



# Advancing New Outcomes: Findings, Recommendations, and Actions



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, and on behalf of the Commission to Study Residential Placement of Children, I am pleased to submit the 2018 annual summary report, *Advancing New Outcomes: Findings, Recommendations, and Actions of the West Virginia Commission to Study Residential Placement of Children*.

West Virginia has experienced a child welfare crisis that is being driven by the drug epidemic. This crisis has fueled the number of children that are unsafe in their homes.

The Commission to Study Residential Placement of Children believes that the best way to reduce the number of children in foster care is to find creative ways to work with the family to address their issues, while keeping children with their families.

The Family First Prevention Services Act, passed in February 2018, will allow states to spend federal child welfare dollars on preventive efforts to keep families together.

The accomplishments written in this report could not have been achieved without the partnership of many individuals. With continued collaboration, we will overcome the challenges facing the children of our state.

Sincerely,

A handwritten signature in blue ink that reads "Bill J. Crouch".

Bill J. Crouch  
Cabinet Secretary

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## PREFACE

The Commission to Study Residential Placement of Children (Commission) was created in 2005. The Commission's purpose is to be the "mechanism to achieve systemic reform by which all of the state's child-serving agencies involved in the residential placement of at-risk youth jointly and continually study and improve upon this system and make recommendations to their respective agencies and to the Legislature regarding funding and statutory, regulatory and policy changes." These recommendations shall be used to "establish an integrated system of care for at-risk youth and families that make prudent and cost-effective use of limited state resources by drawing upon the experience of successful models and best practices in this and other jurisdictions, which focuses on delivering services in the least restrictive setting appropriate to the needs of the child, and which produces better outcomes for children, families and the state."

As required by West Virginia Code §49-2-125(d), and provided in this report, the Commission continues to study the following:

- The current practices of placing children out-of-home and into residential placements, with special emphasis of out-of-state placements;
- The adequacy, capacity, availability and utilization of existing in-state facilities to serve the needs of children requiring residential placements;
- Strategies and methods to reduce the number of children who must be placed in out-of-state facilities and to return children from existing out-of-state placements, initially targeting older youth who have been adjudicated delinquent;
- Staffing, facilitation and oversight of multidisciplinary treatment planning teams;
- The availability of and investment in community-based, less restrictive and less costly alternatives to residential placements;
- Ways in which up-to-date information about in-state placement availability may be made readily accessible to state agency and court personnel, including an interactive secure website;
- Strategies and methods to promote and sustain cooperation and collaboration between the courts, state and local agencies, families and service providers including the use of inter-agency memoranda of understanding, pooled funding arrangements and sharing of information and staff resources;
- The advisability of including no-refusal clauses in contracts with in-state providers for placement of children whose treatment needs match the level of licensure held by the provider;
- Identification of in-state service gaps and the feasibility of developing services to fill those gaps, including funding;
- Identification of fiscal, statutory and regulatory barriers to developing needed services in-state in a timely and responsive way;
- Ways to promote and protect the rights and participation of parents, foster parents and children involved in out-of-home care;
- Ways to certify out-of-state providers to ensure that children who must be placed out-of-state receive high quality services consistent with this state's standards of licensure and rules of operation; and
- Any other ancillary issue relative to foster care placement.

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## FOUNDATIONS OF CHANGE

### The Critical Issue

In West Virginia, about 85 percent of children in foster care come from homes with substance abuse. The drug epidemic is “the driving force in [the] child welfare crisis,” the West Virginia Department of Health and Human Resources (DHHR) said in a statement in February 2018.

“West Virginia is experiencing a child-welfare crisis that is being driven by the drug epidemic,” said Jeremiah Samples, DHHR Deputy Secretary. “We can't just react; we have to get in front of the problem.”

“Increased levels of substance abuse, including but not limited to opioids, have devastated many American families, and the child welfare system has felt the effects,” concludes a report by five researchers with the Office of the Assistant Secretary for Planning and Education (ASPE) of the U.S. Department of Health and Human Services.

A federal study published last year, which employed both statistical analyses and interviews with 188 child welfare professionals, found that on average, a 10 percent increase in a county's overdose death rate corresponded with a 4.4 percent increase in the rate at which children entered the foster care system.

Similarly, a 10 percent increase in a county's drug-related hospitalization rate was associated with a 2.9 percent increase in new entries into the foster care system.

A second briefing paper, stemming from a federal study, observed that substance abuse tended to correlate with “more complex and severe child welfare cases,” meaning, for instance, “higher degrees of child neglect” and “maltreatment.”

In such cases, caseworkers reported finding it more difficult to get parents “to comply with court orders” or to find “families to care for children because in many cases, multiple family members are misusing opioids.”

Leadership at the federal level offers some hope for stemming the flow of children into foster care. The Family First Prevention Services Act (FFPSA), passed in February 2018, will allow states to spend federal child welfare dollars on preventive efforts, such as substance abuse and mental health treatment programs, to keep families together.

The Commission's goal is to be proactive rather than reactive when it comes to West Virginia's families. Rather than picking up the pieces when a family has been separated, the Commission would like the family to remain whole while fixing the issues with potential to pull them apart. With passage of the FFPSA, this may be one step closer to meeting this goal for West Virginia families.

## **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, West Virginia Court Improvement Program and others to support its goals in the study of the residential placement of children.

Outside of the formal Commission meetings, members and 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 on goals of ensuring that needed, quality services are provided in, or as close as possible to, the community in which each child resides and improving the state's internal systems of care for all out-of-home children.

## **SYSTEM OF CARE GUIDING PRINCIPLES**

Since the first Commission to Study Residential Placement of Children's report in 2006 (Advancing New Outcomes: Findings, Recommendations, and Actions), the Commission has been guided by the System of Care Principles. The System of Care concept for children and adolescents with mental health challenges and their families was first published in 1986 (Straul & Friedman) and provided a definition for system of care along with a framework and philosophy to guide its implementation. Since then, the System of Care concept has shaped the work of nearly all jurisdictions across the nation. With the 25<sup>th</sup> anniversary and new insights emerging, the System of Care concept and philosophy have been updated. The System of Care concept explains how a child-serving system should function toward a framework for system reform based on a clear philosophy and value base.



## **Updated System of Care Concept and Philosophy**

### **DEFINITION**

#### **A system of care is:**

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network; builds meaningful partnerships with families and youth; addresses their cultural and linguistic needs; and helps to improve outcomes at home, in school, in the community, and throughout life.

### **CORE VALUES**

#### **Systems of care are:**

- Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Community-based, with the focus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

### **GUIDING PRINCIPLES**

#### **Systems of care are designed to:**

- Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
- Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
- Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
- Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
- Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
- Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management coordination and integrated care management.
- Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.



- Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
- Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
- Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
- Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
- Protect the rights of children and families and promote effective advocacy efforts.
- Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

Source: [www.wvsystemofcare.org](http://www.wvsystemofcare.org)

## **KEY ACCOMPLISHMENTS OF 2018**

During 2018, the Commission examined the requirements established by West Virginia Code §49-2-125(d). In conjunction with responsibilities set forth by state code, the Commission focused on the following priority goals for 2018: Transformational Collaborative Outcomes Management (TCOM); Provider Input at the Multidisciplinary Team (MDT) and Court Hearings; Implementation of Every Student Succeeds Act (ESSA) (focus on children in foster care); and Transitioning Youth Aging Out of Foster Care.

The following are the Commission's key accomplishments based on the Priority Goals for 2018 through the work of members and collaborative partners:

### **CURRENT PRACTICES OF PLACING CHILDREN OUT-OF-HOME AND INTO RESIDENTIAL PLACEMENTS, WITH SPECIAL EMPHASIS ON OUT-OF-STATE PLACEMENTS**

#### **U.S. Department of Justice**

In 2014, the U.S. Department of Justice (DOJ) initiated an investigation under Title II of the Americans with Disabilities Act (ADA) of West Virginia's service system for children with serious mental health conditions. The DOJ interviewed complainants and stakeholders in West Virginia, visited numerous treatment facilities, and reviewed documents over the course of its investigation.

On June 1, 2015, the DOJ notified West Virginia of its conclusion that West Virginia does not comply with Title II of the ADA. West Virginia disagrees with that conclusion but has offered several commitments to the DOJ to ensure compliance with the ADA.

Through the statewide expansion of DHHR's wraparound programs (currently known as Safe at Home West Virginia and Children's Mental Health Wraparound Program), Children's Mobile Crisis Response, Therapeutic Foster Family Care Continuum and Assertive Community Treatment, children will receive services in the most integrated setting appropriate to the needs of the individual.

DHHR provided several key pieces of data to the DOJ in 2017, and those data elements were brought current again during discussions with the DOJ in the Fall of 2018.

### **ADEQUACY, CAPACITY, AVAILABILITY AND UTILIZATION OF EXISTING IN-STATE FACILITIES TO SERVE THE NEEDS OF CHILDREN REQUIRING RESIDENTIAL PLACEMENTS**

#### **Safe at Home West Virginia**

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 to 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 on wraparound community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.

Some of the most common successes achieved by youth and families as reported by stakeholders in interviews in August 2018 were: improved grades and school attendance, improved behavior or emotional regulation, youth sobriety, youth taking responsibility for themselves, healthier family and peer relationships, living in a safer location, increased parenting skills, and achieving permanency.

Local Coordinating Agencies did particularly well in developing high quality Wraparound and Crisis Safety Plans, where the content of those plans demonstrated a strong adherence to the wraparound model.

At twelve months, Safe at Home youth were more likely to have returned home from congregate care than youth from the historical comparison group; spend less amount of time in congregate care than do the matched comparison youth, and at a statistically significant rate; and more likely to return to their home county than youth in the historical matched comparison group.

When youth do need to enter foster care, Safe at Home youth are more likely to be placed in a relative home, and at a statistically significant rate. Safe at Home youth are also more likely to reunify as compared to cohorts at a statistically significant rate.

## **STRATEGIES AND METHODS TO REDUCE THE NUMBER OF CHILDREN WHO MUST BE PLACED IN OUT-OF-STATE FACILITIES AND TO RETURN CHILDREN FROM EXISTING OUT-OF-STATE PLACEMENTS, INITIALLY TARGETING OLDER YOUTH WHO HAVE BEEN ADJUDICATED DELINQUENT**

### **Transformational Collaborative Outcomes Management (TCOM)**

Transformational Collaborative Outcomes Management (TCOM) is a framework that includes the philosophy, strategies and tools to address the needs of those served by youth placed in out-of-state facilities or returning from existing out-of-state placements. TCOM includes a structured assessment that directly informs service/intervention planning which includes the Family Advocacy and Support Tool (FAST), the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA). The TCOM tools provide effective decision-making at every level of the system because it involves a shared understanding of the current needs and strengths of children, youth, and caregivers.

The WV FAST will support effective interventions with the entire family and be utilized by the DHHR Youth Service Workers who are involved with the Youth Services Program. The WV CANS will be utilized when a child is being placed out-of-home and utilized typically by service providers.

In 2018, the following was continued:

- Experts Training (training-the-trainers);
- Automated certification process;
- All DHHR Youth Service Workers trained on the use of the WV CANS and received annual certification/recertification;
- The CANS Algorithms used for decisions for placement and treatment in the Safe at Home West Virginia wraparound program, the Regional Clinical Reviews and the Out-of-State Clinical Reviews; and

- Promoted the Family First Prevention Services Act (FFPSA), the TCOM model for Youth Service staff that include a Family Assessment (WV FAST) and the Case Plan to identify both the child as a "candidate" and specified services as required by FFPSA.

### **Regional Clinical Review Teams, Out-of-State Review Teams, and Conference Calls**

The Regional Clinical Review Process is a coordinated effort to provide a comprehensive and coordinated clinical review of designated youth. The process has several steps to assure that the review is objective, thorough, and includes a standardized assessment tool utilized in all reviews. The role of the review process is to identify what the youth's current treatment and permanency needs are and serve as a resource to the youth's individual Multidisciplinary Team (MDT).

The goal is to determine that the type and level of services matches the treatment and permanency needs by evaluating that:

- The care being provided meets the youth's assessed need;
- The facility where the youth is placed has the program in place to meet the youth's need;
- The youth and family/legal guardian are involved in the treatment and their input is being considered in the treatment and discharge planning process;
- Discharge planning is occurring from the time of admission throughout the youth's treatment; and
- The identified discharge plan is detailed and specific and addresses continued treatment and permanency needs.

Each DHHR Region has one team consisting of community members that represent group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children's Mental Health Wraparound (WRAP), community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally. This team participates in Regional Clinical Review Teams, Out-of-State Review Teams and conference calls.

Regional Clinical Coordinators (RCC) assist and coordinate the activities of the Clinical Review Team/Process by establishing working relationships with community partners and ensuring that the Clinical Review Process is completed as outlined in the established protocols and timeframes. The RCCs also provide resource awareness and system navigation to families, probation staff, therapists, social workers, and other service providers responsible for developing individualized, person-centered treatment plans. RCC services are available to children and families regardless of the child's custodial status.

In 2017-18, there were 16 children reviewed by Regional Clinical Review Teams, 148 reviewed by Out-of-State Review Teams, and 98 reviewed via Conference Calls.

### **Bureau for Juvenile Services (BJS) Conference Call-Meetings**

Senate Bill 393 required DHHR to establish non-secure facilities for the rehabilitation of youth status offenders. Therefore, all youth who were status offenders at Robert Shell (a secured facility) had to be transitioned to an alternative placement. After a meeting regarding a youth whose IQ was 44, and in need of a specialized placement, the West Virginia Division of Corrections and Rehabilitation, Bureau for Juvenile Services (BJS) and other stakeholders began having conference call meetings on June 29, 2017, to discuss alternative placements for vulnerable children who have special needs and who have been placed within the Bureau for Juvenile Services. These calls have continued through 2018.

A total of 181 youth have been staffed. Thirteen of the 181 youth had duplicated reviews for a total of 168 unduplicated youth being reviewed. Currently there are 21 youth on the review list.

The ages of the youth are: youth 12 years and under (62); youth 13 to 14 years (64); youth 15 to 17 (54); and youth 18 years and older (1).

Placements: youth in-state (66); youth out-of-state (46); youth remaining in their own home with services (39); youth committed to Bureau (8).

A total of 106 youth were identified Intellectually/Developmentally Disabled. Forty-three were below an Intelligence Quotient (IQ) of 70; 41 were Borderline (70-85 IQ); and 22 were within the Autism Spectrum.

The weekly conference call participants include staff and administrators from Bureau for Juvenile Services; DHHR's Bureau for Children and Families Regional Directors (4); DHHR's Bureau for Behavioral Health; DHHR's Interstate Compact Placement of Children (ICPC) Central Office; DHHR's Bureau for Medical Services; PSIMED (mental health provider); Supreme Court of Appeals of West Virginia, Division of Probation and Division of Children and Juvenile Services; West Virginia Department of Education, Diversion and Transition Programs; child's probation officer; and child's primary DHHR worker.

## **STAFFING, FACILITATION AND OVERSIGHT OF MULTIDISCIPLINARY TREATMENT PLANNING TEAMS**

### **Provider Input at MDT and Court Hearings**

During 2018, DHHR's Bureau for Children and Families (BCF), and the Court Improvement Program (CIP) began addressing a concern regarding service providers not receiving notifications/having input at Multidisciplinary Treatment (MDT) meetings and Court Hearings. Although the lack of notifications to providers for MDT and Court Hearings appear to be isolated, BCF and CIP took the following steps:

- The DHHR staff were notified that notification to MDTs and Court are required and that when a provider cannot attend, the monthly reports by providers can be shared at MDT and Court Hearings to allow the provider to have input.
- The CIP and DHHR managers will develop a survey for DHHR staff to identify where MDTs are working well and where improvements are needed.

### **Educational Input at Multidisciplinary Treatment (MDT) Teams**

On May 2, 2018, a Memorandum signed by Honorable Gary Johnson, Administrative Director, Supreme Court of Appeals of West Virginia, Steven Paine, West Virginia State Superintendent of Schools, and Bill J. Crouch, Cabinet Secretary, West Virginia Department of Health and Human Resources (DHHR) and sent to West Virginia County Superintendents of Schools and DHHR Community Services Managers.

The Memorandum recognized the legal mandates and the importance for educators at the MDT meetings and a commitment for the notification and participation of school officials at Multidisciplinary Treatment Team meeting.

### **AVAILABILITY OF AND INVESTMENT IN COMMUNITY-BASED, LESS RESTRICTIVE AND LESS COSTLY ALTERNATIVES TO RESIDENTIAL PLACEMENTS**

#### **Bureau for Behavior Health, Children's Wraparound**

The Children's Mental Health Wraparound initiative of DHHR's Bureau for Behavioral Health (BBH) is modeled after the National Children's Wraparound Model and philosophy. The purpose of Children's Mental Health Wraparound is to prevent out-of-home placement of children with serious emotional disturbances and have them thrive at home with their families and in their schools and communities.

Currently, Children's Mental Health Wraparound services are provided in six counties (Cabell, Kanawha, Raleigh, Marion, Harrison, and Berkeley) by five agencies (Braley and Thompson/ResCare, National Youth Advocate Program, Necco, Pretera, and FMRS). In the State Fiscal Year 2018, the BBH Children's Mental Health Wraparound Program had 118 referrals. Of these, 43 were accepted into the Children's Wraparound Program. Of the 75 not accepted, 39 did not meet eligibility requirements, 18 were unable to be contacted after numerous attempts, 12 of the parents declined the voluntary services, and four were not accepted during a brief period of funding transition. Any referrals not accepted received recommendations and referrals for other services to help meet the family's needs.

The following are findings for Children's Mental Health Wraparound accepted cases:

- 24 or 52% are male;
- 16 or 35% are age 11 or younger;
- 4 or 9% have been adopted;
- 8 or 17% are in the care of a relative/guardian;
- 23 or 50 % of these accepted referrals were involved with DHHR's Child Protective Services;
- 11 or 24% of accepted referrals are children who have an intellectual/developmental disability (IDD) diagnosis in addition to a serious emotional disturbance (SED) diagnosis and are not eligible for IDD Waiver or have not applied for IDD Waiver;
- 6 or 13% have a diagnosis of Autism;
- 39 or 85% receive Medicaid; and
- 12 or 26% have a parent incarcerated or a parent with a history of incarceration.

The Children's Wraparound successfully maintained 41 or 89% of accepted children/youth who were at risk of placement in their homes and communities by providing individualized, strength-based, trauma-focused, community-based planning and intensive intervention that safely preserves family relationships and empowers children and families to help meet their own needs.

### **Family First Prevention Services Act (FFPSA)**

The FFPSA redirects federal Title IV-E funds to provide prevention services to keep children safely with their families and out of foster care. When foster care is needed, FFPSA allows federal reimbursement for care in family-based settings and certain residential treatment programs for children.

FFPSA program instructions include a list of services that will be reimbursable. These services are evidence-based (promising practices, supported, or well-supported). The services have not been rated yet, but 12 have been approved by the U. S. Department of Health and Human Services (DHHS), Administration for Children and Families (ACF), Children’s Bureau. This is important because 50% of expenditures must be in the well-supported category.

The following 12 prevention services and programs will be reviewed for the Clearing House:

#### **Mental Health**

- Parent-Child Interaction Therapy
- Trauma Focused-Cognitive Behavioral Therapy
- Multisystemic Therapy
- Functional Family Therapy

#### **Substance Abuse**

- Motivational Interviewing
- Multisystemic Therapy
- Families Facing the Future
- Methadone Maintenance Therapy

#### **In-Home Parent Skill-Based**

- Nurse-Family Partnership
- Healthy Families America
- Parents as Teachers

#### **Kinship Navigator Programs**

- Children Home Society of New Jersey Navigator Model
- Children’s Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (KINTech)
- DHHR statewide presentations to stakeholders regarding the implementation of the FFPSA

### **Expanded School Mental Health Approach (ESMHA)**

The Expanded School Mental Health Approach (ESMHA) is an integrated approach that builds on core services typically provided by schools. It is a three-tiered framework that includes the full continuum of mental health prevention, early intervention and treatment services. The four expected outcomes of this approach are reduced barriers to learning; improved academic performance; improved attendance; and improved school functioning/behavior. There are 40 ESMH sites in 20 counties.



### **Trauma Informed Elementary Schools (TIES)**

Trauma-Informed Elementary Schools (TIES) is a program designed to bring trauma-informed services to early elementary school classes, pre-K through grade 1. TIES is nationally recognized and research driven. The TIES program is funded by the Claude Worthington Benedum Foundation and DHHR's Bureau for Behavioral Health for the 2018-19 school year.

The goal of TIES is to bring early intervention to children who exhibit symptoms of chronic stress, or trauma, in the classroom, symptoms that interfere with the child's ability to learn, such as disruptive, defensive, or withdrawn behavior. Schools receive training; have a resource liaison available for consultation and parent education; and receive a therapeutic toolbox for the classroom.

For children in need of treatment, Crittenton can work collaboratively with the school and the child's family to build an integrated environment that helps the child develop self-regulation skills. Crittenton is currently partnering with elementary schools in Hancock, Ohio, Tyler and Wood counties. Sustainability planning is underway to extend TIES beyond the 2018-19 school year.

### **Children's Mobile Crisis Response**

Children's Mobile Crisis Response is currently in two pilot areas. United Summit Center serves Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur counties. FMRS serves Raleigh County and surrounding area in West Virginia.

The program links children and their families/caregivers to services in the community, involves families in treatment, and avoids unnecessary hospitalization or residential placement. The Children's Mobile Crisis Response has served 445 children/youth. Of the 928 crisis calls taken, 345 were managed by phone, 566 required an in-person response, 335 crisis plans were completed.

The Mobile Crisis Program will continue for another year through DHHR's Office of Drug Control Policy.

### **WAYS IN WHICH UP-TO-DATE INFORMATION ABOUT IN-STATE PLACEMENT AVAILABILITY MAY BE MADE READILY ACCESSIBLE TO STATE AGENCY AND COURT PERSONNEL, INCLUDING AN INTERACTIVE SECURE WEB SITE**

#### **Child Placement Network**

The West Virginia Child Placement Network (WVCPN) was launched in 2005 as a centralized resource for identifying daily placement availability for children when they cannot remain in their own homes. In August 2006, the WVCPN was awarded the 2006 State Information Technology Award in the Government to Government category. In January 2008, the "Facility Detail" screen added the placement criteria for IQ Range(s); accepted ages; mental; physical; and court-involved. In July 2010, the WVCPN "Daily Report" began featuring real-time data, export options, and the ability to refresh the data contained in the report to the current second. In February 2012, the provider type, "Transitional Living" was added. Currently, the WVCPN has 76 participating facilities. The WVCPN website address is <http://www.wvdhhr.org/wvcpn/>.

## **The West Virginia Adult Behavioral Health Placement Network**

The West Virginia Adult Behavioral Health Placement Network is a centralized resource for identifying daily availability of residential crisis, group home and treatment services across West Virginia for adults with mental health and/or substance abuse issues. There are currently 76 licensed service agencies that provide regular updates about bed vacancies, with additional detail about accepted ages, gender, and type of behavioral health challenge. The website also provides updates on new facilities or expansions in services as available. The website is intended to be a source of information for those seeking available resources throughout West Virginia. To access the West Virginia Adult Behavioral Health Placement Network, visit <http://www.wvdhhr.org/wvabhpn/>.

## **STRATEGIES AND METHODS TO PROMOTE AND SUSTAIN COOPERATION AND COLLABORATION BETWEEN THE COURTS, STATE AND LOCAL AGENCIES, FAMILIES AND SERVICE PROVIDERS INCLUDING THE USE OF INTER-AGENCY MEMORANDA OF UNDERSTANDING, POOLED FUNDING ARRANGEMENTS AND SHARING OF INFORMATION AND STAFF RESOURCES**

### **Implementation of Every Students Succeeds Act (ESSA): Focus on Foster Care Children**

A memorandum was provided to West Virginia County School Superintendents and DHHR Community Services Managers from the Honorable Gary Johnson, State Superintendent of Schools Steven L. Paine, and DHHR Cabinet Secretary Bill Crouch which stated, “It is imperative that school districts develop a protocol that works best for each county in adhering to ESSA, West Virginia law, and this commitment to our state’s children.”

The Education of Children in Out-of-Care Advisory Committee developed a guiding tool on conducting MDTs. Additionally, the agreement for the exchange of data as required by ESSA was finalized.

The West Virginia Department of Education (WVDE) is reviewing exemplary programs to close the gap for children in foster care.

In the 2017-18 school year, the WVDE, Office of Diversion and Transition Programs collected data from the following:

- 6,109 educational records with the DHHR, FACTS database for children in out-of-home (OOH) care
- 6,082 children had attendance records in WVEIS
- 3,023 children of the matches are assessment eligible (grades 3-8 and grade 11)
- 2,652 children had assessment records
- There were 369 missing assessment from eligible students

General Summative Assessment Results for grades 3-8 and grade 11 are measured by five categories: Exceeds Standard; Meets Standard; Partially Meets Standard; and Does Not Meet Standard.

- OOH student scores were lower in English/Language Arts and Mathematics for all grade levels (3-5<sup>th</sup> grade, 6-8<sup>th</sup> grade, and 11<sup>th</sup> grade).
- Proficiency Breakdown: Although most children in OOH care did not meet expectations, data indicated that some students did not take tests in English/Language Arts or Mathematics.

- The participation Rates for children in OOH care was lower in each area than English Language Learners (ELL), Low Socio-Economic Status (SES) and Special Education (SPED).
- Attendance Rates: OOH students were equal to Low SES and SPED at 92%. Whereas, all other students reflected 93% and ELL 95% participation rate.

In addition, the role of the local schools and the DHHR county offices, ensures collaboration, communication, and implementation of Every Students Succeeds Acts (ESSA). This is the responsibility of the DHHR Community Services Manager (CSM) and/or designee to ensure these partnerships are made and maintained.

### **The West Virginia Adult Drug Courts Program**

The West Virginia Adult Drug Courts (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 National Association of Drug Court Professionals, key ingredients of the Drug Court model (known as the Ten Key Components (NADCP, 1997) which became the core framework not only for Drug Courts but for most types of problem-solving court programs. The West Virginia ADC is operated 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.

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.

For State Fiscal Year 2018 the average annual cost per drug court participant was \$3,814 as compared to \$19,425 in the Regional Jail or \$26,081 in a Division of Corrections and Rehabilitation prison. These costs include intensive supervision, treatment, case management, and drug testing.

As of June 30, 2018, there were 28 operating ADC programs comprising 34 individual courts covering 46 counties.

### **The West Virginia Juvenile Drug Court Program**

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.

JDCs 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 protocol and procedures established by the Supreme Court of Appeals of West Virginia.

The program seeks to divert non-violent, juvenile offenders engaging substance abuse from the traditional juvenile court process to a non-adversarial, intensive, individualized outpatient substance

abuse treatment process which includes parental involvement and cooperation. All JDCs use evidence-based treatment approaches and assessments and are evaluated annually.

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.

For State Fiscal Year 2018, the average cost per youth was \$1,057. This cost includes intensive supervision and individualized treatment services and includes services to the family. This contrasts with the approximately \$110,000 annually in a residential or correctional facility placement. There were 291 participants served by the JDC programs for State Fiscal Year 2018.

As of June 30, 2018, there were 16 operational JDC programs.

## **THE ADVISABILITY OF INCLUDING NO-REFUSAL CLAUSES IN CONTRACTS WITH IN-STATE PROVIDERS FOR PLACEMENT OF CHILDREN WHOSE TREATMENT NEEDS MATCH THE LEVEL OF LICENSURE HELD BY THE PROVIDER**

### **No-Refusal Clauses**

In 2015, DHHR attempted to add “no-refusal” language in new contractual agreements. In 2015-16, litigation between DHHR and service providers who opposed these contractual changes resulted in a compromise to not include the “no-refusal” language at that time.

## **IDENTIFICATION OF IN-STATE SERVICE GAPS AND THE FEASIBILITY OF DEVELOPING SERVICES FILL THOSE GAPS, INCLUDING FUNDING**

### **Socially Necessary Services Redesign**

Socially Necessary Services (SNS) are services provided to children and families which are necessary to provide for the child’s safety, permanency and well-being, but are not covered through Medicaid. To build in accountability and control cost, the SNS program is being revised. The SNS Redesign will deliver the following:

- The most appropriate services to meet the needs of our children and families;
- Reunification and family preservation services are targeted;
- The cost of the services is controlled to only meet the needs of children and families; and
- Ensure appropriate monitoring and oversight of services and providers.

In 2018, the following was initiated as part of the SNS Redesign:

- DHHR entered into contracts with active SNS providers;
- A Gap Analysis was conducted of all SNS providers to gather information on what SNS services are being provided and where these services are located;
- A Request to Become an SNS Provider process was developed to ensure that potential SNS providers in the location and services are needed; and
- Providers choosing to become a SNS Provider will submit a packet of information/documentation to DHHR's Bureau for Children and Families, Office of Children and Adult Services, Regulatory Management Unit for approval prior to submitting an enrollment packet.

### **Transitioning Youth from Foster Care**

In 2018, the Commission to Study Residential Placement of Children, Service Delivery and Development (SDD) Workgroup updated the It's My Move wallet cards to include a scan code that links directly to the It's My Move website. The It's My Move website is a program that assists youth in gaining life skills to support them as they transition to adulthood. The website includes the Readily at Hand checklist of key documents and experiences needed as youth transition to adulthood. Youth can set up their own account, track their own progress, add notes, and save their information as they move through the checklist.

The following related goals are underway or have been achieved:

- Readily at Hand, <http://www.itsmymove.org/rah.php>, is an online and printable checklist of essential skills and experiences and links to information about needed documents. Updates to the website are currently underway.
- Youth who are transitioning to adulthood are provided the desk guide and wallet card for the It's My Move website, [www.ItsMyMove.org/raf.php](http://www.ItsMyMove.org/raf.php). The wallet cards have been updated to include a scan code that links to It's My Move and Readily at Hand.

## **IDENTIFICATION OF FISCAL, STATUTORY AND REGULATORY BARRIERS TO DEVELOPING NEEDED SERVICES IN-STATE IN A TIMELY AND RESPONSIVE WAY**

### **Office of Drug Control Policy**

In 2017, House Bill 2620 was signed into law creating the Office of Drug Control Policy (ODCP). Under the direction of DHHR Cabinet Secretary Bill J. Crouch, the ODCP leads development of all programs and services related to the prevention, treatment and reduction of substance use disorder, in coordination with DHHR's Bureaus and other state agencies. The goal of the ODCP is to maximize funds to fight substance and opioid abuse. The ODCP wishes to expand neonatal centers (i.e., Lily's Place) to support mothers and babies born addicted to substances and opioids and develop treatment beds for substance use disorder through the Medicaid waiver.

## **West Virginia Service Array (Family Resource Networks; Community Collaboratives; and Child Welfare Oversight/Collaborative)**

The 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. FRNs provide indirect services, including managing, supervising, and coordinating a variety of programs and initiatives in their respective community. The FRNs work with the Family Resource Centers where direct services are provided.

The FRNs assist the multi-county Community Collaborative Groups and Regional Summits to identify existing services and service gaps in the community.

Community Collaborative Groups identify needs of the children and families in their community. When a need is identified, the Community Collaborative will first seek to meet that need within their community and in partnership with community providers and service agencies. If a service or group of services is not available to meet the identified need, the Collaborative group is expected to forward the request to the Regional Summit to identify any resources in the area that lie outside the Community Collaborative Group's scope. If, after collaborating with the Regional Summit, a service is identified that cannot be met at the DHHR regional level, the Regional Summit will communicate that need to the chair of the DHHR, Child Welfare Oversight team.

## **WAYS TO PROMOTE AND PROTECT THE RIGHTS AND PARTICIPATION OF PARENTS, FOSTER PARENTS AND CHILDREN INVOLVED IN OUT-OF-HOME CARE**

### **Support for Kinship Providers/Relatives**

DHHR is looking at implementing a program, such as the Kinship Navigator Program, to provide support for Kinship Providers/Relatives. The Kinship Navigator Program will help caregivers "navigate" other forms of government assistance, short-term expenses for the relative child, and technical support through the process of Kinship Legal Guardianship if the caregiver wishes to make a legal commitment to the child.

## **WAYS TO CERTIFY OUT-OF-STATE PROVIDERS TO ENSURE THAT CHILDREN WHO MUST BE PLACED OUT-OF-STATE RECEIVE HIGH QUALITY SERVICES CONSISTENT WITH THIS STATE'S STANDARDS OF LICENSURE AND RULES OF OPERATION**

### **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.

The following summary outlines the 2018 out-of-state monitoring visits. While violations are noted, each facility also had positive programming aspects and is working on weaknesses through corrective action plans:

- **Hermitage Hall**, Nashville, TN – This was a return visit completed in January 2018. The facility was previously reviewed in November 2016 and since that time had four requests for investigations. Educational weaknesses identified included teacher certification issues; wide spans of grade levels in elementary and middle grade classrooms; lack of Career Technical Education (CTE) options; lack of structure leading to excessive restraints; no continuum of services for students with disabilities; expired IEPs; scheduling issues; and confusion about the rights of parents who retain educational rights.
- **Devereux**, Viera, FL – The review was completed in March 2018. No major violations were found – Devereux has a very low turnover rate of employees with many in the school and on the treatment team employed for more than 20 years. Strengths identified include teachers are certified in special education; classrooms are observed four times per week through observation rooms; excellent technology availability and use; lesson plans are standard-based and contain quality instruction; educational field trips are provided monthly; and outdoor recreation opportunities are provided for students. A change in Florida State Standards no longer requires CTE coursework to graduate. Therefore, Devereux currently has no CTE programming in place where formerly they had an on-site cosmetology program. The facility administration was encouraged to develop partnerships for students to participate in community-based opportunities for work experience and career planning.
- **George Junior Republic**, Grove City, PA – A follow-up visit was conducted in March 2018. A DHHR team along with one WVDE representative visited George Junior to determine progress since the placements to this facility were suspended in January 2015. The team had the same concerns after the visit regarding treatment of WV youth, details of programming and attitude towards feedback and discussion regarding changes that should be considered.
- **Timber Ridge**, Winchester, Virginia – A review was completed in May 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, Transition Services, including a focus on the lack of CTE offerings, and Notification to Transition Specialist of Upcoming Discharges to provide support and planning with the home county in West Virginia.
- **Natchez Trace**, Waverly, TN – A review was completed in September 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, provision of FERPA training to school staff, and Notification to Transition Specialist of Upcoming Discharges.
- **Foundations for Living**, Mansfield, Ohio – A review was completed November 2018 (reports pending). Weaknesses identified include no CTE programs offered due to acute care in self-harm, trafficking, drug and alcohol treatment, and mental health concerns.



## CONCLUSION

Thirteen years ago, the West Virginia Legislature tasked the Commission to Study Residential Placement of Children to “achieve systemic reform of the residential placement of at-risk youth” and to “continually study, improve and make recommendations to the West Virginia Legislature and other stakeholders regarding funding, statutory, regulatory and policy changes.”

This report represents the commitment of the Commission toward meeting these standards. It is an in-depth look at the goals, progress and collaboration with various groups to move forward with positive change and development for West Virginia children and families. The Commission continues to prioritize the needs of West Virginia children and their families in decision-making, which ultimately produces better outcomes for children, families and the state.

## APPENDIX A

### 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:
  - Group Residential Care
  - Psychiatric Facility (long-term)
  - 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.

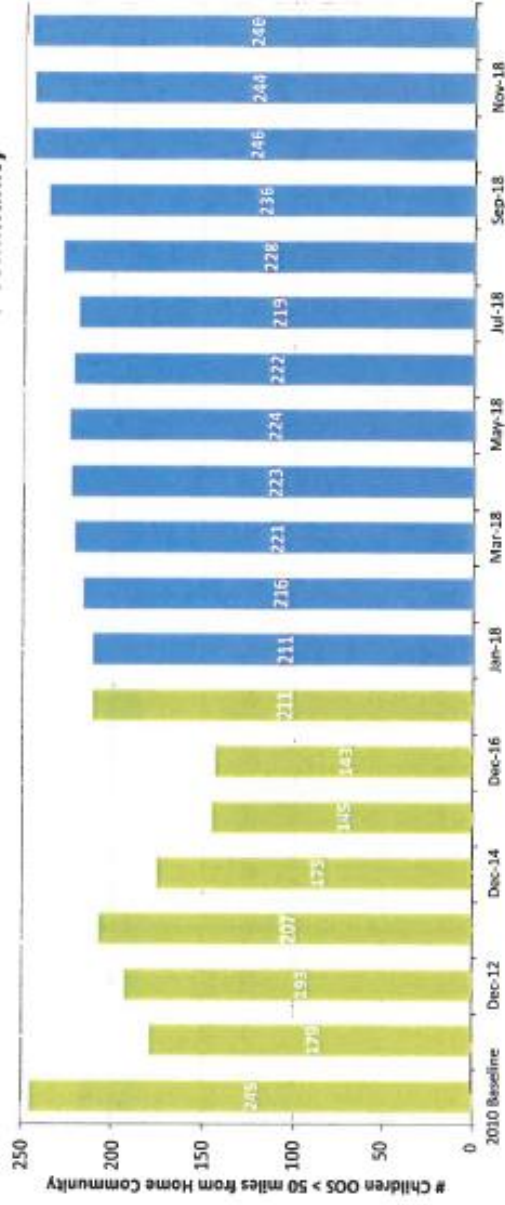
Data is extracted each month based on updated information in FACTS to provide a point-in-time analysis referred to as the Performance Scorecard (the final Scorecard for 2018 is found on the next page). Though the population of young people being monitored by the Commission is necessarily limited, the ongoing work of the Commission 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.

## West Virginia Commission to Study Residential Placement of Children Performance Scorecard

June 2018

Out-of-Home Placements	Group Residential Care	Psychiatric Facility (Long Term)	Psychiatric Facility (Short Term)	Total
<b>In State</b>	<b>627</b>	<b>58</b>	<b>30</b>	<b>715</b> (73%)
< 50 miles from Home Community <b>A</b>	254	19	13	286 (29%)
> 50 miles from Home Community <b>C</b>	373	39	17	429 (44%)
<b>Out of State</b>	<b>214</b>	<b>53</b>	<b>1</b>	<b>268</b> (27%)
< 50 miles from Home Community <b>B</b>	40	6	0	46 (5%)
> 50 miles from Home Community <b>D</b>	174	47	1	222 (23%)
<b>Total</b>	<b>841</b>	<b>111</b>	<b>31</b>	<b>983</b> (100%)

**Out-of-State Placements >50 miles from Home Community**



## West Virginia Commission to Study Residential Placement of Children Performance Scorecard

June 2018

Out-of-Home Placements	Group Residential Care	Psychiatric Facility (Long Term)	Psychiatric Facility (Short Term)	Total
<b>In State</b>	<b>627</b>	<b>58</b>	<b>30</b>	<b>715</b> 73%
< 50 miles from Home Community <b>A</b>	254	19	13	286 29%
> 50 miles from Home Community <b>C</b>	373	39	17	429 44%
<b>Out of State</b>	<b>214</b>	<b>53</b>	<b>1</b>	<b>268</b> 27%
< 50 miles from Home Community <b>B</b>	40	6	0	46 5%
> 50 miles from Home Community <b>D</b>	174	47	1	222 23%
<b>Total</b>	<b>841</b>	<b>111</b>	<b>31</b>	<b>983</b> 100%

\*\*

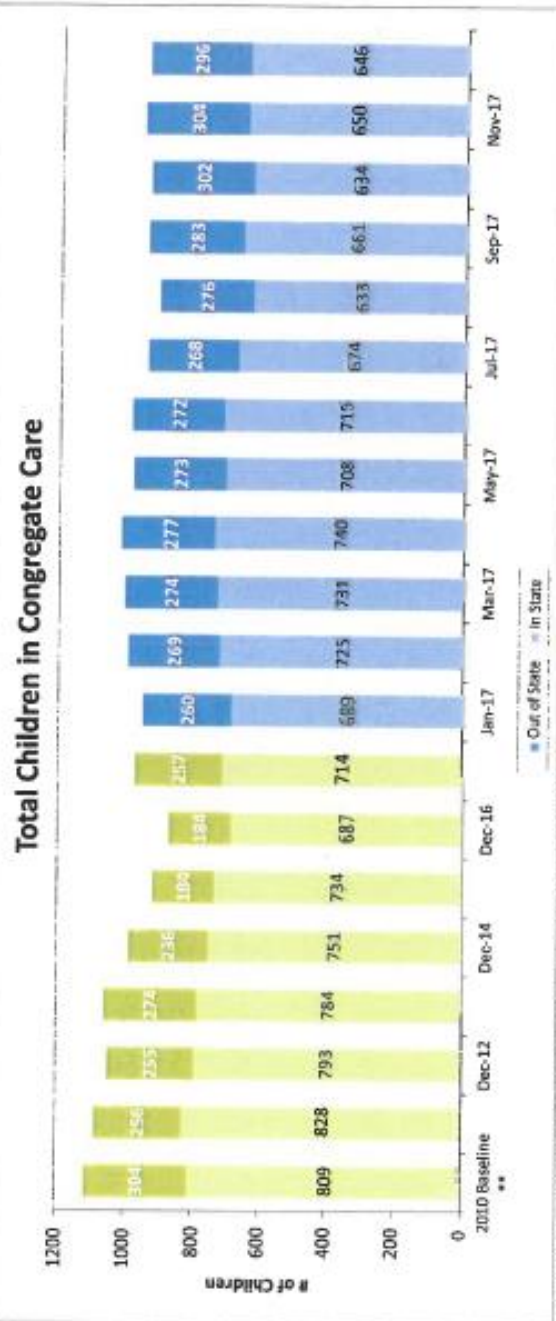


\* The improvement target for 2017 is to have less than 129 children placed out-of-state and greater than 50 miles from their home community  
 \*\* Baseline is the average of October, November and December of 2010

## West Virginia Commission to Study Residential Placement of Children Performance Scorecard

June 2018

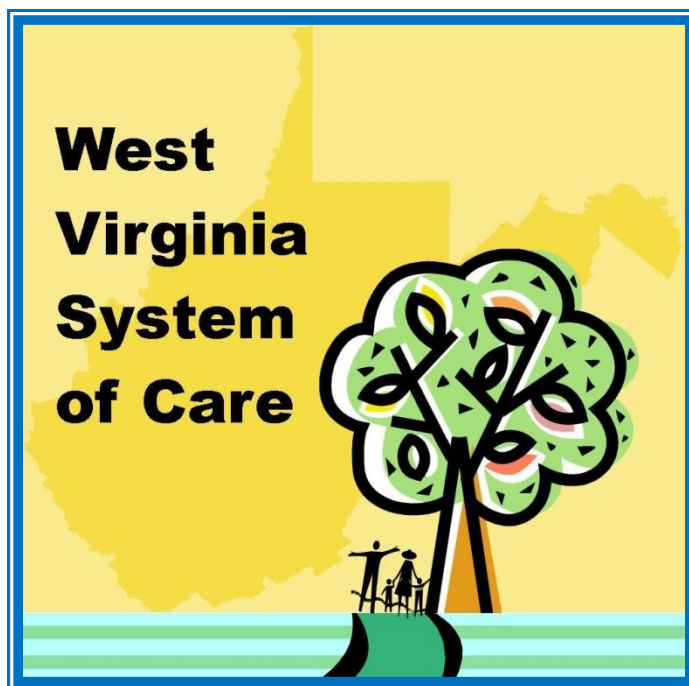
Out-of-Home Placements	Group Residential Care		Psychiatric Facility (Long Term)		Psychiatric Facility (Short Term)		Total
<b>In State</b>		<b>627</b>	<b>58</b>	<b>30</b>	<b>715</b>	<b>73%</b>	
< 50 miles from Home Community	<b>A</b>	254	19	13	286	29%	
> 50 miles from Home Community	<b>C</b>	373	39	17	429	44%	
<b>Out of State</b>		<b>214</b>	<b>53</b>	<b>1</b>	<b>268</b>	<b>27%</b>	
< 50 miles from Home Community	<b>B</b>	40	6	0	46	5%	
> 50 miles from Home Community	<b>D</b>	174	47	1	222	23%	
<b>Total</b>		<b>841</b>	<b>111</b>	<b>31</b>	<b>983</b>	<b>100%</b>	



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

## APPENDIX B

### Out-of-State Youth Statistics October 2018



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

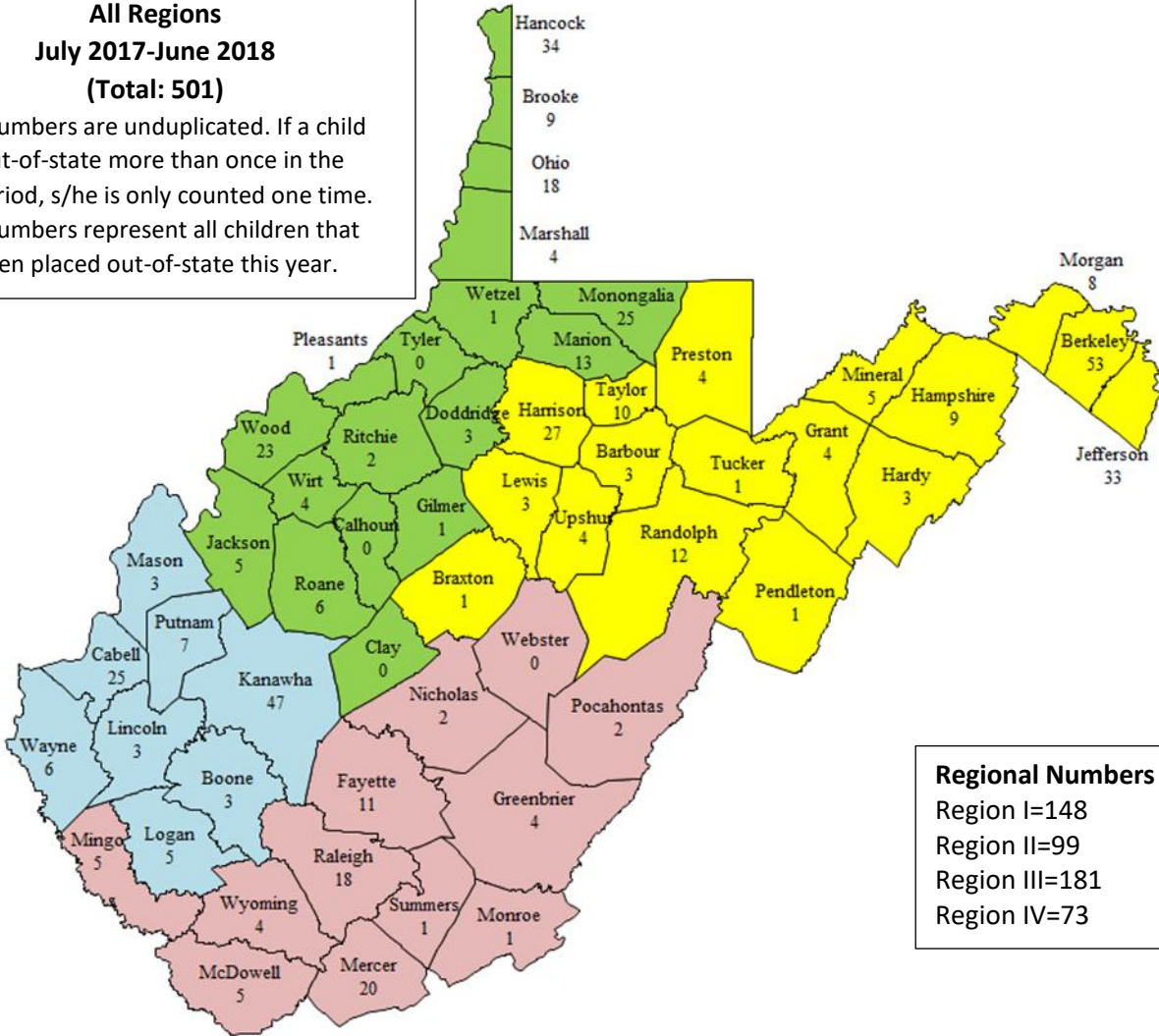
This report covers youth in state's custody who are out-of-state in group residential facilities, psychiatric residential treatment facilities, and specialized foster care.



## Youth in Out-of-State Placement

**Out-of-State Youth  
All Regions  
July 2017-June 2018  
(Total: 501)**

These numbers are unduplicated. If a child went out-of-state more than once in the time period, s/he is only counted one time. These numbers represent all children that have been placed out-of-state this year.



**Regional Numbers**  
 Region I=148  
 Region II=99  
 Region III=181  
 Region IV=73



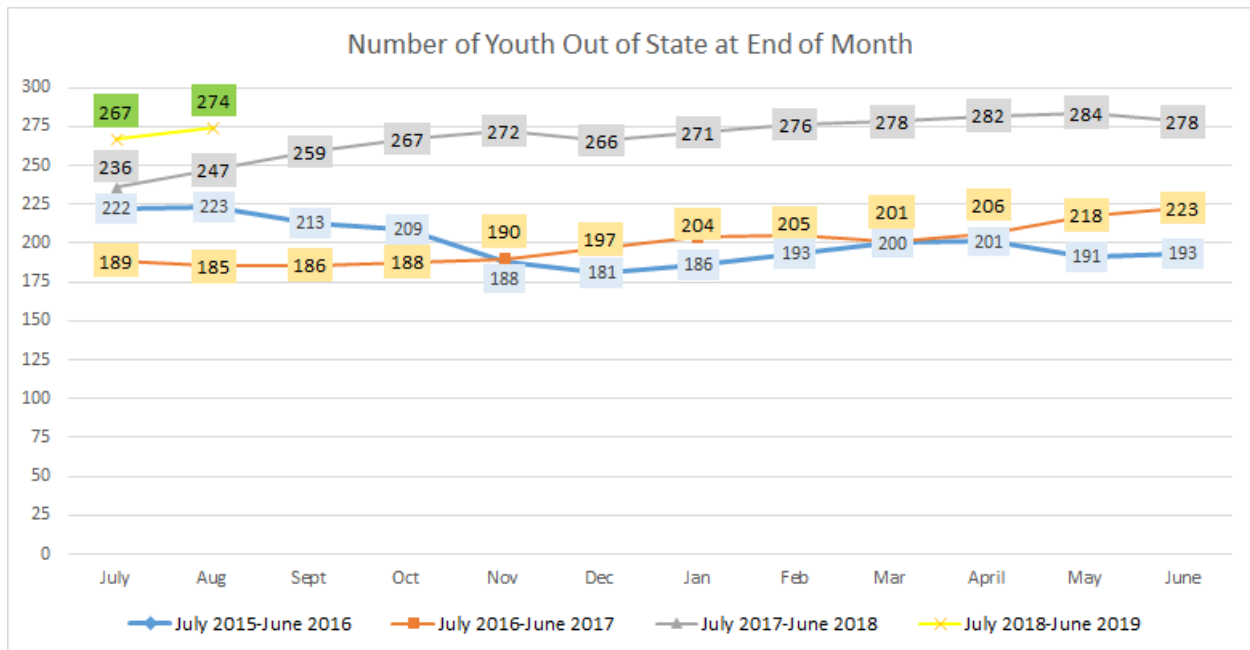
## Annual Numbers

	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014	2012-2013
State Total	501	415	425	477	492	533

## Monthly Count

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

- 2017-2018: 268
- 2016-2017: 199
- 2015-2016: 204
- 2014-2015: 270
- 2013-2014: 292



## Out-of-State Youth Demographics, July 2017-June 2018

Gender	Males: 382 (76%)    Females: 119 (24%)
Age at placement OOS	10 years old or younger: 31 (6%) 11-14 years old: 161 (32%) 15-17 years old: 280 (56%) 18 years old or older: 29 (6%)
<b>Information below is from 414 youth</b>	
State Wards	49 (12%)
Adopted Youth	49 (12%)
Intellectual Disabilities	Mild or Moderate IDD: 64(15%) Autism (low and high functioning): 32 (8%) Borderline Intellectual Functioning: 47 (11%) Total: 143 youth (35%)
Sex Offenders	Without an Intellectual Disability: 30 (7%) With an Intellectual Disability: 20 (5%)
Sexual Behaviors	105 (25%)
Adjudicated Delinquents	190 (46%) Charges only: 46 (11%)
Adjudicated Status Offenders	80 (19%) Charges only: 20 (5%)
Substance Abuse	106 (26%)

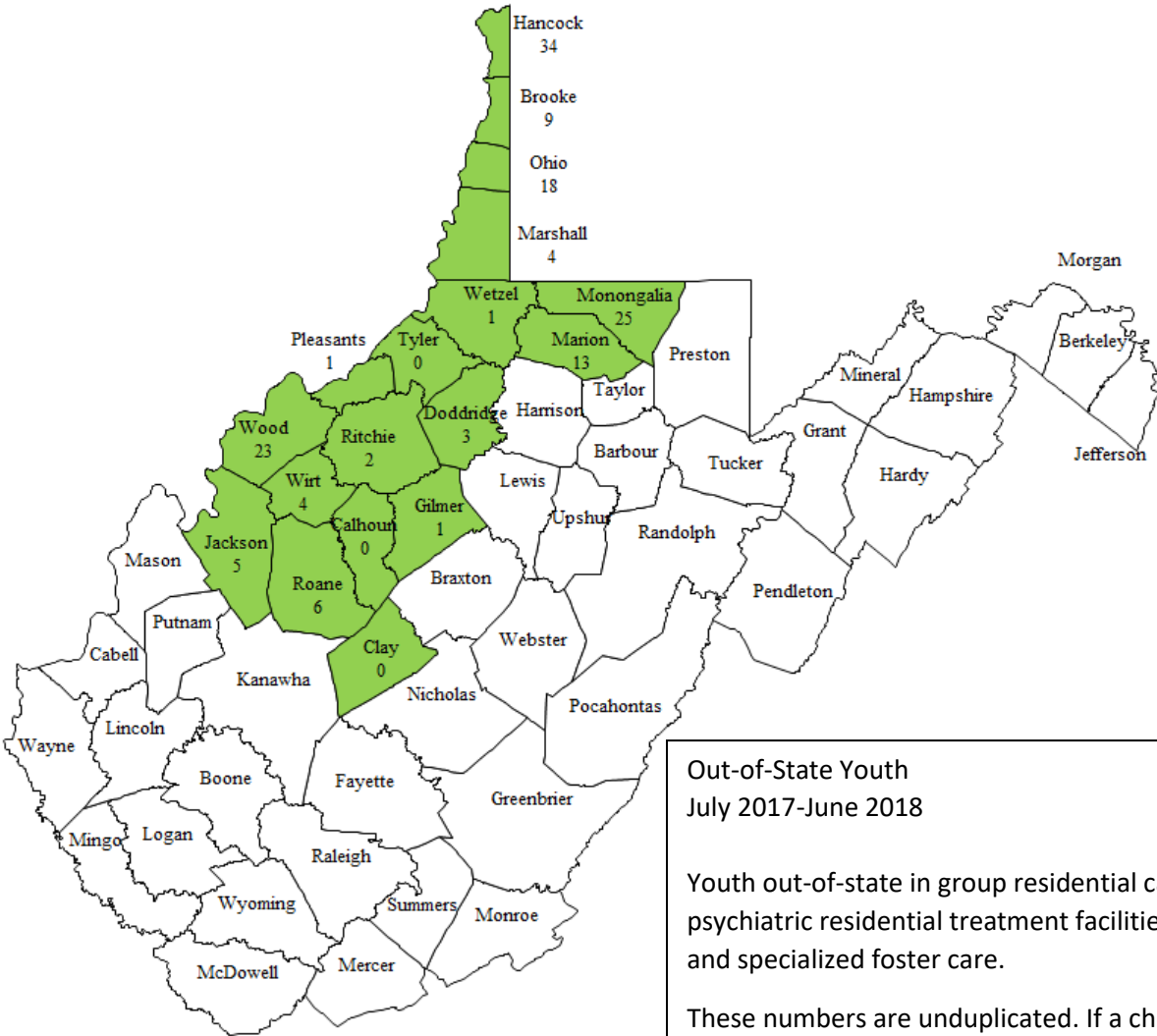
### Review of Youth

Each region has one team. This team participates in conference calls, Regional Clinical Review Teams, Out-of-State Review Teams and conference calls. These teams consist of community members representing group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children’s Mental Health Wraparound (WRAP), community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

# of Kids Reviewed in 2017-2018	Regional Clinical Review Teams	Out-of-State Review Teams	Conference Call
<b>Region I</b>	1	27	21
<b>Region II</b>	15	33	49
<b>Region III</b>	0	67	2
<b>Region IV</b>	0	21	26
<b>State Total</b>	<b>16</b>	<b>148</b>	<b>98</b>

# Regional Reports

**Region I**  
**July 2017-June 2018**



**Out-of-State Youth**  
**July 2017-June 2018**

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

These numbers are unduplicated. If a child went out-of-state more than once in the time period, s/he is only counted one time. These numbers represent all children that have been placed out-of-state this year.

**2017-2018: 148**

**2016-2017: 107**

**2015-2016: 104**

## Out-of-State Youth Demographics, July 2017-June 2018

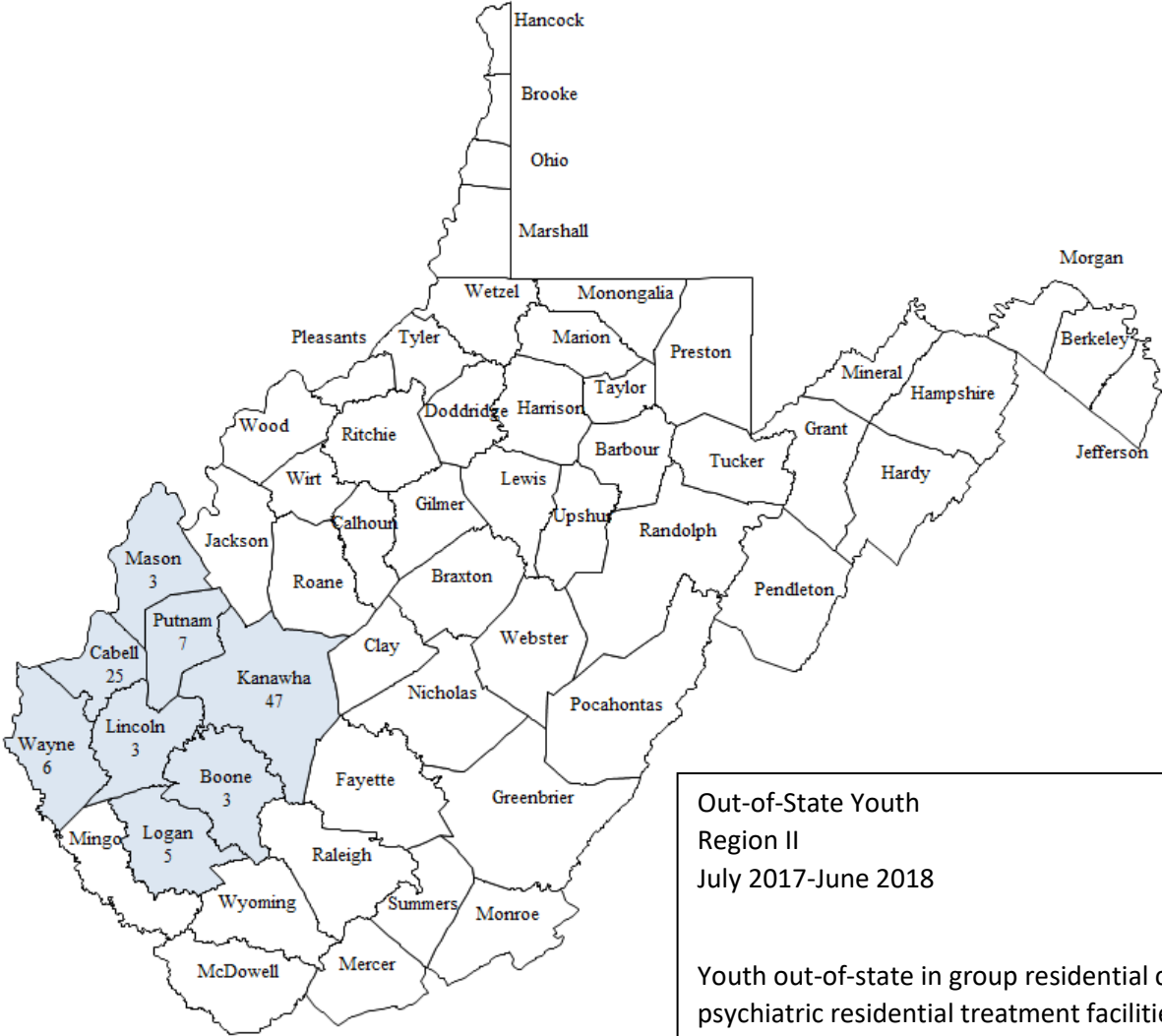
Gender	Males: 115 (77%)    Females: 33 (23%)
Age at placement OOS	10 years old or younger: 9 (6%) 11-14 years old: 49 (33%) 15-17 years old: 80 (54%) 18 years old or older: 10 (7%)
<b>Information below is from 137 youth</b>	
State Wards	11 (8%)
Adopted Youth	9 (7%)
Intellectual Disabilities	Mild or Moderate IDD: 20 (15%) Autism (low and high functioning): 6 (4%) Borderline Intellectual Functioning: 17 (12%) Total: 43 youth (31%)
Sex Offenders	Without an Intellectual Disability: 11 (8%) With an Intellectual Disability: 6 (4%)
Sexual Behaviors	37 (27%)
Adjudicated Delinquents	59 (43%) Charges only: 24 (18%)
Adjudicated Status Offenders	20 (15%) Charges only: 2 (1%)
Substance Abuse	39 (28%)

### Review of Youth

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 representing group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children’s Mental Health Wraparound (WRAP), community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

# of Kids Reviewed in 2017-2018	Regional Clinical Review Teams	Out-of-State Review Teams	Conference Call
<b>Region I</b>	1	27	21

**Region II**  
**July 2017-June 2018**



**Out-of-State Youth**  
**Region II**  
**July 2017-June 2018**

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

These numbers are unduplicated. If a child went out-of-state more than once in the time period, s/he is only counted one time. These numbers represent all children that have been placed out-of-state this year.

**2017-2018: 99 youth**

**2016-2017: 68 youth**

**2015-2016: 65 youth**

## Out-of-State Youth Demographics, July 2017-June 2018

Gender	Males: 72 (73%)    Females: 27 (27%)
Age at placement OOS	10 years old or younger: 6 (6%) 11-14 years old=36 (36%) 15-17 years old: 56 (57%) 18 years old or older: 1 (1%)
<b>Information below is from 85 youth</b>	
State Wards	9 (11%)
Adopted Youth	11 (13%)
Intellectual Disabilities	Mild or Moderate IDD: 19 (22%) Autism (low and high functioning): 11 (13%) Borderline Intellectual Functioning: 14 (16%) Total: 44 youth (51%)
Sex Offenders	Without an Intellectual Disability: 7 (8%) With an Intellectual Disability: 8 (9%)
Sexual Behaviors	21 (25%)
Adjudicated Delinquents	30 (32%) Charges only: 8 (10%)
Adjudicated Status Offenders	22 (26%) Charges only: 9 (5%)
Substance Abuse	14 (16%)

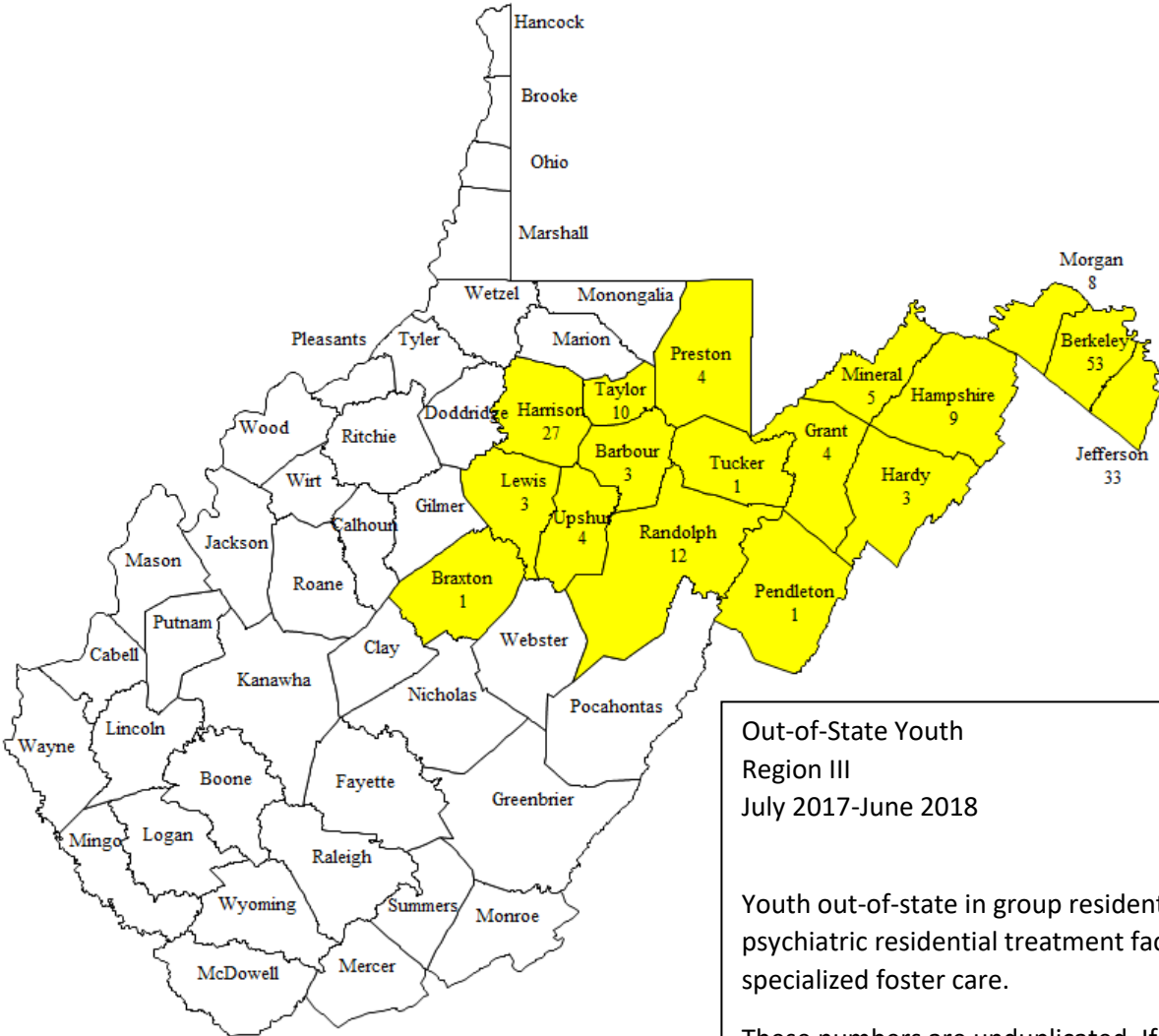
### Review of Youth

Each region has one team. This team participates in conference calls, Regional Clinical Review Teams, Out-of-State Review Teams and conference calls. These teams consist of community members representing group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children’s Mental Health WRAP, community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

# of Kids Reviewed in 2017-2018	Regional Clinical Review Teams	Out-of-State Review Teams	Conference Call
<b>Region II</b>	15	33	49



**Region III**  
**July 2017-June 2018**



Out-of-State Youth  
Region III  
July 2017-June 2018

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

These numbers are unduplicated. If a child went out-of-state more than once in the time period, s/he is only counted one time. These numbers represent all children that have been placed out-of-state this year.

**2017-2018: 181 youth**

**2016-2017: 177 youth**

**2015-2016: 175 youth**

## Out-of-State Youth Demographics, July 2017-June 2018

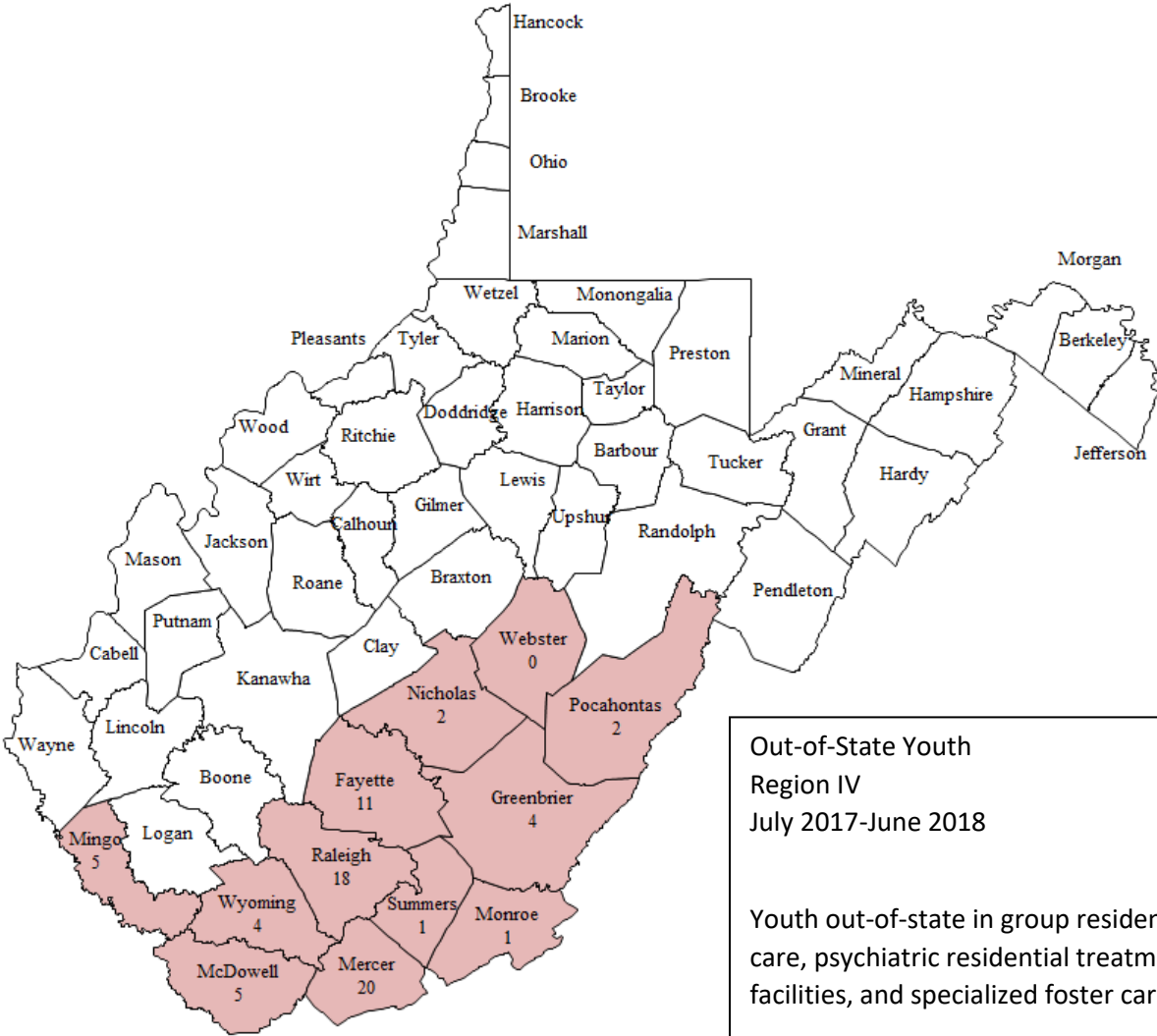
Gender	Males: 138 (76%)    Females: 43 (24%)
Age at placement OOS	10 years old or younger: 16 (9%) 11-14 years old: 56 (31%) 15-17 years old: 102 (56%) 18 years old or older: 7 (4%)
<b>Information below is from 134 youth</b>	
State Wards	18 (13%)
Adopted Youth	20 (15%)
Intellectual Disabilities	Mild or Moderate IDD: 15 (11%) Autism (low and high functioning): 8 (6%) Borderline Intellectual Functioning: 12 (9%) Total: 35 youth (26%)
Sex Offenders	Without an Intellectual Disability: 8 (6%) With an Intellectual Disability: 5 (4%)
Sexual Behaviors	28 (21%)
Adjudicated Delinquents	73 (54%) Charges only: 10 (7%)
Adjudicated Status Offenders	27 (20%) Charges only: 9 (7%)
Substance Abuse	35 (26%)

### Review of Youth

Each region has one team. This team participates in conference calls, Regional Clinical Review Teams, Out-of-State Review Teams and conference calls. These teams consist of community members representing group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children’s Mental Health WRAP, community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

# of Kids Reviewed in 2017-2018	Regional Clinical Review Teams	Out-of-State Review Teams	Conference Call
Region III	0	67	2

**Region IV**  
**July 2017-June 2018**



**Out-of-State Youth**  
**Region IV**  
**July 2017-June 2018**

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

These numbers are unduplicated. If a child went out-of-state more than once in the time period, s/he is only counted one time. These numbers represent all children that have been placed out-of-state this year.

**2017-2018: 73 youth**

**2016-2017: 63 youth**

**2015-2016: 81 youth**

## Out-of-State Youth Demographics, July 2017-June 2018

Gender	Males: 57 (78%)      Females: 16 (22%)
Age at placement OOS	10 years old or younger: 6 (8%) 11-14 years old: 20 (27%) 15-17 years old: 42 (58%) 18 years old or older: 5 (7%)
<b>Information below is from 58 youth</b>	
State Wards	11 (19%)
Adopted Youth	9 (16%)
Intellectual Disabilities	Mild or Moderate IDD: 10 (17%) Autism (low and high functioning): 6 (10%) Borderline Intellectual Functioning: 4 (7%) Total: 20 youth (34%)
Sex Offenders	Without an Intellectual Disability: 4 (7%) With an Intellectual Disability: 1 (2%)
Sexual Behaviors	19 (33%)
Adjudicated Delinquents	28 (53%) Charges only: 4 (7%)
Adjudicated Status Offenders	11 (19%) Charges only: 1 (2%)
Substance Abuse	18 (31%)

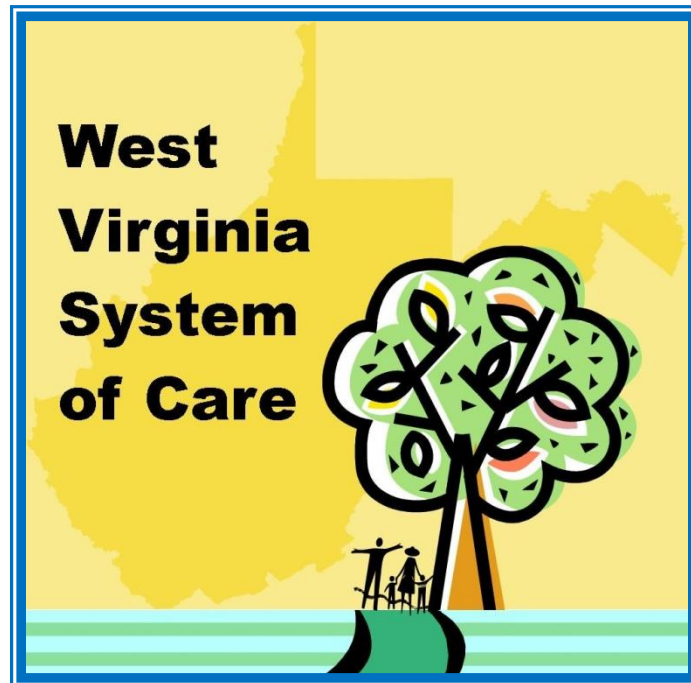
### Review of Youth

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 representing group residential facilities, psychiatric residential treatment facilities and acute care hospitals, treatment foster care, Safe at Home and Children’s Mental Health WRAP, community mental health centers, and agencies working with youth with intellectual disabilities. Individuals with expertise in certain areas may be called upon occasionally.

# of Kids Reviewed in 2017-2018	Regional Clinical Review Teams	Out-of-State Review Teams	Conference Call
<b>Region IV</b>	0	21	26

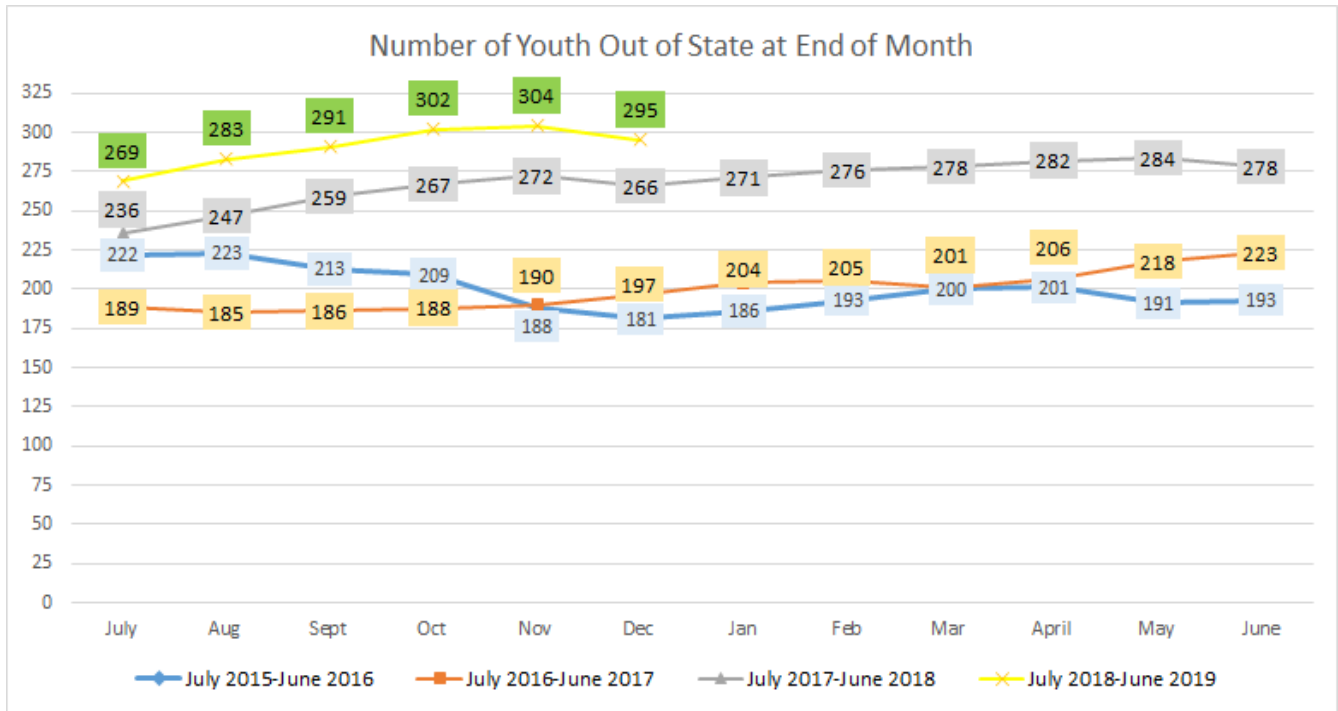
# Out-of-State Youth July 2018-June 2019 Monthly Stats (December 2018)

Prepared by Tammy Pearson, Marshall University



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

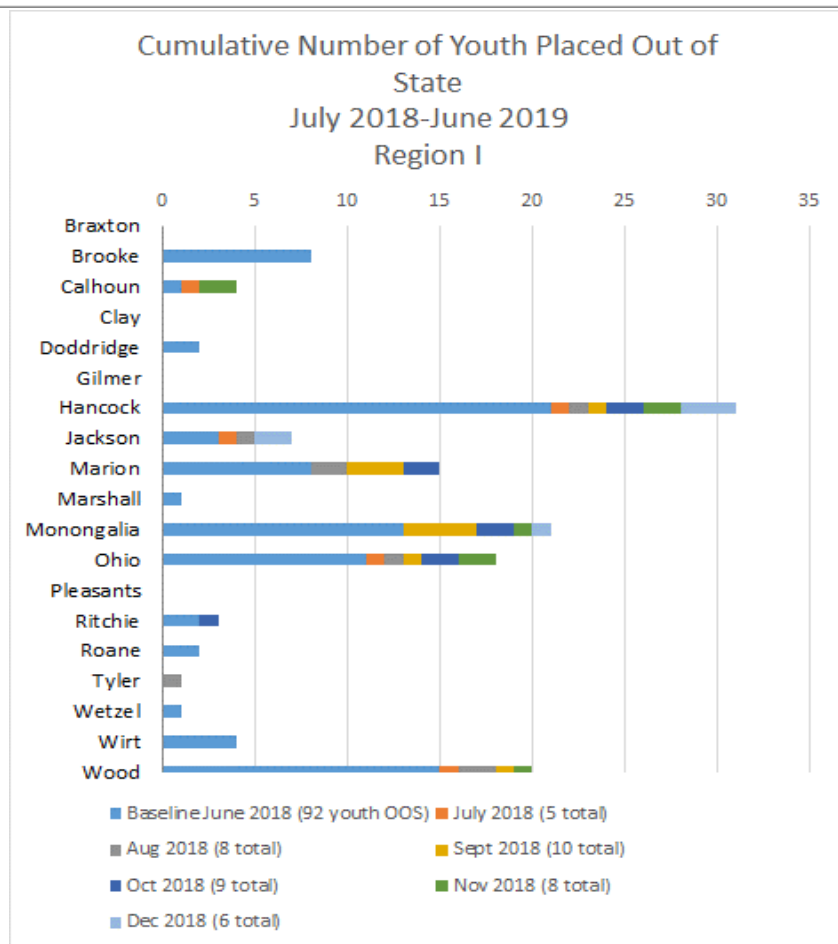
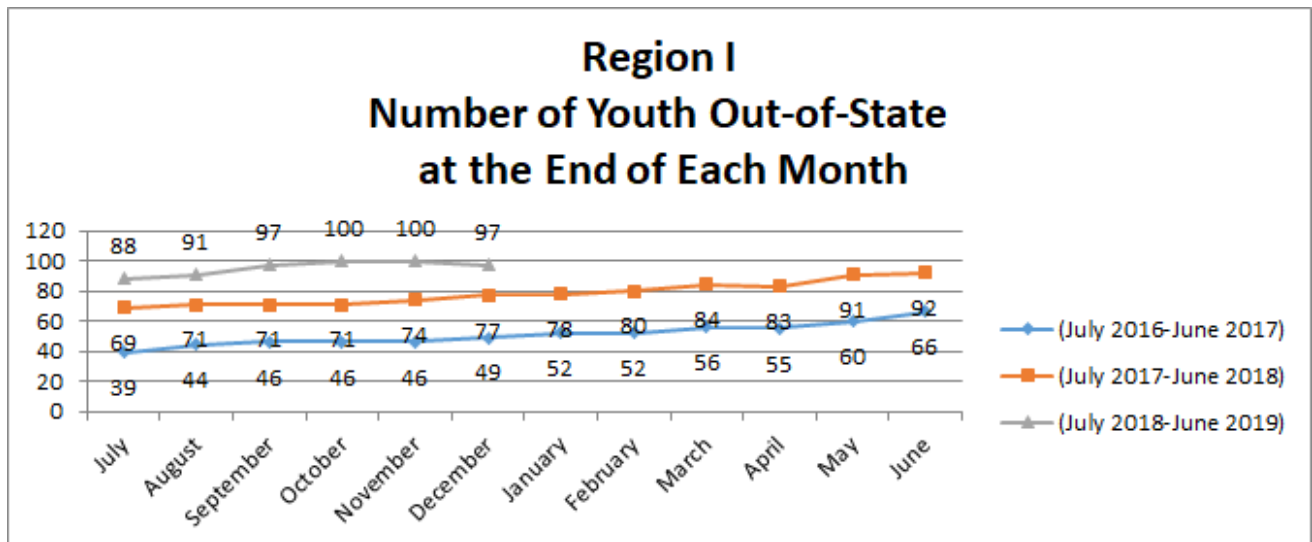
## Statewide Out-of-State Youth



## Out-of-State Youth Demographics, December 31, 2018

Total Number on December 31, 2018: 295	
Gender	Males: 224 (76%)      Females: 71 (24%)
Age	10 years old or younger: 18 (6%) 11-14 years old: 91 (31%) 15-17 years old: 155 (53%) 18 years old or older: 31 (10%)
Information below is from 188 youth	
State Wards	31 (16%)
Adopted Youth	21 (11%)
Intellectual Disabilities	Mild or Moderate IDD: 57 (30%) Autism (low and high functioning): 13 (7%) Borderline Intellectual Functioning: 15 (8%) Total: 85 youth (45%)
Sex Offenders	Without an Intellectual Disability: 14 (7%) With an Intellectual Disability: 11 (6%)
Sexual Behaviors	62 (33%)
Adjudicated Delinquents	69 (34%) Charges only: 19 (10%)
Adjudicated Status Offenders	32 (17%) Charges only: 4 (2%)
Substance Abuse	31 (16%)

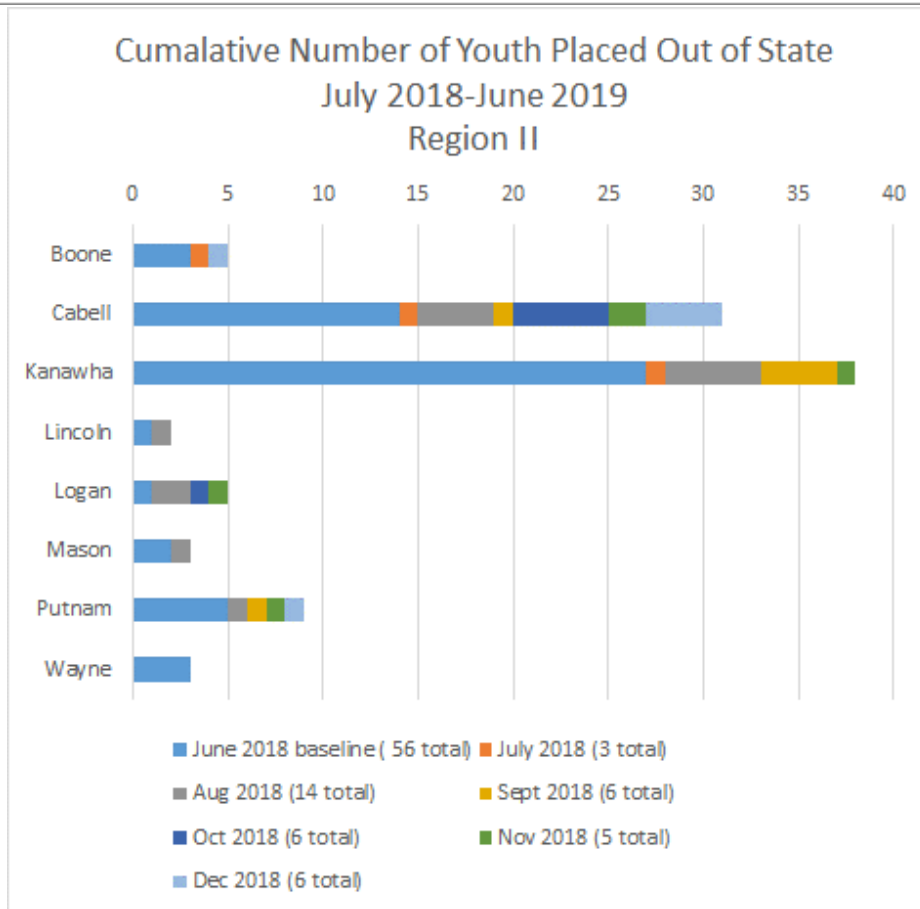
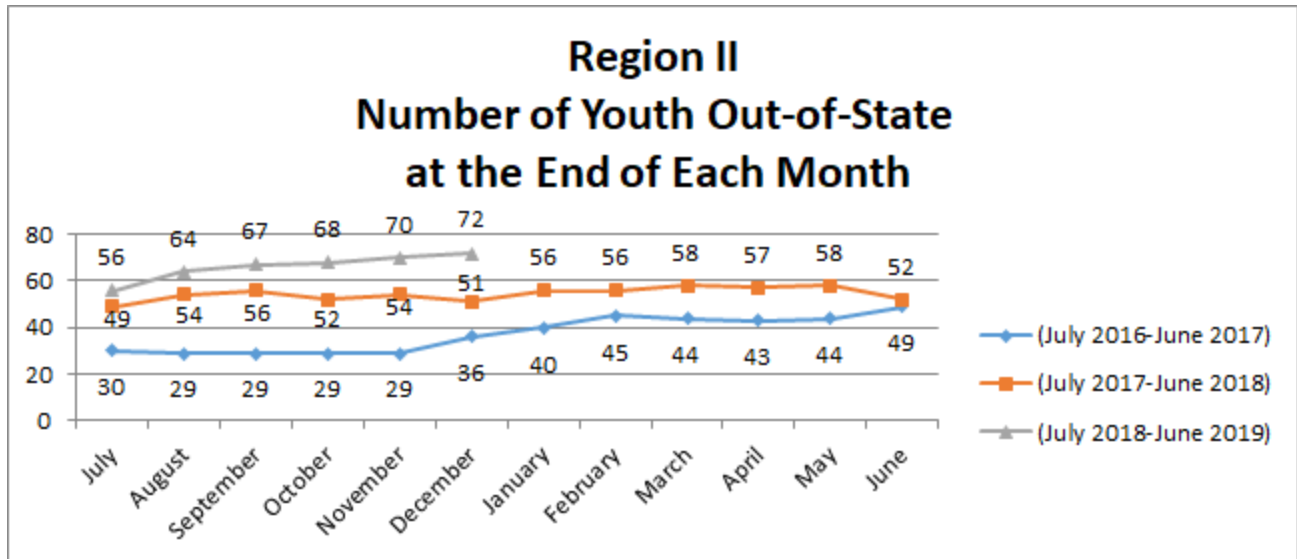
## Region I Out-of-State Youth



<b>Region I Total Number on December 31, 2018: 97</b>	
Gender	Males: 72 (74%)    Females: 25 (26%)
Age	10 years old or younger: 6 (6%) 11-14 years old: 26(27%) 15-17 years old: 52 (54%) 18 years old or older: 13 (13%)
<b>Information below is from 68 youth</b>	
State Wards	7 (7%)
Adopted Youth	3 (3%)
Intellectual Disabilities	Mild or Moderate IDD: 15 (15%) Autism (low and high functioning): 3 (3%) Borderline Intellectual Functioning: 9 (9%) Total: 27 youth (28%)
Sex Offenders	Without an Intellectual Disability: 6 (6%) With an Intellectual Disability: 5 (5%)
Adjudicated Delinquents	27 (27%) Charges only: 10 (10%)
Adjudicated Status Offenders	5 (5%) Charges only: 1 (1%)
Substance Abuse	12 (12%)

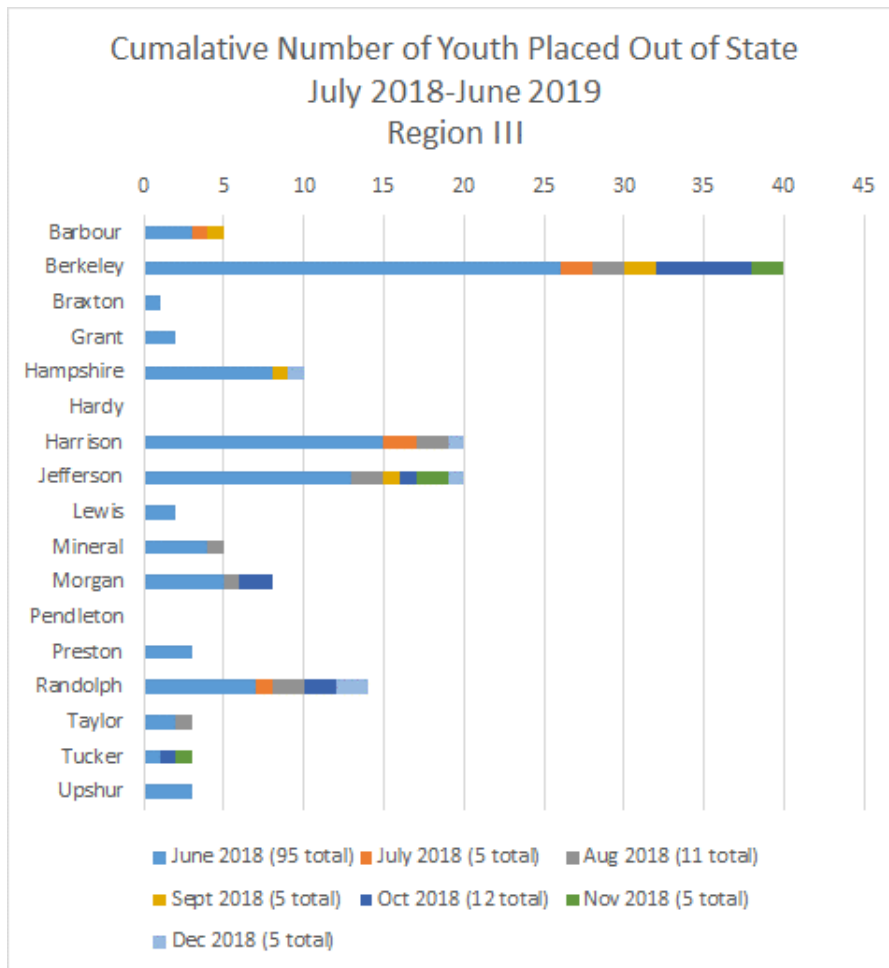
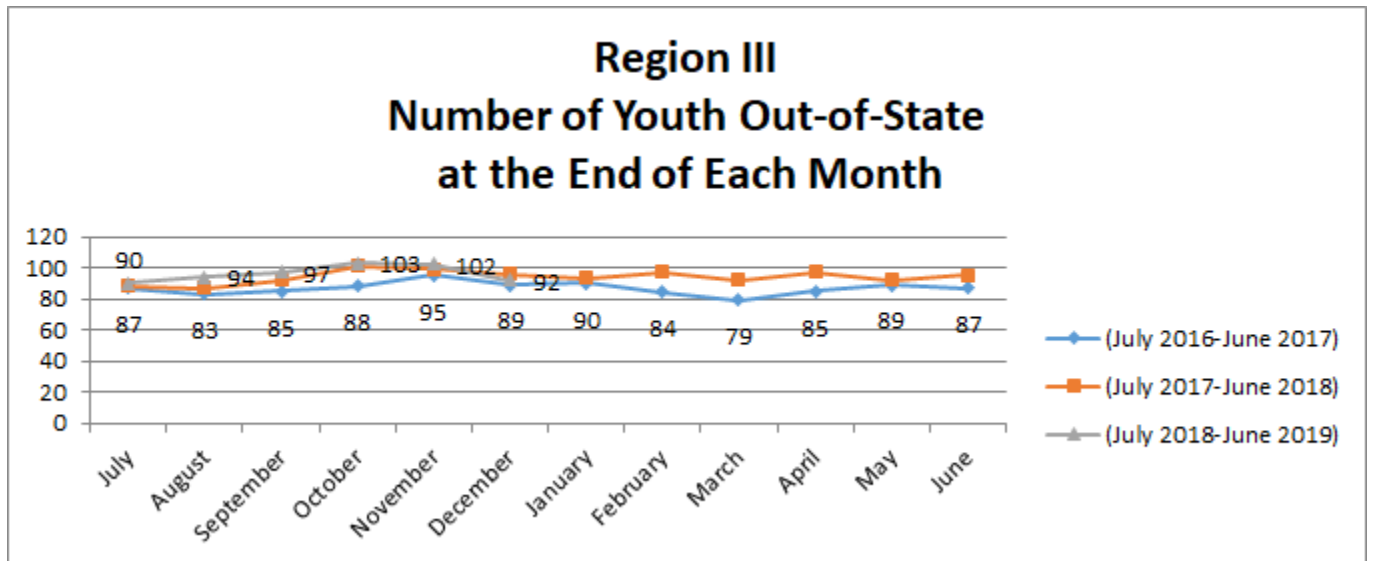


## Region II Out-of-State Youth



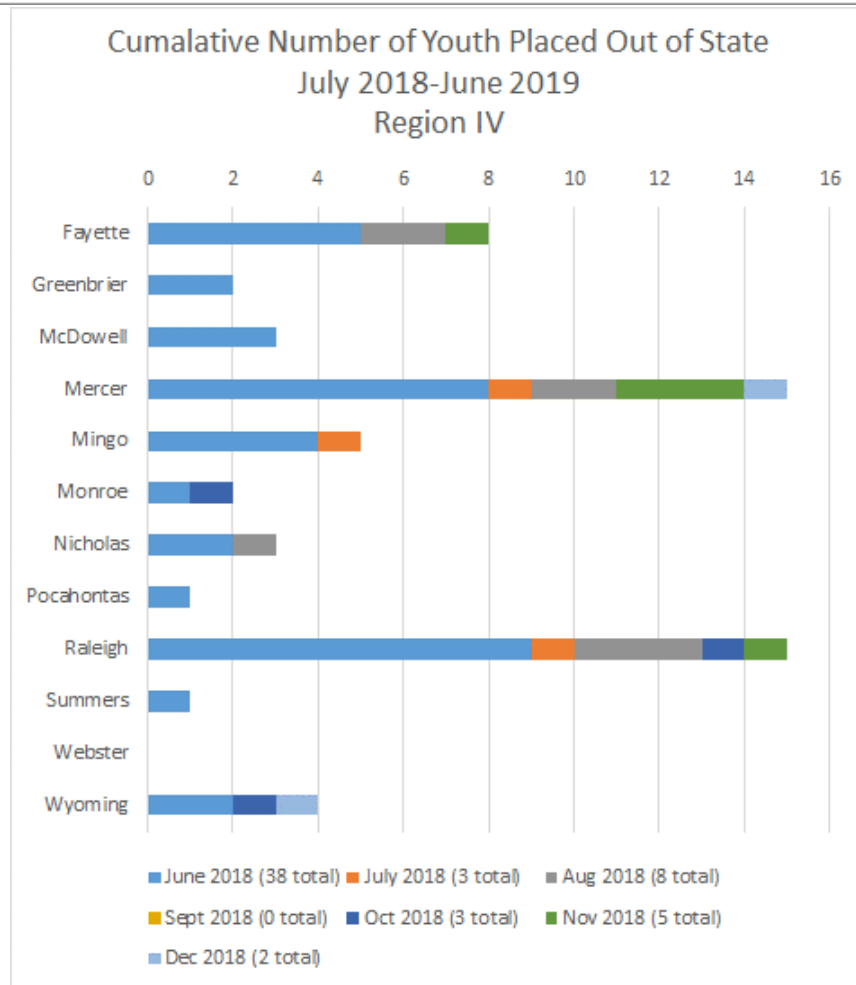
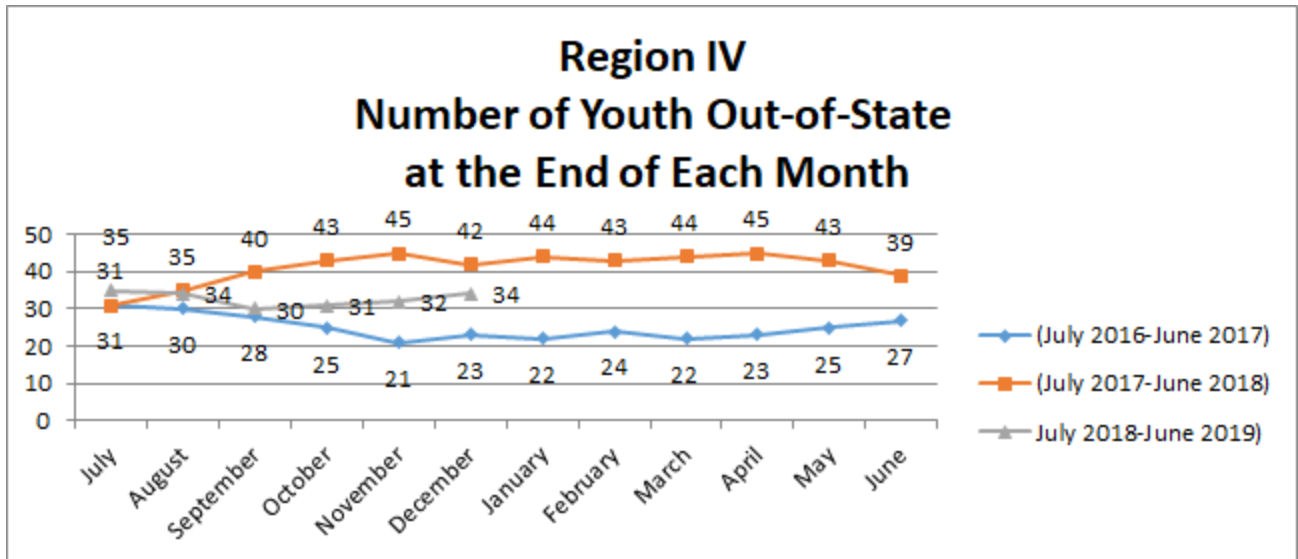
<b>Region II Total Number on December 31, 2018: 72</b>	
Gender	Males: 53 (74%)    Females: 19(26%)
Age	10 years old or younger: 6 (8%) 11-14 years old: 26 (36%) 15-17 years old: 35 (49%) 18 years old or older: 5 (7%)
<b>Information below is from 54 youth</b>	
State Wards	8 (15%)
Adopted Youth	7 (13%)
Intellectual Disabilities	Mild or Moderate IDD: 21 (39%) Autism (low and high functioning): 4 (7%) Borderline Intellectual Functioning: 3 (6%) Total: 28 youth (52%)
Sex Offenders	Without an Intellectual Disability: 1 (2%) With an Intellectual Disability: 4 (7%)
Sexual Behaviors	15 (28%)
Adjudicated Delinquents	14 (26%) Charges only: 4 (7%)
Adjudicated Status Offenders	12 (22%) Charges only: 1 (2%)
Substance Abuse	8 (15%)

**Region III  
Out-of-State Youth**



<b>Region III Total Number on December 31, 2018: 92</b>	
Gender	Males: 75 (82%) Females: 17 (18%)
Age	10 years old or younger: 5 (5%) 11-14 years old: 24 (27%) 15-17 years old: 51 (55%) 18 years old or older: 12 (13%)
<b>Information below is from 42 youth</b>	
State Wards	9 (21%)
Adopted Youth	9 (21%)
Intellectual Disabilities	Mild or Moderate IDD: 10 (24%) Autism (low and high functioning): 4 (10%) Borderline Intellectual Functioning: 3 (7%) Total: 17 youth (40%)
Sex Offenders	Without an Intellectual Disability: 4 (10%) With an Intellectual Disability: 2 (5%)
Sexual Behaviors	14 (33%)
Adjudicated Delinquents	18 (43%) Charges only: 4 (10%)
Adjudicated Status Offenders	8 (19%) Charges only: 2 (5%)
Substance Abuse	6 (14%)

## Region IV Out-of-State Youth

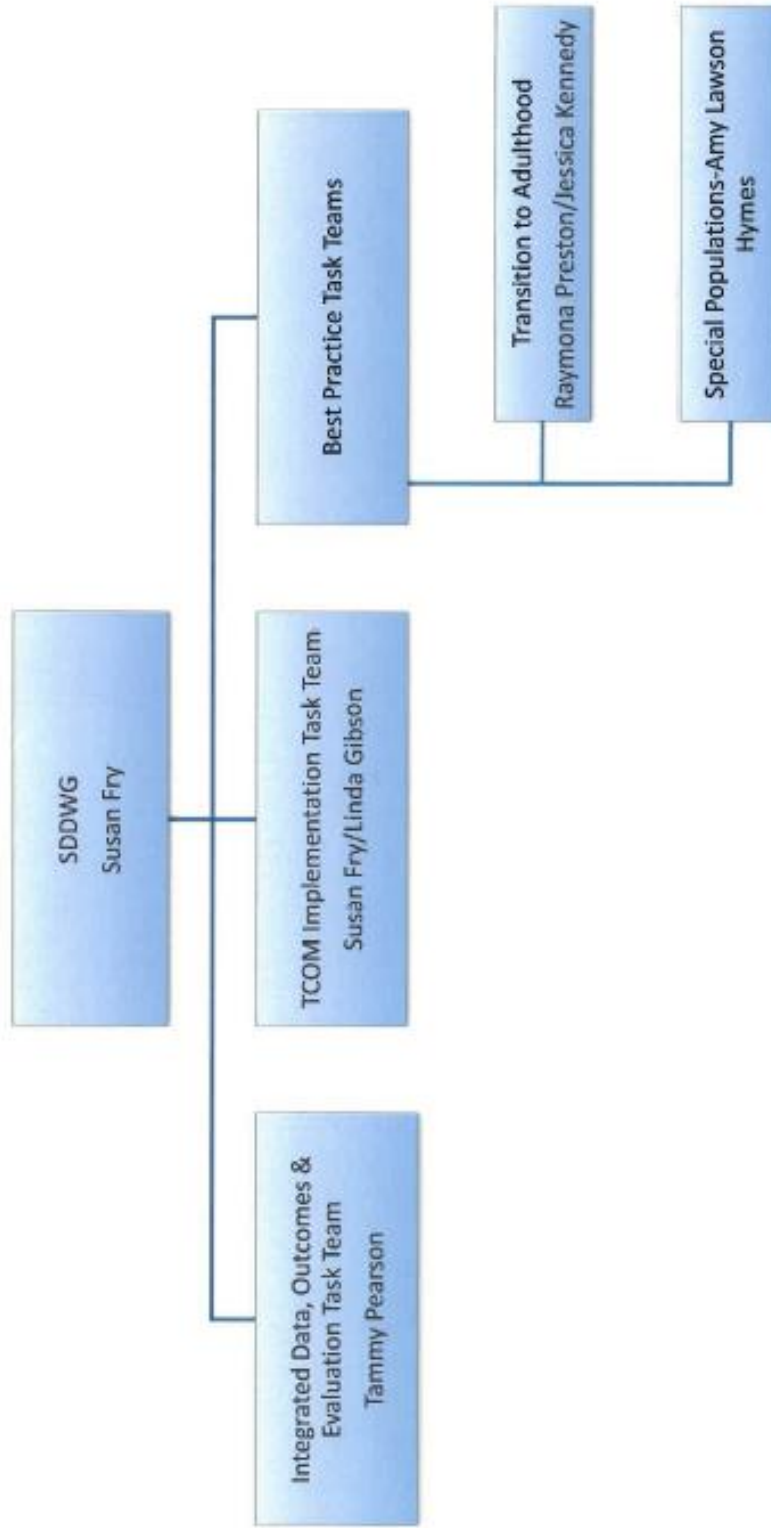


<b>Region IV Total Number on December 31, 2018: 34</b>	
Gender	Males: 24 (71%)    Females: 10 (29%)
Age	10 years old or younger: 1 (3%) 11-14 years old: 15 (44%) 15-17 years old: 17 (50%) 18 years old or older: 1 (3%)
<b>Information below is from 24 youth</b>	
State Wards	7 (39%)
Adopted Youth	2 (8%)
Intellectual Disabilities	Mild or Moderate IDD: 8 (33%) Autism (low and high functioning): 2 (8%) Borderline Intellectual Functioning: 0 (0%) Total: 10 youth (41%)
Sex Offenders	Without an Intellectual Disability: 3 (13%) With an Intellectual Disability: 0
Sexual Behaviors	11 (46%)
Adjudicated Delinquents	10 (42%) Charges only: 1 (4%)
Adjudicated Status Offenders	7 (29%) Charges only: 0
Substance Abuse	5 (21%)

## **APPENDIX C**

# **SERVICE DELIVERY & DEVELOPMENT**

# Service Delivery & Development Work Group





1. Susan Fry - Chair – Stepping Stones, Inc. \*
2. Raymona Preston – Stepping Stones, Inc. \*
3. Karen Yost – Protera
4. Lisa Zappia –Pretera
5. Linda Watts - WV DHHR-BCF - 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 Heldroth – WV DHHR – BCF Region I RPM
14. Christa James–WV DHHR-BCF Region I CWC
15. – WV DHHR – BCF Region II
16. Amy Lawson Hynes\* – WV DHHR-BCF – Deputy Commissioner
17. Charles Batch – ResCare
18. Beth Morrison - WVDHHR-BHHP
19. Mark Allen– Burlington United Methodist Family Services
20. Debi Gillespie- Bureau of Juvenile Services, DCR
21. Mindy Thornton – Necco
22. Tammy Pearson\* – Marshall University
23. Agnie Vic – River Park Hospital
24. Katrina Harmon – WVCCA Executive Director
25. Linda Gibson – WVDHHR-BCF \*
26. Gary Keen – WVDHHR – BCF
27. Amy Rickman – Necco
28. Jason Deussenbery - Necco
29. Lorie Bragg – WVDHHR-BCF Region IV CWC
30. Melody Plumley – Children’s Home Society
31. Michelle Dean – WVDHHR-BCF
32. Carla Harper – WVDHHR – BCF
33. Andrea Blankinship – B&T/Rescare
34. Nikki. Tennis – WV DHHR – BBHHP
35. Tina Martin-Keyser – WV DHHR-BCF
36. Becky Sanders – Elkins Mountain School
37. Elizabeth Kennedy – WV DHHR – BBHHP
38. Josh Van Bibber – WV DHHR – BBHHP
39. Jessica Kennedy\* – WVDHHR-BCF Region I CWC
40. Stephanie Plybon – Davis Stuart
41. Christina Bertelli-Coleman-WVDHHR-BCF
42. Stephanie Lester – WVDHHR-BCF

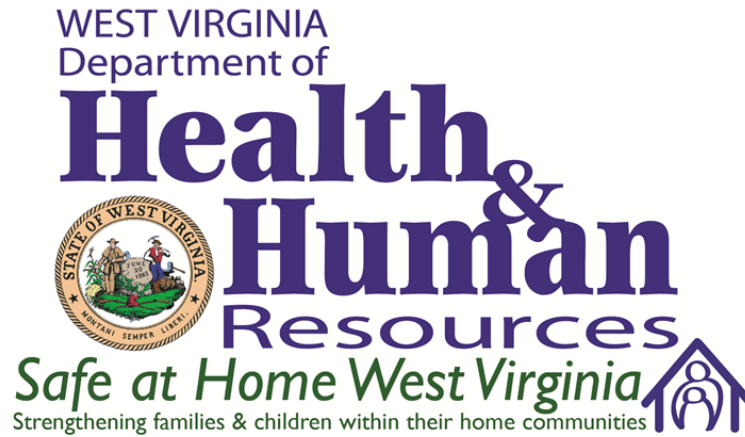
### Service Delivery and Development Work Group Task Teams

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

1. Older Youth Transitioning to Adulthood Best Practice Task Team – Raymona Preston, Jessica Kennedy
2. Special Population Youth Staffing – Amy Lawson Booth
3. Integrated Data, Evaluation and Outcomes Task Team– Tammy Pearson
4. 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 as well as ongoing additional projects and responsibilities as assigned.*

## APPENDIX D



***Our children and families will be:***  
***Safe***  
***Successful***  
***Healthy***  
***Supported***

### 2018 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 youth ages 12 to 17 years 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 on wraparound community-based services to achieve better outcomes for children and families which are aimed at returning and keeping children in their communities.
- According to Fiscal Year 2014 data, West Virginia had the highest foster care entry rate in the nation (9.8 children per 1,000 compared to a national entry rate of 3.5).
- Safe at Home's implementation rolled out in three phases.
  - Phase 1 began October 1, 2015 and included 21 counties.
  - Phase 2 began August 1, 2016 and added an additional 24 counties.
  - Phase 3 began April 1, 2017 and the remaining 20 counties were added bringing 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 their time in foster care, 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.
- Semi-annual progress reports have been submitted to the Administration for Children and Families every October and April since the program's implementation, with the first report submitted on April 30, 2016.
- All semi-annual progress reports are posted to the Safe at Home website for public viewing.
- Planning is currently underway to sustain Safe at Home when Waiver funding ends at the end of 2019, from both a program and financial perspective.

### **Service/Model Development**

- Local Coordinating Agencies serve as the lead to identify the service needs of youth and access community services for Safe at Home youth. DHHR partners with these agencies through a grant process, followed by provider agreements.
- Criteria for the target population:
  - Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis (or possible diagnosis) of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to standard diagnostic criteria) currently in an in- or out-of-state residential placement and cannot return successfully without extra support, linkage and services provided by Wraparound.
  - Youth, ages 12 to 17 (up to the youth's 17th birthday) with a diagnosis (or possible diagnosis) of a severe emotional or behavioral disturbance that impedes his or her daily functioning (according to standard diagnostic criteria) at risk of out-of-state residential placement and utilization of Wraparound can safely prevent the placement.
- Wraparound 101 overview training is being used to standardize the introduction of Wraparound for DHHR staff, probation officers, judges, providers, leadership, and informal supports.
- An in-depth one-and-a-half-day Wraparound 101 training is used to train DHHR staff that refer youth and the wraparound facilitators who deliver the services.
  - This team has identified wraparound champions that continue to assist with the delivery of these trainings.
- 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.
- Matrices that outline the responsibilities of both child welfare staff and facilitators have been developed as an additional resource.
- The Wraparound Model Manual, which contains a program overview and pertinent documents and templates to use for Safe at Home, can be used as a foundation for Local Coordinating Agencies.  
<https://dhhr.wv.gov/bcf/Services/Documents/Safe%20at%20Home%20WV%20Program%20Manual%207-22-17.pdf>
- DHHR continues to produce a quarterly newsletter that is emailed to recipients and is posted to the Safe at Home website.
- The CANS 2.0 and automated CANS system is used to identify strengths and needs of youth referred to Safe at Home. Currently, the online CANS system is being expanded to track referrals to Safe at Home, transmit data between the Local Coordinating Agencies and Regional Offices, and facilitate on-demand management reporting.

## Evaluation

- Hornby Zeller Associates was awarded the evaluation contract July 1, 2015.
- The independent evaluator developed, maintains and now is enhancing the automated CANS 2.0.
- The evaluators annually conduct stakeholder interviews, administer surveys, and complete case record reviews as part of the process evaluation.
- The process evaluation also includes an annual fidelity review to measure the extent to which Local Coordinating Agencies are implementing wraparound with fidelity to the model and complying with Safe at Home's case standards.
- The evaluators utilize quantitative data from the State's child welfare case management system (FACTS) and the CANS database to measure outcomes, such as, congregate care entry, length of stay in congregate care, maltreatment, and improved well-being.
- Data from FACTS and invoice payment data from the Local Coordinating Agencies are used to complete the cost evaluation.
- All evaluation findings are included within each semi-annual progress report and are posted to the Safe at Home website for public viewing.

## Data

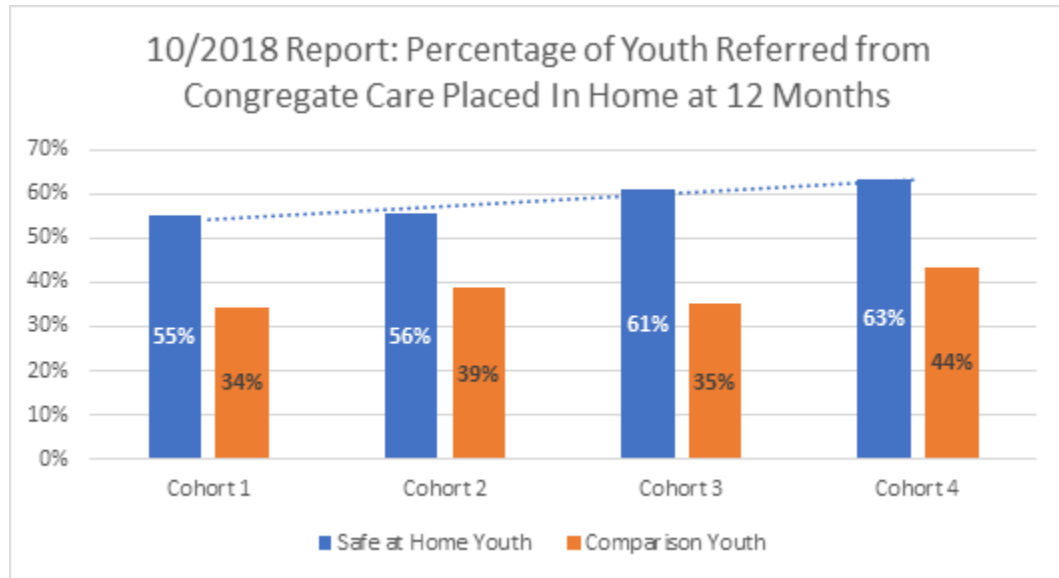
- Originally, the data workgroup developed a tracking spreadsheet to watch placement activity across the State. This spreadsheet will soon be replaced by the expansion to the automated CANS system in early 2019.
- The data workgroup also developed a brief spreadsheet for completion by field staff to track cases referred to wraparound services. This assists with payment reconciliation until automation is achieved in FACTS.
- In-depth data analysis is provided by the evaluator, Hornby Zeller Associates, and is included in each semi-annual progress report.

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

## Positive Outcomes/Evaluation Highlights

- Some of the most common successes achieved by youth and families as reported by stakeholders in interviews in August 2018 were:
  - improved grades and school attendance;
  - improved behavior or emotional regulation;
  - youth sobriety;
  - youth taking responsibility for themselves;
  - healthier family and peer relationships;
  - living in a safer location;
  - increased parenting skills; and
  - achieving permanency.
- Local Coordinating Agencies did particularly well in developing high quality Wraparound and Crisis Safety Plans, where the content of those plans demonstrated a strong adherence to the Wraparound model. Fidelity measures were created by the National Wraparound Initiative and scored by the extent to which those standards were met by reviewers in each case. Overall, fidelity scores were higher than what was reported last year, and improvement was often demonstrable between the initial and most recently created plans within a case.

- Youth/family feedback about the program in August 2018 was overwhelmingly positive.
- The outcome analysis looks at youth in six-month cohort periods based on the date of referral. This allows the evaluative team to see the extent to which there are improvements over time. Additionally, youth from Safe at Home are matched to youth in a historical comparison group through a statistical technique called Propensity Score Matching.
- At twelve months, Safe at Home youth were more likely to have returned home from congregate care than youth from the historical comparison group.



- Safe at Home youth spend less amount of time in congregate care than do the matched comparison youth, and at a statistically significant rate ( $p < .01$ ).

October 2018 Report: Average Length of Stay in Congregate Care Within 6 and 12 Months			
Cohort	Group	Average Days in Congregate Care within 6 Months	Average Days in Congregate Care within 12 Months
1	Safe at Home	101	167
	Comparison	137	239
2	Safe at Home	84	144
	Comparison	131	237
3	Safe at Home	61	126
	Comparison	122	219
4	Safe at Home	70	139
	Comparison	127	217
5	Safe at Home	64	-
	Comparison	115	-

- Safe at Home youth are also more likely to return to their home county than are youth in the historical matched comparison group. Most results are statistically significant as well.

October 2018 Report: Youth County Movements				
Cohort	Group	Denominator	Percent at 6 Months	Percent at 12 Months
<b>From Out-of-County to Home-County</b>				
1	Safe at Home	66	59%	64%
	Comparison	69	28%	39%
2	Safe at Home	96	61%	59%
	Comparison	103	29%	48%
3	Safe at Home	74	81%	72%
	Comparison	85	33%	45%
4	Safe at Home	87	75%	69%
	Comparison	107	28%	50%
5	Safe at Home	91	66%	-
	Comparison	97	35%	-

- When youth do need to enter foster care, Safe at Home youth are more likely to be placed in a relative home, and at a statistically significant rate ( $p < .01$ ).

October 2018 Report: Percentage of Youth Placed in Relative Homes			
Group	Denominator	Percentage in Relative Foster Homes at 6 Months	Percentage in Relative Foster Homes at 12 Months
Safe at Home	87	70%	65%
Comparison	100	24%	31%

- Youth in Safe at Home are also more likely to reunify, with many cohorts doing so at a statistically significant rate.

October 2018 Report: Youth Reunified Within Six and Twelve Months of Referral				
Cohort	Group	Number of Out-of-Home Cases	Percent Reunified within 6 Months	Percent Reunified within 12 Months
1	Safe at Home	78	35%	47%
	Comparison	77	14%	29%
2	Safe at Home	120	40%	49%
	Comparison	118	16%	36%
3	Safe at Home	92	52%	61%
	Comparison	100	17%	32%
4	Safe at Home	112	53%	60%
	Comparison	133	17%	35%
5	Safe at Home	125	48%	-
	Comparison	129	17%	-

## APPENDIX E

OMB Control No: 0970-0307

Expiration Date: 09/30/2019

### State Court Improvement Program 2018 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.

- **CQI Analyses of Required CIP Projects** (Joint Project with Agency and Hearing Quality Project) *It is ok to cut and paste responses from last year, but please update according to where you currently are in the process.*

#### Joint Project with the Child Welfare Agency: New View Project

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

The New View project was established as a method to help the West Virginia Court Improvement Program, (CIP), meet its mission *to advance practices, policies, and laws that improve the safety, timely permanency, well-being of children, and due process for families in child abuse/neglect and juvenile cases*. The Supreme Court of Appeals of West Virginia (SCAWV) through its CIP 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 aimed 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 DHHR'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 and involved 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, CIP staff and the New View Attorney prepare an order for a circuit judge to sign. Once the order is entered, the viewer begins looking at the complete circuit court file and the DHHR file. They then interview case 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.

Additionally, the project hopes to collaborate with DHHR in finding solutions to systemic issues discovered by the project.

In 2016, the efficacy and evaluation of the project was examined. Needs recognized included validity in evaluation measurements and reliability in outcome measurements. Past evaluations were largely qualitative and based on a multitude of independent reviewers. New View 2.0 evaluation will continue to be qualitative but will now include quantitative measures.

Based on findings from New View evaluation the goal of New View 2.0 will be: *Intrinsic and extrinsic barriers to successful transition to adulthood will be identified, documented, and ameliorated through New Review Reports so that youth ages 15 and older are prepared to exit state care.*

**Identify the specific safety, permanency, or well-being outcome this project is intended to address.**

This project focuses on well-being and safety. The primary goal of the project is to ensure that youth ages 15 and older are prepared to exit state care. This will reduce the likelihood of becoming homeless, victims of human trafficking, or entry into the adult correctional system.

**Approximate date that the project began:** Planning began in 2012. New View 1.0 was active 2013-September 30, 2017. New View 2.0 planning began in 2017 with the intention to pilot New View 2.0 in 2019.

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

Phase IV

**How was the need for this project identified? (Phase I)**

At a national conference in 2011, a West Virginia team of judges and DHHR officials discovered that West Virginia is one of the top five states for the number of children in out-of-home care. The West Virginia team was impressed by Georgia's Cold Case Project. "Cold Case" refers to children who have been in long-term foster care. With assistance from CIP grants, West Virginia borrowed from Georgia's experiences to do its own project with variations. New View is a court inspired and court led project to improve outcomes of children in care.

There continues to be a need for this project. As of May 31, 2018, there are 6,702 West Virginia children in foster care. Programs that focus on difficult cases have been effective in West Virginia. 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. In fact, about 20% of children reviewed in year 4 of New View were either actively involved with Safe at Home or were recommended for the program.

***The need for New View 2.0:***

For many children who age out of care in West Virginia each year, adoption or guardianship day never comes.

In looking at the previous iteration of New View, 60% of children reviewed during the first 3 years of the project were ages 17-19 at the time of review. Only 14% of children reviewed reached permanency through adoption, guardianship, or by remaining in care. Over half of the children reviewed through the New View project simply aged out of care.



BCF data on 613 children who turned 18 while in care July 2014 through June 2017, show adoption of only one youth. Unfortunately, 23% refused help after 18 by refusing to sign a contract to remain in care for services. While this could be due to multiple factors, for purposes of what is best for West Virginia children, the goal of New View 2.0 will be to identify, document, and ameliorate intrinsic and extrinsic barriers to improve successful transition to adulthood. This will be accomplished through New View reviews and recommendations to ensure that youth ages 15 and older are prepared to exit state care.

**What is the theory of change for the project? (Phase II)** *If you do not yet have a theory of change and/or would like assistance, please indicate such in the space below.*

The Court will provide New View review for children/youth identified by a predictive model as high risk for aging out of care so that:

- child/youth preferences and intrinsic and extrinsic barriers to meaningful connections and successful transitions to adulthood are identified;
- New Viewers make specific recommendations to address the identified barriers and issues to the Court and the multidisciplinary team (MDT);
- court orders address identified barriers and service needs; and
- important transition to adulthood needs are addressed for those youth likely to age out of care.

**Have you identified a solution/intervention that you will implement? If yes, what is it? (Phase III)**

New View will continue as the intervention but with a more concise focus based on evaluation of New View 2013-2017. New View 2.0 will meet emergent needs of youth ages 15 and older in West Virginia.

**What has been done to implement the project? (Phase IV)**

Readiness assessment and planning the implementation of the pilot project are currently underway. When New View was initiated in 2013, it was rolled out statewide. New View 2.0 will be piloted in a smaller area. The intent is to build more community resources and awareness of the project before expanding it to a larger area.

**What is being done or how do you intend to monitor the progress of the project? (Phase V)**

*Be specific in terms of what type of evaluation (e.g., fidelity or outcome, comparison group, etc.) or data efforts you have in place or plan to have in place to assess your efforts. If you have already evaluated your effort, how did you use this data to modify or expand the project?*

Work with SCAWV IT Division is underway to develop a database that will house data and provide reports to track the progress of the project. Effectiveness will be measured by cohort (year) in the following primary measures:

- Increase permanent connections: Defined as unpaid community or familial connections that are to continue once child exits custody. *Each child given a score 1-4. This score should increase with each cohort.*
- Increase access to transition services: defined as connections to services needed to live independently for youth over age 17. *Each child given a score 1-4, based on the number of services he/she is connected. This score should increase with each cohort.*
- Increase awareness of transition needs: defined as documented discussion of connections to services needed to live independently for youth ages 15-16. *Each child given a score 1-4, based on the number of services they are aware of. This score should increase with each cohort.*

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

Continued assistance with developing a solid evaluation and implementation plan would be helpful.

**Hearing Quality Project:** Quantifying Quality Q<sup>2</sup>

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

This project will increase youth participation in court hearings, as this is an indicator of a quality hearing. A DHHR caseworker and child abuse and neglect professional survey of 2017 showed youth are present at hearings only about 25% of the time.

The primary objective of this project is to reduce distance related barriers to youth participation. The long-term goal is to increase participation of youth in hearings in our pilot circuit(s). The intermediate goal is to implement one or more alternative means for participation of youth in court hearings. Immediate goal is to convince judges and professionals that youth participation is vital so there will be a stake in decreasing barriers to youth participation.

**Approximate date that the project began:** 2016

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

Phase III: Identifying and researching various solutions to address distance as a barrier for youth participation in court hearings.

**How was the need for this project identified? (Phase I)**

In conjunction with the agency partner, a survey on hearing attendance was conducted in spring 2017. The CIP extended the survey to participants in the annual Cross Training in July 2017. These surveys revealed that most often the youth and foster parents were not in attendance at hearings. From there the Q2 project was initiated to delve deeper and determine actions to increase youth attendance. It was determined that resources would be used to focus on increasing youth attendance at hearings. CIP and the agency partner conducted a follow-up survey for caseworkers on barriers to youth attendance in February 2018. The top barriers cited were workload constraints, concern that the child may be re-traumatized, and distance from the child’s placement.

The CIP cannot affect workloads and without substantial evidence that children are re-traumatized by court hearings in West Virginia, the project will focus resources on reducing the impact of distance through a specific, doable intervention.

**What is the theory of change for the project? (Phase II) *If you do not yet have a theory of change and/or would like assistance, please indicate such in the space below.***

CIP and the agency will develop a pilot project to decrease barriers to youth participation in court hearings and educate judges and workers of the value of youth participation so that:

- alternative means of participation are implemented; and
- the barriers of distance to court hearings are ameliorated.

**Have you identified a solution/intervention that you will implement? If yes, what is it? (Phase III)**

We are looking at alternative methods of court participation for youth. There are multiple variables to consider and we are working with the SCAWV's Information Technology Department and Administrative Office to ensure compliance with security. After identifying allowable and appropriate alternative methods, we will implement a pilot project in one West Virginia circuit.

**What has been done to implement the project? (Phase IV)**

Once we have a variety of feasible solutions from Phase III, we will identify a circuit for the pilot project and will collect baseline data in that circuit to measure the project impact.

**What is being done or how do you intend to monitor the progress of the project? (Phase V)** *Be specific in terms of what type of evaluation (e.g., fidelity or outcome, comparison group, etc.) or data efforts you have in place or plan to have in place to assess your efforts. If you have already evaluated your effort, how did you use this data to modify or expand the project?*

We are currently determining what will be the most valid data to collect.

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

How to determine the best way to capture baseline data for our pilot project. We want to ensure that continuous quality improvement is included in our project.

- **Trainings, Projects, and Activities** For questions 1-9, provide a *concise* description of work completed or underway to date in FY 2018 (October 2017-June 2018) in the below topical subcategories. For question 1, focus on significant training events or initiatives held or developed in FY 2018 and answer the corresponding questions.

**Trainings**

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>How many persons attended?</i>	<i>What type of training is it? (e.g., conference, training curriculum/program, webinar)</i>	<i>What were the intended training outcomes?</i>	<i>What type of training evaluation did you do? S=Satisfaction, L=Learning, B=Behavior, O=Outcomes</i>
Data	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	GALs, attorneys, prosecuting attorneys, judicial staff Anyone who may use JANIS to create orders or judicial staff who enter information into the old CAN database. New secretaries and law clerks.	JANIS/CAN: 78 JANIS  Regional JANIS: 22 as of 7/30/18  Have an additional 53 registered for August-September trainings  ~50 at New Law Clerks Conference	Judicial staff were trained via WebEx on how to enter data into CAN data within JANIS. Regional training sessions were held to explain how to use JANIS to write orders.	JANIS/CAN: how to enter clean, accurate, quality data into JANIS/CAN for purposes of measuring timeliness in child abuse and neglect procedure. Learn how to use the Juvenile Abuse and Neglect Information System (JANIS) to create petitions, orders, and motions that are compliant with Title IV-E.	<input checked="" type="checkbox"/> S <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> B <input checked="" type="checkbox"/> O <input type="checkbox"/> N/A

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>How many persons attended?</i>	<i>What type of training is it? (e.g., conference, training curriculum/program, webinar)</i>	<i>What were the intended training outcomes?</i>	<i>What type of training evaluation did you do? S=Satisfaction, L=Learning, B=Behavior, O=Outcomes</i>
Hearing quality	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Circuit Court Judges and New Circuit Court Judges	99	Judicial Conference	To inform the judges of law updates, judicial benchbook tools, timing of hearings, and findings needed at each stage of the case.	<input checked="" type="checkbox"/> S <input checked="" type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A
Improving timeliness/permanency	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Multiple disciplines (attorneys, social workers, counselors, providers etc.)	877 over 4 days	Annual Cross Training Conference "Moving Forward Together"	Learn the procedure of a Chapter 49 child abuse and neglect case  Explore treatment needs in addressing child abuse and neglect  Explore specialized topics to improve practice  Learn updates in the law	<input type="checkbox"/> S <input checked="" type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>How many persons attended?</i>	<i>What type of training is it? (e.g., conference, training curriculum/program, webinar)</i>	<i>What were the intended training outcomes?</i>	<i>What type of training evaluation did you do? S=Satisfaction, L=Learning, B=Behavior, O=Outcomes</i>
Quality legal representation	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Law students	6 completed the Spring 2018 course	Law Course Class	To train law students on the specific requirements of child abuse and neglect cases, judicial benchbook tools, timing of hearings, and the responsibilities of attorneys in abuse and neglect cases	<input checked="" type="checkbox"/> S <input checked="" type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A
Engagement & participation of parties	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Circuit Court Judges	99	Judicial Conference	Provide update on law and discussion on Performance Measures.	<input checked="" type="checkbox"/> S <input checked="" type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A
Well-being	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Multiple disciplines (attorneys, social workers, counselors, providers etc.)	877 over four days	Annual Cross Training Conference "Moving Forward Together"	Explore treatment needs in addressing child abuse and neglect  Explore specialized topics to improve practice	<input checked="" type="checkbox"/> S <input checked="" type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A
ICWA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					<input type="checkbox"/> S <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input checked="" type="checkbox"/> N/A

<i>Topical Area</i>	<i>Did you hold or develop a training on this topic?</i>	<i>Who was the target audience?</i>	<i>How many persons attended?</i>	<i>What type of training is it? (e.g., conference, training curriculum/program, webinar)</i>	<i>What were the intended training outcomes?</i>	<i>What type of training evaluation did you do? S=Satisfaction, L=Learning, B=Behavior, O=Outcomes</i>
Sex Trafficking	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	and Multiple disciplines (attorneys, social workers, and counselors	93	Session titled "Human Trafficking" at Annual Cross Training 2017	To raise awareness of this issue with each discipline and to provide information so that a professional could identify victims and treat them as such.	<input checked="" type="checkbox"/> S <input checked="" type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A
Other:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					<input type="checkbox"/> S <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> N/A

# West Virginia Court Improvement Program

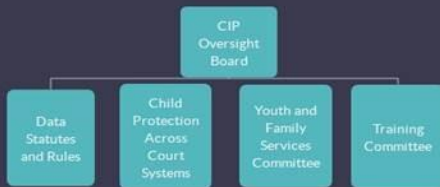
# FY 2018 YEAR IN REVIEW

**700+**

Professionals received free training on child abuse and neglect topics through CIP Training

**CIP FUNDING RENEWED UNTIL 9/30/2024 THROUGH FFPSA**

## Court Improvement Program Committees



**4**

Four committees drove the work completed by the CIP during this year.

**6**

Six work groups were active this year.

**121**

121 representatives from multiple disciplines were on committees and work groups this year

## Court Improvement Program Projects



### JANIS

Updates and enhancements continued during FY 18. Data collection child abuse and neglect cases and Performance Measure reporting was added into JANIS. Five regional training sessions were held for individuals using JANIS to create orders. Over 20 training sessions were held to train judicial staff how to use JANIS



### New View

Evaluation of New View 2013-2017 lead to the creation of New View 2.0. This project will be piloted in March 2019



### Q2

Quantifying quality focuses on improving hearing quality. Based on surveys conducted in WV, this project will focus on youth presence at hearings.

Ongoing Projects

**17**

New View \* JANIS \*Increasing Title IV P-Rate\* Compliance with Federal child welfare laws \*Data collection and evaluation \*Overlap/JAA Review\* CPAC Annual Report on risk Factors and JAA Outcomes\* Impact of SB 393 \*Review of children who are away from supervision \*Out of Home Education\* Judicial BenchBook \*Annual Cross Training \*Children and the Law course\* GAL/Professional tracking

Time Limited Projects

**19**

Q2 Improving Hearing Quality \*New View 1.0 Evaluation \*New View 2.0 Development \* JANIS Form Modification \* JANIS Phase VI \*Increasing data sharing among stakeholders \*Increasing communication between DHHR and Family Court on Investigation Outcomes\* Guardianship Form Revision\* JAA Order review and revision \* JANIS Regional training Develop CAN 101/102\* Reaching Out training



# APPENDIX F

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

### Annual Report

2018

The *Education of Children in Out-of-Home Care Advisory Committee* focused on the following major objectives during 2018: (1) Build a data sharing system between the West Virginia Department of Health and Human Resources and the West Virginia Department of Education to implement the provisions of the federal Every Student Succeeds Act, called ESSA, which requires the West Virginia Department of Education to annually report on the educational status and achievement of children in foster care; (2) Increase educational participation in multi-disciplinary teams; and (3) Monitor the educational programs of children placed out-of-state.

#### **Build a Data Sharing System**

During 2018, a Data Use Agreement was established between the West Virginia Department of Health and Human Resources (DHHR) and the West Virginia Department of Education (WVDE) which enables WVDE to include children in foster care as a subgroup in the state's achievement testing program and to annually report their test scores and educational outcomes. The agreement also permits WVDE to report data on the measurement of school stability (number of schools attended during a school year) for children in foster care, an important factor in educational success, as well as to report on other important educational parameters such as attendance, discipline and graduation rate. The data agreement specifies the data elements to be provided to WVDE and use restrictions. During 2018, DHHR provided a file containing the following identity elements to WVDE for all individuals ages 3 to 21 years of age that were placed within foster care for at least one day within the time period July 1, 2017 to May 1, 2018:

- First Name
- Last Name
- FACTS Client ID
- Number
- Birth Date
- Social Security Number
- Race
- County of Removal
- County of Placement
- Hispanic Indicator

The data provided by DHHR was extracted from the DHHR FACTS (Families and Children Tracking System) which serves as the West Virginia Statewide Automated Child Welfare Information System for foster care and adoptive populations. These identity elements were matched against identity elements contained within the WVDE WVEIS (West Virginia Education Information System). Matches that were determined to be reliably accurate were used to extract educational status and assessment data for the foster care population. The data agreement also serves to lay the groundwork for establishing a bi-

directional web service for not only identifying foster care populations to WVDE on an annual basis but to also provide the following enhancements:

- Immediate notification to WVDE of a foster care placement
- Identification of ongoing developments to WVDE as regards to the foster care child
- Return of important education stability data regarding attendance, discipline, and coursework to DHHR Case Management Teams.

The current system used to implement the Data Use Agreement utilizes secure File Transfer Protocol (FTP) to transmit the data from DHHR servers to WVDE servers.

As a result of the development of the Data Use Agreement, WVDE is preparing a report on the educational status and achievement of children in foster care for the 2017-18 school year. The report will be available during the spring of 2019.

A copy of the Data Use Agreement is available from WVDE or DHHR.

### **Increase Educational Participation in Multi-Disciplinary Teams (MDTs)**

The Education of Children in Out-of-Home Care Advisory Committee formed a subcommittee that focused on increasing educational participation in multi-disciplinary team meetings in 2017. During 2018, the sub-committee developed a joint agency memorandum from the State Superintendent of Schools, the DHHR Cabinet Secretary and the Administrative Director of the Supreme Court of Appeals of WV which was sent to county superintendents of schools, DHHR Community Services Managers, circuit court judges, school attendance directors, guardians ad litem and other key stakeholders on the matter of the notification and participation of school officials at multi-disciplinary team meeting. The memorandum provides:

- Background information on the numbers, average length of stay and educational status of children in foster care;
- Information on the West Virginia statutes that mandate participation by school officials in MDT meetings;
- Information on the critical role that educators play in MDT meetings;
- The current status of inconsistent participation by school officials in MDT meetings across the state and its impact on the planning of services for children in foster care;
- Information on how coordination among agencies is required to meet the needs of children in foster care and how the new ESSA requirements for children in foster care establish a mechanism for coordination and planning at the local level; and
- A plea for school officials and DHHR personnel to jointly establish written procedures to ensure educational participation in MDT meetings.

A copy of this memorandum is included at the end of this report.

During 2018, the chair of the subcommittee, in conjunction with a circuit court judge, provided training to school administrators at a state conference.

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

The WVDE and DHHR Memorandum of Understanding and Out-of-State Monitoring Guidelines set the parameters for the review of five facilities each year that serve West Virginia youth placed out-of-state through the court system for non-educational reasons.

WVDE has the responsibility for oversight of compliance issues related to educating West Virginia students with disabilities and a general oversight of the provision of education for all West Virginia students court ordered to out-of-state facilities. The facilities must follow state policies and procedures as well as federal special education law. The West Virginia local education agencies (LEAs) are responsible for the cost of the educational component for students with disabilities court ordered to out-of-state placements. WVDE has historically shared a portion of this financial obligation with the LEAs and continues to pay a portion of the cost as well as take responsibility for managing the payment process, the monitoring of educational programming and providing assistance and training to facilities as needed.

## **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. The following summary outlines the 2018 out-of-state monitoring visits. While violations are noted, each facility also had positive programming aspects and is working on weaknesses through corrective action plans:

- **Hermitage Hall**, Nashville, TN – This was a return visit completed in January 2018. The facility was previously reviewed in November 2016 and since that time had four requests for investigations. Educational weaknesses identified included teacher certification issues; wide spans of grade levels in elementary and middle grade classrooms; lack of Career Technical Education (CTE) options; lack of structure leading to excessive restraints; no continuum of services for students with disabilities; expired IEPs; scheduling issues; and confusion about the rights of parents who retain educational rights.
- **Devereux**, Viera, FL – The review was completed in March 2018. No major violations were found – Devereux has a very low turnover rate of employees with many in the school and on the treatment team employed for more than 20 years. All teachers are certified in special education; classrooms are observed four times per week through observation rooms; technology availability and use was excellent; lesson plans are standards based and contain quality instruction; educational field trips provided monthly; outdoor recreation opportunities for students. A change in Florida State Standards no longer requires CTE coursework to graduate. Therefore, Devereux currently has no CTE programming in place where formerly they had an on-site cosmetology program. The facility administration was encouraged to develop partnerships for students to participate in community-based opportunities for work experience and career planning.
- **George Junior Republic**, Grove City, PA – A follow-up visit was conducted in March 2018. A DHHR team with one WVDE representative visited George Junior to determine

progress since the placements to this facility were suspended in January 2015. The team had the same concerns after the visit regarding treatment of WV youth, details of programming and attitude towards feedback and discussion regarding changes that should be considered.

- **Timber Ridge**, Winchester, Virginia – A review was completed in May 2018. Corrective Action Plan includes work toward improving teacher certification issues, IEP Services, Transition Services, including a focus on the lack of CTE offerings, and Notification to Transition Specialist of Upcoming Discharges to provide support and planning with the home county in West Virginia.
- **Natchez Trace**, Waverly, TN – A review was completed in September 2018. Corrective Action Plan includes work toward improving Teacher Certification issues, IEP Services, provision of FERPA training to school staff, and Notification to Transition Specialist of Upcoming Discharges.
- **Foundations for Living**, Mansfield, Ohio – A review was completed November 2018 (reports pending). Weaknesses identified include no CTE programs offered due to acute care in self-harm, trafficking, drug and alcohol treatment, and mental health concerns.

### **Transition Specialist Activities:**

WVDE's Office of Diversion and Transition Programs (ODTP) has 18 professionals working as transition specialists. These transition specialists assist out-of-home students in returning to school, transitioning to work, or reunifying with their communities once they leave an institution of another out-of-home environment. The activities these professionals dedicated their time to during the 2017-18 Fiscal Year are:

- Developed the Transition Education Action Map (T.E.A.M.) plan for transition and counseling staff to better serve our students. The T.E.A.M. plans allow ODTP staff to create student-focused individual PBIS plans that follow students through each transition phase, including their return to the public school system.
- Attended and participated in various professional development opportunities including Handle with Care, KidStrong, and the Student Success Summit.
- Facilitated community-based robotics initiatives such as the competition in Mercer County that included multiple participating counties. Assisted with Nicholas County robotics initiative. These engagement projects stemmed from an early ODTP program called STARS for middle school students who returned to public schools. These initiatives are started in public schools where an out of home child has transferred and is willing to participate.
- Reformed the WVDE ODTP student database to accurately reflect all students served and to gather required documentation for Title I Federal Monitoring.
- Created database for out-of-state students served and participated in five out-of-state facility monitoring visits.
- Improved overall communication, relationships, and graduation requirements with out-of-state facilities.
- Provided professional development to transition staff in the following areas: trauma informed care, WVEIS ZOOM, Microsoft OneDrive, Career Integrated Experiential Learning, Option Pathway, FERPA, Early Warning System, College Foundation of West Virginia, Graduation 20/20, as well as county graduation requirements and credits.

## Goals for 2019

During 2019, the Education of Children in Out-of-Home Care Advisory Committee will continue to work on: (1) facilitating the implementation of the foster care provisions of the “Every Student Succeeds Act” (ESSA); (2) increasing educational participation in multi-disciplinary team meetings; (3) reporting on the educational status and achievement of children in out-of-home care; and (4) improving and expanding transitional services. In addition, the Advisory Committee will begin to review nationally validated evidence-based education programs to improve the educational achievement and outcomes for children in foster care.



**MEMORANDUM**

**TO:** County Superintendents of Schools  
Community Service Managers

**FROM:** Honorable Gary Johnson, Administrative Director, Supreme Court of Appeals of West Virginia  
Steven L. Paine, Ed.D. *G.J.*  
State Superintendent of Schools *SNP*

Bill J. Crouch *BAC*  
Cabinet Secretary, Department of Health and Human Resources

**SUBJECT:** NOTIFICATION AND PARTICIPATION OF SCHOOL OFFICIALS AT MULTIDISCIPLINARY TREATMENT TEAM MEETINGS

**DATE:** May 2, 2018

At any given time, thousands of West Virginia children are in the care of the West Virginia Department of Health and Human Services due to abuse and neglect or juvenile status or delinquency matters. Nearly ten thousand children were in state care in 2016<sup>1</sup> with an average length of stay of 17-18 months and, based upon current data for 2017, the number of children in care is expected to increase. Studies conducted by the West Virginia Department of Education found that the academic achievement of children in state care was lower than all the subgroups for which reporting was required under the *No Child Left Behind Act*. West Virginia children in care experience more school disciplinary issues, including suspension and expulsions, and lower achievement scores on state assessments in reading and math as compared to their school-age

<sup>1</sup> For the federal fiscal year of 2016, 9802 total unique foster care children/youth were in state care in West Virginia. This number was derived from mandated federal compliance reporting for foster care and was obtained from the West Virginia Department of Health and Human Resources semiannual Adoption and Foster Care Analysis and Reporting System (AFCARS) submissions.

peers.<sup>2</sup> Other state and national studies have shown that children in care experience higher drop-out and retention rates, and even lower college graduation rates, as compared to children not in care.<sup>3</sup> At times, these children face further instability with school and record transfers.

West Virginia recognizes the importance of educators for not only their close and consistent contact with children, but also for their unique opportunity to advocate for and assist in providing programs and services for these children and their families. As a result, West Virginia statutes mandating multidisciplinary treatment team meetings identify a representative from education as a crucial member of multidisciplinary treatment teams (MDT) in abuse and neglect cases, as well as in juvenile delinquency cases. Pursuant to **West Virginia Code §49-4-405** regarding child abuse and neglect cases, **the multidisciplinary treatment team consists of “an appropriate school official,”** among others. Pursuant to **West Virginia Code §49-4-406** regarding juvenile proceedings, **the multidisciplinary treatment team shall consist of the “county school superintendent or the superintendent’s designee”** with notice at least seven days prior to the meeting. And, for juveniles adjudicated as delinquents who are ordered to undergo an examination while in the custody of the West Virginia Division of Juvenile Services, **West Virginia Code §49-2-907** provides that **the multidisciplinary treatment team consist of an “appropriate school official or representative.”** In addition to West Virginia statutes, the mandatory invitation and attendance of an education official at multidisciplinary treatment team meetings is also cited within the Youth Services Policy Manual<sup>4</sup> and the WVDE Counselor’s Handbook.<sup>5</sup> A desk guide to aid in conducting effective MDTs is also accessible on the WV DHHR website.<sup>6</sup>

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<sup>2</sup> West Virginia Out-of-Home Care Education Task Force, *Reaching Every Child: Addressing Educational Attainment of Out-of-Home Care Children in West Virginia* (2011), available at [http://www.wvdhhr.org/oos\\_comm/reports/reaching%20every%20child%20report%2011-23-05.pdf](http://www.wvdhhr.org/oos_comm/reports/reaching%20every%20child%20report%2011-23-05.pdf).

<sup>3</sup> National Working Group on Foster Care and Education, *Fostering Success in Education: National Factsheet on the Educational Outcomes of Children in Foster Care* (2014), available at <http://cdn.fe2success.org/wp-content/uploads/2012/05/National-Fact-Sheet-on-the-Educational-Outcomes-of-Children-in-Foster-Care-Jan-2014.pdf>.

<sup>4</sup> West Virginia Department of Health and Human Resources, *Youth Services Policy Manual*, 48-55 (2017), available at <http://www.dhhr.wv.gov/bcf/policy/Documents/Youth%20Services.pdf>.

<sup>5</sup> West Virginia Department of Education, *Counselor Handbook*, 25 (1998), available at <https://wyde.state.wv.us/counselors/Counselorhandbook/documents/WVReportingAbuse.pdf>.

<sup>6</sup> West Virginia Department of Health and Human Resources, *MDT Desk Guide* (2016), available at [http://www.dhhr.wv.gov/bcf/policy/Documents/Multidisciplinary%20Team%20\(MDT\)%20Desk%20Guide.pdf](http://www.dhhr.wv.gov/bcf/policy/Documents/Multidisciplinary%20Team%20(MDT)%20Desk%20Guide.pdf).

Inconsistent practices across West Virginia have resulted in the absence of education officials at some multidisciplinary treatment team meetings thereby disrupting the planning of educational services for children in the abuse and neglect and juvenile systems. A complete multidisciplinary treatment team is critical in preparing and implementing comprehensive, individualized service plans for children and families and preventing delays in the delivery of educational services. The state of West Virginia is committed both to ensuring that children receive critical education services and to promoting effective, appropriate, and confidential communication between systems.

Meeting the legal requirements for educational participation in multidisciplinary team meetings requires planning and coordination at the local level by county school district and DHHR personnel. The recently enacted *Every Student Succeeds Act* (ESSA) contains key protections for students in foster care to promote school stability and educational success. One of these key protections includes establishing points of contact with local education and child welfare agencies to ensure collaboration, communication, and implementation of the new law. In this regard, we are requesting that county school districts establish procedures to ensure educational participation in multidisciplinary team meetings in coordination with DHHR personnel. It is imperative that school districts develop a protocol that best works for each county in adhering to ESSA, West Virginia law, and this commitment to our state's children.

cc: Circuit Court Judges  
School Attendance Directors  
Guardians ad Litem  
Regional Directors  
Department of Health and Human Resources  
Child Protective Services and Youth Services Workers



**EDUCATION OF CHILDREN IN OUT-OF-HOME CARE  
ADVISORY COMMITTEE**

**MEMBERSHIP LIST**

November 8, 2018

West Virginia Department of Education

Jacob Green, Chair, Superintendent, Office of Diversion & Transition Programs  
Mollie Wood, Assistant Director, Office of Diversion & Transition Programs  
Rebecca Derenge, State Coordinator, McKinney-Vento  
Rachel Stewart, Out-of-State Transition Specialist, Office of Diversion & Transition Programs  
Sheila Paitsel, Coordinator, Office of Federal Programs  
Shelly Stalnaker, Coordinator, Alternative Education, Office of Diversion & Transition Programs  
Frank D. Andrews, Retired Superintendent of the Office of Institutional Education Programs

West Virginia Department of Health and Human Resources

Linda Watts, Deputy Commissioner, Bureau for Children and Families  
Randall Kirk, Families and Children Tracking System  
Christina M. Bertelli-Coleman, Program Mgr. II, Regulatory Mgt., Children and Adult Services

Supreme Court of Appeals of West Virginia

Cindy Largent-Hill, Director, Division of Children & Juvenile Services  
Stephanie Bond, Director, Division of Probation  
Brenda Hoylman, Child Welfare/Juvenile Justice Manager, Division of Children & Juvenile Services

West Virginia Division of Juvenile Services

Denny Dodson, Central Office Administrator

Child Care/ Service Provider Organizations

Robin R. Renquest, Senior Director, Pressley Ridge  
Shannon Bragg, Executive Director, Alliance for Children  
Susan Fry, Executive Director, Stepping Stones, Inc.  
Kelly Thompson, Associate Director, Mission WV  
Michelle Vaughn, Director of Shelter Care Service, Children's Home Society of WV

County School Districts

Robin Lewis, Superintendent, Lewis County Schools  
Eddie Ivy, Lead Attendance Director, Kanawha County Schools  
Melissa Harper, Homeless Facilitator, Kanawha County Schools (proxy)

## **APPENDIX G**

# **JUVENILE DRUG COURTS & ADULT DRUG COURTS**



West Virginia

# Juvenile Drug Court

FY 2018

Supreme Court of Appeals of West Virginia

Division of Probation Services

Stephanie Bond  
Director

Nick Leftwich  
State Drug Court Coordinator

Julianne Wisman  
Counsel

Alicia Fields  
Quality Assurance Specialist  
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 §49-4-703 and are designed and operated consistent with the developmental and rehabilitative needs of the juveniles and operate under uniform protocol and procedures established by the WV Supreme Court of Appeals.
- The program seeks to divert non-violent, juvenile offenders engaging substance abuse 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 to prevent and/or reduce future court involvement for the JDC involved juveniles. The objectives are to eliminate illegal substance use, improve educational outcomes, and enhance positive life choice decision making.
- All JDCs use evidence-based treatment approaches and assessments and are evaluated annually.
- Referrals to JDC can be made via complaint or petition 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, 2018, there were sixteen (16) operational JDC programs serving the following counties: Berkeley, Boone, Brooke, Cabell, Hancock, Harrison, Jefferson, Kanawha, Lincoln, Logan, McDowell, Mercer, Monongalia, Morgan, Ohio, Pleasants, Putnam, Raleigh, Randolph, 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 2018, the average cost per youth was \$1,057. This cost includes intensive supervision and individualized treatment services and includes services to the family. This is in contrast to the approximately \$110,000 annually in a residential or correctional facility.
- There were 291 participants served by the JDC programs for fiscal year 2018.
- National reports support the effectiveness of JDC's that adhere to best practices and evidence-based practices from the fields of adolescent treatment and delinquency prevention.





West Virginia

# ADULT DRUG COURTS

FY 2018

Supreme Court of Appeals of West Virginia

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- The West Virginia Adult Drug Court (ADC) Program is a cooperative effort of the criminal justice, social service, substance abuse treatment, and law enforcement systems.
- The ADCs are established in accordance with The West Virginia Drug Offender Accountability and Treatment Act (*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 2018 the average annual cost per drug court participant was \$3,814 as compared to \$19,425 in the Regional Jail or \$26,081 in a Division of Corrections and Rehabilitation prison. These costs include intensive supervision, treatment, case management, and drug testing.
- As of June 30th, 2018, 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 800 total participants served in FY 2018.

