2017 Annual Progress Report

Advancing New Outcomes

Findings, Recommendations, and Actions

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR CHILDREN & FAMILIES

West Virginia Commission to Study
Residential Placement of Children
Bureau for Children and Families
February 2018

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bill J. Crouch
Cabinet Secretary

A MESSAGE FROM THE CABINET SECRETARY

As Cabinet Secretary of the West Virginia Department of Health and Human Resources (DHHR), 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 of 2017.

Over the last several years, the Commission has gradually reduced the number of children placed out-of-state. This could not have been achieved without the partnership of many individuals. Although there is still work to be done to further reduce the number of children in out-of-home placement, with continued collaboration, we will overcome the challenges facing our state.

Sincerely,

Bill J. Crouch
Cabinet Secretary

2017 COMMISSION MEMBERS

Commission to Study Residential Placement of Children

Bill J. Crouch, Chair
Cabinet Secretary

The Honorable Jack Alsop
Circuit Court Judge
Webster County

Cynthia E. Beane
Commissioner
Bureau for Medical Services
WV Department of Health and Human Resources

Stephanie Bond
Director
Probation Services
WV Supreme Court of Appeals

Cammie Chapman
Director
Division of Children's Services
WV Supreme Court of Appeals

Susan Fry
Director
Stepping Stones
(Group Residential)

Jessica Ritchie-Gibson
Youth Representative

Jacob Green
Superintendent of Institutional Education
WV Department of Education

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

Cindy Largent-Hill
Juvenile Justice Commission
WV Supreme Court of Appeals

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

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

Rhonda Hayes
Parent/Family Representative

The Honorable Gary Johnson
Administrative Director
WV Supreme Court of Appeals

Dr. Steven L. Paine
State Superintendent of Schools
WV Department of Education

William Marshall
Director
Division of Juvenile Services
WV Department of Military Affairs & Public Safety

Philip W. Morrison II
Executive Director
WV Prosecuting Attorneys

The Honorable Phillip M. Stowers
Circuit Court Judge
Putnam County

Nancy Sullivan
Acting Commissioner
Bureau for Behavioral Health and Health Facilities
WV Department of Health and Human Resources

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

Linda Watts
Acting Commissioner
Bureau for Children and Families
WV Department of Health and Human Resources

<u>Administrative Staff to Commission</u>
Linda (Dalyai) Gibson
Bureau for Children and Families
WV Department of Health and Human Resources

PREFACE

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

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.

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 analyzed 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.

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, Acting 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 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 many child-serving agencies and organizations, both public and private. There are many 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 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 the 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 report on children in West Virginia custody (through DHHR).

- 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 DHHR's Families and Children Tracking System (FACTS).
- To use placement population definitions established by the Commission for performance outcomes metrics.

The goal is to have 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 2017 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 West Virginia's children at risk of out-of-home care.

Pivotal Accomplishments from 2006 to 2017

From the time the West Virginia Commission to Study Residential Placement of Children published its original 13 recommendations in *Advancing New Outcomes 2006*, many 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.

Numerous 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. Below are the Priority Goals along with the Key Accomplishments of 2017.

KEY ACCOMPLISHMENTS OF 2017

Keeping the Commission's priority goals as the focus, these accomplishments represent the work for January 2017 through December 2017. The accomplishments may apply to more than one priority goal area.

1. Appropriate Diagnosis and Placement

GOAL: 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.

Three-Tiered Foster Care

DHHR's Bureau for Children and Families fully implemented a three-tiered family foster care program in West Virginia statewide. 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 continuum includes: Traditional Foster Care, Treatment Foster Care, Intensive Treatment Foster Care.

Safe at Home West Virginia

DHHR's Bureau for Children and Families received a federal IV-E waiver in fall 2014. The IV-E waiver, which echoes the Commission to Study the Residential Placement of Children's Priority Goals for Implementation, will allow West Virginia to improve its child welfare system and serve children in their home communities through the Safe at Home West Virginia demonstration project.

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.

Phase 3 of Safe at Home West Virginia rolled 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.

As of September 30, 2017, 1, 172 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 58 youth from out-of-state residential placement back to West Virginia, 171 youth have stepped down from in-state residential placement to their communities, and 15 youth have returned home from an emergency shelter placement. West Virginia has prevented the residential placement of 713 at risk youth.

As of September 30, 2017, 728 DHHR staff have been trained in using the Child and Adolescent Needs and Strengths (CANS) comprehensive assessment tool. During this reporting period, 114 people have been certified or re-certified in the administering of the CANS.

All stakeholders were asked to share both the formal and informal services that youth/families have received during their participation in Safe at Home West Virginia. The 10 most common services included: individual therapy, tutoring, school advocacy, family therapy, life skills, youth coaching, medication management, community outings, mentoring, and parenting classes.

Children's Mental Health Wraparound

DHHR's, Bureau for Behavioral Health and Health Facilities fully implemented its Children's Mental Health Wraparound that serves four pilot areas including Berkeley, Cabell, Kanawha, Harrison, Marion, and Raleigh counties. The Children's Mental Health Wraparound is evidence-based and modeled after the National Wraparound Initiative and Safe at Home West Virginia program. It will serve youth with severe emotional disturbance/complex support needs in parental custody who are in or at risk of placement in an intensive psychiatric treatment setting. Of the 112 referrals to the Children's Mental Health Wraparound, 51 referrals were accepted.

Regional Clinical Reviews

The West Virginia System of Care has worked through three processes to identify gaps in services and barriers to serving youth in the state and returning youth to the state. These processes are the Regional Clinical Review Team, the Out-of-State Review, and Conference Calls. These processes have 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.

Comparatively, for FY 2012-2013, 533 youth were placed out-of-state; FY 2013-2014, 492 youth were placed out-of-state; FY 2014-2015, 477 youth were placed out-of-state; FY 2015-2016, 425 youth were placed out-of-state; and this FY 2016-2017, 415 youth were placed out-of-state. Overall, there is a 22% decrease from 2012-2013 to 2016-2017.

Through these teams, some of the gaps in services identified include limited services for youth with an intellectual disability including Autism; youth age 10 or younger requiring intense treatment; and a lack of treatment foster care homes. (More information about the West Virginia System of Care End of Year Report can be found in Appendix E).

Youth in Foster Care Report, Point-In-Time

The Youth in Foster Care Report provides a review of the placement and ages of youth who are in the custody of West Virginia over the last four years at a specific point-in-time for each year (October 2014, 2015, 2016, and 2017).

- Since 2014, the number of youth in the custody of the state has steadily increased. When comparing October 2014 with October 2017, there was a 46% increase.
- An increase in the number of youth ages 11 and younger has been seen from 2014 to 2017. This most likely is due to substance abuse issues in the biological family.
- In October 2014, only 18% of the youth in the state's custody were in a certified kinship/relative, kinship/relative or department adoptive home. In October 2017, 50% of the youth were in this type of placement.
- In October 2017, 81% of the youth were in a home type setting. Only 20% of the youth were in congregate care.
- Fewer than 800 youth were being served in foster care placements in October 2017 than were in October 2016. This may be due to an increase in the number being served by kinship and relatives.
- The total number of youth in custody of the state has increased, as has the number of youth being placed in out-of-state group residential and psychiatric treatment facilities. The number of youth out-of-state compared to the entire population of youth in state custody shows that the percentage has not changed. (More information on the Number of Youth in Foster Care Point in Time Report can be found in Appendix E)

2. Expanded Community Capacity

GOAL: 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 that place greater emphasis on upfront prevention approaches.

Family Resource Networks

The 47 Family Resource Networks (FRNs) are organizations that understand and are responsive to the needs and opportunities in West Virginia communities. Partnering with citizens and local organizations, the FRNs develop, coordinate, and administer innovative projects and provide needed resources. The FRNs are in West Virginia's 55 counties and have a resource directory for each county in West Virginia.

Through the work of the FRNs and partner organizations, $10.5 million is received in additional funding and $3.8 million in donations, with more than 85,000 in volunteer hours statewide.

The West Virginia Alliance of Family Resource Networks (WVAFRN) is developing a website as part of a Benedum Foundation grant. The website will include a link to each of the FRNs that will include their resource directories, programs, and current events. The WVAFRN website is: http://wvfrn.org/ and a quick directory can be found at: http://wvfrn.org/quick-directory/.

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.

Adult Drug Courts

As of June 30, 2017, there were 28 operating Adult Drug Courts (ADC) programs comprising 34 individual courts covering 46 counties: Berkeley, Boone, Brook, Cabell, Calhoun, Doddridge, Fayette, Greenbrier, Hampton, 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.

For FY 2017, the average annual cost per drug court participant was $6,072 as compared to $20,155 in the Regional Jail or $26,081 in the Division of Corrections prison. These costs include intensive supervision, treatment, case management, and drug testing.

There were 657 active participants in the ADCs as of June 30, 2017. (More information about the West Virginia Adult Drug Courts can be found in Appendix H.)

Juvenile Drug Courts

As of June 30, 2017, there were 14 operational Juvenile Drug Courts (JDC) programs serving the following counties: Boone, Brook, Hancock, Harrison, Kanawha, Lincoln, Logan, McDowell, Mercer, Monongalia, Ohio, Pleasants, Putnam, Raleigh, Randolph, Richie, Wayne, Wirt, and Wood counties.

For FY 2017, the average cost per youth was $5,054. This cost includes intensive supervision, drug testing, some treatment services and specialized activities. This contrasts with approximately $110,000 for the same period in a Division of Juvenile Services (DJS) facility or a residential group facility.

On June 30, 2017, there were 154 active JDC participants in West Virginia. (More information about the Juvenile Drug Court can be found in Appendix H.)

Three Branch Institute on Improving Child Safety and Preventing Child Fatalities, "Developing a Culture of Safety in the Mountain State"

To promote access to evidence-based prevention and early intervention services for children and families, referral policies and funding mechanisms were reviewed for early home visitation programs, and a flow chart and diagram were developed to assist in determining eligibility.

To identify children and families at earliest signs of risks with priority on children under 1 years of age, resource teams are being formed to assist Child Protective Service Workers, and current data around the effectiveness of parenting classes and other available services is being researched.

To prevent child maltreatment deaths, a multidisciplinary in-depth review and analysis from all organizations tracked child fatalities, including those not known to Child Protective Services.

3. Best Practices Deployment

GOAL: 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.

Throughout this report were examples of the deployment of best practices being shared with stakeholders. These processes include: West Virginia System of Care, Regional Clinical Reviews; DHHR's Safe at Home West Virginia; DHHR's Children's Mental Health Wraparound; Education of Children in Out-Of-Home Care Advisory Committee; West Virginia Interagency Consolidated Monitoring; and Adult and Juvenile Drug Courts.

4. Workforce Development

GOAL: 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.

Court Improvement Training Conferences

The Court Improvement Program's Free Cross-Training Child Abuse/Neglect and Juvenile Law, "Moving Forward Together," were held on July 10-11, 2017 at Lakeview Resort in Morgantown and July 17-18, 2017 at the Charleston Civic Center in Charleston.

5. Education Standards

GOAL: 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.

Educational Transition Programs

The West Virginia Department of Education (WVDE), Office of Diversion and Transition Programs (ODTP) has increased the number of Transition Specialists to 18. Transition Specialists serve students who face unique educational challenges because they are placed in facilities out of their home for adjudicated and status related offenses, mental health services, or specialized medical needs. They work closely with these students to ensure, once they leave a placement, they can enroll in public school or higher education, complete their high school graduation track and develop the necessary skills for employment. Additionally, Transitional Specialists work with Local Education Agencies (LEA) to assist with students at risk of placement in a facility outside their home. (More information in the Education of Children in Out-of-Home Care Advisory Committee Annual Report can be found in Appendix G.)

6. Provider Requirements

GOAL: 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.

West Virginia Interagency Consolidated Out-of-State Monitoring

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.

7. Multidisciplinary Treatment Team Support

GOAL: The Multidisciplinary Treatment Team concept will be supported as intended and assist enhancing the processes statewide.

Education of Children in Out-Of-Home Care Advisory Committee, Multidisciplinary Treatment (MDT) Task Team

The Education of Children in Out-of-Home Care Advisory Committee formed a Multidisciplinary Treatment (MDT) Task Team. The task team developed materials to increase the awareness of the importance of WVDE's participation in MDT meetings including a joint letter to key school officials from the State Superintendent of Schools, Cabinet Secretary of DHHR and the Supreme Court of Appeals of West Virginia. The task team also developed tools to facilitate educator participation in MDT meetings including a checklist, guidance document, brochure and model report format. (More information in the Education of Children in Out-of-Home Care Advisory Committee Annual Report can be found in Appendix G.)

8. Ongoing Communication

GOAL: 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 1, 2017, October 12, 2017 and December 7, 2017. The meetings were held in Charleston, West Virginia at the Saint John XXIII Pastoral Center.

Commission members serve on many other committees and workgroups such as the Court Improvement Program; Education of Children in Out-of-Home Care Advisory Committee; and Service Delivery and Development Workgroup.

9. Effective Partnerships

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

West Virginia Interagency Consolidated Out-of-State Monitoring

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.

In 2017, the following on-site facility reviews were completed:

- Grafton (VA)
- Bellaire (OH)
- Abraxas (PA)
- Bradley Center (PA)
- Alabama Clinical Schools (AL)

New View Project

The purpose of the New View project is to provide meaningful recommendations to multi-disciplinary treatment teams and circuit courts to help in achieving permanency and well-being for the child. Additionally, the project hopes to collaborate with DHHR in finding solutions to systemic issues discovered by the project. The project views children's cases from a predictive model of children who are likely to linger in out-of-home care. The project intervenes in cases where children are lingering in care and have not reached permanency.

To date, the New View Project has resulted in the return of 40 children from out-of-state facilities and has prevented another 286 from placement in congregate or foster care. (More information on the Court Improvement Program, New View Project can be found in Appendix F.)

Every Student Succeeds Act (ESSA)

To promote the Foster Care Provisions of Every Student Succeeds Act (ESSA), the Advisory Committee continues to support and advise the WVDE and DHHR in the development of a joint data system to report on the educational status and achievement of children in the foster care system and policies, procedures and agreements to ensure school stability.

During 2017, the WVDE and DHHR issued a joint guidance document for county school districts and local and regional DHHR staff entitled: Educational Stability for Homeless Children and Children in Foster Care. The document provides answer to questions regarding the implementation of the federal law and provides guidance on working cooperatively to achieve school stability for children in out-of-home care. (More information in the Education of Children in Out-of-Home Care Advisory Committee Annual Report can be found in Appendix G.)

10. Performance Accountability

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

Court Improvement Program, Away from Supervision/Runaway Youth Workgroup

The Court Improvement Program (CIP), Away from Supervision workgroup monitors data on children who are away from supervision or who have run away from out-of-home care, and makes collaborative proposals for systemic improvement.

The workgroup identifies the causes and issues of when children are habitually away from supervision or who have run away from out-of-home care; implements solutions for the identified causes and issues; and evaluates and disseminates findings. In addition, the CIP, Away from Supervision workgroup recently began tracking youth trafficking/exploitation of children in out-of-home care when away from supervision.

NEXT STEPS FOR 2018

On December 7, 2017, the Commission to Study Residential Placement of Children's members met to review and revise the current Priority Goals. With the purpose of preventing out-of-home care, the Commission's Priority Goals for 2018 would allow stakeholders to focus their energy and work toward common goals and intended outcomes/results that are responsive to a changing environment. The Commission identified the following seven Priority Goals for 2018:

1. Transformational Collaborative Outcomes Management (TCOM)
2. Promote Information Exchange Between Providers
3. Provider Input at MDT and Court Hearings
4. Data Development and Delivery
5. Implementation of Every Student Succeeds Act (ESSA) (focus on children in foster care)
6. Support Kinship Providers/Relatives
7. Transitioning Youth Aging out of Foster Care

CONCLUSION

As we move forward, the Commission will continue to build upon and refine the past year's accomplishments and to address the Commission's 2018 Priority Goals with a sharpened 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.

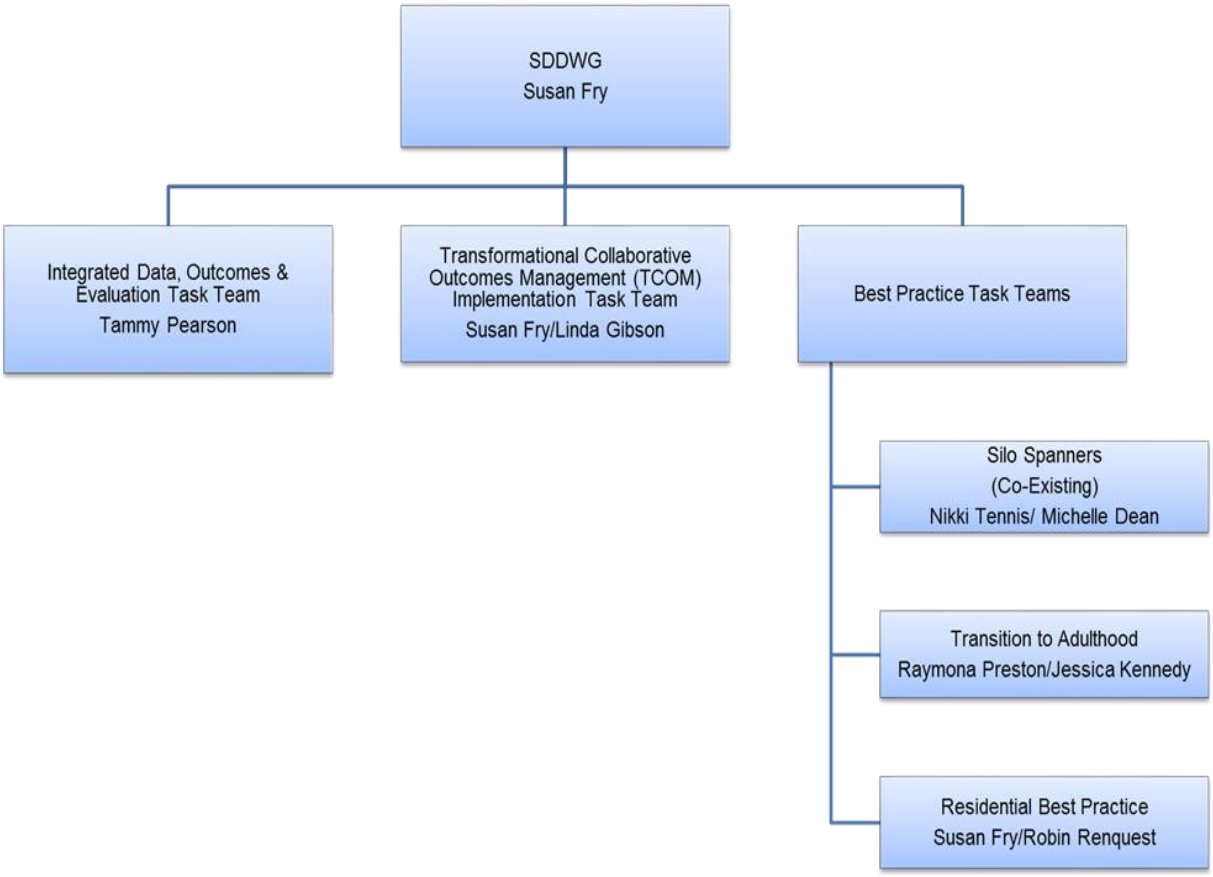
6. Quality Assurance: Meaningful outcomes are measured and play an important role in improving the quality of care to children and their families at a system level, service level and family/child level.

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


SDDWG
Susan Fry
Integrated Data, Outcomes & Evaluation Task Team
Tammy Pearson
Transformational Collaborative Outcomes Management (TCOM) Implementation Task Team
Susan Fry/Linda Gibson
Best Practice Task Teams
Silo Spanners
(Co-Existing)
Nikki Tennis/ Michelle Dean
Transition to Adulthood
Raymona Preston/Jessica Kennedy
Residential Best Practice
Susan Fry/Robin Renquest

Service Delivery & Development Work Group Members

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

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. Residential Treatment Best Practice Task Team – Susan Fry & Robin Renquest
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. TCOM Implementation Task Team – Susan Fry & Linda Dalyai

** 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.*

APPENDIX C

Our children and families will be:
Safe
Successful
Healthy
Supported

2017 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 counties added.
- Implementation of Phase 3 began on April 1, 2017, in the final 20 counties to bring the program to a statewide implementation.

- Safe at Home West Virginia requires 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.
- The third semi-annual progress report was submitted on April 30, 2017.
- The fourth semi-annual progress report was submitted on October 30, 2017.
- All semi-annual progress reports are posted to the website for public viewing.
- Sustainability planning has begun for the transition out of the waiver in the fall of 2019.

Service/Model Development

- Local Coordinating Agencies serve as the lead for the wraparound facilitation (care coordination) of Safe at Home West Virginia wraparound services. DHHR partners with these agencies through a grant process and then provider agreements.
- Criteria for the target population:
    - Youth ages 12 to 17 (up to the youth's 17th birthday) with a possible 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 possible 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 possible 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 possible 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 DHHR 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.
- Matrixes that outline the responsibilities of both child welfare staff and facilitators have been developed.
- 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, updated and posted online at: https://dhhr.wv.gov/bcf/Services/Documents/SafeHome%20WV%20Program%20Manual%207-22-17.pdf .

- 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 CANS 2.0.
- The independent evaluators have conducted interviews for the process evaluation for the last 3 semi-annual progress reports.
- The independent evaluators have conducted 2 sets of fidelity reviews as part of the process evaluation.
- The independent evaluators also continue to evaluate West Virginia's outcomes as well as a cost evaluation.
- All evaluation findings are included within the semi-annual progress reports that are posted to the website for public viewing.

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.
- A cross disciplinary group with extensive wraparound experience has developed an Applied Wraparound training. This training is an advanced training to further develop skills of wraparound facilitators. The training has been tested and a Train the Trainers scheduled for February 2018.

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.
- In-depth data and analysis are provided by Hornby Zeller Associates and is included in each Semi-annual progress report.

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

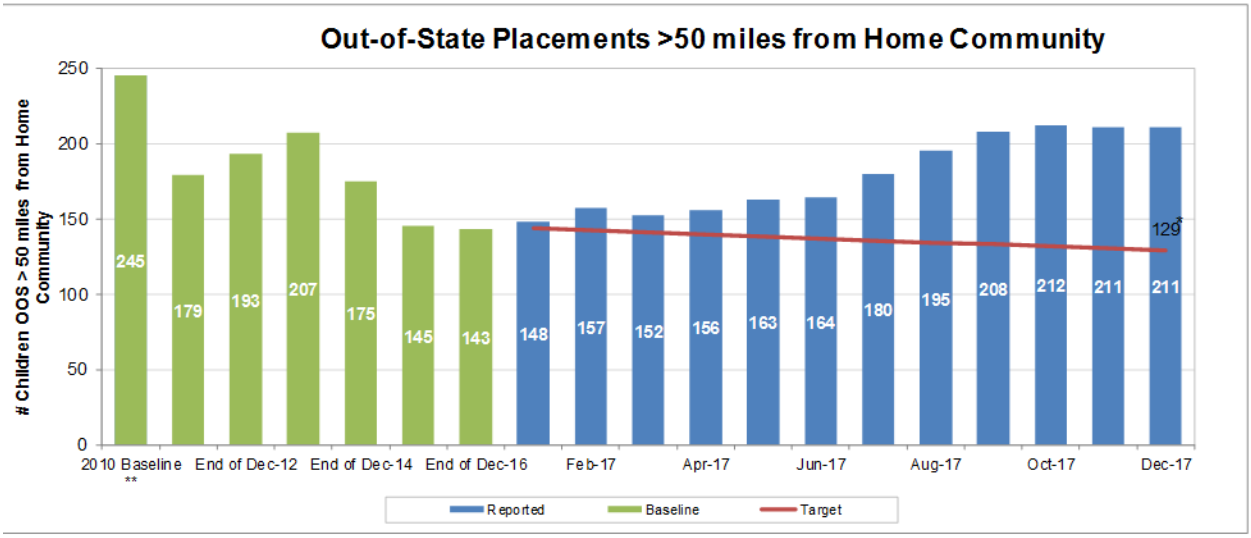
APPENDIX D

West Virginia Commission to Study Residential Placement of Children

Performance Scorecard

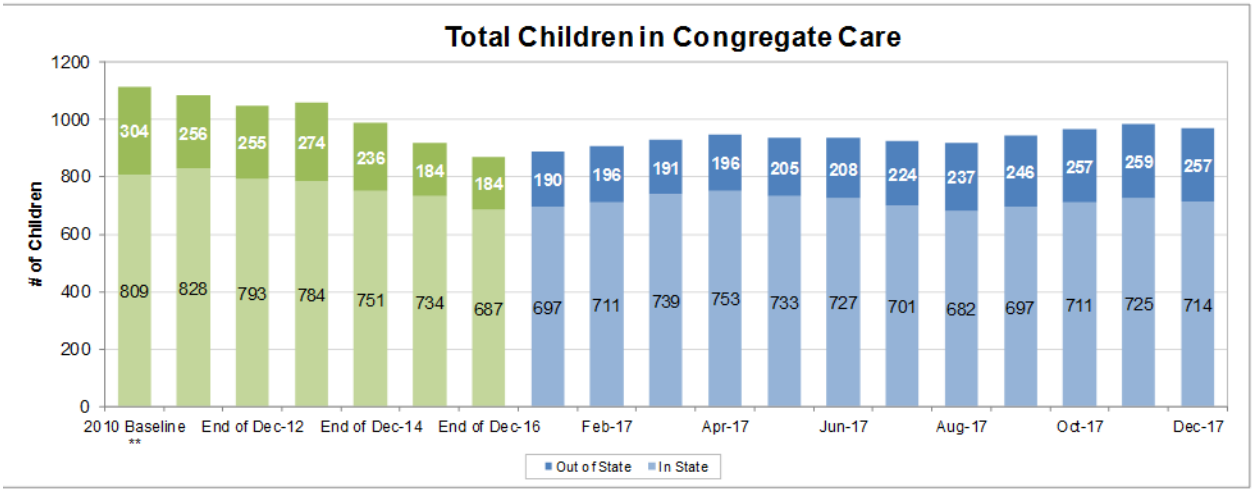
December 2017

Out-of-Home Placements	Group Residential Care	Psychiatric Facility (Long Term)	Psychiatric Facility (Short Term)	Total	
In State	**631**	**57**	**26**	**714**	74%
< 50 miles from Home Communit A	244	21	11	**276**	29%
> 50 miles from Home Communit C	387	36	15	**438**	45%
Out of State	**193**	**58**	**0**	**251**	26%
< 50 miles from Home Communit B	36	4	0	**40**	4%
> 50 miles from Home Communit D	157	54	0	**211**	22%
Total	**824**	**115**	**26**	**965**	100%



* The improvement target for 2017 is to have less than 129 children placed out-of-state and greater than 50 miles from their home community

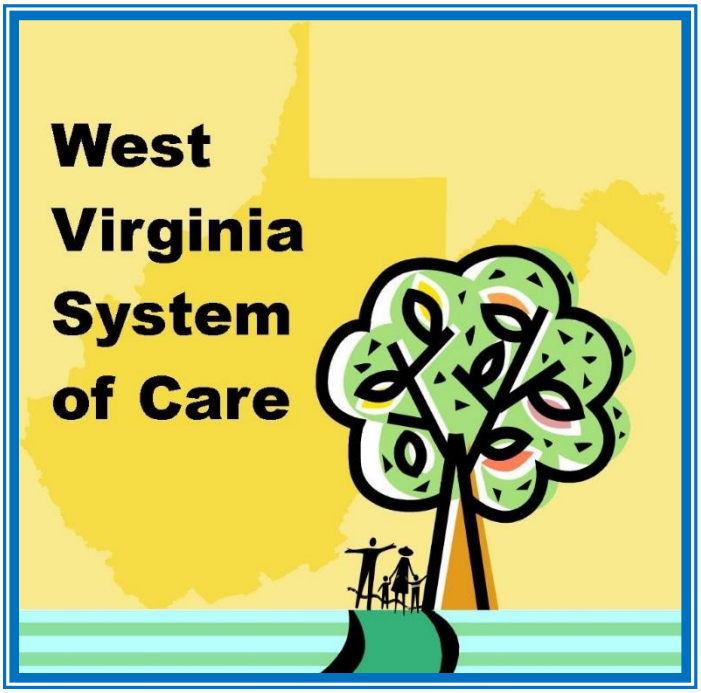
** Baseline is the average of October, November and December of 2010



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

APPENDIX E

System of Care End of Year Report
July 1, 2016-June 30, 2017



West Virginia 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

Table of Contents

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.

Because 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 decided that all youth who were out-of-state should be reviewed 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 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 21 years 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 West Virginia youth.

Data Collection

Data is collected in several ways.

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

For youth, currently in the custody of DHHR, who are currently out-of-state or who are returning, information is collected from the DHHR 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 a FACTS report in the month they enter an out-of-state facility or return to West Virginia. 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.

Information regarding youth who are staffed at the Out-of-State Review and Regional Clinical Review Teams is sent to the West Virginia System of Care Director.

Executive Summary

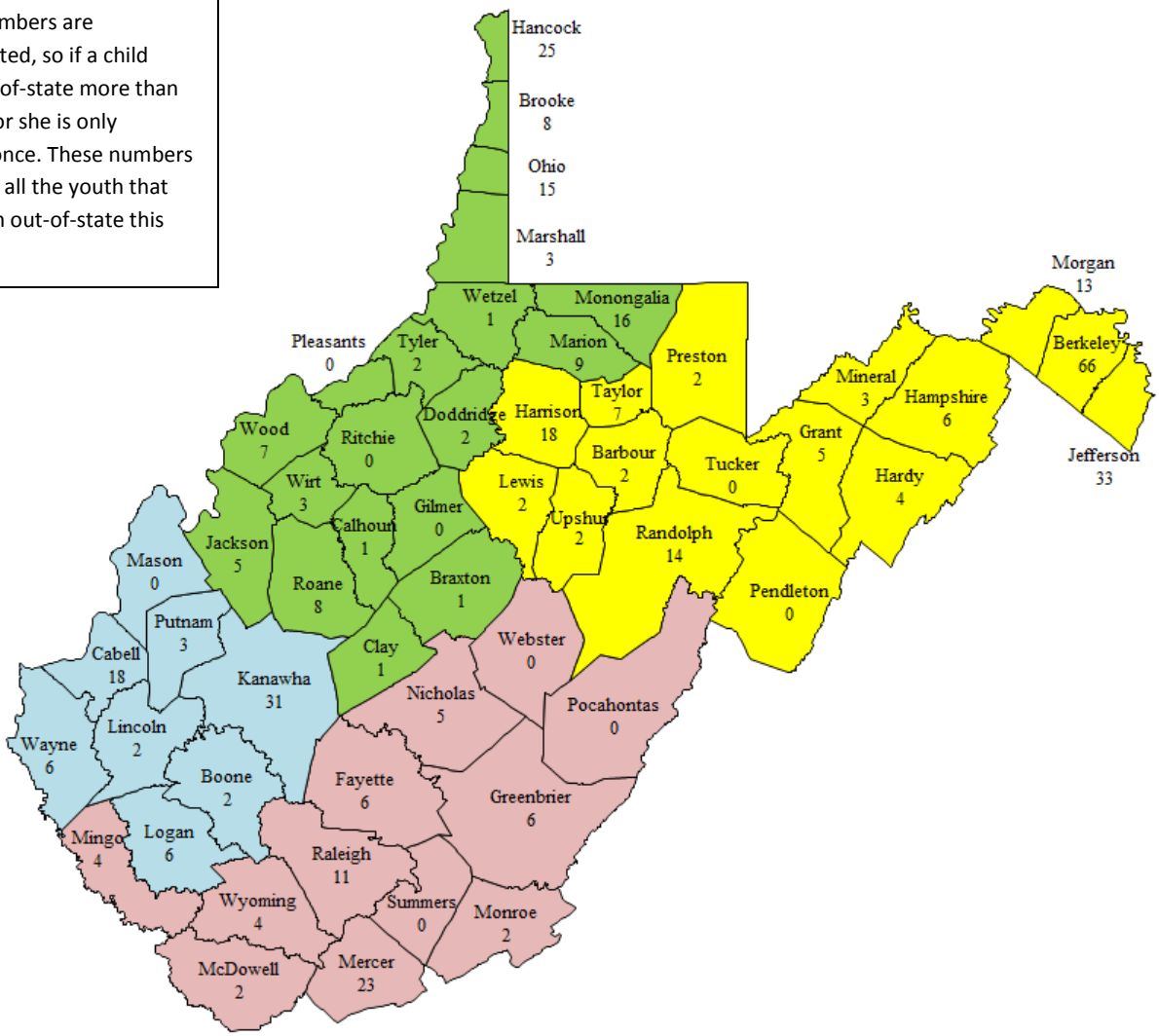
- West Virginia System of Care is a public/private/consumer partnership dedicated to building the foundation for an effective community-based continuum of care that empowers children at risk of out-of-home care and their families.
- This year, the West Virginia System of Care has worked through three 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 three processes are the Regional Clinical Review Team, the Out-of-State Review Team and Conference Calls.
- The number of youth being placed out-of-state only slightly decreased this year. This year (July 2016-June 2017), 415 youth were placed out-of-state. Last year, 425 youth were placed out-of-state.
- Overall, there was a 22% decrease from 2012-2013 to 2016-2017.
- The demographics of youth being placed out-of-state remains the same. There are more males than females and the youth are usually 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.
- Out of the 415 youth out-of-state last year, 75% were reviewed by an out-of-state review team.
- There were 58 youth reviewed through a Regional Clinical Review that were at risk of being placed out-of-state last year. Recommendations were followed 86% of the time.
- Through these teams, some of the gaps in services identified include limited services for youth with an intellectual disability including Autism; youth age 10 or younger requiring intense treatment; and a lack of treatment foster care.

Youth Out-of-State

Out-of-State Youth
All Regions
July 2016-June 2017
(Total-415)

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 youth that have been out-of-state this year.

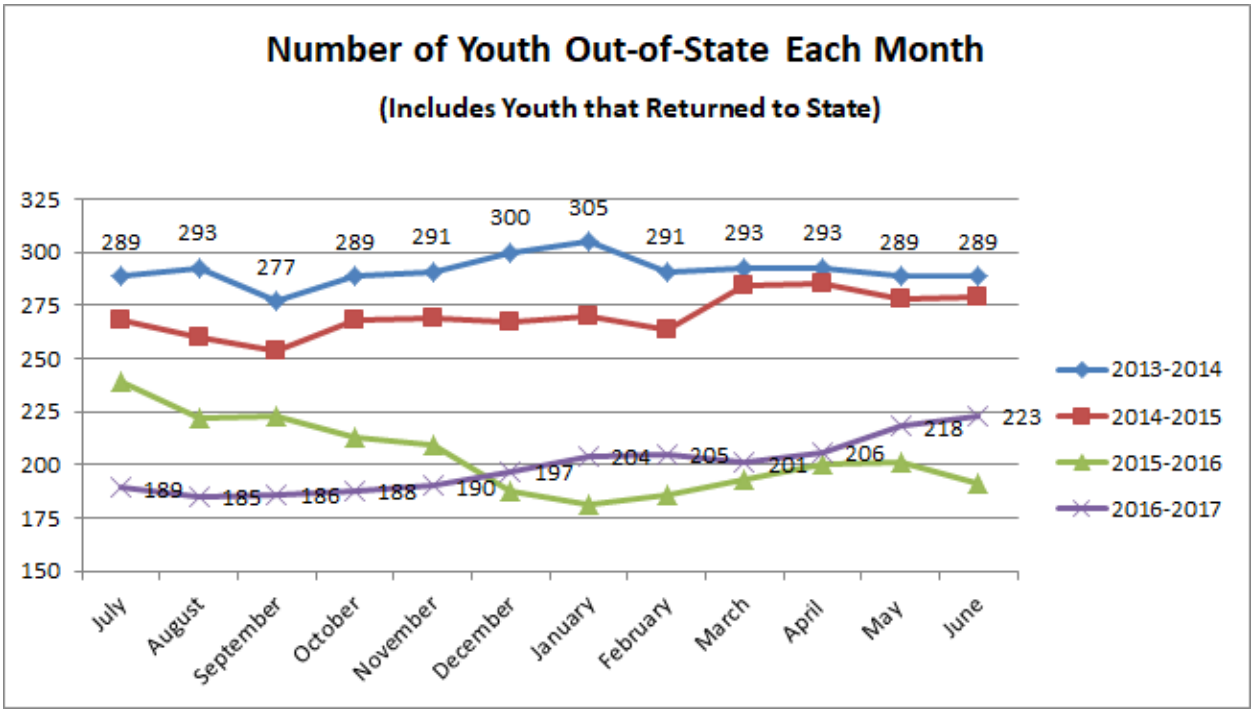


Annual Numbers

	2016-2017	2015-2016	2014-2015	2013-2014	2012-2013
State Total	415	425	477	492	533

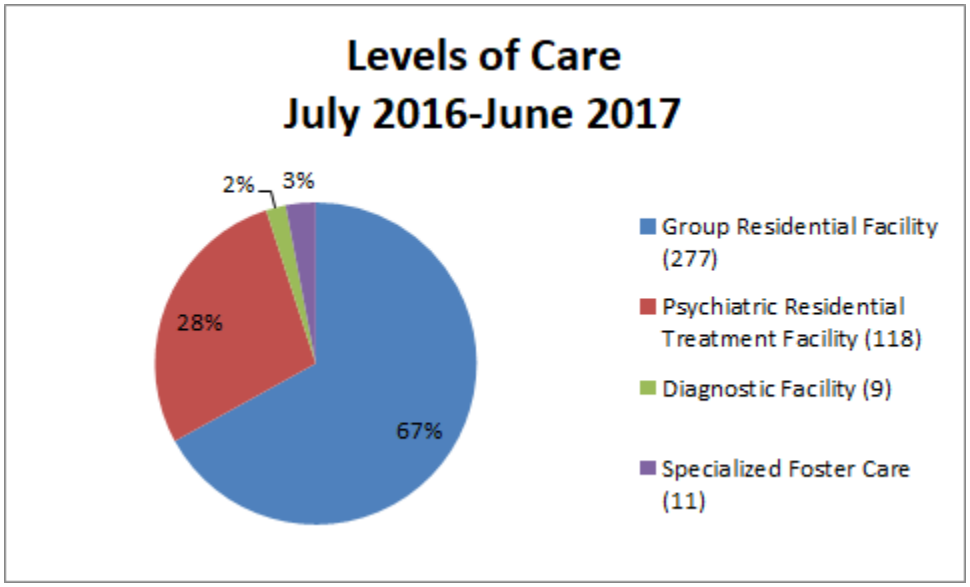
The overall average number of youth out-of-state each month has decreased. The average number of youth out-of-state each month was:

- **2016-2017=199**
- 2015-2016=204
- 2014-2015=270
- 2013-2014=292



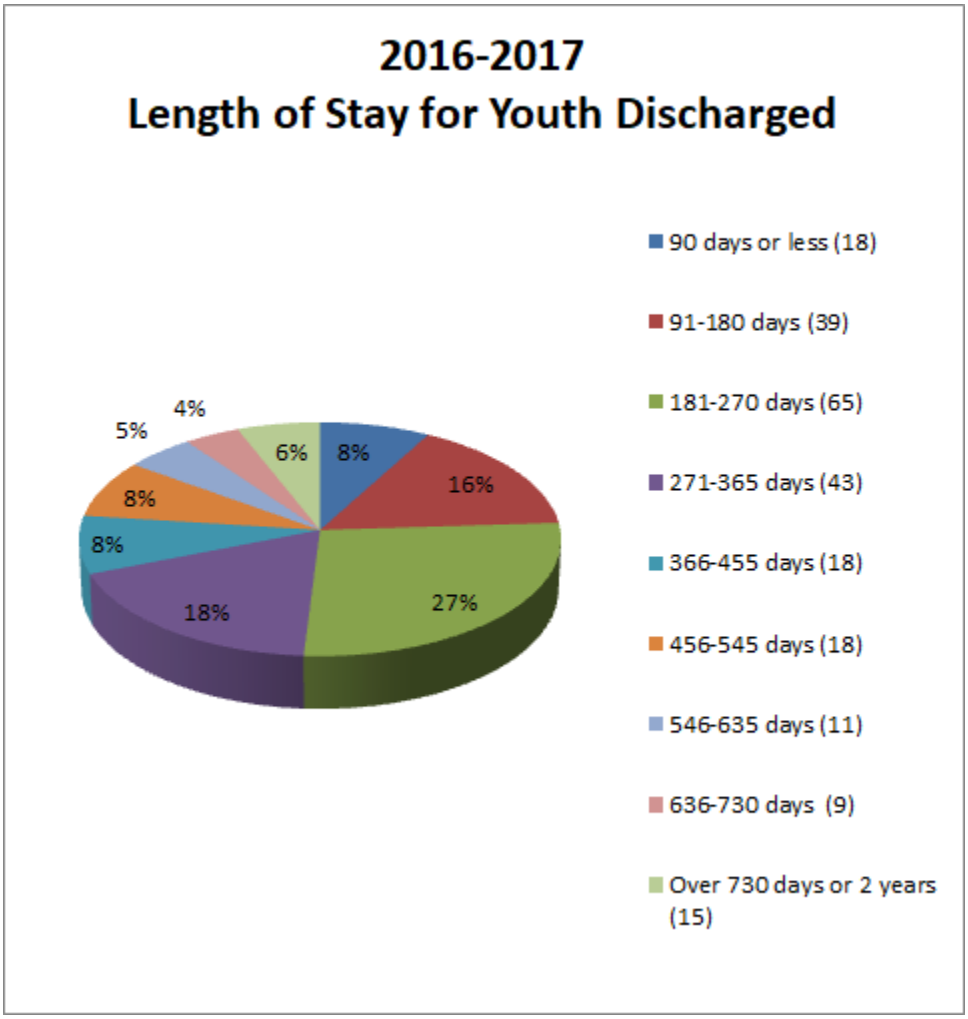
Levels of Care

The information below indicates the current level of care of the youth or the level at discharge. The majority (67%) of youth were in a group residential facility. Last year, 61% of the youth were placed in group residential care.



Length of Stay

There were 236 youth that returned to West Virginia. The average length of stay was 332 days. This is being skewed by youth who remain out for more than one year.



Demographic Highlights of Youth

- From July 2016-June 2017, 415 youth were out-of-state. Last year, 425 youth were out-of-state.
- This year, 310 males (75%) and 105 females (25%) were placed out-of-state.
- The youth were the following ages when placed out-of-state (not current age):
  - 10 years old or younger - 24 youth (6%), a decrease from last year when 41 youth (10%) were placed out-of-state
  - 11-14 years old - 148 youth (36%)
  - 15-17 years old - 219 youth (53%)
  - 18 or older - 24 youth (6%)
- At the time of this report (December 20, 2017), 236 youth had been discharged. The youth were the following ages when discharged:
  - 10 years old or younger - 5 youth (2%)
  - 11-14 years old - 48 youth (20%)
  - 15-17 years old - 146 youth (62%), increase from last year's 52%
  - 18 or older - 37 youth (16%), decrease from last year's 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
- 165 youth or 70% were out-of-state one year or less.
- 92 or 22% of youth had been out-of-state at least twice since 2007.
- 57 youth or 14% of youth had moved from one out-of-state facility to another without returning to the state first since 2007.

Review of Youth

This year, the Regional Clinical Review and Out-of-State Review processes remained the same, but the team structures were modified to meet the current needs of the youth being reviewed. Each region has one team. This team participates in Conference Calls, Regional Clinical Review Teams and Out-of-State Review Teams. These teams consist of community members who represent group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, DHHR's Safe at Home West Virginia program and Children's Mental Health Wraparound, community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

This year, a conference call process was established. Many times, youth need to be quickly reviewed by the team. The youth may have already been through a Regional Clinical Review Team, diagnostic evaluation, or other formal assessment processes. If there is a clear picture on what the child needs, then a conference call can occur.

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 to collect information regarding the gaps in services, identify system issues and barriers and make recommendations to assist the youth in returning to West Virginia.

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

- Out of the 415-youth out-of-state, July 2016-June 2017, 311 or 75% of the youth were reviewed. Out of the 311 youth, 123 youth were reviewed July 2016-2017.
- Some of the gaps in services identified included:
  - No psychiatric residential treatment facilities (PRTFs) 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 PRTF services for youth who are already age 18 or older are available in state.
  - Limited group residential services for youth who are age 18 or older.
  - Very limited services for youth with an intellectual disability.
  - There are no in-state level 3 facilities that can 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 address 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 the state's custody because they cannot obtain the needed services for youth; they can only obtain psychiatric residential treatment facilities (PRTF) level services. DHHR's Children's Mental Health Wraparound for youth in parental custody was implemented in October 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 the youth's current treatment and permanency needs and

serve as a resource to the youth's individual 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.

- Out of the 415-youth out-of-state from July 2016-June 2017, 103 or 25% of the youth had been reviewed through a Regional Clinical Review Team at some point in their life.
- **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 services to keep the youth in West Virginia. Some youth are never placed out-of-state. **Between July 2016 and June 2017, 58 youth were reviewed who were at risk of going out-of-state; two youth were already placed out-of-state.**

Recommendations	Were Recommendations Followed?
34 youth were to remain in state	For the youth recommended to remain in-state, 29 out of 34 or 85% remained in the state at least for four months.
18 youth were to be placed out-of-state	For the youth recommended to be placed out-of-state, 11 out of 18 or 61% were placed out-of-state, even though they may not have gone to one of the facilities recommended. Although the recommendations were not followed, the youth remained in-state and this is a positive outcome.
4 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: two remained in state and two were placed out-of-state. *
2 youth were returned to the team	Two youth were to return to the team for further recommendations but did not. Both youth remained in the state

***Recommendations Followed:** The recommendations are considered to have been followed if the following criteria are met. Youth Go Out-of-State: If the youth goes out-of-state within three months, the recommendation was considered to have been followed. Youth Remain in State: If the youth remained in state for at least four months, the recommendation was considered to have been followed.

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

Recommendations	Were Recommendations Followed?
Both youth were recommended to return to services in WV. *	Neither youth could do that.

***Recommendations Followed:** The recommendations are considered to have been followed if the following criteria are met. Youth Remain Out-of-State: If the youth remained out-of-state for at least four months, the recommendation was considered to have been followed. Youth Return to State: If the youth returns to the state within three months, the recommendation was considered to have been followed.

Conference Calls

Not all youth require an extensive review by the Regional Clinical Review Team. Often youth have been reviewed many times, have many assessments, and the youth's needs are clear. Conference calls are usually scheduled at least every two weeks but can be pulled together quickly to brainstorm services and placement ideas for the youth. A formal set of recommendations are sent to the youth's MDT.

- A total of 39 conference calls were completed this year. Twenty of those were regarding the youth placed out-of-state this year.

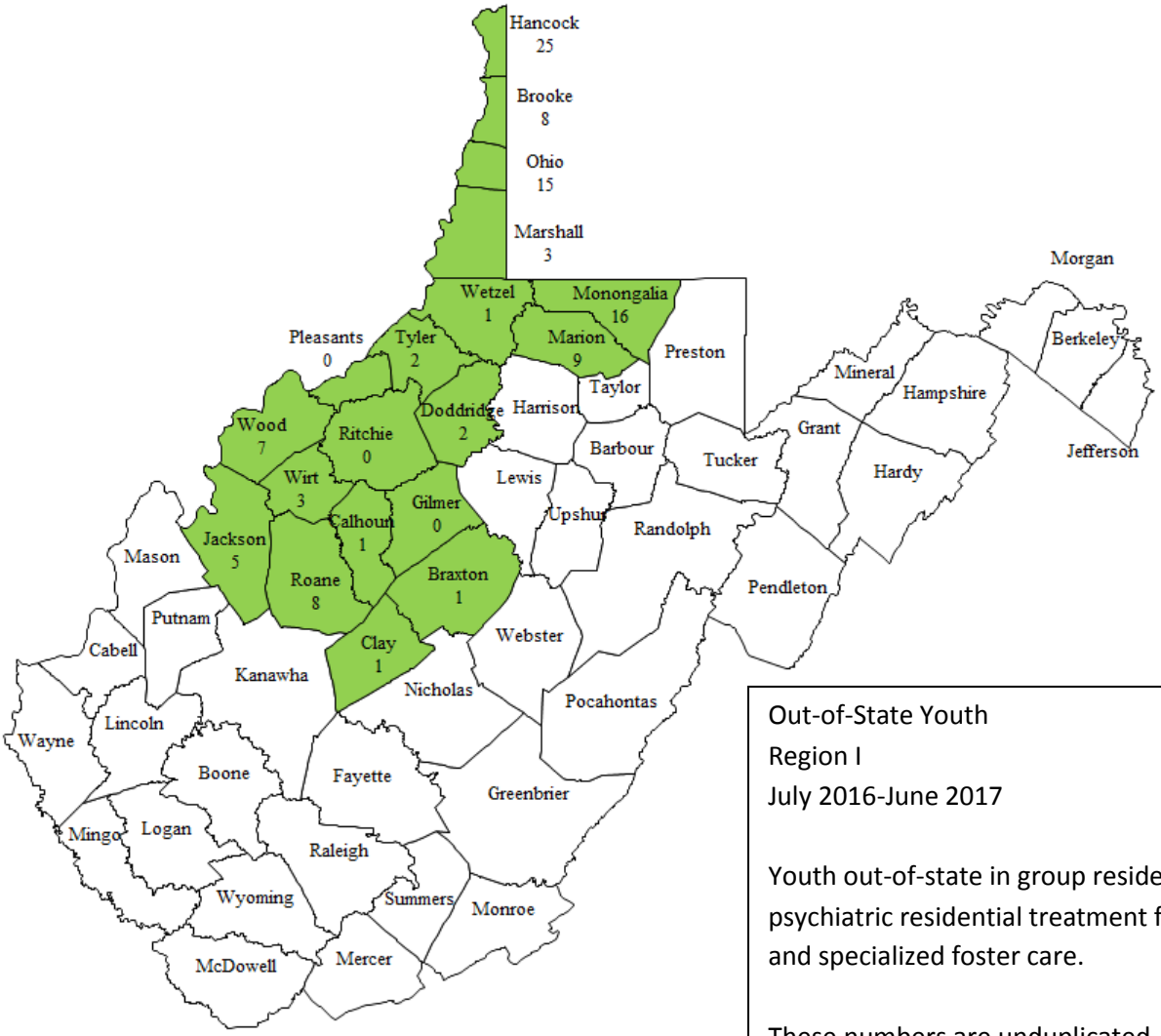
Next Steps

Next year, 2017-2018, the Statewide Review Team Coordinator and the Regional Clinical Coordinators will work both with providers and DHHR to ensure barriers to placing youth in-state are eliminated. Teams will be assessed and revised to meet the needs of the youth in each specific region.

Data specific to youth as they are placed will be collected and reported to determine the continued needs of the youth in West Virginia.

Regional Reports

Region I
July 2016-June 2017



Out-of-State Youth
Region I
July 2016-June 2017

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 youth who have been out-of-state this year.

2016-2017=107

2015-2016=104

Region I
July 2016-June 2017

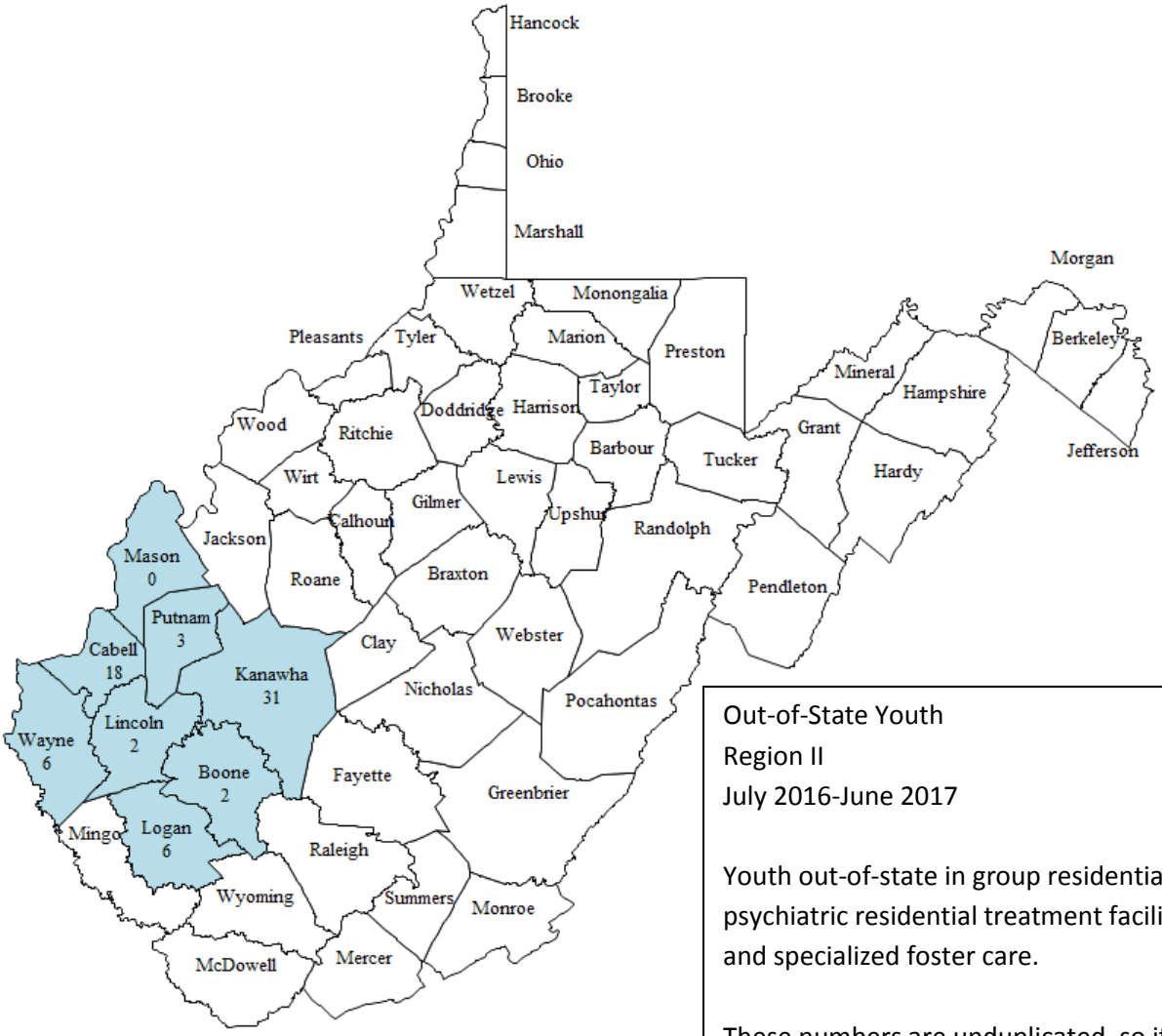
Demographics:

- 107 youth were placed out-of-state last year. The previous year, 104 youth were placed out-of-state.
- 80 or 75% of the youth were male and 27 or 25% were female.
- Youth were the following ages at placement:
  - 10 or younger - 7 or 7%
  - 11-14 years old - 39 or 36%
  - 15-17 years old - 53 or 50%
  - 18 or older - 8 or 7%
- The level of care youth was placed are as follows:
  - Psychiatric Residential Treatment Facility - 24 or 22%
  - Group Residential -73 or 68%
  - Diagnostic - 8 or 8%
  - Specialized Foster Care - 2 or 2%

Reviews:

- 15 youth were reviewed through a Regional Clinical Review Team (July 2016-June 2017).
- All youth but two were at risk of going out-of-state.
  - Eight youth were recommended to remain in the state for services.
  - Five youth were recommended to go out-of-state to receive services.
  - Two youth were recommended to return from out-of-state.
  - Recommendations were followed 60% of the time.
- 39 youth were reviewed through the Out-of-State Review Team this year.
- 14 youth were reviewed through a Conference Call.

Region II
July 2016-June 2017



Out-of-State Youth
Region II
July 2016-June 2017

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 youth who have been out-of-state this year.

2016-2017=68 youth
2015-2016=65 youth

Region II
July 2016-June 2017

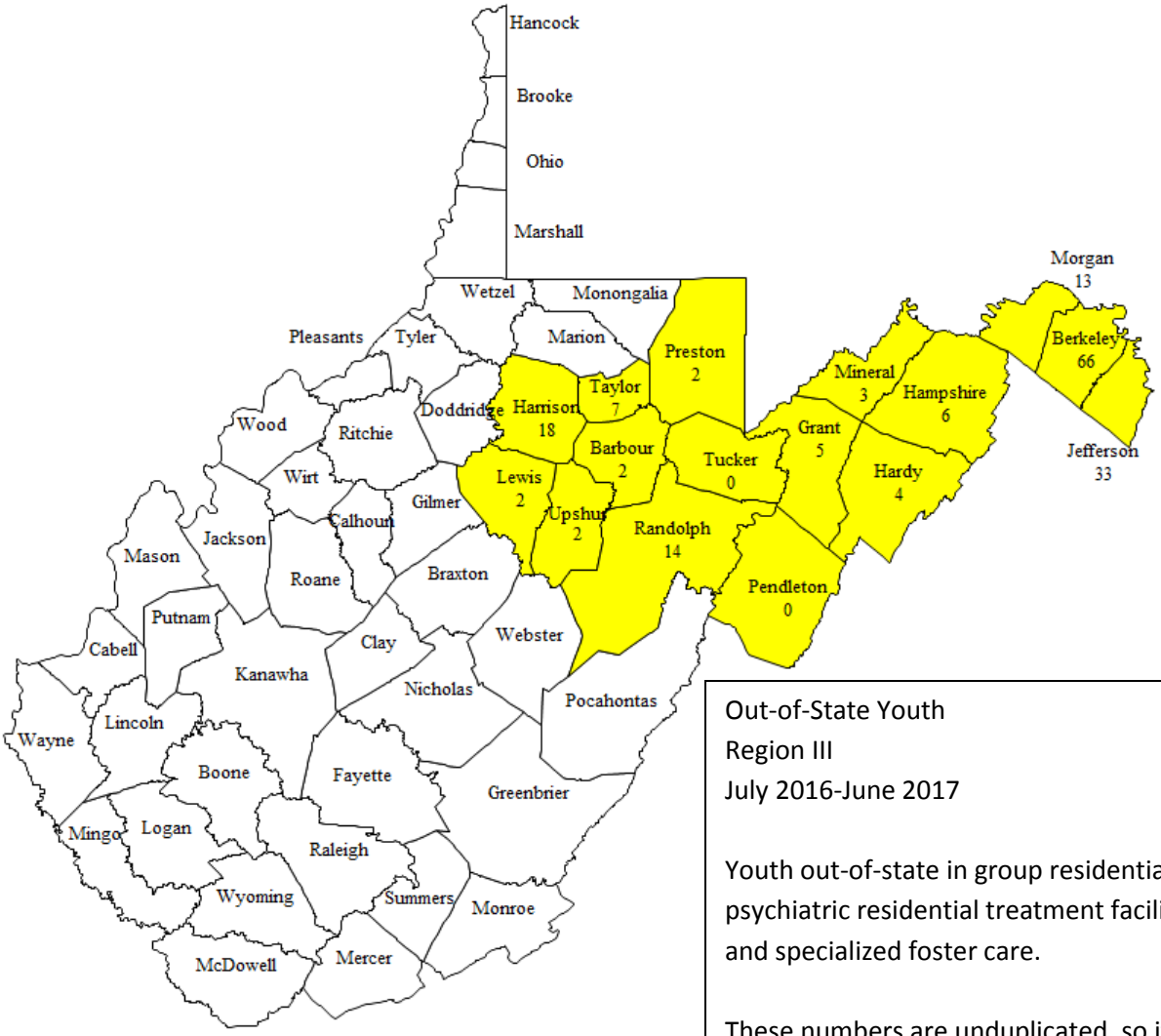
Demographics:

- 68 youth were placed out-of-state last year. The previous year 65 youth were out-of-state.
- 52 or 76% of the youth were male and 16 or 24% were female.
- Youth were the following ages at placement:
  - 10 or younger - 6 or 9%, decrease from last year's 23%
  - 11-14 years old - 28 or 41%, large increase from last year's 26%
  - 15-17 years old - 30 or 44%
  - 18 or older - 4 or 6%
- The level of care youth was placed are as follows:
  - Psychiatric Residential Treatment Facility - 35 or 52%
  - Group Residential Non - 31 or 46%
  - Diagnostic - 1 or 1%
  - Specialized Foster Care - 1 or 1%

Reviews:

- 36 youth were reviewed through Regional Clinical Review Teams (July 2016-June 2017). All youth were at risk of going out-of-state.
  - 20 youth were recommended to remain in the state for services.
  - 12 youth were recommended to go out-of-state to receive services.
  - Four youth were recommended to remain in the state for services or go out if services could not be secured in-state.
  - Recommendations were followed 81% of the time.
- 24 youth were reviewed through the Out-of-State Review Team.
- Seven youth were reviewed through a Conference Call.

Region III
July 2016-June 2017



Out-of-State Youth
Region III
July 2016-June 2017

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 youth who have been out-of-state this year.

2016-2017=177 youth
2015-2016=175 youth

Region III
July 2016-June 2017

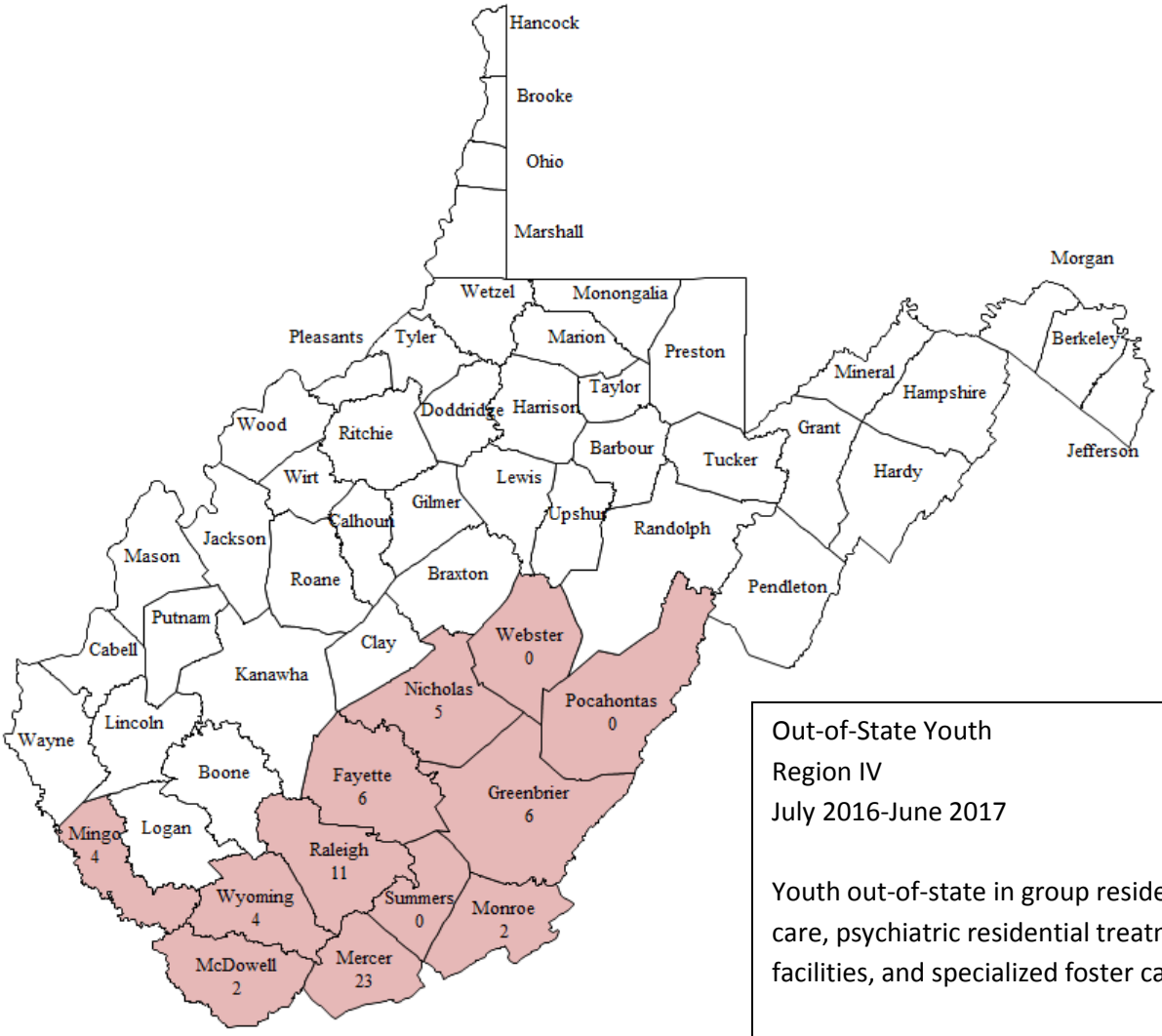
Demographics:

- 177 youth were placed out-of-state last year. There were 175 youth placed the previous year.
- 131 or 74% of the youth were male and 46 or 26% were female.
- Youth were the following ages at placement:
  - 10 or younger - 5 or 3%, decrease from last year's 13%
  - 11-14 years old - 64 or 36%, decrease from last year's 43%
  - 15-17 years old - 96 or 54%
  - 18 or older - 12 or 7%
- **The level of care youth was placed are as follows:**
  - Psychiatric Residential Treatment Facility - 32 or 18%
  - Group Residential -142 or 80%
  - Diagnostic - None
  - Specialized Foster Care - 3 or 2%

Reviews:

- Three youth were reviewed through a Regional Clinical Review Team (July 2016-June 2017). The youth were at risk of going out-of-state.
- Two youth were recommended to remain in the state for services.
- One youth was recommended to go out-of-state to receive services.
- Recommendations were followed 67% of the time.
- 35 youth were reviewed through the Out-of-State Review Team.
- Eight youth were reviewed through a Conference Call.

Region IV
July 2016-June 2017



Out-of-State Youth
Region IV
July 2016-June 2017

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 youth who have been out-of-state this year.

2016-2017=63 youth

2015-2016=81 youth

Region IV
July 2016-June 2017

Demographics:

- 63 youth were placed out-of-state last year. There were 81 youth out-of-state the previous year. Region IV is the only Region to show a decrease last year. This region had the lowest number of youth out-of-state.
- 47 or 75% of the youth were male and 16 or 25% were female.
- Youth were the following ages at placement:
  - 10 or younger - 6 or 10%
  - 11-14 years old - 17 or 27%, decrease from last year's 36%
  - 15-17 years old - 40 or 63%, increase from last year's 49%
  - 18 or older - None
- The level of care youth was placed are as follows:
  - Psychiatric Residential Treatment Facility - 28 or 45%
  - Group Residential - 31 or 49%
  - Diagnostic - None
  - Specialized Foster Care - 4 or 6%

Reviews:

- Four youth were reviewed through a Regional Clinical Review Team (July 2016-June 2017).
- Four youth were at risk of going out-of-state.
  - Two youth were recommended to remain in the state for services.
  - Two youth were recommended to return to the team for further recommendations but did not. The two youth did remain in the state.
- Recommendations were followed 100% of the time.
- 25 youth were reviewed through the Out-of-State Review Team.
- Eight youth were reviewed through a Conference Call.

APPENDIX F

State Court Improvement Program 2017 Annual Self-Assessment Report

OMB Control No: 0970-0307
Expiration Date: 09/30/2019

State Court Improvement Program 2017 Annual Self-Assessment Report
This self-assessment is intended as an opportunity for Court Improvement Programs (CIPs) to review progress on required CIP projects, joint program planning and improvement efforts with the child welfare agency, and ability to integrate CQI successfully into practice. Questions are designed to solicit candid responses that help CIPs apply CQI and identify support that may be helpful.
I. **CQI Analyses of Required CIP Projects** (Joint Project with Agency and Hearing Quality Project)

Joint Project with the Child Welfare Agency: **New View Project**
Provide a concise description of the joint project selected in your jurisdiction.
The Supreme Court of Appeals of West Virginia (WVSCA) through its Court Improvement Program established the New View Project in 2013. The project uses a predictive model to generate a list of children who are likely to linger in out-of-home care. The project aims to view the top forty children on the list each year to provide new insight on the cases and make specific recommendations for achieving permanency and well-being for the children identified.
Seventeen predictors are applied to the West Virginia's Bureau for Children and Families' Adoption and Foster Care Analysis and Reporting System (FACTS) data to create the list of children. The predictors include sex, race, date of first removal to foster care, number of foster care placements, and case plan goals, among other factors. By the time a viewer gets a New View case from the predictive model, 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.
After determining the children or young adults who will be a part of the project, the Court's staff prepares an order for a circuit judge to sign. Once the order is entered, the viewer begins by looking at the complete circuit court file and the DHHR file. They then interview the case's stakeholders, which may include caseworkers, guardians' ad litem, prosecuting attorneys, CASA workers, therapists, case managers, and most importantly, the child. The viewer then prepares and files a report with the circuit court. The purpose of the New View project is to provide meaningful recommendations to multi-disciplinary teams and circuit courts to help in achieving permanency and well-being for the child. Additionally, the project hopes to collaborate with the West Virginia DHHR in finding solutions to systemic issues discovered by the project.

Identify the specific safety, permanency, or well-being outcome this project is intended to address.
This project focuses on permanency. The primary goal of the project is to help children reach and maintain permanency.
Approximate date that the project began: Planning began in 2012
Which stage of the CQI process best describes the status of project work?
The project just entered Phase V, evaluation and assessment. This year we will focus on evaluation of the project and use the findings to reevaluate the intervention. Analysis of New View project, years one through four, and working on sustaining the project beyond grant funding will drive New View Project activities in the coming year. There will be no new cases reviewed during this period.
How was the need for this project identified?
In 2011, a West Virginia team of judges and Department of Health and Human Resources (DHHR) 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 1,100 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.
With assistance from the Court Improvement Program grants, West Virginia borrowed from Georgia's experiences to do its own project with variations. New View was a court inspired and court led project to improve those the outcomes of children in care.
A recent in-depth evaluation of the cases reviewed in the first two years of the project (included with this assessment), revealed the most frequently occurring barriers to permanency for the children viewed. Court analysts also provided recommendations on how the Court Improvement Project (CIP) and its partners can seek to reduce or remove those barriers.
There continues to be a need for this project. We know that programs that focus on difficult cases are effective in our state. The Safe at Home Program began as a demonstration project in October 2015. This program is under the auspices of DHHR and focuses on children ages 12-17, particularly those in out-of-state facilities, in-state congregate care, and those at risk of removal from their home. To date, the program has resulted in the return of 40 children from out-of- state facilities and has prevented another 286 from placement in congregate or foster care.
The New View project was established as a method to help WVCIP meet its mission to advance practices, policies, and laws that improve the safety, timely permanency, and well-being of children and due process for families in child abuse/neglect and juvenile cases.
What is the theory of change for the project?
The Court will provide New View review for children/youth identified by a predictive model as high risk for lingering in foster care *so that* child/youth preferences and barriers to: permanency, meaningful connections, and successful transitions to adulthood are identified *so that* New Viewers make specific recommendations to address the identified barriers and issues to the Court and the multidisciplinary team (MDT) *so that* court orders address identified barriers and service needs *so that* timely permanency is achieved and that important transition to adulthood needs are addressed for those youth aging out of care.
If you do not yet have a theory of change and/or would like assistance, please indicate such in the space below.
Currently, we are content with our theory of change for this project. However, if this period of evaluation leads to significant project modification for the future, we could need assistance.
Have you identified a solution/intervention that you will implement? If yes, what is it?
The New View project process intervenes in cases where children are lingering in care and have not reached permanency. Some examples of what viewers have done to benefit the children viewed are below:

 A few children were reconnected with siblings or other family members.
 Several children were referred to the MODIFY program.
 Viewers helped explore the possibility of military service for a couple of the children.
 Viewers helped find and recommend more appropriate placements and treatment for children.
 Viewers helped children explore their interests. For example, a viewer found that a young man had a unique interest in rodeos and found training programs that might further his interest.
 Viewers helped with aged-out youths in finding housing, services, and employment training.

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

What has been done to implement the project?

New View is in its fourth year. An attorney was contracted to be a full-time viewer. A secure database to house information collected was built in 2013. New View Project staff and BCF leaders meet periodically to discuss progress and give/receive feedback.

What is being done or how do you intend to monitor the progress of the project?

Regular updates on the New View Project are provided to the CIP Oversight Board. Data Analysts serve as intermediators between Viewers and software programmers on database maintenance and changes. We conducted an in-depth evaluation of all cases viewed during the first two years of the project in May 2017 and could identify systemic issues as well as implementation fidelity problems. During this next year, we will reevaluate the current project design, identify measures that reflect long-term impact of the project, and focus on sustainability.

What assistance or support would be helpful from the CBCC or Children's Bureau to help move the project forward?

The CBCC will be a collaborative partner throughout the evaluation and redesign process. See attached work plan (Appendix B) for specific steps we will collaborate with the CBCC the on.

Hearing Quality Project: The Q2 project: Quantifying Quality

Provide a concise description of the joint project selected in your jurisdiction.

The WVSCA through its CIP started a subcommittee, which is working to collect data that will be used to identify weaknesses and barriers surrounding hearing attendance. Hearing attendance of all applicable parties (e.g. children, respondents, GAL) can be used to measure hearing quality.

Approximate date that the project began: 2016

Which stage of the CQI process best describes the status of project work?

We are currently in Phase I and are identifying and assessing our needs. While there is anecdotal evidence of poor hearing attendance, we are seeking ways to measure this. We are gathering preliminary information through surveys.

How was the need for this project identified?

West Virginia currently collects data and reports on 17 performance measures related to timeliness in child abuse and neglect cases. Though timeliness measures have helped make judges aware of child abuse and neglect time frames, which in turn has decreased time to permanency from 547 days in 2009 to 443 days in 2016, these measures cannot give us insight into the quality of hearings. This project will help us measure the courts performance with respect to due process, specifically hearing attendance. The attendance of all applicable parties is important because the future and wellbeing of a child or children are at stake. One case may involve multiple parties and each party has pertinent information on the case that may help an advocate to better champion their needs. Finally, attending hearings can bolster parties' participation in court orders and often help parties take the process more seriously.

What is the theory of change for the project?
We are in the process of developing the theory of change for this project based on our vision that every case will experience due process.
If you do not yet have a theory of change and/or would like assistance, please indicate such in the space below.
We are receiving assistance from Eva Klain, JD of the American Bar Association on this project. We will reach out to the Center for Courts when we are ready to formalize our theory of change.
Have you identified a solution/intervention that you will implement? If yes, what is it? We are in the preliminary information-gathering phase of this project. Results from surveys distributed this year, will help us to see if there are discernable patterns in hearing attendance, which will help us to develop an effective solution.
What has been done to implement the project?
With our partners from DHHR, a survey was created and distributed to 700 DHHR caseworkers statewide during February and March of 2017. There were 219 completed surveys. Caseworkers reported that children over 14 and foster parents were least likely to attend hearings. While this is a significant finding, we are looking for additional perspectives. We are revising the survey questions and will distribute it at the annual Cross Training in July 2017. Professionals such as CASAs, Guardians *ad litem*, Judges, and providers will be asked to take the survey.
What is being done or how do you intend to monitor the progress of the project?
We are developing a project plan that will outline goals, identify partners, evaluation, outcomes, and timeframes. Adherence to the project plan will be monitored through quarterly subcommittee meetings and updates will be provided to the CIP Oversight Board.
What assistance or support would be helpful from the CBCC or Children's Bureau to help move the project forward?
We would be interested in adapting an existing assessment tool or would like assistance in developing one.
II. Trainings, Projects, and Activities For questions 1-9, provide a ***concise*** description of work completed or underway to date in FY 2017 (October 2016-June 2017) in the below topical subcategories.

For question 1, focus on significant training events or initiatives held or developed in FY 2017 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 including attorneys, social workers, and judicial staff	To provide an introduction on the benefits of the CIP supported project JANIS. Demonstrate the value of this web-based statewide program that creates quality child abuse/neglect	Follow up surveys, tracked the number of new JANIS users, and number of cases entered into the system.

			petitions, motions, and orders.	
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 the case.	Evaluation forms completed by attendees
Improving timeliness/ permanency	☒Yes ☐No	Multiple disciplines (attorneys, social workers, counselors, providers etc.)	To train anyone involved in child abuse and juvenile cases on procedure, law updates and resources available to help achieve permanency	Follow up online surveys
Quality legal representation	☒Yes ☐No	Law students	To train law students on 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 students' course 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.

APPENDIX G

Education of Children in Out-of-Home Care Advisory Committee

Annual Report
2017

The *Education of Children in Out-of-Home Care Advisory Committee* focused on the following major objectives during 2017: (1) Increase Educational Participation in Multi-Disciplinary Treatment Teams; (2) Implement the Foster Care Provisions of Every Student Succeeds Act; (3) Expand Statewide Transitional Services; and (4) Monitor the Education Programs of Children Placed Out-of-State.

Increase Educational Participation in Multi-Disciplinary Teams (MDTs)

Participation by a school official at MDT meetings in child abuse and neglect cases and juvenile delinquency cases is required by West Virginia law (WV Codes 49-4-405; 49-4-406; and 49-2-907). Inconsistent practices across West Virginia have resulted in the absence of educational officials at some multi-disciplinary team meetings. In response to this issue, the Advisory Committee formed a task group that partnered with the Judiciary's Court Improvement Program (CIP). The task group was chaired by Cammie Chapman, Director of Children's Services, Supreme Court of Appeals of WV. The task group developed materials to increase the awareness of the importance of education's participation in MDT meetings including a joint letter to key school officials from the State Superintendent of Schools, Secretary of DHHR and the Supreme Court of Appeals of WV. The task group also developed tools to facilitate educator participation in MDT meetings including a checklist, guidance document, brochure and model report format. Implementation of these activities was initiated by a training of school administrators on January 25, 2018.

Implement the Foster Care Provisions of Every Student Succeeds Act (ESSA)

The Advisory Committee continues to support and advise WVDE and DHHR in (1) the development of a joint data system to report on the educational status and achievement of children in the foster care system and (2) policies, procedures and agreements to ensure school stability. The completion of these activities is required under the new federal law.

During 2017, the Department of Education and the Department of Health and Human Resources issued a joint guidance document for county school districts and local and regional health and human resource staff entitled: Educational Stability for Homeless Children and Children in Foster Care. The document provides answer to questions regarding the implementation of the federal law and provides guidance on working cooperatively to achieve school stability for children in out-of-home care.

Expand Statewide Transitional Services

Over the past year and a half, the WVDE, Office of Diversion and Transition Programs (ODTP) has increased the number of Transition Specialists employed around the state to 18, reduced the territory they cover, and expanded their role with Local Education Agencies (LEAs).

ODTP transition staff serve students who face unique educational challenges because they are placed in facilities out of their home for adjudicated and status related offenses, mental health services, or specialized medical needs. They work closely with these students to ensure, once they leave a placement, they can enroll in public school or higher education, complete their high school graduation track (e.g. Diploma, Option Pathway, or TASC) and help develop the necessary skills for employment. Transition Specialists assist schools in understanding all the educational options available to best meet the student's needs. Additionally, transition staff work preventatively with LEAs to assist with other students in the county at risk of placement in a facility outside their home. This collaborative work is specific to the county's needs for their students.

Attached is a map outlining the most updated transition map and staff contact information.

Monitor the Educational Programs of Children Placed Out-of-State

During 2017 WVDE Advisory Committee members from the Office of Federal Programs and Office of Diversion and Transition, in conjunction with DHHR staff, monitored the education programs of West Virginia children placed in five out-of-state facilities. The facilities monitored were:

Grafton School, Winchester, VA
Bellaire JCB, Cleveland, OH
Abraxas Academy, Morgantown, PA
The Bradley Center, Pittsburgh, PA
Alabama Clinical Schools, Birmingham, AL

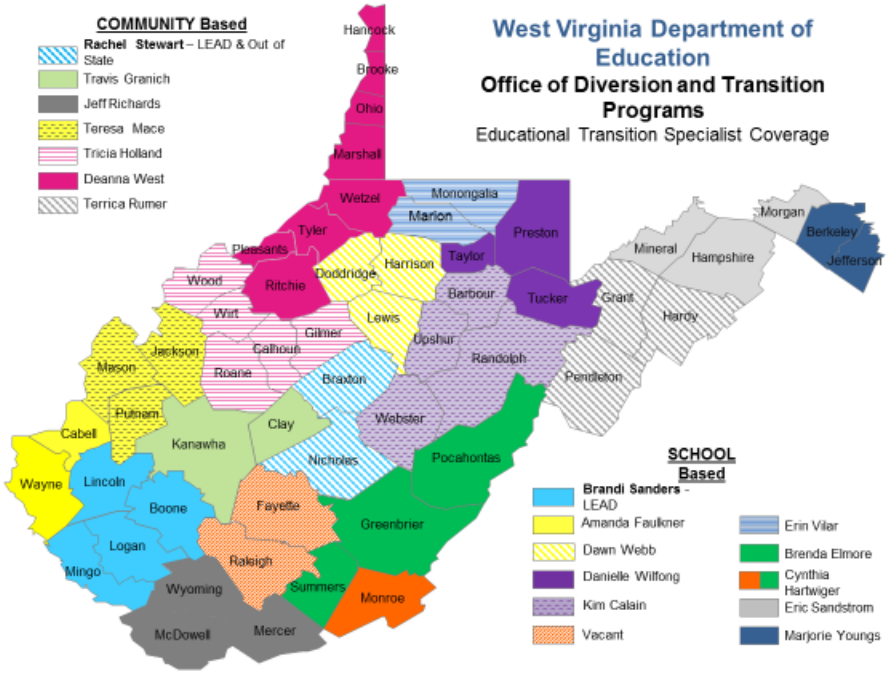
A summary of the monitoring findings may be obtained from Sheila Paitsel, Assistant Director, Office of Federal Programs, WVDE.

Goals for 2018

At its January 2018 meeting, the Advisory Committee established the following goals for the year: (1) Increase educational participation in MDT meetings through implementation of the task group's initiatives; (2) Development of an educational resource manual for judicial personnel; and (3) Increase awareness of transitional programs and services.

Office of Diversion and Transition Programs (ODTP) Transition Specialist

NAME	LOCATION	ADDRESS	OFFICE PHONE	EMAIL	COUNTIES
Mollie Wood ASSISTANT DIRECTOR	Office of Diversion & Transition Programs	Building 6, Room 728 1900 Kanawha Blvd. East Charleston, WV 25305-033	304-558-8833	mbwood@k12.wv.us	Office of Diversion & Transition Programs
Teresa Mace	Putnam Co YRC	3266 Winfield Rd Winfield, WV 25213	304-586-2055	teresa.mace@k12.wv.us	Putnam, Mason, Jackson
Tricia Holland	Wood Co YRC	1400 12th Street Vienna, WV 26105	304-295-3024	tricia.holland@k12.wv.us	Wood, Wirt, Roane, Calhoun, Gilmer
Brenda Elmore	Davis-Stuart	207 Cottage Drive Lewisburg, WV 24901	304-647-5407	belmore@k12.wv.us	Greenbrier Pocahontas
Brandi Sanders	Donald R. Kuhn / Lincoln Co HS	*1 Lory Place Julian, WV /81 Lincoln Panther Way, Hamlin, WV 25523*	304-369-2987 304-842-6000 x4307	bdsander@k12.wv.us	Boone, Logan, Lincoln, Mingo
Eric Sandstrom	Board of Child Care	715 Brown Road Martinsburg, WV 25404	304-274-3688	psandstrom@k12.wv.us	Morgan, Mineral, Hampshire
Rachel Stewart	Nicholas Co Board of Ed	400 Old Main Drive Summersville, WV 26651	304-872-3611 x243	rastewart@k12.wv.us	Nicholas, Braxton & Out of State
Kim Calain	Elkins Mountain School	100 Bell Street Elkins, WV 26241	304-637-0313	kimberly.calain@k12.wv.us	Randolph, Upshur, Barbour, Webster
Amanda Faulkner	Pressley Ridge Grant Gardens	2580 Grant Gardens Road Ona, WV 25545	304-743-3974	amanda.faulkner@k12.wv.us	Cabell, Wayne
Erin Vilar	Academy Programs	*5 Crosswind Drive Fairmont, WV 26554*	304-363-3348	erin.vilar@k12.wv.us	Monongalia, Marion
Jessica Pastine	Kenneth "Honey" Rubenstein	141 Forestry Camp Drive Davis, WV 26260	304-259-5252	jpastine@k12.wv.us	Tucker, Taylor, Preston
Cynthia Hartwiger	Davis-Stuart	207 Cottage Drive Lewisburg, WV 24901	304-647-5407	chartwiger@k12.wv.us	Monroe/Western Greenbrier
Jeff Richards	Sam Perdue	843 Shelter Road Princeton, WV 25740	304-425-4689	jeffrey.r.richards@k12.wv.us	Mercer, McDowell, Wyoming
Marjorie Youngs	Board of Child Care	715 Brown Road Martinsburg, WV 25404	304-274-3688	myoungs@k12.wv.us	Berkeley, Jefferson
Dawn Webb	United High School	1349 Shinnston Pike Clarksburg, WVV 26301	304-326-7560	dawn.webb@k12.wv.us	Doddridge, Harrison, Lewis
Deanna West	Ritchie County Middle	105 Ritchie Co School Rd Ellenboro, WV 26346	304-869-3512	deanna.wayne@k12.wv.us	Wetzel, Tyler, Ohio, Pleasants, Ritchie, Hancock, Brooke, Marshall
Travis Granich	Clay Co Board of Ed	285 Church St, Clay, WV 25043	304-587-4266	travis.granich@k12.wv.us	Kanawha, Clay
Terrica Rumer	Moorefield High School	401 N Main Street Moorefield, W 26836	304-530-6034	trumer@k12.wv.us	Pendleton, Grant, Hardy
Vacant	Beckley Center	4712 Robert C Byrd Drive Beckley, WV 25801	304-250-6570		Raleigh, Fayette



APPENDIX H

West Virginia

ADULT DRUG COURTS

FY 2017

Supreme Court of Appeals of West Virginia

Division of Probation Services

Stephanie Bond
Director

Robert L. McKinney, II
Counsel

Nick Leftwich
Drug Court Specialist

Alicia Holman
Quality Assurance Data Analyst

- 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 (*West Virginia Code* § 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 Supreme Court of Appeals of West Virginia.
- 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 decreased use of residential treatment centers.
- For FY 2017 **the average annual cost per drug court participant was $6,072.00** as compared to $20,155 in the Regional Jail or $26,081 in a Division of Corrections prison. These costs include intensive supervision, treatment, case management, and drug testing.
- As of June 30, 2017, 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 **657** active participants in the ADCs as of June 30, 2017.

West Virginia Juvenile Drug Court

FY 2017

Supreme Court of Appeals of West Virginia

Division of Probation Services

Stephanie Bond
Director

Robert L. McKinney, II
Counsel

Nick Leftwich
Drug Court Specialist

Alicia Holman
Quality Assurance Data Analyst

- 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 *West Virginia Code* § 49-4-703 and are designed and operated consistent with the developmental and rehabilitative needs of the juveniles and operate under uniform policies and procedures established by the Supreme Court of Appeals of West Virginia.
- 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 intervention, to reduce or prevent future court involvement for the JDC involved juveniles. The objectives include 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 June 30th, 2017, there were fourteen (14) operational Juvenile Drug Court programs serving the following counties: Boone, Brooke, Hancock, Harrison, Kanawha, Lincoln, Logan, McDowell, Mercer, Monongalia, Ohio, Pleasants, Putnam, Raleigh, Randolph, Ritchie, Wayne, Wirt, and Wood Counties
- 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 2017, **the average cost per youth was $5,054.** This cost includes intensive supervision, drug testing, some treatment services and specialized activities. This is in contrast to approximately $110,000 for the same time period in a Division of Juvenile Services (DJS) facility or a residential group facility.
- Most treatment and case management services are provided by the local Youth Reporting Centers, operated by DJS, and their mental health provider.
- On June 30, 2017, there were **154** active JDC participants 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.