 to 2014

From the time the WV Commission to Study Residential Placement of Children published its original 13 recommendations in *Advancing New Outcomes 2006*, a number of strategies have been implemented through annual action plans. The Commission continues to rely on working groups whose members have the appropriate expertise, resources and responsibility to carry out specific recommendations. The Commission has remained flexible throughout, tackling emerging issues and including the support of other collaborations and initiatives that can advance specific Commission goals.

Dozens of key accomplishments from the previous years were the result of principle-based collaborative efforts, and made it possible for West Virginia to advance new outcomes. A detailed summary of these accomplishments is contained in *Advancing New Outcomes Progress Report 2013*, which may be downloaded from the Commission's web page.

PRIORITY GOALS FOR IMPLEMENTATION

In 2012, the Commission reviewed its original thirteen recommendations, and consolidated those still active with new ones that support the vision and charge of the Commission. A detailed multi-year work plan for implementation with expected performance outcomes, identification of responsible groups and individuals, and a timeline for completion of the major activities within each strategy is based on the ten priority goals:

1. Appropriate Diagnosis and Placement

Implement and maintain ways to effectively sustain accurate profile/defined needs (clinical) of children in out-of-home care, regardless of placement location, at the individual, agency, and system levels to include clinical review processes, standardized assessments, total clinical outcomes management models, etc., that result in the most appropriate placements.

2. Expanded Community Capacity

Expand in-state residential and community-based program and service capacity for out-of-home children through systematic and collaborative strategic planning to include statewide programs such as Building Bridges, System of Care, and systems such as the Automatic Placement and Referral System (APR), and greater emphasis on upfront prevention approaches.

3. Best Practices Deployment

Support statewide awareness, sharing, and adoption of proven best practices in all aspects (e.g., treatment, education, well-being, safety, training, placement, support) regarding the Commission's targeted populations.

4. Workforce Development

Address staffing and development needs, including cross-systems training, that ensure a quality workforce with the knowledge, skills, and capacity required to provide the programs and services to meet the requirements (e.g., assessments, case management, adapt best practices, quality treatment, accountability) of those children in the Commission's targeted populations.

5. Education Standards

Ensure education standards are in place and all out-of-home children are receiving appropriate quality education in all settings and that education-related programs and services are meeting the requirements of all out-of-home children, regardless of placement location.

6. Provider Requirements

Require placements in all locations be made only to providers meeting West Virginia standards of licensure, certifications and expected rules of operation to include demonstrated quality in all programs and services that meet West Virginia Standards of Care.

7. Multidisciplinary Team (MDT) Support

Support the Multidisciplinary Treatment Team (MDT) concept and assist enhancing present MDT processes statewide.

8. Ongoing Communication

Develop appropriate and timely cross-system and public communications regarding the work of the Commission that fosters awareness and the continued commitment of stakeholders to reduce the placement of children outside of their community of residence and to enhance in-state capacity to reduce the number of children in West Virginia requiring out-of-home care.

9. Effective Partnerships

Continue to seek strong partnerships with individuals, agencies, organizations, other commissions and special initiatives that advance the overarching goals and strategies of the Commission.

10. Performance Accountability

Ensure accountability through monitoring performance outcomes, improving processes and sharing information with all stakeholders.

KEY ACCOMPLISHMENTS OF 2015

Keeping the Commission's priority goals as the focus, these accomplishments represent the work for January 2015 through December 2015. The accomplishments may apply to more than one priority goal area.

1. Appropriate Diagnosis and Placement

Implement and maintain ways to effectively sustain accurate profile/defined needs (clinical) of children in out-of-home care, regardless of placement location, at the individual, agency, and system levels to include clinical review processes, standardized assessments, total clinical outcomes management models, etc., that result in the most appropriate placements.

- The WV System of Care worked through two processes to identify gaps in services, barriers to serving youth in the state, and returning youth to the state. These processes have also prevented youth from being placed in out-of-state services, identified services appropriate for the youth and assisted in the planning for youth returning to the state. These two processes are the Regional Clinical Review Team and the Out-of-State Review Team. The number of youth being placed out-of-state continues to decrease. Two years ago (2012-2013) 533 youth were placed out-of-state. Last year (2013-2014) 492 youth were placed out-of-state, and this year (2014-2015) 477 youth were placed out-of-state, an 11% decrease in 3 years. Regional clinical review teams continued to provide comprehensive, objective, clinical review for children at risk as a resource for the child's Multidisciplinary Treatment Team (MDT).

A total of 58 regional clinical review team meetings took place between January and December 2015, to review 131 youth.

- 21 youth who received a clinical review in 2015 were prevented from out-of-state placement.

- The Bureau for Children and Families is currently in the process of developing program standards for a request for applications to broaden the family foster care program statewide. This will create a three-tiered foster care program in West Virginia that will serve children through traditional foster care, treatment foster care and intensive treatment foster care.
- The Universal Assessment, WV Child and Adolescent Needs and Strength (CANS) was cross walked with the National Child Traumatic Stress Network Trauma CANS version and CANS sub-modules and was approved by the Praed Foundation in May 2015.
- WV continues to move toward utilizing the Total Clinical Outcome Management (TCOM) framework to measure, report, and build system capacity, especially in community-based service delivery and supports.
- Hornby Zeller Associates, Safe At Home WV evaluators, has developed the Automation of the WVCANS 2.0. The site is complete and they have written a user guide that is being reviewed by a few of our WVCANS experts. All users are being set up in their system with a plan to go live by the middle of February.
- The Department of Health and Human Resources (DHHR), Bureau for Children and Families, provided grants for licensed behavioral health agencies with direct children's service experience to act as local coordinating agencies in the implementation of the high fidelity Wraparound Model, with supporting services, for West Virginia's Safe at Home WV Wraparound.
- A comprehensive and searchable Provider Directory was added to the Bureau of Medical Services website to allow members, parents or legal guardians of members, and field office staff to have access to a directory of a variety of behavioral health providers that are available in throughout our state. This is checked on a regular basis to ensure that true up to date information is available on this site: http://www.wvcca.org/directory.html.

2. Expanded Community Capacity

Expand in-state residential and community-based program and service capacity for out-of-home children through systematic and collaborative strategic planning to include statewide programs such as Building Bridges, System of Care, and systems such as the Automatic Placement and Referral System (APR), and greater emphasis on upfront prevention approaches.

- The Safe at Home WV Services and Supports survey and results were completed by the Family Resource Networks, Regional Children's Summits and Community Collaborative Group members in June 2015. The Safe at Home WV Services and Supports included a listing of the core services within a wraparound model. The Family Resource Networks, Regional Children's Summits and Community Collaborative Group members were asked to determine if each of the 17 core services existed in their respective county. *(Safe at Home WV)*
- The Community Self-Assessment survey and results were completed by the Family Resource Networks, Regional Children's Summits and Community Collaborative Group members in July 2015. The

Community Self-Assessment looks at the readiness (based on the member's knowledge) of communities to implement a wraparound model as prescribed from the National Wraparound Initiative. *(Safe at Home WV)*

- The Office of Maternal, Child and Family Health met with the Pediatric Medical Advisory Board on April 17, 2015, to form a workgroup to develop age-appropriate trauma screening questions for addition to the HealthCheck forms. *(The Three Branch Institute)*
- The Family Resource Networks, who are involved in county/community based prevention/tertiary initiatives, will continually assess the services available to community family members (community service array). As team members of the Community Collaborative Groups, who will be reviewing children's needs, this information will be shared and solutions will be identified. When Community Collaborative Groups identify systemic barriers or need additional assistance, they will seek further assistance by forwarded their concerns to the Regional Summits.
- The Three Branch Committee for Substance Use in Pregnancy was created to "Safely reduce the reliance on out-of-home placement of children by reducing the incidence of substance exposed infants placed in out-of-home care". A collaborative planning approach was chosen to bring together existing programs and partnerships to promote consistency and achieve collective impact and to include ALL substances. Collaboratively, members have increased the number of treatment and recovery residences from 409 to 759; added Certified Recovery Coaches from 0 to 201; promoted Opioid Treatment Centers becoming licensed behavioral health programs; increased the number of physicians providing buprenorphine, 46 to 187 physicians waivered (164 Medicaid); and added Moms and Babies programs from 0 to 4.
- Governor's Advisory Council on Substance Abuse directed funding to support a START partnership pilot, a joint initiative between the Bureaus for Children and Families and Behavioral Health and Health Facilities. (Three Branch Committee for Substance Use in Pregnancy)
- 1-844-HELP-4-WV 24/7 real-time call line clinical & recovery staff providing warm hand-offs, transportation and follow-up. *(Three Branch Committee for Substance Use in Pregnancy)*
- "As of December 31, 2015, 830 participants have successfully graduated from West Virginia's Adult Drug Courts (ADCs), which have a graduation rate of 52%. The recidivism rate for graduates over the past two years is 9.4%... One year post graduation recidivism rate is only 1.8%. As of the end of December 2015, there were 25 operating ADC programs comprising 31 individual courts covering 43 counties… and 448 active clients." (More information about the WV Adult Drug Courts can be found in Appendix H.)
- "As of December 31, 2015, there are 15 operational Juvenile Drug Courts (JDCs) programs comprised of individual courts covering 17 counties. On December 31, 2015, there are with 197 active JDC cases. 492 participants have successfully graduated from West Virginia's JDCs. The JDCs have a graduation rate of approximately 50.5%. The recidivism rate for graduates is 14.6% as compared to 55.1% in traditional juvenile probation." (More information about the WV Adult Drug Courts can be found in Appendix H.)

3. Best Practices Deployment

Support statewide awareness, sharing, and adoption of proven best practices in all aspects (e.g., treatment, education, well-being, safety, training, placement, support) regarding the Commission's targeted populations.

- Safe at Home WV revised plan was presented to the Children's Bureau in mid-January 2015. Hornby Zeller Associates was awarded the contract that began July 1, 2015. Safe at Home West Virginia was rolled out on October 1, 2015, in the counties of Berkeley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam and Wayne. These initial counties were chosen based upon areas of highest need as reflected by the number of children in out of home care and areas of most readily available services.
- The Safe at Home WV Wraparound Advisory Team was formed. By December 2015, 58 youth have been referred to Safe at Home WV for Wraparound Services (24 in out-of-state placements; 26 in in-state placements; and 8 cases were prevented from residential placement). A total of 4 youth have returned to West Virginia, 5 youth have returned to their communities from in-state residential placements, and 8 youth were prevented from entering residential placement.
- Presentations have been provided to the members of the Community Collaborative Groups and Regional Children's Summits regarding Safe at Home WV and they have been asked to take the 10 Principles of Wraparound (that also align with the Commission priority goals) back to their agencies and offices and discuss thoroughly with their staff. They are also reviewing information regarding the youth in the Safe at Home WV target population and those in out-of-state placements.
- Development of the Wraparound Model work plan and products have been drafted. *(Service Delivery & Development Work Group)*

4. Workforce Development

Address staffing and development needs, including cross-systems training, that ensure a quality workforce with the knowledge, skills, and capacity required to provide the programs and services to meet the requirements (e.g., assessments, case management, adapt best practices, quality treatment, accountability) of those children in the Commission's targeted populations.

- In June 2015, direct service staff was surveyed to gage their level of knowledge of the Comprehensive Assessment Planning System (CAPS) Statewide Implementation and the Child Adolescent Needs and Strengths (CANS) assessment tool utilized by the CAPS and determine additional training and informational disbursement needed. *(Service Delivery & Development Work Group, CAPS Task Team)*
- A basic training entitled "Developmental Disabilities and Co-Existing Disorders: An Overview" along with a Training of Trainers curriculum was developed. This cross-sector training that also serves as relationship-building opportunities for providers in the mental health, IDD and child welfare systems. *(Service Delivery & Development Work Group, Silo Spanners)*
- HealthCheck operational policy was revised to include procedures that ensure continuity of operations when one or more Foster Care Liaison staff is absent. *(Three Branch Institute)*

- The Bureau for Public Health, Office of Maternal, Child and Family Health collaborated with the Bureau for Children and Families to improve quality and timeliness of FACTS data. In September 2013, 17% EPSDTs were scheduled for an exam within the first day of placement. In May 2015, this percentage increased to 63.2%.
- The Wraparound Model Task Team developed and provided the Wraparound 101 training targeted stakeholders in June 2015.

5. Education Standards

Ensure education standards are in place and all out-of-home children are receiving appropriate quality education in all settings and that education-related programs and services are meeting the requirements of all out-of-home children, regardless of placement location.

- The West Virginia Department of Education and the Out-of-Home Care Education Advisory Committee will continue to study the educational growth of children in out-of-home care. Specifically, they wish to investigate why students are not included in the data; investigate the student growth data discrepancy; examine and study the proficient students and see why these students are doing better; obtain change of placement data and correlate with assessment data; and examine disciplinary infractions to see if the infractions made are accurate and consistent across the state.

6. Provider Requirements

Require placements in all locations be made only to providers meeting West Virginia standards of licensure, certifications and expected rules of operation to include demonstrated quality in all programs and services that meet West Virginia Standards of Care.

- The development of a retrospective review tool was initiated to capture expectations for quality Comprehensive Assessment and Planning System (CAPS) and Comprehensive Assessment Reports (CAR) that includes the Child and Adolescents Needs and Strengths (CANS). *(Service Delivery & Development Work Group, Comprehensive Assessment and Planning System Task Team)*
- The Bureau for Medical Services implemented prior authorizations for atypical psychotics for children 6-18 years on August 1, 2015. Prior authorization for younger children is already a requirement. A key next step for the workgroup is to develop an evidence-based professional education program that can be delivered to DHHR staff, practitioners and other professionals working with children in foster care.
- On August 1, 2015, the Bureau for Medical Services (BMS) implemented a prior authorization process for atypical antipsychotics for foster children between the ages of 6 and 18 years. In addition, BMS is exploring a prior authorization process for stimulant medications, specifically for children in foster care. The workgroup is also continuing to develop a plan for provider education.
- To better understand prescribing practices, the Bureau for Public Health, Bureau for Medical Services and the Bureau for Children and Families undertook a case review of 68 case records for foster children prescribed psychotropic medications from three or more classes; nearly all (63/68; 93%) of these foster children had record of a hyperkinetic syndrome diagnosis, primarily Attention Deficient

Disorder (ADD) and Attention Deficient Hyperactivity Disorder (ADHD) (59/63; 94%). These prescriptions were primarily written by psychiatrists (78%) and did not exceed the recommended daily dosage (83%).

7. Multidisciplinary Team (MDT) Support

Support the multidisciplinary treatment team (MDT) concept and assist enhancing present MDT processes statewide.

- To reduce the reliance of out-of-home placement of children by identifying needs of children when involvement begins, the Three Branch Institute, Out-of-Home Placement Workgroup coordinated cross system strategies with the IV-E Waiver process; conducted a survey to capture a snapshot of how MDTs are conducted; developed and released statutorily required Multidisciplinary Treatment (MDT) Team Curriculum and Training Package; revised and distributed a MDT Desk Guide; and supported the Implementation of Child and Adolescent Needs and Strengths (CANS) in WV.
- The statutorily required Multidisciplinary Treatment (MDT) team curriculum and training package was piloted on May 29, 2015. The training curriculum and training package will be maintained by the Court Improvement Program's newly joined Behavioral Health and Multidisciplinary Treatment (MDT) Team Committee chaired by Judge Bloom.

8. Ongoing Communication

Develop appropriate and timely cross-system and public communications regarding the work of the Commission that fosters awareness and the continued commitment of stakeholders to reduce the placement of children outside of their community of residence and to enhance in-state capacity to reduce the number of children in West Virginia requiring out-of-home care.

- The Commission members and guests traveled to Prestera Center at Pinecrest in Huntington, WV, on August 27, 2015, to hold their quarterly meeting and hear and see first-hand what is happening in the area regarding the out-of-home population. The goal of this meeting was to allow the community to communicate their actions and barriers they face when children need to be placed out-of-home, and gain support toward improving outcomes.

9. Effective Partnerships

Continue to seek strong partnerships with individuals, agencies, organizations, other Commissions and special initiatives that advance the overarching goals and strategies of the Commission.

- In February 2015, the Mentoring & Oversight for Developing Independence with Foster Youth launched a "We Still Care" project to provide care packages to youth throughout the year to show them that even as they transition out of foster care, there are those that do still care. Along with the care packages, sponsors will provide cards and letters of support. During the year, 440 packages have been sent to youth ages 17 to 21 across the state that is identified in the National Youth in Transition

Database cohorts. We Still Care received donations due to a partnership with the Taylor County Collaborative Family Resource Network. Donations are tax-deductible and are given by individuals and organizations across West Virginia.

- The West Virginia Interagency Consolidated Out-of-State Monitoring process continues to ensure children in foster care and placed outside of the state of West Virginia are in a safe environment and provided behavioral health treatment and educational services commensurate with WV DHHR and WVDE standards. *(West Virginia Interagency Consolidated Out-of-State Monitoring Team)*

  In 2015, the following on-site reviews were completed:
  - George Junior Republic – Group Residential Level II Facility (PA)
    The Bureau for Children and Families suspended placement at the facility in April 2015 and all youth were to be moved from the facility as soon as appropriate placements were found.
  - Timber Ridge - Group Residential Level II Facility (VA)
  - Summit Academy - Psychiatric Residential Treatment Facility (PA)
  - Liberty Point Behavioral Healthcare, UHS - Psychiatric Residential Treatment Facility (VA)
  - Barry Robinson - Psychiatric Residential Treatment Facility (VA)

10. Performance Accountability

Ensure accountability through monitoring performance outcomes, improving processes and sharing information with all stakeholders.

- West Virginia is one of six sites that was selected in November by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to receive an 18-month program of In-Depth Technical Assistance (IDTA) from the National Center on Substance Abuse and Child Welfare (NCSACW) to help us work collaboratively across multiple disciplines to improve outcomes related to the prevention, identification, intervention and provision of treatment and support services for Substance Exposed Infants (SEIs) and their families.
- Bureau for Children and Families initiated a new web-based reporting system to track babies with NAS and Fetal Alcohol Spectrum Disorder. (*Three Branch Committee for Substance Use in Pregnancy)*
- Bureau for Public Health has collected the first year of data for the new required birth certificate components that include substance exposed pregnancies. (*Three Branch Committee for Substance Use in Pregnancy*)
- Bureau of Medical Services has begun data collection on utilization of pregnant women to further analyze the origin of substance exposures, family planning and medication assisted treatment and implemented Medicaid Expansion, Telehealth and MAT Coverage improvements. (*Three Branch Committee for Substance Use in Pregnancy*)

NEXT STEPS FOR 2016

In addition to building upon and refining the past year's accomplishments the Commission anticipates the following progress in 2016:

- The Safe at Home WV, Wraparound Model Task Team is developing a plan to provide a train the trainers." The DHHR, Bureau for Children and Families is identifying our "champions" who will become the trainers of the Wraparound 101 training.
- Deliver "Developmental Disabilities and Co-Existing Disorders: An Overview" and Training of Trainers curriculum to cross-systems audience to promote common language and understanding. *(Service Delivery & Development Work Group, Silo Spanners)*
- Compile the results of the Internal Expertise Survey and develop an Experts contact list and location map to strengthen cross-systems knowledge and networking opportunities for consultation/technical assistance purposes on a state and regional basis. *(Service Delivery & Development Work Group, Silo Spanners)*
- Address content specific workforce development opportunities to supplement introductory concepts introduced in "Developmental Disabilities and Co-Existing Disorders." *(Service Delivery & Development Work Group, Silo Spanners)*
- Integrate issues and needs of children with complex support needs into regional cross-systems networks (e.g., Regional Summits, Community Collaborative Groups, Regional Clinical Review Teams) to build and enhance system responsiveness. *(Service Delivery & Development Work Group, Silo Spanners)*
- Continue to engage participation on Silo Spanners to build cross-system perspective and knowledge, and to influence funding, policies and practice. *(Service Delivery & Development Work Group, Silo Spanners)*
- Develop an educational program that includes the basics of child welfare, an overview of trauma, and promotes understanding of the following: that other interventions should be considered with psychotropic medications; the need for a complete psychiatric evaluation (including physical examination) before making a decision about psychotropic medications and treatments; the responsibility of the medical consenter to decide whether to give informed consent for each psychotropic medication prescribed; how psychotropic medications are used; how to monitor a child for possible side effects or to see if the psychotropic medication is working; what to do if you have concerns about the psychotropic medications prescribed to children in your care; how various classes of psychotropic medications work, their side effects, and examples of medications in each class. *(Three Branch Institute, Trauma and Psychotropic Medications Workgroup)*
- The National Center on Substance Abuse and Child Welfare (NCSACW) will continue to provide technical assistance to help us work collaboratively across multiple disciplines to improve outcomes related to the prevention, identification, intervention and provision of treatment and support services for Substance Exposed Infants (SEIs) and their families. A Collaborative Planning Summit is scheduled for April 28-29, 2016. The objectives for the Summit are: build on progress and planning already underway; identify and prioritize actionable strategies toward accomplishing goals; and establish an accountability structure for plan implementation.
- The Bureau for Children and Families is currently in the process of developing program standards for a request for applications to broaden this program statewide. This will create a three-tiered foster care program in West Virginia that will serve children through traditional foster care, treatment foster care and intensive therapeutic foster care. The targeted goal for release of the respond for applications that is scheduled for March 1, 2016.

- The Three Branch Committee for Substance Use in Pregnancy will: continue to collect and validate data from all state systems; develop a simple dashboard for collecting data from multiple entities working on the same issue to better measure impact; complete the WV guidance document and disseminate statewide; support marketing strategies that improve community perception around "taking children vs. identifying children early and to promote family recovery models"; implement an intensive intervention model for substance abusing parents and families involved with the child welfare system (START program); develop WV guidance related to best practices in identifying, reporting and diagnosing substance use in mothers and babies.
- The West Virginia Department of Education and the Out-of-Home Care Education Advisory Committee will continue to study the educational growth of children in out-of-home care.
- Three additional Adult Drug Courts (ADCs) are in development in the 12th, 28th, and 30th judicial circuits. Two are currently in the planning phase.

CONCLUSION

Over the past year, the data suggests the dependence on out of state placement is trending downward (see Performance Benchmark shown in Appendix D and the WV System of Care End of Year Report in Appendix E). Progress can be attributed to the tireless efforts of the individuals that make up the Commission, its working groups, and its many partners dedicated to changing the child welfare system. We are witnessing how the foundational work has created the basis for improving the service provision we have. As we move forward, we will continue to address the Commission's Priority Goals, sharpen our focus on serving children and families locally (which will decrease the reliance for out of home and out of state care), and continue efforts toward improving the lives of West Virginia's children and families.

APPENDIX A

System of Care Principles Guiding Effective Care for Children, Youth & Families

1. Family Driven: Families have a primary decision-making role in the care of their own children, as well as the policies and procedures governing care for all children in their community and state.

2. Youth Guided: Young people have the right to be empowered, educated and given a decision-making role in their own lives as well as in the policies and procedures governing care for all youth in their community and state.

3. Culturally Competent: Children and families of diverse cultures and language proficiency have comparable access to services; service providers learn about and demonstrate respect for family culture (including attitudes and beliefs about services, child rearing, expression of symptoms, coping strategies, and help-seeking behavior); and diverse families achieve similarly successful outcomes from services.

4. Array of Community-Based Services: A broad and diverse array of community-based services and supports that are consistent with the system of care approach and improved outcomes.

5. Best Practice in Service Delivery: Creating or expanding an individualized, strength-based approach to service planning and delivery practices that have been shown to be effective and/or evidence-based, such as trauma-informed and trauma-specific services.

6. Quality Assurance: Meaningful outcomes are measured and play an important role in improving the quality of care to children and their families at a system level, service level and family/child level.

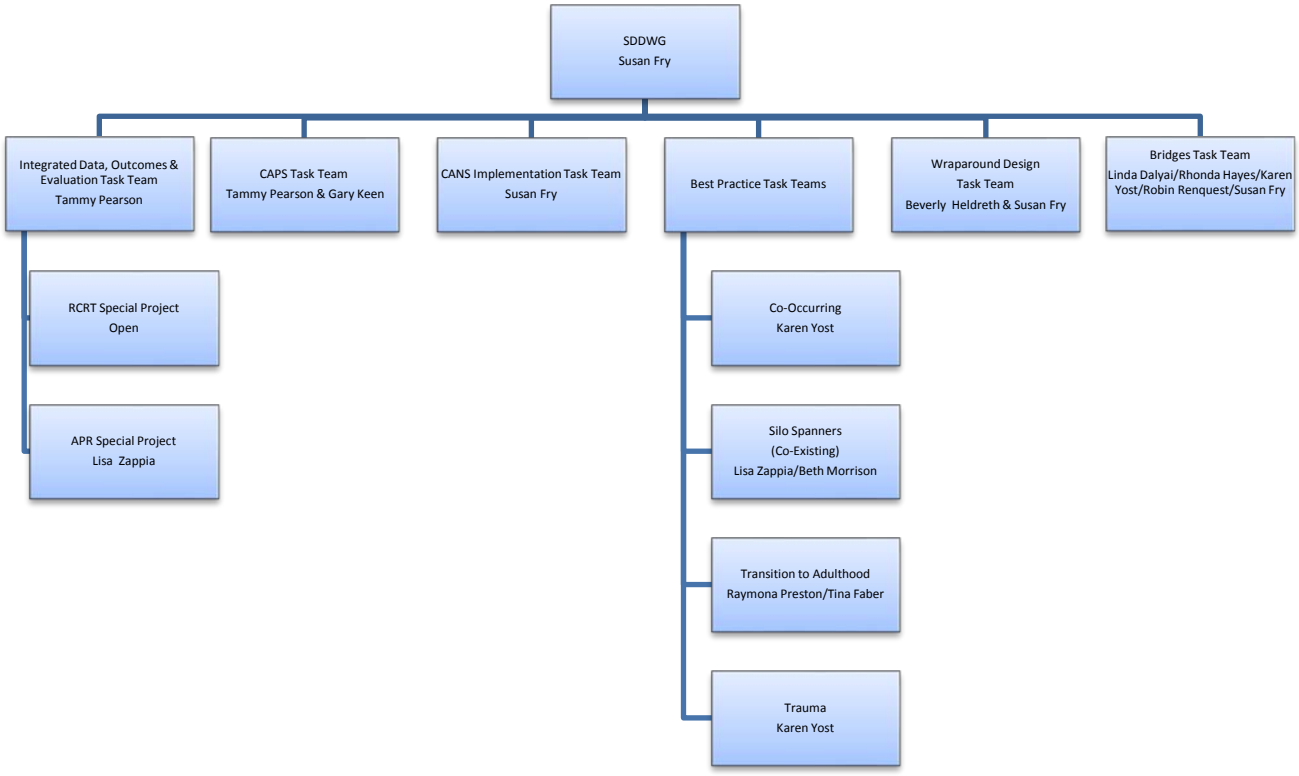
7. Government Accountability: All agencies that serve children, youth and families take the lead for System of Care goals and are responsible for policy, funding, system management and oversight to achieve them.

8. Interagency Collaboration: Interagency structures, agreements and partnerships are maintained that coordinate funding, resources and data to build the System of Care.

Source: www.wvsystemofcare.org

APPENDIX B

SERVICE DELIVERY & DEVELOPMENT WORK GROUP AND COMMITTEES



Service Delivery & Development Work Group Members

1. Susan Fry, Chair – Stepping Stones, Inc. *
2. Raymona Preston – Stepping Stones, Inc. *
3. Karen Yost – Prestera *
4. Lisa Zappia – Prestera *
5. Linda Watts – BCF Deputy Commissioner, WV DHHR
6. Rhonda Hayes – WV Family Advocacy and Support Team (FAST) *
7. Beverly Petrelli – Wellspring-Crittenton Services
8. Renee Ellenberger/Patty Lewis – National Youth Advocate Program
9. Robin Renquest – Pressley Ridge *
10. Amanda Ash – Pressley Ridge
11. Laura Barno – WV DHHR, BCF
12. Brad Gault – Try Again Homes
13. Jackie Columbia – Board of Child Care
14. Beverly Heldreth – Region I RPM, WV DHHR
15. Christa James – Region I CWC, WV DHHR
16. Cheryl Salamacha –Region II Regional Director, WV DHHR
17. Sandra Wilkerson – BCF Region II CWC, WV DHHR
18. Amy Booth – Kanawha County CSM, WV DHHR
19. Kimberly Harrison– WV DHHR, BHHF
20. Beth Cook – Logan County Child Advocacy Center
21. Lora Dunn – Highland Hospital
22. Beth Morrison – WVDHHR, BHHF*
23. Mark Allen – Burlington United Methodist Family Services
24. Debi Gillespie – Division of Juvenile Services
25. Jason Deusenberry – WVDHHR, BHHF
26. Mindy Thornton – Prestera
27. Tammy Pearson – WVSOC *
28. Chris Whitt – River Park Hospital
29. Donna Midkiff – River Park Hospital
30. Linda Dalyai – WVDHHR, BCF*
31. Elva Strickland – WVDHHR, BCF
32. Gary Keen – WVDHHR, BCF *
33. Amy Rickman – Necco
34. Laura Parker-Barua - WVDHHR, BCF
35. Lorie Bragg – WVDHHR-BCF Region IV CWC
36. Melody Plumley – Children's Home Society
37. Michelle Dean – WVDHHR, BCF
38. Misty Prilliman – WVDHHR, BCF

Service Delivery and Development Work Group Task Teams

(Task teams include representative members of the full work group in addition to many additional stakeholders representative of both public and private WV child serving systems.)

1. Building Bridges Oversight Task Team – Rhonda McCormick, Susan Fry, Karen Yost, Linda Dalyai & Robin Renquest
2. Comprehensive Assessment and Planning Task Team (CAPS) – Tammy Watts & Gary Keen
3. Automatic Placement and Referral Special Project (APR) – Lisa Zappia
4. Older Youth Transitioning to Adulthood Best Practice Task Team – Raymona Preston & Tina Faber
5. Co-Occurring Best Practice Task Team – Karen Yost
6. Co-Existing Best Practice Task Team – Beth Morrison & Lisa Zappia
7. Integrated Data, Evaluation and Outcomes Task Team – Tammy Pearson
8. Trauma Best Practice Task Team – Karen Yost
9. Wraparound Task Team – Beverly Heldreth & Susan Fry
10. CANS Implementation Task Team – Susan Fry

** Denotes Task Team & Ad Hoc/Special Project Leaders ** In addition to the above listed task teams, the work group is responsible for the annual review and providing ongoing technical assistance to the Regional Clinical Review Team process and WV CAPS as well as ongoing additional projects and responsibilities as assigned.*

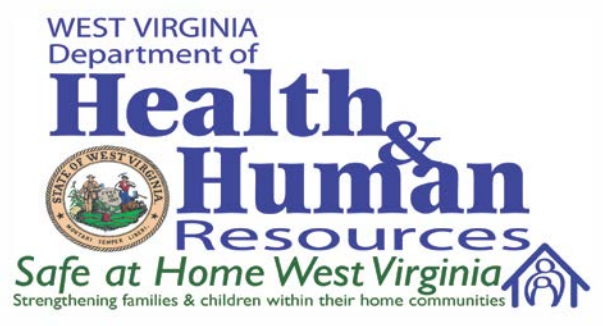
2015 Advanced CANS Experts

Susan Fry, Stepping Stones, Inc. Ramona Preston, Stepping Stones, Inc. Lisa Zappia, Prestera	Andrea Blankenship, Pressley Ridge Abigail Koller, National Youth Advocate Michelle Molisee, Crittenton Services	Joanne Dobrzanski, Family Connections Angie Via Hairson, Riverpark Hospital Melody Plumley, Children's Home Society LuAnn Edge, Potomac Highlands Guild

2015 WV CANS Experts

1. Susan Fry, Stepping Stones, Inc. 2. Raymona Preston, Stepping Stones, Inc. 3. Lisa Zappia, Prestera 4. Melinda Thornton, Prestera 5. Andrea Blankinship, Pressley Ridge 6. Cathy Walker Muncy, Family Options 7. Tina Maloney, Pressley Ridge 8. Lata Menon, Home Base, Inc. 9. Margot Kubichek, Youth Health Service 10. Abigayle Koller, National Youth Advocate Program 12. Michelle Molisee, Crittenton Services 13. Renee Harris 14. Erin Osborne, KVC 15. Jennifer Willett, Academy Programs	16. Patty Mullinax, Family Options 17. Joanne Dobrzanski, Family Connections 18. Terry McCormick, St Johns Children's Home 19. Beth Scohy, Daymark 20. Melanie D' Andrilli, Stepping Stone, Inc. 21. Tiffany Smith, PSIMED/ Division of Juvenile Services 22. Lora Dunn, Highland Hospital 23. Sharon Seitz, NECCO 24. Anastasia Riley, WVU CED 25. Angie Via Hairston, Riverpark Hospital 26. Melody Plumley, Children's Home Society 27. Jessica Cole, Board of Child Care 28. Samantha Robinson	29. Marsha Woods, Youth Services System 30. Taunja Hutchison, Children First 31. Melanie St. Clair, Pressley Ridge 32. LuAnn Edge, Potomac Highlands Guild 33. Deanna Griffith, Genesis Youth Crisis Center 34. Caitlyn Benedict, Lasting Solutions 35. Tracee Chambers, Crittenton 36. Bobby Griffith, WV SOC 37. Cathy Junkins, Burlington UMFS 38. Ann Marlowe, CAPS To Go 39. Jessica Crowder, Alternative Solutions 40. Sarah Stark, Westbrook Health Service 41. Mark McManaway, Wood County youth Reporting Center, DJS

APPENDIX C



Our children and families will be:
Safe
Successful
Healthy
Supported

And our child welfare system will be transformed to meet the needs of children and families.

2015 Update

- West Virginia's Title IV-E Waiver demonstration project, Safe at Home WV, aims to provide wraparound behavioral health and social services to 12-17 year olds with specific identified behavioral health needs who are currently in congregate care or at risk of entering congregate care.
- The Title IV-E Waiver allows the existing level of funding to be refocused. This will allow West Virginia to demonstrate that child welfare programs can achieve better outcomes for children and families if funds are spent for enhanced wraparound community based services aimed at returning and keeping children in their communities.
- WV has the highest foster care entry rate in the nation (8.6 children per 1,000 compared to a national entry rate of 3.3 in FY12).
- Safe at Home WV focuses on universalizing the CANS and providing wraparound services to youth ages 12-17 in congregate care or at risk of entering congregate care, with the vision of maintaining youth in their communities where they have the best chances for success.
- With a goal of developing a model that can be replicated statewide, the demonstration will start in Berkeley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam and Wayne counties.

- In October 2014, BCF was granted a federal Title IV-E Waiver by the U.S. Department of Health and Human Services Administration for Children and Families to conduct a child welfare demonstration project.
- Implementation in the Phase 1 counties began on October 1, 2015, with 21 youth being referred.
- Safe at Home WV will require youth-serving public and private organizations to partner, innovate, and develop a shared commitment to transform the way we serve families.
- Safe at Home WV seeks to increase permanency for all youth by reducing the time in foster placements, increasing positive outcomes for youth and families in their homes and communities, and preventing child abuse and neglect and the re-entry of youth into foster care.
- The 3rd quarter Initial Design and Implementation Plan was submitted on August 14, 2015.
- A Wraparound Advisory Team has been formed to provide oversight, fidelity, and technical assistance to the Local Coordinating Agencies and the Department. The team is made up of Department staff and partners.

Service/Model Development

- Local Coordinating agencies will be the lead for the care coordination of wraparound services. We will partner with these agencies through a grant process.
- The Response for Applications for the Local Coordinating Agencies and Wraparound Facilitators was posted, questions were received, and answers posted. The applicant's intent to apply was submitted by August 10, 2015 and applications were received by August 14, 2015. Statements of work were completed the last week of August 2015. The agencies were required to have their first cohort of staff on board by September 1,2015 The month of September 2015 was spent preparing and training staff as trainers that will then require the local coordinating agencies to train any new staff that are hired and to assist with future phases of training.
- Criteria has been developed for target population:
    - Youth ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis 1) currently in out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by wrap-around
    - Youth ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis 1) currently in in-state residential placement and cannot be reunified successfully without extra support, linkage and services provided by wrap-around
    - Youth ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis 1) at risk of out-of-state residential placement and utilization of wrap-around can safely prevent the placement
    - Youth ages 12 to 17 (up to the age of the youth's 17th birthday) with a diagnosis of a severe emotional or behavioral disturbance that impedes his or her daily functioning (DSM-V Axis 1) at risk of in-state level 1, 2,3 or PRTF residential placement and they can be safely served at home by utilizing wrap-around
- Wraparound 101 overview training has been updated and is being used. This serves as a standardized introduction of wraparound for DHHR staff, Probation Officers, Judges, Providers, Leadership, and informal supports, as well as the training for care coordinators and staff that will be referring to wraparound.

- An in-depth 1 ½ day Wraparound 101 training has been developed and will be used to train BCF staff that refer these cases and the local coordinating agencies and the Care Coordinators/Wraparound Facilitators. Trainings in the Phase 1 counties began the last week in August and the first weeks of September 2015 for BCF staff. The training for the local coordinating agencies will be in the middle of September.
    - This team has identified wraparound champions that will assist with the delivery of these trainings.
    - Development of the referral form, confidentiality and consent for treatment templates is complete.
    - Wraparound Family Handbook is complete and will be for families participating in Safe at Home WV.
    - Development of the Memo of Understanding and Service Agreement templates is complete.
- A wraparound facilitator matrix is compete and will be used as a foundation to develop a wraparound facilitator job description and practice framework for use by the Local Coordinating Agencies.
- The development of the Wraparound Model Manual that contains program overviews and all documents and templates that can be used as a foundation for Local Coordinating Agencies to build an operations manual is complete and will be distributing as appropriate.
- Several smaller workgroups are coordinating to develop trauma informed family engagement model training, support, resources, and guides with at target prior to October 1, 2016. These tools are for use by the Local Coordinating Agencies.
    - Structural changes to service categories
    - Development of performance measures for each service category
    - Removal of the fee for service payment structure
    - Removal of the following services from the utilization matrix:
        - Child Oriented Activity
        - Child-Oriented Group Activity
        - General Parenting
        - Family Crisis Response for Jacob's Law
        - Cognitive-Behavioral Therapy (this will become care coordination through Local Coordinating Agency contracts)
        - Pre-reunification Support
        - Tutoring
        - Homemaker Services
- Changes to eligibility, service definition and provider criteria of existing services:
    - Under Family Support, require the CANS tool be used for Needs Assessment/Service Plan
    - Case Management would not be available as a service option for families enrolled in Safe at Home WV, as the local coordinating agency would be receiving a case rate for the care coordination
    - Family Crisis Response – Remove the requirement for social work license
    - Respite – Evaluate the four types of respite to determine if all are needed. Only one, emergency respite, has been utilized in the past year.
- New Service Development:
    - Peer Support – For adults with substance abuse and/or mental health issues for which they are either undergoing treatment or recently completed treatment. The service providers are paraprofessional peer for recovery support.
    - Youth Coaching – Based on the Circle of Courage model, provides education and youth development skills that have evidence-basis for success.

- The CANS 2.0 has been approved by all interested parties and has been sent for formatting. It is an expanded version of the CANS that incorporates some new areas of assessment. It will assist BCF in gathering information regarding human trafficking.
- Service needs assessments have been completed by the Phase 1 counties as well as several other collaborative groups. BCF has assisted with guidance to the Community Collaborative Groups on developing a strategic plan to guide work on developing services in the identified gaps.

Practice Development

- Policy regarding Wraparound has been written to be stand-alone policy. It will be embedded into Youth Services/Child Protective Services policy when that policy is next updated.
- A guide to filing of wraparound documents has been drafted for use by BCF staff.
- These documents will be provided to staff as part of their Wraparound 101 Training.

Evaluation

- Hornby Zeller Associates (HZA) was awarded the contract that began July 1, 2015. They met with BCF within 5 days of the award for an orientation to Safe at Home WV. Lisa McMullen facilitated a meeting with HZA and the Office of Information Technology (OIT) staff to discuss data pulls and automation of the CANS. The meeting provided some clarity to OIT as to what they would need to develop, which ended up being much less than anticipated.
- The independent evaluators have developed the automation of the WVCANS 2.0. The site is complete and they have written a user guide that is being reviewed by a few of our WVCANS experts. They have conducted user training in the Phase 1 areas. All users are being set up in their system with a plan to go live by the middle of February.
- The independent evaluators have conducted interviews for the first part of their evaluation of our processes.
- The independent evaluators are preparing to begin fidelity reviews as part of the process evaluation.
- HZA has met with the Safe at Home WV Evaluation Workgroup and reviewed evaluation needs and plans. They submitted a draft evaluation plan to the workgroup for review and comments, made updates, and Lisa McMullen submitted the draft evaluation plan to the Administration of Children and Families (ACF) Children's Bureau on August 3, 2015.

Training/Communication

- Susan Richards has developed a team of subject experts of statewide BCF staff to facilitate training in a different manner than the normal classroom training. This group will work with local office staff to facilitate a transfer of learning. They have met several times and have been provided with a wealth of information regarding family engagement and customer service. They were provided with the Wraparound 101 overview training.
- Presentations are being given in various venues, meetings with judges continue, the quarterly newsletter is proceeding well, and the team is sending out weekly email blasts to DHHR employees and community partners.

Data

- This workgroup has developed a tracking spreadsheet to watch placement activity across the state. This will also be used to track re-entry into foster care. They have written a standard operating procedure to guide field staff in completion of the spreadsheet, with timeframes and submission directives.
- They have also developed a brief spreadsheet for completion by field staff to track cases referred to wraparound services. This form will assist with payment reconciliation until automation is achieved in FACTS.

Transformation of WV Child Welfare System to meet the needs of children and families

- DHHR coordinated a full day meeting with residential, shelter care, and specialized foster care providers. The meeting was hosted by the Casey Family Foundation and attended by the Commissioners of the Bureau for Medical Services, the Bureau of Behavioral Health and Health Facilities, the Bureau for Children and Families, the Cabinet Secretary, and Deputy Secretary. The morning focused on the paradigm shift of providing care for West Virginia children, and the day ended with formation of task teams to address the necessary changes. Out of Home Placement partners task force meetings were held on June 5, June 26, and July 10, 2015, to address changes in licensing agreements, performance measures, and rate setting. This work continues.

Fiscal Accounting

- The Developmental Cost Plan has been updated to allow for reimbursement of the startup costs for the Response for Applications. It is being reviewed by DHHR Office of Administration and is to be completed and ready for re-submission on Monday, August 17, 2015.
- BCF Operations is working with DHHR administration to complete the schedule of quarterly payments.
- BCF Operations is working with the Office of Information Technology to determine invoice payment processes for the local coordinating agencies. They are also drafting an invoice document that will be completed by August 28, 2015, so that it can be provided to the local coordinating agencies as part of their training.

Preparation for Phase 2 implementation

- Phase 2 is scheduled for July 1, 2016 in the following counties: Brooke, Hancock, Monongalia, Marion, Ohio, Barbour, Grant, Hardy, Hampshire, Harrison, Lewis, Mineral, Pendleton, Preston, Randolph, Taylor, Tucker, Upshur, Greenbrier, Mercer, Monroe, Nicholas, Pocahontas, and Summers.

Please refer to our website for further information: http://www.dhhr.wv.gov/bcf/Services/Pages/Safe-At-Home-West-Virginia.aspx.

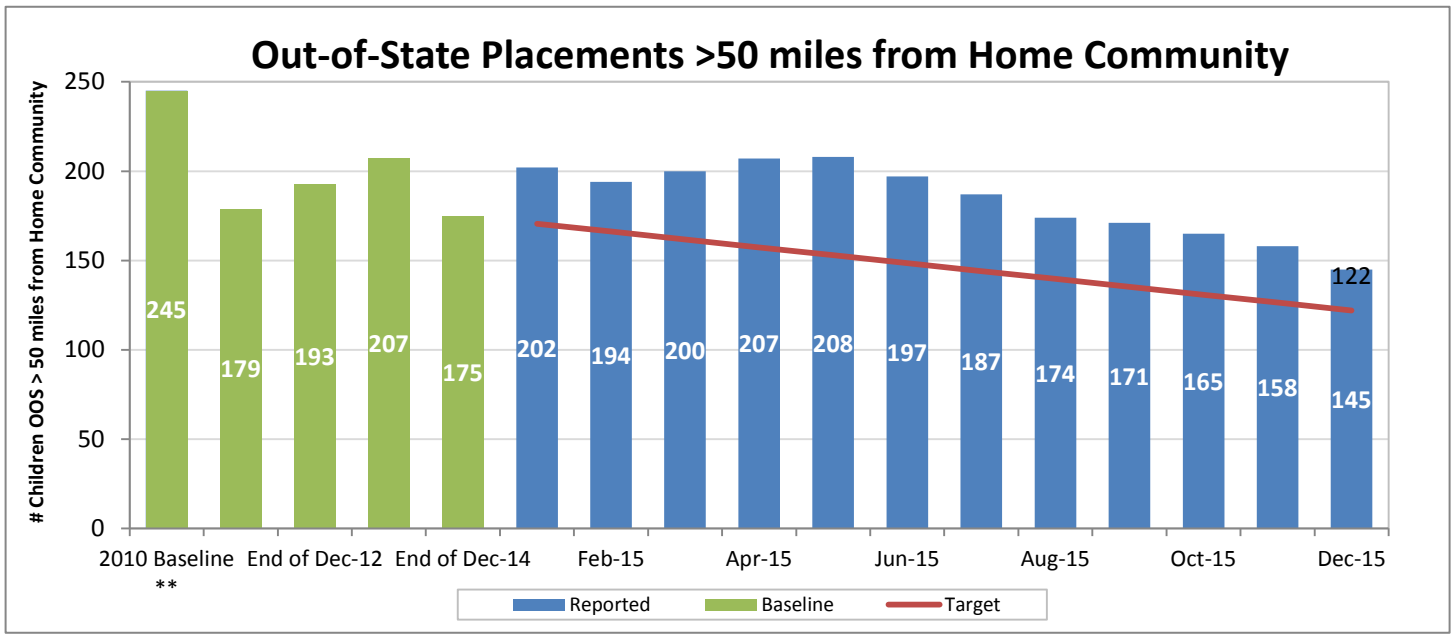
APPENDIX D

WEST VIRGINIA COMMISSION TO STUDY RESIDENTIAL PLACEMENT OF CHILDREN

PERFORMANCE SCORECARD

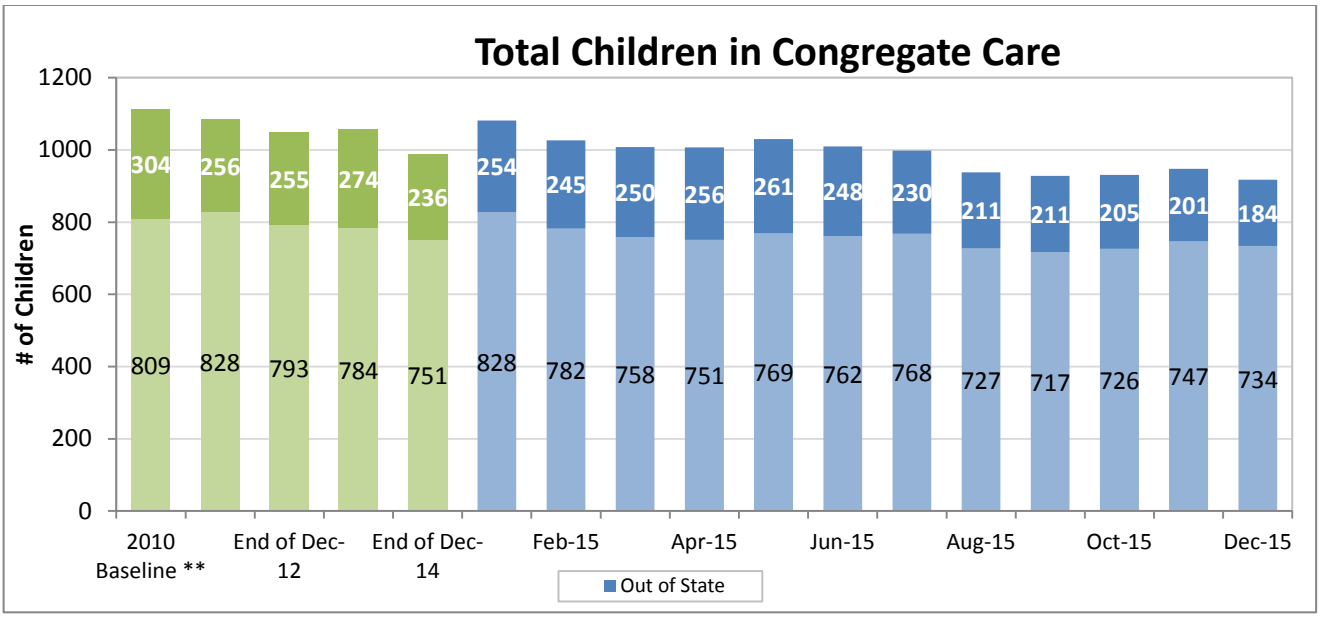
December 2015

Out-of-Home Placements	Group Residential Care	Psychiatric Facility (Long Term)	Psychiatric Facility (Short Term)	Total	
In State	**653**	**58**	**23**	**734**	80%
< 50 miles from Home Community A	265	25	7	**297**	32%
> 50 miles from Home Community C	388	33	16	**437**	48%
Out of State	**116**	**66**	**2**	**184**	20%
< 50 miles from Home Community B	37	2	0	**39**	4%
> 50 miles from Home Community D	79	64	2	**145**	16%
Total	**769**	**124**	**25**	**918**	100%



* The improvement target for 2015 is to have less than 122 children placed out-of-state and greater than 50 miles from their home community

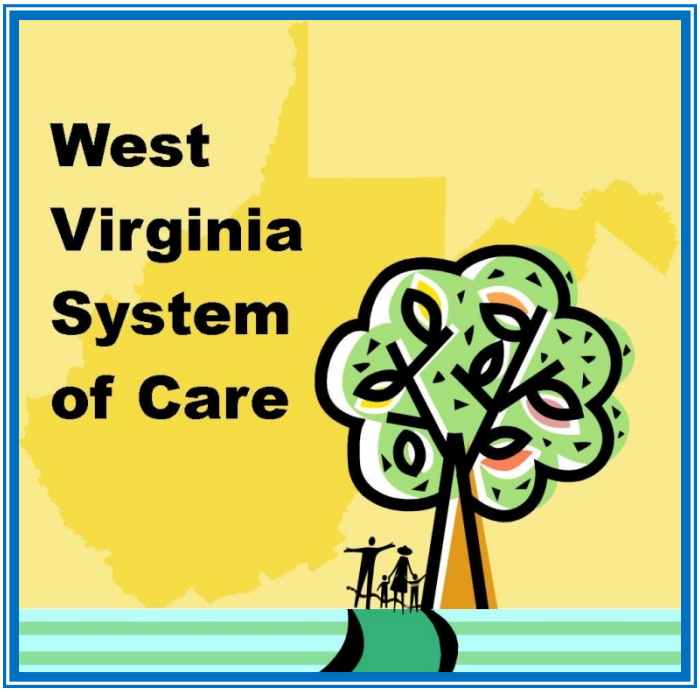
** Baseline is the average of October, November and December of 2010



**Baseline is the total children in congregate care on December 31 for each of 2010, 2011, 2012, 2013, and 2014.

APPENDIX E

WV System of Care End of Year Report
July 1, 2014-June 30, 2015



WV System of Care is a public/private/consumer partnership dedicated to building the foundation for an effective community-based continuum of care that empowers children at risk of out-of-home care and their families.

(Youth in State's custody who are Out-of-State in Group Residential Facilities, Psychiatric Residential Treatment Facilities, and Specialized Foster Care)

Prepared by the Technical Assistance and Evaluation Office,
Robert C. Byrd Center for Rural Health, Marshall University
AND
Integrated Data, Outcomes and Evaluation Task Team

Introduction

A System of Care is a coordinated and organized framework for system reform with a set of core values and principles. It is comprehensive, individualized, and culturally competent, and includes meaningful partnerships with families and youth.

Key Values & Principles underlying West Virginia's System of Care model:

- Multiple services and supports are delivered in a **coordinated** and therapeutic manner as children and their families move through the services systems.
- Ensure **availability** and access to a broad, flexible array of effective community-based **s**ervices and supports **.**
- Families, caregivers, and youth are **full partners i**n all aspects of planning and delivery of their own services and in policies and procedures that govern care for all children and youth .
- Services and supports are delivered within the **least restrictive, most normative environment** that are **clinically appropriate**.
- Ensure services are **integrated** at the system level, with linkages between child-serving agencies and programs.

- Services and supports must be **individualized, strength-based, developmentally appropriate** and delivered in a coordinated manner to meet the needs of each child and family.
- Incorporate continuous **accountability and quality improvement** to track, monitor, and manage effectiveness, outcomes, and practices..
- Services and Supports include **evidence-informed and promising practices** and interventions supported by practice-based evidence.
- Services must be **culturally and linguistically competent** that is sensitive and responsive to family differences.
- Services and supports must be **trauma-informed**.
- Provide appropriate services/supports that facilitate the **transition of youth to adulthood** and to the adult service system
- Protect the **rights of children and families** and promote effective advocacy efforts.
- Promote and incorporate **prevention, early identification, and intervention** in order to improve long-term outcomes

Who are placed out-of-state or are at risk of being placed out-of-state for residential treatment or specialized foster care.

Purpose

This report along with other available data will be used to guide decisions and develop strategies to better serve WV youth.

Data Collection

Data is collected in a number of ways.

Youth Who are Out-of-State, Returning or are At Risk of Going Out-of-State

For youth currently in the custody of the West Virginia Department of Health and Human Resources (WVDHHR), who are currently Out-of-State or who are returning, information is collected from the WVDHHR Families and Children Tracking System (FACTS). FACTS is West Virginia's Statewide Automated Child Welfare Information System (SACWIS). FACTS is an embedded automated case management system. The system is required to store, sort, collate, and report on huge amount of data that is critical for the operation of the Bureau for Children and Families social services. Youth who are in the custody of the state and who are placed Out-of-State in group, residential, or specialized foster care are tracked in this program.

The information in this report was collected from the FACTS reports. The numbers are as accurate as possible. If any inaccuracy occurs it is due to one or more of the following issues related to data collection:

- Some youth do not appear on FACTS report in the month they actually enter an out-of-state facility or return to WV. Sometimes the data is delayed a month.
- Some youth, if discharged at the end of the month, do not appear on the FACTS report.
- Some youth move from one out-of-state placement to another. This move can be from one facility to another or can be to a different program within the same facility.

Diagnosis is provided by APS Healthcare or obtained from Out-of-State Review and Regional Clinical Review documents.

Information in regards to youth who are staffed at the Out-of-State Review and Regional Clinical Review Teams is sent to the evaluation team.

WV Youth Out of State and Gaps in Services

The West Virginia Commission to Study Residential Placement of Children was created by an act of the 2005 Legislature (HB 2334; Section 49-7-34 of WV Code) to achieve systemic reform for youth at risk of out-of-home residential placement, and to establish an integrated system of care for these youth and their families.

As a result of this Study the Regional Clinical Review Process was developed and implemented in 2007.

The Regional Clinical Review Process is a coordinated effort to provide a comprehensive, objective, clinical review of designated youth. The process has several steps to assure that the review is objective and thorough and includes a standardized assessment tool utilized in all reviews. The participants in this process include the legal guardian, a regional clinical coordinator, an individual reviewer, and a regional clinical review team.

In 2014, the State decide that all youth who were out-of-state should be reviewed in order to determine gaps in services, barriers to serving youth in state, and system issues. At the same time this review allowed for the team to make recommendations to assist the youth in to returning to the state. Another review was completed in 2015 and it was determined that the process should be completed on a regular basis. This is being implemented late 2015 and early 2016.

Executive Summary

WV System of Care is a public/private/consumer partnership dedicated to building the foundation for an effective community-based continuum of care that empowers children at risk of out-of-home care and their families.

This year the WV System of Care has worked through two processes to identify gaps in services, barriers to serving youth in the state and returning youth to the state. These processes have also prevented youth from being placed in out-of-state services, identified services appropriate for the youth and assisted in the planning for youth returning to the state. These two processes are the Regional Clinical Review Team and the Out-of-State Review Team.

The number of youth being placed out-of-state continues to decrease. Two years ago (2012-2013) 533 youth were placed out of state. Last year (2013-2014) 492 youth were placed out-of-state and this year (2014-2015) 477 youth were placed out-of-state. That is an 11% decrease in 3 years.

The demographic type of youth being placed out-of-state remains the same. There are more males than females; the youth are usually age 15-17 years old and the majority are Caucasian. 23% of the youth have been placed out-of-state more than once in the last 7 years.

Although diagnoses are not always accurate, as was discovered during the Out-of-State Reviews, the numbers last year indicate that 30% of the youth had an intellectual disability; 25% had a substance abuse or dependence diagnosis and over half of the youth had a behavioral disorder of conduct disorder or oppositional defiant disorder.

This year (July 2014-June 2015) 358 youth out of 476 (75%) were reviewed through a Regional Clinical Review Team and/or an Out-of-State Review Team. As the Out-of-State Review and Regional Clinical Review Teams continue to review youth and assist in placement and identifying services, the state will be able to utilize this data for future planning. (Please refer to the Comprehensive Review of West Virginia Children/Adolescents in Out-of-State Placements for more information on gaps in services.)

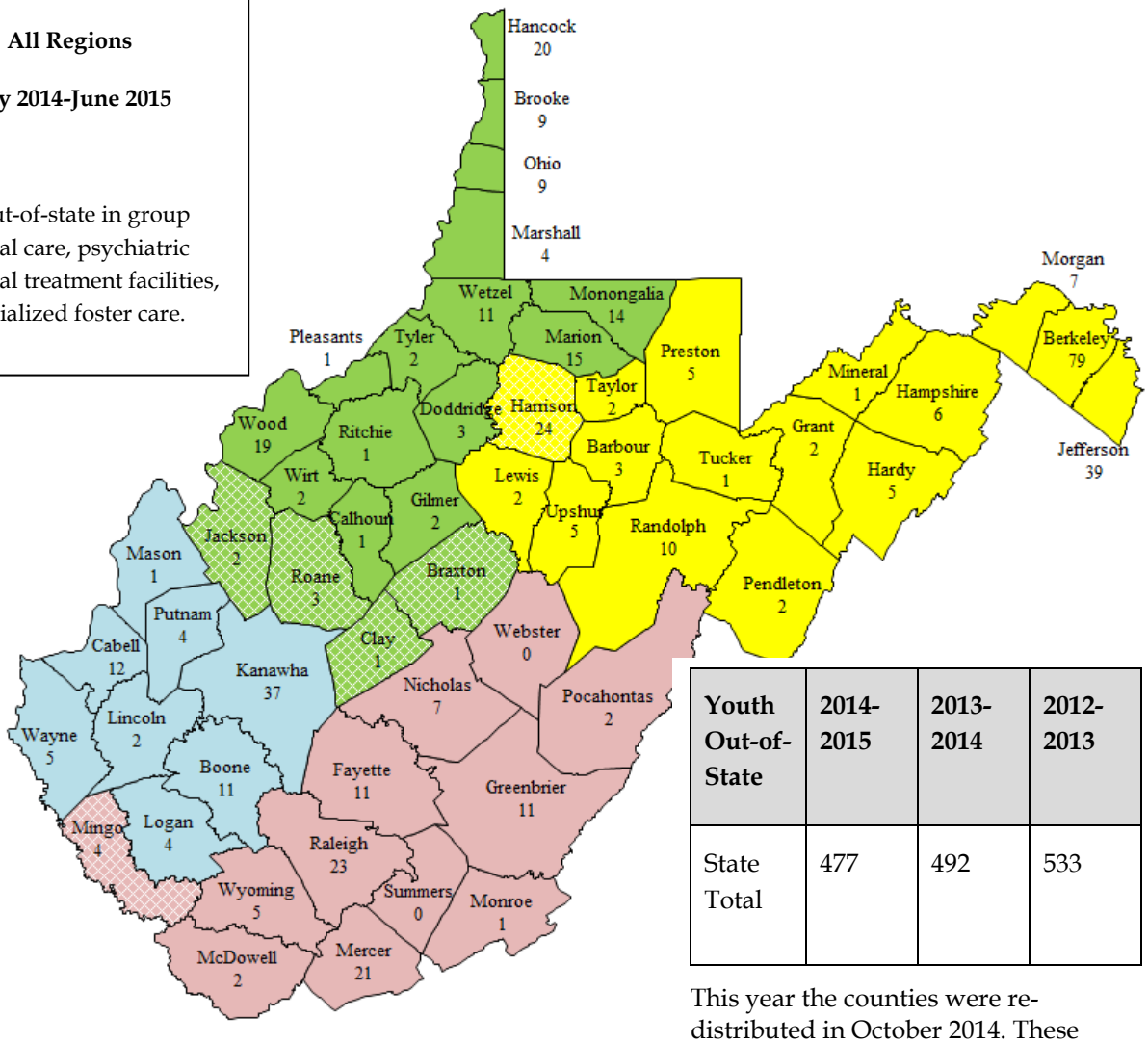
Youth Out-of-State

Out of State Youth

All Regions

July 2014-June 2015

Youth out-of-state in group residential care, psychiatric residential treatment facilities, and specialized foster care.



Youth Out-of-State	2014-2015	2013-2014	2012-2013
State Total	477	492	533

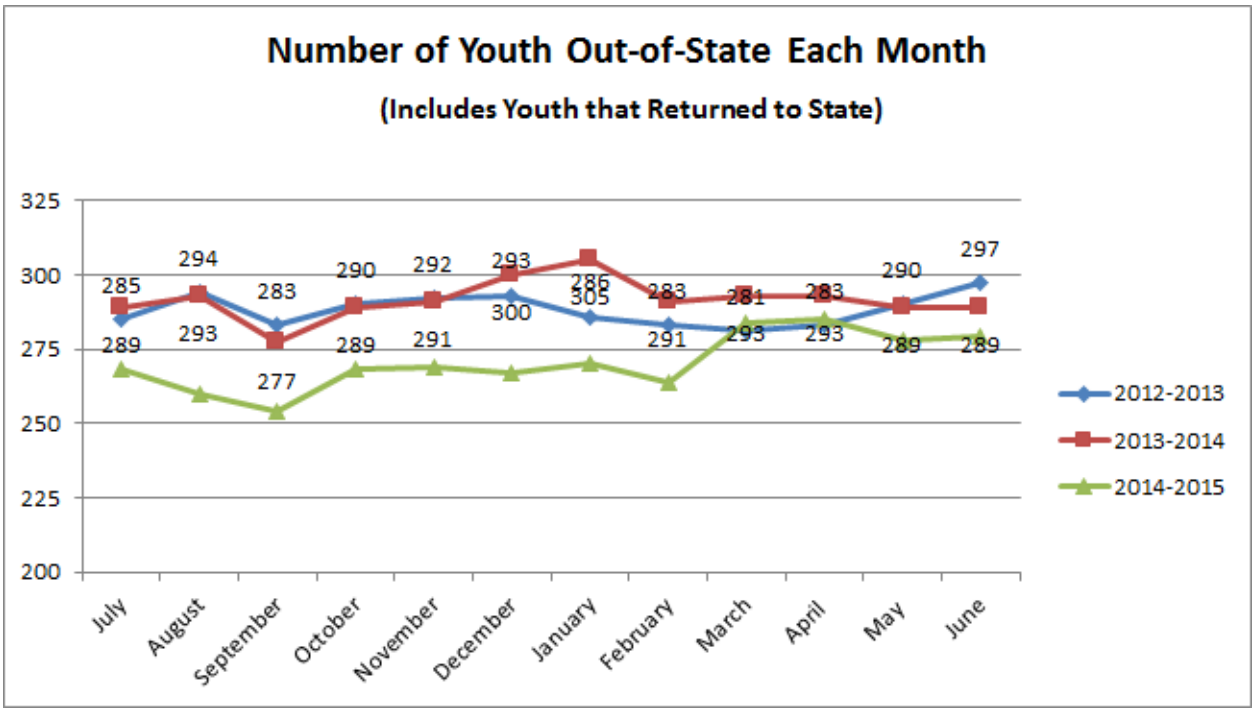
This year the counties were re-distributed in October 2014. These counties are indicated by patterns.

County	Previous Region	New Region
Jackson	2	1
Roane	2	1
Mingo	2	4
Clay	4	1
Braxton	4	1
Harrison	1	3

Monthly Count

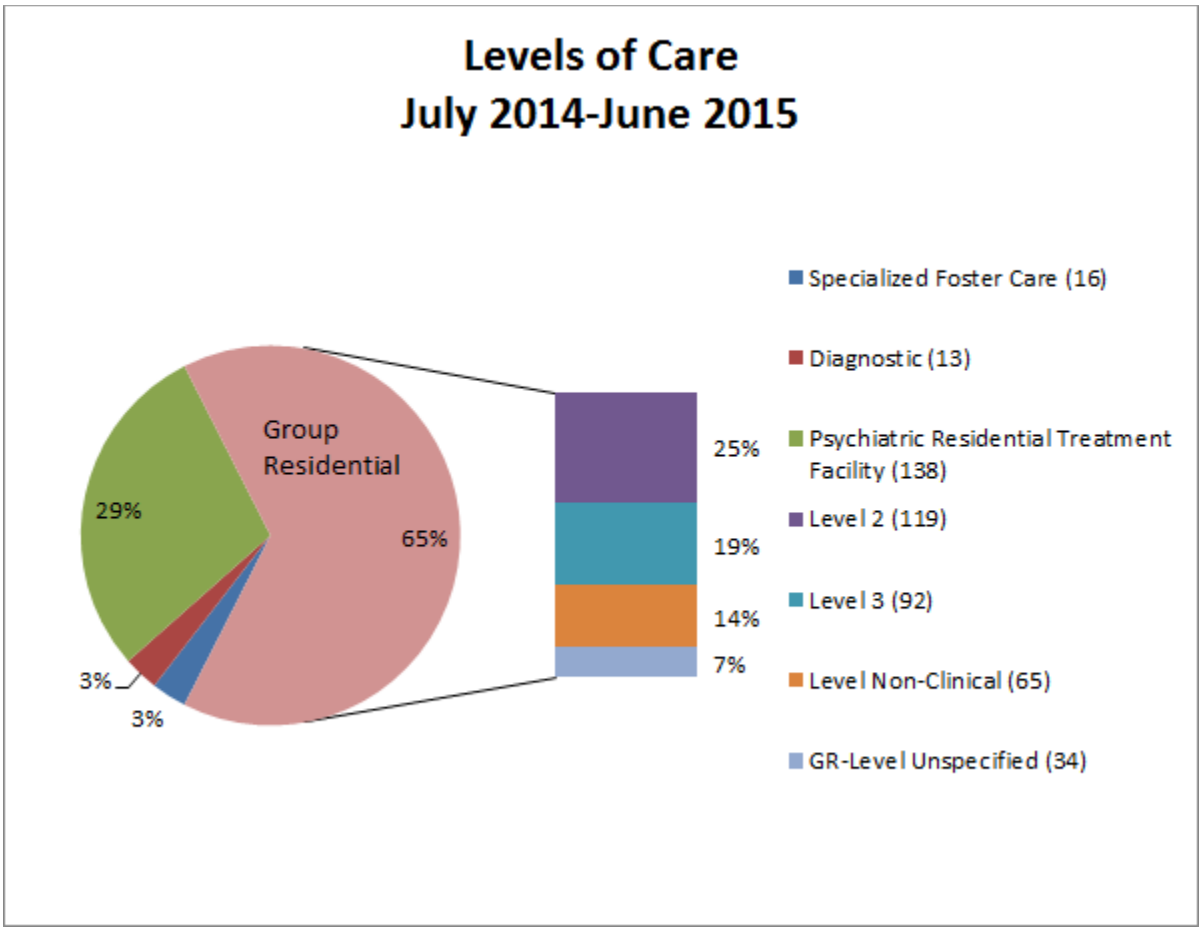
The overall average number of youth out-of-state each month has decreased. The average number of youth out-of-state each month was:

- 2014-2015=270
- 2013-2014=292
- 2012-2013=288



Levels of Care

The information below indicates the current level of care of the youth or the level at discharge. The majority (65%) of youth were in a group residential facility.



Demographic Highlights of Youth

- From July 2014-June 2015 a total of 477 youth were out-of-state. This time last year 492 youth were out-of-state.
- This year 372 males (78%) were placed out-of-state and 105 females (22%).
- The youth were the following ages when placed out-of-state (not current age):
  - 10 years old or younger-44 youth (9%)
  - 11-14 years old-141 youth (29%)
  - 15-17 years old-265 youth (56%)
  - 18 or older-27 youth (6%)
- At the time of this report (July 2015), 207 youth had been discharged. The youth were the following ages when discharged:
  - 10 years old or younger-12 youth (6%)
  - 11-14 years old-32 youth (15%)
  - 15-17 years old-106 youth (51%)
  - 18 or older-57 youth (28%)
- Youth were placed at the following facility types:
  - 65% in a Group Residential
  - 29% at a PRTF
  - 3% in specialized foster care
  - 3% in a diagnostic facility
- It was found that the diagnoses reported were not always accurate, so the following information should be reviewed cautiously.
  - 241 out of 477 youth (51%) had a diagnosis of Oppositional Defiant (130 youth-54%) or Conduct Disorder (111 youth-46%).
  - 204 out of 477 (43%) had a mood disorder, which could include Major Depression, Bipolar Disorder, Dysthymic Disorder or Depressive Disorder Not Otherwise Specified.
  - 99 out of 477 (21%) had an anxiety disorder, which includes Post Traumatic Stress Disorder, Panic Disorder, Generalized Anxiety Disorders, Obsessive Compulsive Disorder and Agoraphobia.
  - 118 out of 477 youth (25%) had a diagnosis of substance abuse or dependence. Substances included Alcohol, Cannabis, Opioids, Sedatives, and Inhalants. Most all of the youth with a diagnosis of substance abuse/dependence were co-occurring with a mental illness diagnosis.
  - 142 out of 477 youth (30%) had an intellectual disability diagnosis. Diagnoses in this category include Mental Retardation, Borderline Intellectual Functioning, Pervasive Developmental Disorder, Autism and Asperger's syndrome. Most all of the youth had this diagnosis co-existing with a mental illness diagnosis.

- The average length of stay at discharge was 374 days. Last year it was 338 days.
- 107 youth or 23% of youth had been out-of-state at least twice since 2007.
- 50 youth or 11% of youth had moved from one out-of-state facility to another without returning to the state first since 2007.

Review of Youth

Out-of-State Reviews

In the summer and fall of 2014, many of the youth were reviewed through the Out-of-State Review process. This was done in order to collect information regarding the gaps in services, identify system issues and barriers and make recommendations to assist the youth in returning to WV.

This process was considered to be beneficial and was completed a second time in the spring of 2015. In 2015-2016, this process will be implemented on a regular basis. (Please refer to the Comprehensive Review of West Virginia Children/Adolescents in Out-of-State Placements for more information on gaps in services.)

- Out of 477 youth out-of-state in 2014-2015, 322 or 68% of the youth were reviewed through this process.
- Some of the gaps in services identified included:
  - No psychiatric residential treatment facilities (PRTF) for youth age 14 or younger that address severe mental health issues.
  - No psychiatric residential treatment facilities (PRTF) services for youth who are already age 18 or older are available in state.
  - Limited group residential services for youth who are age 18 or older.
  - There are no in state level 3 facilities that are able to handle youth who are aggressive and have an intellectual and developmental disabilities (IDD) diagnosis.
  - No in-state programs for intellectual and developmental disability/sex offenders.
  - Services for youth who have experienced trauma at a young age but are older now are limited. No trauma programs in state for youth over the age of 12.
  - There are no in-state residential programs that address trauma with youth who have a diagnosis of intellectual and developmental disabilities (IDD).
  - Lack of treatment foster care.
  - Youth in parental custody may end up in state's custody because they cannot obtain the needed services for youth. Can only obtain psychiatric residential treatment facilities (PRTF) level services.

Regional Clinical Review Team

The clinical review process is a coordinated effort designed to provide a comprehensive, objective, clinical review of designated youth. The process has several steps to assure that the review is objective and thorough and includes a standardized assessment tool utilized in all reviews. The participants in this process include the youth/family/legal guardian, a regional clinical coordinator, an individual reviewer and a regional clinical review team. Information provided during the clinical review process is confidential and protected by federal and state statute. The targeted populations for these reviews are youth currently in out-of-state residential facilities or youth who are at risk of out-of-state placement.

The role of this review process is to identify what the youth's current treatment and permanency needs are and serve as a resource to the youth's individual Multidisciplinary Team (MDT) in guiding decision making. Full reviews as described above can occur or an update review may take place after the youth has had a full review.

Data utilized was from April 2014-June 2015.

There are three types of youth reviewed through a regional clinical review team:

1. **Youth who are at risk of being placed out-of-state**. If a youth is reviewed before placement then the team can help suggest possible community services or other in-state service to keep the youth in WV. Some youth are never placed out-of-state. **April 2014-June 2015, there were 121 youth reviewed that were at-risk of being placed out-of-state.**

Recommendations	Were Recommendations Followed?
90 youth were to remain in state	For the youth recommended to remain in-state, 51 out of 68 (within time frame established)* or 75% were placed in-state.
25 youth were to be placed out-of-state	For the youth recommended to be placed out-of-state, 16 out of 18 (within time frame established)* or 89% were placed out-of-state, even though they may not have gone to one of the facilities recommended.
6 youth were recommended to remain in or go out if necessary	For the youth recommended to remain in state or be placed out-of-state, the following occurred: 3 remained in, one was parental and placement was unknown and 2 were placed out-of-state.*

***Recommendations Followed:** the recommendations are considered to have been followed if the criteria below are met. Youth Go Out-of-State - if the youth goes out-of-state within 3 months, the recommendation was considered to have been followed. Youth Remains In State - if the youth remained in for at least 4 months, the recommendation was considered to have been followed.

Reasons youth were recommended to be placed out-of-state include:

- One of the greatest reasons a youth is placed out-of-state is due to an intellectual disability. This goes across all age ranges and can include youth experiencing trauma, displaying sexual behaviors and aggressive behaviors, or other mental health issues.
- Youth who are age 10 or younger who require intense psychiatric treatment. Many of these youth are displaying abuse reactive behaviors and require intensive trauma treatment. Although trauma treatment is available in the state, it is limited when the need requires a psychiatric residential treatment facility.
- Youth were already court ordered to out-of-state placement before the team met.
- In-state providers denying youth due to behaviors, IQ and other issues.
- Appropriate and accepted for in-state program, but beds not available.
- Youth with the diagnosis of Reactive Attachment Disorder were placed out-of-state.
- No program in-state to meet youth's need, such as female sex offender or youth with traumatic brain injury.

- Referred out-of-state after being unsuccessful in PRTF sex offender programs in-state.
- Intensive mental health needs, such as mood disorders with psychosis.
- Parental case with limited services in-state.

2. **Youth who are already placed out-of-state.** In these cases the team may need to assist with discharge planning and recommend services to successfully return the youth to WV. **April 2014-June 2015, there were 23 youth reviewed who were already placed out-of-state.**

Recommendations	Were Recommendations Followed?
10 youth were recommended to remain in their out-of-state placement. This does not indicate that a placement was not available or that the out-of-state placement was a better placement. Teams often do not recommend a youth return because they do not want to further disrupt the youth.	For the youth recommended to remain out-of-state, 7 out of 8 (within time frame established)* or 88% remained out-of-state.
10 youth were recommended to return to services in WV.	For the youth recommended to return, 2 out of 8 (within time frame established)* or 25% returned.
3 youth were recommended to remain in placement or return to WV	One of the youth has returned.*

***Recommendations Followed**-the recommendations are considered to have been followed if the criteria below are met. Youth Remained Out-of-State - if the youth remained out-of-state for at least 4 months, the recommendation was considered to have been followed. Youth Returned to State - if the youth returns to the state within 3 months, the recommendation were considered to have been followed.

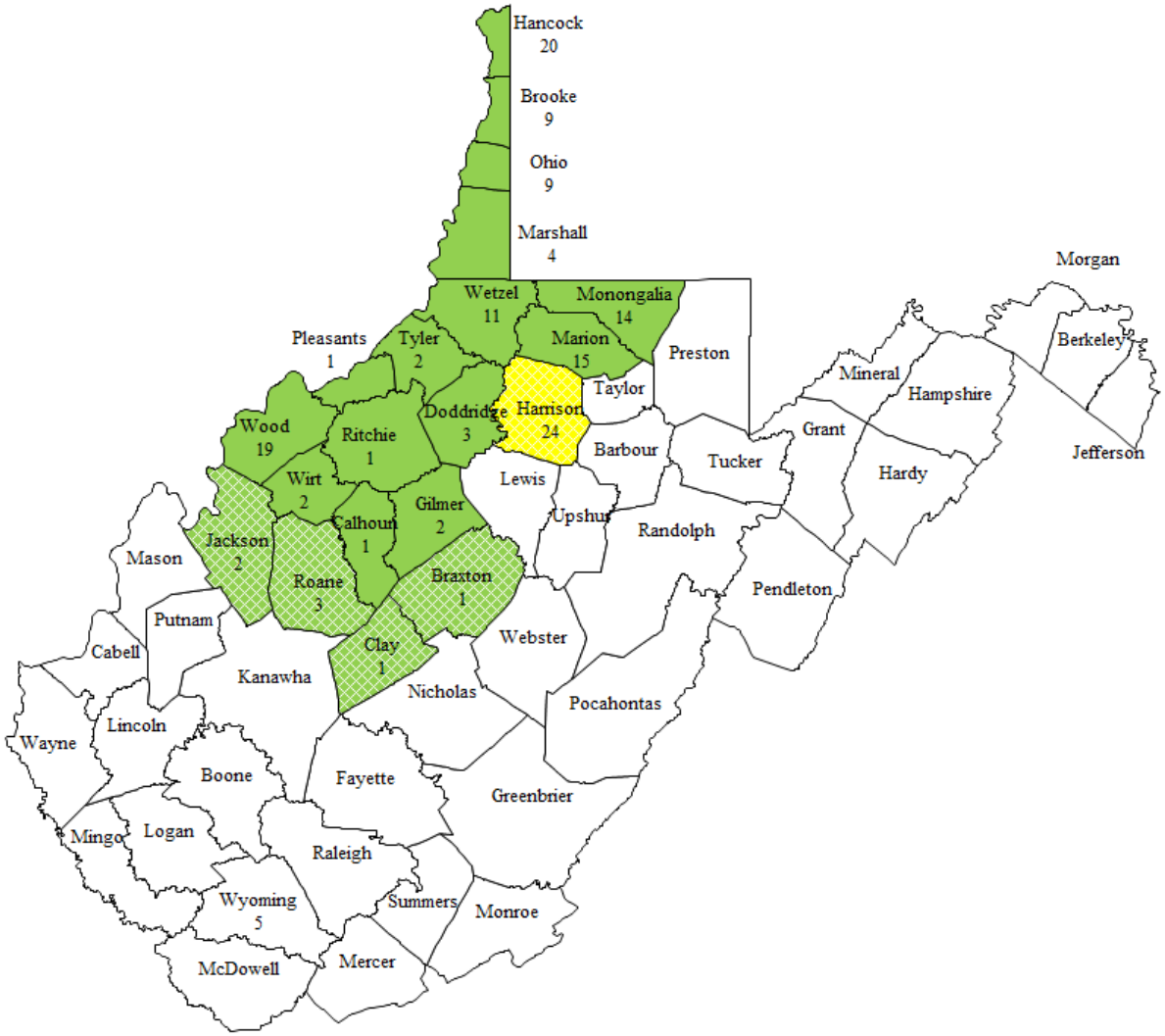
3. **Youth in Parental Custody.** Some youth reviewed through a regional clinical review team are in the custody of their parents and not the state. The follow-up data is limited.
   - 7 youth who were in the custody of their parents were reviewed.
   - The team recommended 5 youth remain in the state, 1 return to state since he had been placed out-of-state by parents, and that 1 youth remain in the state for services or be placed out-of-state for services.
   - Unable to determine if recommendations were followed in all cases.

All Reviews

- 358 youth out of 477 (75%) had an out-of-state review and/or a review by a regional clinical review team, July 2014-June 2015.

Regional Reports

Region I
July 2014-June 2015



Region I
July 2014-June 2015

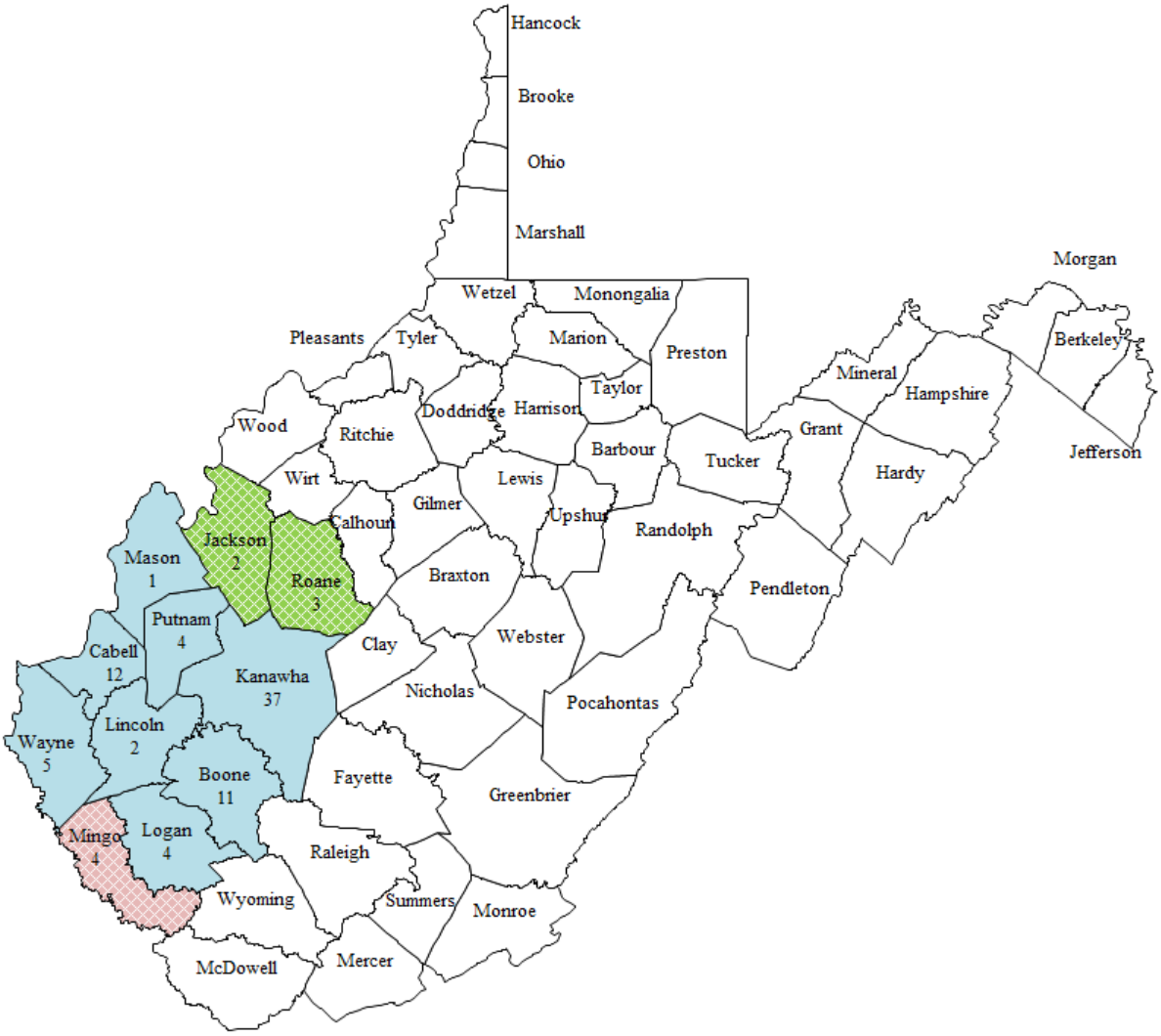
Demographics:

- DHHR redistributed the counties in the state. Region I lost Harrison County to Region III, which was a county that placed many youth out-of-state. The region gained Jackson and Roane counties from Region II and Clay and Braxton from Region IV. (Counties with patterns on the map.) Due to this redistribution we are unable to compare the regions from one year to the next.
- **The numbers below will be for the new counties after redistribution.**
- 120 youth were placed out-of-state last year.
- 97 or 81% of the youth were male and 23 or 19% were female.
- Youth were the following ages at placement:
  - 10 or younger-10 or 8%
  - 11-14 years old-32 or 27%
  - 15-17 years old-74 or 62%
  - 18 or older-4 or 3%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-26 or 22%
  - Level 2 Residential Treatment-16 or 13%
  - Level 3 Residential Treatment-36 or 30%
  - Group Residential Non-Clinical-21 or 18%
  - Group Residential Unspecified-5 or 4%
  - Diagnostic-12 or 10%
  - Specialized Foster Care-4 or 3%

Reviews:

- 49 youth were reviewed through a regional clinical review team (April 2014-June 2015). 39 youth were at risk of going out-of-state and 10 were already out-of-state at the time of review.
  - 33 youth were recommended to remain in the state for services.
  - 2 youth were recommended to go out-of-state to receive services
  - 4 youth were recommended to remain in the state for services or go out if services could not be secured in-state.
  - 5 youth were recommended to remain in their out-of-state placement.
  - 2 youth were recommended to return from out-of-state to WV for services.
  - 1 youth was recommended to remain in their out-of-state placement or return to WV if services could be secured.
  - In two cases more information was needed before a decision could be made.
  - Recommendations were followed 71% of the time.
- 80 youth or 67% were reviewed through the out-of-state review team.
- 34 youth or 28% were reviewed by the regional clinical coordinator through an OOS review form.
- 98 or 82% had at least one type of review.

Region II
July 2014-June 2015



Region II
July 2014-June 2015

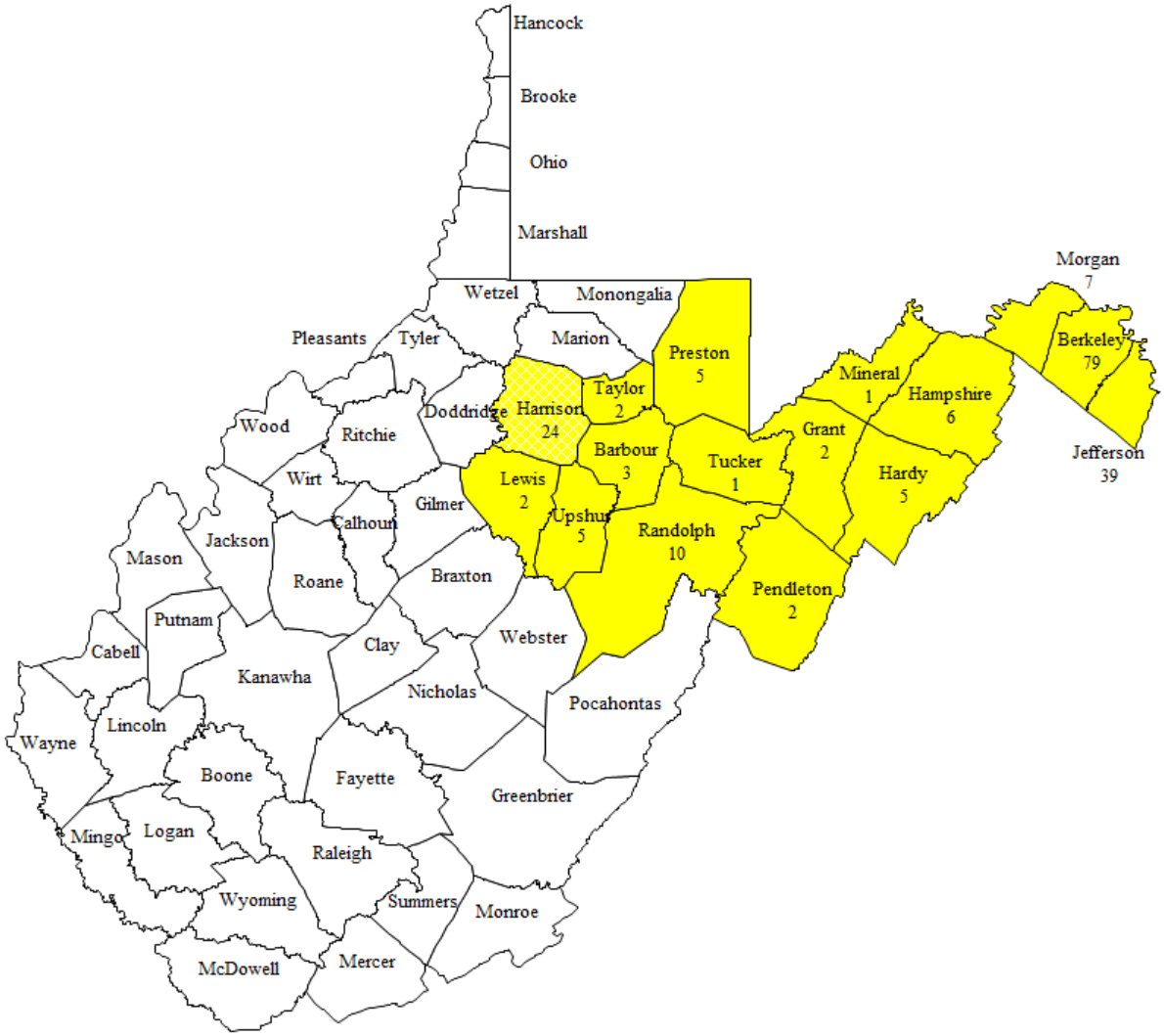
Demographics:

- This year DHHR distributed the counties in the state. Region II lost Mingo County to Region IV and Jackson and Roane Counties to Region I. (Counties with patterns on the map.) Due to this redistribution we are unable to compare the region from one year to the next.
- **The numbers below will be for the new counties after redistribution.**
- 76 youth were placed out-of-state last year.
- 56 or 74% of the youth were male and 20 or 26% were female.
- Youth were the following ages at placement:
  - 10 or younger-14 or 18%
  - 11-14 years old-19 or 25%
  - 15-17 years old-38 or 50%
  - 18 or older-5 or 7%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-32 or 42%
  - Level 2 Residential Treatment-15 or 20%
  - Level 3 Residential Treatment-16 or 21%
  - Group Residential Non-Clinical-7 or 9%
  - Group Residential Unspecified-3 or 4%
  - Diagnostic-None
  - Specialized Foster Care-3 or 4%

Reviews:

- 60 youth were reviewed through a regional clinical review team (April 2014-June 2015). 53 youth were at risk of going out-of-state and 7 were already out-of-state at the time of review.
  - 34 youth were recommended to remain in the state for services.
  - 17 youth were recommended to go out-of-state to receive services.
  - 1 youth was recommended to remain in their out-of-state placement.
  - 6 youth were recommended to return from out-of-state to WV for services.
  - In two cases more information was needed before a decision could be made.
  - Recommendations were followed 70% of the time.
- 58 youth or 76% were reviewed through the out-of-state review team.
- 16 youth or 21% were reviewed by the regional clinical coordinator through an OOS review form.
- 66 or 87% had at least one type of review.

Region III
July 2014-June 2015



Region III
July 2014-June 2015

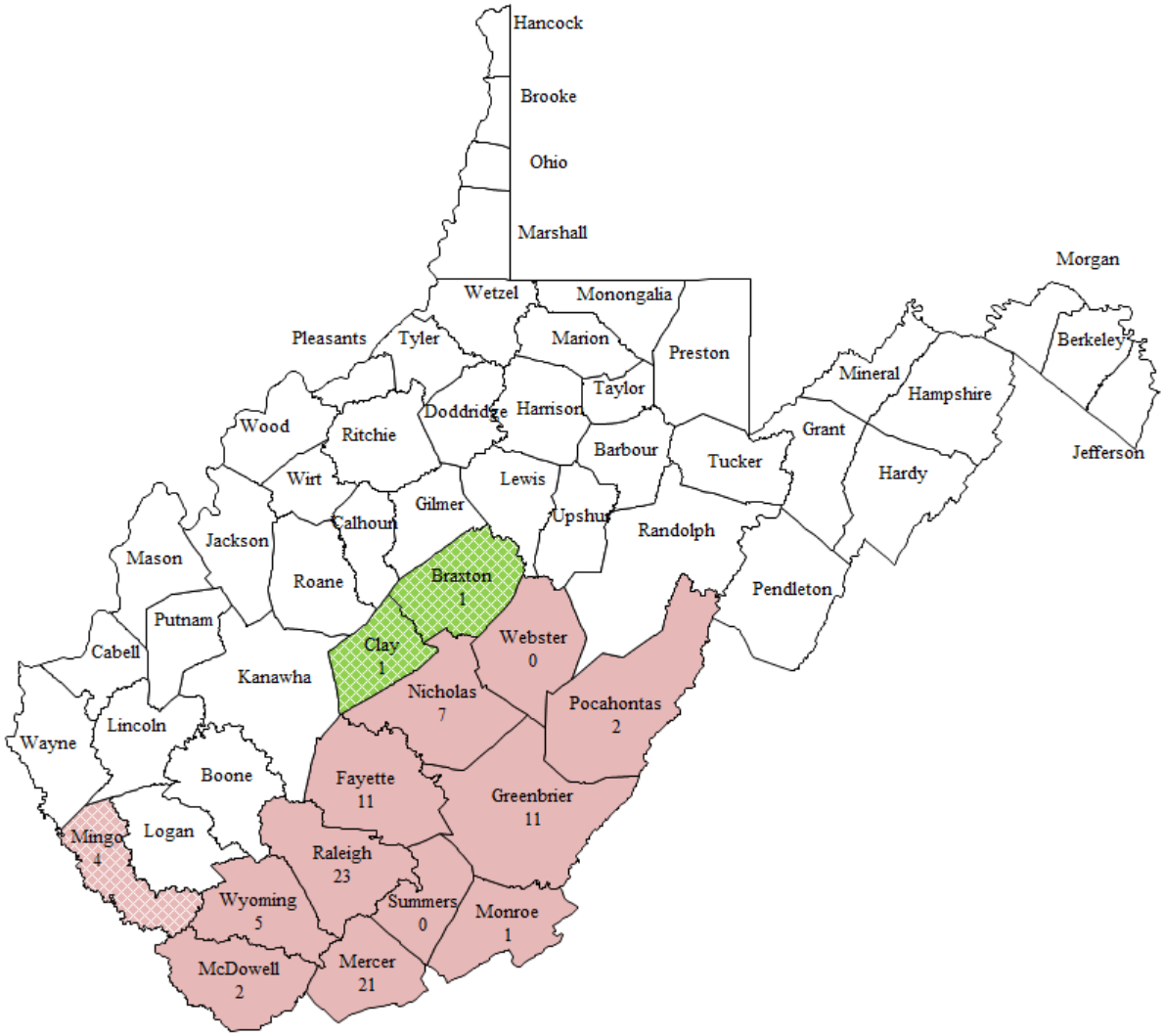
Demographics:

- This year DHHR redistributed the counties in the state. Region III gained Harrison County from Region I, which was a county that placed many youth out-of-state. (Counties with patterns on the map). Due to this redistribution we are unable to compare the region from one year to the next.
  - **The numbers below will be for the new counties after redistribution.**
  - 194 youth were placed out-of-state last year.
  - 146 or 75% of the youth were male and 48 or 25% were female.
  - Youth were the following ages at placement:
    - 10 or younger-10 or 5%
    - 11-14 years old-66 or 34%
    - 15-17 years old-108 or 56%
    - 18 or older-10 or 5%
  - **The level of care youth were placed are as follows:**
    - Psychiatric Residential Treatment Facility-44 or 23%
    - Level 2 Residential Treatment-78 or 40%
    - Level 3 Residential Treatment-25 or 13%
    - Group Residential Non-Clinical-27 or 14%
    - Group Residential Unspecified-14 or 7%
    - Diagnostic-1 or 1%
    - Specialized Foster Care-5 or 3%

Reviews:

- 15 youth were reviewed through a regional clinical review team (April 2014-June 2015). 11 youth were at risk of going out of state and 4 were already out-of-state at the time of review.
  - 8 youth were recommended to remain in the state for services.
  - None of the youth were recommended to go out-of-state to receive services.
  - 3 youth were recommended to remain in the state for services or go out if services could not be secured in-state.
  - 4 youth were recommended to remain in their out-of-state placement.
  - None of the youth were recommended to return from out-of-state to WV for services.
  - Recommendations were followed 92% of the time.
- 129 youth or 66% were reviewed through the out-of-state review team.
- 25 youth or 13% were reviewed by the regional clinical coordinator through an OOS review form.
- 135 or 70% had at least one type of review.

Region IV
July 2014-June 2015



Region IV
July 2014-June 2015

Demographics:

- This year DHHR redistributed the counties in the state. Region IV lost Braxton and Clay Counties to Region I. The region gained Mingo County from Region II. (Counties with patterns on the map.) Due to this redistribution we are unable to compare the region from one year to the next.
- **The numbers below will be for the new counties after redistribution.**
- 87 youth were placed out-of-state last year.
- 73 or 84% of the youth were male and 14 or 16% were female.
- Youth were the following ages at placement:
  - 10 or younger-10 or 12%
  - 11-14 years old-24 or 27%
  - 15-17 years old-45 or 52%
  - 18 or older-8 or 9%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-36 or 42%
  - Level 2 Residential Treatment-10 or 11%
  - Level 3 Residential Treatment-15 or 17%
  - Group Residential Non-Clinical-10 or 11%
  - Group Residential Unspecified-12 or 14%
  - Diagnostic-None
  - Specialized Foster Care-4 or 5%

Reviews:

- 20 youth were reviewed through a regional clinical review team (April 2014-June 2015). 18 youth were at risk of going out of state and 2 were already out-of-state at the time of review.
  - 11 youth were recommended to remain in the state for services.
  - 7 youth were recommended to go out-of-state to receive services.
  - None of the youth were recommended to remain in their out-of-state placement.
  - 2 youth were recommended to return from out-of-state to WV for services.
  - In one case more information was needed before a decision could be made.
  - Recommendations were followed 86% of the time.
- 55 youth or 63% were reviewed through the out-of-state review team.
- 5 youth or 6% were reviewed by the regional clinical coordinator through an OOS review form.
- 59 or 68% had at least one type of review.

APPENDIX F

West Virginia Court Improvement Program
Annual Self-Assessment Report
December 2015

The purpose of this report is to create an opportunity to reflect on what you are doing, why you are doing it and if efforts are having the intended results. Questions are designed to solicit candid responses that help you identify what is working well, areas that need improvement and the type of support that would be most helpful. This is intended to be a helpful tool for you and a helpful tool for us to identify how best to use our resources.

The report is made of 7 sections with corresponding questions. Section I allows you to identify two high resource and or high priority projects and discuss them in-depth from a CQI perspective. Section II focuses on current priority areas and driving forces within your state that may be affecting your work. Section III requests a concise accounting of projects/activities in specific topical areas. Section IV focuses on collaborative efforts. Section V centers on CQI needs. Section VI asks you to do a self-assessment of your CIP's current capacity. Section VII provides a space for you to report on your timeliness and other performance measures.

I. CQI Analyses of Projects

Identify **two (2)** of your highest priority/highest resource CIP projects that were in some stage of the CQI process in FY 2015. Review and respond to the questions below about these projects. We understand you may be early in the process and may not be able to answer all of these questions. If applicable, indicate where you were in the process when the fiscal year ended and what plans you have for furthering the work.

Project # 1 **Juvenile Abuse and Neglect Information System (JANIS)**

Briefly describe the project and indicate the approximate date the CIP began working on it.

1. ***Identify and assess needs***. Think about why you decided to focus on this issue. What is the need you were trying to address? What are the outcomes you were hoping to achieve? What evidence (e.g., data) did you have of the need for improvement?

   The Juvenile Abuse and Neglect Information System (JANIS) is a project aimed at improving the timeliness and quality of pleadings and orders in child abuse and neglect cases in order to improve outcomes and to maximize federal funding for children in state care.

   As long as the West Virginia Court Improvement (CIP) has existed, it has worked to improve the timeliness and quality of court orders and pleadings in child abuse/neglect (CAN) cases, in accord with the Adoption and Safe Families Act of 1997, and other state and federal laws. A

push came in the early 2000s, when West Virginia became more aware of the impact of removal findings on federal Title IV-E funding. The Department of Health and Human Resources began sharing the amount of federal funding lost at least partly due to lack of findings in court orders. As a result, CIP created the desktop version of the Juvenile Abuse and Neglect Information System (JANIS), pursuant to a court administrative order in January 2004, and a 2003 amendment to then-West Virginia Code § 49-7-29:

The supreme court of appeals, in consultation with the department of health and human resources and the division of juvenile services in order to eliminate unnecessary state funding of out-of-home placements where federal funding is available, shall develop and cause to be disseminated no later than the first day of July, two thousand three, form court orders to effectuate provisions of chapter forty-nine of this code which authorize disclosure and transfer of juvenile records between agencies while requiring maintenance of confidentiality, the provisions of Title 142 U.S.C. Section 620, *et seq*., and Title 42 U.S.C. Section 670, *et seq*., relating to the promulgation of uniform court orders for placement of minor children and the regulations promulgated thereunder, for use in the magistrate and circuit courts of the state.

Circuit judges and magistrates, upon being supplied the form orders required by the provision of this section, shall act to ensure the proper form order is entered in such case so as to allow federal funding of eligible out-of-home placements.

After the Title IV-E Review in 2011, the Bureau for Children and Families (BCF) and CIP collaborated to spread the word of required Title IV-E findings/language and encourage use of JANIS software through state and local trainings. The judges continued to receive copies of their orders with the required removal findings, but now they received them quarterly, and the reports added cases in which permanency findings (i.e. “reasonable efforts to achieve permanency or finalize the permanency plan”) were overdue. The combined efforts resulted in marked improvement of the Title IV-E penetration rate (P-rate) that continues to climb and that enabled the state to apply for and implement a Title IV-E waiver demonstration project called Safe at Home WV this year.

More than a way to maximize federal funding, JANIS offered the possibility of more timely entry of orders, as users could choose language options and store case details for subsequent pleadings and orders. It also made it easier to remember instructions for the guardian *ad litem* on their duties, requests for child support, encouragement of the educational stability of subject children, multidisciplinary treatment team (MDT) provisions, and permanency findings.

2. ***Develop theory of change***. Do you have a theory about the causes of the problem? What is your "theory of change" (how do you think your activities/interventions will improve the outcomes)?

   The concept of JANIS is that attorneys will seize an efficient way of preparing high-quality pleadings and orders, which in turn will increase Title IV-E funding and positive outcomes for children and families.

Despite an administrative order and CIP-sponsored statewide and on-demand JANIS training, some attorneys who prepared pleadings and orders were reluctant to adopt JANIS. It was apparent from tracking of downloads of desktop JANIS and review of non-compliant IV-E orders that not everyone was using JANIS. Feedback included that JANIS could be more user-friendly and would be better as an application that could be shared with others (e.g., between prosecuting attorney and caseworker or respondent attorney and assistant). At the same time, judges' assistants were feeling hampered by the increasing data entry required for the Court's Child Abuse and Neglect (CAN) Database, so the idea emerged that JANIS pleadings and orders could be connected to the CAN database to reduce the data demand on the assistants.

CIP experienced some setbacks in the update of JANIS to a web-based application that could connect to the CAN database, mostly due to developer issues. Currently, the JANIS update has momentum with a new developer and is slated for release of orders and then pleadings in phases, as described in the implementation section below.

3. ***Develop/select solution.*** How did you select your activities/interventions (e.g., evidence-based, empirically supported, best-practices, etc.[1])

   JANIS is a best-practices project supported by collaborative CIP partners. Timely, quality pleadings and orders contribute to timeliness and permanency for children, and they increase the federal funding available to help children in state care.

4. ***Describe the implementation of the project.*** What did the CIP do to implement the project? What did others (e.g. judges, attorneys) do? Did you do anything to ensure fidelity of the implementation (that is, anything to ensure the program was implemented as it was supposed to be)?
   If the project has not yet been implemented, please briefly describe your intentions/plans for implementation.

   Currently, the JANIS update is progressing, as CIP counsel and staff have been updating pleadings and orders from the old desktop JANIS and working closely with the new developer. Web-based JANIS is slated for release of orders and then pleadings in three phases:

   - the first phase of orders, expected to be released in late January to early February 2016, will allow the user to generate petitions and orders for all of the general hearings in a typical child abuse and neglect case;
   - phase two, anticipated to be completed around July 2016, will provide twelve more orders related to specific types of child abuse and neglect cases and the connection to the CAN Database; and

[1] Definitions for evidence-based, empirically-supported and best-practices are available in the appendix.

- phase three will be the final stage, wrapping up the creation of all remaining orders and motions that are expected to be completed around January 2017.

With the support of CIP Chair Judge Gary Johnson, the first phase will be briefly tested by a pilot county (Nicholas) before it is presented to the CIP oversight board in January 2016. After JANIS has been presented and approved by the board, statewide release and web-based training will commence. As each phase is implemented, CIP will provide new web-based training.

5. ***Describe any monitoring/evaluations/assessments of your project and how you intend to apply the findings***. How are you monitoring implementation and changes? What data collection tools/methods did you (will you) use to assess effectiveness? What evidence is there that the activities/intervention were effective? What evidence is there that the activities/intervention were implemented with fidelity? Describe how evaluation/assessments were used to inform the project. Does the intervention need to be adjusted, stopped? Does the problem still exist? Was your theory of change supported?
    a. If the project has not yet been evaluated/assessed, please briefly describe your intentions/plans for evaluation/assessment.

User feedback in the pilot JANIS county will be instrumental in guiding further development of the project. Such user feedback will be sought at each stage of implementation. Title IV-E reports from BCF will help show whether the project is aiding in IV-E compliance, and the CAN Database will gauge if JANIS has an impact in performance measure data.

6. Is this project a priority for you in 2016? ☒Yes ☐ No

7. Would you like a CQI consult around this project? ☒Yes ☐ No

It would be great to have assistance in evaluating the effectiveness of the web-based JANIS project. We have also been consulting with Eva Klain of the ABA in developing a better procedure for formal motions to terminate parental rights, the result of which we will help satisfy that performance measure of "Time to Petition to Terminate Parental Rights." With a rule change likely in 2016, such motion will be implemented in phase three of web-based JANIS in early 2017.

Project # 2 **New View Project**

Briefly describe the project and indicate the approximate date the CIP began working on it.

1. ***Identify and assess needs***. Think about why you decided to focus on this issue. What is the need you were trying to address? What are the outcomes you were hoping to achieve? What evidence (e.g., data) did you have of the need for improvement?

In 2011, a West Virginia team of judges and Bureau for Children and Families (BCF) officials discovered at a national conference that West Virginia is one of the top five states for the number of children in out-of-home care per 1,000 children in the population. More than 1,000 West Virginia children whose parents' rights had been terminated are waiting to be adopted, according to AFCARS data.

The team was impressed by Georgia's Cold Case Project. Georgia uses the term "cold case" for children who have been in long-term foster care. More information about the Georgia Cold Case Project is available at http://cj4c.georgiacourts.gov/content/cold-case-project.

With assistance from the Court Improvement Program grants, West Virginia borrowed from the Georgia's experiences to do its own project, which varied from the original in a few ways. First, it is named "New View" to convey the project's positive energy and fresh perspective in the quest for permanency. Second, courts are more involved, with the child's court file(s) viewed, in addition to BCF's file(s), and the court, BCF, and counsel for parties receive a permanency report for the child. The purpose of the project remains the same: to breathe new life into a case and make concrete recommendations for achieving permanency.

2. ***Develop theory of change***. Do you have a theory about the causes of the problem? What is your "theory of change" (how do you think your activities/interventions will improve the outcomes)?

   Everyone involved in child abuse/neglect and juvenile cases has tremendous demands on his or her time. BCF caseworkers are often newer and experience high turnover. Circuit court judges who hear the cases have general jurisdiction, so while child abuse/neglect and juvenile cases are priorities and account for a large percentage of their time, the judges also have criminal, civil, appellate, and administrative responsibilities. Prosecuting attorneys also handle criminal cases and do not regularly attend multidisciplinary treatment team (MDT) meetings, as determined in the 2008 CIP MDT Study. Attorneys appointed for children and parents in the cases either work at busy public defender offices or are panel attorneys who have made the same hourly rates since 1990—rates that have not kept up with inflation over the past 25 years—so these attorneys usually handle other types of cases, too, or take as many appointments as possible.

   By the time a viewer gets a New View case from the predictive model—which lists children likely to linger or age out in state care—the child has usually had multiple placements and may have been in state care for years, in multiple cases. The viewer is able to concentrate attention and share a novel perspective that can stimulate or support progress in the case in the form of permanency options (e.g., family connections), transition plan ideas (e.g., training, MODIFY enrollment), and general well-being recommendations.

3. ***Develop/select solution.*** How did you select your activities/interventions (e.g., evidence-based, empirically supported, best-practices, etc.).

   New View is empirically supported. The Georgia Cold Case Project on which New View is based had resources for an in-depth evaluation process and report and was shown to be successful in finding permanency and resources for children on the cold list. New View also has similarities to the nationally supported court-appointed special advocate for children (CASA) model, in which volunteer CASAs make independent assessments and recommendations on behalf of children.

4. ***Describe the implementation of the project.*** What did the CIP do to implement the project? What did others (e.g. judges, attorneys) do? Did you do anything to ensure fidelity of the implementation (that is, anything to ensure the program was implemented as it was supposed to be)?

   New View is in its third year. Each year, the project hired contract attorneys who were trained to view files, meet with people involved with the assigned cases, and complete narrative reports and file review forms. Court staff created a database for the file review forms and entered data for each one, continuing to improve the 100-question form and process each year. CIP Judges Gary Johnson and Derek Swope called judges whose cases were selected to explain the project and encourage them to sign "New View orders," which most judges entered giving the viewers access to the court files and people involved in the selected cases. BCF staff prepared agency files for the viewers and were available to answer viewers' questions. CIP judges, CIP staff, and BCF leaders meet periodically with the viewers to discuss progress, give/receive feedback, and review the draft New View Project report, which is anticipated to be completed in February 2016. The report, unlike the specific viewer narrative reports in each child's case, will share non-identifying statistical data and systemic recommendations from the viewed cases in the first two years of the project.

5. ***Describe any monitoring/evaluations/assessments of your project and how you intend to apply the findings***. How are you monitoring implementation and changes? What data collection tools/methods did you (will you) use to assess effectiveness? What evidence is there that the activities/intervention were effective? What evidence is there that the activities/intervention were implemented with fidelity? Describe how evaluation/assessments were used to <u>inform</u> the project. Does the intervention need to be adjusted, stopped? Does the problem still exist? Was your theory of change supported?

The project has been monitored by reviewing the viewers' reports and file review forms, meeting with the viewers, and surveying BCF staff and judges on their experiences with New View. All of these sources were used to assess how the project is going and whether it is benefiting the chosen children. Here is a brief summary of what we have found:

- Traditional forms of permanency (i.e., reunification, adoption, minor guardianship, and kinship care) have been achieved in some New View cases, but not in the majority, in which several children turned 18 before or soon after viewing. One child reached permanency before viewing commenced, with the biological mother's parental rights being reinstated. A few children attained guardianship or adoption before or during the time of viewing. Sometimes, permanency was achieved by emancipation. Approximately half of the children viewed aged out before or during viewing. It is difficult to know how many children reached and sustained permanency for the reasons stated below.
- A major lesson of the project is that permanency is not static or permanent. In a particular month, a child might be close to permanency, only for the likelihood to be dashed because of a crisis. A few children had been adopted before viewing, but their permanency crumbled as the adoptive parents pursued status offense cases and then relinquished their rights. Two young women were on the road to adoption or guardianship, but both were in crisis before the end of viewing.
- While the viewers have not always been able to aid children in traditional permanency, they have made recommendations that enhanced the children's well-being, such as getting the children appropriate services, placements, personal documents, and training. With the help of a private investigator, they have also been able to locate runaway children or the children's family members in some cases. They have sometimes also been able to reconnect siblings who want to be in contact.
- Several viewers worked with the multidisciplinary treatment team (MDT) members to give detailed recommendations for case plans and transitional plans.
- The project is not without challenges. There are lags sometimes between generation of the predicted list and commencement of viewing; the project has finite funding and staffing; viewers have not always been able to complete reports in a timely manner for various reasons; and a few local players have been resistant to the viewers.

6. Is this project a priority for you in 2016? ☐Yes ☐ No ☒ To be determined

7. Would you like a CQI consult around this project? ☐Yes ☐ No ☒ TBD

II. Trainings, Projects, and Activities

For questions 1-9, provide a ***concise*** description of work completed or underway in FY 2015 (October 2014-September 2015) in the below topical subcategories. For question 1, focus on significant training events or initiatives held or developed in FY 2015 and answer the corresponding questions.

For questions 2-9, indicate (*yes/no*) if you worked on a project or activity in this area. If the answer is yes, that you conducted a project or activity in the area, please complete the table. If the answer is no, skip to the next question. For each project/activity, please provide a brief description, categorize the project by selecting one of the sub-categories available in the drop down box (e.g., for quality hearings, the sub-categories include *court observation/assessment, process improvements, specialty/pilot courts, court orders/title IV-E, mediation, appeals, other*) and identify the stage of your work by selecting the appropriate state from the drop down box (*identifying and assessing needs, developing a theory of change, selecting a solution, implementing your project, or assessing/evaluating your work*)[2].

Questions 2-9 ask you to describe the purpose of the project or activity and how the project or activity will contribute to continuous quality improvement (CQI) in the identified area. Please use the "other" categories to include specific projects that are important to you but do not necessarily fit as part of the CQI process. ***If you have a project/activity that fits into multiple categories (e.g., youth engagement and well-being), please choose the category you think fits it best and only report the project <u>once.</u>***

1. **Trainings**

Topical Area	Did you hold or develop a training on this topic?	Who was the target audience?	What were the intended training outcomes?	How did you evaluate this training?
Data	☒Yes ☐No	Judges' assistants and New Circuit Court Judges	To update all assistants of database changes. To improve data entry compliance. To educate new staff and Judges on the purpose and functionality of the Child Abuse and Neglect (CAN) Data Collection.	With a follow-up survey from Survey Monkey, the results of which reviewed by the Court data analysts.
Hearing quality	☒Yes ☐No	Law clerks New judges	To inform the law clerks of law updates, judicial benchbook tools, timing of hearings, and findings needed at each stage of case.	Training evaluation reviewed by judicial education staff and law clerk training committee.
Improving timeliness/ permanency	☒Yes ☐No	Multiple disciplines (attorneys, social workers, counselors, etc.)	To train anyone involved in child abuse and juvenile cases on procedure,	With a follow-up survey from Survey Monkey, reviewed by the CIP training

[2] A description of each stage of work is available in an appendix to this document.

			law updates, and resources available to help achieve permanency.	committee.
Quality legal representation	☒Yes ☐No	Attorneys, Law Students	To encourage attorneys to support non-offending parents as co-petitioners in child abuse and neglect cases.	Asked how likely the attorneys were to try co-petitioning during the webinar. Will do a follow-up survey in a few months to see if they are using co-petitioning. The CIP training committee reviewed law student evaluations of the "Child Protection and the Law" course at WVU College of Law.
Engagement & participation of parties	☒Yes ☐No	CASA volunteers and others interested	To encourage participants to collaborate locally with schools, law enforcement, and medical providers, and to practice self-care.	Training evaluation and report to CIP oversight board in January 2016.
Well-being	☒Yes ☐No	Circuit Court Judges	To give judges practical tips on recognizing and treating childhood trauma and on expectations of children's attorneys.	Feedback to judicial education committee for use in planning future child abuse/neglect segments of judicial training.
ICWA	☐Yes ☒No			
Sex Trafficking	☒Yes ☐No	Magistrates	To inform magistrates of the warning signs of trafficking and of resources for finding missing children, including children in state care.	With a follow-up survey from Survey Monkey, reviewed by the magistrate court staff and training committee.
Other:	☐Yes ☒No			

2. **Data Projects**. Data projects include any work with administrative data sets (e.g., AFCARS, SACWIS), data dashboards, data reports, fostering court improvement data, case management systems, and data sharing efforts.

Do you have a data project/activity? ☒Yes ☐ No

Project Description	How would you categorize this project?	Work Stage (if applicable)
Benchview: The Benchview reporting site is a compilation of reporting from the Child Abuse and Neglect Database. Benchview was designed to allow Judges to view their own real-time performance measures for child abuse and neglect cases and compare time frames with statewide data.	Data dashboards	Evaluation/Assessment
Child Abuse and Neglect (CAN) Database: The CAN Database is used to collect detailed case information on all child abuse and neglect cases filed in West Virginia. It collects hearing dates and permanency information so the state can make assessments of its foster case laws and judicial processes and efforts to develop and implement a plan for systemic improvement	Case management systems	Evaluation/Assessment
JANIS: The Juvenile Abuse and Neglect Information System (JANIS) were developed by the West Virginia Supreme Court of Appeals and the Court Improvement Program Oversight Board. The objective of the system is to facilitate and expedite the handling of child abuse and neglect cases by efficiently generating IV-E compliant case orders and motions. This project will also share important case data elements with the CAN Database.	Agency Data Sharing Efforts	Selecting Solution
Data Reports from the CAN Database: The Court Services analysts prepare quarterly reports for review by the CIP Child Protection Across Court Systems (C-PACS) committee on judicial referrals to Child Protective Services (CPS), the use co-petitioning and battered parent adjudication, and types of maltreatment indicated in petitions. They also submit biannual statistical reports to the CIP oversight board. Judges receive personalized reports on their CAN database performance measures at each judicial conference. The public can view statewide data trends and individual judges' statistics on certain permanency measures at http://www.courtswv.gov/public-resources/CAN/statistics.html.	Data Reports	Evaluation/Assessment
New View Project Cold Case List: The Bureau for Children (BCF) and Families authorizes analyst Andy Barclay and Casey Family Programs to run a predictive model on BCF's quarterly AFCARS data to get the "cold list" of children to be viewed each New View year (three times so far). BCF then decrypts the list and helps identify case numbers and judges for each child in the	Agency Data Sharing Efforts	Evaluation/Assessment

top-50 “coldest” cases. The list includes each child’s age, number of placements, permanency plan, TPR status, last type of placement, and more. The New Viewers, in turn, share their reports on individual children with BCF leaders and local workers.		

Do you have data reports that you consistently view? ☒ Yes ☐ No

If Yes, around which topics?
☐Hearing quality ☒ Timeliness ☒Permanency ☐Well-being ☐Education ☐ Engagement of youth ☒Engagement of Parents ☐Other Engagement ☐ Quality Legal Representation ☐ICWA ☐DCST ☐Runaway Youth ☐Other:_____

3. **Hearing Quality.** Hearing quality projects include any efforts you have made to improve the quality of dependency hearings, including court observation/assessment projects, process improvements, specialty/pilot court projects, projects related to court orders or title IV-E determinations, mediation, or appeals.
   Do you have a hearing quality project/activity? ☒ Yes ☐ No

Project Description	How would you categorize this project?	Work Stage (if applicable)
JANIS: Please see Section I, Project #1, for more details about the Juvenile Abuse and Neglect Information System (JANIS). JANIS pleadings and orders help ensure that important information is considered and findings made at each stage of a child abuse and neglect case.	Courts Orders/Title IV-E	Selecting Solution
Title IV-E Order Information Exchange: For about a decade, the Court and Bureau for Children and Families have shared information on Title IV-E compliance. The BCF IV-E staff sends the Court quarterly reports on orders/cases missing IV-E removal and permanency findings or having procedural irregularities (e.g., split of legal and physical custody, unexplained delay between CTW finding and placement). The Court then shares a memo and the judges’ charts with the judges, who receive biannual certificates of achievement if they have had no IV-E issues flagged since the last judicial conference. The BCF and Court employees relay questions on specific cases, and the Court has been able to find several orders that the IV-E staff did not have to review, thereby increasing the state’s IV-E reimbursement P-rate.	Courts Orders/Title IV-E	Implementation

4. **Improving Timeliness of Hearings or Permanency Outcomes.** Timeliness and permanency projects include any activities or projects meant to improve the timeliness of case processing or achievement of timely permanency. This could include general timeliness, focus on continuances or appeals, working on permanency goals other than APPLA, or focus on APPLA and older youth.

   Do you have a Timeliness or permanency project/activity? ☒ Yes ☐ No

Project Description	How would you categorize this project?	Work Stage (if applicable)
Please also see data projects in No. 2 on page 10, as the CAN database, Benchview, and JANIS all contribute to timely hearings and permanency for children. You can see data trends (2010 to 2014) that show improvement in time to adjudication, disposition, TPR, and permanent placement at http://www.courtswv.gov/public-resources/CAN/pdfs/statewide-trends-2010-2014.pdf.	General/ASFA	Evaluation/Assessment

5. **Quality of Legal Representation.** Quality of legal representation projects may include any activities/efforts related to improvement of representation for parents, youth, or the agency. This might include assessments or analyzing current practice, implementing new practice models, working with law school clinics, or other activities in this area.

   Do you have a quality legal representation project/activity? ☐ Yes ☐No

Project Description	How would you categorize this project?	Work Stage (if applicable)
Adjudication as a Battered Parent and Co-Petitioning Study: The CIP Child Protection Across Court Systems (C-PACS) committee has been working with the NCJFCJ and Joyce Yedlosky of the WV Coalition Against Domestic Violence to study the state's innovative practices of co-petitioning with non-offending parents/relatives and of battered parent adjudication. The Court Services Division started sharing data on outcomes of cases with co-petitioning versus general cases, which showed more timely permanency for children in the co-petitioning cases. CIP members Catherine Munster and Joyce Yedlosky presented nationally and conducted WV CIP's first webinar on the subject in 2015.	New Practice Models	Develop Theory of Change

Guardian ad Litem (GAL) Approval and Training: The Court has made significant efforts to improve representation of children in child abuse/neglect and juvenile cases, including appeals, in the past few years. In addition to annual cross-training conferences, CIP helped make GAL-specific training a requirement in state code. In 2012, the Court began holding training for GALs every two years. Next, it implemented the Guidelines for Children's GALs in Child Abuse and Neglect (CAN) Cases in 2014, which included a new written GAL report to be filed before the disposition hearing (see Appendices A and B of the Rules of Procedure for Child Abuse and Neglect Proceedings, http://www.courtswv.gov/legal-community/court-rules/child-abuse/child-abuse-contents.html). The Children's Services Division maintains the list of approved CAN GALs, a condensed version of which is available at http://www.courtswv.gov/public-resources/CAN/pdfs/GAL-list-by-county.pdf	New Practice Models	Evaluation/Assessment
"Child Protection and the Law" course at the West Virginia University (WVU) College of Law: For five years, CIP has sponsored the first child abuse and neglect course at the state's only law school with adjunct (CIP-member) professors Catherine Munster and Teresa Lyons. Nearly 70 law students have completed the three-credit spring course to date. Students who complete the course are presumptively approved as child abuse/neglect GALs in the state.	Law School Clinics	Evaluation/Assessment
Legal Resources: CIP publishes an annually updated Judicial Benchbook for Child Abuse and Neglect Proceedings and will share a new Juvenile Law Guide in January 2016, at www.wvcip.com. These resources, as well as the 2010 The Time is Now video, help counsel understand the purposes, time frames, and laws applicable to child abuse/neglect and juvenile cases.	Other	Implementation

6. **Engagement & Participation of Parties.** Engagement and participation of parties includes any efforts centered around youth, parent, foster family, or caregiver engagement, as well as projects related to notice to relatives, limited English proficiency, or other efforts to increase presence and engagement at the hearing.

   Do you have an engagement or participation of parties project/activity? ☒ Yes ☐No

Project Description	How would you categorize this project?	Work Stage (if applicable)
MDT Desk Guide and Curriculum: The CIP Multidisciplinary Treatment Team (MDT) Study Committee updated the MDT desk guide and training curriculum, which are intended to improve the quality of participation of MDT members (i.e., attorneys, caseworkers, parents, children, foster parents, educators, service providers, etc.) and work product (i.e., recommended case/permanency/transition/aftercare plans) of MDTs. They are still being implemented.	Other	Implementation
CASA conference: CIP provides financial support for the annual Court-Appointed Special Advocate (CASA) conference and even helped one year with the CASA Association's administration expenses when CASA funding was especially tight. Courts with CASAs value the volunteers' independent advocacy for children.	Other	Evaluation/Assessment
Support of the Foster Advocacy Movement (FAM): CIP invites former foster youths to participate at its trainings and meetings. Currently, Jessica Gibson, one-time youth in foster care and now Pressley Ridge treatment coordinator, is an active board member. At its November board meeting, CIP had a card shower to write cards to young adults who receive care packages from FAM/MODIFY.	Youth Engagement	Identifying/Assessing Needs

7. **Well-Being.** Well-being projects include any efforts related to improving the well-being of youth. Projects could focus on education, early childhood development, psychotropic medication, LGBTQ youth, trauma, racial disproportionality/disparity, immigration, or other well-being related topics.

   Do you have any projects/activities focused on well-being? ☒ Yes ☐No

Project Description	How would you categorize this project?	Work Stage (if applicable)
New View Project: New View contract attorneys review court and agency files and also sometimes attend hearings and multidisciplinary treatment team (MDT) meetings when invited. They also speak with the children and people involved in their cases whenever possible. The viewers' reports and participation provide detailed recommendations and assistance with selected children's permanency and well-being, as well as suggestions for systemic improvement.	Other	Evaluation/Assessment

8. **ICWA.** ICWA projects could include any efforts to enhance state and tribal collaboration, state and tribal court agreements, data collection and analysis of ICWA compliance, or ICWA notice projects.

   Do you have any projects/activities focused on ICWA? ☐ Yes ☒No

Project Description	How would you categorize this project?	Work Stage (if applicable)

9. **Preventing Sex Trafficking and Strengthening Families Act (PSTFSA).** PSTFSA projects could include any work around domestic child sex trafficking, the reasonable and prudent parent standard, a focus on runaway youth, focus on normalcy, collaboration with other agencies around this topic, data collection and analysis, data sharing, or other efforts to fully implement the act into practice.

   Do you have any projects/activities focused on PSTSFA? ☒ Yes ☐No

Project Description	How would you categorize this project?	Work Stage (if applicable)
Trafficking workgroup: After attending the CIP National Convening on Trafficking and Child Welfare in June, CIP members formed a human trafficking workgroup to draft legislation to improve the state's human trafficking law, to increase penalties for traffickers and patrons, and to provide more support to victims, including restitution, services, immunity for trafficking-related offenses, and expungement of records. The group—which included members from victim advocacy groups and all three branches of state government—drafted a bill that will be introduced during the 2016 state legislative session. It is hoped that the commission created in the bill will work on implementation of trafficking provisions, such as public awareness and training.	Sex Trafficking	Selecting Solution
Runaway Workgroup/Youth Services Committee: Both the CIP Youth Services Committee and ad hoc Runaway Workgroup are working on trauma-informed ways to prevent children from running away from state care and to find children who have run from state care. Data collection, NCIC reporting procedures, provider/foster parent training, and protocols are being discussed by the multidisciplinary groups.	Focus on Runaway youth	Develop Theory of Change
2015 Legislation: The CIP-drafted House Bill 2200, which reorganized Chapter 49 of the West Virginia Code, included the following amendment to APPLA (another planned permanent living arrangement), to comply with the Preventing Sex Trafficking and	Other	Implementation

Strengthening Families Act of 2014: In addition, in the case of any child for whom another planned permanent living arrangement is the permanency plan, the court shall (1) inquire of the child about the desired permanency outcome for the child; (2) make a judicial determination explaining why, as of the date of the hearing, another planned permanent living arrangement is the best permanency plan for the child; and, (3) provide in the court order compelling reasons why it continues to not be in the best interest of the child to (i)return home, (ii)be placed for adoption, (iii) be placed with a legal guardian, or (iv) be placed with a fit and willing relative.		
2015 Amendments to Procedural Rules: After passing H.B. 2200, CIP made corresponding amendments to the Rules of Procedure for Child Abuse and Neglect Proceedings and the Rules of Juvenile Procedure. Details in the case plan and findings for permanent placement reviews now include the following: When the child's permanency plan is another planned permanent living arrangement (APPLA), the efforts to place the child permanently with a parent, relative, or in a guardianship or adoptive placement; the child's desired permanency outcome; and the steps taken to ensure that the foster family follows the "reasonable and prudent parent standard" to allow the child regular opportunities to engage in age -- or developmentally -- appropriate normal childhood activities.	Reasonable & Prudent Parent	Implementation

III. Priority Areas & CIP Resources

a. What would you consider your top **two** priority areas for FY 2016?

☒ Data projects ☐ Hearing quality

☐ Timeliness/permanency ☐ Quality of legal representation

☐ Engagement of Parties ☐ Well-being

☒ Preventing Sex Trafficking & Strengthening Families

☐ ICWA ☐ Other:_____

b. Are there any outside driving forces that determine your priorities or consume a lot of your time? (For example, legislative involvement or directives, budget concerns, consent decrees and class action litigation, highly publicized child fatalities, unaccompanied minors, etc.)

The Preventing Sex Trafficking and Strengthening Families Act of 2014 shines a spotlight on human trafficking issues.
Several initiatives have emphasized keeping children in their homes and committees whenever possible:

- the Department of Justice letter to WVDHHR on the mental health system's need to comply with *Olmstead* and the ADA; (http://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf);
- the Governor's Intergovernmental Task Force on Juvenile Justice and Pew Foundation study (http://www.governor.wv.gov/Documents/Final%20Report%20of%20the%20WV%20Intergovernmental%20Task%20Force%20on%20Juvenile%20Justice.pdf), which led to WV Senate Bill 393 in 2015; and
- the DHHR Safe at Home WV (Title IV-E Demonstration) Project (http://www.dhhr.wv.gov/bcf/Services/Pages/Safe-At-Home-West-Virginia.aspx).

IV. CIP Collaboration and Participation in Child Welfare Program Planning and Improvement Efforts

10. For FY2014, you described how the CIP planned to assist with and participate in round three of the CFSR and program improvement process. We are interested in your progress or any changes to this plan.

a. Has your plan changed? If so, how?
No, the focus has not changed. CIP still receives quarterly updates from BCF at its Federal Review/Data/Statutes/Rules committee meetings.

b. How have you moved this plan forward in FY2015?
It is the same/no change.

c. What barriers have you encountered (if any) in increasing your participation with round three of CFSR?
Because West Virginia's review is not until 2017, the collaboration has lacked a sense of urgency.

d. Have you received any technical assistance on this issue? If so, what was it and how was it helpful to you?
No, CIP has not, except our regional ACF partners share program instructions and related information.

11. For FY2014 you described how the CIP will assist with and participate in the CFSP/APSR processes with the child welfare agency in an ongoing fashion. We are interested in your progress or any changes to this plan.

a. Has your plan changed? If so, how?
No.

b. How have you moved this plan forward in FY2015?
BCF invited Court staff/CIP members to various meetings on the APSR and asked for CAN Database data to supplant its report.

c. What barriers have you encountered (if any) to working with the child welfare agency in the CFSP/APSR process in an ongoing fashion?
N/A.

d. Have you received any technical assistance on this issue? If so, what was it and how was it helpful to you?
No.

12. How are you involved, if at all, with the child welfare agency's CQI efforts?

☒ Contributing data ☐Receiving data ☒Jointly using data

☒ Collaborative meetings ☒ Collaborative systems change project(s)

☐ Other:_____

V. CQI Current Capacity Assessment

a. How is the CIP progressing with CQI overall? Please provide a brief description of how you integrate CQI into your work.
CIP is fairly competent at reviewing data and feedback to inform its decisions. It always ponders how it is doing and how it can improve, whether through meetings, formal evaluations, or informal feedback.

b. Do you have any of the following resources to help you integrate CQI into practice?

☒CIP staff with CQI (e.g., data, evaluation) expertise

☐Consultants with CQI expertise ☐a University partnership

☐Contracts with external agencies to assist with CQI efforts

☐Other resources:_____

c. Describe the largest challenges your CIP faces with implementing CQI into your work.
The biggest barriers are budgetary. It is challenging to do in-depth CQI of all projects on a tight CIP budget with limited staff.

d. Please review the list of capacities below. Select the ***three*** capacity areas that you would like to increase your knowledge of or enhance your ability to do in the next fiscal year.

☐CQI generally	☐Data collection methodologies
☐ Data analysis	☐Understanding/applying data
☒ Evaluation design	☐Tool development
☐Policy change implementation	☐CQI commitment (buy-in)
☐Collaboration w/agencies	☒Data-driven decision-making
☐Participation in CFSR process	☐Performance measurement

☐Participation in CFSP/APSR process ☐Community partnerships
☐Awareness of evidence-based practices ☐Research partnerships
☐Leadership ☐Data systems
☐Currently available data (e.g., AFCARS) ☒Tracking implementation/changes
☐Training evaluation

Evaluation/CQI efforts specific to:

☐Preventing Trafficking and Strengthening Families Act
☒Quality legal representation ☒Hearing quality
☐Timeliness/Permanency ☒Well-being
☒Engagement/Presence of Parties ☐ ICWA

☐Other:_____

VI. Self-Assessment – Capacity

We would like you to assess your current capacities related to knowledge, skills, resources, and collaboration by responding to the following 3 sets of questions.

1. Please indicate your level of agreement to the following statements.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
I have a good understanding of CQI.	☐	☐	☐	☐	☒	☐	☐
I understand how to integrate CQI into all our work.	☐	☐	☐	☐	☒	☐	☐
I am familiar with the available data relevant to our work.	☐	☐	☐	☐	☐	☒	☐
I understand how to interpret and apply the available data.	☐	☐	☐	☐	☒	☐	☐
The CIP and the state child welfare agency have shared goals.	☐	☐	☐	☐	☒	☐	☐
The CIP and the state child welfare agency collaborate around program planning and improvement efforts.	☒	☐	☐	☐	☒	☐	☐
We have the resources we need to fully integrate CQI into practice.	☐	☐	☒	☐	☐	☐	☐
I have staff, consultants, or partners who can answer my CQI questions.	☐	☐	☐	☐	☒	☐	☐

2. How frequently do you engage in the following activities?

	Never	Rarely	Sometimes	Often	Always
We use data to make decisions about where to focus our efforts.	☐	☐	☐	☒	☐
We meet with representatives of the child welfare agency to engage in collaborative systems change efforts	☐	☐	☐	☒	☐
We evaluate newly developed or modified programs/practices.	☐	☐	☒	☐	☐
We use evaluation/assessment findings to make changes to programs/practices.	☐	☐	☐	☒	☐
CQI is integrated into all our projects.	☐	☐	☒	☐	☐

3. Please review the descriptions of the different levels of collaboration. Using the scale provided, please indicate the extent to which you currently interact with each other partner identified below.

	Networking 1	Cooperation 2	Coordination 3	Coalition 4	Collaboration 5
Relationship Characteristics	--Aware of organization --Loosely defined roles --Little communication	---Provide info to each other --Somewhat defined roles --Formal communication	--Share information and resources --Defined roles --Frequent communication --Some shared	--Share ideas --Share resources --Frequent and prioritized communication --All member have a	--Members belong to one system --Frequent communication is characterized by mutual trust

	--All decisions made independently	--All decisions made independently	decision making	vote in decision-making	--Consensus is reached on all decisions

	No Interaction at all 0	Networking 1	Cooperation 2	Coordination 3	Coalition 4	Collaboration 5
State Child Welfare Agency	☐	☐	☐	☐	☒	☐
Tribal Child Welfare Agencies	☒	☐	☐	☐	☐	☐
Tribal Courts	☒	☐	☐	☐	☐	☐
Department of Education/ School	☐	☐	☐	☐	☒	☐
Law enforcement	☐	☐	☒	☐	☐	☐
Juvenile justice agency (e.g., DOJ)	☐	☐	☐	☒	☐	☐
Behavioral/mental health	☐	☐	☒	☐	☐	☐
Substance abuse/addictions management agency	☐	☐	☒	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐	☐

VII. Timeliness Data & Performance Measurement

The purpose of asking all the CIPs to report on timeliness measures has been to prompt you to identify available data, examine how you are currently doing, and make comparisons to how you have done in the past on specific measures. The goal is to help you identify where you are and encourage you to use data in a meaningful way in your systems change efforts. As such, we have restructured the timeliness requirements so that you can still report on the timeliness measures but have the option to report on other measures that you have found particularly meaningful in your work.[3]

1. **Timeliness.** Provide a narrative below describing where you are getting data and how you are calculating the timeliness measures you report. What is your universe of cases (e.g., what is your sample, exit or entry cohort, etc.)? Is the data from the agency (e.g., SACWIS), from a court case management system (e.g., Odyssey) or from another source? Do you have any concerns with the accuracy of the data?

	Baseline Measure (FY 2013)	FY 2014	FY 2015	CIP Projects Targeting Measures (if applicable) [If this measure was targeted by an intervention (e.g., efforts made to improve timeliness), please list the project or activity here]
Required Timeliness Measures (All measures are reported in the year that the end/final date occurred. For example, FY 2014 "Time to TPR" average includes all records that had the TPR within FY2014.)				
4G. Time to First Permanency Hearing	308.2 days	267.7 days	259.6 days	This data is collected in our statewide judicial Child Abuse and Neglect case

[3] The OJJDP Toolkit that includes these performance measures is available online at: http://www.ojjdp.gov/publications/courttoolkit.html

				management system. This measure is an average statewide total of days. It is calculated from all records in which original petition filing date and the permanency planning determination date are available.
4H. Time to Termination of Parental Rights Petition	n/a	n/a	n/a	We are working on changing the rules to implement a process where can measure time from filing original petition to filing of termination motion by having a formal motion for TPR within the existing child abuse/neglect case.
4I. Time to Termination of Parental Rights	325.6 days	282.3 days	281.5 days	This data is collected in our statewide judicial Child Abuse and Neglect case management system. This measure consists of the average (mean) time from filing of the original petition to termination of parental rights for each respondent. All respondent items including applicable dates for both items will be included in the calculation. If a respondent was added as a result of an Amended Petition, or service was delayed to a respondent who was included in the original petition, time to the Termination of Parental Rights would be calculated from the date the respondent was added or served rather than the original petition date.
4A. Time to Permanent Placement	495.2 days	452.0 days	435.2 days	This data is collected in our statewide judicial Child Abuse and Neglect case management system. Time to placement is measured by the average time from filing of the original petition to permanent placement. This is calculated using all records including both original petition filing date and the date of permanent placement.
Optional Measures				
Time to Reunification				
Time to Adoption				
Time to Guardianship				
Time to Emancipation				
Time to Subsequent Permanency Hearings				
1B. Percentage of Cases that				

Re-enter within 1 year				

2. **Other Measures**. What other measures do you collect that you find particularly useful?
   Do you currently or have you recently collected any data on quality legal representation or quality court hearings that you would be willing to discuss and share?

	Baseline Measure (FY 2013)	FY 2014	FY 2015	CIP Projects Targeting Measures (if applicable) [If this measure was targeted by an intervention (e.g., efforts made to improve timeliness), please list the project or activity here]
Other Timeliness Measures				
4B. Time to Adjudication	81.7 days	65.8 days	73.9 days	This data is collected in our statewide judicial Child Abuse and Neglect case management system. This measure will include calculating the average time from filing of the original petition to adjudication. The average will be calculated using all respondent records including original petition filing date and the beginning date of the adjudicatory hearing date for each respondent. If a respondent was added after the preliminary hearing as a result of an Amended Petition, or service was delayed to a respondent who was included in the original petition, time to the Adjudicatory Hearing would be calculated from the date the respondent was added or served rather than the original petition date.
4D. Time to Disposition	279.4 days	246.9 days	253.6 days	This data is collected in our statewide judicial Child Abuse and Neglect case management system. This measure will include calculating the average time from filing of the original petition to disposition. The average will be calculated using all respondent records including original petition filing date and the date of the earliest provided disposition date for each respondent. If a respondent was added after the preliminary hearing as a result of an Amended Petition, or service was delayed to a respondent who was included in the original petition, time to

				the Disposition Hearing would be calculated from the date the respondent was added or served rather than the original petition date.

APPENDIX A: DEFINITIONS

Definitions of Evidence

Evidence-based practice – evidence-based practices are practice that have been empirically tested in a rigorous way (involving random assignment to groups), have demonstrated effectiveness related to specific outcomes, have been replicated in practice at least one, and have findings published in peer reviewed journal articles.

Empirically-supported- less rigorous than evidence-based practices are empirically-supported practices. To be empirically supported, a program must have been evaluated in some way and have demonstrated some relationship to a positive outcome. This may not meet the rigor of evidence-base, but still has some support for effectiveness.

Best-practices – best practices are often those widely accepted in the field as good practice. They may or may not have empirical support as to effectiveness, but are often derived from teams of experts in the field.

Definitions for Work Stages

Identifying and Assessing Needs – This phase is the earliest phase in the process, where you are identifying a need to be addressed. The assessing needs phase includes identifying the need, determining if there is available data demonstrating that this a problem, forming teams to address the issue.

Develop theory of change—This phase focuses on the theorizing the causes of a problem. In this phase you would identify what you think might be causing the problem and develop a "theory of change". The theory of change is essentially how you think your activities (or intervention) will improve outcomes.

Develop/select solution—This phase includes developing or selecting a solution. In this phase, you might be exploring potential best-practices or evidence-based practices that you may want to implement as a solution to the identified need. You might also be developing a specific training, program, or practice that you want to implement.

Implementation – the implementation phase of work is when an intervention is being piloted or tested. This includes adapting programs or practices to meet your needs, and developing implementation supports.

Evaluation/assessment – the evaluation and assessment phase includes any efforts to collect data about the fidelity (process measures: was it implemented as planned?) or effectiveness (outcome measures: is the intervention making a difference?) of the project. The evaluation assessment phase

also includes post-evaluation efforts to apply findings, such as making changes to the program/practice and using the data to inform next steps.

APPENDIX G

Education of Children in Out-of-Care Advisory Committee

During 2015, the Education of Children in Out-of-Care Advisory Committee and the Department of Education continued its work to improve educational services for children in out-of-home care. The Advisory Committee completed its work on an interagency agreement termed the West Virginia Collaborative Partnership for Ensuring Educational Success for Children in Out-of-Home Care. The agreement, signed by the Department of Education, Department of Health and Human Resources, Division of Juvenile Services, and the Supreme Court of Appeals of West Virginia establishes goals and a guiding framework for interagency collaboration for the education of children in out-of-home care.

The Advisory Committee also completed a preliminary analysis of the educational status and academic achievement data of children in out-of-home care for the school years 2012-2013 and 2013-2014 using a match of records from Department of Education and Department of Health and Human Resources data bases. The major finding from this study was that children in out-of-home care are seriously behind their school-aged peers in academic achievement, representing one of the lowest at-risk subgroups for which data is reported by the Department of Education. Moreover, the data demonstrated a trend between academic achievement and school stability. Children with more school placements had poorer academic outcomes. The study also found that a significant number of children in out-of-home care did not take the state's standardized achievement test. As a result of the study, the Advisory Committee made a number of recommendations to improve educational services for children in out-of-home care. The Commission unanimously endorsed the following recommendation:

"***Modify the West Virginia Educational Information System (WVEIS) to provide the capability to produce data and reports on the educational status, achievement and outcomes of children in out-of-home care."***

In support of the above recommendation, the Annie E. Casey Foundation in a recent report titled *Sustaining Momentum: Improving Educational Stability for Young People in Foster Care* stated, "One barrier in meeting the educational needs of children in foster care is that they are not counted as a group in the way English language learners, racial and ethnic minority groups, students raised in poverty and those with disabilities are."

In addition to the above initiatives, the Advisory Committee and Department of Education continued its efforts to eliminate educational barriers for children in out-of-home care by working with service providers, providing and disseminating information and providing transition services through the Office of Institutional Educational Programs for students returning from placements.

APPENDIX H

West Virginia

ADULT DRUG COURTS

2016

Supreme Court of Appeals of West Virginia

Division of Probation Services

Michael B. Lacy
Director

Lora J. Maynard
Deputy Director for Drug Courts

Robert L. McKinney, II
Counsel

Timothy P. Hanna
Development and Training Specialist

Sean Noland
QA and Field Support Coordinator

- The West Virginia Adult Drug Court (ADC) Program is a cooperative effort of the criminal justice, social service, substance abuse treatment, and law enforcement systems.
- The ADCs are established in accordance with The West Virginia Drug Offender Accountability and Treatment Act (§62-15-1, et seq.) and are designed and operated consistent with the Ten Key Components of Drug Courts and operate under policies and procedures established in consultation with the WV Supreme Court of Appeals.
- All ADCs use evidence-based treatment approaches and assessments and are to be evaluated annually.
- Referrals to ADC can be made by judicial officials, law enforcement, probation officers, prosecutors, and defense counsel. The final acceptance of participants into ADC must be approved by the Prosecutor and the Drug Court Judge.
- The program is structured in three phases. The minimum program length is one (1) year. Drug Courts may include pre-adjudication or post-adjudication participation.
- Program components include: intensive supervision, frequent, random, and observed drug testing, meetings between participants and their probation officer, counseling sessions for participants, court appearances for participants, and community service.
- The program seeks to achieve a reduction in recidivism and substance abuse among offenders and to increase the likelihood of successful rehabilitation through early, continuous, and intense treatment; mandatory periodic drug testing; community supervision; appropriate sanctions and incentives; and other rehabilitation services, all of which is supervised by a judicial officer.
- Cost savings for the criminal justice system stem from reduced re-arrests, law enforcement contacts, court hearings, and use of jails or prisons. Other cost savings for the State result from reduced decreased use of residential treatment centers.
- For FY 2012-2013, **the average annual service cost per drug court participant was $7,100.00** as compared to annual incarceration costs of $17,611 in jail or $28,369 in prison.
- As of December 31, 2015, **830** participants have successfully graduated from West Virginia's ADCs, which have a Graduation Rate of 52%. **The recidivism rate for graduates over the past two years is 9.4%** (recidivism is defined as any subsequent arrest for a serious offense (carrying a sentence of at least one year) resulting in the filing of a charge). **One year post graduation recidivism rate is only 1.88%.** This is in contrast to nearly an 80% recidivism rate for incarcerated drug offending individuals.
- As of the end of December 2015, there were twenty five (25) operating ADC programs comprising thirty-one (31) individual courts covering forty-three (43) counties: Berkeley, Boone, Brooke, Cabell, Calhoun, Doddridge, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Monongalia, Monroe, Morgan, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Tyler, Upshur, Wayne, Wetzel, Wirt, Wood, and Wyoming counties. Three additional ADC's are in development in the 12th, 28th and 30th judicial circuits. Two circuits are currently in the planning phase.
- National reports support the effectiveness of ADCs that adhere to best practices and evidence-based practices from the fields of substance abuse treatment and counseling.
- There are **448** active clients in the ADCs as of December 31, 2015.

West Virginia Juvenile Drug Court 2016

Supreme Court of Appeals of West Virginia

Division of Probation Services

Michael B. Lacy
Director

Lora J. Maynard
Deputy Director for Drug Courts

Robert L. McKinney, II
Counsel

Timothy P. Hanna
Development and Training Specialist

Sean Noland
QA and Field Support Coordinator

- The West Virginia Juvenile Drug Court (JDC) Program is a cooperative effort of the juvenile justice, social service, substance abuse treatment, law enforcement and education systems.
- JDC's are established in accordance with §49-4-703 and are designed and operated consistent with the developmental and rehabilitative needs of the juveniles and operate under uniform protocol and procedures established by the WV Supreme Court of Appeals.
- The program seeks to divert non-violent, juvenile offenders exhibiting substance abuse behavior from the traditional juvenile court process to a non-adversarial, intensive, individualized outpatient substance abuse treatment process which includes parental involvement and cooperation.
- The goal is, through early/earlier intervention, to prevent/reduce future court involvement for the JDC involved juveniles. The objectives are improved general functioning of the juveniles and increased family self-sufficiency.
- All JDCs use evidence-based treatment approaches and assessments and are evaluated annually.
- Referrals to JDC can be made by judicial officials, law enforcement, school personnel, probation officers, prosecutors, child protective services/youth services workers, and parents.
- The program is structured in four-phases. The minimum program length is twenty eight (28) weeks. Additionally, six (6) months of aftercare is offered to each graduate.
- There are five (5) entry levels into the JDC: pre-petition diversion; signed, but non-filed petition; filed petition (pre-adjudicatory); filed petition (post-adjudicatory); and as a condition of probation.
- Program components include: intensive supervision, frequent, random, and observed drug testing, meetings between juveniles and probation officer and parents and probation officer, counseling sessions for juveniles and for families, court appearances for juvenile and parents, and community service.
- As of December 31, 2015, there were fifteen (15) operational JDC programs comprised of seventeen (17) individual drug courts in Wayne, Logan, Mercer, Putnam, Boone, Lincoln, Hancock/Brooke, Monongalia, Randolph, Kanawha, Jefferson, Harrison, Wood, Berkeley, McDowell, Ohio, and Raleigh counties.
- **492** participants have successfully graduated from West Virginia's JDCs as of December 31, 2015 which have a graduation rate of approximately 50.5%. **The recidivism rate for graduates is 14.6% as compared to 55.1% in traditional juvenile probation** (recidivism defined by a new petition in the juvenile system or a new arrest in the adult system).
- Cost savings for the criminal justice system stem from reduced re-arrests, law enforcement contacts, court hearings, and use of detention centers. Other cost savings for the State result from reduced out-of-home placement and decreased use of residential treatment centers.
- For FY 2012-13, **the average cost per graduating youth was $6,900** This cost includes intensive supervision and individualized treatment services and includes services to the family. This is in contrast to $96,000 for the same time period in a DJS facility, $44,000 in a residential group facility and $99,000 in a hospital treatment facility.
- On December 31, 2015, there are **197 active** JDC cases in West Virginia.
- National reports support the effectiveness of JDC's that adhere to best practices and evidence-based practices from the fields of adolescent treatment and delinquency prevention.