2016

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
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Jim Justice, Governor
Bill J. Crouch, Cabinet Secretary

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DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Bill J. Crouch
Cabinet Secretary

A MESSAGE FROM THE 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.*

This report provides important background on the Commission's work and key accomplishments completed in 2016.

Over the last several years, the Commission has been able to gradually reduce the number of children placed in out of state placements. This accomplishment could not have been made without the collaborative work of many individuals. We realize there is still a lot of work to be made in reducing the number of children in out-of-home placement, but are confident that as we continue to work collaboratively, we will meet the challenges facing our state.

Sincerely,

Bill J. Crouch
Cabinet Secretary

2016 COMMISSION MEMBERS

Commission to Study Residential Placement of Children

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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 13 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 10 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. In March 2016, SB 329 eliminated the sunset for the Commission to Study Residential Placements of Children.

West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF) 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 West Virginia demonstration project. As a partner in the Safe at Home West Virginia project, the Commission's members will participate on the cross-discipline workgroups specific to the Safe at Home West Virginia project.

For More Information

Background information, including studies, reports, data analyses and minutes of Commission meetings, is available online: http://www.wvdhhr.org/oos_comm/. Additional inquiries may be addressed to Linda Watts, Deputy Commissioner, Office of Programs and Resource Development, 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.

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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, and Out-of-State Provider Certification 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 Safe at Home West Virginia, 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 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 constitutes 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 2016 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 2016

From the time the West Virginia 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. This information is available on the Commission's web page: http://www.wvdhhr.org/oos_comm/default.htm.

PRIORITY GOALS FOR IMPLEMENTATION

In 2012, the Commission reviewed its original 13 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 10 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 Treatment Team Support

Support the Multidisciplinary Treatment Team concept and assist enhancing present Multidisciplinary Treatment Team 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 2016

Keeping the Commission's priority goals as the focus, these accomplishments represent the work for January 2016 through December 2016. 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 West Virginia 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 two processes are the Regional Clinical Review Team and the Out-of-State Review Team. 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. The number of youth being placed out-of-state continues to decrease. Three years ago (2012-2013), 533 youth were placed out-of-state. Two years ago (2013-2014), 492 youth were placed out-of-state. Last year (2014-2015), 477 youth were placed out of state. This year (2015-2016), 425 youth were placed out-of-state. That is a 20% decrease in four years.

- The Bureau for Children and Families is implementing a three-tiered family foster care program in West Virginia statewide. The three-tiered foster family model will be implemented by several of our licensed child placing providers who were selected and received grant funds for the development of this model. Each provider will be required to recruit and train individuals for eight Tier 2 (treatment) foster homes and individuals for three Tier 3 (intensive treatment) foster homes within six months of the start of the grant period, which began on November 1, 2016. These homes may be existing foster care homes or new homes. This three-tiered foster care program will serve children through traditional foster care, treatment foster care, and intensive treatment foster care. The foster family care model provides a milieu of treatment services and supports to ensure safety, well-being and permanency goals can be met in a family-like setting either through reunification and/or adoption. The Family Foster Care Model will be structured as followed:
    - **Traditional Foster Care** is the system that West Virginia has historically provided. This level of care is ideal for children who have no significant indicators of trauma, behavioral, emotional and/or developmental issues and difficulty in school, home, and community. These children do not exhibit any high-risk behaviors, have any significant medical issues, or assessed needs for mental or behavioral health treatment.
    - **Treatment Foster Care** is the level of care to be used for children who exhibit a mild to moderate level of trauma, behavioral, emotional and/or developmental issues as identified through the Child Adolescent Needs and Strengths (CANS) assessment. These children may present with moderate risk behaviors and have moderate difficulty in school, home and community. This level would include pregnant/teen mothers and other children who have medical needs that exceed preventative measures. This level will be used for all children entering care on an emergency basis.
    - **Intensive Treatment Foster Care** will be the level of care used for children who exhibit significant indicators of trauma, behavioral, emotional and/or developmental issues. These children present with high risk behaviors and have significant difficulty in school, home and community. This level will be used for children who are stepping down from a higher level of care, are at risk for out-of-state placement, can be supported in the community as an alternative to residential care, are drug-exposed infants with additional medical needs, and children who are considered to be medically fragile as diagnosed by a physician.
- Safe at Home West Virginia evaluators, Hornby Zeller Associates (HZA), have developed the Automation of the West Virginia CANS 2.0 which is currently being used for Safe at Home Wraparound recipients. This system provides the framework needed to guide decision applications to include the development of specific algorithms for the appropriate intensity of services including intensive community services, treatment foster care, residential treatment, and other traditional outpatient care.
- The 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 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 throughout West Virginia. This

directory 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 47 Family Resource Networks (FRNs) are organizations that understand and are responsive to the needs and opportunities in West Virginia communities. The FRNs are in all West Virginia's 55 counties. Partnering with citizens and local organizations, the FRNs develop, coordinate, and administer innovative projects and provide needed resources. The FRNs have a resource directory for each county in West Virginia. Currently, a website is being developed, as a part of the Benedum grant, which will include a link to each of the FRNs that will include their resource directories, programs, and current events.
- The FRNs Service Agreement includes attending and/or participating in the (multi-county) Community Collaborative Groups and Regional Children's Summits to identify existing services and service gaps in the community.
- "As of December 20, 2016, 1,002 participants have successfully graduated from West Virginia's Adult Drug Courts (ADC), which have historically held a graduation rate of 52%. The recidivism rate for graduates over the last two years is 9.4% (recidivism is defined as any subsequent arrest for a serious offense, which carries a sentence of at least a 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." (More information about the West Virginia Adult Drug Courts can be found in Appendix H.)
- "As of December 20, 2016, there were 16 operational Juvenile Drug Courts (JDC) programs in Boone, Brook, Hancock, Harrison, Kanawha, Lincoln, Logan, McDowell, Mercer, Monongalia, Ohio, Pleasants, Putnam, Raleigh, Randolph, Wayne, Wirt, and Wood counties. 614 participants have successfully graduated from West Virginia's JDC as of December 20, 2016, 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 is defined by a new petition in the juvenile system or new arrest in the adult system)." (More information about the Juvenile Drug Court 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, and support) regarding the Commission's targeted populations.

- The West Virginia Child and Adolescent Needs and Strength (CANS) tool is designed to support individual

case planning and the planning and evaluation of service systems.

- As of December 9, 2016, 474 youth have been referred to Safe at Home West Virginia for wraparound services. Of those 474:
    - 33 youth have returned to West Virginia.
    - 74 youth have returned to their communities from in-state residential placement.
    - 210 youth have been or are being prevented from entering residential placement.
    - 4 youth have returned to their community from shelter placement.

- The West Virginia Interagency Consolidated Monitoring Manual of Out-of-State Residential Facilities was updated in 2016 to streamline the review process for monitoring and reviewing out-of-state facilities that serve West Virginia youth.

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.

- 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 wraparound facilitators and staff that will be referring to wraparound. (Safe at Home West Virginia)
- The BCF Division of Training has implemented a new training plan for Child Welfare and Adult Services staff. The plan outlines the four years of required training established by SB 559 and includes training on trauma, substance abuse, domestic violence, culture and diversity, and family centered practice. The new plan includes a competency test that new workers must pass before taking a caseload that includes a knowledge test, mock interviews, and a decision making assessment. West Virginia is one of the first states in the nation to implement a worker-level competency test.

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.

- In 2016, the West Virginia Department of Education (WVDE) and the Out-of-Home Care Education Advisory Committee studied the educational growth of children in out-of-home care. Although preliminary, they found students in out of-home care were not included in the data and there were some student growth data discrepancies.

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 Regional 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, thorough, and includes the CANS in all reviews. The role of this process is to identify the youth's current treatment and permanency needs.
- The West Virginia Comprehensive and Planning System (CAPS) Retrospective Review Tool was finalized in 2016. This review tool is used to assess the quality of the CAPS in all regions. The CAPS target population include youth who are:
    - Adjudicated as delinquent and referred to DHHR where the court is considering placing the juvenile in DHHR's custody or out-of-home care.
    - Adjudicated status offenders who are referred to DHHR for services under provisions of West Virginia Code 49-5-11 and 11a.
    - At risk of placement in Group Residential Care or Psychiatric Residential Treatment Facility. Examples of some risk factors include:
        1. Age of child/youth – older children tend to be at greater risk of placement in congregate care.
        2. Number and type of placements prior to involvement with DHHR.
        3. Risky Behaviors (i.e., drug abuse, history of self-injury, chronic aggressive or destructive behavior, suicidal ideation or acting out, and patterns of runaway).

7. Multidisciplinary Treatment Team Support

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

- Previously, the Commission's Multidisciplinary Treatment Team workgroup updated the Multidisciplinary Treatment Team desk guide and training curriculum, which are intended to improve the quality of participation of Multidisciplinary Treatment Team 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 Multidisciplinary Treatment Team. The desk guide was distributed to all youth services and child protective services caseworkers. In July 2016, the resource materials were provided at the Court Improvement Program's Cross Trainings. (CIP Self-Assessment Report)
- Through participation of its service provider members, the Education of Children in Out-of-Home Care Advisory Committee identified the need for Educational representation at Multidisciplinary Treatment Team meetings. (Education of Children in Out-of-Home Care Advisory Committee)

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 met in June 16, 2016 and December 15, 2016. Both meetings were held in Charleston, West Virginia at the Saint John XXIII Pastoral Center. In both meetings, positive strides were taken to understand how specific issues are affecting the child welfare system as a whole, while presenting evidence that the reliance on out-of-state placement for youth is continuing to trend downward.

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.

- 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 DHHR and WVDE standards. *(*West Virginia Interagency Consolidated Out-of-State Monitoring Team*)*
    - In 2016, the following on-site facility reviews were completed:
        - Gulf Coast (FL)
        - New Hope Carolinas (SC)
        - Coastal Harbor (GA)
        - Abraxas I Marienville (PA)
        - Hermitage Hall (TN)

10. Performance Accountability

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

- The Regional Clinical Review Process and the Out-of-State Review Process were supported internally by management who reinforced the use of the Regional Clinical Reviews by reviewing every child/youth who was at risk of being sent out-of-state.
- The Clinical Review 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.

NEXT STEPS FOR 2017

In addition to building upon and refining the past year's accomplishments, the Commission anticipates the following progress in 2017:

- Phase 3 of Safe at Home West Virginia is scheduled to roll out April 1, 2017 in the final 20 counties to bring the program to a statewide implementation. The counties are: Braxton, Calhoun, Clay, Doddridge, Fayette, Gilmer, Jackson, McDowell, Marshall, Mingo, Pleasants, Raleigh, Ritchie, Roane, Tyler, Webster, Wetzel, Wirt, Wood, and Wyoming.
- The Bureau for Behavioral Health and Health Facilities (BBHHF) will increase the Expanded School Mental Health (ESMH) services. ESMH services augment the standard services provided in schools by:
    - Emphasizing the shared responsibility among families, students, the school, and community mental health agencies;
    - Being committed to the full continuum of mental health services, including assessment, education, and promotion of well-being, prevention, early intervention, and treatment (BBHHF initiatives);
    - Expanded School Mental Health (ESMH) services is a multi-tiered system of support where schools and strategic community partners work together to enhance student mental health in schools. It is a framework that:
        - Includes the full continuum of prevention, early intervention, and treatment;
        - Serves all students;
        - Builds upon core programs/services being provided by schools; and
        - Emphasizes shared responsibility between schools, mental health providers and other community partners.
- BBHHF is piloting Children's Mental Health Wraparound. It is evidence-based and modeled after the National Wraparound Initiative and West Virginia Safe at Home Program. It will serve youth with Severe Emotional Disturbance/complex support needs in parental custody that are in or at risk of placement in an intensive psychiatric treatment setting. It will pilot in Berkeley, Cabell, Kanawha, Harrison, Marion, and Raleigh counties.
- The Education of Children in Out-of-Home Care Advisory Committee will continue its efforts in 2017 to foster collaboration among agencies and groups and make recommendations in the development of plans and implementation of foster care provisions of the Every Student Succeeds Act (ESSA).
- The Education of Children in Out-of-Home Care Advisory Committee will continue to study and identify barriers, and make recommendations to improve the attendance of educational personnel at MDT meetings.
- The Education of Children in Out-of-Home Care Advisory Committee will continue to study and identify barriers and make recommendations in removing barriers to educational access and transition for children in out-of-home care. They will seek to further examine these issues and study those students in out-of-home care who are 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.

- The Court Improvement Program, Youth Services Committee created the Away from Supervision Workgroup to review the data from the Bureau for Children and Families. The workgroup determined that in order to better understand the causes surrounding why children are away from supervision, which could mean anything from being out of the appropriate area for more than fifteen minutes to being a runaway, a review team needed to be created. The first review will be held in February 2017 (CIP Self-Assessment Report).

CONCLUSION

Over the past year, the data indicates the dependence on out-of-state placement is trending downward (see Performance Benchmark shown in Appendix D and the West Virginia 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. 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.

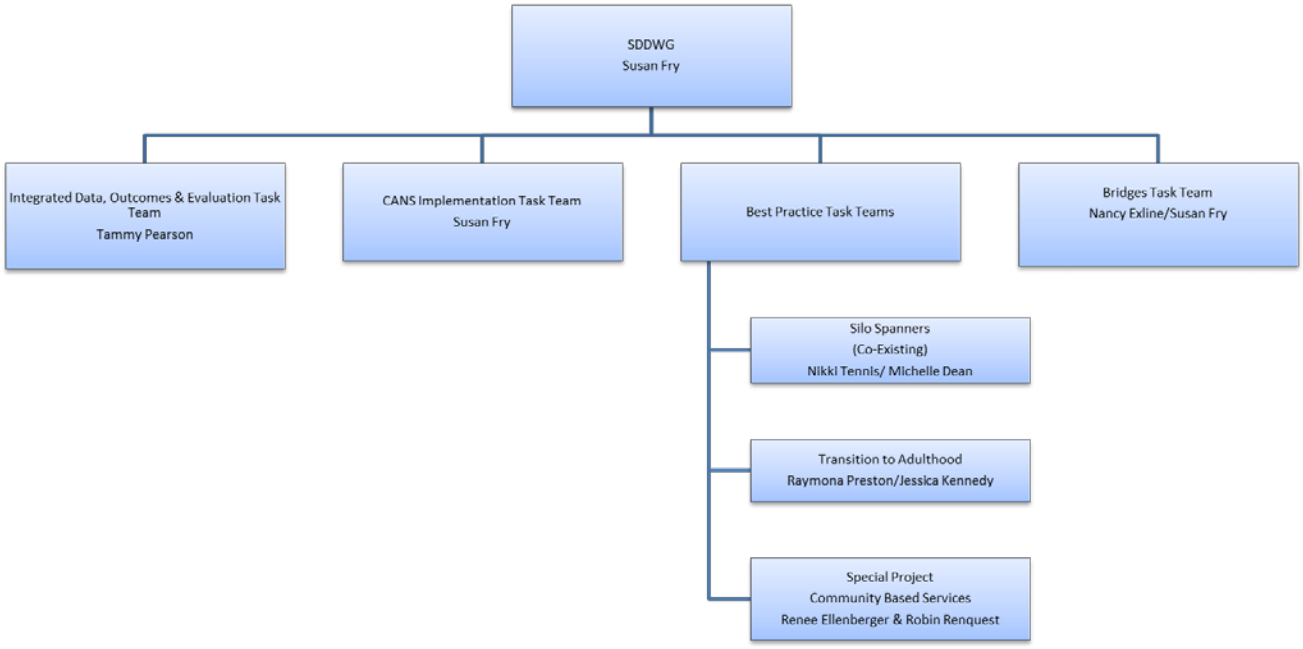
7. Government Accountability: All agencies that serve children, youth and families take the lead for System of Care goals and are responsible for policy, funding, system management and oversight to achieve them.

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



Service Delivery & Development Work Group Members

1. Susan Fry - Chair – Stepping Stones, Inc. *	23. Beth Morrison - WVDHHR-BHHF
2. Nancy Exline – WV DHHR- BCF Commissioner *	24. Mark Allen– Burlington United Methodist Family Services
3. Raymona Preston – Stepping Stones, Inc. *	25. Debi Gillespie- Division of Juvenile Services
4. Karen Yost – Prestera	26. Mindy Thornton – Prestera
5. Lisa Zappia –Prestera	27. Tammy Pearson – WVSOC *
6. Linda Watts - WV DHHR-BCF Deputy Commissioner	28. Chris Whitt – River Park Hospital
7. Rhonda Hayes – Family Advocacy and Support Team (FAST) –Legal Aid of WV	29. Donna Midkiff – River Park Hospital
8. Beverly Petrelli- Wellspring-Crittenton Services	30. Linda Dalyai – WVDHHR-BCF
9. Renee Brady*- National Youth Advocate Program	31. Elva Strickland – WVDHHR-BCF
10. Patty Lewis – National Youth Advocate Program	32. Gary Keen – WVDHHR – BCF
11. Robin Renquest – Pressley Ridge *	33. Amy Rickman – Necco
12. Amanda Ash – Pressley Ridge	34. Jason Deusenbery - Necco
13. Laura Barno – WV DHHR- BCF	35. Lorie Bragg – WVDHHR-BCF Region IV CWC
14. Brad Gault – Try Again Homes	36. Melody Plumley – Children's Home Society
15. Jackie Columbia – Board of Child Care	37. Michelle Dean – WVDHHR-BCF*
16. Beverly Heldreth – WV DHHR – BCF Region I RPM	38. Misty Prilliman – WVDHHR – BCF
17. Christa James–WV DHHR-BCF Region I CWC	39. Andrea Blankinship – B&T/Rescare
18. Cheryl Salamacha – WV DHHR-BCF Region II Regional Director	40. Nikki. Tennis – WV DHHR – BBHHF*
	41. Tina Martin
19. Sandra Wilkerson – WV DHHR – BCF Region II CWC	42. Becky Sanders – Elkins Mountain School
20. Amy Booth – WV DHHR-BCF – Deputy Commissioner	43. Terri Gogus – WV DHHR – BBHHF
21. Kimberly Harrison– WV DHHR - BHHF	44. Elizabeth Kennedy – WV DHHR – BBHHF
22. Lora Dunn – Highland Hospital	45. Josh Van Bibber – WV DHHR - BBHHF

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 – Nancy Exline, Susan Fry
2. Older Youth Transitioning to Adulthood Best Practice Task Team – Raymona Preston, Jessica Kennedy
3. Silo Spanners Task Team – Nikki Tennis, Michelle Dean
4. Integrated Data, Evaluation and Outcomes Task Team– Tammy Pearson
5. CANS Implementation Task Team – Susan Fry
6. Special Project – Renee Brady, Robin Renquest

** 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.*

Service Delivery & Development Work Group and Task Team Descriptions

Service Delivery & Development

The Service Delivery and Development Work Group provide expertise and cross-system collaborative recommendations and products to support the WV Commission to Study Residential Care of Children. The SDDWG researches and prioritizes best practices in supporting West Virginia youth and their families in being safe, well, happy and able to pursue their hopes and dreams.

The work group is responsible for the annual Out-Of-State Review report; providing ongoing technical assistance to the Regional Clinical Review Team process and annual review; ongoing technical assistance to community forums; technical assistance and support to the service array process; and additional projects and responsibilities as assigned.

- **Task Team: WV BRIDGES Task Team**
  - Focus Area: Out of Home Care Best Practice
  - Product/Process: Implementing & Assessing BRIDGES Performance Guidelines
  - Mission: The work group's purpose is to create a public/private/family/youth cross system partnership guide aligning residential care service delivery with the Building Bridges Joint Resolution Principles and Values. Through assessing current practice, assessing systemic issues, developing implementation strategies, implementing outcomes monitoring, training and support WV residential care will begin planned short and long term implementation of the building bridges performance guidelines
  - WV Bridges Executive Summary: The WV Building Bridges initiative is a national effort in partnership with SAMHSA and the American Association of Children's Residential Centers (AACRC) to advance a set of values and principles for comprehensive, coordinated and collaborative community approaches to address the needs of both youth and their families when a youth requires out of home treatment. A joint resolution developed by a nationwide "summit" of family members, youth and professionals outlined these values and principles in 2006. Following this joint resolution has been the development of outcome indicators and best practice guidelines that describe what one might expect from residential treatment in keeping with the national joint resolution. An agency self- assessment will allow organizations, families and communities to assess themselves against these performance guidelines and indicators.

- **Task Team: Integrated Data, Outcomes and Evaluation Task Team**

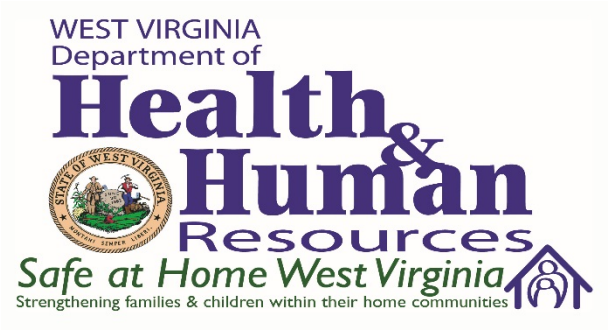
- Focus Area: Youth in the custody of the state that receive services out of state and the Regional Clinical Review Process.
- Purpose: Joint task team with cross membership between the WV System of Care State Implementation Team and Service Delivery and Development Work Group developed to provide technical assistance, data analysis, and recommendations to improve the WV System of Care service delivery model through data collection, analysis and recommendations.
- Mission: This work group is responsible for ensuring that the members of the WV System of Care and Service Delivery and Development are aware of the trends and outcomes for youth out of state, who are in the custody of WV. The group also reviews the impact that the Regional Clinical Review teams have on this population.

- **Task Team: Co-Existing Best Practice/Silo Spanners Task Team**
  - Focus Area: Identify evidence based practices for treatment of youth with co-existing disorders. The target population was any person from birth – 21 years of age who has been diagnosed with both a mental illness and Moderate Mental Retardation through Borderline Intellectual Functioning (IQ between 35 and 84). The following developmental disorders are included: Pervasive Developmental Disorder, Autism Disorder, and Asperger's Disorder.
  - Product/Process: In order to meet our task team goal, the team identified current strengths, weaknesses, opportunities and challenges associated with WV's current system in treating this population. In doing so, it was clear that WV has made strides in providing services to these individuals. Many of the weaknesses or challenges identified were discussed throughout this process and it became clear that reconfiguration of services already in place or additional training would be some quick implementation strategies that would positively impact the service delivery to this population. Recommendations at the practice and system level for statewide implementation were made.
  - Mission: This work group's mission was to develop an approach to earlier identification of I/DD/MI disorders so that services and support can be introduced sooner to the child and their family to allow them to grow into as self- sufficient an adult as possible with the resources available to support them in their efforts throughout the life span to help them achieve their maximum potential.
  - Executive Summary: The work group completed an analysis of the current system (strengths, weaknesses, opportunities, and challenges) for this population of youth and conducted research that both focused on best/promising practices and evidence based practices for this population. Recommendations were made that focused on early identification through standardized assessment and screening, parent training, individualized treatment planning that focused on parent and child strength's, additional training for providers to assist them in better understanding and treating this population, a review of current administrative policies and procedures that may be prohibiting providing seamless services to children and families in this population, and collaborating with higher education to build strong curriculums for working with this population. Finally, development of a work group which consists of members of all of agencies serving this population to develop strategies to integrate treatment, increase service capacity, identify outreach/support opportunities, reconfigure beds if needed, and blend/identify funding opportunities/strategies

- **Task Team: Older Youth Transitioning to Adulthood Best Practice Team**
    - Task Team: Older Youth Transitioning to Adulthood Best Practice Team
    - Focus Area Older youth ages 16 – 21 years aging out of the foster care system.
    - Product/Process Evaluate current practice and promote enhancement of service delivery to older youth by identifying transition markers and subsequent service pathways for youth Current and emerging tasks include integrating the Older Youth Checklist/Readily at Hand cross-system; development of a standardized transition plan that communicates readiness issues and suggested skills training targets; the development of a well-being checklist that addresses physical and behavioral health readiness; and, the development of a standardized life skills training curriculum that incorporates ACLSA into a group practice approach.
    - Mission Promote best practice and garner youth investment in implementing consistent transition services for youth aging out of the foster care system.

- **Task Team: WV Child and Adolescent Needs and Strengths (CANS) Implementation Task Team**
    - Focus Area: WV CANS Development and Implementation Oversight and Coordination
    - Product/Process: Coordinating the development of the WV CANS as well as overseeing training, certification, implementation, revisions and total clinical outcomes management.
    - Mission: Improve service delivery through the comprehensive and coordinated utilization of an assessment instrument that can cross system and communication barriers by creating a common assessment language while addressing the child and family status in a comprehensive manner. The common vision is to help youth and families achieve their goals. .
    - WV CANS Super Development and Implementation Task Team Executive Summary: The task team will oversee the utilization of the WV CANS as a meaningful information integration tool that will help child serving systems with their most important work - improving the lives of children and their families. The task team will guide the utilization of the WV CANS resulting in a fundamental shift in how systems utilize assessment information to guide decision making. The task team is charged with the development, implementation, tool updates/additions/support documents, training, super user certification, annual refresher, training data analysis, revision, algorithms/thresholds, automation, outcomes management and monitoring of the WV CANS. This task team is comprised of Advanced CANS Experts, CANS Experts, evaluator and cross system representatives. The task team will meet quarterly.

APPENDIX C



Our children and families will be:
Safe
Successful
Healthy
Supported

2016 Update

- West Virginia's Title IV-E Waiver demonstration project, Safe at Home West Virginia, 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.
- West Virginia has the highest foster care entry rate in the nation (9.8 children per 1,000 compared to a national entry rate of 3.5 in FY14).
- Safe at Home West Virginia 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 started 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.
- Implementation of Phase 2 began on August 1, 2016 with 24 more counties.
- Implementation of Phase 3 is in process and will roll in the final 20 counties to bring the program to a statewide implementation.
- Safe at Home West Virginia 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 West Virginia 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 first Semi-annual progress report was submitted on April 30, 2016.
- The second Semi-annual progress report was submitted on October 30, 2016 and is still being reviewed by the Federal Children's Bureau.
- 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 wraparound facilitation (care coordination) of wraparound services. We will partner with these agencies through a grant process.
- Criteria for the 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 or out-of-state residential or PRTF residential placement and they can be safely served at home by utilizing wraparound
- 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 wraparound facilitators 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 Wraparound Facilitators.
    - This team has identified wraparound champions that continue to assist with the delivery of these trainings.
- 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 posted to our website.
- The CANS 2.0 has been in full use as well as the automated CANS data base.

Evaluation

- Hornby Zeller Associates (HZA) was awarded the contract that began July 1, 2015.
- The independent evaluators have developed and maintain the automation of the WVCANS 2.0.
- The independent evaluators have conducted interviews for the first part of their evaluation of our processes.
- The independent evaluators conducted fidelity reviews as part of the process evaluation.
- The independent evaluators also continue to evaluate West Virginia's outcomes.

Training/Communication

- Training continues with each phase of implementation as well as with new worker training.
- CANS training and certification continues throughout the state with all partners.
- DHHR continues to produce a newsletter that is emailed to recipients as well as posted to our website.
- DHHR continues to send weekly email blasts with information regarding Safe at Home West Virginia and wraparound in general.

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. There is 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 assists with payment reconciliation until automation is achieved in FACTS.

Please refer to our website for further information: http://safe.wvdhhr.org.

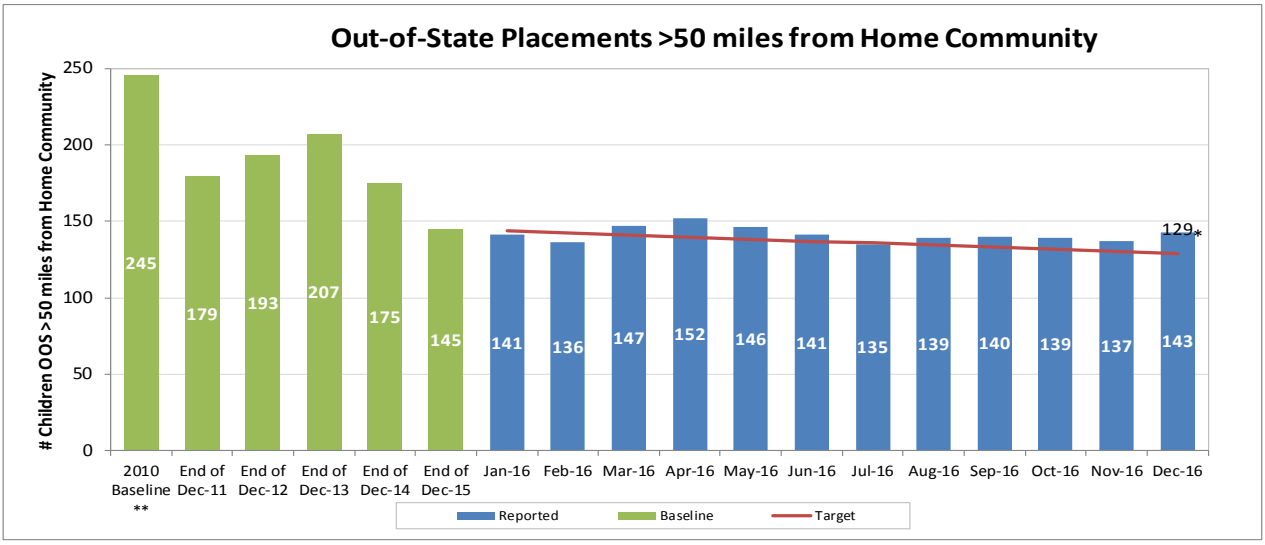
APPENDIX D

West Virginia Commission to Study Residential Placement of Children

Performance Scorecard

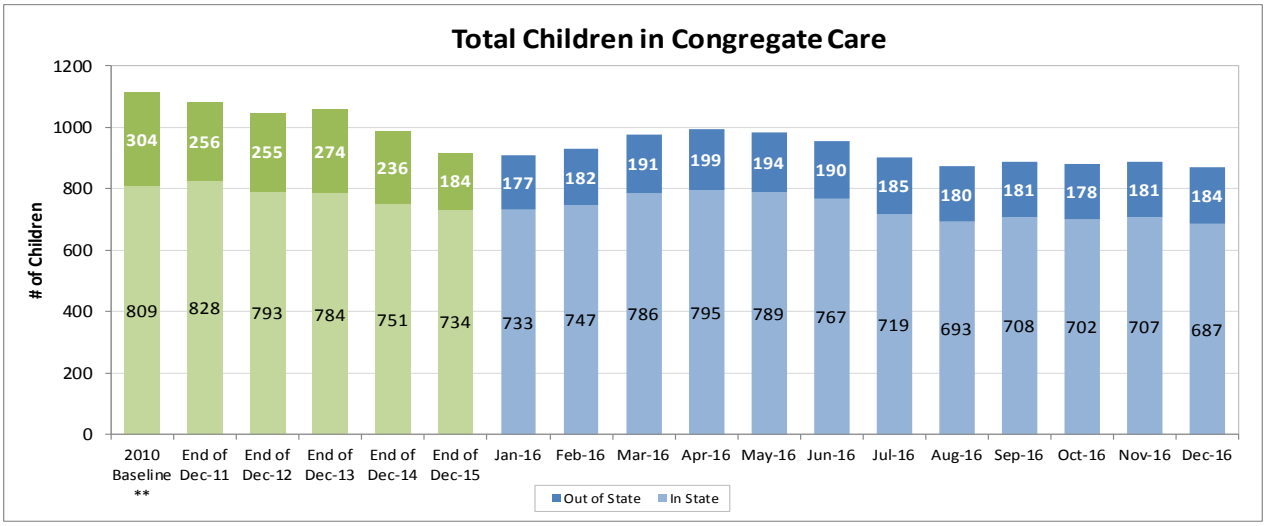
December 2016

Out-of-Home Placements	Group Residential Care	Psychiatric Facility (Long Term)	Psychiatric Facility (Short Term)	Total	
In State	**595**	**59**	**33**	**687**	79%
< 50 miles from Home Community A	258	26	14	**298**	34%
> 50 miles from Home Community C	337	33	19	**389**	45%
Out of State	**124**	**59**	**1**	**184**	21%
< 50 miles from Home Community B	40	1	0	**41**	5%
> 50 miles from Home Community D	84	58	1	**143**	16%
Total	**719**	**118**	**34**	**871**	100%



* The improvement target for 2016 is to have less than 129 children placed out-of-state and greater than 50 miles from their home community

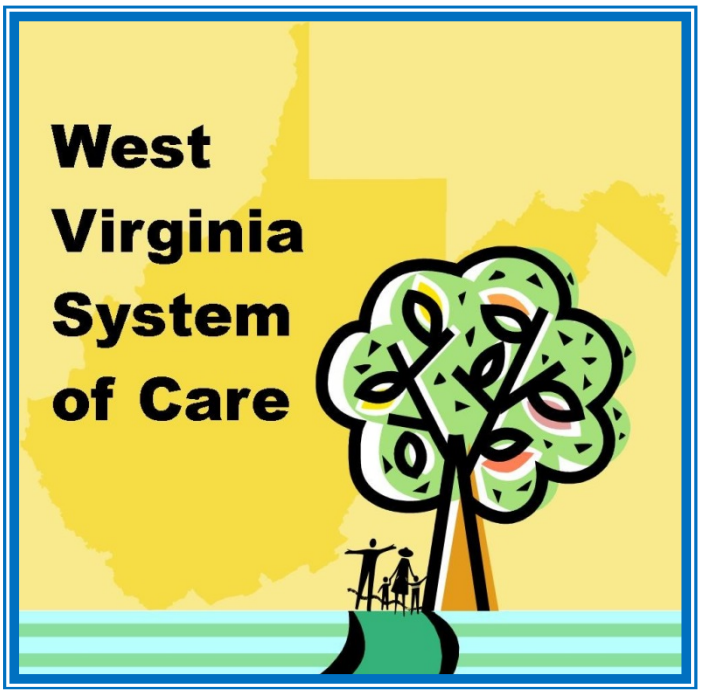
** Baseline is the average of October, November and December of 2010



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

APPENDIX E

WV System of Care End of Year Report
July 1, 2015-June 30, 2016



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 Tammy Pearson, WV System of Care Director

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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.

System of Care Principles

1. Family-Driven: This means 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: This means 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 & Linguistically Competent:
This means that children and families of diverse cultures and language proficiency have comparable access to services; that 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 that diverse families achieve successful outcomes from services.
4. Array of Community-Based Services: This means there is a broad and diverse array of community-based services and supports that are consistent with the system of care approach and improve outcomes.
5. Best Practice in Service Delivery: This means 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.
6. Quality Assurance: This means that 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:
This means that 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:
This means that interagency structures, agreements and partnerships are maintained that coordinate funding, resources and data to build the System of Care.

History

The West Virginia Commission to Study Residential Placement of Children was created by an act of the 2005 Legislature (HB 2334; **Section 49-2-125 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 was being implemented late 2015 and early 2016.

Target Population

Youth who are in the legal custody of DHHR, ages 0 to 21years old.
AND who are placed out-of-state or are at risk of being placed out-of-state for residential treatment or specialized foster care. Youth in parental custody are also reviewed as appropriate.

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).

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 WV System of Care Director.

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. Three years ago (2012-2013) 533 youth were placed out of state. Two years ago (2013-2014) 492 youth were placed out-of-state and last year (2014-2015) 477 youth were placed out-of-state. This year (2015-2016) 425 youth were placed out-of-state. That is a 20% decrease in 4 years.

The demographics of youth being placed out-of-state remains the same. There are more males than females and the youth are usually age 15-17 years old but there has been an increase in the number of youth between the ages of 11-14 in the last year. 21% of the youth have been placed out-of-state more than once since 2007.

Although diagnoses are not always accurate, as was discovered during the Out-of-State Reviews, the numbers indicate that 47% of the youth had a Mood disorder; 28% of the youth had an intellectual disability; 22% had a substance abuse or dependence diagnosis; and over half of the youth had a behavioral disorder of conduct disorder or oppositional defiant disorder.

From January 2014-June 2016, 373 youth out of 425 or (88%) were reviewed through a Regional Clinical Review Team and/or an Out-of-State Review Team.

Through these teams some of the gaps in services identified include limited services for youth with an intellectual disability including Autism; younger youth age 10 or younger requiring intense treatment; and youth requiring specialized treatment for such disorders as traumatic brain injury.

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).

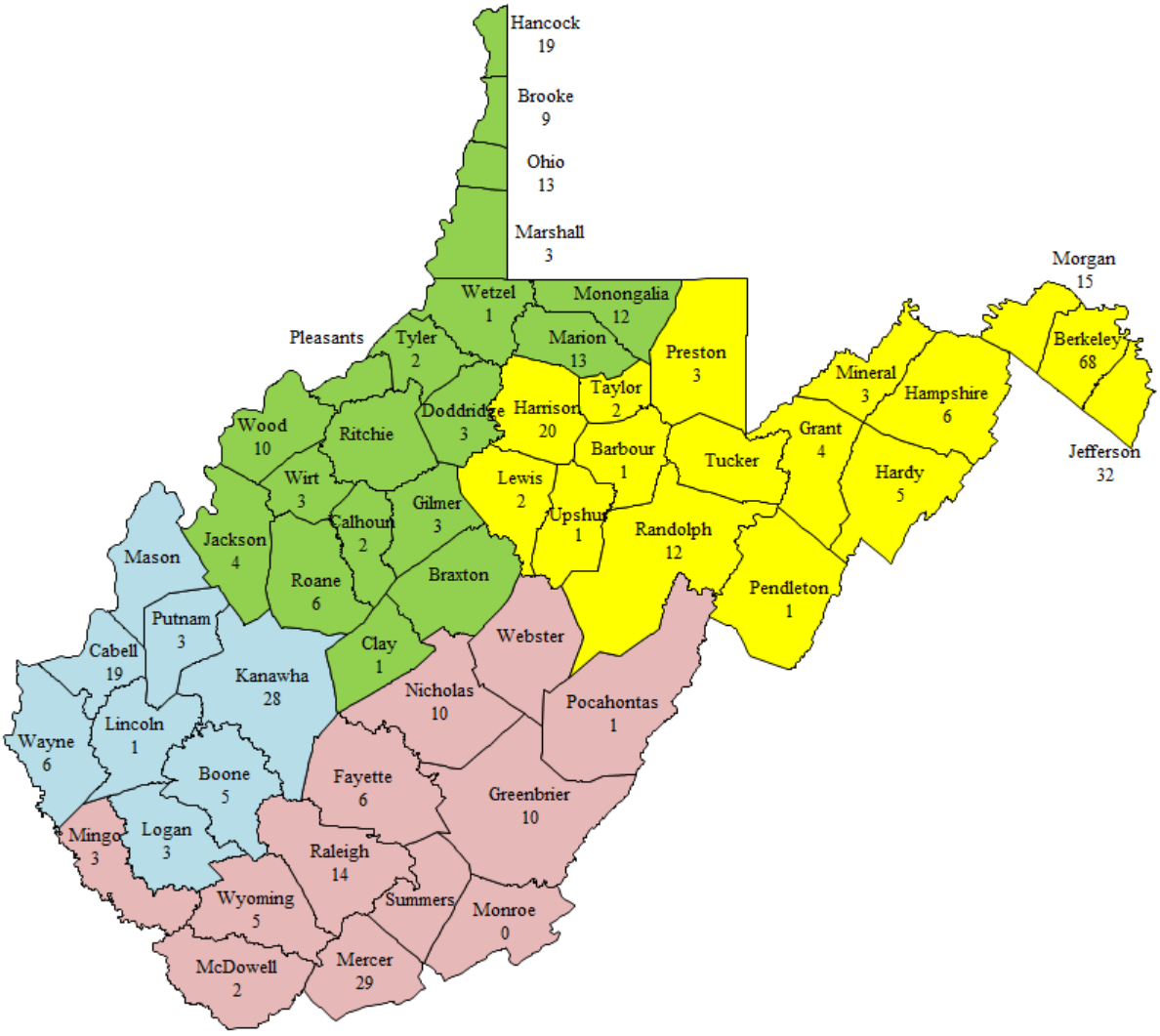
Youth Out-of-State

Out of State Youth

All Regions

July 2015-June 2016

(Total-425)

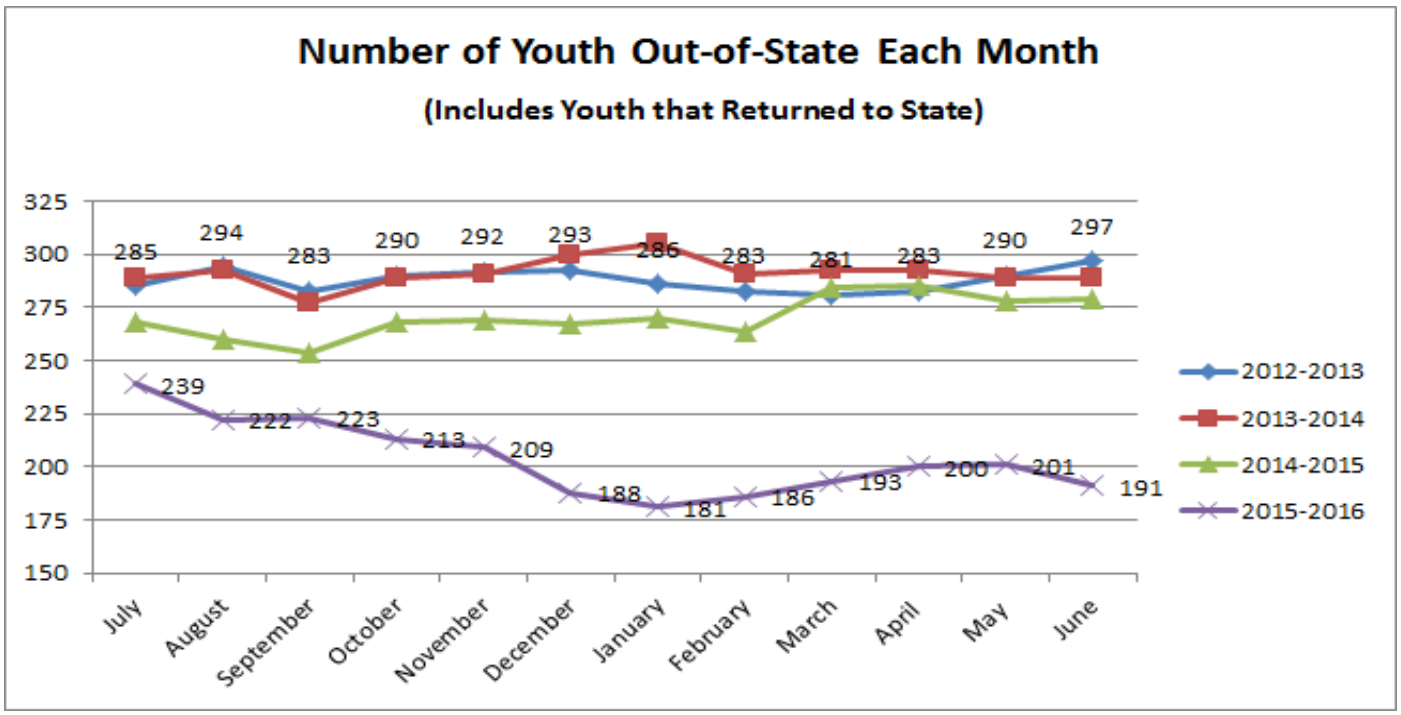


Annual Numbers

	2015-2016	2014-2015	2013-2014	2012-2013
State Total	425	477	492	533

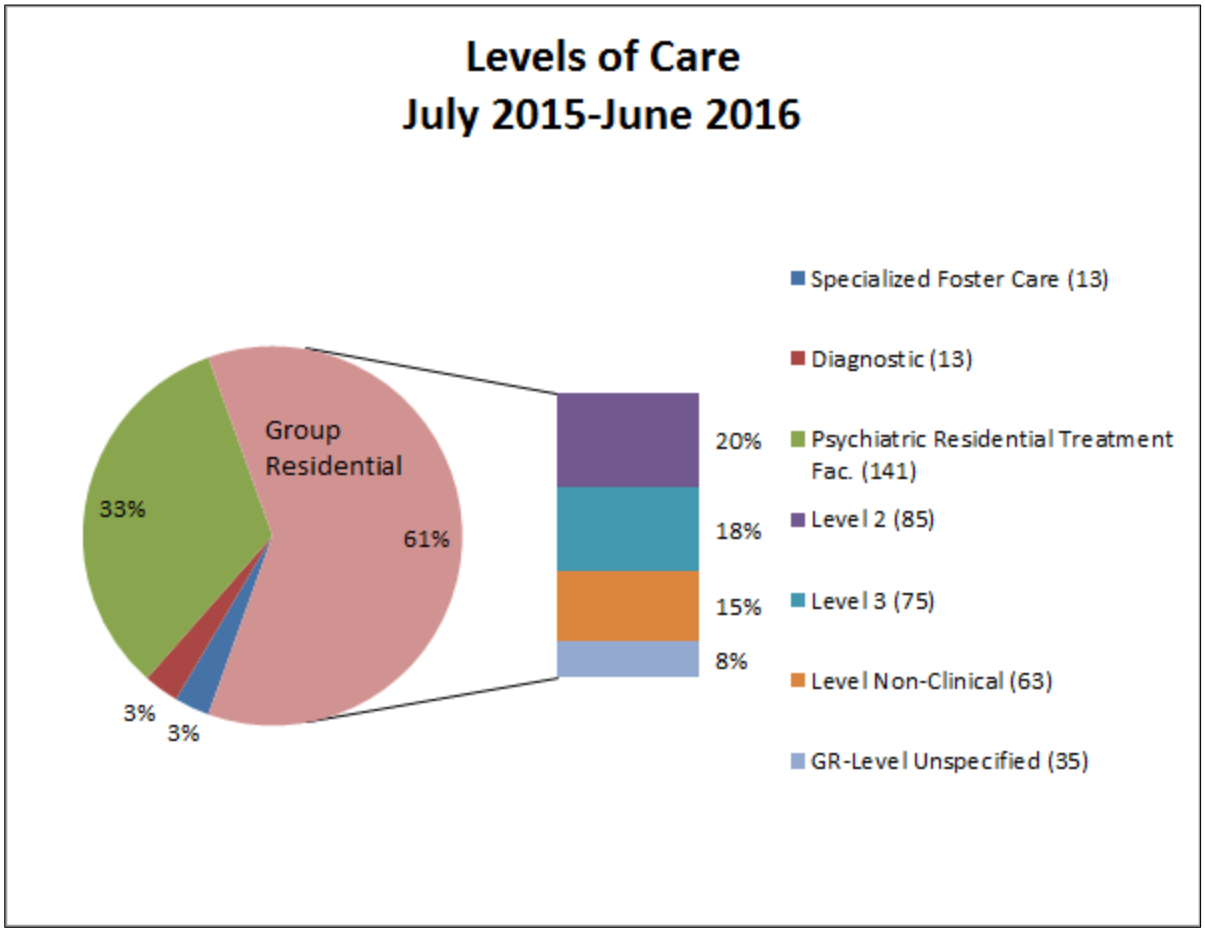
The overall average number of youth out-of-state each month has decreased. The average number of youth out-of-state each month was:

- **2015-2016=204**
- 2014-2015=270
- 2013-2014=292
- 2012-2013=288



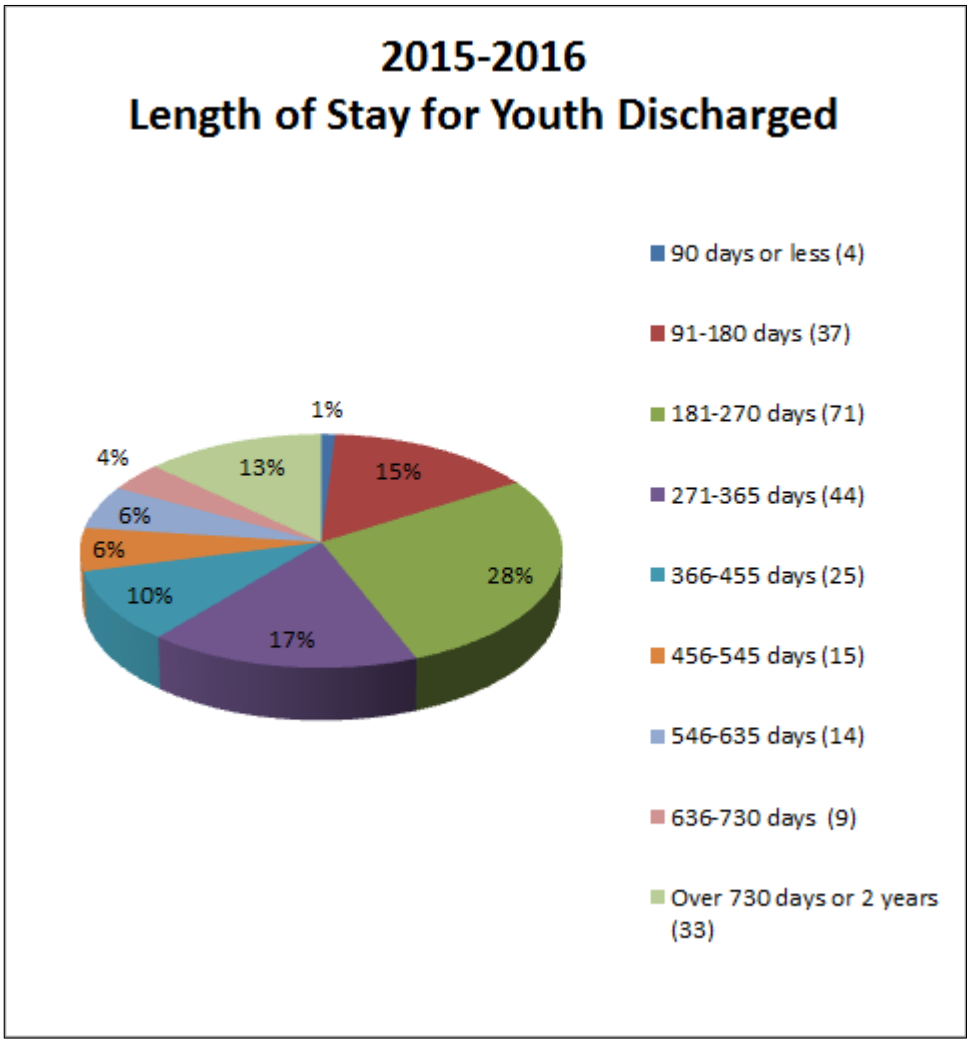
Levels of Care

The information below indicates the current level of care of the youth or the level at discharge. The majority (61%) of youth were in a group residential facility.



Length of Stay

There were 252 youth that returned to WV. The average length of stay is 437 days. This number is deceiving since this year 33 youth were able to return to WV after being out-of-state for 2 years or more. Another 23 youth returned after being out-of-state for 1 ½ years-2 years.
156 youth or 62% were out-of-state 1 year or less.



Demographic Hi-Lights of Youth

- From July 2015-June 2016 a total of 425 youth were out-of-state. This time last year 477 youth were out-of-state.
- This year 331 males (79%) were placed out-of-state and 94 females (21%).
- The youth were the following ages when placed out-of-state (not current age):
  - 10 years old or younger-41 youth (10%)
  - 11-14 years old-158 youth (37%)-This is an increase from last year in which 29% of the youth fell in this age range.
  - 15-17 years old-205 youth (48%)
  - 18 or older-21 youth (5%)
- At the time of this report (November 2016), 252 youth had been discharged. The youth were the following ages when discharged:
  - 10 years old or younger-11 youth (4%)
  - 11-14 years old-53 youth (21%)
  - 15-17 years old-131 youth (52%)
  - 18 or older-57 youth (23%)
- Youth were placed at the following facility types:
  - 61% in a group residential
  - 33% at a psychiatric residential treatment facility
  - 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. Diagnoses were available for 412 youth.
  - 101 out of 412 youth (25%) had a diagnosis of Oppositional Defiant. 116 out of 412 youth (28%) had a diagnosis of Conduct Disorder.
  - 194 out of 412 (47%) had a mood disorder, which could include Major Depression, Bipolar Disorder, Dysthymic Disorder or Depressive Disorder Not Otherwise Specified.
  - 110 out of 412 (27%) had an anxiety disorder, which includes Post Traumatic Stress Disorder, Panic Disorder, Generalized Anxiety Disorders, Obsessive Compulsive Disorder and Agoraphobia.
  - 89 out of 412 youth (22%) had a diagnosis of substance abuse or dependence. Substances included Alcohol, Cannabis, Opiods, Sedatives, and Inhalants. Most all of the youth with a diagnosis of substance abuse/dependence were co-occurring with a mental illness diagnosis.
  - 115 out of 412 youth (28%) had an Intellectual disability diagnosis. Diagnoses in this category include Mild-Severe Intellectual Disability, 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.

- 156 youth or 62% were out-of-state 1 year or less.
- 88 youth or 21% of youth had been out-of-state at least twice since 2007.
- 50 youth or 12% 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).

- In this fiscal year **July 2015-June 2016**, 167 youth were reviewed.
- Some of the gaps in services identified included:
  - No psychiatric residential treatment facilities (PRTF's) for youth age 14 or younger that address severe mental health issues. This year Highland Hospital did open a PRTF for younger youth but youth still are being placed out-of-state.
  - No psychiatric residential treatment facilities (PRTF's) 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.
  - Very limited services for youth with an intellectual disability.
  - 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.
  - Most of the Group Residential Facilities in-state are trauma-informed and offer trauma-based therapy. There are no programs in-state that addresses trauma ONLY for youth age 12 or older. There is a program (BRIDGES-PRTF) that offers the service for younger youth.
  - 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. Treatment Foster Care pilot successfully completed and more treatment foster care contracts have been awarded.
  - 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. Children's Mental Health Wraparound for youth in parental custody were implemented in October of 2016.

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.

This year (July 2015-2016), 57 youth were reviewed.
(Data not available on 6 youth due to them being parental cases or absence of information)

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. **Between July 2015 and June 2016, 53 youth were reviewed who were at risk of going out of state.**

Recommendations	Were Recommendations Followed?
31 youth were to remain in state	For the youth recommended to remain in-state, 23 out of 28 or 79% remained in the state. 3 cases were parental and follow through with recommendations is unknown.
13 youth were to be placed out-of-state	For the youth recommended to be placed out-of-state, 11 out of 13 or 85% were placed out-of-state, even though they may not have gone to one of the facilities recommended.
9 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: 9 remained in state and 3 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 Remain In State- If the youth remained in for at least 4 months, the recommendation was considered to have been followed.)

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. **Between July 2015 and June 2016, 4 youth were reviewed who were already out-of-state**

Recommendations	Were Recommendations Followed?
1 youth were recommended to remain in their out-of-state placement. Teams often do not recommend a youth return because they do not want to further disrupt the youth.	The youth did remain out of state.
1 youth was recommended to return to services in WV.	The youth did return.
2 youth were recommended to return to WV or move to another out-of-state facility.	Recommendations were followed.

***(Recommendations Followed**-The recommendations are considered to have been followed if the criteria below are met. Youth Remain Out-of-State- If the youth remained Out-of-State for at least 4 months, the recommendation was considered to have been followed. Youth Return to State- If the youth returns to the state within 3 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 in 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.
- No program in-state to meet youth's need, such as, female sex offender or youth with traumatic brain injury.
- Intensive mental health needs, such as, mood disorders with psychosis.
- Parental case with limited services in-state.

Next Steps

Next year, 2016-2017 the Regional Clinical Review and Out-of-State review processes will remain the same but the team structures will be modified to meet the current needs of the youth being reviewed. Each region will have one team. This team will participate in conference calls, Regional Clinical Review Teams and Out-of-State Review Teams. These teams will consist of community members that represent group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children's Mental Health WRAP, community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

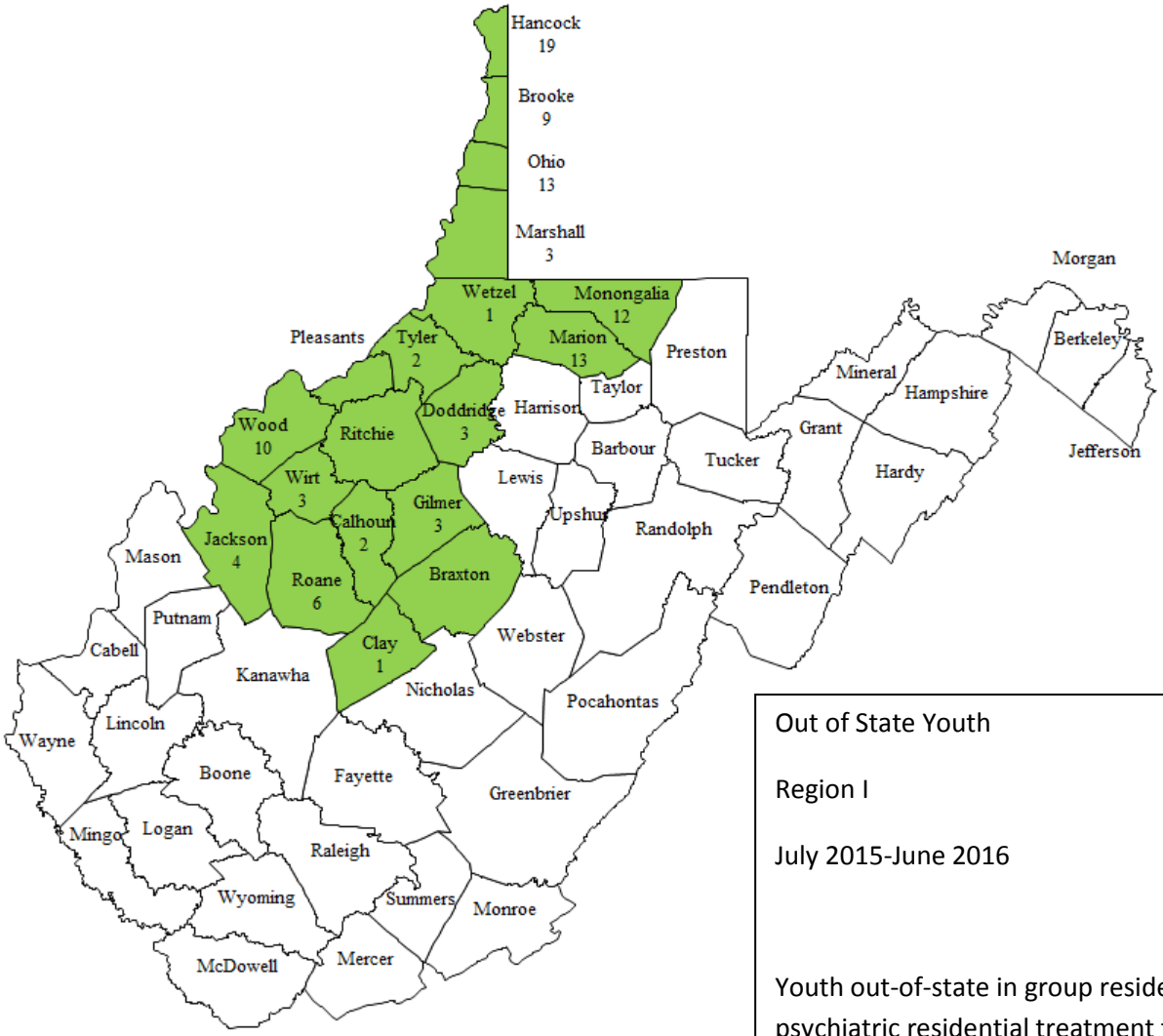
Conference calls will increase in 2016-2017. Many times youth need to be quickly reviewed by the team. The youth may have already been through a Regional Clinical Review Team, diagnostic, or other formal assessment process. If there is clear picture on what the child needs then a conference call occur. This will help prevent youth from being placed out-of-state and will assist in returning youth to the state.

Teams will also be reviewing youth that are in-state and have been in placement for a long length of time and permanency has not been secured. These youth can be reviewed through any process described above.

In 2016-2017, the State Review Team will be initiated. Some members of the above teams may participate. This team is utilized when a youth is either in a residential group facility or psychiatric residential treatment facility and has been there for over 1 year and is not progressing; or the youth has a mental health diagnosis or an intellectual disability that is preventing him or her from transitioning to a less restrictive level of care, or the youth has no family to return to and permanency has not been secured.

Regional Reports

Region I
July 2015-June 2016



Out of State Youth

Region I

July 2015-June 2016

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

These numbers are unduplicated, so if a child went out of state more than once, he or she is only counted once. These numbers represent all the kids that have been out of state this year.

Region I
July 2015-June 2016

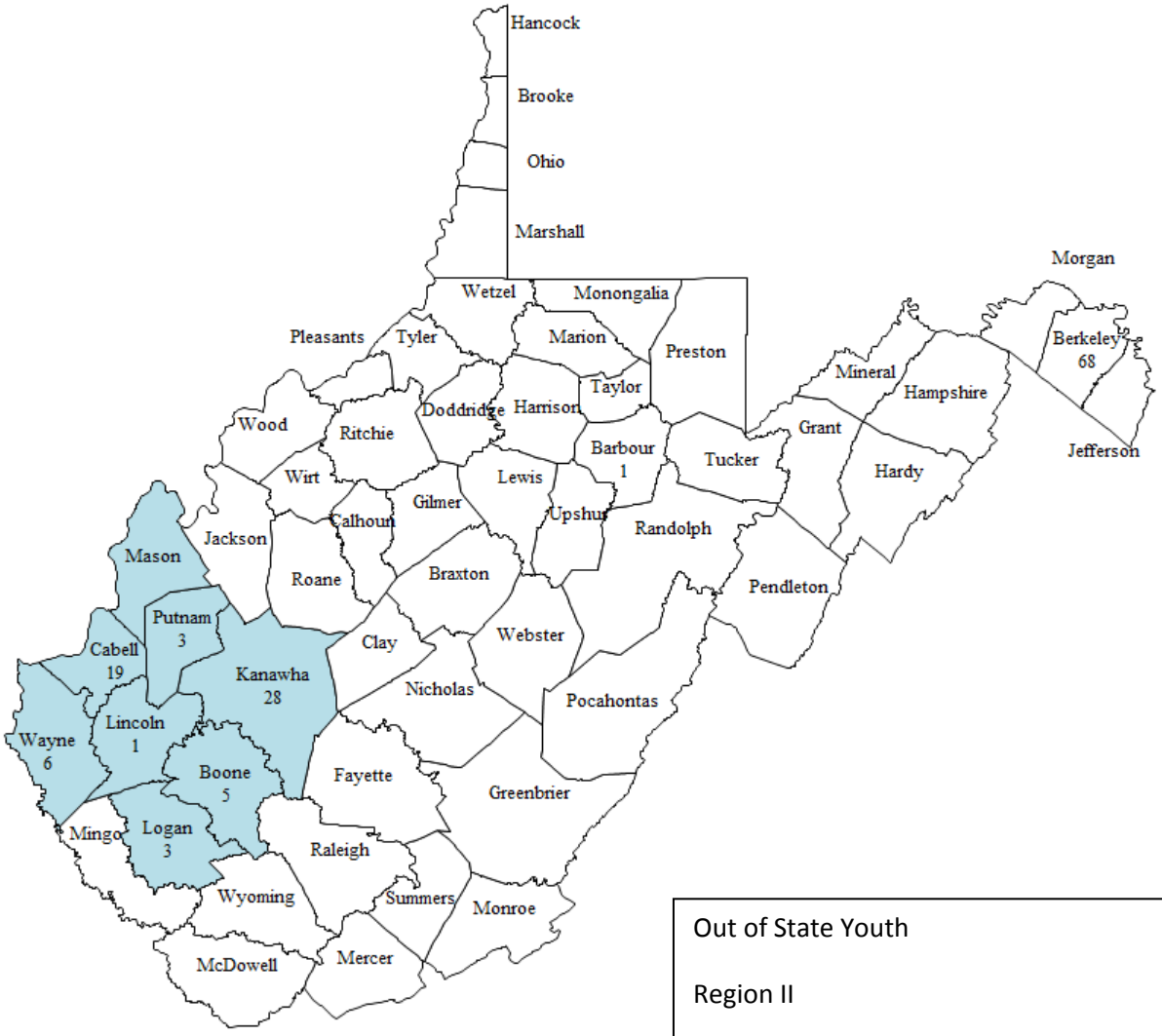
Demographics:

- 104 youth were placed out-of-state last year. This is a decrease from the 120 that were placed out-of-state the previous year.
- 84 or 81% of the youth were male and 20 or 19% were female.
- Youth were the following ages at placement:
  - 10 or younger-8 or 8%
  - 11-14 years old-36 or 35%, which is an increase from last year's percentage of 27%
  - 15-17 years old-55 or 53%, which is a decrease in last year's percentage of 62%
  - 18 or older-5 or 5%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-33 or 32%, an increase from last year's 22%.
  - Level 2 Residential Treatment-10 or 10%
  - Level 3 Residential Treatment-25 or 24%, a decrease from last year's 30%.
  - Group Residential Non-Clinical-15 or 14%
  - Group Residential Unspecified-6 or 6%
  - Diagnostic-12 or 12%
  - Specialized Foster Care-3 or 3%

Reviews:

- 24 youth were reviewed through a Regional Clinical Review Teams (July 2015-June 2016).
- All youth were at risk of going out of state.
  - 9 youth were recommended to remain in the state for services.
  - 6 youth were recommended to go out-of-state to receive services
  - 7 youth were recommended to remain in the state for services or go out if services could not be secured in-state.
  - In two cases more information was needed before a decision could be made and in one case the youth was in parental custody and outcomes are unknown.
  - 11 youth were prevented from going out of state.
  - Recommendations were followed 76% of the time.
- 47 youth were reviewed through the Out-of-State Review Team this year
- 96 or 92% had at least one type of review January 2014-June 2016.

Region II
July 2015-June 2016



Out of State Youth

Region II

July 2015-June 2016

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

These numbers are unduplicated, so if a child went out of state more than once, he or she is only counted once. These numbers represent all the kids that have been out of state this year.

Region II
July 2015-June 2016

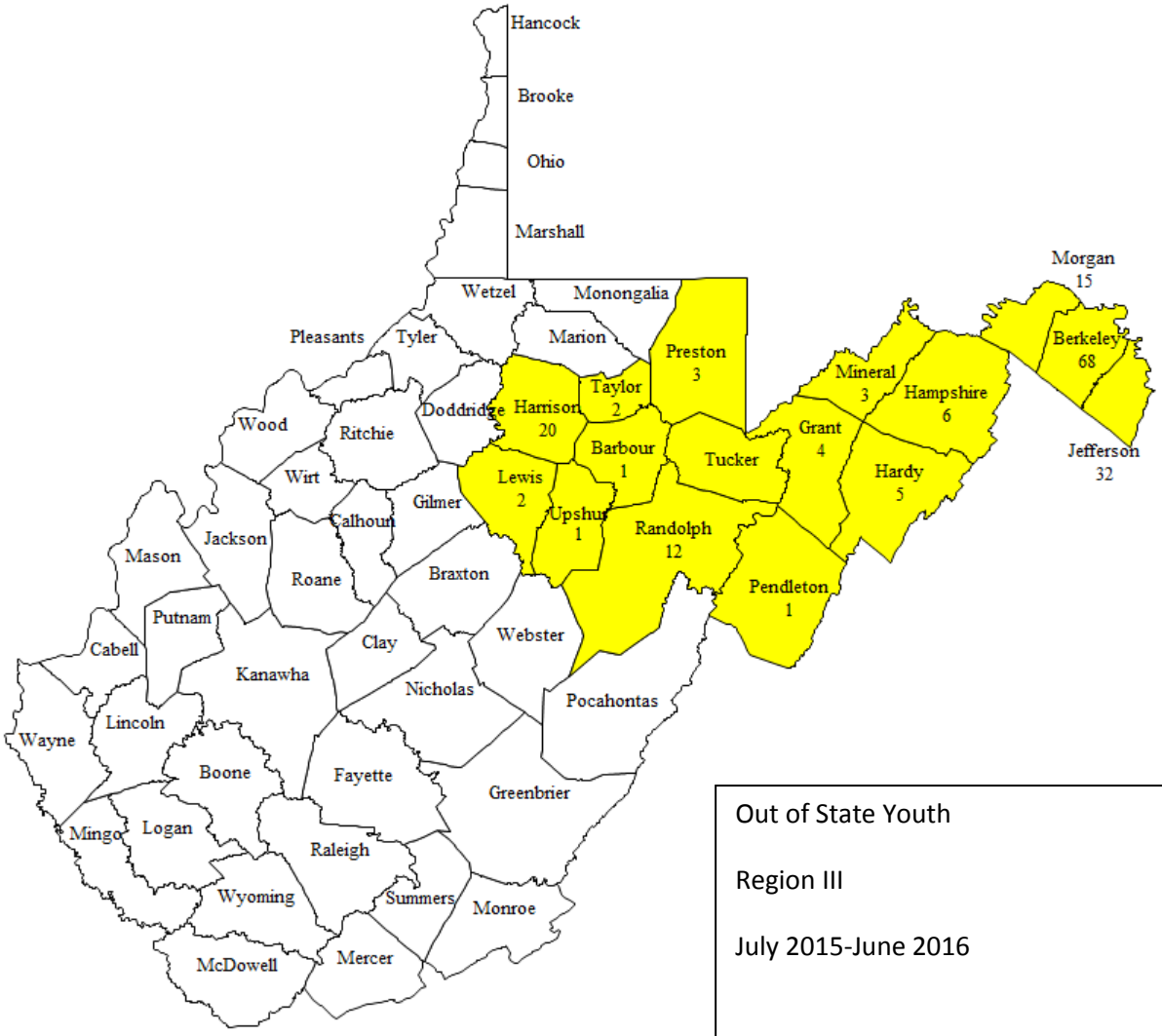
Demographics:

- 65 youth were placed out-of-state last year. This is a decrease from the 76 that were placed out-of-state the previous year.
- 46 or 71% of the youth were male and 19 or 29% were female.
- Youth were the following ages at placement:
  - 10 or younger-15 or 23%, increase from last year's 18%
  - 11-14 years old-17 or 26%
  - 15-17 years old-29 or 45%, decrease from last year's 50%
  - 18 or older-4 or 6%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-33 or 51%, increase from last year's 42%
  - Level 2 Residential Treatment-5 or 8%, decrease from last year's 20%
  - Level 3 Residential Treatment-14 or 22%
  - Group Residential Non-Clinical-7 or 10%
  - Group Residential Unspecified-2 or 3%
  - Diagnostic-None
  - Specialized Foster Care-4 or 6%

Reviews:

- 25 youth were reviewed through a Regional Clinical Review Teams (July 2015-June 2016).
- 23 youth were at risk of going out of state and 2 were already out-of-state at the time of review.
  - 15 youth were recommended to remain in the state for services.
  - 6 youth were recommended to go out-of-state to receive services.
  - 1 youth was recommended to remain in the state for services or go out if services could not be secured in-state.
  - 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 96% of the time.
- 23 youth were reviewed through the Out-of-State Review Team.
- 58 or 89% had at least one type of review January 2014-June 2016.

Region III
July 2015-June 2016



Out of State Youth

Region III

July 2015-June 2016

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

These numbers are unduplicated, so if a child went out of state more than once, he or she is only counted once. These numbers represent all the kids that have been out of state this year.

Region III
July 2014-June 2015

Demographics:

- 175 youth were placed out-of-state last year. This is a decrease from the 194 that were placed out-of-state the previous year.
- 139 or 79% of the youth were male and 36 or 21% were female.
- Youth were the following ages at placement:
  - 10 or younger-10 or 13%, increase from last year's 5%
  - 11-14 years old-76 or 43%, increase from last year's 34%
  - 15-17 years old-81 or 46%, decrease from last year's 56%
  - 18 or older-8 or 5%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-36 or 21%
  - Level 2 Residential Treatment-61 or 35%, decrease from last year's 40%
  - Level 3 Residential Treatment-24 or 14%
  - Group Residential Non-Clinical-36 or 21%, increase from last year's 14%
  - Group Residential Unspecified-15 or 9%,
  - Diagnostic-1 or 1%
  - Specialized Foster Care-1 or 1%

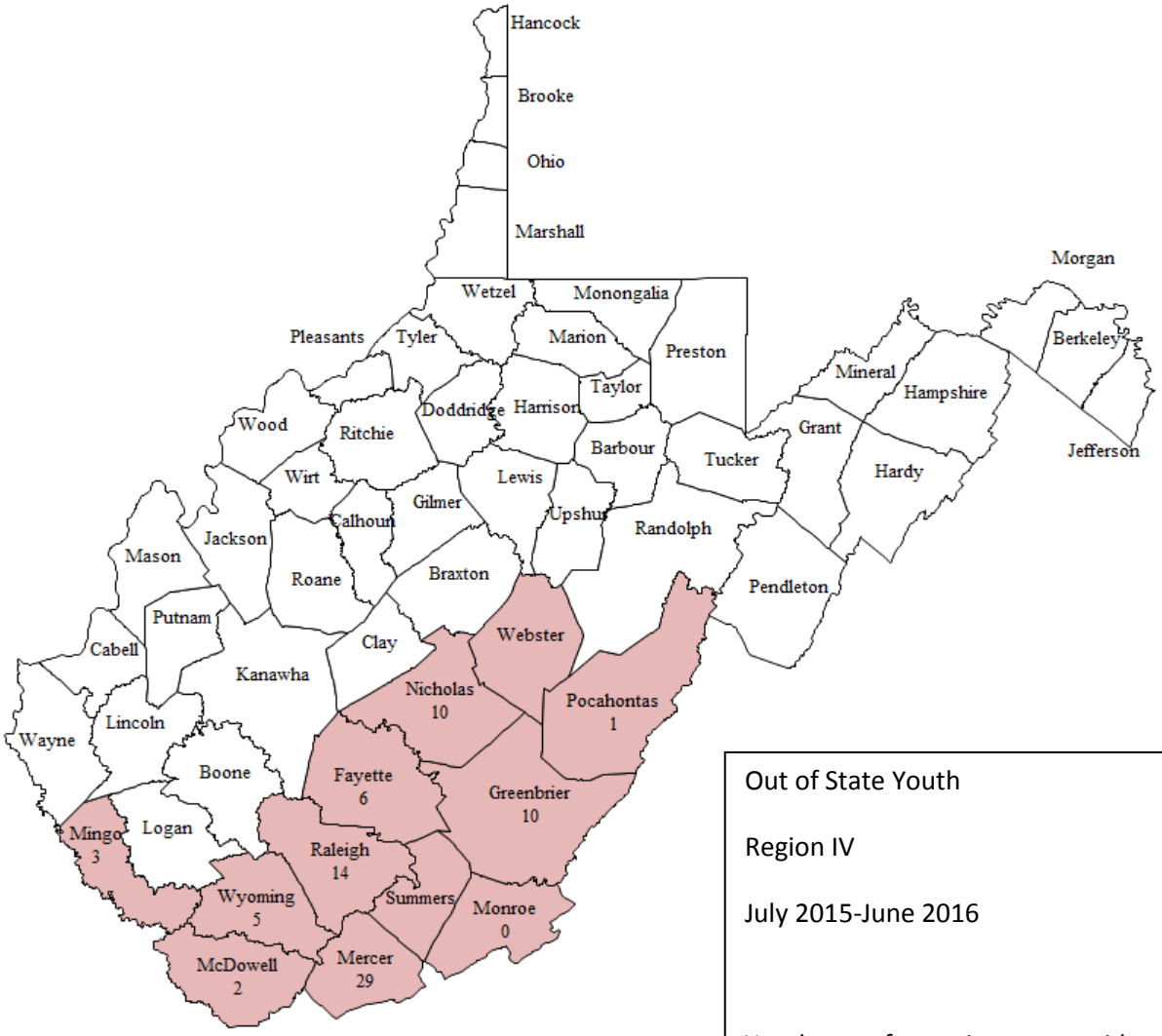
Reviews:

- 3 youth were reviewed through a Regional Clinical Review Teams (July 2015-June 2016).

1 youth were at risk of going out of state and 2 were already out-of-state at the time of review.

  - 1 youth were recommended to remain in the state for services. (parental case)
  - 1 youth was recommended to remain in their out-of-state placement.
  - 1 youth was recommended to return from out-of-state to WV for services.
  - Recommendations were followed 100% of the time. (low numbers)
- 66 youth were reviewed through the Out-of-State Review Team.
- 149 or 85% had at least one type of review January 2014-June 2016.

Region IV
July 2015-June 2016



Out of State Youth

Region IV

July 2015-June 2016

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

These numbers are unduplicated, so if a child went out of state more than once, he or she is only counted once. These numbers represent all the kids that have been out of state this year.

Region IV
July 2015-June 2016

Demographics:

- 81 youth were placed out-of-state last year. This is a decrease from the 87 that were placed out-of-state the previous year.
- 62 or 77% of the youth were male and 19 or 23% were female.
- Youth were the following ages at placement:
  - 10 or younger-8 or 10%
  - 11-14 years old-29 or 36%, increase from last year's 27%
  - 15-17 years old-40 or 49%
  - 18 or older-4 or 5%
- **The level of care youth were placed are as follows:**
  - Psychiatric Residential Treatment Facility-38 or 47%
  - Level 2 Residential Treatment-8 or 10%
  - Level 3 Residential Treatment-12 or 15%
  - Group Residential Non-Clinical-5 or 6%
  - Group Residential Unspecified-12 or 15%
  - Diagnostic-None
  - Specialized Foster Care-5 or 6%

Reviews:

- 8 youth were reviewed through a Regional Clinical Review Team (July 2015-June 2016).
- 8 youth were at risk of going out of state.
  - 1 youth was recommended to go out-of-state to receive services.
  - 6 youth were recommended to remain in the state for services.
  - 1 youth was recommended to remain in the state for services or go out if services could not be secured in-state.
- 31 youth were reviewed through the Out-of-State Review Team.
- 70 or 86% had at least one type of review January 2014-June 2016.

APPENDIX F

State Court Improvement Program 2016 Annual Self-Assessment Report

This assessment creates an opportunity for each Court Improvement Programs (CIPs) to reflect on its work, why the work is being done 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 all CIPs and a resource for the Children's Bureau to identify how best to use federal resources.

The report is comprised of seven sections with corresponding questions. Section I asks CIPs 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 asks about 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 2016. 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. For each project identified, please complete the following seven steps.

Project # 1 **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 need were you 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[1].)

   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

[1] Definitions for evidence-based, empirically-supported and best-practices are available in Appendix F[l].

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)?
    a. If the project has not yet been implemented, please briefly describe your intentions/plans for implementation, or steps of implementation (if in process, but not yet fully implemented).

New View is in its fourth year. Previously, 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. In August 2016, the Court hired an attorney to be a full time New Viewer. With one attorney, the reports and data collection should be more consistent. It is anticipated that with a full-time New Viewer a minimum of forty cases will be viewed. The viewer enters data for each case into the database created by the Court staff. 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. The New Viewer and BCF leaders meet periodically to discuss progress and give/receive feedback.

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?
    a. If the project has not yet been evaluated/assessed, please briefly describe your intentions/plans for evaluation/assessment.

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
7. Would you like a CQI consultation for this project? ☒Yes ☐ No

Project # 2 (repeat the above process, steps 1-7, for the second project identified)

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 need were you 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 a less-than-stellar 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 guardians *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 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, JANIS is being used by thirty-one prosecuting attorney offices (out of fifty-five offices) and fifty-two attorneys. It allows the user to generate petitions and order for all of the general hearings in a typical child abuse and neglect case.

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

   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)?
   a. If the project has not yet been implemented, please briefly describe your intentions/plans for implementation, or steps of implementation (if in process, but not yet fully implemented).

   Currently, web-based JANIS is available to all prosecuting attorney's offices and guardian *ad litems.* The Court staff and CIP attorneys provided training at the CIP crossing training and through web-based training. The Court staff is schedule to provide individual on-site training throughout 2017. The developer, Court staff and CIP attorneys are continuing to develop new motions and orders related to specific types of child abuse and neglect cases. In 2017, work

will continue to connect JANIS to the CAN Database and to integrate JANIS with the circuit clerks' e-filing system.

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.

Court staff monitors the number of users and the frequency of the use of the program. User feedback is instrumental in guiding further development of motions and orders, as well as "bugs" in the software. By providing individual trainings, users and developers can better understand the issues and work together in solving them. Title IV-E reports from BCF are used to determine if the orders produced by JANIS are aiding in IV-E compliance. Additionally, once operational, the CAN Database will gauge if JANIS has an impact in West Virginia's performance measures.

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

7. Would you like a CQI consultation for this project? ☒ Yes ☐ No

II. Trainings, Projects, and Activities For questions 1-9, provide a ***concise*** description of work completed or underway in FY 2016 (October 2015-September 2016) in the below topical subcategories.

For question 1, focus on significant training events or initiatives held or developed in FY 2016 and answer the corresponding questions.

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	Multiple disciplines (attorneys, social workers)	To introduce the web-based state-wide program which creates quality child abuse/neglect petitions, orders and motions.	With a follow-up survey from Survey Monkey, reviewed by the CIP training committee.

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?*
Hearing quality	☒Yes ☐No	Circuit Court Judges and New Circuit Court Judges	To inform the judges 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 judicial education 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, law updates, and resources available to help achieve permanency.	With a follow-up survey from Survey Monkey, reviewed by the CIP training committee.
Quality legal representation	☒Yes ☐No	Law Students	To train law students the specific requirements of child abuse and juvenile cases, judicial benchbook tools, timing of hearings, and the responsibilities of attorneys in abuse and neglect cases.	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	Circuit Court Judges	To encourage judges to identify non-offending parents as co-petitioners in child abuse and neglect cases.	Training evaluation reviewed by judicial education staff and judicial education committee.
Well-being	☒Yes ☐No	Magistrate	To inform magistrates on the mandatory reporting of abuse and neglect statute and the process to report through centralized intake	Training evaluation reviewed by judicial education staff and magistrate education committee
ICWA	☐Yes ☒No			

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?*
Sex Trafficking	☒Yes ☐No	Circuit Court Judges and Multiple disciplines (attorneys, social workers, and counselors)	To raise awareness of this issue with each discipline, to provide information so that a professional could identify victims and treat them as such.	Training evaluation reviewed by judicial education staff and judicial education committee.
Other:	☐Yes ☐No			

Questions 2-9 ask you to indicate (*yes/no*) if you worked on a project or activity in a specific topic 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 worked on, please provide a brief description, categorize the project by selecting one of the sub-categories available in the drop down menu (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 stage from the drop down menu (*identifying and assessing needs, developing a theory of change, selecting a solution, implementing your project, or assessing/evaluating your work*)[2].

In the space provided under Project Description, please 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. 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 once.***

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 (skip to #3)

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

[2] A description of each stage of work is available on page 69 at the end of Appendix F.

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) was 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	Implementation
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.	Agency Data Sharing Efforts	Implementation
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 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	Agency Data Sharing Efforts	Evaluation/Assessment

Project Description	How would you categorize this project?	Work Stage (if applicable)
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:_____
☐Other: _____

How are these reports used (to further the Court Improvement Project's priorities)?

These reports are reviewed and discussed quarterly by the CIP committees, namely Child Protection Across Court Systems Committee, Joint Data, Statutes, and Rules & Federal Review Committee and the Oversight Board. The committees then create their goals for the year based upon this data and other information.

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 (skip to #4)

Project Description	How would you categorize this project?	Work Stage (if applicable)
JANIS: Please see Question 2, Project #3, 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	Implementation

Project Description	How would you categorize this project?	Work Stage (if applicable)
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 (skip to #5)

Project Description	How would you categorize this project?	Work Stage (if applicable)
Please also see **data projects** in Question 2, 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. You can also see the data for 2015 and 2016 (year to date) at http://www.courtswv.gov/public-resources/CAN/statistics.html.	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 (skip to #6)

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

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 W.Va. 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 (now retired), Joyce Yedlosky and Teresa Lyons conducted training at various state-wide legal conferences.	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 six 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 90 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 shared a new Juvenile Law Guide in January 2016, at www.wvcip.com. These resources,	Other	Implementation

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

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. The desk guide was distributed to all youth services and child protective services caseworkers. It was also included in the resource materials at the CIP Cross Trainings in July 2016.	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, onetime youth in foster care and now Pressley Ridge treatment coordinator, is an active board member.	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 (skip to #8)

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 (skip to #9)

Project Description	How would you categorize this project?	Work Stage (if applicable)
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.
	Choose an item.	Choose an item.

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)
2016 Legislation: 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 was introduced during the 2016 state legislative session. The bill did not pass, but the CIP board plans to reintroduce the bill for the 2017 state legislative session.	Sex Trafficking	Selecting Solution

Project Description	How would you categorize this project?	Work Stage (if applicable)
Away from Supervision Workgroup: The CIP Youth Services Committee created the Away from Supervision Workgroup to review the data from Bureau for Children and Families. The workgroup determined that in order to better understanding the causes surrounding why children are "away from supervision" – which could mean anything from being out of the appropriate area for more than fifteen minutes to being a runaway – a review team needed to be created. The first review will be held in February 2017.	Focus on Runaway youth	Identifying/Assessing Needs
	Choose an item.	Choose an item.

III. Priority Areas & CIP Resources

1. 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:_____

2. 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.) In July 2016, the Director of the Division of Children's Services of the Supreme Court of Appeals of West Virginia and the CIP administrator announced she was resigning effective September 30, 2016. The Court hired a new director and CIP administrator. This change has created some delay in the implementation and continuation of some of our projects and initiatives.

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

1. 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?
There are no barriers at this time. The Statewide Assessment is due by February 1, 2017, and the actual case reviews and systemic factor stakeholder interviews will occur between April and September 2017. The Timeline has caused more of an emphasis to be placed on obtaining both qualitative and quantitative date to assist in the completion of the Statewide Assessment. CIP will assist in providing data from the CAN database and participating in stakeholder interviews on the system factors level of functioning statewide.

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

2. 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 and CIP members to various meetings on the APSR and asked for CAN Database data to supplement 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? Not applicable.

d. Have you received any technical assistance on this issue? If so, what was it and how was it helpful to you? Not applicable.

3. 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

1. 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.

2. Which of the following CBCC Events/Services have you/your staff engaged in in the 2016 Fiscal Year?

☒ Annual CIP Meeting ☐ CQI Consult (*Topic*:_____)

☐ CQI Workshop – Quality Legal Representation ☐ CQI Workshop – Quality Hearings
☐ Constituency Group – ICWA ☒ Constituency Group – Anti-Trafficking
☐ Constituency Group – New Directors ☒ Constituency Group – APPLA/Older Youth
☒ CIP All Call –- *What % of All Calls does your CIP participate in? 100%*

3. 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:_____

3. Describe the largest challenges your CIP faces with implementing CQI into your work. Our director of ten years resigned. The new director does not have the same expertise in CQI as the previous director.

4. 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 partnership
☐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 the Court Improvement Program administrator to assess their 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 --All decisions made independently	---Provide info to each other --Somewhat defined roles --Formal communication --All decisions made independently	--Share information and resources --Defined roles --Frequent communication --Some shared decision making	--Share ideas --Share resources --Frequent and prioritized communication --All member have a vote in decision-making	--Members belong to one system --Frequent communication is characterized by mutual trust --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?

   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 fr om the date the respondent was added or served rather than the original petition date. The CIP analysis work diligent on checking the accuracy of the data.

	Baseline Measure (FY 2014)	**FY 2015**	**FY 2016**	**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				
4G. Time to First Permanency Hearing	267.7 days	259.6 days	251.8 days	
4H. Time to Termination of Parental Rights Petition	N/A	N/A	N/A	Currently, West Virginia law does not require a separate parental rights petition. Generally, the request for termination of parental rights is included in the initial petition. So far, the CIP Data, Statute and Rules committee has not been successful in getting this procedure changed.
4I. Time to Termination of Parental Rights	282.3 days	281.5 days	296.9 days	
4A. Time to Permanent Placement	452.0 days	435.2 days	428.0 days	

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

Optional Measures				
Time to Reunification				
Time to Adoption				
Time to Guardianship				
Time to Emancipation				
Time to Subsequent Permanency Hearings	87.4 days	85.9 days	82.2 days	
1B. Percentage of Cases that Re-enter within 1 year				

2. **Other Measures**. What other measures do you collect that you find particularly useful? See chart below.

   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? Currently, no.

	Baseline Measure FY 2014	**FY 2015**	**FY 2016**	**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	65.8 days	73.9 days	76.6 days	
4D. Time to Disposition	246.9 days	253.6 days	265.3 days	

Definitions of Evidence

Evidence-based practice –practices 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- are less rigorous than evidence-based practices and 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 –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 – This 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 - This 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-HOME CARE
ADVISORY COMMITTEE

ANNUAL REPORT

2016

Background

At the close of 2015, the Department of Education's Office of Institutional Education Programs (presently renamed the Office of Diversion and Transition) completed a study of the academic achievement of children in out-of-home care and presented the results to the Commission on the Residential Placement of Children. The results of the study concluded that children in foster care, as a group, exhibited the **lowest level of academic achievement of any identified subgroup** for which academic testing is required under the *No Child Left Behind Act*. Further, the results indicated that children in foster care frequently changed schools resulting in disruption of their educational program. This lack of **school stability** has been identified as a major factor contributing to poor educational outcomes for students in out-of-home care.

The study conducted by the Department of Education took months to complete because children in foster care have not been included as a federally mandated subgroup in the state's education information system. The fact that the educational performance of these children have been excluded from federal and state reporting and oversight led the Annie E. Casey Foundation to state in a recent report, *"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."*

During the past decade many studies have been conducted by states and organizations demonstrating the poor educational outcomes for children in foster care and the barriers they face to an appropriate educational program. As a result, these children have now been included in the recently enacted federal education law entitled the **Every Student Succeeds Act**.

Implementation of the Every Student Succeeds Act

On December 10, 2015, President Obama signed the **Every Student Succeeds Act (ESSA)**, amending the Elementary and Secondary Education Act. This legislation includes important protections for children in foster care that require state and local education agencies to collaborate with child welfare agencies to ensure the educational stability of children in foster

care. Specifically, the new federal law provides the following protections for students in foster care: (1) the right to remain in the same when in the child's best interest; (2) immediate enrollment in school and transfer of school records; (3) provision of school transportation to allow children in foster care to remain in the same school; (4) designation of points of contact at the state and local levels by education and child welfare agencies to ensure collaboration and oversight of the implementation of the foster care provisions of ESSA; and (5) required data collection and reporting by the state education agency on student achievement and graduation rates for students in foster care.

During 2016, the Advisory Committee and its members fostered collaboration, participated in, and provided advice and counsel on the state's activities pertaining to the implementation of the requirements of the Every Student Succeeds Act for children in foster care. These activities included:

1. Building a Quality Data System for Reporting on the Educational Status and Outcomes of Children in Out-of-Home Care – the Advisory Committee fostered collaboration and participated in the integration of DHHR's FACTS data system with WVDE's WVEIS system to provide the annual reports needed for children in foster care under the new federal law.

2. Fostering Collaboration Among State and Local Education and Child Welfare Agencies Regarding the Education of Children in Foster Care – the Advisory Committee provided council to the Department of Education's Office of Federal Programs and its DHHR members participating in the establishment of points of contact for collaboration at the state and local levels.

3. Immediate Enrollment and Transfer of Records – Advisory Committee members provided advice and counsel on the amendment of policies and procedures to ensure immediate enrollment of children in foster care.

The Advisory Committee will continue in 2017 to participate in and provide recommendations on the implementation of the ESSA provisions for children in foster care.

Identification of Issues Relating to the Education of Children in Out-of-Home Care

Through participation of its service provider members, the Advisory Committee identified the following issues pertaining to the education of children in out-of-home care:

(a) Educational representation at MDT meetings
(b) Timely school enrollment because of absence of school records including the need to define "immediate" pertaining to the federal mandate in ESSA to "immediately enroll students"

(c) Timely enrollment for children who go from schools on regular school schedules to schools on block schedules
(d) Obtaining a student's IEP for residential case files
(e) Transfer of school credits
(f) Access to Drivers Education which is often necessary for employment

Identification of Best Educational Practices for Children in Out-of-Home Care

Dr. Robin Lewis, a member of the Advisory Committee and Executive Director, RESA I and staff presented information to the Committee on the implementation of **Check and Connect** in RESA I. Check and Connect, developed at the University of Minnesota and nationally validated, is a comprehensive intervention program designed to enhance student engagement at school and with learning for marginalized, disengaged students in grades K-12, through relationship building, problem solving and capacity building, and persistence. A goal of Check and Connect is to foster school completion with and academic and social competence. It is comprised of four components –

1. A mentor who works with students and families for a minimum of two years;
2. Regular checks, utilizing data schools already collect on students' school adjustment, behavior and educational progress;
3. Timely interventions, driven by data, to reestablish and maintain the students' connection to school and learning and to enhance the student's social and academic competencies; and
4. Engagement with families.

The results of the pilot project for at-risk students in RESA I, including children in foster care, was very impressive. Amanda Davis of **Mission West Virginia** is implementing Check and Connect in Clay County Schools with children in foster care under a project called **The Bridge**.

The Advisory Committee is studying the results of these projects for the purpose of identifying it as a best practice for children in out-of-home care.

Ongoing Efforts

The Advisory Committee continues to support, hear reports and provide recommendations on the joint efforts by WVDE and DHHR to monitor the education programs of children placed out-of-state and the transition programs and services provided by Department of Education field staff for students returning from in-state and out-of-state placements.

Goals for 2017

The Advisory Committee will work on the following goals in 2017:

1. Continue to foster collaboration among agencies and groups and make recommendations in the development of plans and implementation of the foster care provisions of the Every Student Succeeds Act.

2. Identify barriers and successful practices and make recommendations to improve the attendance of educational personnel at MDT meetings.

3. Facilitate problem solving in removing barriers to educational access and transition for children in out-of-home care.

4. Identify best educational practices to close the achievement gap for students in foster care.

APPENDIX H

West Virginia **Juvenile Drug Court** 2016

Supreme Court of Appeals of West Virginia

Division of Probation Services

Michael B. Lacy
Director

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- 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 20, 2016, there were sixteen (16) operational JDCs comprising fifteen (15) JDC programs in Boone, Brooke, Hancock, Harrison, Kanawha, Lincoln, Logan, McDowell, Mercer, Monongalia, Ohio, Pleasants, Putnam, Raleigh, Randolph, Wayne, Wirt, and Wood Counties
- **614** participants have successfully graduated from West Virginia's JDCs as of December 20, 2016 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 20, 2016, there were 142 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.

West Virginia

ADULT DRUG COURTS

2016

Supreme Court of Appeals of West Virginia

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- 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 cost per drug court participant was $7,100.00** as compared to $18,250 in jail or $24,000 in prison. These costs include intensive supervision, treatment, case management, and drug testing.
- As of December 20, 2016, **1002** participants have successfully graduated from West Virginia's ADCs, which have historically held 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.
- On December 20, 2016, there were twenty eight (28) operating ADC programs comprising thirty four (34) individual courts covering forty-six (46) counties: Berkeley, Boone, Brooke, Cabell, Calhoun, Doddridge, Fayette, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Tyler, Upshur, Wayne, Wetzel, Wirt, Wood, and Wyoming counties.
- 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 were **474** active clients in the ADCs as of December 20, 2016.