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Performance Audit of Nevada's Child Welfare System Final Report for the Legislative Counsel Bureau Audit Division Pursuant to A.B. 629

Nevada Institute for Children's Research and Policy

UNLV School of Social Work

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Commissioned by the Nevada State Legislative Counsel Bureau Audit Division

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Final Report: October 15, 2008

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Special thanks to all agency staff and administration that worked with us to help make this report possible.

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EXECUTIVE SUMMARY

Assembly Bill 629 of the 2007 Nevada Legislature mandated that a performance audit of Nevada's child welfare agencies be conducted. This legislation was passed in response to documented concerns regarding the appropriate provision of services by the agencies, including inconsistent data and multiple safety issues. The UNLV Research Team comprised of staff from the Nevada Institute for Children's Research and Policy, the School of Social Work and the William S. Boyd School of Law was hired by the state to conduct the audit. The purpose of the findings and recommendations of this audit are to assist in improving the Nevada child welfare system. Pursuant to A.B. 629, this study includes multiple components, including, but not limited to:

- Random, unannounced site visits to the agency offices to review open and closed cases. This review included the Unified Nevada Information Technology for Youth (UNITY) and paper files concerning children reported as neglected or abused.
- Interviews with child welfare agency supervisors and/or managers, and agency administrators.
- Focus groups with direct practice workers from all three jurisdictions to glean information regarding barriers and suggestions for improvement.
- Review of each region's policies and procedures to determine whether they adhere to applicable state and federal regulations.
- Review of recommendations from various independent reports to ascertain whether the recommendations were successfully incorporated into practice.
- Law and policy analysis, including a review of each agencies' policies and procedures.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Case Reviews

During the course of the audit, 195 cases were reviewed among the three child welfare agencies in the State. 60% were investigations (CPS) and 40% were permanency cases. During the audit, reviewers identified 10 cases (5%) where a safety concern regarding lack of appropriate visitation by the caseworker with the child was presented to agency supervisors and/or administration. The agencies reviewed all cases, ensured the safety of the children and noted that most concerns were due to a lack of appropriate documentation in UNITY and/or the case file. Lack of appropriate documentation in UNITY and/or the case files was the primary area of deficiency noted by the reviewers, making it difficult to accurately represent whether the agencies were handling cases appropriately.

A review of the cases revealed that there were 302 separate reports and/or referrals for these 195 cases. Of the 302 reports/referrals, 51% were unsubstantiated, 32% were substantiated, 13% were information only reports, 2% were voluntary services, and for 2%, the determinations were unknown. In 47.7% of the cases the child(ren) had been removed from the home at least once. Documented reasons for removal included neglect (73%) and abuse (27%). Length of stay in out of home placements ranged from 0 to 536 days. The average lengths of stay for the most

common out of home, non-relative placements were: foster homes at 113 days; shelter homes at 44 days; hospitals at 36 days; Kids Kottage at 26 days and Child Haven at 7 days.

There were several deficiencies noted in either appropriate documentation and/or case management during the audit. Some of the primary deficiencies included:

Safety Assessments – Although safety assessments were documented in 99.5% of all cases reviewed, documentation of safety assessments being conducted at intervals required by NAC 432B.185 are inconsistent.

- Intervals with a compliance rate <50% included: before each court review; before unsupervised visits; when a significant event/change occurred; and after reunification.

Recommendation: Ensure that safety assessments are completed by caseworkers at all mandated intervals as required by state regulations. This process may include staff training regarding safety assessments and clearly indicating in policy and procedures when safety assessments must be conducted. Supervisors should be required to verify that safety assessments are completed at the appropriate intervals.

Indian Children – Only 65.5% of applicable cases showed documentation that the agency asked or attempted to ask if the child was an Indian child pursuant to federal law (Indian Child Welfare Act – ICWA).

Recommendation: Enforce mandates that all applicable cases must include documentation that the agency asked or attempted to ask if the child was an Indian child pursuant to ICWA. Enhance training on ICWA and require supervisory oversight to ensure that ICWA requirements are followed. Policies and procedures at each agency (or a collaborative policy of all three agencies) should be developed to provide specific procedures for compliance and should include acceptable forms of documentation to be included in case files.

Parental Notification – Notification of custody hearings, foster care or other out of home placement or court hearings to a noncustodial parent was evident in only 46.5% of applicable cases.

Recommendation: In any case where there is a known or probable noncustodial parent, caseworkers should document attempts to notify the noncustodial parent of all applicable actions in the case. Policies and procedures should reflect acceptable means of identifying and providing notification to noncustodial parents. Documentation of efforts to identify and notify (or attempts) should be made in all cases where both parents are not directly involved in the case.

Siblings – 40% of all cases involved sibling groups which experienced out of home placements were separated in their placements. Although the majority of these cases included documentation of viable reasons for the separation, 6 cases did not.

Recommendation: Increase efforts to keep sibling groups together and enforce mandates to document all instances where siblings are separated, including specific justification and/or reasons for the separation. Additional training and supervisory oversight, as well as specific policies and procedures should be developed at each agency.

Placement – Just over half (55.1%) of all applicable cases reviewed documented that a diligent search for an appropriate relative placement was made. Only 49.4% included documentation that efforts were made to place the child as close to home as possible. Although only 8.6% of

children in the cases reviewed were placed out of state, none of the cases included documented quarterly updates from the placements.

Recommendations: Improve documentation of placement efforts including diligent search, placing the child as close to home as possible, and receipt of updates for out of state placements. Training should be developed and/or enhanced to ensure that all caseworkers are aware of applicable laws, resources, and appropriate documentation techniques. Ensure that caseworkers are aware of and utilize diligent search resources and document all efforts in the case file.

Case Plans – Almost 18% of all applicable permanency cases reviewed did not have a case plan on file that the reviewers were able to locate. Of the 60 case plans that were reviewed, severe documentation inconsistencies were noted in the following areas:

- Efforts to place siblings together;
- Statements of health and education records;
- Indication of the proximity of the child's school;
- Supervisory approval of the case plan;
- Formal updates every 6 months;
- Separate case plans for each parent involved;
- Completion of the case plan within 45 days of removal; and
- If a concurrent plan existed, documentation to address if both plans progressed simultaneously.

Recommendations: Mandate supervisory oversight to ensure that all applicable permanency cases have a case plan, tailored to the needs of the child and family, on file. Review policies and procedures to ensure that caseworkers and supervisors are aware of all mandatory components and procedures for preparing and documenting case plans. Training should focus on how to tailor case plans to the specific needs of the child and family, rather than preparing "cookie cutter" case plans.

Provision of Services – The Functional Risk Assessment Protocol (FRAP) was documented as having been used in just over half (54.4%) of all cases reviewed. In 38% of all cases, there was no documentation that services were offered to families. Due to the method of tracking service provision in case notes, this area was difficult to access with a great degree of certainty. Reviewers also noted that often the services provided did not address the needs of the family. In 3 cases, lack of appropriate bilingual services were noted. Deficiencies in services for children were also noted:

- Only 56.7% of applicable cases had a documented health screening (EPSDT) for the child in the case file.
- Only 22.4% of applicable cases had copies of school records included in the case files.
    - » Educational assessments were requested and/or completed in only 5% of applicable cases.
    - » 26.5% of children in out of home placement were enrolled in multiple schools as a result of the placement (Range= 1-3).
    - » Only 42.9% of applicable cases included evidence of efforts to keep the child at her original/home school or indicated reasons for a change of schools.

Recommendations: Improve documentation of service provision to children and families. This may include the need to update software programs to allow for ease of documentation and consistency in terms of services offered and services utilized. The documentation system should also allow agencies to identify service needs by tracking waiting lists, underutilized

services, and inaccessible or unavailable services which are needed to meet client needs. If the current software system cannot be updated to include fields for tracking services, agencies should implement policies to mandate that this information is included in case notes. Caseworkers and supervisors may also benefit from additional and/or enhanced training on identifying and providing services that best meet the needs of the child and family.

Caseworker Visits – Caseworkers are required by law to conduct in person visits with children at least monthly and in their placement at least every 60 days. A portion of each visit must be spent alone with the child. The audit found that in applicable cases (n=77):

- Only 36.4% included documentation of monthly visits;
- 65% provided evidence of visits made in the placement at least every 60 days; and
- Only 18.2% indicated that a portion of each visit was conducted alone with the child.

Recommendations: To ensure the safety of all children under the care of a child welfare agency, state and federal requirements for caseworkers visits should be strongly enforced by all agencies, administrators, supervisors and caseworkers. Policies and procedures should highlight these mandates and include oversight to ensure that these visits occur and are documented appropriately in the case files. Agencies (and/or the state) may consider sanctions for failure to comply with certain safety-related mandates.

Supervisory Oversight – Only 54.4% of the cases reviewed included documentation of supervisory oversight (i.e.: through acknowledgement of case notes, case staffing and individual supervisory meetings).

Recommendations: Policies and procedures should clearly specify the roles and responsibilities of supervisors, including when caseworkers need supervisor approval, the frequency of case reviews by supervisors, and specific mandatory components of cases that supervisors should be checking for in all cases. Supervisor qualifications should be reviewed to ensure that all supervisors have the knowledge and expertise to properly supervise and advise caseworkers.

Case Closure – 2 cases reviewed provided no documentation of regarding the reasoning for case closure. Only 57.7% of applicable cases (n=142) included documentation that a safety assessment was conducted before case closure. No cases where the child was at least 14 years old and eligible for adoption had documentation of a signed consent by the child. No cases where the goal was adoption had social summaries included in their case files.

Recommendations: Improve documentation of reasons for case closure and develop and/or enhance collaborative policies to ensure consistency regarding reasons for case closures statewide. Enforce mandates that safety assessments must be completed prior to case closure and documented in the case file. Require that supervisors ensure that all appropriate documentation, consents, assessments, etc. are included in the case file prior to case closure and before services/contact with the child and family are terminated.

Supervisor Interviews

Through the interviews with the supervisors the researchers gained an idea of how they felt the agency was working to protect children and serve families. All of the supervisors that participated in these interviews expressed both their successes and challenges. Overwhelmingly supervisors reported that they felt that the staff really cared about the children and families they work with, but often felt overwhelmed with the size of the job they are tasked to do. The most frequently noted concerns in serving families were regarding caseloads and service availability for families. Further, the supervisors had multiple recommendations for how to change the system to improve the welfare of children and families. Some of the most frequently noted recommendations included: reducing caseloads, improving service availability, reducing waiting times for families to receive services, and improving existing law and policy to support good social work practice.

Improve Services for Families

Virtually all supervisors interviewed for this project, regardless of agency affiliation, noted that the services available for families are either inadequate or unavailable. In some cases the services do not exist at all and in others they felt that the services were not of high quality, or the waiting lists were so long that families could not be served in a timely manner. Specific recommendations included: domestic violence services, mental health services, substance abuse treatment, prevention services, and non-acute services for teens with behavior problems.

Recommendations: Complete a full needs assessment in all jurisdictions to determine areas with the greatest need. Seek out additional grant funding and/or philanthropic support to supplement existing services to increase their capacity to serve more clients.

Improve Worker Caseloads

Almost every supervisor interviewed in all jurisdictions indicated that caseloads in their areas were too high. This may have been because of the office being short staffed, i.e. open positions that they are having trouble filling, or the amount of work associated with their cases is more than they feel can be completed in a regular 40 hour workweek. Often a high caseload was given as the reason documentation was not done on time or at all.

Recommendations: Conduct a thorough workforce study to measure the amount of time workers spend on various tasks including: home visits, phone calls, service coordination, documentation and travel time. This study should also include an assessment of the amount of time workers spend on individual cases to assess appropriate caseload numbers.

Caseworker Focus Groups and Surveys

Focus Groups

Focus groups were conducted for workers (exclusive of supervisors, managers and administrators) from all three agencies. A total of 68 workers participated in four separate focus groups. The focus groups were a positive experience and workers felt they had a voice in the process, which is something they would like from their own agencies. While respondents were able to identify strengths within their agencies and the child welfare system as a whole, it became clear that workers are suffering from low morale and burnout due to high caseloads and constant pressure. Workers want their administrators to know they are dedicated workers and would not be here if they didn't care but they want to be acknowledged and treated with the respect they deserve given their difficult jobs. They are committed to doing whatever it takes to

provide quality service to the children and families on their caseloads and this is evidenced by the many suggestions workers had for improvement of the system. These suggestions ranged from specific suggestions for training and court improvement to more general suggestions regarding policy development.

Recommendations: Agencies should establish a system for soliciting feedback from workers in a manner that is open and responsive. Specific comments and recommendations from workers provided in the full report should be reviewed by the State and the local child welfare agencies to assist in developing systemic improvements that are practice based.

Staff Surveys

All agency staff were given an opportunity to provide input to the research team through an online survey. There were 87 respondents to the survey with representation from each of the three jurisdictions. The three top areas of discussion were UNITY, training, and services. UNITY should be a priority in terms of systemic change as it is a difficult system to use and the perception is that the information currently contained in the system is not accurate. Respondents felt training was an area in need of improvement both for new workers and experienced staff who should have access to on-going advanced child welfare training. Respondents had many suggestions for training topics that would improve their ability to adequately do their jobs but also indicated that it is difficult to obtain approval for training or take time from their job to attend. The final area of improvement that was important to respondents was the area of service provision. Often it is a lack of basic necessities that brings a family to the attention of child welfare and there are limited community resources to improve the situation. It was also noted that service providers of substance abuse and mental health treatment are limited in the state.

Recommendations: Staff suggested that a new system be purchased or, if that is not possible, UNITY should at least be redeveloped and revised so it is easier to use and therefore contains accurate information. The surveys also indicated the need for a comprehensive child welfare training program to be implemented statewide to prepare caseworkers for fieldwork. Additionally, more services need to be provided to parents, foster parents, adoptive parents, and to children. The preference is to increase services with a focus on prevention and to increase concrete services such as funding for rent, utilities and food. Efforts should also be made to increase mental health and substance abuse services and/or make them more accessible to child welfare clients.

Law and Policy Analysis

A review of each agency's policies and procedures was performed by conducting a comparative analysis of the policies and procedures with state and federal laws and regulations, recommendations provided in various independent reports of Nevada's child welfare system, and some best practices identified by the research team. Of the 283 components analyzed, 201 were laws and/or regulations and 86 were recommendations and/or best practices (some recommendations were duplicative of laws and/or regulations, so not all components were mutually exclusive). Overall, agencies' policies and procedures did not consistently include mandated laws and policies, although Washoe County included substantially more than the Division of Child and Family Services (DCFS), or Clark County Department of Family Services (DFS) (DCFS-43%; DFS-37%; WCSS-82%). All agencies faired worse with including identified recommendations and best practice (DCFS-14%; DFS-13%; WCSS-37%). This may be due in part to the fact that many of these recommendations have been made only within the past couple of years. Caseworker surveys indicate that workers rarely refer to the agency policies and

procedures (32.2% indicated only a few times a year) and that some (8%) never refer to them. The administrator interviews identified several areas of concern and change at the administrative levels regarding policies and procedures. Each agency has a different procedure for notifying staff of changes in policies and procedures and two administrators noted concerns with utilizing email to provide notification of new policies and procedures to staff. The two local agencies also noted that training procedures are in place to assist staff with understanding and implementing new policies and procedures.

Recommendations: Policies and procedures at all agencies need to be updated to include all mandatory provisions of state and federal law, as well as to incorporate best practices and recommendations as deemed appropriate by the State and local agencies. Policies and procedures should be developed in a user friendly manner – including simplification of policies, elimination of contradictory policies, and available in electronic format – that is consistent with ethical guidelines and takes into consideration the practical application of caseworker and supervisory functions. Procedures to update, inform and appropriately train all workers on the proper application and meaning of new policies and procedures (as well as some old policies and procedures that are not consistently followed) should be a priority of all agencies. Agencies need appropriate funding to provide administrative support to update policies and procedures and provide adequate training to staff.

Inclusion of Panel Recommendations and Federally Approved Action Plans

The Blue Ribbon Panel, through it's report, action plans and incorporation of recommendations from other experts, provided 178 recommendations to improve child welfare services in Nevada. This report analyzed the implementation of those recommendations directly attributable to the child welfare agencies, a total of 106 recommendations statewide.

Clark County DFS received 52 recommendations. DFS was determined to have: substantially completed 6% (3) of the recommendations; not completed 67% (35) of the recommendations; and 27% (14) were unable to be determined based on the information provided and/or collected for this audit. Washoe County Department of Social Services received 25 recommendations attributable to the agency for action. Washoe County DSS was determined to have: substantially completed 20% (5) of the recommendations; not completed 56% (14) of the recommendations; and 24% (6) were unable to be determined based on the information provided and/or collected for this audit. The State Department of Child and Family Services, which oversees the rural child welfare functions, received 29 recommendations attributed to the agency for action. DCFS was determined to have: substantially completed 14% (4) recommendations; not completed 45% of the recommendations; and 41% (12) were unable to be determined based on the information provided and/or collected for this audit.

A review of the Statewide Collaborative Policies indicated that the State has substantially accomplished 11 of the 12 identified action steps included in the analysis of the State Program Improvement Plan (PIP). The only element which was not identified in the audit was a standardized intake-screening instrument. However, policies provided to the research team for the purposes of this audit did include a Collaborative Policy on Intake which includes components of tracking response times and response criteria. Therefore, it is concluded that the State is substantially in compliance with the action items identified by the Children's Bureau as not having met the performance measures identified as of June 2007.

The Corrective Action Plan, dated September 2006, outlines eleven objectives with 42 individual action steps identified to meet those objectives. According to the most recent Corrective Action Plan matrix found on the DCFS website, 28 of the 42 action steps have been completed. According to the most recent data available through the Nevada Department of Health and Human Services, Division of Child and Family Services, four of the eleven objectives have been self identified as not completed. The primary reason cited for incomplete objectives was a need to pass legislation during the 2007 Legislative Session. The case review process and interviews conducted as a part of this audit indicate that increased attention to Objective 2 is needed, since lack of appropriate documentation at all levels was identified as a primary concern throughout the audit period.

Administrator Interviews

Telephone interviews were conducted with administrators of all three agencies at the end of the project once all other data collection had been completed. All three agencies' administrators participated in the interviews, as well as additional administrative staff at DCFS. The purpose of these interviews was to solicit input from administrators regarding the status of child welfare services at their agencies, including community relations, staffing, UNITY, best practice, and laws and policies. Overall agency administrators seem to be hopeful in terms of improvement and change. They have some differing views in terms of the best ways to improve UNITY and what's important. However, they all discussed some new practices, policies and procedures that each agency has moved forward with to improve services for families involved in child welfare. A similar theme was heard in discussing these improvements and recommendations and this was a look toward child welfare as a whole system and seeing these agencies as a piece of the child welfare system. These agencies have a role to play, but rely heavily on other organizations to provide services to create successful outcomes for children and families and this should be kept in mind when working on recommendations for improvement and directing those toward the most appropriate organization in the child welfare system.

CONCLUSIONS AND OVERALL RECOMMENDATIONS

The Child Welfare System in Nevada has many strengths as well as areas that are in need of improvement. The agencies were very cooperative during the audit and showed a keen interest in working to develop better practices to improve internal functioning and service to the community. This review has demonstrated that the agencies are not neglectful of their duties or commitments to keep children safe in the community, however, severe changes need to be implemented to provide better service to families. The agencies are not consistent in practice, documentation, or in implementing policies and procedures that are dictated by the law, and there is a lack of incorporation of best practice recommendations. It is noted that many laws and recommendations have been implemented with the past few years, however, all agencies need to arrive to a situation where timely changes can be instituted. Agencies should also make a strong commitment to build morale within agencies and with the community in order to increase productivity and support for improvements. In order for the child welfare system to comply fully with the law and implement the recommendations set forth in this report as well as other preceding recommendations, support is needed by the state of Nevada, and the federal government, and needs to be sought through other private and public entities.

The child welfare system in Nevada has undergone significant scrutiny in the last few years, and like those many reports before this one, the current audit's findings led the team to make certain recommendations for improvement. All three agencies must be committed to working together to prioritize and make these changes to improve the system to better serve children and their families. There are several more specific areas where overall recommendations should be implemented to create a more comprehensive workable child welfare system.

1. Stronger investments and enhancements in human resources.
All agencies need to make a stronger investment in their human resources, to include comprehensive training (initial and ongoing) for new and existing staff, support in continuing education, competitive salary rates as well an appropriate overload system, and smaller caseloads. This strategy would improve worker morale and may help to reduce turnover in the case worker positions. New solutions should be examined and policies restructured to maximize work time and productivity as well as incorporate a more thorough system of accountability.

2. Improve documentation practices and electronic data management systems.
Child welfare agencies should focus efforts on implementing change is in their case work documentation practices and use of the existing electronic data management system. Agencies should work toward implementing a system that is more complete, accurate and user friendly for both line workers and administration. This data entry system should be created to produce reports that will allow for frequent analysis of policies, procedures, and state and federal laws. This would improve documentation of ICWA, placement efforts, services offered and provided, and ease supervisory oversight. The new system should also include a clear tracking of supervisor involvement which was also found lacking across the state. This report should be available at the county and the state level. Without proper documentation, meaningful conclusions and recommendations are challenging and this is one area that was lacking throughout all stages of the current investigation. By implementing a new system, more time should be available to ensure that all children are visited as appropriately outlined by federal, state, and agency guidelines.

3. Improve supervision of caseworkers.
Supervision is an important role in this process and supervisors should be properly trained and have time to monitor case worker compliance and assist when needed. Policies and procedures should clearly specify the roles and responsibilities of supervisors, including when caseworkers need supervisor approval, the frequency of case reviews by supervisors, and specific mandatory components of cases that supervisors should be checking for in all cases. Supervisor qualifications should be reviewed to ensure that all supervisors have the knowledge and expertise to properly supervise and advise caseworkers.

4. Update policies and procedures – statewide and agency specific.
Policies and procedures at all agencies need to be updated to include all mandatory provisions of state and federal law, as well as to incorporate best practices and recommendations as deemed appropriate by the State and local agencies. Policies and procedures should be developed in a user friendly manner – including simplification of policies, elimination of contradictory policies, and available in electronic format – that is consistent with ethical guidelines and takes into consideration the practical application of caseworker and supervisory functions, and appropriate training of all staff. Agencies need appropriate funding to provide administrative support to update policies and procedures and provide adequate training to staff.

5. Stronger investments in the child welfare system.
Many of the recommendations suggested may have a financial commitment. The state and individual agencies should consistently work to seek out additional grant funding and/or philanthropic partnerships to support improvements within the child welfare system and to supplement existing services and increase the capacity to serve more clients. By investing in improving the components listed above, the cost to benefit ratio will prove to be very cost efficient as the need for services may decrease and this will also help with the sustainability of federal dollars.

6. Continue to monitor child welfare agencies and develop sustainable best practice models.
Child welfare agencies need to be continually monitored to ensure compliance with state and federal laws, as well as with the design and implementation of best practice models. Service delivery systems should also be monitored to identify available resources and service needs to enhance the child welfare system in the community. Oversight of the child welfare agencies should be streamlined and administered in collaboration with the agencies to ensure coordinated efforts to improve services for children and families in Nevada.

INTRODUCTION AND BACKGROUND

CHILD WELFARE IN NEVADA

Nevada's child welfare system has historically functioned in a bifurcated manner, where responsibilities and services were split between the state and the two major population bases, Washoe and Clark counties. Under the bifurcated system, Washoe and Clark counties had responsibility over child protective services in their counties, while the State Division of Child and Family Services (DCFS) had responsibility for child protection in the remaining 15 rural counties, as well as all foster care and adoption services across the state. Essentially, children and families involved in the child welfare system in Clark or Washoe counties would start out with county administration over their case and then, in some cases, would later be transferred over to the supervision and administration of state agencies.

In 2001, the Nevada State Legislature began the process of integration of the child welfare system in order to establish a better continuum of care for children and their families. Assembly Bill 1 started the process of transferring responsibility over foster care and adoption services from the state to the county level in both Clark and Washoe counties. Under this new legislation, the state would still provide and administer child welfare services in the 15 rural counties. Additionally, the state DCFS would provide oversight to the two county agencies in terms of administration of federal monies, technical assistance and quality improvement. The transfer to the Washoe County Department of Social Services was completed in January 2003 and the transfer to the Clark County Department of Family Services was completed in October 2004.

Although the state has primary authority and responsibility for developing and administering the child welfare system in Nevada, the state must still follow minimum federal guidelines for ensuring the safety and well-being of children for whom the system was created. In an effort to evaluate the performance of the state, the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau developed and administered the Child and Family Services Review (CFSR) for Nevada which was conducted in February 2004. The CFSR was developed to assess the State's "performance on seven child welfare outcomes pertaining to children's safety, permanency, and well being and on seven systemic factors related to the State's capacity to achieve positive outcomes for children and families." The CFSR for Nevada indicated that the State was not in substantial conformity with any of the seven child welfare outcomes which were based on twenty-three individual indicators. However, the State was found to be in substantial conformity with four of the seven systemic factors (based on twenty-two indicators) which included:

- Statewide Information System (1 indicator)
- Training (3 indicators)
- Agency Responsiveness to the Community (3 indicators)
- Foster and Adoptive Parent Licensing, Recruitment, and Retention (5 indicators)

The State was not in substantial conformity with the remaining three systemic factors which included:

- Case Review System (5 indicators)
- Quality Assurance System (2 indicators)
- Service Array (3 indicators)

In response to the CFSR, in March 2005 the State of Nevada Division of Child and Family Services developed the CFSR Program Improvement Plan. The plan incorporated four priority practice areas to address deficiencies for twenty-nine of the forty-five indicators. The priority areas addressed safety strategies, engagement strategies, case planning and management strategies and collaboration strategies. For each indicator the plan identifies action steps to be taken, the person accountable, the methods for measuring improvement, benchmarks toward achieving the goal, and projected dates for achieving the benchmark. The Administration for Children and Families has approved the plan and efforts are currently underway to achieve the goals established in the state plan.

The Nevada State Legislature has also made efforts to reduce the rate of child maltreatment and improve systems to achieve better outcomes for children and families who come into contact with the child welfare system in Nevada. As provided above, in 2001 the Legislature approved Assembly Bill 1 which began the process of de-bifurcation of the child welfare systems in Nevada in an effort to create a streamlined system of management and services for child welfare. The 2003 Legislature also enacted several bills pertaining to child welfare. Assembly Bill 132 made court proceedings concerning abuse or neglect of children presumptively open to the public in an effort to engage the community and hold child welfare agencies accountable for their actions. In that same year, Assembly Bill 381 made significant changes to the laws concerning the process of reviewing child fatalities in the state, which focused on improving practices within the child welfare system to reduce the number of child deaths caused by abuse and neglect. In 2005 the Nevada Legislature approved legislation that would penalize persons who allowed a child to be present where crimes involving controlled substances were committed (AB 465) and penalize persons who knowingly leave a child unattended in a vehicle under certain circumstances (SB 287). The Legislature is also consistently making efforts to ensure that state laws are in compliance with the Federal Child Abuse Prevention and Treatment Act (CAPTA) (SB 296, 2005).

Despite these efforts, several cases of child fatalities and indications of inconsistent data and under-reporting of child deaths involving child maltreatment prompted a vast amount of media attention and public scrutiny of the State's child welfare agencies. As a result, several assessments and reviews were conducted to identify system deficiencies and provide suggestions to improve different aspects of the system. The reports of these groups include: The Blue Ribbon Panel Report; Edward E. Cotton Study; Child and Family Services Reviews; and National Expert Panel/ Independent Child Death Review Panel. The following is a short introduction to each report.

Report of the Blue Ribbon Panel for the Review of Child Deaths

The Blue Ribbon Panel reviews child fatality reports from Nevada's child welfare system in order to support the safety of children and prevent future deaths. It is overseen by the Department of Health and Human Services and was last convened in 2006/2007. The Panel has made recommendations regarding the UNITY system, the Child Abuse Hotline and caseload recommendations. The full text of this document, along with appendices, is located on the internet at http://www.dcfs.state.nv.us/DCFS_ChildFatalities_BlueRibbon.htm.

Administrative Review of Child Abuse and Neglect Investigations by Edward E. Cotton
During the spring of 2006 the County Management for the Clark County Department of Family Services solicited a random sample review of open cases. The Edward E. Cotton Report was the response to this assessment in which 1,352 cases were reviewed from May to October 2006. The data includes information on the safety of the children, visitation, case planning, children in substitute care and cases with children in intact families. The full text of this document is located on the internet at http://www.dcfs.state.nv.us/ChildFatalities/BlueRibbon/Attachment08.pdf.

Nevada Child and Family Services Review – Program Improvement Plan
The Child and Family Service Reviews (CSFR) are performed by the U.S. Department of Health and Human Services (HHS) every three years. HHS assesses state programs in the areas of safety, permanency, and family and child well being. The CSFR is a two-step process in which data profiles from the Children's Bureau are assessed and compared to the national standards. HHS also performs on-site visits, which include interviews with children and families associated with child welfare, as well as affiliated third parties. At the end of the review, a comprehensive report is compiled. This report includes detailed information regarding compliance with policy and law for each category of safety, permanency and well-being. This document is located on the web at http://www.dcfs.state.nv.us/Nevada_CFSR_Program_Improvement_Plan.pdf.

Independent Child Death Review and Expert Panel
Keeping Kids Alive, the National Center for Child Death Review, convened a national expert panel to conduct independent reviews of child deaths in Clark County, Washoe County and DCFS Rural Region from 2001-2004. The two reports from these reviews included findings concerning the hotline system, relative placements, parental reunification, referrals, when to close a case, responsiveness to the community, and many suggestions regarding intake and investigation. The panel hopes the state will use the recommendations to discover solutions for child welfare practices. The full report of the Clark County Review is located on the web at http://www.dcfs.state.nv.us/ChildFatalities/BlueRibbon /Attachment04a.pdf. The full report of the Washoe County and DCFS Rural Region Review is located on the internet at http://www.dcfs.state.nv.us/ChildFatalities/BlueRibbon/Attachment04b.pdf.

2008 PERFORMANCE AUDIT OF NEVADA'S CHILD WELFARE AGENCIES

In response to these reports, the Nevada State Legislature introduced legislation in the 2007 Legislative Session to provide funding to allow the Legislative Auditor to enter into a contract with an independent consultant to conduct a performance audit of each child welfare agency (AB629). On October 30, 2007, the Legislative Commission agreed to hire the UNLV team, consisting of the Nevada Institute for Children's Research and Policy (NICRP), William S. Boyd School of Law, and School of Social Work to conduct the performance audit. The UNLV Research Team undertook this study in order to provide the Legislature with a detailed look at the operations of the child welfare system in Nevada, its policies and procedures, the current laws and recommendations and how they affect our children. The purpose of the findings and recommendations is to assist in improving the Nevada child welfare system. Pursuant to A.B. 629, this study includes multiple components, including, but not limited to:

- Random, unannounced site visits to the agency offices to review open and closed cases. This review included the Unified Nevada Information Technology for Youth (UNITY) and paper files concerning children reported as neglected or abused.
- Interviews with child welfare agency supervisors and/or managers, and agency administrators.
- Focus groups with direct practice workers from all three jurisdictions to glean information regarding barriers and suggestions for improvement.
- Review of each region's policies and procedures to determine whether they adhere to applicable state and federal regulations.
- Review of recommendations from reports such as the Ed Cotton Report and the Clark County Blue Ribbon Panel to ascertain whether the suggestions were successfully incorporated into practice.
- Law and policy analysis, including a review of each agencies' policies and procedures.

The project work plan utilized by the research team for the performance audit of Nevada's child welfare agencies is comprised of five primary components designed to address the objectives presented in the response to the request for proposals (RFP). The components included:

- A thorough planning process for the project;
- An in-depth case review for substantiated cases of child abuse and neglect as well as a brief review for unsubstantiated cases;
- An interview process with child welfare agency management and administration;
- A series of focus groups and surveys with direct practice field workers in child welfare at all three participating agencies; and
- A thorough legal and policy analysis.

The planning process was conducted by the research team in the first two months of the project. The planning phase allowed the research team the opportunity to thoroughly introduce the project to agency administrators, solicit feedback, solidify procedures and develop case review and interview protocols as well as data collection tools prior to the formal project implementation phase. The introduction covered the scope of the project, the activities that were to be conducted under the purview of the project, and the roles and responsibilities of the research team and the agencies themselves. Standardized data collection tools and protocols were created to capture the information requested by AB 629. The protocols aimed at addressing potential barriers that may have been encountered in the process and provided instructions and options for resolving any problems.

The second component of the project included in-depth case review for both open and closed cases of substantiated child abuse & neglect as well as a brief review for unsubstantiated cases. Case reviews were conducted over a period of six months from the end date of the planning phase. Case reviews of both opened and closed cases allowed the research team to collect and analyze data to assess the appropriateness of agency and case worker practices for handling child welfare cases in relation to applicable laws, policies and best practices. A stratified random sample of substantiated cases and unsubstantiated cases was drawn, controlling for agency size and proportionate case distribution. Two field researchers were primarily responsible for

conducting thorough reviews of both closed and open cases of substantiated and unsubstantiated child abuse and neglect for a specified time period. Researchers conducted UNITY reviews of each case prior to reviewing the paper case files during the field site visits.

The third component of the project included supervisor/manager and administrator interviews. Interviews with supervisors/managers were conducted over a period of six months from the end date of the planning phase concurrently with the case review process. Informational interviews were conducted at the beginning of the unannounced site visits, and exit interviews addressing specific findings that needed to be brought to the supervisor/manager's attention were conducted at the conclusion of the visit. Procedural and policy information about each agency was gathered during the initial interview. At the end of the visit, the exit interview was conducted to ensure that any errors or omissions in case files or cases needing specific follow up were brought to the attention of the supervisor/manager for immediate resolution. This type of information was provided in writing and was provided to a pre-set hierarchy of administration. Agency administrator interviews were conducted at the end of the project, after all other data collection was completed.

The fourth component of the project included the focus groups which were conducted with direct practice child welfare workers. The focus groups were conducted over a period of six months from the end date of the planning phase concurrently with the case review process. The focus groups were conducted to gain the workers' perspectives on agency policies and practices, with recommendations for solutions to identified organizational, agency or community issues. In an effort to allow all caseworkers the opportunity to provide input, the research team also developed an online survey to capture this data in a format that was both easily accessible and confidential.

The final component of the project consisted of a thorough legal and policy review of applicable state and federal laws and regulations that affect agency policy and practice. The policy analysis was conducted over a period of six months from the end date of the planning phase during the same time period as the case review process. The research team compiled all relevant state and federal laws and regulations related to child welfare to utilize in a comparative analysis of agency policies and practices. Analysis of applicable state and federal laws and regulations in relation to data collected regarding agency policies and practices assisted the team in providing a basis for determining compliance by the child welfare agencies.

This report will present the findings and recommendations for the last four components described above: case reviews (including UNITY reviews and site visits); management and administrator interviews; caseworker focus groups and surveys; and law and policy analysis. Each section will include a description of the research team's methods for data collection, a description of the findings and a conclusion including recommendations for improvement. The Executive Summary of this report outlines the findings and recommendations for each of these sections.

THE UNLV RESEARCH TEAM

The Nevada Institute for Children's Research & Policy (NICRP) was founded in 1998 as part of the vision of former First Lady Sandy Miller, who wanted to have an organization in place whose role was to apply credible research and rigorous policy analysis to problems confronting Nevada's children. The NICRP is a not-for-profit, non-partisan research center in the School of Public Health at UNLV that is dedicated to advancing awareness and understanding of children's issues in Nevada. NICRP focuses its attention on issues relevant to children across the state, using data and research to develop appropriate policy recommendations to advance children's causes. NICRP also conducts academic and community-based research in order to guide program evaluation and development of programs and services in the community that serve children and families. The mission of the NICRP is to conduct rigorous academic and community-based research that will guide public policy and program development in an effort to enhance the lives of Nevada's children. To learn more about NICRP, visit our website at www.nic.unlv.edu.

The *School of Social Work* was established in 1969 as an instructional and research program at UNLV. It's mission is to educate professional social workers who will become effective leaders and practitioners in the fastest growing region of the United States. The mission of the School's Research Center is to create an interdisciplinary university and community partnership focusing primarily on research, evaluation, program development, and training that addresses contemporary issues facing both individuals and communities. The SSW has worked collaboratively the State of Nevada Division of Child and Family Services (DCFS) for more than thirty years and has supported the Division's mission and programming through research, evaluation, and workforce development and training. Its' faculty have conducted extensive research into Nevada's child welfare and children's mental health systems, having received funding from the US Children's Bureau and the National Institute of Mental Health, as well as the State of Nevada's DCFS.

The *Boyd School of Law* operates the Thomas and Mack Legal Clinic, in which law faculty have special expertise in child welfare, education, juvenile justice, and immigration. Utilizing interdisciplinary teams of law, social work, and education students, the Clinic represents the interest of clients interfacing with southern Nevada's child welfare agencies and the courts. An integral part of the Child Welfare Clinic is working directly with children and families involved with child welfare system, understanding and applying current state and federal laws regarding child welfare, and working closely with local child welfare agencies to advocate on behalf of the children in their care. Clinical staff, with the assistance of students enrolled in the clinic program, conduct extensive legal research in the area of child welfare and remain current on related statutory laws, policies, regulations and case law.

CASE REVIEWS

METHODS

Case Selection

The research team requested a list of all cases that had been either opened or closed by all three child welfare agencies in calendar year 2007. The State Division of Child and Family Services (DCFS) provided the list for all three agencies in electronic format. Project researchers drew a random sample of cases that were provided on the list. A proportionate sampling distribution was utilized to select the total number of cases that would be sampled in Nevada, from each agency, and from each district or region within the agencies. Assuming 30% variability in the data, the minimum number of cases sampled would be 171 based on a total case list of 17,396 (3,681 open and 13,715 closed). Cases were selected randomly by SPSS (statistical software), however, open and closed cases on the list we received were sampled evenly from the districts. Due to the proportionate sampling method, it was likely that some offices would statistically have a sample of 0 or 1 case. However, in order to ensure that all offices were sampled, a minimum of two cases (one open and one closed) were reviewed at each office site. This resulted in a final sample size of 195 cases which were reviewed over a six month period. The data collected in this study has a 95% confidence interval, with less than a 5% chance that the results obtained are due to error or chance.

Proportionally, there are far more investigations annually than permanency or long term cases. Therefore, to gain a clearer picture of the system and its process, the researchers over sampled to ensure there was at least one permanency file reviewed at each office location. This often resulted in reviewing a minimum of three cases at each site. If in the random selection of cases for that office no permanency cases were selected, the over sample for that site was scanned to include the first permanency case on the list.

SPSS Process

Agency organizational charts were used to determine the districts for each agency. Cases were sampled based on district. In some cases a district contains multiple sites. When this happened the sample size for that district was equally divided among offices, as there was no way to tell which office was the largest. The research team ensured that at least 2 cases were reviewed at each site, including one open, one closed and if it wasn't already selected, one permanency file was added.

SPSS was used to draw the samples. The case list was separated by each district within an agency. The list was then separated by open and closed cases for that district. Next, based on the sample size selected, the program randomly selected the appropriate number of cases from the list of open and closed cases separately. In order to ensure that enough "back up cases" were selected, researchers randomly selected at least twice as many cases as were needed from each district. This was done so that if a case was deemed inappropriate (i.e. opened in error or from the wrong office) during the UNITY review other cases were available for selection.

To select cases from the computer generated list researchers simply started at the top of the list and moved to the bottom selecting cases until the appropriate number from that district had been selected. Attention was paid to who the caseworker was and specific efforts were made to select

cases from different workers. Therefore, if a case had already been selected in an office from one worker, that case would be skipped and the next case on the list from a different worker would be selected. Duplications in workers were only acceptable if there was no other alternative (small offices may only have a couple workers) or if the duplication was in an open and a closed case. These lists were treated separately, therefore it was acceptable to have an open and a closed case from the same worker. This process was repeated for every district until cases had been selected for review at all the offices.

Case Review Process

A data collection tool was created by the team and utilized to summarize information contained in both UNITY as well as the paper case files found on site. A data dictionary was created to decrease variability in reviewers' responses to questions. Additionally, in many cases the tool asks questions related to only one child. The identified child was selected randomly, but then checked to be sure that child was appropriate for the review. The child whose name was first alphabetically and also was involved in the most recent report/investigation or permanency case was included as the identified child.

Cases were first reviewed in UNITY and all case notes available on the day of the review were saved to a flash drive. This first review was used to fill in as much information as possible and identify areas where clarification was necessary or concerns were noted. This information was then taken to the site visits where cases were requested and reviewed on site. The data tool was compared with the paper file, and additional information was collected. This was used to verify UNITY information and collect additional information not contained in UNITY. Additionally, if questions or concerns were noted from the UNITY review, the paper file was used as the first step to fill in those gaps and answer the questions. If this did not satisfy the concerns management staff were informed of these concerns at the conclusion of the site visit.

At the end of each site visit the manager or supervisor was given a "debriefing form" and an exit interview was completed if the supervisor was available. This form contained the total number of cases reviewed, any cases that were unavailable for review and any questions or concerns that arose out of the case reviews. Safety concerns were presented to management and/or administration with a request that the case be reviewed and a response provided to the research team within 24 hours.

NOTE: The data collection tool was developed, in large part, based on current state and federal laws and regulations. Where applicable, references to laws and regulations are noted in the tables.

SITE VISITS

Process Overview

Throughout the course of the project, staff completed 19 site visits across the state. The team conducted 10 DCFS rural region visits, 8 Clark County visits and one Washoe County visit. Site visits were unannounced and conducted during normal business hours. For the rural sites, which included all DCFS field offices with the exception of the Carson City office, researchers called the office one day before the visit to ensure that someone would be physically in the office for the site visit. There were either two or three researchers present for every site visit conducted.

Site visits lasted between one hour and two days depending on the size of the office and the number of cases selected for review. In all offices at least two cases were selected for review, however in the case of Washoe County where all cases are located at one site the team reviewed 40 cases over the course of two days. In order to limit time spent in each field office and minimize disruption, a thorough review of each case in the case management program UNITY was conducted prior to each site visit. During these site visits the research team not only conducted case reviews but also interviews with supervisors.

For each site visit researchers arrived at the field office and introduced themselves to the person at the front desk letting them know that they were there to complete the legislative audit site visit then requested to see the designated point of contact for that agency. When the contact person was reached the researchers explained the process for the site visits. The researchers were flexible regarding when the supervisor was interviewed – this could be done before or after the case review portion of the visit. Typically the supervisor interview was done first while an administrative person or other caseworker retrieved the selected case files for review.

Locating Paper Case Files

A list of selected cases was provided to the supervisor. Depending on the type of office and the agency, cases may or may not be located on site. At Washoe County, there was only one office so all files were located with the exception of one file where the child had been adopted and therefore the case was sent to Carson City for archiving. Otherwise all cases, open and closed, were located on site. In the Rural offices most cases were located on site as they store their closed case files in each office. In some cases the process is for closed cases to go to the region's main office, however this did not pose a problem for the research team on this project. In Clark County, cases that are pending closure are sent to the supervisor for that unit to approve. Once approved the file is then sent to the "business office" for each location. At the business office files are "sanitized", which means that all duplicate copies, UNITY printouts, and other extraneous information is destroyed and the file is organized. Files are then sent to the County's Central Office where the information is scanned and saved in the imaged database. Additionally in Clark County, the research team was notified that for all unsubstantiated investigations all information was destroyed therefore there would be no imaged documentation. Therefore, any additional information collected (school records, medical records, etc.) during the course of the investigation would not be imaged and stored. For those closed cases where information was imaged and saved in their on-line system researchers were given access to a computer in their records department to view these electronic documents.

Unclear Safety Status

During the case review processes the research team identified certain cases where the safety status of the children involved in the case was unclear. A safety concern was defined as something either in the case file or missing from the case file (either UNITY or paper) that caused a reviewer to question the safety of the child(ren). Identified safety concerns were first presented to another member of the research team who reviewed the facts and either agreed with the concern or found evidence to explain and eliminate the concern. All identified safety concerns during the course of the audit were regarding the length of time between visits to the child(ren) by the caseworker. When evidence of regular visits were absent or notes were unclear as to where the child was seen or if the child had been seen, the agency was contacted for follow up and asked to verify that someone had seen the children and that they were in fact safe. There was at least one safety concern identified and addressed in each of the three agencies. The table below indicates the number of concerns reported for each agency office. When a safety concern was noted, either during the UNITY review prior to the site visit or the paper case review on site, the designated agency contact was notified immediately. Often these concerns stemmed from lack of documentation in terms of worker visitation with the children.

Agency	Unclear Safety Status	Total Cases Selected from the Agency	Percent (out of total cases reviewed in that agency)
DFS	2	113	1.7%
DCFS	6	42	14.3%
WCDSS	2	40	5%

Identified safety concerns were relayed verbally via telephone or in person during the site visit as well as written via email. The agency was asked to investigate the matter and provide a response in writing to the Nevada Institute for Children's Research and Policy. Responses for all safety concerns were received and in all cases the agency indicated that the workers had seen the children, however documentation was inadequate.

Overall there were 10 cases where safety concerns were identified and the agencies were notified. There were a total of two in Washoe County, two in Clark County, and six in the various rural offices. This represents 5.1% of all cases reviewed (n=195). On average, agencies responded quickly, usually within 24 hours, to the request for additional follow up. All agencies also provided written responses to these safety concerns, usually via email, within one day to one month of the initial report of a safety concern.

Conclusion of Site Visits

At the end of every site visit the researchers completed a "debriefing form." This form indicated the names of the members of the research team, names of all staff that assisted with the visit, the number of cases selected for review and the number of cases reviewed. This form also indicated the number of cases that were unavailable for review at the time of the site visit and the reason. Most times a case was unavailable because the case was closed and it had been sent to another office for imaging or storage. Additionally, this form indicated the case name and number for any cases where concerns were noted. These concerns were not necessarily safety concerns, but mostly areas where documentation was incomplete both in UNITY and the accompanying paper file so that the researchers could not clearly understand the circumstances of the case. If there were questions or concerns this was reviewed with the supervisor assisting with the site visit that day. The debriefing form was completed and reviewed with the supervisor and a copy was left

for their records. In addition some sites requested to keep the list of cases reviewed at their site and if requested this was provided.

FINDINGS

Demographics

A total of 195 cases were reviewed during the course of the performance audit. Of the cases reviewed, 60% were classified as an investigation file (CPS) and 40% were classified as a permanency file. These determinations were based upon the case worker assignment in the file. Investigation files are those where the case is being investigated and the family does not have a long term plan yet as they are assessing the family and investigating the allegations. A permanency case is one where the investigation is complete and the family requires longer term services. At this time the family is assigned a permanency worker to help them complete their case plan. Please refer to Table 1: Case Review – Site and Case Types for an exact breakdown of cases reviewed per agency and per site.

Demographic information was also gathered on the 195 children that were selected for review. Overall, slightly more female children's cases were reviewed (55.9%). In the permanency cases, slightly more male case files were reviewed (57.7%). The ethnicity of approximately 30% of the children in the cases reviewed was Hispanic. Approximately 77% of the children were reported as Caucasian, 16% were reported as African American, 3% were reported as mixed race, and 1% Asian and .5% Pacific Islander. For more details please refer to Table 2: Case Review Demographic Information. These trends are consistent across CPS and Permanency cases. Only three cases did not have race identified. There were a few concerns regarding the methods of reporting race and/or ethnicity in the case files. In some instances the race and/or ethnicity did not match with the biological mother and/or father. Case records did not document the method for collecting the race or ethnicity of the child. Proper documentation is important in order to determine trends related to race and/or ethnicity in child welfare.

Data on the current placement of the child was also collected. The majority of children are living with their parents (71.8%) either because they were never removed or have been returned to live with their parents. For the permanency cases, the children are divided between living with their parents (37.2%), relatives (29.5%), or foster care (19.2%). There were no children identified as missing from their locations during the audit. For more details please refer to Table 2: Case Review Demographic Information**.**

Table 1: Case Review – Site and Case Type						
	Cases	**Percent**	**CPS Investigation**	**Percent**	**Permanency**	**Percent**
Cases Reviewed	195	100%	118	60.0%	77	40.0%
Cases Status						
Open	97	49.7%	52	44.4%	45	57.7%
Closed	98	50.3%	66	55.6%	32	42.3%
Total	195	100.0%	118	100.0%	77	100.0%
Cases Reviews Per Agency						
DCFS	42	21.5%	30	25.42%	12	15.6%
DFS	113	57.9%	64	54.24%	49	63.6%
Washoe DSS	40	20.5%	24	20.34%	16	20.8%
Total	**195**	**100.0%**	**118**	**100.00%**	**77**	**100.0%**
Cases Reviews Per Office						
DCFS						
DCFS Battle Mountain	4	9.5%	3	10.0%	1	8.3%
DCFS Carson City	9	21.4%	7	23.3%	2	16.7%
DCFS Elko	4	9.5%	3	10.0%	1	8.3%
DCFS Ely	4	9.5%	3	10.0%	1	8.3%
DCFS Fallon	3	7.1%	2	6.7%	1	8.3%
DCFS Pahrump	3	7.1%	2	6.7%	1	8.3%
DCFS Silver Springs	3	7.1%	2	6.7%	1	8.3%
DCFS Tonopah	4	9.5%	2	6.7%	2	16.7%
DCFS Winnemucca	4	9.5%	3	10.0%	1	8.3%
DCFS Yerington	4	9.5%	3	10.0%	1	8.3%
Total	**42**	**100.0%**	**30**	**100.0%**	**12**	**100.0%**
DFS						
DFS Central (Rancho)	35	31.0%	15	23.4%	20	40.8%
DFS East	8	7.1%	1	1.6%	7	14.3%
DFS Main (Pecos)	15	13.3%	12	18.8%	3	6.1%
DFS MLK	20	17.7%	11	17.2%	9	18.4%
DFS North	12	10.6%	6	9.4%	6	12.2%
DFS Renaissance	5	4.4%	5	7.8%	0	0.0%
DFS South (Henderson)	8	7.1%	7	10.9%	1	2.0%
DFS West	10	8.8%	7	10.9%	3	6.1%
Total	**113**	**100.0%**	**64**	**100.0%**	**49**	**100.0%**
Washoe DSS	**40**	**20.5%**	**24**	**60.00%**	**16**	**40.00%**

Table 2: Case Review Demographic Information						
	Cases	Percent	CPS (Investigation)	Percent	Permanency	Percent
Child's Gender						
Male	86	44.1%	58	49.2%	28	36.4%
Female	109	55.9%	60	50.8%	49	63.6%
Total	**195**	**100.0%**	**118**	**100.0%**	**77**	**100.0%**
Child's Race						
None Documented	3	1.5%	3	2.5%	0	0%
Caucasian	150	77.0%	93	78.6%	57	74.36%
African-American	32	16.4%	17	14.5%	15	19.23%
Asian	2	1.0%	1	0.9%	1	1.30%
Pacific Islander	1	0.5%	0	0.0%	1	1.30%
Declined to Answer	1	0.5%	1	0.9%	0	0%
Mixed raced	6	3.1%	3	2.6%	3	3.85%
Total	**195**	**100.0%**	**118**	**100.0%**	**77**	**100.0%**
Child's Ethnicity						
Non-Hispanic	132	67.7%	76	64.41%	56	72.73%
Hispanic	54	27.7%	36	30.51%	18	23.38%
Unable to determine	1	0.5%	1	0.85%	0	0.00%
Declined to answer	8	4.1%	5	4.24%	3	3.90%
Total	**195**	**100.0%**	**118**	**100.0%**	**77**	**100.0%**
Child's Current Placement						
Parent(s)/caregiver(s)	42	21.5%	13	11.1%	29	37.2%
Foster parent	15	7.7%	0	0%	15	19.2%
Relative/Fictive kin	30	15.4%	7	6.0%	23	29.5%
Home-child never removed	98	50.3%	93	78.6%	5	7.7%
Other	10	5.1%	5	4.3%	5	6.4%
Total	**195**	**100.0%**	**118**	**100.0%**	**77**	**100.0%**

Reason for Referral

Researchers recorded a summary of the reason for the family's most recent involvement with the child welfare agency. The categories for reasons for involvement included some form of alleged abuse, neglect or both. Abuse allegations were grouped as either physical, sexual abuse, or emotional abuse. Neglect was divided into 10 separate categories, identified in Table 3 below. Cases that had multiple allegations were grouped into each of the existing applicable categories. For example in one case the reason for the agency's most recent involvement could be that the parent was using drugs, abusing the child and leaving them home unsupervised. This one case would be considered to have three reasons for the most recent involvement. Therefore there are far more reasons for involvement than actual number of cases. Researchers recorded a total of 269 reasons for the agency's most recent involvement for the 195 cases reviewed.

Abuse

There were a total of 87 reasons for recent involvement that were categorized as some form of abuse. Eighteen of those were categorized as sexual abuse. 28.8% of these allegations involved step parents of the children. 55.6% reports alleged that natural parents sexually abused their children, and 11.1% of reports involved siblings abusing fellow siblings.

Among the cases reviewed, 67 reasons for most recent involvement were regarding allegations of physical abuse. 50.7% of these allegations were made by mandated reporting agencies: schools, day care centers, hospitals and law enforcement. In 7.5% of these cases the report came from hospital staff reporting severe physical injuries to a child they were treating. 6.0% of cases involved allegations of physical abuse to child inflicted by foster parents, while another 13.4% were against a mother's boyfriend or other step parent. 67.2% of the allegations were made against the child's natural parents. In addition to these allegations of physical abuse, there were also 3 allegations of emotional abuse.

Neglect

There were 182 reasons for the family's most recent involvement that included allegations of child neglect. The table below breaks out the type of neglect listed as the reason for the agency's most recent involvement.

Table 3: Reason for Most Recent Involvement: Neglect		
Type of Neglect (N=182)	**Count**	**Percent**
Lack of Supervision	33	18.1%
Filthy Home	9	4.9%
Educational Neglect	4	2.2%
Lack of Necessities	10	5.5%
Failure to Protect	12	6.6%
Abandonment	14	7.7%
Medical Neglect	12	6.6%
Domestic Violence	23	12.6%
Parent in Jail	14	7.7%
Parental Substance Abuse	51	28.0%
Total	182	100.0%

Within the medical neglect category, there were allegations involving parents not getting prescriptions for their children and also not making medical appointments. In addition, there were a couple of cases that mentioned a lack of medical insurance as a reason for the medical neglect.

Domestic violence was also a frequent category under neglect. Among these cases some form of domestic violence resulted in law enforcement responding to the scene and child protective services were called. The majority of these cases involved the child's biological parents, but some did involve the child's grandparents.

Parental Substance Abuse

In 26.2% of all cases reviewed parental substance abuse was a factor in the agency's most recent involvement with the family. Of these 51 instances, 58.8% involved some kind of drug, 35.3% involved alcohol, and 5.9% involved an unknown substance. In 5.9% of these cases parents were arrested for driving under the influence (DUI) with children in the vehicle. 11.8% of these

cases were reported from a hospital where a baby was born drug exposed. Additionally, 27.5% of these cases were opened because of lack of supervision or abandonment directly related to substance abuse.

Parent in Jail

There were fourteen allegations placed in the "Parent in Jail" category. There were cases where one or both of the child's parents were arrested and there was no one else available to care for the child at the time of the arrest. Four of these cases also involved some form of parental substance abuse. The other reasons for arrest included theft, burglary, assault, and domestic violence.

Investigation Information

An examination of protocols for case investigations (Table 4**:** Investigation Information and Safety Assessments) revealed that in 90.1% of cases reviewed, the person responsible for the child's welfare was immediately notified of the investigation and that caseworkers documented how the investigation was conducted in nearly 95% of the cases.

One important aspect of investigation is ensuring that the child is safe by conducting a safety assessment. Almost all the cases (99.5%) included documentation of a safety assessment for the child selected and 77.6% had a safety assessment conducted for the current investigation. The safety assessment was typically conducted at the initial face to face interaction with the child (80.7%). Documentation that a safety assessment was conducted prior to unsupervised visits was evident in 39.1% of the cases when appropriate and only 50% before returning a child to their parents after a removal. A safety assessment is also supposed to be conducted if a significant event or change affecting the household occurs. A significant event was defined as the parent, foster parent, or other care provider having experienced a major life event that can affect his/her ability to care for the child (i.e.: birth, marriage, or death in the family). In almost half of the cases (41.9%) this was unable to be determined. Safety assessments are not consistently documented prior to court reviews (23.1%), or after reunification with families (34.8%). Prior to case closure, assessments are only documented 57.7% of the time. The case notes often give a brief notion of the safety of the child, however formal documentation of safety assessments should be a priority ensuring that the safety of the child is thoroughly investigated at the determined priority intervals, as required by law and agency policy.

Table 4: Investigation Information and Safety Assessments										
		NA			Yes		No		Unknown	
	n	Cases	%	n*	Cases	%	Cases	%	Cases	%
Person responsible for the child's welfare was immediately notified of the investigation? *NRS 432B.270(1)&(3)*	195	3[1]	1.5%	192	173	90.1%	18	9.4%	1	0.5%
Manner in which the investigation was initiated was documented *NAC432B.155*	195	2	1.0%	193	183	94.8%	10	5.2%	0	0.0%
Information obtained during the investigation was recorded in writing? *NAC432B.155*	195	2	1.0%	193	187	96.9%	6	3.1%	0	0.0%
Safety										
Documentation that a safety assessment was EVER conducted *NAC 432B.185*	195	2	1.0%	193	192	99.5%	1	0.5%	0	0.0%
A safety assessment was conducted: *NAC 432B.185*										
• at the initial face-to-face with the child?	195	3[2]	3.5%	192	155	80.7%	32	16.7%	5	2.6%
• before any unsupervised visits between the child and the parent(s)/caregiver(s)?	195	126	67.2%	69	27	39.1%	35	50.7%	7	10.1%
•before returning the child to the custody of the parent(s)/caregiver(s)?	195	149	76.4%	46	23	50.0%	23	50.0%	0	0.0%
•due to a significant event or change that affects the household ?	195	152	77.9%	43	10	23.3%	15	34.9%	18	41.9%
•before each court review?	195	127	66.6%	65	15	23.1%	44	67.7%	6	9.2%
•after reunification of the family?	195	149	75.9%	46	16	34.8%	27	58.7%	3	6.5%
•before closure of the case?	195	53[3]	27.2%	142	82	57.7%	49	34.5%	11	7.7%

**Note: Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no".*

[1]Two cases were out of state cases or ICPC (Interstate Compact for the Protection of Children) and one case the parent had died so there was no person responsible to contact.

[2]Two cases were ICPC and in one case the child was taken to jail.

[3]There are a total of 54 cases that are marked open, however in some instances, the case is open in UNITY pending a supervisors approval for closure, or the case was an ICPC.

Investigation Timing

Information was also collected regarding the date the referral was made, the date it was assigned to an investigator and the date of the first face to face contact with the identified child. For the majority of cases the referral and assignment happened on the same day or the very next day. However the number of days between the date of the referral and the date of first face to face contact had a range of 0 to 27 days. The overall average was 1.71 days (SD = 3.36). Upon review of these cases there were lags in time between the referral and the face to face visits because parents would cancel scheduled home visits, or the address and contact information given by the source was incorrect. In most cases there was some contact with the family made within the first couple of days, but this was not always face to face contact with the children. Overall, only 9% of cases involved a time frame of 6 or more days between the referral and the face to face visit with the child. Workers in all jurisdictions seemed to be doing very well in making sure response times were met. According to the Director of the Clark County Department of Family Services, "Nevada policy has three response time frames, Immediate (3 hours), 24 hours and 72 hours" and the rural counties have even longer in certain instances. The table below represents averages among cases and does not distinguish between the different required time frames. Given the research team's access level to UNITY and case files, we were unable to determine with certainty the appropriate response time frame and therefore recorded only the time between the date of the report and the date of the initial face to case contact.

Table 5: Number of Days between Report and First Face to Face Contact by Agency

Agency	Minimum	Maximum	Average	Std. Deviation
Clark County	0	20	2.1	2.9
Washoe County	0	27	1.32	3.5
DCFS	0	23	1.4	3.9

Note from Washoe County: *Regarding Table 5 above, "I would recommend that in the future the focus be on the response requirement assigned by the supervisor and the actual response time by the case worker. The report currently reflects an overall response perspective but does not give a sense of whether the agency responded to the specific case circumstances in a timely manner."*

Determinations

Information for all reports and referrals were compiled in a separate database that included information for every report regarding the identified child. This information was then analyzed to look at type of allegations for the first allegation, as well as the number of substantiated, unsubstantiated and information only reports among all cases and among each agency.

Table 6: Case Determinations		
	Count	**Percent**
Substantiated	96	31.8%
Unsubstantiated	155	51.3%
Voluntary Services - No Determination	6	2.0%
Information Only - No Investigation	40	13.2%
Unknown	5	1.7%
Total	302	100.0%

Overall the case reviews contained information regarding 302 reports/referrals for the 195 cases reviewed. There were multiple reports or referrals for most cases, while some cases only had one report/referral on record. Table 6: Case Determinations shows that the majority of reports/referrals reviewed were unsubstantiated at 51.3% of the total. About one third of the reports/referrals were recorded as substantiated.

In Clark County the distribution between substantiated and unsubstantiated cases is fairly even at 41.5% and 50% respectively, while in both Washoe County and DCFS there are nearly twice as many unsubstantiated cases as substantiated cases. This may point to the need for further training or clarification regarding substantiation criteria to ensure that determinations are made uniformly across the state.

Table 7: Case Determinations by Agency (Percents out of Agency Totals)						
	Clark County		**Washoe County**		**DCFS**	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Substantiated	54	41.5%	22	22.2%	20	27.4%
Unsubstantiated	65	50.0%	48	48.5%	42	57.5%
Voluntary Services - No Determination	0	0.0%	6	6.1%	0	0.0%
Information Only - No Investigation	9	6.9%	22	22.2%	9	12.3%
Unknown	2	1.5%	1	1.0%	2	2.7%
Total	130	100.0%	99	100.0%	73	100.0%

***Note from Clark County**: The Director noted in a comment on the draft that according to their records their substantiation rate is actually much lower than the numbers presented in the table above.*

***Note from Washoe County:** In response to Table 7, "While we agree that further training and discussion in this area would be helpful, it would have been better to have the reviewers assess the findings in the specific cases to determine if they believed there was an adequate basis to substantiate the investigation. This discrepancy has been around for a long time and, at least in part, is to the screening in/out decisions made by each jurisdiction.*

Table 8: Allegation Type displays the allegation categories for all 302 reports. The vast majority of reports were for neglect at 74.5% of all reports reviewed, with physical abuse a distant second

at only 16.2%. Additionally, this table shows that regardless of the determination there were similar proportions of allegation types.

Table 8: Allegation Type						
	All Allegations		Substantiated		Unsubstantiated	
	Count	Percent	Count	Percent	Count	Percent
Neglect	225	74.5%	70	72.9%	116	74.8%
Physical Abuse	49	16.2%	18	18.8%	28	18.1%
Emotional Abuse	14	4.6%	7	7.3%	5	3.2%
Sexual Abuse	7	2.3%	1	1.0%	6	3.9%
No Allegation	7	2.3%	0	0.0%	0	0.0%
Total	302	100.0%	96	100.0%	155	100.0%

In over half (51.7%) of the cases, the child's mother was the alleged perpetrator, followed by the child's father at 13.2%, then both parents at 15.9% of all cases. The remaining cases had perpetrators including a significant other of the biological parent (7.3%) or some other person, which could include facility staff, babysitters, and foster parents. In 4.6% of cases the perpetrator was unable to be determined using the available case information. Additionally, 87.7% of incidents occurred in the home.

Child Removal

For the following analysis, cases were selected based on removal from the home. This includes some investigation cases where children were removed. In 47.7% of cases reviewed, a child had been removed from the home at least once in the case history. Agencies have been successful at documenting that immediate efforts were made to let the guardian know that the child was taken into protective custody. However, improvements could made in the documentation of notification of court hearings to a parent/guardian not residing in the home in which the child was removed, which occurred in only 46.5% of applicable cases. Documentation that a court hearing was conducted within the 72 hour period after being taken into custody was evident in 88.1% of the cases. Documentation of whether the worker asked if the child was an Indian child, pursuant to federal ICWA requirements, was found in only 62.6% of the cases.

Table 9. Child Removal										
		NA			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
Was the child ever removed from the home? *NRS432B.390*	195	0	0	195	93	47.7%	102	52.3%	0	0.0%
If the child was removed from the home:										
There is documentation that the agency asked, or attempted to ask, a parent, legal guardian or relative of the child (if available) whether the child is an Indian child, *NRS 432b.067 & NRS432B.397*	93	2	2.2%	91	57	62.6%	28	30.8%	4	4.4%
There is documentation that the agency immediately made reasonable efforts to inform the person responsible for the child's welfare that the child had been placed in protective custody. *NRS 432B.309(7)*	93	4	4.3%	89[1]	82	92.1%	5	5.6%	2	2.2%
Was a hearing conducted within 72 hours after being taken into custody (excluding weekends and holidays) to determine whether the child should remain in protective custody? *NRS 432B.470(1)*	93	9	9.7%	84[2]	74	88.1%	9	10.7%	1	1.2%
If both parents were not living in the home, was the non custodial or joint custodial parent notified of the initial protective custody hearing, foster care, out of home placement or court hearing? NAC 432B.290	93	50	53.8%	43	20	46.5%	23	53.5%	0	0.0%

Table 9 Note. Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no". From the 93 cases, two cases were ICPC cases and did not apply to any of the questions in this table. [1]Other than the two ICPC cases, in two cases there was no person responsible for the child's welfare. [2]Other than the two ICPC cases, the child had been returned home and a hearing was unnecessary.

Siblings/Other Children

In 54 cases where children were removed from the home, siblings were involved. 28 of those cases involved a child who was removed from the home where at least one sibling remained. In 60.7% of cases these cases (n=28), a safety plan to ensure the safety of the other children was documented. Approximately 40% of the time when siblings are involved (n=54), the siblings are not placed together. However, in most cases it appears that there were valid reasons for separation, including:

- a sibling may have been staying with another relative out of state at the time of removal so was left in relative care;
- one child was with the parent while arrested and was placed in emergency shelter while the other sibling was in the care of a relative;
- siblings live separately, prior to CPS involvement;
- siblings may have different biological parents;
- new child is born and family that cares for siblings are not able to care for the new infant;
- need for special medical attention; and
- children are at the same shelter but are separated due to age.

In some instances it is unclear why the children were separated (n=6) because reasons for separation were due to a lack of resources or reasons for separation were not documented in a clear manner. For example, in one case, there were three children removed, two of those children were placed together in a home and one child remained in a temporary shelter. There was no documentation in the notes to explain why one child was left in the temporary facility. Another example involved a Spanish-only speaking family including both verbal and non-verbal children. The verbal children were placed in a Spanish speaking home and the non-verbal children were placed in a separate home. There was no indication if the Spanish speaking home did not have the ability to care for all the children. Lastly, in one case, the older children were removed because they were targets of abuse, however, younger children were not removed as they were not the targets of abuse and did not have any injuries and appeared well cared for. These younger two children were voluntarily placed with the maternal aunt, as were the other two children after being released from the emergency shelter. Children in this case were separated only temporarily while the background check was completed on the maternal aunt.

Table 10. Child Removal Siblings/Other Children										
		NA			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
If a child was removed, there is documentation that the agency developed a safety plan to ensure the safety of all other children remaining in the home/facility? *NAC 432B.160(3)*	93	2	2.2%	28[1]	17	60.7%	8	28.6%	3	10.7%
If the child has siblings, were they EVER separated in an out of home placement? *NRS 127.2825*	93	2	2.2%	54[2]	21	38.9%	33	61.1%	0	0.0%

Note. Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no". [1]n refers to cases where other children were remaining in the home. [2]n refers to the number of children who have siblings who were also removed.

***Reason for Removal** (NRS 432B.390)*

The reason for the most recent removal was collected qualitatively in an open ended question on the data collection tool. The reasons for removal were typically some form of abuse or neglect, however there were some instances where a child was removed and placed in a shelter because of circumstances beyond the parent's control, including a case where the caretaker was hospitalized and the parents could not be located quickly. The following sections will describe the categories created and summarize some of the circumstances associated with cases placed in those categories. Although there were often multiple reasons for removal, an attempt was made to identify the primary reason for removal which was used in this analysis.

Neglect Related (n=68)

- *Inadequate Housing/Availability of Caretaker*
  The most frequent reason for removal that was neglect related had to do with the availability of a caretaker. Sometimes this was a parent or guardian that had been arrested and couldn't care for the child, or parents who refused to pick up a child from another caregiver or institution. Of the 68 neglect related reasons for removal, 63% were some form of abandonment, or parent's inability to care for the child because they were incarcerated, homeless or otherwise unavailable. In 19% of neglect related cases the parent or parents were incarcerated and no other relatives were available and therefore the agencies had to take custody of the children and place them in shelter care. In the remaining cases parents either had inadequate housing or could not be located.

  In 8% of neglect related cases the reason for removal was listed as "filthy home". These were places where the conditions of the home were so dirty it was deemed unsafe and children were removed.

- *Parental Substance Abuse*
  The next most frequently occurring reason for removal was related to parental substance abuse. There were 13 cases where the primary reason for removal was parental substance abuse. Of these cases 23% were cases where infants were removed because they were born drug exposed or tested positive for drugs in the hospital. In 53.8% of cases the

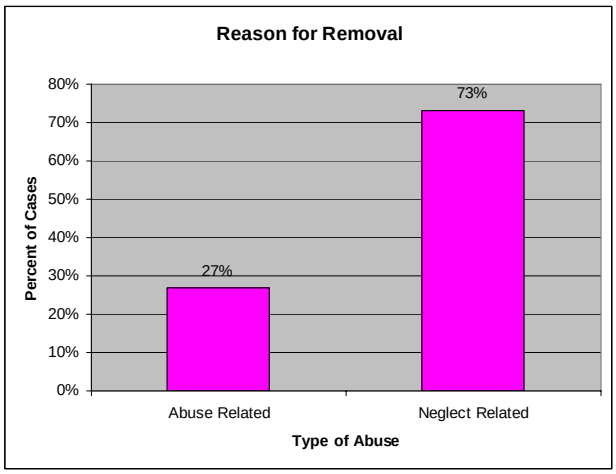
parent was seen intoxicated in public, or was so intoxicated that they could not care for the child and child protective services was called. The remaining cases were families that had previous contact with the child welfare system and were given instructions and resources to be clean and sober, but had failed to follow through so children were removed.

- *Lack of Supervision/Medical Neglect*
  In the remaining neglect related cases children were removed from their homes because of a gross lack of appropriate supervision creating an unsafe environment or the parent/guardian not getting appropriate medical care for their children. There were 8% of all neglect related cases that fell into this particular category.

Abuse Related (n=25)

- *Sexual/Emotional Abuse*
  Of the 25 cases where the reason for the most recent removal was abuse, one fifth of them were because of allegations of either sexual or emotional abuse. In 60% of the cases the alleged perpetrator was not a biological parent. In these cases it was a parent's significant other, a neighbor, or an adoptive parent. In the other 40% of cases the perpetrator was a biological parent. All but one of these reasons for removal were allegations of sexual abuse, the remaining reason was emotional abuse.

- *Physical Abuse*
  The remaining 80% of abuse related reasons for removal were allegations of physical abuse. These were either allegations where a parent could not explain an injury or bruise, or where the children or other concerned adult was alleging physical abuse. In 10% of these cases the physical abuse occurred in conjunction with other forms of domestic violence. In 55% of cases there was physical evidence of injury on the child including bruising, swelling, redness and even broken bones. In the majority of these reasons for removal, the parents were the alleged perpetrators second only to the significant others of biological parents.



Placement

For cases where children were removed from the home, 55.1% of the cases included documentation that the agency did a diligent search to find relative placements, and that 68.2% gave preference to a relative placement. Nearly 72% of cases showed that caseworkers are requesting placements in consideration with distance to the parent/caregiver if that suits the best interest of the child. However, improvements could be made in efforts to place the child near home (49.4%). Very few children were placed in a home out of state (8.6%) and for those children, quarterly update reports were not found in the case documentation.

Table 11. Child Removal - Placement

		NA			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
If the child was removed from the home, is there documentation that the agency:										
• conducted a diligent search to find relatives?	93	10[1]	10.8%	78	47	60.3%	28	35.9%	8	10.3%
• gave preference in placement to a relative who was suitable and able to provide care/guidance, regardless of whether the relative resided within the State. *NRS 432B.390(7)*	93	15[1]	16.1%	78	38	48.7%	25	32.1%	15	19.2%
• submitted a plan to the court designed to achieve placement in a safe setting as near the residence of the parent(s)/caregiver(s), as is consistent with the best interests and special needs of the child, including a description of where the child should be placed? *NRS 432B.540*	93	8[1]	8.6%	85	58	68.2%	15	17.6%	12	14.1%
Was the child placed in a facility, other than under an emergency admission, WITHOUT a court order? *NRS 432B.6077*	93	3[2]	3.2%	90	3	3.3%	86	95.6%	1	1.1%
If temporary placement was necessary, is there documentation that efforts were made to place the child as close to home as possible? *NAC 432B.220*	93	12[1]	12.9%	79	39	49.4%	39	49.4%	3	3.8%
If temporary placement was necessary, is there documentation that immediate plans were made to return the child to their home? *NAC 432B.220*	93	12[1]	12.9%	79	51	64.6%	27	34.2%	3	3.8%

Table 11. Child Removal – Placement Continued										
		NA			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
Regarding the child's most recent removal, was the child placed in a home out of state or out of the agency's jurisdiction?	93	0	0.0%	93	8	8.6%	85	91.4%	0	0.0%
• If yes, are the quarterly update reports documenting child well-being in the case file?	8	1[3]	12.5%	7	0	0.0%	6	85.7%	1	14.3%

Note. Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no". From the 93 cases, 2 cases were ICPC cases and did not apply to any of the questions in this table with the exception of the last two questions.
[1]*Child was returned home or child was in juvenile detention.*
[2]*Court order was not necessary due to voluntary removal*
[3] *Quarterly Updates were not due at the time of the case review.*

Data were also collected regarding the type of placements used for children in the cases selected for this review. The data tool collected information on the type of placement and dates for when the child was in the given placement. Researchers did not notice a substantial amount of change in placement where this was not explained and/or warranted. If excessive changes were noted the information would have been captured in the "Notes" section of the tool and analyzed later in this section. Table 12 below illustrates the types of placements and average time in each type of placement.

Table 12: Out of Home Placements - Length of Stay (days)			
	Minimum	**Maximum**	**Average**
Foster Homes	1	536	112.62
Shelter Homes	1	367	44.29
Relative Placements	2	2193	218.6
Child Haven	0	58	7
Kids Kottage	1	366	25.7
Hospital	1	188	36.2
Non-Relative Placement	25	89	57
Parental Placement	61	303	150.14
Independent Living	65	153	112.7
Runaway Status	1	16	6.7

Case Planning

Case plans are designed to outline specific tasks parents must complete in order for the child to return home or to outline other permanency goals. The case plan specifies objectives such as obtaining and/or maintaining employment, adequate housing, substance abuse counseling, domestic violence assessment and counseling, or other objectives related to child safety. The case plan should also include barriers to providing a safe environment for the child, strengths of the family, and a description of the type of home/institution in which the child is placed. The case plan is a legal document.

This section was analyzed using only permanency cases (77). Of those cases, 3 cases were not applicable to this analysis. Two of those cases were voluntary placement so a case plan was not required. One of the cases was very recent and the deadline for the case plan to be submitted was after the date of the case review. For the remaining 74 cases, 81% had a case plan in the file, while 17.6% of the cases did not have a documented case plan that could be located by the reviewers. One case (1.4%) was identified as unknown where the documentation of a case plan was not able to be determined because the paper file was sent to another office to be archived and was not available for review. The analyses for the remaining questions were conducted on the 60 case files that did have a case plan. For a few questions (i.e. siblings, education, adoption) the content is not applicable to all cases and so the final percentages are based on the number of cases to which the question applied.

Table 13: Case Plan Inclusions *(NAC 432B.190(2) & NAC 432B.400)*

		N/A			Yes		No		Unknown	
	n	**Cases**	**%**	**n**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
Is there a case plan in the file?	77	3[1]	0	74	60	79.3%	13	17.6%	1	2.4%
Does the case plan include:										
• identification of barriers to providing a safe environment for the child?	60	0	0.0%	60	54	90.0%	6	10.0%	0	0.0%
• identification of strengths of the family?	60	0	0.0%	60	54	90.0%	6	10.0%	0	0.0%
• clarification of responsibilities to address barriers?	60	0	0.0%	60	58	96.7%	2	3.3%	0	0.0%
• overall goals and objectives of the case?	60	0	0.0%	60	59	98.3%	1	1.7%	0	0.0%
• step-by-step proposed actions/activities of all persons?	60	0	0.0%	60	58	96.7%	2	3.3%	0	0.0%
• description of services offered/provided to prevent removal or to reunify the family of the child?	60	0	0.0%	60	51	85.0%	9	15.0%	0	0.0%
• description of the type of home/institution in which the child is placed, including safety and appropriateness of placement?	60	3[2]	5.0%	57	49	86.0%	8	14.0%	0	0.0%
• description of efforts that will be made to place siblings together?	60	32	53.3%	28	16	57.1%	12	42.9%	0	0.0%
• plan for family visitation, including visiting siblings if siblings are not residing together?	60	3[2]	5.0%	53	40	75.5%	13	24.5%	4	7.5%

Table 13: Case Plan Inclusions Continued										
		N/A			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
• (if goal is adoption or placement in another permanent home) description of steps to finalize including recruitment of adoptive parents?	60	59	96.7%	1	1	100.0%	0	0.0%	0	0.0%
• statement indicating the proximity of the school in which child enrolled at the time was considered a factor?	60	34[3]	56.7%	26	5	19.2%	20	76.9%	0	0.0%
• specified timeline for completing goals, objectives and activities?	60	0	0.0%	60	48	80.0%	12	20.0%	0	0.0%
• approval by the case worker's supervisor?	60	0	0.0%	60	33	55.0%	24	40.0%	3	5.0%
• updates at least every 6 months?	60	11	18.3%	49	9	18.4%	39	79.6%	1	2.0%

Note: Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no".

[1] *Plan is not yet required.*

[2] *Children are in the home.*

[3] *Only applicable if child was K-12.*

Certain aspects of the case plan were consistently represented (present at least 90.0% of cases) across case workers and agencies such as:

- the identifications of barriers to providing a safe environment;
- responsibilities to address barriers;
- overall goals and objectives;
- family strengths;
- step by step actions for each individual involved;
- detailed description of adoption strategies if that is the goal for that child: and
- documentation of an annual review.

Components that were found in at least 75% of cases included:

- plan for visitation with siblings;
- specific timelines to complete objectives;
- documentation of a plan for permanent placement within 12 months of removal;
- documented evidence that parents were encouraged to participate in the development of the plan; and
- if the child was over 16, there was documented efforts to provide services to the child to live independently.

Other areas assessed were not documented consistently and could use some attention for improvement. These areas included:

- documenting efforts to place siblings together;
- statements of health and education records;

- indication of the proximity of the school;
- approval by a supervisor (assessed by a signature from the supervisor on the case plan);
- formal updates every 6 months;
- separate case plans written for each parent involved;
- completion of the case plan within 45 days of removal; and
- if a concurrent plan existed, documentation to address if both plans progressed simultaneously.

Documented permanency goals were also reviewed. The audit found that the majority of children had a main goal of reunification (70.0%) with their parents/guardians. The next most common permanency goals were maintenance with the home after returning with legal guardians (18.3%), placed with an alternative legal guardian or relative (5.0%), adoption (3.3%), independent living (1.7%), or other permanency living arrangement (1.7%).

Table 14: Case Plan Completion

		N/A			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
There is a separate plan written for each parent/caregiver?	60	6[1]	10.0%	54	21	38.9%	31	57.4%	2	3.7%
Is there evidence that the parent(s)/caregiver(s) were encouraged to and/or participated in the development of the case plan? *NAC 432B.190(3)*	60	1[2]	1.7%	59	48	81.4%	10	16.9%	1	1.7%
If reasonable efforts were waived, was a judicial review held within 30 days of removal? *NRS 432B.393 (1,3) & NRS 432B.553(1)*	60	60	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Did the agency document a plan for the permanent placement of the child within 12 months of when the child was removed (or within 30 days of removal if reasonable efforts were not required)? *NRS 432B.553(1)*	60	0	0.0%	60	48	80.0%	11	18.3%	1	1.7%
Is there documentation that the permanency plan was reviewed annually? *NRS432B.553*	60	46	76.7%	14	13	92.9%	0	0.0%	1	7.1%
Was the (first) case plan completed within 45 days after the date the child was removed from his/her home? *NAC 432B.400*	60	0	0.0%	60	33	55.0%	25	41.7%	2	3.3%

Table 14: Case Plan Completion Continued

		N/A			Yes		No		Unknown	
	n	Cases	%	n	Cases	%	Cases	%	Cases	%
Is there a concurrent plan?	60	0	0.0%	60	34	56.7%	23	38.3%	3	5.0%
If so, is there documentation that both plans are being worked simultaneously?	60	26	43.3%	34	21	61.7%	10	29.4%	3	8.7%
If the child is age 16 or older, is there documentation that the case worker provided services designed to prepare the child to live successfully and independently as an adult? *NAC 432B.410*	60	53	88.3%	7	6	85.7%	1	14.3%	0	0.0%

Note: Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no".

[1] *Only one parent involved.*

[2] *Adoption case.*

Provision of Services

To determine if appropriate services were referred to parents and children, information was gathered from the Family Risk Assessment Protocol (FRAP) and case worker notes in UNITY. From the cases reviewed, the FRAP was used for approximately half of the cases (54.4%).

Table 15. Assessment of Need

		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
Was the Family Risk Assessment Protocol (FRAP) used?	195	106	54.4%	68	34.9%	21	10.8%
Were any services offered to the child's parents? *NRS 432B.240 & 432B.405*	195	121	62.1%	74	37.9%	0	0.0%
Were the services utilized linked to the FRAP?	65[1]	54	83.1%	11	16.9%	16	24.6%
Were there follow-up risk assessments done? *NAC 432B.180*	195	10	5.1%	163	83.6%	22	11.3%

[1] *This number indicates the total number of applicable cases, those where the FRAP was used and services were offered.*

Family Services

Services were offered to families more often if a child had been removed from the home (80.6%) or if the case was a Permanency case (84.6%) compared to an investigation case (47.0%). In most situations (83.1%), services recommended to the parents were linked to the FRAP. Table 16 shows the number of parents who were referred for various services, as well as those that received direct assistance and the number of parents that actually used the services. All information was collected during the case file reviews. Referrals were noted when the case notes indicated that a referral for services had been provided, direct assistance was defined as an instance where the worker or agency actually paid for the services or enrolled them in services, and utilization was defined as the documented use (attendance, acceptance, etc) of the services.

Table 16: Family Services						
Services Offered to the Child's Parents:	Referral		Direct Assistance		Utilization	
	Count	Percent*	Count	Percent*	Count	Percent*
Substance Abuse	49	40.5%	6	5.0%	26	21.5%
Housing	15	12.4%	6	5.0%	9	7.4%
Parenting classes	52	43.0%	5	4.1%	32	26.4%
Daycare	6	5.0%	6	5.0%	7	5.8%
Homemaker services	3	2.5%	2	1.7%	1	0.8%
Domestic violence counseling	23	19.0%	3	2.5%	14	11.6%
Mental health counseling	39	32.2%	10	8.3%	26	21.5%
Emergency Fund grants	9	7.4%	10	8.3%	9	7.4%
Welfare agency (Food stamps, TANF)	22	18.2%	4	3.3%	5	4.1%
Health care-Parent/caregiver	2	1.7%	4	3.3%	1	0.8%
Health care-Child	8	6.6%	3	2.5%	7	5.8%
Anger Management	13	10.7%	3	2.5%	12	9.9%
Public Health Nurse	3	2.5%	2	1.7%	4	3.3%
Transportation	13	10.7%	17	14.0%	14	11.6%
Job training	2	1.7%	3	2.5%	3	2.5%

** Percents in this table are based on the total number of affirmative responses out of the total number of cases where services were offered to the parents (n=122)*

This chart does not include services provided to children or to foster parents/relative placements. Information for this chart was obtained from case notes. Documentation of services through case notes makes assessment of service delivery and use very difficult to track and may be an underestimate of the case workers efforts. It is suggested that a new system of tracking service referrals and use is developed that will provide accurate information. It is important to also document whether lack of use is due to waiting list or unavailability of needed services. This will allow the agency to fully understand what services are most needed and used by clients and can provide strong grounds for new service implementation.

Child Services

Three areas were assessed regarding services for the child: mental health, medical, and educational needs.

- *Mental Health*
  The FRAP identified 13.2% of the children screened as possibly needing additional mental health services and 23.1% were identified using other risk assessments. (For the time frame under review, the FRAP was not consistently used as the risk assessment.) For the children identified as needing mental health services, approximately 85% were referred for services and 55% were documented to have received services. Missing referrals could be due to a child who is currently in treatment and does not need a referral, an undocumented referral, or a lack of a referral. The extent of referrals and use of service were difficult to determine based on the method of documentation (in case notes).

Table 17: Children's Mental Health Services							
		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%

Were any mental health needs identified through the FRAP?	106[1]	14	13.2%	89	84.0%	3	2.8%
Were mental health needs identified through any other means other than the FRAP?	195	45	23.1%	147	75.4%	3	1.5%
If Questions #1 and #2 are Yes, was a mental health screening performed?	52	24	46.2%	12	23.1%	16	30.8%
Was the child referred for mental health services?	52	44	84.6%	7	13.4%	1	1.9%
Did the child receive recommended mental health services?	44	24	54.5%	4	9.0%	16	36.3%

[1]*This chart shows a difference in the total n for each question. The first n is only those cases where a FRAP was documented as used. The second question is for all cases. The next two are only those cases where mental health needs were identified. The final n in this chart indicates the total number of cases where needs were identified and the child was referred for services.*

- *Medical*
  An Early and Periodic Screening, Diagnosis and Treatment (EPSDT) test, also known as a well check, is typically performed when a child is removed from the home and is required for all children entering the foster care system. Regarding children removed from the home, almost 40% had received EPSDT services. There were 30 cases where the child was placed into a foster home and 56.7% of those cases had a documented EPSDT. The EPSDT policy was not implemented until May of 2006 and the current review examines removals that may have occurred prior to this date. The data presented here may underestimate the true number of children removed from the home that receive EPSDT services after the policy had been implemented. Regarding documentation of health issues, a small percentage of the cases (8.2%) record detailed prescription medication, however, it is impossible to determine from the case review if medication is not being reported in UNITY. When a child is not with their parent/guardian, the agency seems to be utilizing in person visits and phone calls to update the parents concerning their child's health.

Table 18: Children's Medical Services

		Yes		No		Unknown	
	n	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
Was an EPSDT (well check) done?	93[1]	37	39.8%	42	45.2%	14	15.1%
Is there documentation of the child's prescription medications?	195	16	8.2%	179	91.8%	0	0.0%
What types of documentation are included in the case file to indicate that the agency is engaging the parent(s)/caregiver(s) regarding their child's health care?							
• Parent Letter	77	3	3.9%				
• Parent Phone Call	77	28	36.4%				
• Parent In Person	77	33	42.9%				
• Parent Transportation	75	5	6.7%				
• Parent Consent	63	0	0.0%				

[1] *This number represented children who were ever removed from the home.*

- *Educational* For children who are of school age, 22.4% have school records in their file and only 6.5% were referred for an educational assessment, but not all the assessments were recorded in the file. For the children who had to change schools (n=11), 7 of the children

changed schools twice, 2 changed once and 2 changed three times. Currently, workers are documenting efforts to keep the child enrolled in the original school or why a change of schools is needed just under half of the time (42.9%).

Table 19: Children's Educational Services

		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
Are copies of the school records in the case file? *NAC 432B.400(2)(q)*	107	24	22.4%	83	77.6%	0	0.0%
Is there documentation in the case file that an educational assessment was requested and/or completed?	107	7	6.5%	100	93.5%	0	0.0%
If yes, is a copy of the assessment in the case file?	7	3	42.9%	4	57.1%	0	0.0%
If the child was in an out of home placement, was the child enrolled in multiple schools as the result of being in out of home placement?	35[1]	11	31.4%	15	42.9%	9	25.7%
Is there evidence in the case file that the agency made efforts to keep the child enrolled in his/her original school OR indicated specific reasons why the child should not remain at his/her original school? *NAC 432B.400(2)(p)*	35[1]	15	42.9%	20	57.1%	0	0.0%

[1] *These totals represent only those cases where the child had been in an out of home placement and was of school age.*

Court Reporting

For several cases, court reports were not available in the file or electronically resulting in an unknown answer. For some of the questions, the total number of cases reviewed for this criteria were less because the question did not apply. For example, if a question is regarding school and the child is not of school age, then the case did not apply and therefore was not included in the analysis for that question. For purposes of this review, the most recent court report and semi-annual assessment, as applicable, were utilized to answer the questions in the data collection tool.

Although the majority of the court reports include documentation of reasonable efforts (86.2%), information such as conditions of child's residence, school records, physical and mental health of the child, and family background are documented inconsistently. It was noted that in 12 cases (20.3%) documentation was provided regarding whether or not the child was sent to an emergency medical provider. However, if this type of care was not necessary, it would not be expected to be in the report and by the information provided, determinations were not able to be made whether that level of care was necessary.

Table 20: Most Recent Court Report for Permanency Cases *(NRS 432B.540)*							
		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
Does the most recent court report address:							
• documented reasonable efforts?	59	50	84.7%	3	5.0%	6	10.2%
• conditions of the child's residence?	59	36	61.0%	17	28.8%	6	10.2%
• school records?	38	13	34.2%	19	50.0%	6	15.8%
• mental health background?	59	28	47.5%	25	42.3%	6	10.2%
• physical health background?	59	35	59.3%	18	30.5%	6	10.2%
• social background of the family?	59	28	47.5%	25	42.3%	6	10.2%
• financial situation of the family?	59	29	49.1%	24	40.7%	6	10.2%

Note: Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no".

When examining the most recent semi-annual assessment, documented reasonable efforts are present in the majority of the reports (83.1%), however family functioning, determined risk of reunification with parent/guardian, and family strengths and resources are not documented consistently.

Table 21: Semi-Annual Assessment Reports *(NAC 432B.420)*							
		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
Does the most recent court report include:							
• the current level of functioning of the child's family?	59	45	76.3%	6	10.2%	8	13.6%
• an update of the history of the family as it pertains to the risk which prompted placement of the child into foster care?	59	46	78.0%	5	8.5%	8	13.6%
• the current risk to the child if s/he were returned to the custody of his/her parents or legal guardians?	44	24	54.5%	12	27.3%	8	18.2%
• the services required to meet the child's needs?	59	35	59.3%	16	27.1%	8	13.6%
• the strengths and resources of the family of the child?	59	23	39.0%	28	47.5%	8	13.6%
• reasonable efforts?	59	49	83.1%	2	3.4%	8	13.6%

Caseworker Visitations

An analysis of permanency cases was conducted to determine if the child received proper visitation from the assigned caseworker. The total count of permanency cases is 78, however, one case is an out of state case and is subject to the Interstate Compact on the Placement of Children (ICPC) so the caseworker was unable to provide in person visitations therefore was not included in the analysis. The review of the documentation determined that 36.4% of children received a visit from the caseworker on a monthly basis and 64.9% children received a visit in their placement at least every 60 days. In only 18.2% of these cases did the caseworker document that a portion of the visit was time spent alone with the child for assessment.

Table 22: Caseworker Visitation with Child *(NAC 432B.405)*

		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
Did the child receive a visit from their case worker at least monthly? *(NAC432B.315(2))*	77	28	36.4%	49	63.6%	0	0%
Did the child receive a visit, in their placement, from their case worker at least every 60 days?	77	50	64.9%	26	33.8%	1	0.1%
Did the case worker document that s/he spent at least a portion of the visit alone with the child?	77	14	18.2%	63	81.8%	1	0.1%

In all child welfare cases, caseworkers are to be in contact with the parents/guardians and the foster parents if involved in the case. Documentation of contact with the parents was found in 96.4% of the cases and documentation of contact with foster parents was documented in 87.3% of the cases. The majority of the contact with parents/guardians and foster parents was face to face and over the telephone.

Table 23: Caseworker Visitation with Parent/Foster Parent

		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
In the case file, is there evidence of the case worker's attempts to contact the primary parent(s)/caregiver(s)?	195	188	96.4%	6	3.1%	1	0.5%
If Yes, what type of contact?							
Telephone		43	22.1%				
Face to face		141	72.3%				
Letters		3	1.5%				
Other		1	0.5%				
Missing		7	3.6%				
In the case file, is there evidence of the case worker's attempts to contact the foster parents?	55	48	87.3%	7	12.7%	0	0%
If Yes, what type of contact?							
Telephone		19	34.5%				
Face to face		30	54.5%				

Supervisory Oversight

Supervisory oversight was determined by supervisory acknowledgement of case notes, case staffing, and individual supervisory meetings. This oversight was only documented in 54.4% of the cases reviewed. This may be due to the reliance on UNITY compared to paper files in which the supervisors are not documenting cases that are reviewed or individual appointments with case workers. Without this documentation is it difficult to determine if the case worker is receiving adequate guidance.

Case Closure

Documentation of a formal safety assessment conducted prior to the closure of a case was found in 57.7% of the cases reviewed. At the time of closure, 55.4% of the cases that contained goals for permanency had achieved those goals. If a child had been in foster care for 14 or more months continuously, 40% of those cases had begun the process of termination of parental rights. If parental rights were terminated and a child was not able to be placed in an adoptive home

within 90 days, proper documentation was present. If the case was set for adoption, at case closure 14.3% of the cases had been finalized within a 24 month period. For the children who had been in foster care for less than 24 months, 71.4% were in the process of finalizing adoption within the 24 month time frame. In adoption cases, there was no documentation of reasonable efforts to finalize documentation and for children with a permanency goal of adoption no case files reviewed contained social summary.

Table 24: Case Closure

		Yes		No		Unknown	
	n	Cases	%	Cases	%	Cases	%
Was a safety assessment of the child conducted before closure of the case? *NAC 432B.180*	142	82	57.7%	49	34.5%	11	7.7%
Has the child's permanency goal been achieved?	74	41	55.4%	28	37.8%	5	6.8%
If the child was in foster care for 14 or more of the preceding 20 months, was the TPR initiated? *NRS 432B.553(2)*	5	2	40.0%	3	60.0%	0	0.0%
If the child had NOT been placed into an adoptive home within 90 days after termination of parental rights, did the agency identify and document the obstacles to placement of the child? *NAC 432B.2625*	1	1	100.0%	0	0.0%	0	0.0%
If the child is 14 years of age or older, have they signed a consent for adoption? *NRS 127.020*	3	0	0.0%	3	100.0%	0	0.0%
Has the child's adoption been finalized within 24 months of the most recent entry into foster care?	7	1	14.3%	4	57.1%	2[1]	28.6%
If the child has been in foster care less than 24 months, are steps in place to finalize the adoption within the 24 month time frame? *NAC 432B.400*	7	5	71.4%	0	0.0%	2[1]	28.6%
Are there demonstrated reasonable efforts to finalize adoption?	7	0	0.0%	5	71.4%	2[1]	28.6%
If the child's permanency goal is adoption, is there a current social summary on file?	7	0	0.0%	4	57.1%	3[2]	42.9%

Note: Percentages of Yes, No and Unknown cases were derived from the total cases that applied the question. If applicable records were not available for review on a case, "unknown" was marked instead of a "no".
[1]Two cases were ICPC and the information was not available.
[2] Two cases were ICPC and the information was not available and the paper file was not available for review for the third case.

Reasons for Case Closure

As part of the case review document, information regarding criteria used for closure of the case was documented in narrative form. The documented reasons for case closure include:

- *No Evidence to Support Allegations*
  There were 43 cases where investigators indicated there was no evidence to support the allegations. In 5 cases it was indicated that the risk factors were not severe enough to warrant involvement. In three cases the case was closed based on the denial of allegations by the alleged perpetrator of the abuse/neglect and in three cases the case was closed based on the denial of the allegations by the alleged victim. For the remaining cases, the case was closed

after investigation due to a lack of evidence to support substantiation of the allegations. Although this was the documented reason for closure of the case, there was no clear documentation linking the allegations and evidence, or lack thereof, to agency policy regarding substantiation. For example, in one case it was documented that the case "did not meet the criteria for neglect" but what the criteria is and what evidence, if any, was found was not documented. In another case the documentation indicated that the family was referred for services surrounding a domestic violence incident and trauma to the children but the allegations were unsubstantiated. It is difficult to understand why the case was unsubstantiated because the investigator did not document the criteria for substantiation.

- *Issue Resolved/Completed Case Plan/Reunification*
  Thirty-one cases were closed because the parent had resolved the issue that brought them to the attention of child welfare or had completed the case plan and their children had been reunified. There was also a case where the Court dismissed the Petition against the parents but there was no documentation to indicate why this occurred.
- *Child Safe and Needs Met*
  There were 27 cases closed where documentation indicated that at the time of closure the child was safe and all needs were being met. Some cases had substantiated allegations and some did not. The child was considered safe for various reasons including: alleged perpetrator no longer in the home or corrective action taken by parent to provide for safety of child (i.e. cleaned home, obtained stable housing, or completed treatment). There were several cases that indicated the report might have been due to a neighborhood dispute or a custody issue and that the child was safe.
- *Child Placed in Relative Care*
  There were 15 cases in this category. Most of these cases closed as a result of a relative being granted temporary or legal guardianship of the child. Most often that relative was the grandparent. In the remaining cases, the child was placed with the non-custodial parent.
- *Reporter Recanted Allegations*
  There were seven cases where the reporter recanted the allegation. In all seven cases the reporter was a relative and in four of those cases the child recanted the allegation.
- *Child Ran Away from Placement*
  There were three cases where the youth had recently turned 18 and signed an agreement to remain in care. In two cases, the youth left the foster home to live with a girlfriend so the case was closed. In the other case, the youth ran from the placement. The youth's whereabouts were unknown and the case was closed.

- *Adoption Finalized*
  There were two permanency cases in which adoption of the children was finalized and the case closed.
- *Treatment Complete*
  There were two cases where the parents had completed treatment for substance abuse issues and had accessed other community resources, for example, WIC and Medicaid. In both cases there was a safety plan in place should the parents relapse.
- *Isolated Incident*
  There were two cases that were closed upon determination that the incident was isolated. In one case the mother hit the child with a belt but does not regularly do so. In the other case, the father left the child alone in a car, admitted it was a poor decision, and assured that it would not happen again.
- *Child in Juvenile Justice System*
  There was one case that was reported to CPS as a medical neglect case because the parents refused to sign temporary guardianship to the grandmother so she could access medical/psychological treatment for the youth. This case was closed when the youth was charged with sexual assault against his mother and the case was opened to probation. The youth was not in the care of his parents and would not be returning so the case was closed.
- *Unknown*
  There were two cases where there was absolutely no documentation to indicate why a case was closed. Supporting materials, such as case notes, were reviewed to assist in interpretation on reasons for closure, but that was not available for these two cases.

Comparisons Between Agencies

The majority of the analyses conducted focused on the child welfare system as a whole. Certain questions were selected in order to determine if there were significant differences in performance among the three agencies. These questions were selected based on initial frequencies. If the frequency for any one response was above 90%, researchers determined that there would not likely be differences between the agencies. If the frequencies were between 40.0% and 90.0% questions were considered for analysis based on relevance and number of available cases for analysis for that particular question. Questions selected include differences in child removal rates, safety assessments, documentation and case planning. A cross tabulation was constructed for 17 questions by agency and then tested for significance using a Chi Square analysis (see Table 25 below). Significant differences were found for four of the questions analyzed.

According to this analysis, Washoe County documents the use of the FRAP significantly more than DFS and DCFS. There does not seem to be a difference between DFS and DCFS regarding this question. In case planning, Washoe County documents separate case plans for each parent/guardian significantly more than DFS and DCFS. DFS documents separate plans significantly ($p = .036$) more than DCFS. Washoe County and DCFS had completed case plans on file within 45 days of removal significantly more that DFS. There was no statistically significant difference between Washoe County and DCFS ($p = .854$). Last, also under case planning, Washoe had significantly higher rates of documented supervisor approval on case plans compare to DCFS and DFS. Similarly, DCFS approached ($p = .058$) statistically significantly higher documented supervisor approval on case plans compared to DFS.

Table 25: Agency Comparisons							
	DFS		Washoe		DCFS		Sig.
	Yes	No	Yes	No	Yes	No	p
Was the child ever removed from the home?	51.3%	48.7%	47.5%	52.5%	38.1%	61.9%	0.341
Gave preference in placement to a relative who was suitable and able to provide care/guidance, regardless of whether the relative resided within the State?	80.9%	19.1%	70.6%	29.4%	88.9%	11.1%	0.505
Safety Assessment							
• prior to unsupervised visits between the child and his/her parent(s)/caregiver(s)?	46.9%	53.1%	40.9%	59.1%	37.5%	62.5%	0.85
• due to a significant event or change that affects the household of a parent, foster parent, or other care provider?	40.0%	60.0%	33.3%	66.7%	50.0%	50.0%	0.933
• before each court review?	28.9%	71.1%	16.7%	83.3%	22.2%	77.8%	0.676
• after reunification of the family with the child?	41.4%	58.6%	22.2%	77.8%	33.3%	66.7%	0.572
• before closure of the case?	66.3%	33.8%	51.7%	48.3%	63.6%	36.4%	0.381
Court Reporting							
School Records	23.5%	76.5%	71.4%	28.6%	50.0%	50.0%	0.078
Services							
Was the Family Risk Assessment Protocol (FRAP) used?	54.2%	45.8%	81.1%	18.9%	58.5%	41.5%	.016*
Were any services offered to the child's parents?	63.7%	36.3%	70.0%	30.0%	50.0%	50.0%	0.150
Case Plan							
• located in the file	78.6%	21.4%	100.0%	0.0%	75.0%	25.0%	0.188
• separate plan for each parent/guardian	37.8%	62.2%	90.0%	10.0%	0.0%	100.0%	0.000***
• supervisor approval	42.5%	57.5%	83.3%	16.7%	66.7%	33.3%	0.032*
• description of efforts to place sibling together	52.2%	47.8%	33.3%	66.7%	83.3%	16.7%	0.275
• first plan completed within 45 days after the date the child was removed	44.2%	55.8%	83.3%	16.7%	87.5%	12.5%	0.009**
Supervisor Oversight							
Was there documentation of supervisory oversight	51.3%	48.7%	65.0%	35.0%	52.4%	47.6%	0.315

*Note. Statistical Significance indicated by *p<.05, **p<.01, ***p<.000.*

Note from Washoe County: *In response to Table 24, "Washoe County is rated very low in the safety assessment milestones. Our local practice it to attach the most current safety assessment to the court report for each review and permanency hearing. It should also be noted that Nevada has not identified a specific out of home safety assessment tool or process but rather relies on use of the initial safety assessment or specific documentation in the case notes.*

NARRATIVE CASE REVIEW INFORMATION

At the end of each of the case review forms a space was provided for any narrative information. This section was used for reviewers to include notes regarding inconsistencies, noted errors, or general comments about the flow of a given case. This portion of the data collection tool was also used to provide notes to the reviewer conducting the paper case review regarding information that was not available in UNITY, but should be found in the paper file. The information in this section was then entered in the database with the rest of the case review information. It was then extracted and organized into 10 categories.

Timing of the Investigation

In two of the cases reviewed the investigation of the case seemed to be especially brief. In both cases the investigation summary was completed the same day as the report coming into the agency.

Poor or Inadequate Case Notes

In four cases the reviewer noted errors or inconsistencies in the actual documentation of case notes. These errors included case notes with the wrong year in the date, which was noted when it was out of order in the sequence of case notes. In another instance there were multiple case notes that were the same for the same date, but one was listed as in person and the other indicates it was contact via telephone; reviewers couldn't discern which was accurate. In another case the transfer summary mentioned interviews with grandparents, but there are no notes with any details of when this occurred or any details of the conversation. Finally, there were several cases where children's addresses, parent's contact information, etc. was not up to date in UNITY or were conflicting depending on where the information was obtained. At times this contact information was listed in a case note and then different information listed in the person detail section of UNITY. In other cases the parents were contacted via telephone, but no contact information for the family was recorded in UNITY. Some of these errors were remedied by a review of the paper file, but often the paper file did not answer these questions. In other cases it was difficult to follow the details of the case due to inaccurate dates entered for notes or missing information on the details of an event. For example, there were several instances where large gaps in case notes did not allow reviewers to understand what had happened with a case for months at a time.

Inadequate Provision of Services

These notes indicate cases where upon review of the documentation researchers felt that investigations were inadequate or services provided did not address the needs of the family. For example there were several cases where collaterals involved in the case should have been interviewed and were not. Also there were several cases where the child's Native American status was not investigated until the case was transferred to in-home services and not at removal as it should have been. In another case an investigation was open for a period of six months, during which time the assigned worker had done only one visit with the children. This case was transferred to another worker five months later who spoke with the children again, regarding a report accepted six months prior. In several cases documentation indicates a lag in time between when the report was generated and when the case was assigned to an investigator. In one case both children were under 5 years of age and the allegation was sexual abuse, however the case was not assigned to an investigator for three days. In most other cases categorized in this section reviewers felt that there was inadequate visitation with either children or parents. There were 27

notes categorized in this section and in 33.3% (n=9) of cases the note was regarding inadequate visitation with the children or the parents. Other notes in this category included appropriateness of referrals for services. In 14.8% (n=4) of these cases there was an indication by the reviewer that the family may have benefited from services, but there were no referrals made.

In three cases (11.1%) there was some difficulty in the provision of services. In all three cases language was a barrier. In one case the child was not able to have clinical assessment because there were no Spanish speaking providers available, in another it took a month for the parents to be able to enroll in a Spanish parenting class. In another case a child that only spoke Spanish was placed in non-Spanish speaking home for a period of 15 days. All three of these instances point to the need for more services to be available for Spanish speakers in Nevada.

Appropriate or Positive Comments

At times if the reviewer felt that this case was managed especially well, they would include a note in this section to indicate that. There were a total of 132 comments written in the notes section of the data collection tool. In 3.7% (n=5) of cases the reviewer indicated that the work was especially well done. Some of the comments include mention of excellent or detailed notes, and additional follow up with the family to ensure services had been accessed – even after the case had been closed.

Issues with UNITY Documentation

In 28 cases the reviewers commented on issues regarding UNITY documentation. One of the most frequently occurring notes were regarding the amount of time a case was left open in UNITY after the case worker had completed the closing summary and all casework had essentially stopped. This time often ranged from a couple of months to almost a year in a few cases. In 21.4% (n=6) cases notes indicated that the case was closed to the worker but still open in UNITY for one month or more.

Another noted issue concerning UNITY is regarding contact information for parents. Often in UNITY the parent's address or phone number were not entered into the database, however notes indicate home visits or phone calls. This shows that the worker had the contact information, but did not enter it into the appropriate location in UNITY. Other times this information would be recorded in UNITY, but conflicting (often more up to date) contact information would be written in case notes or on scratch paper in the paper case file. Other notes indicated that the case was confusing due to incomplete explanations in case notes. In families with multiple parents and children or other people living in the home, there were times when case notes would refer to people by first name only without explaining their relationship to the child or parents. This created a problem when trying to understand what happened in a given case.

Other issues included incorrect dates for notes, placements or removals. Most seemed to be simple typos that were recognized because the timing of events as listed was impossible. For example in one case the first case note was dated in 2000, but the notes indicate that the family didn't even live in Nevada until 2006. Or in another case where the removal status was not updated to show that the child was returned to their home, although this is indicated in the case notes. The remaining notes in this area have to do with other inaccurate information in UNITY, including conflicting genders of children in different windows and case notes, or inconsistent race or ethnicity information.

Case Plan Issues
In 11 cases a note was written regarding the case plan in the file. The majority of notes regarding case plans were indications that case plans were completed for only one parent when both parents were involved, or one case plan was completed for both parents when they each should receive separate plans. Either of these becomes problematic when looking at the parent's ability to complete the case plan. In a case where a father is not involved with the children, but the case plan is written to include what the mother and father must do, this can increase the amount of time it takes for the mother to be reunified with her children because the father is not completing his case plan.

Similarly there were other instances where a case plan was noted in the case file, but it was for a parent who could not be located and there was no case plan in the file for the parent who had been involved with the child.

The other frequently noted issue in this category has to do with what seemed like "cookie cutter" case plans. This could be identified by case plans that were clearly cut and pasted. Some plans were for just the mother, but would refer to parents instead of just the mother. Or others would refer to "children" in the case plan when there was only one child involved in the current case. In a few cases the case plan actually contained names of people not involved in the case – which makes it seem that the worker simply copied the entire case plan and tried to change only the names on the document, instead of writing a new case plan for each family.

Safety Issues and Worker Visitation
There were seven notes categorized as having to do with worker visitation and other safety issues. Most have to do with the timing of the included safety assessments and concern about when they were completed. Some had dates that were before the date of the face to face meeting with the child and there was concern over the ability to assess safety before you see the child. In the other cases there was concern regarding how often the worker visited the home or the children. In one note the reviewer indicated that the mother voluntarily placed the child with a family friend, but there are no notes indicating that the worker visited this home to ensure that it was safe for the child. In another case the reviewer noted that during the investigation the worker only spoke to one of two children in the home.

Problems with Agency Process
In six cases reviewers noted issues with the process followed during the case. In four out of the six cases these issues were regarding the investigation process. In these cases interviews were not completed with all children, there was concern over the length of time it took to contact the parents and one where the investigation was conducted by a supervisor rather than an investigator. In the remaining cases in this category, there were documented problems with the ICPC process where it took 2 months to discover paperwork issues that further delayed the approval of the out of state placement, which further delayed the child's placement in a permanent home. In another case the caseworker changed three times in five months.

Comments on Other Documentation
There were 18 cases including notes about other missing pieces of documentation. These ranged from incorrect dates and time frames in reports and case notes to medical problems noted in case notes but not on the child's medical passport. There were also cases in this section noting that for one family there may have been 2 cases that were not linked in UNITY which helped to fill in some of the gaps or missing information. Additionally these cases included notes regarding information not in the paper file or found electronically that should have been in the file including court reports and case plans.

Note from Washoe County: *"The medical passport is not a statewide program, and, as I understand, it is available in Clark County only."*
Reviewer's Response to Comment*: According to the research team's review of UNITY files there were 5 cases in Washoe County that contained a medical passport in UNIY as well as 8 DCFS cases, and 18 Clark County cases that also had a medical passport in the UNITY file.*

Questionable Allegations or Determinations
In some cases reviewers had questions regarding the decision making process that either created the allegations or the decisions regarding substantiation. There were seven cases that included a note categorized in this section. In terms of allegations, reviewers questioned the allegation category selected given the information available regarding the report/referral. In one case the referral source states that the mother left and the grandparents are unable to care for the child. In this case the allegation was "legal protection and substance abuse" and not "abandonment". In another case the referral detail states physical abuse to the child (bruising) and possible alcohol abuse by the father. In this instance the allegation listed is then parental alcohol and substance abuse and sexual abuse. There could have been additional information provided to the agency through the course of investigation or follow up that created the allegations, however without clear documentation it was difficult for reviewers to understand the reasons for the allegation categories listed in UNITY.

Another issue noted was with the determinations made in some of these cases. In very few cases is there a clear discussion of the pattern of thought or legal backing for the decisions to substantiate or unsubstantiate the allegations in a case. For five cases in this category the reviewer expressed confusion or concern over the substantiation decision. Caseworkers should improve documentation to include descriptions as to how determinations were made in each case so that outside reviewers or supervisors can understand why certain decisions were made.

CONCLUSION AND RECOMMENDATIONS – CASE REVIEWS

During the course of the audit, 195 cases were reviewed among the three child welfare agencies in the State. 60% were investigations (CPS) and 40% were permanency cases. During the audit, reviewers identified 10 cases (5%) where a safety concern regarding lack of appropriate visitation by the caseworker with the child was presented to agency supervisors and/or administration. The agencies reviewed all cases, ensured the safety of the children and noted that most concerns were due to a lack of appropriate documentation in UNITY and/or the case file. Lack of appropriate documentation in UNITY and/or the case files was the primary area of deficiency noted by the reviewers, making it difficult to accurately represent whether the agencies were handling cases appropriately.

A review of the cases revealed that there were 302 separate reports and/or referrals for these 195 cases. Of the 302 reports/referrals, 51% were unsubstantiated, 32% were substantiated, 13% were information only reports, 2% were voluntary services, and 2% were unknown. The child(ren) were removed from the home in 47.7% of the cases. Documented reasons for removal included neglect (73%) and abuse (27%). Length of stay in out of home placements ranged from 0 to 536 days. The average lengths of stay for the most common out of home, non-relative placements were: foster homes at 113 days; shelter homes at 44 days; hospitals at 36 days; Kids Kottage at 26 days and Child Haven at 7 days.

There were several deficiencies noted in either appropriate documentation and/or case management during the audit. Some of the primary deficiencies included:

Safety Assessments – Although safety assessments were documented in 99.5% of all cases reviewed, documentation of safety assessments being conducted at intervals required by NAC 432B.185 are inconsistent.

- Intervals with a compliance rate <50% included: before each court review; before unsupervised visits; when a significant event/change occurred; and after reunification.

Recommendation: Ensure that safety assessments are completed by caseworkers at all mandated intervals as required by state regulations. This process may include staff training regarding safety assessments and clearly indicating in policy and procedures when safety assessments must be conducted. Supervisors should be required to verify that safety assessments are completed at the appropriate intervals.

Indian Children – Only 65.5% of applicable cases showed documentation that the agency asked or attempted to ask if the child was an Indian child pursuant to federal law (Indian Child Welfare Act – ICWA).

Recommendation: Enforce mandates that all applicable cases must include documentation that the agency asked or attempted to ask if the child was an Indian child pursuant to ICWA. Enhance training on ICWA and require supervisory oversight to ensure that ICWA requirements are followed. Policies and procedures at each agency (or a collaborative policy of all three agencies) should be developed to provide specific procedures for compliance and should include acceptable forms of documentation to be included in case files.

Parental Notification – Notification of custody hearings, foster care or other out of home placement or court hearings to a noncustodial parent was evident in only 46.5% of applicable cases.

Recommendation: In any case where there is a known or probable noncustodial parent, caseworkers should document attempts to notify the noncustodial parent of all applicable actions in the case. Policies and procedures should reflect acceptable means of identifying and providing notification to noncustodial parents. Documentation of efforts to identify and notify (or attempts) should be made in all cases where both parents are not directly involved in the case.

Siblings – 40% of all cases involving sibling groups which experienced out of home placements were separated in their placements. Although the majority of these cases included documentation of viable reasons for the separation, 6 cases did not.

Recommendation: Increase efforts to keep sibling groups together and enforce mandates to document all instances where siblings are separated, including specific justification and/or reasons for the separation. Additional training and supervisory oversight, as well as specific policies and procedures should be developed at each agency.

Placement – Just over half (55.1%) off all applicable cases reviewed documented that a diligent search for an appropriate relative placement was made. Only 49.4% included documentation that efforts were made to place the child as close to home as possible. Although only 8.6% of children in the cases reviewed were placed out of state, none of the cases included documented quarterly updates from the placements.

Recommendations: Improve documentation of placement efforts including diligent search, placing the child as close to home as possible, and receipt of updates for out of state placements. Training should be developed and/or enhanced to ensure that all caseworkers are aware of applicable laws, resources, and appropriate documentation techniques. Ensure that caseworkers are aware of and utilize diligent search resources and document all efforts in the case file.

Case Plans – Almost 18% of all applicable permanency cases reviewed did not have a case plan on file that the reviewers were able to locate. Of the 60 case plans that were reviewed, severe documentation inconsistencies were noted in the following areas:

- Efforts to place siblings together;
- Statements of health and education records;
- Indication of the proximity of the child's school;
- Supervisory approval of the case plan;
- Formal updates every 6 months;
- Separate case plans for each parent involved;
- Completion of the case plan within 45 days of removal; and
- If a concurrent plan existed, documentation to address if both plans progressed simultaneously.

Recommendations: Mandate supervisory oversight to ensure that all applicable permanency cases have a case plan, tailored to the needs of the child and family, on file. Review policies and procedures to ensure that caseworkers and supervisors are aware of all mandatory components and procedures for preparing and documenting case plans. Training should focus on how to tailor case plans to the specific needs of the child and family, rather than preparing "cookie cutter" case plans.

Provision of Services – The FRAP was documented as having been used in just over half (54.4%) all cases reviewed. In 38% of all cases, there was no documentation that services were

offered to families. Due to the method of tracking service provision in case notes, this area was difficult to assess with a great degree of certainty. Reviewers also noted that often the services provided did not address the needs of the family. In 3 cases, lack of appropriate bilingual services were noted. Deficiencies in services for children were also noted:

- Only 56.7% of applicable cases had a documented EPSDT for the child in the case file.
- Only 22.4% of applicable cases had copies of school records included in the case files.
  - » Educational assessments were requested and/or completed in only 5% of applicable cases.
  - » 26.5% of children in out of home placement were enrolled in multiple schools as a result of the placement (Range= 1-3).
  - » Only 42.9% of applicable case files included evidence of efforts to keep the child at her original/home school or indicated reasons for a change of schools.

Recommendations: Improve documentation of service provision to children and families. This may include the need to update software programs to allow for ease of documentation and consistency in terms of services offered and services utilized. The documentation system should also allow agencies to identify service needs by tracking waiting lists, underutilized services, and inaccessible or unavailable services which are needed to meet client needs. If the current software system cannot be updated to include fields for tracking services agencies should implement policies to mandate that this information is included in case notes. Caseworkers and supervisors may also benefit from additional and/or enhanced training on identifying and providing services that best meet the needs of the child and family.

Caseworker Visits – Caseworkers are required by law to conduct in person visits with children at least monthly and in their placement at least every 60 days. A portion of each visit must be spent alone with the child. The audit found that in applicable cases (n=77):

- Only 36.4% included documentation of monthly visits;
- 65% provided evidence of visits made in the placement at least every 60 days; and
- Only 18.2% indicated that a portion of each visit was conducted alone with the child.

Recommendations: To ensure the safety of all children under the care of a child welfare agency, state and federal requirements for caseworkers' visits should be strongly enforced by all agencies, administrators, supervisors and caseworkers. Policies and procedures should highlight these mandates and include oversight to ensure that these visits occur and are documented appropriately in the case files. Agencies (and/or the state) may consider sanctions for failure to comply certain safety-related mandates.

Supervisory Oversight – Only 54.4% of the cases reviewed included documentation of supervisory oversight (i.e.: through acknowledgement of case notes, case staffing and individual supervisory meetings).

Recommendations: Policies and procedures should clearly specify the roles and responsibilities of supervisors, including when caseworkers need supervisor approval, the frequency of case reviews by supervisors, and specific mandatory components of cases that supervisors should be checking for in all cases. Supervisor qualifications should be reviewed to ensure that all supervisors have the knowledge and expertise to properly supervise and advise caseworkers.

Case Closure – 2 cases reviewed provided no documentation of regarding the reasoning for case closure. Only 57.7% of applicable cases (n=142) included documentation that a safety assessment was conducted before case closure. No cases where the child was at least 14 years

old and eligible for adoption had documentation of a signed consent by the child. No cases where the goal was adoption had social summaries included in their case files.

Recommendations: Improve documentation of reasons for case closure and develop and/or enhance collaborative policies to ensure consistency regarding reasons for case closures statewide. Enforce mandates that safety assessments must be completed prior to case closure and documented in the case file. Require that supervisors ensure that all appropriate documentation, consents, assessments, etc. are included in the case file prior to case closure and before services/contact with the child and family are terminated.

SUPERVISOR INTERVIEWS

At each site visit the researchers requested to conduct a brief interview with a supervisor located at that site. In instances where there was one supervisor for multiple office locations only one interview was conducted. Additionally, there were times when supervisors requested to include their manager in the interview and this was allowed when requested.

METHODS

During each site visit researchers requested to conduct a short semi-structured interview with a supervisor that was on site that day. In some cases the supervisor participated in the interview alone, while in other instances the supervisor invited someone else to participate in the interview at the same time. In a few offices the supervisor requested that the district manager participate in the interview with them. In most cases the supervisor that was designated as the point of contact for the office was also the supervisor that participated in the interview. In the rural areas one supervisor will sometimes oversee more than one office in that area. In these cases that supervisor was only interviewed once.

Supervisors were given an informed consent form that reviewed the purpose, risks and benefits of participation in the interview. Supervisors were advised that their participation was voluntary and that they could end the interview at anytime. Researchers conducted interviews with 25 supervisors. No supervisors that were asked to participate refused to participate in the interview. However, in a few instances the supervisor requested that their manager participate in the interview as well. In these cases they were interviewed together and demographic information was recorded for each individual.

Basic demographic information including, position title, years of experience and their office location was collected for each participant. Interviews were tape recorded when participants allowed. These recordings were used to supplement notes taken during interviews.

Interview questions included information regarding strengths of their units, barriers to providing services, methods for supervision, barriers to providing services to families, and recommendations for improvements in the child welfare system.

Data collected during these interviews was entered into NVivo 2.0, a qualitative data analysis software program, for analysis. Questions were analyzed for themes using the questions as initial groupings. Discussion of responses will be organized around each question asked during the interview.

FINDINGS

Demographics

Twenty-five supervisors were interviewed for this portion of the project and their demographic information is presented in the table below.

Table 26: Supervisor Interviews – Agency Counts		
Agency Name	**Count**	**Percent**
Nevada Division of Child and Family Services	10	40%
Clark County Department of Family Services	10	40%
Washoe County Department of Social Services	5	20%

Table 27: Supervisor Interviews – Site Counts			
Office Location	**Agency**	**Count**	**Percent**
Carson City	DCFS	3	12%
Battle Mountain	DCFS	1	4%
Reno	WCDSS	5	20%
Ely	DCFS	1	4%
Elko	DCFS	1	4%
Silver Springs	DCFS	1	4%
Fallon	DCFS	1	4%
Pahrump	DCFS	2	8%
Pecos (Main)	DFS	1	4%
Martin Luther King	DFS	1	4%
Renaissance	DFS	2	8%
East	DFS	1	4%
North	DFS	1	4%
South (Henderson)	DFS	2	8%
Central (Rancho)	DFS	1	4%
Total	--	25	100%

**Supervisors were interviewed at all sites visited; however in rural areas there was often only one supervisor that covered several offices. In that case only the one supervisor was interviewed.*

Table 28: Supervisor Interviews – Work History and Caseloads			
Variable	**Minimum**	**Maximum**	**Average**
Length of Time with the Agency (in years)	1.5	31	11.1
Length of Time as Supervisor (in years)	.33	13	3.4
Length of Time in Child Welfare (in years)	9	30	17.5
Number of Workers Supervised	3	29	6.3
Average Number of Cases(Permanency)	16	50	26.5
Average Number of Cases (Investigations)	11	30	17.5

Interview Questions

Supervisors were asked a series of questions to understand the strengths of their units, basic process in their position, barriers faced and recommendations for improvement.

Strengths

First supervisors were asked about the strengths of their workers and asked to tell us what they felt their units did really well. Responses were similar in that many focused on individual work ethic and group cohesiveness. Many responded that their unit works well together and that they were cohesive. Other supervisors noted that their workers are supportive of one another and will fill in for each other or help out to ensure that families are getting the services they need. Other supervisors made comments about their workers skills, noting that they were great with documentation, or that they work really hard to maintain children in the home. Some even mentioned that their workers are really great at "meeting ASFA deadlines within policy." Workers were also described as dedicated, committed, and self-sufficient. Supervisors described their units' ability to work within existing constraints to overcome barriers, noting that "workers really go above and beyond…this is not a 9 to 5 job and they really care." Some supervisors mentioned that their areas are lacking in available services and that workers have to still try to get families the services or supports they need: "Workers are creative and think outside the box – and really just work together to be resourceful and do whatever needs to be done for the benefit of the kids."

Overall, supervisors in all jurisdictions were very positive about their staff in their abilities to work with families and overcome systemic barriers. Most supervisors noted that they understand that the job of a caseworker is difficult, but that their workers have good attitudes and really work together to be supportive of each other and do the best they can for the families on their caseloads.

Supervision of Workers

Supervisors were also asked about how they supervise the work of their staff. Supervisors listed many different tasks that they complete to ensure that their staff are serving families and following policy and statutes.

Many supervisors mentioned one-on-one meetings to review the progress of a case. Most said that these meetings happen informally all the time when workers will come in with questions about a case or questions on how to handle certain situations. Formally, some staff reported having weekly one-on-one meetings to review cases, while others stated that these meetings were scheduled monthly. In these scheduled meetings workers review their caseload with the supervisor, discuss case progression and address any questions or concerns that the worker or supervisor may have. Most also stated that in addition to speaking to caseworkers, they review UNITY and use the reports that are generated from that system, including missing data reports. However, a few of the supervisors noted that they get more information from speaking to the workers because "UNITY is not always up to date" and that when a "case is complicated, the notes often don't get put in because the worker just doesn't have the time."

One supervisor said that she gets regular feedback from other professionals that work with the caseworkers regarding how they interact with the family and how the case is progressing. Some supervisors said that they actually attend child and family team meetings, go on home visits or

attend court hearings to provide support to the workers. Many reported that they ensure that cases are closed on time and that all assessments are completed prior to closure.

For supervisors in the rural areas where one supervisor may be over offices in different physical locations, they discussed the importance of e-mail and cell phones to help provide supervision when they can't physically be with the workers. Many of them discussed the importance of being available for their workers via telephone when they are not physically in the office together.

One supervisor said that her job was a combination of "education, monitoring and guidance", while another noted that she tries to look for explanations in case notes to know why a worker is making certain decisions and when she doesn't understand she will speak with the worker and try to educate them on best practices, agency policy and state and federal statutes.

Overall, supervisors use a variety of methods to oversee their workers, and most feel that they have a pretty firm grasp on what's happening in their unit.

Criteria for Opening a Case (Investigations and Permanancy)

Supervisors were asked how they determine when to open a case. In some jurisdictions this question didn't apply to certain supervisors. In Clark and Washoe counties supervisors are separate for investigations and permanency cases. Therefore supervisors over permanency units do not open cases – they are simply forwarded to their unit. In many of the rural areas, however, supervisors and workers will work on both ends of a case, conducting both the investigations and working toward achieving permanency for the child. For these supervisors decisions to open cases can fall on their shoulders.

Supervisors indicated that to decide to open a case they look at the information and decide whether or not it meets NRS standards. If it does it is assigned out for investigation, if not it is recorded as information only. One supervisor noted that in some instances they need to try to determine if this is a custody issue and, if it is, they try to avoid those cases. They need to get as much information as possible from the reporters to be able to make informed decisions. Another supervisor noted that many of the tools are very helpful, including the new risk assessment tool, stating "it's really clear whether you should consider opening a case." Supervisors reported that they primarily look at safety and determine if they feel they have a child that is a victim or potentially unsafe. In rural areas they also review to see if there are duplicate reports from neighboring towns. In one rural area they even reported that they look at community needs to determine when to open a case to ensure that the community will respect their decision. One also reported that all cases regarding children five years and younger are automatically investigated because the child can't speak for themselves.

In summary, supervisors' responses across jurisdictions were fairly consistent. Those supervisors that make these decisions often focus on statutes and policy to make determinations about opening a case. They rely on information provided by the reporters and try to assess the safety of the child. If they feel the child may be unsafe then they will assign the case for investigation.

Criteria for Closing a Case

Participants were also asked about how they make determinations to close a case, and again the responses were fairly consistent across participants and agencies. All supervisors reported that ultimately it is their decision about when to officially close a case, but most reported that this is a joint decision between the worker and the supervisor. Many said they will discuss the facts of the case and they will come to the decision together about when it is appropriate to close the case. In one case the supervisor stated that she will sometimes bring in the manager for another opinion. Some supervisors mentioned that they review documentation to ensure that it has all been completed before approving the closure of a case. The supervisors also stated that they use agency guidelines and the closure process depends on the way the case is closing, meaning that processes used to close a case where the children are being reunified with parents is different than a case where the child is aging out of the system.

For the most part supervisors want to ensure that services provided are appropriate and that all the children are safe. They reported that they review case plans where appropriate and assess how the family is doing. One supervisor relayed a process at their site where before a case is closed the worker must go before another supervisor (not the one they had been working with on the case) and present the case and if that supervisor approves and everything checks out then the case can be closed. In one office the supervisor noted that sometimes it's not their decision and the courts can decide when a case should be closed.

Barriers to Providing Services to Families

During the interview, participants were asked to describe what they saw as barriers "to providing services to families". The responses to this question were again fairly consistent across agencies. The responses were reviewed and summarized into several different categories including: lack of funding for families, inadequate compensation for workers, structural issues, and service issues.

Lack of Funds for Families

Many of the supervisors reported that a major barrier to providing quality services for families was the lack of funds available for families. They said that available funds could be used for things like emergency assistance with rent, guardianship fees, legal fees, etc. Also families could use this money to help pay for services, especially foster parents who are spending time and money driving children to specialists, therapists, and doctors. This can be a strain on those families, especially in the rural areas when specialists can be hours away. The lack of access to emergency funds is apparent when families need just a small amount of money to help with one issue that affects the rest of their lives. One participant said, "For example, a person may not have the $27 he needs to get a consulate card. Without this card that parent can't get services, apply for jobs, etc. This means that when those things are included in a case plan that parent simply can't complete their case plan – over $27." Additionally this supervisor noted that the process for receiving these emergency funds should be more flexible. "There are times when the process gets in the way – and a family needs the money today – but it takes five days to process – or we can only pay with a check and they need cash…". Another supervisor said that additional funding for their agency could really help because they had recently been instructed not to drug test parents, due to the cost. This worker explained, "The problem is that without these tests workers cannot verify the allegations of parental substance abuse."

Inadequate Compensation

Supervisors also discussed their own compensation and professional development as a barrier to serving families. In many of the rural areas supervisors discussed the difficulty in maintaining enough staff to mange their caseload. They noted that in the rural areas it is difficult to find qualified people that are willing to do this job. According to participants, caseworkers at DCFS are required to be social workers, where in Washoe and Clark counties they do not have to be social workers – their background can be in other related fields. This presents a problem in the rural areas because they have vacant positions, but no one qualified to fill them. Some supervisors attributed this to their location as well as inadequate pay stating, "There is no incentive to work in the rural areas because of the pay discrepancy. You can make a lot more starting in Washoe or Clark – so on top of the less desirable location – we don't pay as well." Another supervisor stated that the agency requires her to continue her education and attend trainings, but she can't get the time off work to attend the training.

Structural Barriers

There were several areas that supervisors saw as barriers to providing services that are really issues imbedded in the structure of the child welfare system or agency in which these supervisors operate. The number one barrier listed in this category had to do with the high caseloads of the workers. Participants reported in all agencies that caseloads were too high to be able to effectively work with families. Many stated that due to their high caseloads they did not have the time to spend with individual families that they would like. High caseloads were also noted as a reason for delayed documentation. This barrier seemed to be amplified in the rural areas where things like travel time to meet with families takes up even more time in each day. In the rural areas some workers will spend the majority of their time in a car if they need to visit children or families that are spread across their jurisdiction. Some supervisors saw other issues embedded in the structures of the welfare system that impede their ability to serve families. One of these was waiting lists for services, this can severely impair a family's ability to complete a case plan or do what's best for their family.

Along those same lines, one supervisor pointed out that the undocumented immigrants they work with have special barriers, especially when attempting to navigate the various social services. This supervisor felt that it was important for the agencies as a whole to be more culturally sensitive, starting with having more Spanish speaking workers in the agency to help assist these families.

At least one supervisor in all three agencies noted that some aspect of the court system was a barrier for them in providing services to families. Some reported difficulties with judges, district attorneys and public defenders. One supervisor noted that she felt that the court system was really their number one barrier to serving families in their area. This supervisor expressed that the district attorneys in her area may need additional training. In her experience they tend to forget that these are civil cases, and not criminal cases. She suggested that the court improvement project be done again in the rural areas of the state. Echoing this sentiment in one of the urban offices one of the supervisors noted that the agency "needs to do a better job of reaching out to partner agencies. Some partners feel diminished by our administration and not listened to. A lot feel marginalized. We need a smaller more personal agency, where we can connect with more people from different areas…it would be nice if there were more teamwork."

Another issue that came up as a barrier was the use of their data collection system UNITY. This system is used by all three agencies in the state to maintain documentation on all of the families in the child welfare system.

The final issues discussed as a structural barrier was policy implementation. A few of the supervisors indicated that at times policies are implemented across the state without consideration for certain special circumstances in the rural areas. This supervisor mentioned not having enough staff to adhere to standards, especially in regard to having workers available 24 hours a day. She stated, "We don't have an overnight shift, so our workers have to take turns – then if they're out all night on a call they still have to be at work the next day. But if they are too tired to drive – this can set the whole office back."

Suggestions and Recommendations

At the conclusion of the interview the supervisors were asked if they had any suggestions or recommendations for ways to improve child welfare in Nevada. The responses with this question were categorized as recommendations that would be implemented on an internal agency level and those that would need to be implemented widely either within the community or the profession.

Staffing and Compensation

Recommendations internal to the office or agency included several recommendations about equalizing pay across agencies. Those supervisors at DCFS noted that in the rural areas DCFS case workers make a lower salary than their counterparts in either Washoe or Clark County. For areas that are near one of these other counties it makes it more difficult to recruit new employees when they know that just a few miles away they can make more money. Also, in the rural areas a few supervisors suggested that there should be a supervisor assigned to each office and not one supervisor covering multiple offices. In one office she noted that it's often difficult to be at one of the more rural offices very often. Another noted that she spends so much time in her car driving from one location to another it may be a better use of time to station her at one office and hire another supervisor to cover the others. Another recommendation on the internal level had to do with staffing as well. A few supervisors from DCFS mentioned their frustration in only being allowed to hire licensed social workers as caseworkers. This creates a problem when they find a candidate in their area that knows the community and its available resources, but that person cannot be a case worker because their degree is in education and not social work so they cannot be licensed without going back to college for a second degree. This supervisor noted that the training academy could allow these individuals to become stronger in child welfare and social work even if they are not licensed social workers. In addition to these ideas another supervisor recommends that the agencies spend more time cross training between units so that they each understand what each unit does and how they work. This could promote collaboration and understanding regarding process and time frames when the units each intersect. Other supervisors mentioned the need for overtime pay, as the workload is such that using flex-time is impractical. Others also noted that staffing could be improved by providing additional education to staff to help them think "outside the box" and think of more creative ways to help families.

UNITY

Other recommendations for internal changes were geared at the agency's computer data recording program, UNITY. One participant recommended that there be improvements made in this system to ensure that workers are aware of all windows that need to be completed for an

investigation. This could be a set path in the system that forces you to complete windows or a checklist or form that indicates all sections that need to be completed for workers to check off as they go through. This supervisor also felt that the UNITY reports they receive should provide "more missing data information." Along the same lines other participants noted that they would recommend that more support be offered to the workers in terms of additional clerical staff that could assist with documentation or entry in to the UNITY system. This was especially emphasized in some of the rural offices where there is only one worker left to handle everything.

Court Systems

An area where many participants indicated a need for improvement to a system external to the agency was in the local court system or in relationships with area district attorneys. In all jurisdictions at least one supervisor indicated the court system as a recommended area for improvement. While a few supervisors even noted that the relationships between child welfare and the district attorney's office had become more adversarial and they would like to see a change in this relationship to better serve families.

In addition to improving relationships between the two agencies, one supervisor from Clark County noted that it would be helpful to break up the court calendar so that workers are not spending entire days in court waiting for their case to be heard. This supervisor indicated that this had been done by one judge but would like the others to follow suit. Additionally another supervisor noted that she would like to see better legal representation for parents in these cases. She felt that their attorneys often do not really advocate for the parents. These attorneys may need additional training to improve their services for parents.

Note from Washoe County: *"I believe we have a very constructive and positive relationship with the Washoe County District Attorney's Office.*

Services

Many supervisors had ideas for how to improve service delivery for families. These recommendations ranged from improvements to existing services to suggestions for how to streamline the entire process of obtaining services for families. One supervisor from Clark County suggested creating a "one stop shop" for families where different agencies that are often accessed by families (like housing, welfare, job assistance, and daycare) are housed in one location and have liaisons that assist in expediting paperwork and helping families access services quickly. She noted that workers can spend an entire morning on the phone trying to get answers to the family's questions or otherwise assist in navigating the system.

Other supervisors suggested better daycare assistance programs for low-income families, and programs that allow financial assistance to kinship care families. In terms of kinship care supervisors explained that for some relatives it is a financial hardship to care for these children, but the agency is limited in how to help them. Many of these families end up having to become licensed foster parents, in order to receive payment to assist in the cost of caring for these children.

Additional service improvement recommendations included:

- Homemaker Services for families to help give practical assistance in cleaning, parenting, budgeting, etc.
- Have a crisis nurse available for when parents need a break.

- Offer family group counseling so that the case plan is family centered and family driven – Also hire outside facilitators for these meetings to provide a neutral party who can direct the conversation and ensure that all points of view are heard.
- Have celebrations for family reunifications.
- Additional family preservation services or voluntary services.
- In all jurisdictions families need better free and low cost services such as substance abuse treatment. It is especially important that these are subsidized because often parents cannot afford to pay for the services necessary for reunification.
- Transportation services – "we need to provide bus tokens for more than just one day".
- Develop more "visitation centers" where parents can be coached on their parenting during visitation to learn more positive ways to interact with their children. This would improve relationships and allow children to go home sooner.
- Create more services for children that are aging out of the system.
- Decrease wait times for access to emergency services – sometimes this is an issue with availability of services while in other circumstances it is a product of the lengthy agency approval processes.
- Financial assistance to kinship care families to help with costs of housing and caring for the children.
- Provide more support for parents entering the child welfare system. Create a mentorship program where successful parents can help guide new parents through he system.

Systemic/Community Recommendations

Supervisors also had recommendations that deal more with the child welfare system as a whole, or agency policies and practices. These recommendations were grouped together and are presented below.

A few of the supervisors discussed how they feel the agency is perceived in the community and how this may affect their ability to do their jobs. One noted "caseworkers should get more respect in the community – similar to the level of police officers and probation officers." This person discussed how case workers go into many dangerous situations and unstable homes, similar to law enforcement, but are not elevated to that level and should receive similar benefits packages and counseling to handle these stressful situations. On the same topic, some supervisors indicated that they would like to see an effort to improve the general public's perception of child welfare by providing more education about what the agency does and the difference between CPS and permanency. Another noted that this could also be done by providing additional training for mandated reporters to help them understand the agency's function and further clarify what should and should not be reported.

Others discussed some shortcomings of the child welfare system as a whole. Many noted that the system needs to shift to be more proactive than reactive. They recommend that resources be allocated toward prevention so that children do not have to be removed as often. These supervisors also recommended that the agencies should concentrate more on "social work" and using that model in their practices. In line with this thought is the idea that the agency and system focus should be on the needs of the families they work with and not always the costs associated. This supervisor stated that we should concentrate on what the client needs first not necessarily at what the community can provide the client. This would help to identify gaps in the system.

Supervisors also had thoughts on possible improvements to legislation and legislative process. A few supervisors expressed concern that legislators making these decisions don't have first hand knowledge of the challenges faced in the field, or an understanding of the trauma inflicted by removing a child from his or her home. One participant stated, "Legislators need to look at the long term effects of removals on children – services to families are most helpful when they help maintain the children in the home – this is where more resources should be directed." Another said that child welfare should be a priority – but in terms of assistance to the agencies it doesn't seem like it is in Nevada. One participant even noted that "before laws are made legislators should shadow an investigator or supervisor and see what its like."

Others had very specific law and policy recommendations:

- Allow for flexible funding in the budgets – most supervisors interviewed mentioned that discretionary emergency funding would be very effective in assisting families. Some examples included funds that could help remedy situations where a relatively small amount of money for a home repair would make a home safe for children, however without that the children would have to be removed. Others noted that wait times for emergency funds can impede the process as often children or families need things to happen immediately to prevent removal or risk or harm to the children.
- Several supervisors indicated a need for the review of the law of consanguinity indicating that the current law reduces the number of qualified placements for children. Noting that this often really ties their hands and causes them to have to remove children and place them with non-relative foster parents or in shelter care until the "fictive kin" can become licensed foster parents and are able to take the children.
- Others noted that there should be exceptions to the rules regarding children under three being allowed in shelter care. "We need some way to get them out of the police car immediately."
- Concerns about laws regarding the termination of parental rights – one worker felt that the current laws do not allow children to achieve permanency as quickly as they should, citing an example of a parent who is sentenced to many years in prison and will never be able to care for their child.

Some simply recommended more consistency across the state and county agencies – stating that all three agencies do things differently and it often feels like there are three different states. While others advocated for changes within the agencies, they were concerned about multiple changes made all at once, or insufficient training regarding new changes. One Clark County supervisor specifically noted concern regarding the new hotline policy that allows only hotline personnel the ability to decide whether to screen out a referral. This supervisor felt that the unit supervisors should have more input in this process.

CONCLUSION AND RECOMMENDATIONS

Through the interviews with the supervisors the researchers gained an idea of how they felt the agency was working to protect children and serve families. All of the supervisors that participated in these interviews expressed both their successes and challenges. Overwhelmingly supervisors reported that they felt that the staff really cared about the children and families they work with, but often felt overwhelmed with the size of the job they are tasked to do. The most

frequently noted concerns in serving families were regarding caseloads and service availability for families. Further, the supervisors had multiple recommendations for how to change the system to improve the welfare of children and families. Some of the most frequently noted recommendations included: reducing caseloads, improving service availability, reducing waiting times for families to receive services; and improving existing law and policy to support good social work practice.

Improve Services for Families

Virtually all supervisors interviewed for this project, regardless of agency affiliation, noted that the services available for families are either inadequate or unavailable. In some cases the services do not exist at all and in others they felt that the services were not of high quality, or the waiting lists were so long that families could not be served in a timely manner. Specific recommendations included: domestic violence services, mental health services, substance abuse treatment, prevention services, and non-acute services for teens with behavior problems.

Recommendations:

1. Complete a full needs assessment in all jurisdictions to determine areas with the greatest need.
2. Additional funding should be allocated to support and enhance existing services and public/private partnerships should be explored to increase the capacity to serve more clients.

Worker Caseloads

Almost every supervisor interviewed in all jurisdictions indicated that caseloads in their areas were too high. This may have been because of the office being short staffed, i.e. open positions that they are having trouble filling, or the amount of work associated with their cases is more than they feel can be completed in a regular 40 hour workweek. Often a high caseload was given as the reason documentation was not done on time or at all.

Recommendations:

1. Conduct a thorough workforce study to measure the amount of time workers spend on various tasks including: home visits, phone calls, service coordination, documentation and travel time. This study should also include an assessment of the amount of time workers spend on individual cases to assess appropriate caseload numbers.

CASEWORKER FOCUS GROUPS AND SURVEYS

Caseworkers from all three agencies were invited to participate in one of four focus groups held in various locations across the state. Caseworkers were also invited to participate in an online survey to ensure that all caseworkers had an opportunity to provide input on the audit.

METHODS

Focus Groups

Four focus groups were conducted with direct practice caseworkers in the three Nevada child welfare jurisdictions. One focus group was conducted with the Washoe County Department of Social Services. Two focus groups were conducted with the Clark County Department of Family Services to accommodate the size of the agency. Two were conducted with the Division of Child and Family Services. One of those was conducted from Elko via videoconference to accommodate rural offices. A follow-up phone call was scheduled with one rural office that was unable to connect with the original focus group due to technical difficulties. A total of 68 workers participated in all four focus groups. The majority of participants (86%) were female. Slightly less than half (42%) of the workers had a bachelor's degree, while 58% had completed some graduate work or had a graduate degree. Many of the workers had degrees in social work, however other degrees included psychology, human ecology, criminal justice, as well as marriage and family counseling and education. Nearly one third (32%) of participants were investigators, slightly more than one quarter (26.5%) were permanency workers, and approximately 39% listed "other" type of worker.

The facilitators initially planned to conduct focus groups with only investigators and permanency workers, but chose to open up the recruitment to all types of workers in each agency to ensure all workers had the opportunity to share their thoughts on the functioning of the child welfare system. No supervisors or managers were allowed to participate in the focus groups because the facilitators wanted to ensure that workers felt comfortable answering questions and identifying problems without the potential for repercussions from upper management.

Participants were recruited in two ways. Agency contacts were emailed a flyer with details regarding location and time of the focus group and those contacts sent out all-staff bulletins announcing the event. In addition, each agency office was sent an 11x17 poster announcing that agency's focus group, and the contact person was asked to post it in a common area where workers would see it.

All focus groups were held from 12:00 p.m. to 1:00 p.m. with lunch provided as incentive for participation. Prior to beginning the focus group discussion, each participant was asked to complete an anonymous participant demographic form. The format for the focus group was a round-table discussion led by a facilitator with a second facilitator responsible for taking notes and asking clarification questions as needed.

Surveys

The caseworker survey was open to all employees of the three child welfare jurisdictions, Division of Children and Family Services, Washoe County Social Services and Clark County Department of Family Services. This survey was created in an online format and distributed

through email. An email with the instructions and the link was distributed to the directors of each child welfare agency on June 4, 2008 and these individuals were asked to forward the email to all caseworkers by June 6, 2008. The survey was scheduled to remain open until midnight on June 30, 2008 giving individuals approximately 3 weeks to complete the survey. Several reminder emails were sent out in an effort to ensure that the caseworkers would receive the survey.

The caseworker survey was created by the Child Welfare Audit team at the UNLV Nevada Institute for Children's Research and Policy and the School of Social Work. The caseworker survey consisted of an introduction and consent page and contained 27 items. The questions in this survey addressed specific issues in child welfare such as organizational, community, and systemic barriers to service delivery, caseload issues, training needs, and other barriers to effective child welfare practice in Nevada. All items addressed in the caseworker survey were included in the Focus Group and it was estimated that the survey would take approximately 15-20 minutes to complete.

FINDINGS

Focus Groups

The format for the focus group was a round table discussion. In order to provide some structure to the discussion, a set of open-ended questions were developed. These questions included:

- What do you feel that your agency does well?
- What are some of the strengths?
- What are some of the problems you encounter on a regular basis in providing quality service to your clients?
- Do you have any suggestions or recommendations for how to overcome these barriers?
- What are some of the problems you encounter using UNITY as a case management tool?

All data was qualitative, and was collected via facilitator notes. Data was analyzed using NVivo, a qualitative data analysis program.

Strengths

Caseworkers were asked about their agency's strengths and what they believed the agency does really well. The question asked the caseworkers to examine how the agency assists caseworkers with their duties and how the agency serves as an asset to child welfare. In the analysis of the discussion, several themes were identified: caseworker commitment to their jobs and focus on teamwork, support of caseworkers by management, specific agency practices as well as policies and procedures, positive collaborations with the community, and the agency focus on staff training.

- *Case Worker Commitment*
  One caseworker asserted that individual caseworkers are the reason for agency strength and success rather than the child welfare agency as a whole. Direct practice workers felt that agency employees genuinely care for the children and families on their caseloads. They put a lot of effort into being creative with limited resources. The dedication and perseverance of these caseworkers were seen as the basis for their frustrations with the agency. They work well with families despite the lack of resources and negative environment. Workers observed

that they as a whole work hard, focus on the big picture, and feel that many new caseworkers have had to "hit the ground running" with limited support. Workers felt that despite the fact that they handle huge caseloads and have lots of pressure and responsibilities on them due to the nature of their jobs, they manage to keep a good sense of humor and feeling of dedication to the families. Workers also shared a general feeling that employees are becoming more team oriented. Due to the recent hiring of a large number of diverse new workers, the teamwork issue was viewed as particularly important, as it is essential for more experienced workers to assist new workers in learning to do their jobs. Not only does teamwork improve the services provided to the clients, but it also improves communication among workers in different units.

- *Agency Efforts to Assist Case Workers*
  Caseworkers believed that management is attempting to alleviate the pressures on child welfare workers. Participants felt that overall management responds to problems and is trying to think of new ways to make sure workers have help completing their work in a timely fashion. Workers did identify the institution of the placement team as a great resource that alleviates one of the most time-consuming tasks for permanency workers. Another agency praised their management for providing support staff such as runners, dictation and transcription assistants, and data entry assistance for UNITY. The UNITY support staff assists with the input and updating of records; streamlining paperwork; enter in court dates; assist with closure screens; and enter case plans. Workers felt that this type of support was essential in helping caseworkers do their jobs effectively. Good internal services such as Family Preservation and clinical support are strong and helpful. Workers felt that communication between management and workers is improving.

- *Agency Policies, Procedures, and Practice*
  Workers from one agency stated that the agency makes an effort to be on top of best practices and are open to trying new things and taking suggestions from the employees. That same agency was also commended for its hiring practices and acknowledged that good people are hired and management rigorously interviews interns who have been in field practicum with the agency. In addition, the agency is supportive of workers' decisions in the field. This agency's focus is on preventative and proactive services rather than reactive (which other workers cited as an problem with their agencies), which workers felt was positive. In addition, workers from another agency identified the agency's efforts to include them in the development of new policies and procedures as a positive factor.

- *Training*
  Overall, workers felt that their agencies were putting a new focus on training on a number of different issues, and that additional training for the experienced workers and for new workers would streamline and improve agency practice.

- *Collaboration with Community*
  Several workers mentioned that there is a new push to inform the community about child welfare practice and to work with local philanthropic organizations to address identified needs. They also had an interest in seeking additional grant funds to provide a greater array of services for clients.

Barriers

Participants were also asked to discuss barriers they encountered while doing their jobs. In the analysis of the discussion, several themes were identified: community problems such as a lack of community resources and services and difficulties with existing services, several agency-related issues such as policy and procedure issues, difficulties with caseloads, employment issues such as high turnover rates, problems with the court systems, and inter-agency relationships.

- *Community*
  There were some basic frustrations expressed regarding the community in general and there is a general feeling that transience makes casework difficult. Specific issues include:
  - Several workers shared a need for community education regarding mandated reporting
  - Others are concerned that the perceptions of what child welfare workers are able to do are incorrect particularly with regard to removal from the home.
  - Participants specifically wanted the public to be educated about the laws child welfare workers have to operate within and about the process workers must progress through as mandated by laws and agency policies.
  - Workers shared that they struggle with false reporting, for example, where parents or neighbors who are fighting call CPS to make false allegations, which is a waste of resources.
  - In addition, other agencies try to go through child welfare to get resources for families and should have additional information about other available community resources.

- *Resources and Services*
  Workers felt that there were several specific issues regarding a lack of community services. Some concerns included:
  - Many stated they need more information about existing services, as there seems to be a communication gap within the agencies regarding resources available in the community. Several caseworkers stated that they contact other workers in order to locate appropriate resources for their clients.
  - There is a distinct need for additional resources. Specific services that were identified as lacking included:
    1. Substance abuse counseling
    2. Transportation services for clients
    3. Translation services for monolingual families
    4. Mental health services
  - Funding for child and youth programs was also identified as being needed.
  - Several workers stated that there needs to be assistance for families in getting medical insurance because lack of insurance or insufficient insurance delays access to services and therefore keeps the family on the worker's caseload.
  - Rural participants identified distance to existing services as a barrier, and stated that additional placement options were needed in the rural areas. Local foster homes, kinship care, and independent living (particularly for older adolescents) options are necessary because youth are often placed in foster homes in other cities or towns requiring significant travel for the worker, which is cost-prohibitive and time consuming especially when considering high caseloads.

  There were several identified difficulties with existing services including:

- Incompetent or inappropriate service providers on a list without the option for other providers.
- Difficulties qualifying children for services because of Medicaid eligibility problems stemming from a child in out of home placement or who has been returned to the care of his or her parent.
- Long waiting lists for services and high provider caseloads leading to a denial of services.
- Additional problems with "red tape" and insurance.
- One worker shared a feeling that there is a "what can you do for me" attitude among many clients, which is difficult to handle.

- *Agency*
  Some workers shared that the business model being utilized to run the agency was not working as well as it should. The agency is working reactively in response to lawsuits instead of proactively. One drawback of the reactive approach, particularly with regard to changes in policy and practice, is the unintended problems it can create in the long term. Workers felt that the reactive actions demonstrate fear and that the agency is controlling of worker actions without adequate understanding of those actions.

  Workers at multiple agencies felt that their agency does not use the strengths-based model they expect workers to use with their clients. If the agency wants to improve its practice, it needs to work with staff on a strengths-based model rather than having unreachable standards for performance. Workers felt that the agency philosophies need to be revisited so people are appreciated and treated well in recognition of all the work they do.

  Several workers felt that there was a lack of consistency among supervisors and managers. For example, when trying to get emergency assistance for a family, some supervisors will sign the request and others will not, so workers have gotten used to asking the supervisors who will, even if it is not that worker's direct supervisor. Others felt that there was an overall lack of supervisor availability to assist workers. One example included the worker waiting 2-3 weeks for a supervisor signature on a document.

- *Policies and Procedures*
  There were several common frustrations regarding policies and procedures.
  - Agencies should standardize eligibility criteria for services so there is no confusion about who is eligible and who is not.
  - 4 day, 10 hours a day shift was a "no-win" situation, particularly because it was difficult to balance home and work life.
  - Frustration at the case note documentation policy, stating that the policy is very detailed, making it unmanageable and often contradictory.
  - Frustration at the lack of specialists assigned to sex abuse cases – they felt that those investigations required additional training and a specific comfort level with that type of case, and without specialists, those cases were not being handled properly.
  - Rural workers universally shared frustrations with mileage, transportation, and overtime, and requirements for the ways that agency vehicles are utilized.
  - There were other frustrations with the drug testing policies, overtime and flex time policies, the required assessments that must be completed, the bureaucratic and complicated legal requirements of the job, and not only contradictory policies and procedures, but overly detailed and specific policies and procedures.

- Workers stated that they feel over-regulated and trapped, unable to complete their job requirements due to all the restrictive policies. Workers particularly focused on the contradictory policies – because they are so detailed they contradict and set workers up for automatic failure, which wears out workers and lowers morale.
- Workers felt burdened by the fact that the worker is the person "ultimately responsible for everything" without sufficient agency backup.
- Workers also felt that the screening criteria for investigations needs to be improved to reduce erroneous investigations, particularly when the system has been set in motion and there's no evidence, but it cannot be stopped.
- In addition, workers felt that overly detailed policies and procedures put both them and their supervisors in a difficult position, because the worker feels that he/she must do what is necessary for the child/family even if it risks going against policy, and that leaves supervisors with a difficult choice to make between rule-enforcement and quality service.
- Workers felt that frontline workers should participate in the development of policies, and that other agencies that would be affected by the policies, such as local law enforcement, should be brought in at the outset for review and agreement prior to implementing the policy.
- Finally, workers felt that not enough consideration is involved in many policy changes – while the intent is good, there has not been enough thought about possible adverse effects.

- *Case Management*
  Many workers cited their caseload as a significant problem. High caseloads negatively affect a worker's ability to effectively provide services, and many workers consistently stated that there are simply not enough hours in a workweek to complete all their necessary job duties. Many workers felt that the balance between conducting visits and documenting visits in UNITY is a difficult one, and several workers shared that UNITY is not a priority when the choice is between conducting a visit to ensure a child is safe or entering information into UNITY. Additionally, workers felt frustrated that if a visit is not documented within 30 days, that it seems to be "erased" and must be treated as if it never happened. Additional frustrations include:
  - The burden of training new workers and the caseload sharing that occurs as new workers start.
  - Frustrations regarding emergencies that occur and how they reduce the number of hours that each worker has available to conduct their regular case management activities.
  - Stress and frustration over the demands of paperwork were shared almost universally.
  - Workers shared that vacation and sick time felt impossible because the work doesn't stop when you're out and it is extremely difficult to catch up, particularly if you work in a small office and there is limited backup from other workers.
  - Universally, workers stated that their frustration with these problems is primarily due to their inability to meet the needs of their clients and perception that their clients are suffering.

- *Employment*
  The discussion of employment issues primarily focused on the high employee turnover rates leading to a lack of an experienced workforce and short-staffed offices. Retention and recruitment were suggested as was to reduce the turnover rate. Most responses indicated retention should be a primary focus for agency activities, providing incentives and

recognition for workers before morale dips so low it cannot be recovered and the worker leaves. Feelings of "sinking" and "not achieving" were cited as common frustrations and impediments to morale. Not only does the turnover affect the agency's capacity to serve clients, it upsets the clients as well since they have to cope with a lack of consistency in individual worker practice. In addition, workers feel that the agency is not supportive of shift changes or other worker needs. Some workers stated that there is a culture of fear cultivated at their agencies, based on "seemingly random" firings where workers are escorted out by security, an "if you don't like it, quit" attitude, and unclear standards for firing workers. Additionally, rural workers felt that recruitment should be a focus for the rural offices, because without additional incentives to move to a small town, it is difficult to recruit qualified staff. In addition, management and administrative turnover was cited as difficult, because of the broad changes that occur when there is a new administration.

- *Agency Resources*
  A lack of agency resources was also identified by participants as affecting their work, particularly at the end of the fiscal year. One participant shared that the office had once run out of paper completely and had to wait until the new fiscal year to order these supplies. Others felt that the agency doesn't provide sufficient funding to pay for required assessments or evaluations for clients. Others felt that the budget did not include enough funding for travel, and insufficient cars or cell phones for workers.

- *Inter-agency Relationships*
  Many workers felt that the departments within the agency do not communicate well with each other. One example shared was when a client changed her address and only told her licensing worker, and the on-going worker was unable to find the child for a time. Workers would like to see a sense of team spirit and consistency among workers, particularly across agencies, rather than "pitting one against the other". Without good communication, workers felt that the stress of the job increases significantly and they would like to see a "one family" concept.

- *Court/Legal Challenges*
  An additional frustration shared was the amount of time workers are spending in court. Time spent in court reduces the worker's available time for other case management activities and leads to additional stress due to falling further behind. In addition, workers feel that the judges often critique them and their judgment, rather than the parents, which leads to a lack of accountability of the parents and a system that cannot work well together. In addition, attorneys working on these cases change the focus of Child & Family Teams (CFTs) into a discussion of litigation not problem solving.

Solutions and Recommendations

The focus groups were designed to allow workers to voice their frustrations, but also to share their ideas for solving their problems. Participants were asked to make suggestions and recommendations for the problems identified in the previous section. In the analysis of the discussion, several themes were identified: those focusing on resources and services, agency and system changes, policy changes, changes to the court system, and training.

Resources and Services

- Development of lines of communication with service providers, and suggested a department or group within the agency that develops and manages contracts with service providers and focuses on identifying new community agencies for partnerships so that responsibility does not lie with workers.
- Workers were very interested in working with service providers to have accountability plans in place, and action steps in place to facilitate planning.
- A family-centered assessment process and developing a continuing-care treatment plan as well.
- Understanding that funds are a problem for the agencies, they suggested informal agency fundraisers – such as a "donate $3 to wear jeans on dress-down Fridays" in order to accumulate funds in a discretionary account.

Agency & System Changes

Suggestions for systemic improvement are:

- Increase the number of front line workers.
- Practice the strengths-based philosophy for both clients and staff.
- Develop a comprehensive procedural manual to supplement the policy manual.
- Hire additional support staff to assist workers in doing their jobs.
- Utilize Maslow's Hierarchy of Needs when developing plans for parents. Clients cannot focus on substance abuse treatment if they are homeless and hungry.
- A community-based service model would increase collaborations with other agencies.
- Workers felt there is a lack of focus on children and families and that the agencies must refocus and remember why they are there.
- Increased collaboration and communication among workers – for example, allowing another caseworker in an office to conduct a home visit for a worker who has been called to an emergency or who has been in court. This issue was particularly applicable to rural staff that may have to travel to conduct home visits.
- Additional satellite offices were recommended to increase contact and build relationships with communities.
- Management of specific day-to-day activities was unnecessary for both the workers and the supervisors, and suggested that agencies needed to learn to trust the workers.
- More shared responsibility for cases, particularly in the rural offices, to find creative ways to free up time for relationship building with families and children, and utilize existing resources to support workers.
- A feedback loop for management and caseworkers.
- Workers were interested in identifying ways to streamline processes, paperwork and reporting.
- They suggested that licensing should dually license a home as a foster home and a shelter home to increase the availability of emergency care, and that requirements for foster parents and visitation of foster homes should be clarified and improved.
- Recommended improving screening of cases to reduce time spent on inappropriate investigations.
- Consider travel costs and time when allowing workers to support other offices.
- Set a cap on caseloads.

- All three agencies should identify and use a standardized, centralized assessment, which can be forwarded out to service agencies for treatment rather than paying for an initial assessment, which is different at each agency.
- Agency practices be revised to include permanency workers in the first 2-3 weeks of an investigation so ongoing and consistent services can be provided.
- Agency policies should be developed with a focus on understanding families/clients, allow workers to exercise their judgment and experiences, and trust the workers to do a good job.
- In addition to hiring support staff to assist workers with UNITY and other paperwork, support staff could serve as emotional support for caseworkers, and assist them with handling job related stress.

Court

- Each agency should have a court team, similar to models in Pennsylvania or California, which would reduce the combative nature of the agency's relationship with the district attorney's office.
- Consider guardianship options prior to beginning the TPR/adoption process.
- Criteria are established for each child to receive an attorney.
- Workers only are brought into court if they are needed or the judge requires them to be there in order to free up their time for case management.
- Hire specific support staff to assist with the development of court reports.

Training & Education

- Training curriculum for foster parents, CASAs and mandated reporters should be revisited and improved.
- More professional development opportunities (and the time to attend them) for new and established workers.
- New workers have additional hands-on or on-the job training with an experienced worker before they go out on their own.
- "Cross-training" of workers is important – teaching permanency workers about investigations so that all the workers understand and appreciate the others' work.
- Workers recommended workshops for community partners, such as judges, lawyers, service providers, and members of the public about the legal framework of child welfare, defining clearly "what [the agency] actually does", and clarifying when referrals are appropriate. They felt that these types of workshops would help the public to see child welfare as a support system not as "evil or negative" which would improve the worker's ability to work with the public in a more positive light.
- Specific training topics of interest mentioned by workers included:
    1. Ethics
    2. Interviewing skills
    3. Court testimony
    4. Mental health
    5. Sexual abuse
    6. Evidence-based practice
    7. Report writing
    7. Attachment disorders
    8. Advocacy
    9. Life skills
    10. Child development and trauma
    11. HIPPA
    12. Medication awareness/effects
    13. Federal/State child welfare laws.

UNITY

- UNITY needs to be able to generate reports.
- UNITY needs to be streamlined so there isn't as much repetition in data entry
- Increased accessibility.
- Windows in UNITY to document and access services.
- A quick reference guide available.
- Mobile access to UNITY through a laptop would improve ability to complete paperwork and access information.
- UNITY needs to be updated to ensure that all options are available as choices (for example, when new schools are built they should be added to the database).
- It should auto-fill information in multiple windows where possible (such as updated address information).
- Spell check should be available within UNITY.
- Additional training and refresher courses on using UNITY.

Surveys

Demographic Information

A total of 87 individuals completed the online Case Worker Survey. The majority of the respondents were female (88.5%). Regarding education, 49.4% of the respondents have a Bachelors Degree and 40% have a graduate degree. The majority of individuals have their highest degree in the field of social work (61%), followed by psychology (11.5%), and counseling (7%).

Agency Information

The majority of the surveys were received from individuals from Washoe County Family Services (49.4 %), while 33.3% of the surveys were received from the Division of Child and Family Services and 13.9% were received from the Clark County Department of Family Services. Respondents have worked for their current agency for an average of 5.6 years (SD=5.6), been employed in their current position for 3.2 years (SD=3.8), and worked in the field of child welfare 9.0 years (SD=7.6) with about 10% of respondents working in the field of child welfare for over 20 years.

Respondents served various departments within their agency including investigation (33.3%), permanency (29.8%), and a third reporting other roles including mental health provider, adoptions, voluntary assignment, foster care, drug court, and trainee. Specific titles of respondents were diverse. Almost half of the respondents reported their specific title with their agency to be social worker (42.5%), while 12.6% were family service specialist, 12.6% were supervisors, and 8.1% were case managers. Please note that secondary levels within each title were not indicated in this analysis (i.e. social worker I, II, etc.).

A multivariate analysis of variance was conducted for the following questions among the three agencies. No significant differences were found among individuals from different agencies so all responses are reported together.

The majority of respondents (51.7%) feel that the agencies are supportive of their caseworkers and a quarter (25.1%) feel that the agency does not provide adequate support. Respondents refer

to the agency's policy and procedures manual either weekly (17.2%), monthly (24.1%) or a few times a year (32.2). A small percentage, 8%, indicated they never refer to the manual.

On average, workers have 17 cases (SD=15.3). Forty percent indicate their current caseload is representative of the load they normally carry; however 26.4% indicated their caseload was less than usual. Respondents also indicated they have on average 26.8 (SD=18.6) children on their caseload with 19.5% indicating that this is less than usual and 37.9% indicating the number of children is about average. Regarding worker caseload, 56.3% of workers indicated they felt they were able to adequately serve the families assigned and 18.3% felt this was not possible. However, only 26.4% of workers indicated they felt they have enough time to manage their caseload where 45.9% felt they did not. Caseworkers seem to be able to focus their time on meeting the needs of the families but do not feel they have time to complete related tasks of case management.

Three key areas were assessed regarding specific practices with clients: worker safety, cultural assessment, and the usefulness of concurrent case planning. When conducting home visits, 40.2% indicated that they sometimes feel unsafe while 29.9% rarely feel this way. When assessing a family, the majority of individuals (51.7%) always consider ethnicity and/or cultural issues when making final decisions while 27.6% sometimes consider ethnicity and/or cultural issues and only 3.4% rarely take those factors into consideration. Consideration of cultural issues can be key to successful results in child welfare. When developing a case plan, 78.1% feel that concurrent planning is a useful tool for child welfare practice. Concurrent planning is crucial to minimizing the length of time a child remains in care because both plans are worked at the same time rather than waiting for the primary permanency plan to fail before moving toward the concurrent plan.

In response to specific questions regarding UNITY, approximately 44% of respondents feel that Unity is not a user-friendly data management system while only 20.7% feel that it is a user-friendly system. Regarding data entry into UNITY, 67.8% felt that it was important that information is entered into the database in a timely fashion while 16.1% feel it is only somewhat important. The average respondent spends approximately 9.1 (SD=6.3) hours per week entering information into UNITY. 29.8% of respondents indicated that they spend over 10 hours a week entering information and 10.3% indicated that they spend an average of 20 hours per week entering information.

Open Ended Questions

Four opportunities were provided for the respondents to provide open responses including comments on UNITY, case management activities, personal and professional development, improvements to the child welfare system in Nevada, and an open question for respondents to include any other comments.

UNITY

There is an overall feeling that UNITY is not a user-friendly system for individuals within the child welfare system and a priority should be placed on adjusting this data management system for more accurate reporting. Only 3% of respondents indicated that it was an effective and easy data management tool. The majority of the respondents felt that the system was very frustrating to use and inadequate training was provided. Comments revolved around difficulties with the system and suggestions for improvement. Specific problems and suggestions are as follows:

- Overall, there are too many windows in UNITY making the system very hard to navigate. Respondents indicated that it is challenging to remember which screens need to be completed because the system does not automatically flow to the next necessary screen.
- Another related problem respondents indicated was UNITY's inability to prepopulate fields across windows. There are several windows, which require the entry of repeat information. It takes valuable time to re-enter the same information numerous times.
- Respondents also indicated that changing information in UNITY is very time-consuming and frustrating. There is not a spell check option in UNITY, which leads to many errors in the notes, which cannot be corrected immediately. The process to change data is long and cumbersome.
- It was suggested that supervisory control over changing simple mistakes would speed up the process and allow for more accurate data. Also, the ability to update information at the time it is noted would also lead to more accurate data.
- It was also noted that the system creates alerts indicating information needs to be updated (such as a child's paid placement is approaching expiration) but UNITY will not allow the information to be modified immediately. It is necessary to wait for the expiration to update the information.
- There are also issues when there are multiple programs or workers assigned to a family. Cases that have several individuals assigned, who are no longer a part of the case, creates issues when completing Nevada Initial Assessment (NIA) and other data entry activities.
- There is not an easy way to track or enter information for providers.
- It is difficult to identify family members when there are multiple participants with the same name.
- Several workers indicated that even though it is understood that documentation is extremely important, high caseloads make it difficult to have time to enter the data. There are times when entering data could take an entire day, which does not allow workers to be in the field. UNITY can only be accessed from the computer at the workers desk; however, the majority of the time workers are in the field, in meetings or in court, which makes the system impractical.
- UNITY is supposed to reduce paperwork, yet after information is entered, often the requirement is to print out a hard copy for the file.

- Respondents also indicated that UNITY runs very slow, information tends to get lost in the system, and UNITY is constantly updating or adding features and it appears to be very time consuming and difficult for the workers. A few respondents indicated that working with the UNITY help desk does not seem to be effective.

Some suggestions for UNITY improvement include:

- The use of clerks dedicated to data entry, which would leave caseworkers more time with families.
- Utilizing military time to avoid data entry errors regarding time.
- Allow case notes to indicate more than one category rather than duplicating the same note (i.e. child contact and care provider contact).
- Access the person detail window from the case directory.

- Access case notes from the NIA window while writing related reports and having unlimited space per page.
- It was noted by a respondent that California has a child welfare data management system similar to Nevada's, which has been redeveloped and revised and works very well. It may be worthwhile to investigate other systems that have proven to be useful.

Top Three Time Consuming Case Management Activities

Caseworkers were asked to list the three most time-consuming case management activities. The majority of caseworkers (57%) indicated that one of the most time consuming activities was completing paperwork. This includes case documentation in the paper file (31%), writing and reviewing court reports and gathering supplemental information (21%), completing intake summaries, treatment summaries, S.A.F.E. home studies, ICPC applications, end of month reports, and agency documentation such as travel authorizations (15%). Similarly, over 50% of respondents indicated that one of the most time consuming activities was entering information into UNITY.

Other activities that were reported to be very time-consuming were home visits (18%), providing services and/or referrals (16%), client contact (15%), travel time between appointments (12.8%), and appearing in court (8.1%). Several respondents also mentioned that unproductive meetings and individual time trying to obtain training because official training is not available are time-consuming.

The following is a list of other activities that were provided by respondents. These are presented in no particular order.

- Clerical activities such as creating and organizing files/data, responding to E-mails
- Arranging visitation
- Supervision of visits
- Case staffing
- Managing foster parents
- Rigidly following protocols
- Collateral contacts
- Reviewing incomplete referrals
- Reviewing cases
- Communicating with Nevada State Welfare
- Searching for old information
- Preparing new adoption cases

- Research to find families and relatives the agency is unable to locate
- Confirming appointments children have attended
- Placement disruptions/crisis management.
- Handling problems with supervisors and/or case workers
- Supervising staff
- Consultation
- Reviewing reports with staff and clients

Personal and/or Professional Development

Regarding the need for personal and professional training, respondents were extremely varied in their responses. Some general comments were made that caseworkers need more standardized training to prepare for fieldwork. It was also mentioned that training should include information regarding the overall layout of the child welfare system and how the different departments work as a whole. Another general issue mentioned was the need for more continuing education training for professional license maintenance. In the rural areas, where the requirement for employment is licensure as a social worker, the training needed to maintain that licensure is not available. It is reportedly difficult to receive time and funding assistance to attend training.

Several respondents indicated particular areas where training is needed. Some of these areas include: domestic violence, ethics, mental health issues regarding children, training for management and supervisory duties, forensic investigative skills, substance abuse in children and adults and how to implement parent education classes on the effects of substances, documentation and case management skills, and training on cultural competence in the field.

There was also a sense that respondents did not feel that adequate training was provided on specific policies and laws particular to their area of employment and more advanced training was needed for senior staff. Respondents also indicated a need for some personal development that would affect them professionally such as time management, stress management, personal safety training, and overall training on professionalism and professional development.

Further suggestions for additional training include:

- Interviewing children and families
- Assessment administration (i.e. Ansel Casey Test Training)
- Adoption in general and working with adoptive families
- Conferences for cutting edge research.
- Techniques and knowledge for growing areas of concern, such as Aspergers Syndrome, Autism, etc.
- Have trainings that bring judges and social workers together so both parties are aware of the other's philosophy.
- Step-by-step guidelines (a manual) of how to do functions for UNITY.
- Better and more simplified UNITY training.
- Updated, concise and consistent guidelines for stages of development.

- Skills for working with adults afflicted with ADD.
- Would like a video recorder to record parents with their children and use a self-analysis type of teaching tool.
- Training for ILP
- Training for the administration to learn how to motivate employees and work on strengthening the agency.
- Physical/ sex abuse training.
- How to screen potential foster/adoptive parents. How to work with foster parents.
- HIPPA
- Court reporting and other legal writing skills.
- Training for stakeholders, including schools and courts on 432B.
- Training for ILP workers to learn about different funding sources, creative uses for those funds, expedited procedures on accessing funds for ILP teens in care. Training for supervisors to learn how to better access available funds.
- Training on communication skills.
- Training on Medication Management.
- Training for developing policies.
- Training on taking reports from the public.
- Learning best practice tools.
- Ethics – would be helpful if offered more often.
- More clinical training in general.
- How to find resources.
- Time Management.
- Injury Identification
- Child rearing
- Knowledge in drug paraphernalia

Top Three Improvements to the Nevada Child Welfare System

Caseworkers were asked, with an unlimited budget, what are the top three items that need to be addressed. Over half of the respondents indicated that more social workers are needed in order to provide more time for case management and to lower caseloads. Over 15% of respondents indicated that more clerical and/or paraprofessional assistance would be beneficial in completing case notes and other mandatory reports. Workers also believe that there should be a salary increase and/or benefits to recruit and retain workers, which would include overtime for new and existing workers and incentives for those in rural areas.

A second concern expressed by many respondents was the need for increased funding for services offered to biological, foster and adoptive parents as well as children. Also, the inclusion of concrete services like monetary assistance with utilities, rent, food, and clothing would be extremely helpful. Increased funding to improve access to mental health and medical treatment, provide more in-home services for families, increase prevention programs and additional training for foster parents were considered important.

Also included in workers' top three improvements would be to replace UNITY with a different system. Some other suggestions for areas of improvement were particular to the rural areas, including the purchase of better functioning vehicles, cell phones, and more training opportunities. Other common responses include the addition of an on-site service provider who can provide referrals, make appointments with other agencies, or provide treatment on-site (i.e.

mental health). The purchase of writing/quick pads, laptops with UNITY, or computer pens would make documentation more convenient.

The following list includes individual responses that may provide useful ideas for improvement.

Parent/Child Services

- Create a parenting hotline – "what do I do when …?"
- Create a mentor program, where parents who have graduated from the system can assist new parents that have had their children removed
- Foster parent appreciation events
- Provide free and accessible birth control
- Make birth control mandatory for clients who have children in protective custody.
- More housing opportunities for families in safe areas
- Have staff do the transporting for the social worker's clients – taking children to court, meetings, etc.
- Offer more incentives for foster homes and adoptive families such as student loan forgiveness, higher payment, etc.
- Increase sibling contact if separate placements
- Allow children to keep Medicaid when they return home to parents (until case closure).
- Increased accountability for clients obtaining funding

Specific Resources

- Build a state mental health hospital in Elko
- Create a children's advocacy center in Reno area to promote a cooperative multidisciplinary approach to child sexual abuse cases
- Have Quest Diagnostics have a drug-testing site at social services.
- Agency-based therapeutic intervention units (family preservation, clinical response) that will respond right after an investigation is initiated
- More bilingual counseling services.
- Educate the public about what constitutes child abuse
- Create neighborhood care system in rural areas
- Create a clinical program using masters level social work interns to meet the needs of the neighborhood center

Policy, Procedure and Courts

- Simplified policy (eliminate cumbersome practices) that conforms to ethic codes
- Family Mental Health Court
- Use a City Council to represent the division instead of the District Attorney's office
- Educate legislators about the work that is done in the child welfare system. Free trainings for stakeholders who do not know how child welfare works, or the meaning of the mission statement
- Rewrite child welfare laws regarding investigations and allowed findings
- Educating the court system that the agency should be vacating cases and returning children when there are no longer any safety concerns, and then the agency can offer some kind of intensive in home support program to prevent children from re-entering the system.

- CAP attorney for every child 5 years and up

Staff Needs

- More availability and locations for supervised visitation centers.
- More flexible staff schedules.
- Retirement for social workers at 20 years
- Hire employee morale specialists to research and implement employee retention programs
- Improve leadership, and make supervisors and managers accountable for the same level of documentation as front-line workers.
- Provide easy access to gift cards, etc., for youth who need money quickly. Present policy takes minimum of 2 weeks before a check or gift card is in the worker's hand
- Develop a centralized system for intake.
- More supervisor positions
- Devote more money to worker safety
- Snow tires for the state cars, and more cars with four-wheel-drive
- Increase the emergency on-call pager rate, as it has not been changed in over 10 years.
- Have a partner to respond to all reports
- When on call be able to take car home especially in rural areas

Final Comments to Improve Child welfare in Nevada

The last question of the survey allowed respondents to provide any last comments or suggestions regarding the Nevada child welfare system. Many comments were reiterations from the previous questions such as there is not enough time to fulfill all duties effectively, hire more workers, increase funding to provide adequate services, and worker problems with Unity. There were many respondents who indicated that it is essential for the state to include travel time for visitations and placements when considering appropriate caseloads for workers. This would increase effectiveness of the workers. There was also a sense that some staff members (8% of respondents) do not feel supported or appreciated by upper management and administrators. The following include a combination of individual comments and suggestions provided by respondents:

- Caseworkers suggested that case files should be organized more efficiently to better display the information needed.
- On-call workers need to be able to contact supervisors for advice or consultation.
- Managers and supervisors need to communicate with each other to ensure they give workers the same directives.
- Employees need to be trained to embrace teamwork and a strengths-based perspective.
- There should be in-house counselors to assist social workers with difficult cases and extreme stressors.
- Early retirement benefits similar to law enforcement should also be available since both professions work with similar populations.
- Because of the unrealistic caseloads, and the poor treatment of frontline workers by the administration, we have a very high turnover. It takes about two years to learn this job, and

most people do not stay with the position for that long. This costs the county money when they have to continuously train new hires, and also causes the children and families to suffer every time they are connected with a new, inexperienced worker.

- It would also be effective to enhance relationships with the court system and judges. Sometimes too much time is spent working with the attorneys, or making sure the foster parents are happy, it is difficult to focus on working with the children and families. The demands from the court and the department are impossible to meet, unless one can accept that the job is never done.
- Rural populations have different needs that should be addressed and reflected in the policies and procedures. This includes worker pay and incentives needed to maintain staff in these areas. There was also a concern that due to recent budget cuts, the social work programs in the north may be in danger of closing which would impact the availability of new, educated social workers in the rural areas. There also seems to be a need for more child and adolescent psychologists in the rural population.
- Overall when dealing with families, it appears that workers feel that some of the policies are very rigid which impacts the ability to help the family. There needs to be better procedures to determine if a claim against a family is untrue and work with the families accordingly and there is a need to develop a clear tool and guidelines for the removal of children. Families would also be better served if caseworkers were allowed to assist one another with child visitation and if policies would be adjusted so that children in a stable home for over 6 months should only have to be visited in placement quarterly.
- Families and children are in need of more services and quicker access to them. Some workers believe that families participating in services should have an investment in receiving services to increase commitment such as a slight fee.
- With regard to services provided to children in care, there is a concern that many children are misdiagnosed, medicated and put in higher levels of care than are necessary.
- Regarding foster parents, federal or local funds should be available to provide foster parents with the option to remain home with the children. This would be helpful in the long run, resulting in an increase in high school graduates, college attendance and stable living. Hopefully this would result in less teen pregnancies and less interaction with the juvenile system. However, foster and adoptive parents should have to attend a sort of boot camp environment to receive training to effectively handle the foster children and licensing homes should follow strict rules or follow the SAFE home study for adoption recommendations.

CONCLUSION AND RECOMMENDATIONS

Focus Groups

Overall, the focus groups were a positive experience and workers felt they had a voice in the process, which is something they would like from their own agencies. While respondents were able to identify strengths within their agencies and the child welfare system as a whole, it became clear that workers are suffering from low morale and burnout due to large caseloads and consistent pressure. Workers want their administrators to know they are dedicated workers and would not be here if they didn't care but they want to be acknowledged and treated with the respect they deserve given their difficult jobs. They are committed to doing whatever it takes to provide quality service to the children and families on their caseloads and this is evidenced by

the many suggestions workers had for improvement of the system. These suggestions ranged from specific suggestions for training and court improvement to more general suggestions regarding policy development.

Surveys

There were 87 respondents to the survey with representation from each of the three jurisdictions. The three top areas of discussion were UNITY, training, and services. UNITY should be a priority in terms of systemic change as it is a difficult system to use and the perception is that the information currently contained in the system is not accurate. It was suggested that a new system be purchased or, if that is not possible, UNITY should at least be redeveloped and revised so it is easier to use and therefore contains accurate information.

A comprehensive child welfare training program should be implemented statewide to prepare caseworkers for fieldwork. Respondents felt training was an area in need of improvement both for new workers and experienced staff who should have access to on-going advanced child welfare training. Respondents had many suggestions for training topics that would improve their ability to adequately do their jobs but also indicated that it is difficult to obtain approval for training or take time from their job to attend. Development of a comprehensive training program is essential to provide caseworkers with the tools to do their jobs.

The final area of improvement that was important to respondents was the area of service provision. Caseworkers indicate that more services need to be provided to parents, foster parents, adoptive parents, and to children. The preference is to increase services with a focus on prevention and to increase concrete services such as funding for rent, utilities and food. Often it is a lack of basic necessities that brings a family to the attention of child welfare and there are limited community resources to improve the situation. It was also noted that service providers of substance abuse and mental health treatment are limited and efforts should be made to increase services and/or make them more accessible to child welfare clients.

LAW AND POLICY ANALYSIS

METHODS

Members of the research team with expertise in legal research compiled all relevant state and federal laws and regulations related to child welfare to conduct a comparative analysis of agency policies and procedures. The relevant state and federal laws and regulations that were reviewed included:

- Nevada Revised Statutes (NRS), Sections 127 and 432B;
- Nevada Administrative Code (NAC), Section 432B;
- Child Abuse Prevention and Treatment Act (CAPTA)
- Adoption and Safe Families Act (ASFA); and
- Indian Child Welfare Act (ICWA)

In addition to the applicable laws and policies, the research team reviewed relevant reports, recommendations and best practice literature to identify policy elements to utilize in the comparative analysis of the agencies' policies and procedures. Those included:

- Blue Ribbon Panel Recommendations (BRP);
- Children's Bureau Office Best Practices (CBO);
- The Ed Cotton Report Recommendations (ECR);
- Independent Child Death Review Panel for Clark County Recommendations (ICDR); and
- Five-Year Child and Family Services Statewide Plan for FY 2005-2006 (CFSP)

Researchers utilized the guidelines of the audit to identify specific laws, regulations, recommendations and best practices to use as a comparison against the written policies and procedures of each agency. These policy and procedure components, as outlined in the chart below, were then categorized based on a normal case timeline, from intake to closure. Not all applicable laws, regulations, best practices and recommendations are utilized in this review. The research team only included those laws, regulations, best practices and recommendations which were applicable to the audit and were identified as having potential for being included in a child welfare agencies' written policies and procedures.

The research team requested each child welfare agency to provide copies, in electronic format, of all written policies and procedures of the agency which directly impact the provision of services and the administration of cases. The agencies provided their policies and procedures to the research team on the following dates in the formats listed:

Agency	Date of Receipt	Format
State of NV DCFS	2/3/08	CD provided by agency
Clark County DFS	2/29/08	CD provided by agency
Washoe County DSS	2/12/08	Email

Research team members read through each of the agencies' policies and procedures to identify a written expression of each of the identified components. If the agencies' policies and procedures included the particular component, then a check mark was placed next to that component in the appropriate agency column.

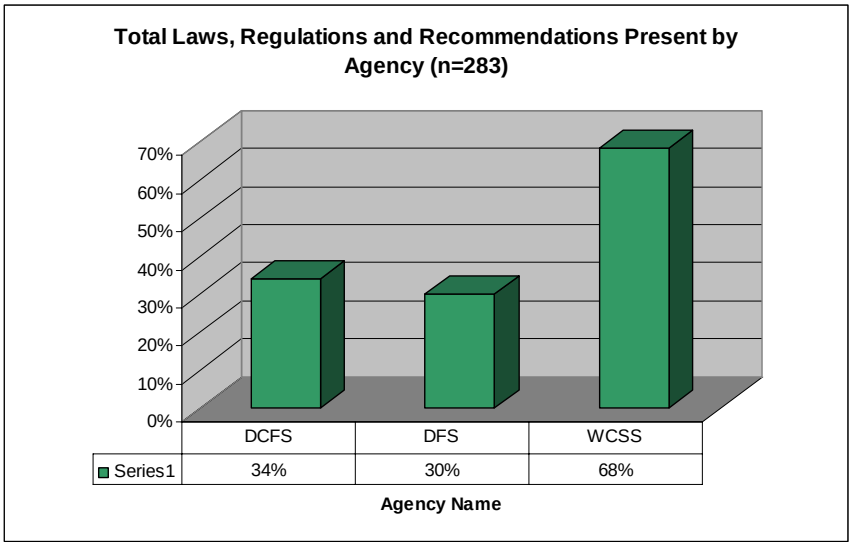
This review includes only those policies and procedures which were provided to the research team by the respective agency. Therefore, any revisions or updates to policies or procedures made after the documents were provided to the research team are not included in this analysis. Additionally, some of the agencies' policies and procedures included "Collaborative Policy" which are identified as being adopted and approved by all three child welfare agencies. Only those agencies that actually provided the "collaborative policies" in their policies and procedures were given check marks for including the policy, as appropriate.

Table 28 beginning on page 90 identifies both mandatory and recommended components that could be included in each of the child welfare agencies' policies and procedures. The components are categorized by general topic area which follows the pattern of a case from intake to closure, with additional components covering supervisory oversight, caseload ratios, administration, confidentiality and training. All components which reference a state or federal law or regulation are provided in *italics* for ease in identification of mandatory components. Each component listed is followed by an acronym which references a law or regulation, a recommendation or a best practice. Acronyms included in the chart are as follows:

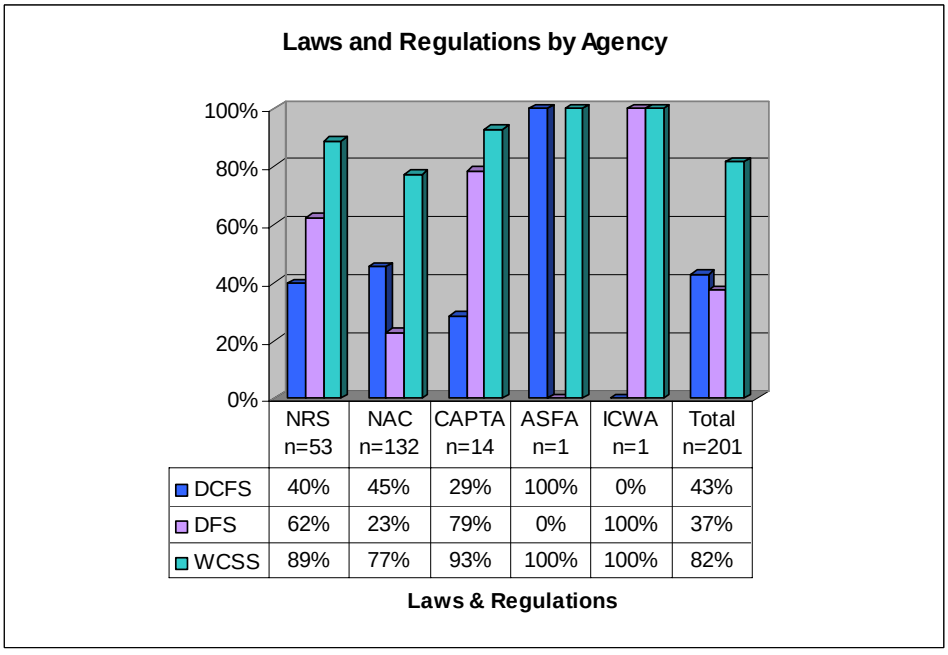
ACRONYMS	
Adoption & Safe Families Act	ASFA
Blue Ribbon Panel	BRP
Child Abuse Prevention & Treatment Act	CAPTA
Children's Bureau Office	CBO
Child and Family Services Statewide Plan for FY 2005-2009 (Five-Year)	CFSP
Ed Cotton Report	ECR
Independent Child Death Review Panel for Clark County, Nevada	ICDR
Nevada Administrative Code	NAC
Nevada Revised Statute	NRS
Indian Child Welfare Act	ICWA

Findings

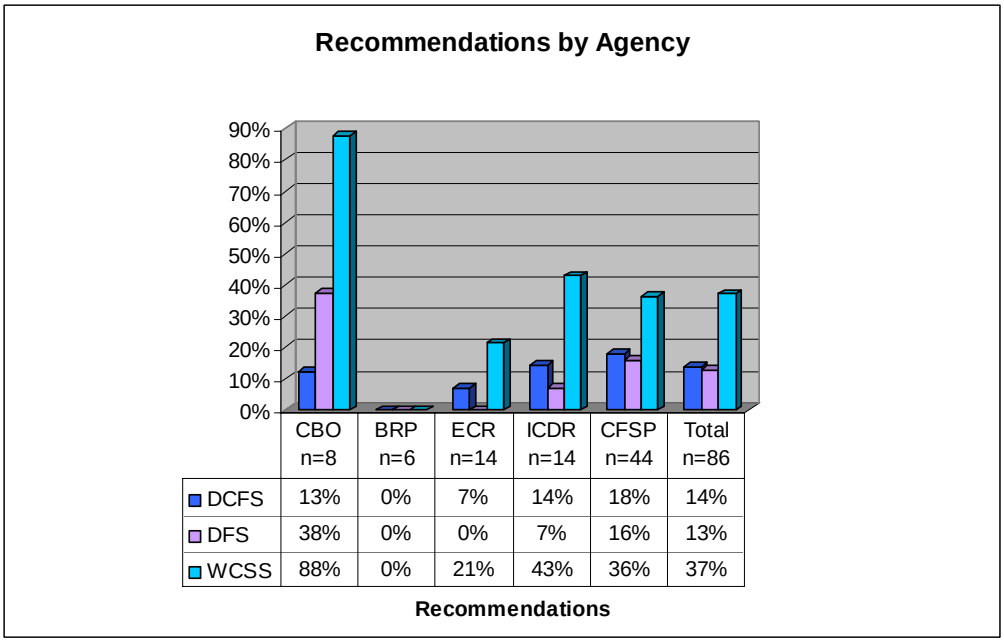
The Policy and Procedures analysis is comprised of 283 components identified by the research team as representing applicable laws, regulations, recommendations, guidelines and best practices. Of the 283 components included in the review, Nevada Division of Child and Family Services' (DCFS) Policies and Procedures included 98, Clark County Department of Family Services' (DFS) Policies and Procedures included 86 and Washoe County Department of Social Services' (WCDSS) Policies and Procedures included 196.



The analysis included 201 laws and regulations from the NRS, NAC, CAPTA, ASFA and ICWA. DCFS included 86 of these laws and regulations in their policies and procedures, DFS included 75 and WCDSS included 164.



The analysis also included 86 components from recommendations made in various reports over the past several years, as well as best practice recommendations. Several of these recommendations also corresponded with components included under the laws and regulations. DCFS' policies and procedures included 12 of these recommendations/best practices, DFS' policies and procedures included 11 and WCDSS' policies and procedures included 32. The chart below illustrates the recommendations and/or best practices that were incorporated in each agencies written policies and procedures.



	CBO n=8	BRP n=6	ECR n=14	ICDR n=14	CFSP n=44	Total n=86
DCFS	13%	0%	7%	14%	18%	14%
DFS	38%	0%	0%	7%	16%	13%
WCSS	88%	0%	21%	43%	36%	37%

Caseworker Surveys

The caseworker surveys (see page 66) which were conducted as part of the audit included some questions about the agencies policies and procedures. Respondents were asked to indicate how often they refer to the agencies' policies and procedures manual. The responses indicate that overall (including respondents from all three child welfare agencies), workers refer to the agency's policy and procedures manual either weekly (17.2%), monthly (24.1%) or a few times a year (32.2%). A small percentage, 8%, indicated they never refer to the manual. The surveys also indicated that there was a sense that respondents did not feel that adequate training was provided on specific policies and laws particular to their area of employment and more advanced training was needed for senior staff. Additional recommendations regarding policies and procedures included training for developing policies and simplification of policies (eliminate cumbersome practices) that conform to ethic codes.

Administrator Interviews

Administrators' interviews (see page 101) included some questions regarding their procedure for notifying staff of changes in agency policy. The Washoe County administrator indicated that they

have a policy specialist that is tasked with monitoring and working with different groups to develop new policies. Supervisors are told about new policies in weekly meetings and they are given any documentation that accompanies them and they are supposed to bring the information back to the workers. Information is also sent out via e-mail, and a policy manual that is updated regularly is kept on their agency intranet system. In certain circumstances the policy specialist will schedule trainings and the units will be trained on the policy and have the ability to ask questions. Additionally he mentioned that they do also attend the state sponsored trainings when those policies change. He said that keeping up with all the changes can be challenging, especially when things are sent over email and they get ignored or being able to get everyone out to the group trainings in a timely manner.

In Clark County the administrator discussed the new training unit that has been established, and assistant managers, as well as managers are responsible for scheduling training for their unit. This is a change from the previous practice where policy changes were sent out via e-mail and management staff were responsible for administering the change to all personnel.

Table 29: Policy and Procedure Analysis

POLICY AND PROCEDURE COMPONENTS	DCFS	DFS	WCSS
INTAKE			
Intake explores nature of reporter's concern, evaluates report. (NAC 432B.140)		X	X
Intake explains agency's responsibility/available resources that could be used. (NAC 432B.140)		X	
Requires intake worker to provide support/encouragement to reporter by: (CBO)			
• Explaining purpose of CPS			X
• Emphasizing importance of reporting			X
• Explaining how report will be tracked			X
• Explaining types of cases CPS takes			
• Explaining what information is needed from reporter	X	X	X
• Being sensitive to fears/concerns of reporter			X
• Discussing regulations regarding confidentiality		X	X
• Explaining when/if reporter's identity could be revealed		X	X
Explains provisions for immunity when making "good faith" reports of abuse/neglect (CAPTA)			X
Requires that school personnel have "priority access" in reporting child abuse and neglect. (CFSP)			
Requires that a direct line be available for hospital & law enforcement (ICDR & CFSP)			
Requires wait time on Hotline to be 3 minutes or less (ICDR)			
Includes requirements for paper reporting system for follow-up, tracking & quality assurance of Hotline (ICDR)			
Requires tracking and follow-up on all referrals for service (ICDR)			
Requires agency to assess safety at initial intake (NAC 432B.185)	X	X	X

Includes a policy for the use of statewide, standardized CPS intake screening and risk assessment tools. (CFSP)			
INVESTIGATION AND ASSESSMENT			
Requires agency to assess safety:			
• *At initial face-to-face with child (NAC 432B.185)*	X		X
• *When considering removal of the child(ren) (NAC 432B.185)*	X		X
• Within 24 hours on surviving siblings in child death cases (ICDR)			
Requires a determination of whether situation makes services appropriate or if case may be referred to an agency that provides family assessment services, except in cases of sexual or institutional abuse. (NRS 432B.150(1) & CAPTA)	X	X	X
Requires an investigation to be initiated within 3 days except as stated below. (NRS 432B.260(4))	X	X	X
Requires an immediate investigation if: (NRS 432B.260(2), CFSP & CAPTA)			
• *Child under 5*		X	X
• *High risk of serious harm*		X	X
• *Child Fatality*			X
• *Child lives in home where another child died, child is seriously injured, visible signs of physical abuse*	X	X	X
Requires investigation on accidental deaths of children when lack of supervision is indicated (ICDR)			X
Requires investigation on all deaths designated as undetermined by Coroner (ICDR)			X
Requires "3 and under" unit at CPS to conduct all child death investigations (ICDR)			
Requires supervisory written approval of actions on death investigations (ICDR)			
Includes a forensic interviewing protocol for surviving siblings (ICDR)			
Includes policies and procedures for supervisors/caseworkers to take when parents or potential perpetrators cannot be contacted after the death of a child (ICDR)			
• This policy requires filing a petition for pick up if the death was due to abuse/neglect and automatic substantiation if potential perpetrators have disappeared (ICDR)			
Requires supervisors to ensure due diligence in the location of out of state CPS records at least five years prior to death in suspicious cases (ICDR), including:			
• Identifying prior addresses (ICDR)			
• Contacting states (ICDR)			
• Reviewing/incorporating out of state information into case file (ICDR)			
Requires Coroner and law enforcement records to be obtained and referenced in CPS file on child death investigations (ICDR)			X
Includes specific guidelines to define substantiation criteria in child deaths and surviving siblings (ICDR)			
• Requires supervisor sign-off on these cases (ICDR)			
Includes standards on what constitutes child death case that must be opened for			X

investigation (ICDR)			
• Includes provision that supervisors cannot code down these cases (ICDR)			
Requires that decisions to initiate an investigation when a child dies are made within 24 hours (ICDR)	X		
Requires full investigation of safety of surviving siblings in potential child abuse/neglect fatalities (ICDR)			
Requires that a case is investigated and substantiated for all child abuse deaths, even when there are no siblings (ICDR)			X
Identifies when an investigation is not needed, including: (NRS 432B.260(3))			
• *No imminent danger*		X	X
• *Not vulnerable child*	X	X	X
• *Referral to services will eliminate alleged abuse/neglect of child regarding drug exposed infant*		X	
• *Corporal punishment is not deemed abuse*		X	X
Requires notification to caregiver of investigation immediately after interview with child unless it endangers child (NRS 432B.270(1) & (3))		X	X
Requires notification to alleged perpetrator during initial contact (NRS 432.260)		X	X
Requires that if an investigation is initiated by phone/record review, face-to-face must be attempted on next business day & each day after until resolution has been achieved (NAC432B.155)		X	X
Requires documentation of the manner that the investigation was initiated and that recording of information be obtained (NAC432B.155)		X	X
Requires that investigation must determine: safety, risk, and threat of harm (NAC 432B.160)	X	X	X
• *Determination must consider circumstances of <u>entire</u> family. (NAC 432B.160)*	X		X
Requires that if child unsafe, a safety plan must be established to allow child to stay in home if possible. (NAC 432B.160)	X		X
Requires an evaluation of the parent's capacity to change or if legal action must occur to obtain suitable care for child. (NAC 432B.160)			X
Requires that when conducting an investigation the worker shall: (NAC 432B.160)			
• *Prepare appropriate documentation*			
• *Apply knowledge of cultural and ethnic differences in families*	X		X
• *Assess <u>all</u> environmental factors*	X		X
• *Exercise professional judgment w/o being judgmental*			X
• *Establish priorities for assessment*			X
• *Demonstrate ability to make decisions sensitive to rights & needs of clients*			X
• *Offer services even to hostile or apathetic clients*			X
• *Recognize parents' right to be free of involuntary services when there is no risk to child*			
Requires the agency to notify law enforcement if: (NAC 432B.270)			

• *Child severely assaulted*			X
• *Child systematically tortured*			X
• *Parents' reckless disregard causes serious injury to child*			X
• *Child sexually abused/exploited*			X
• *Physical conditions of home pose threat of serious injury*			X
• *Parent withholds food from child*			X
• *Parent refuses to obtain/consent to medical/psychiatric treatment*			X
• *Parent out of touch with reality*			X
• *Parent abandons child*			X
• *Reason to suspect parent will flee with child*			X
Requires that when a child death occurs on open cases, a new investigation be created (ICDR)	X		
Includes a policy that defines "substantiated reports", "subsequent reports" and "immediate" contact in compliance with federal requirements. (CFSP)			
Includes a policy that defines face-to-face contact in compliance with federal requirements. (CFSP)			X
PROTECTIVE CUSTODY			
Provides that a child MAY be placed in protective custody without consent if immediate action is needed to protect child (NRS 432B.390)		X	X
Provides that a child SHALL be placed in protective custody upon the death of a parent if it was a result of domestic violence (NRS 432B.390)		X	X
Requires that a person placing a child in protective custody shall: (NRS 432B.390)			
• *Take immediate steps to protect other children in home/facility*		X	X
• *Make reasonable efforts to inform person responsible*		X	X
• *Give placement preference to relatives regardless of whether they live out-of-state*	X	X	X
Requires that, upon placing a child in protective custody, agency must ask parent, legal guardian or relative if child is Indian (NAC 432B.397 & ICWA)		X	X
CASE MANAGEMENT			
Requires that if allegations in petition are accepted by the court, the agency must write a report, including: (NRS 432B.540)			
• *Conditions of child's residence*		X	X
• *School record*		X	X
• *Mental, physical & social background of family*		X	X
• *Financial situation*		X	X
Requires that if removal is necessary, the agency must submit a plan designed to achieve placement as near parent as possible, including: (NRS 432B.540)		X	X
• *Description of type, safety & appropriateness of placement*		X	X
• *Description of services to child & parent to facilitate return or permanent placement*		X	X
• *Appropriateness of services*		X	X
• *Description of how the Order of the Court will be carried out*		X	

Requires a written service plan for all substantiated cases (ICDR)			X
Requires that specialty medical exams are mandatory for all unexplained child injuries and required before a case can be unsubstantiated (ICDR)			
Includes substantiation criteria (ECR & CFSP)	X		X
• Requires documentation of substantiation criteria (ECR)			
Requires agency to assess safety: (NAC 432B.185)			
• *Before unsupervised visits with parents*	X	X	X
• *Before returning child to parents*	X	X	X
• *When a significant event or change occurs*	X	X	X
• *Before each Court review*	X	X	X
• *Anytime agency determines safety is jeopardized*	X	X	X
Requires that a risk assessment must occur as part of each significant decision made in a CW case, including provision of services from intake to case closure and must be future oriented (NAC 432B.180)	X	X	X
Includes definition/explanation of "reasonable efforts" (CFSP)	X	X	X
Requires that reasonable efforts must be made to preserve & reunify family: (NRS 432B.393)			
• *To prevent removal*	X		X
• *Before foster care placement*	X		
• *To make it safe for child to return home*	X	X	X
Provides that reasonable efforts are not required if: (NRS 432B.393)			
• *Parent involved in murder*	X	X	X
• *Caused abuse/neglect resulting in substantial bodily harm*	X	X	X
• *Caused extreme or repetitious abuse/neglect*	X	X	X
• *Abandoned child for 60 days*		X	X
• *Parent unknown*			
• *Only token efforts by parent to contact child for 6 months*			X
• *Previous TPR*	X	X	X
• *Previous removal and reunification*			
Includes policy regarding placement of children with relatives where parent resides in home (ECR)			
Disallows relative placements without going through formal, legal system – especially when safety assessments are not conducted on relatives (ICDR)		X	
Includes the process for immediate appeal of a judge's ruling when the worker feels it endangers child (ECR)			
Provides that the caseworker shall promote rights of children to be with family, fully exploring all alternatives to placement outside home (NAC 432B.220)			
Provides that when temporary placement is necessary, the placement must be as close to child's home as possible with immediate plans for returning home (NAC 432B.220)			
Provides that when a child can't be returned home, permanent alternative must be sought (NAC 432B.220)			
Requires caseworker to: (NAC 432B.405 & 315(2), CFSP)			
1. Conduct visits with kids in foster care monthly	X	X	X

2. Conduct visits in the placement every 60 days	X	X	X
3. Conduct a portion of the visit alone with child	X	X	X
4. Meet alone with foster parent if requested	X	X	X
Requires the agency to provide semiannual assessments, including: (NAC 432B.420 and NRS 432B.397)			
• *Current level of family functioning*			X
• *Update of family re: risk that prompted placement*			X
• *Current risk if returned to parent*			X
• *Services required to meet needs of child*			X
• *Strengths/Resources of family*			X
• *Evaluation of progress and recommendations for further supervision, treatment & rehab.*			X
• *Info re: placement of child in relation to sibs, i.e. placed together? Why? Why not? Efforts to do so.*			
Requires assessments to be based on: (NAC 432B.420)			
• *Interviews with family members*	X		X
• *Observation of interaction between family members and child*			X
• *Review of written material/records*			X
• *Contacts of family with other agencies*			X
• *Results of referrals for evaluations*			
Provides that case records must present, current & continuous account of any responsibility taken by agency providing services, including: (NAC432B.320)			
• *Clear/specific material re: child's situation*			X
• *Assessment of family including evaluation of problem, plan for social work, goals for family, periodic assessment of progress on case plan*			X
• *Identifying information*			X
• *Reporting forms*			X
• *Initial complaint*			X
• *Info re: alleged perp & witnesses*			X
• *Findings & results of investigation*			X
• *Actions by, reports to & orders of Court*			X
• *Notification to parents*			X
• *Summaries of contacts*			X
• *Collateral contacts, reports & correspondence*			X
• *Case plan, assessment & social diagnosis*			X
• *Criteria for case closure*			X
• *Documentation of services provided to prevent placement*			X
• *Narrative of termination of services*			X
Requires the use of a checklist on home visits that includes the purpose, quality and frequency of the visit to ensure the safety of the child. (CFSP)			
Includes a policy on relative search and placement (CFSP)			X
Includes a protocol for continued safety assessments of all placements/ homes, including relatives. (CFSP)			

Includes a protocol for assessment of relative placements to identify strengths, needs and resources. (CFSP)			X
Includes minimum standard for visitations with parents and children. (CFSP)			
Includes a protocol for relative search attempts (CFSP)			
CASE PLANS			
Requires a written case plan within 45 days of removal, including: (NAC 432B.400, see also NAC 432B.220)	X	60 days	X
• *Permanency Plan*	X		X
• *Projected date of achievement*	X		X
• *Strengths of family*	X		X
• *Description of services provided to prevent removal*	X		
• *Description of placement, whether in close proximity to parent & least restrictive*			
• *Description of appropriateness of services*	X	X	X
• *Efforts to place siblings together*			X
• *Visitation Plan w/ parents & sibs*	X		X
• *Proximity of school was considered in placement consideration*			
• *Health & education records/information*	X		X
• *Must be updated every 6 mo. & submitted to Court with semiannual Court report*			X
• *Must be submitted to agency located in the county in which the parents of the child reside at least annually*			
Requires the case plan to include: (432B.190)			
• *Barriers to provision of safe environment*	X		
• *Whose responsibility to address barriers*			
• *Defines overall goals of case & step-by-step proposed actions to reach goal within timeframe*	X		X
• *Review & signature of supervisor*	X		X
Requires the agency to provide services to preserve the family and prevent placement outside the home, including: (NAC 432B.240)	State Policy requires referrals for services.		
• *Social work & counseling*	X		X
• *Psychological*	X		X
• *Economic assistance*	X		X
• *Job training & education*			
• *Info re: housing/transportation*	X		X
• *Homemaking services*			
• *Medical services*	X		X
• *Child care*			
• *Parental education & support groups*	X		X
• *Respite care*			
• *Substance abuse treatment*	X		X
• *Domestic violence treatment*	X		X
Specifies that the agency shall establish interagency agreements to ensure that			

cooperative and mutually facilitative services are provided to children and families (NAC 432B.230)			
Requires provision of Independent Living services to youth 16 yrs and older (NAC 432B.410)	X		X
Requires agency to provide an assessment of independent living skills to youth at 15 ½ with a written plan for transition to independent living (NAC 432B.410)	X		X
Includes provisions for in-home services when appropriate (ECR)			
Includes policies and procedures for identifying and securing appropriate resources (resource directory or reference to) (ECR)			X
Includes polices for assessing, documenting and providing for educational services. (CFSP)			
Includes a policy which mandates the caregiver is provided with or has knowledge to obtain a child's educational record within 30-days of placement. (CFSP)			
Includes a protocol for staff awareness and competency in obtaining a child's educational record. (CFSP)			
Includes a policy on the engagement and inclusion of fathers. (CFSP)			
Includes a common definition of concurrent planning that complies with ASFA (adoption and safe family act) guidelines (CFSP)	X		X
Requires that case planning demonstrates timeliness and youth and family involvement. (CFSP)			
Policies reflect utilization of revised concurrent court-approved case planning document. (CFSP)			
Includes policies and protocol on the utilization of shelter care. (CFSP)			
Includes a policy allowing for alternative work hours so plans are developed with the child and family at a time convenient to the family and delivered with the oversight of integrated child and family teams. (CFSP)			
PERMANENCY			
Requires that a permanency plan must be in place at the 12 month mark (or 30 days if reasonable efforts have been waived (NRS 432B.553(1))	X		X
Requires that reasonable efforts must be made to finalize the permanency plan (NRS 432B.553(1), CFSP)	X		X
Requires that if the child has been in foster care for 14 of the most recent 20 months, the agency shall include TPR in the plan, unless: (NRS432B.553(2)) *[ASFA provides that a TPR should be filed if child in care for 15 of the most recent 22 months]*	X	asfa	X
• *Child in care of relative*	X		X
• *Agency has not made reasonable efforts*	X		X
• *Documented compelling reasons that it is not in best interest of child*	X		X
Provides that a TPR should be filed within 60 days if reasonable efforts are waived (ASFA)	X		X
Requires the agency to document progress toward completion of adoption after the TPR (NAC 432B.262(5))			
Provides that if a child is not in an adoptive home within 90 days of TPR the agency shall: (NAC 432B.262(5))			
1. Identify & document obstacles to placement			

2. Specify steps to find appropriate home			
3. Report steps to the Court			
Requires safety assessment to be completed after reunification (NRS 432B.185)	X		X
Includes a definition of "reasonable efforts". (CFSP)			X
Includes a definition of "diligent efforts" (CFSP)			
CASE CLOSURE			
States that services must terminate when: (NAC 432B.310)			
• *Caseworker & supervisor determine goals have been achieved*	X		X
• *Child receives care that meets minimum needs & parents can care w/o agency services*	X		X
• *Requested termination of voluntary case*	X	X	X
• *Court dismissal*	X	X	X
• *Family can sustain adequate care*	X	X	X
• *Family unable to benefit from services & no likelihood of reoccurrence*	X	X	X
• *Family cannot be located*	X	X	X
• *Client deceased & no other children at risk*	X	X	X
• *Adolescent client marries or client reaches age 18 or becomes emancipated*	X	X	X
• *Family moves out of state*	X	X	X
• *Family refuses services and no other legal alternative available to agency*	X	X	X
Provides that client must be involved in decision to close case (NAC 432B.310)	X		X
Provides that case must be closed if safety/risk assessment determines: (NAC 432B.310)			
• *Child is safe*	X		X
• *Risk of future harm is minimal*	X		X
• *Parent is protecting child*	X		X
Provides that a case CANNOT be closed: (NAC 432B.315(1))			
• *If Court determines child in need of protection*	X		X
• *Before 6 mos. After case is opened unless instructed by Court*	X		X
Requires safety assessment to be completed at closure of case (NRS 432B.185)	X		X
Requires supervisor and/or judicial approval prior to allowing reunification when treatment is incomplete. i.e. DV and substance abuse (ICDR)			
Provides that open cases should not be closed on current children with a mother who is pregnant. (ICDR)			
SUPERVISORY OVERSIGHT			
Identifies role of supervisor regarding case consultation regarding risk and safety			X
Requires supervisory meetings to occur regularly and be documented with specific directions to workers (ECR)			X
Includes supervisor/caseworker oversight ratios (BRP)			
• Supervision= 1 supervisor per 5 workers (BRP)			
Identifies action to be taken when caseworker does not document contacts (ECR)			
CASELOAD RATIOS			
Includes caseload size/ratios for caseworkers (BRP, ECR)			

• Assessment/Investigators – maximum 12 active cases per month (BRP)			
• On-going - 17 active families per worker & no more than 1 new case for every 6 open cases (BRP)			
• Combined caseload - 10 active on-going cases and 4 active investigations per worker (BRP)			
• Each team/unit of 5 workers should have one clerical person (ECR)			
ADMINISTRATION			
Policies & procedures of agency must be written (NAC 432B.070(3))	X	X	X
Includes policies and procedures for communicating new policies & procedures with all staff (ECR)			
• Requires written acknowledgement/understanding of new policies and procedures from all staff (ECR)			
Includes a process for case reviews (NAC 432B.070(4))	X		
• *A sample must be reviewed on a quarterly basis (NAC 432B.070(4))*	X		
Includes a procedure for review of grievances (NAC 432B.300)		X	X
Identifies procedure for logging all CPS contacts with families (ICDR)			
Includes interagency coordinated investigations protocols for deaths involving child abuse/neglect (ICDR)			
Includes policy regarding multidisciplinary team to meet quarterly to discuss policy/procedure relating to child death scene, autopsy & circumstantial investigation, and issues related of law enforcement & DA disposition of cases. (ICDR)			
Includes requirement that every case involving an abused/neglected child which results in judicial proceeding shall be appointed a guardian ad litem to represent the child in such proceedings (CAPTA)		X	
CONFIDENTIALITY			
Includes methods to preserve confidentiality of all records to protect the rights of child, parents/guardians (CAPTA)		X	X
Includes requirements that ensure reports will be made available to: (CAPTA)			
• *Subjects of the report*		X	X
• *Government entities*		X	X
• *Citizen/Child fatality review panel*	X		X
• *Grand jury/Court*		X	X
• *Other entities statutorily authorized*		X	X
Includes provisions for disclosure of confidential info to governmental entities to protect children from child abuse/neglect (CAPTA)		X	X
Includes provisions for public disclosure of the finding or info about child abuse/neglect that resulted in a child fatality or near fatality (CAPTA & NRS 432B.290(2))	X	X	X
TRAINING			
Provides that agency will provide ICWA training (NRS 432B.397)		X	
Requires that every 2 years the agency shall assess the need for employee development (NAC 432B.090(2))			
Requires that new staff shall complete 40 hours of child welfare training (NAC 432B.090(2))			

Requires that after the first year of employment, all child welfare workers must obtain 30 hours biennially of child welfare training (NAC 432B.090(2))		X	
Requires that each new employee will be provided an orientation to the agency and position (NAC 432B.090(2))			
Requires that supervisors will be trained on new protocols before or concurrently with caseworkers (ECR)			
Requires staff to be trained on policies and procedures related to the cultural diversity plan. (CFSP)			
Requires training of child and welfare supervisors and case managers, including tribal entities, on Independent living, how to identify significant connections and how to perform diligent search. (CFSP)			
Requires staff to be trained to use the quality assurance system and caseload management reports. (CFSP)			
Requires training in quality worker visits with parents and children (CFSP)			
Requires training on policies for relative search and placement and assessment protocol. (CFSP)			
Requires training on ongoing case management responsibilities to emphasize the importance of providing prospective guardians with information on community resources. (CFSP)			
Requires all hotline, assessment and ongoing permanency child welfare staff to be trained on the intake screening tool and its use for all new referrals and all allegations involving active or ongoing cases. (CFSP)			
Includes a training component for child welfare agency staff, tribal representatives, legal representatives, and the judiciary on what constitutes a "compelling reason" not to file for TPR, "and reasonable efforts." (CFSP)			
Includes child welfare training for use of the TPR checklist (CFSP)			
Requires training for notification and involvement of reviews (CFSP)			
Requires initial & on-going training in risk & safety with scenario-based test to demonstrate proficiency (ECR & CFSP)			

CONCLUSION AND RECOMMENDATIONS – LAW AND POLICY ANALYSIS

Of the 283 components analyzed, 201 were laws and/or regulations and 86 were recommendations and/or best practices (some recommendations were duplicative of laws and/or regulations, so not all components were mutually exclusive). Overall, agencies' policies and procedures did not consistently include mandated laws and policies, although Washoe County included substantially more than DCFS or DFS (DCFS-43%; DFS-37%; WCSS-82%). All agencies faired worse with including identified recommendations and best practice (DCFS-14%; DFS-13%; WCSS-37%). This may be due in part to the fact that many of these recommendations have been made only within the past couple of years. Caseworker surveys indicate that workers rarely refer to the agency policies and procedures (32.2% indicated only a few times a year) and that some (8%) never refer to them. The administrator interviews identified several areas of concern and change at the administrative levels regarding policies and procedures. Each agency has a different procedure for notifying staff of changes in policies and procedures and two administrators noted concerns with utilizing email to provide notification of new

policies and procedures to staff. The two local agencies also noted that training procedures are in place to assist staff with understanding and implementing new policies and procedures.

Recommendations: Policies and procedures at all agencies need to be updated to include all mandatory provisions of state and federal law, as well as to incorporate best practices and recommendations as deemed appropriate by the State and local agencies. Policies and procedures should be developed in a user friendly manner – including simplification of policies, elimination of contradictory policies, and available in electronic format – that is consistent with ethical guidelines and takes into consideration the practical application of caseworker and supervisory functions. Procedures to update, inform and appropriately train all workers on the proper application and meaning of new policies and procedures (as well as some old policies and procedures that are not consistently followed) should be a priority of all agencies. Agencies need appropriate funding to provide administrative support to update policies and procedures and provide adequate training to staff.

RECOMMENDATIONS AND ACTION PLANS

EVALUATION OF INCORPORATION OF RECOMMENDATIONS

Assembly Bill 629, section 5(f) required the Performance Audit to "determine whether the agencies which provide child welfare services have successfully incorporated the recommendations set forth in the Report of the Clark County Blue Ribbon Panel for the Review of Child Deaths and of the Northern Blue Ribbon Panel for the Review of Child Deaths", as well as the 2005 Statewide Child Death Report prepared by the Executive Committee to Review the Death of Children.

The Blue Ribbon Panel met from April 2006 through January 2007 and was made up of experts from multiple disciplines within the state of Nevada to:

> …provide a forum to publicly accept and review the child fatality report prepared by the national experts [National Expert Panel] as well as provide expertise in their areas such as mental health, legal, medical, advocacy, law enforcement, academic training and political thought. In addition, the Panel was convened to help the state move forward by providing assistance with new legislation, corrective action planning and interagency collaboration; development of recommendations from the national expert report; and help the state to address challenges in public perception about accountability and openness.

The Panel reviewed not only the recommendations of the National Expert Panel (contained in the "Report of Findings and Recommendations Child Deaths 2001-2004 – Clark County" and "Report of Findings and Recommendations Child Deaths 2001-2004 – Washoe County and Rural Nevada"), but also the recommendations and best practices contained in: "Administrative Review of Child Abuse and Neglect Investigations" by Edward E. Cotton; the "Assessment of Clark County Department of Family Services Child Abuse Hotline"; the Clark County Department of Family Services "Safe Futures" plan; and the Child Welfare League of America's "Standards of Excellence for Services for Abused or Neglected Children and their Families, Revised 1999" and "Standards of Excellence for Family Foster Care Services, Revised 1995." The work of the Blue Ribbon Panel culminated in three separate "Action Plans" developed for each of the three child welfare agencies in the State.

The 2005 Statewide Child Death Report prepared by the Executive Committee to Review the Death of Children includes child death data from vital statistics, as well as information regarding cases reviewed by the local child death review teams in calendar year 2005. The recommendations put forth in the that report focus on prevention efforts in the areas of suicide and accidental asphyxia caused by co-sleeping, as well as some data collection improvements for local child death review teams. There are no recommendations specific to child welfare agencies contained that report. Therefore, the determination of whether the agencies "successfully incorporated the recommendations…of the…Blue Ribbon Panel…" are based on the recommendations contained in the Action Plans developed by the statewide Blue Ribbon Panel, as well as some specific recommendations outlined in the Blue Ribbon Panel Report.

A table of recommendations from the Blue Ribbon Panel Report and related Action Plans is located in Appendix F. Each recommendation was reviewed to determine whether the item could be directly attributed to the respective child welfare agency. Many of the recommendations were directed at other entities, such as the District Attorney's Office, the Coroner and/or Medical Examiner, Law Enforcement, or the State Legislature. Although all recommendations are included in the table, only those recommendations that could be directly attributed to the child welfare agency were included in the analysis. Those recommendations were then identified as substantially completed, not completed, or unable to determine. These determinations were based on a review of agency policies and procedures, as well as practices identified through the case review and interview processes.

Overall, there were 178 recommendations included. Over half were made to Clark County, more than one-quarter to Washoe County and the remaining recommendations were made to the rural child welfare agency, DCFS.

Of the 91 recommendations for Clark County, only 52 could be directly attributed to the Clark County Department of Family Services for action. Clark County DFS was determined to have: substantially completed 6% (3) of the recommendations; not completed 67% (35) of the recommendations; and 27% (14) were unable to be determined based on the information provided and/or collected for this audit.

Washoe County Department of Social Services received 49 recommendations from the Blue Ribbon Panel, with 25 counted as being directly attributable to the agency for action. Of the 25 recommendations, Washoe County DSS was determined to have: substantially completed 20% (5) of the recommendations; not completed 56% (14) of the recommendations; and 24% (6) were unable to be determined based on the information provided and/or collected for this audit.

The State Department of Child and Family Services, which oversees the rural child welfare functions, received 38 recommendations, with 29 being directly attributed to the agency for action. DCFS was determined to have: substantially completed 14% (4) recommendations; not completed 45% (13) of the recommendations; and 41% (12) were unable to be determined based on the information provided and/or collected for this audit.

EVALUATION OF PROGRESS AND EFFORTS TOWARDS MEETING FEDERALLY APPROVED PLANS

Assembly Bill 629, section 5(g) required the Performance Audit to "evaluate the progress and efforts made towards meeting the requirements set forth in the federally approved Performance [Program] Improvement Plan and Corrective Action Plan."

The Program Improvement Plan (PIP) is laid out in a 100 page matrix which identifies eleven broad categories of outcomes and systemic factors (outlined below). These broad categories are further delineated by 37 different items which each include specific action steps and benchmarks for completion.

Table 30: PIP Outcomes and Systemic Factors
Safety Outcome 1: Children are first and foremost protected from abuse and neglect.
Safety Outcome 2: The continuity of relationships and connections is preserved for children.
Permanency Outcome 1: Children have permanency and stability in their living situations.
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.
Well Being Outcome 1: Families have enhanced capacity to provide for children's needs.
Well Being Outcome 2: Children receive services to meet their educational needs.
Well Being Outcome 3: Children receive services to meet their physical and mental health needs.
Systemic Factor V: Case Review System
Systemic Factor VI: Quality Improvement System
Systemic Factor VII: Training
Systemic Factor VIII: Service Array

A letter from Associate Commissioner of the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, dated June 11, 2007 indicates that Nevada had "achieved the identified specific numeric goals for all outcome measures, except for Safety Outcome 1 Items: Timeliness of Investigations (Item 1), Repeat Maltreatment (Item 2), and Safety Outcome 2 Item: Risk of Harm (Item 4), and Permanency Outcome 1 Item: Permanency goal for child (Item 7)." Therefore, this audit includes an analysis of those items and the related action steps identified within each item in the PIP matrix. Please see Appendix G.

Evaluation of agency action related to the identified PIP measures was based solely on Statewide Collaborative Policies provided by the agencies as part of the documentation requested for the Performance Audit, since all of the measures require the "State" to act. Not all agencies provided all Collaborative Policies. Distinct from the Policies and Procedures analysis, this evaluation included a review of Collaborative Policies provided by all three child welfare agencies.

A review of the Statewide Collaborative Policies indicated that the State has substantially accomplished 11 of the 12 identified action steps included in this analysis. The only element which was not identified in the audit was a standardized intake-screening instrument. However, policies provided to the research team for the purposes of this audit did include a Collaborative Policy on Intake which includes components of tracking response times and response criteria. Therefore, it is concluded that the State is substantially in compliance with the action items identified by the Children's Bureau as not having met the performance measures identified as of June 2007.

The Corrective Action Plan, dated September 2006, outlines eleven objectives with 42 individual action steps identified to meet those objectives. According to the most recent Corrective Action Plan matrix found on the DCFS website, 28 of the 42 action steps have been completed. A list of the objectives, as well as their completion status is listed below.

Table 31: CAP Completion Status	
CAP Objective	**Completion Status**
1. CAPTA compliance [with child death disclosure laws] will be supported through the provision of federal technical assistance to analyze existing Nevada law, practice related to that law, and the development of statutory language, regulations or policies as needed.	Completed 9/22/05 NRS 432B.175 (2007)
2. Child welfare agencies' staff will have an improved capacity to document information in UNITY related to child fatalities and near fatalities.	Completed 9/30/05, 10/30/05
3. Obtain a written State of Nevada Attorney General's Office Opinion on provision of information related to fatalities and near fatalities to clarify the state's responsibilities related to CAPTA and existing Nevada law.	Completed 9/28/05
4. Regulations that correspond to state and federal law will be developed on child fatalities and near fatalities as recommended by the Nevada Attorney General's Office Opinion, the National Resource Center for Judicial and Legal Issues and other pertinent stakeholder input.	Not completed – TBD after 2007 Legislative Session
5. Training will be conducted statewide on all new statute, regulation, and/or related policy changes for child welfare agencies' staff and established multidisciplinary teams for the review of Nevada child deaths, the Executive Committee for the Review of Child Deaths and the Administrative Team for the Review of Child Deaths.	Not completed – TBD after 2007 Legislative Session
6. Based on the Nevada Attorney General's Office Opinion, statute development for NRS 432B.290(2)(3) to contain CAPTA requirements pursuant to ACF Child Welfare manual 2.1A.1, 2.1A.4, on disclosure will be completed.	Completed 11/16/05 (Bill draft requested)
7. Nevada Central Registry and its related policies and informational documents will be updated to ensure compliance with Nevada law in regard to prospective employers' ability to obtain information on substantiated abuse or neglect.	Completed 9/30/05, 10/21/05
8. Ensure that policies and informational documents related to "infants born affected by illegal prenatal substance abuse or withdrawal symptoms" are addressed as required by recently promulgated Nevada law.	Completed 9/28/05, 9/30/05
9. DCFS will develop expanded statewide training that corresponds to new Nevada law regarding the rights of persons subject to an abuse or neglect investigation by child welfare agencies.	Not completed – TBD
10. DCFS will ensure that child welfare agencies come into compliance with NRS 432B.190(k)…and NRS 432B.20(5)…	Partially Complete: Action Steps 1-3 on 9/30/05 Action Steps 4-5 TBD
11. Establishment of the Northern Children's Advisory Council and the Southern CAC to act as a Citizen Review Panels.	Completed 9/30/05 and 1/31/07

According to the most recent data available through the Nevada Department of Health and Human Services, Division of Child and Family Services, four of the eleven objectives have been self identified as not completed. The primary reason cited for incomplete objectives was a need to pass legislation during the 2007 Legislative Session. The case review process and interviews conducted as a part of this audit indicate that increased attention to Objective 2 is needed, since lack of appropriate documentation at all levels was identified as a primary concern throughout the audit period.

ADMINISTRATOR INTERVIEWS

The research team felt that it was important to represent the perspective of agency administrators as well in conducting this audit. Administrators were asked a series of questions regarding community relations, staffing, UNITY (case documentation), outstanding practices, as well as laws and policy recommendations and dissemination.

METHODS

In order to gain an understanding of each agency administrator's perceptions regarding agency policy, practice, successes, challenges and recommendations for change an interview protocol was developed and each agency administrator was invited to participate. All agency administrators participated in a structured interview that lasted between one and two hours. This interview addressed five major topic areas including; community relations/issues, staffing, UNITY (case management software), outstanding practices, and laws and policies. In both Clark and Washoe counties the agency director participated in the interview, however for the Department of Family Services, which administers child welfare services in rural Nevada and also has an oversight role for child welfare across the state, three people participated in the interview including the current Administrator of the Division of Child and Family Services.

Questions were created based on the information that had been collected in focus groups, caseworker surveys, and supervisor interviews. Administrators were provided the questions in advance of the interview. The interview was conducted via telephone. Interviews were not tape recorded, however two members of the research team took notes during the interview. These notes were then typed and analyzed for common themes. The summary analysis is provided in the section below.

FINDINGS

Community Relations/Issues

Administrators were asked about recent agency successes in terms of child welfare in the community as well as any specific areas where the agency could improve community relations. The question was an attempt to gain a better understanding of how each agency works within its own community, and what the administration sees as some successes and challenges.

All three agencies had successes to mention in response to this question. In Washoe County they have developed a couple of multi agency teams that are working to improve their system and interagency cooperation. One that was mentioned was the Child Protection and Enforcement Team which meets monthly to focus on enhancing responses to child welfare cases through addressing and discussing existing issues. The other mentioned was the Model Court Program from the National Council of Family Court Judges. This program is a collaboration of multiple stakeholders to have conversations to "cultivate best practices and collaborate to change existing practices." This group has already made some changes in court processes in Washoe County including changing the times for hearings to work better within caseworker schedules.

In Clark County, the administrator discussed both internal and external successes in terms of community relations. He noted that the internal successes translate to better service to clients which then in turn become external successes. Namely, he mentioned the recent reductions in the population at Child Haven the local shelter care facility. Recently they have reduced median length of stay at Child Haven and stated that now 2/3 of children removed from their homes do not go to Child Haven. He also mentioned their successes in a decrease in the number of children removed by law enforcement as well as grants the agency has received to provide funding to allow medically fragile children to be placed with parents or other family settings. He also noted that internally they are about to deploy some new positions that will reduce caseloads for foster care staff from an average of 39 to 21. In addition he mentioned that the number of investigations has dropped from 20 new investigations per worker per month to between 10 and 12 new cases per month. Finally in Clark County he noted that they are using new safety and risk assessments and they have completed a service assessment that included over 100 stakeholders and really provided a strong increase in a common purpose for improving child welfare as a system.

When the same questions were posed to DCFS administration they noted that their administrators work within 15 different counties so there are multiple communities to consider. However they did note that they are having multiple group meetings with local judges, district attorneys, and the attorney general's office. They also noted that their communities have added more Court Appointed Special Advocates (CASA). In particular they mentioned that in Winnemucca they have created a "Child Emergency Team" in which police, child welfare workers, doctors, etc., provide immediate access to services for children and families in emergency situations. This team works to establish the child's emergency as their number one issue and its given priority status. They also listed some other stakeholder groups, one that contains 22 different agencies and are represented by their leaders to meet and discuss new ideas to improve. In addition they mentioned some other court improvement projects including one that created a "bench book" for sitting judges on child welfare statutes and policies.

Administrators were also asked about areas where they see a need for improvement in community relations and also how they would recommend achieving that change. In Washoe County he reported that they have a strong community level PR person that works with the media to highlight successful programs. Additionally he noted that Washoe County completes a community survey every other year and are continually rated above satisfactory. He noted that while their agency is not in a position to do a full public awareness campaign, they do work with mandated reporters to help them further understand the agency and its purpose and limitations.

In Clark County the administrator discussed their work to develop closer relationships with other agencies in the community. He mentioned their work to help foster parents meet the needs of children in their care and the creation of a foster parent/parent association, although he stated that they still have a long way to go. He also mentioned a need to improve relationships with law enforcement, and create more of a joint investment in the investigation or child abuse cases. He suggested the creation of protocols to help define the relationship and also increased coordination.

DCFS noted that they are always working to improve community relations, as many times in the smaller communities the state programs are the only services available for families. Some challenges they face are among the family resource centers in the rural areas. The administrators noted that these continue to have difficulty in hiring and maintaining staff and that they do not have sufficient funding

to operate and do not have any continuous grants. The administrators recommended that the resource centers need more full time staff, including program administrators, administrative support and grant writers. Another important comment made by DCFS regarding the community concerns budget cuts for existing services. "If other community services have budget cuts, this creates a domino effect on other services. Even though two of three areas of DCFS have not been affected by funding issues, they still feel the effects of budget crises when supporting agencies are cut back. Other recommendations for community relations included mention that smaller agencies with only one or two people cannot effectively implement training while still managing caseloads and that improvements must be made concerning the organizational approach of child welfare stakeholders groups.

Staffing

Staffing is also another important issue that administrators need to consider. Administrators were asked about specific strengths of the staff as well as any staffing barriers and possible recommendations to overcome those barriers.

In terms of strengths in staffing agency administrators discussed a variety of things. In Washoe County some of the strengths he described included the educational backgrounds of their staff, noting that most have a bachelor's degree or master's degree in social work, and if they don't they are encouraged and supported in getting that degree. He noted that they are flexible with giving them time off as well as tuition assistance to complete their education. In addition to this he discussed their in house training unit. In this agency they have created an upgraded position with a lower caseload that is responsible for pairing with new workers and showing them how to do the job. In this system the workers train with one of the senior staff for between three and six months. According to this administrator, this system provides more consistency in training and helps new workers not to feel so overwhelmed.

In Clark County some strengths in staffing included his strong management team, and that now "we are managing for results and we use data to monitor outcomes." He also noted that his staff is dedicated and committed to the child welfare mission. He also noted that they now have better role definition and clarity in management.

For DCFS strengths included the low turnover rates at the managerial and supervisory levels of the agency, also noting that the social workers and mental health professionals have a high level of commitment and work from a strengths based approach in providing one on one relationships with clients. Additionally another strength in their staffing process is a relationship with the state colleges where they have 10 stipend positions for students enrolled in a Master's in Social Work (MSW) program and agree to work for DCFS for each year they receive funding.

Some barriers these agencies face in terms of staffing included issues of difficulty in finding qualified applicants for vacant positions. In all three agencies the administrators discussed this as a barrier. More specifically, the DCFS administrators stated, that there were "continually 10 to 12 vacant positions at a time." In Clark County the administrator noted that the minimum qualifications present a problem for his organization. He noted that in Clark County the minimum requirements are a Bachelor's Degree in a human services area and three years experience in some type of child welfare setting. He said, "these requirements make us critically dependent on the availability of in-service

training, which isn't there. This impedes the status of the organization and the quality of staff available." Another barrier listed by DCFS was the pay differential between working for the state and working for the county. They stated that its more difficult to hire for positions near the urban areas because workers see that they can make more money working for the county than working for the state.

Another barrier mentioned by all three agencies was a negative perception regarding working in public child welfare. Administrators from all three agencies noted that negative publicity received regarding child welfare has created a deterrent for potential applicants , the administrator in Washoe County stated, "I don't think it's a pay issue – but it may be the notion that the work is so difficult that its not worth the pay." In terms of specific way so improve this image, he suggested making the job more appealing by creating a campaign to recruit and value social work. He feels that "the story of making a difference needs to be told." Additionally this administrator suggested that retention should be another area of focus – and making workers feel valued.

There were some barriers that were specific to the rural areas and were expressed by the administration at DCFS. In this case a barrier in terms of staffing includes the ability to provide additional training for workers in remote locations. Often there is not a supervisor at each location, so training is being done through video conferencing from other more populated areas. Also a barrier in the rural areas is all the travel required to service the smaller counties. Another specific DCFS barrier had to do with job classifications. According to DCFS administrators there are some structural issues with the job classification systems that may require people to take a cut in pay to take other positions that are classified lower. They felt that this issue should be reviewed and discussed.

UNITY

UNITY is the electronic case management system that all agencies use to compile case data. Administrators were asked about how they feel their staff is doing in entering information into this system as well as to note some of the challenges in using this system.

Administrators from all three agencies recognized and shared their views on some of the shortcomings of this system. In Washoe County he stated that as a system it functions relatively well, however in terms of UNITY being a tool to help with case management, "it's not there yet." Administration in Clark County said that there "is minimal functionality, but it's not designed around business practices. Therefore it is not designed to adequately function within this agency." He also mentioned that at the managerial level "reports are inadequate to ensure performance." Administrators at DCFS see the ability of staff to input information into the UNITY system as one of their major barriers. They noted that there were several reasons information wasn't transferred to UNITY, listing poor computer skills, and lack of available time for documentation. The administrator in Clark County also noted an additional problem with UNITY was that it's "non-intuitive", meaning that non-experienced staff find it difficult to navigate. In Washoe County the administrator echoed this by noting, "there are 500 + windows in UNITY and no one really understands all the windows – its too complicated so staff learn those windows that they have to and ignore the rest. This means that they may not be entering all the information they need to."

DCFS administration mentioned some strategies that they have been using to try and improve and increase case notes being entered into UNITY. They mentioned that some counties have purchased laptop computers for caseworkers to take with them to enter notes into UNITY during down time, like waiting for their case to be heard in court. Additionally they are looking into hiring more administrative staff to help enter case notes into UNITY. Workers could dictate their notes and transcriptionists would input that into UNITY. All of this being said DCFS administration also said that UNITY needs a full functional evaluation from a program level to really pull out the areas where the program could be improved. Additionally she mentioned that there are 200 files that will be evaluated by UNITY programmers to understand and prioritize their biggest issues.

Washoe County's administrator also discussed the ways that they have tried to improve the consistency and timeliness of entering case notes into UNITY. He mentioned that they have tried to use summary narratives, handwritten notes, dictation equipment and transcriptionists who typed notes then cut and paste them into UNITY. All of these strategies were met with limited success and were eventually discontinued. He said that the real issue is that workers need continual training in what should be in case notes and also need to change the view that case notes are a secondary or tertiary responsibility for workers. Clark County's administrator had similar views noting that it's an agency culture issue and that historically there have been no clear expectations about record keeping, and enforcement of entry into UNITY. He feels, "to improve practice training must be imbedded around UNITY and the state must provide more direction with regard to case notes."

Outstanding Practices and Recommendation for Change

In this section participants were asked to describe any new or cutting edge practices that they have recently implemented, as well as how they feel their agency has been able to respond to the various recommendation reports directed at the child welfare agencies in recent years.

Washoe County's administrator reported that his agency has just recently completed a major reorganization around the Colorado model to move units around to put investigation and permanency units under the same supervisor in an attempt to provide more consistency and decrease any transfer time. Under this new system permanency workers are engaged with the case within the first 7 days of placement, under the old system this took between 30 and 45 days. In addition if a case goes out and comes back into the system it is automatically assigned to the same team to increase a "do it right the first time" attitude. He said that their office has been watching Colorado test this model over the last few years and they have seen marked successes. Washoe County started this initiative on August 3rd and hopes to see improvement in their service delivery.

In Clark County the administrator reported that they are currently in the middle of a one million dollar project to completely re-write all the policies and procedures to improve business practices. He also noted that his agency has made progress regarding medical wrap around services, as well as a visitation center located on the Child Haven campus. In this center the agency provides qualified supervised coaching during parent visits to make this a more positive experience for children and parents. Also he highlighted the agency's child and family team process to increase team decision making. He is hoping to improve this process by implementing an initial assessment scale like one that is used in North Carolina.

Administrators at DCFS highlighted the new program improvement practices, including the new risk and safety policies as well as the Nevada Initial Assessment Tool. Additionally they mentioned the use of the Decision Making Group or DMG in making decisions that all agencies can agree on.

Further, administrators were asked to comment on their agency's ability to respond to the multiple recommendation reports that have been directed toward these agencies in recent years. All three agency's administrators reported that they recognize the need for and welcome good recommendations for improvement. However DCFS administration noted that it has been overwhelming to respond to all of the recommendations and new policies, and feels that a reassessment must be done to evaluate all of their new policies for effectiveness. In Washoe County the administrator said that many of the recent recommendations required partnerships with other agencies and working with them to change some of their practices. One positive note regarding the recommendations were that there was enough time to implement the changes and work with these other agencies. The administrator in Clark County responded that many of the recommendations and program improvement plans did not address the reasons the agency had not been functioning properly, "poor performance was indicated, but no mechanism to address these issues." Further he went on to discuss other recommendation reports that have been released in recent years and said that "no one was really stepping forward to help. They just wanted to find what's wrong. They used monitoring matrices but did not address the problem. They didn't deal with the underlying business practices." He also noted the difficulties in complying with the different demands of reviewers, noting that since he has deployed four full time positions that simply respond to requests for information from these outside agencies. The most common theme among all administrators was the need for ample time and planning to carry out recommendations for change. At DCFS the administrators said that next time changes should be made systematically with time to ensure all staff are fully trained regarding new policies and there should be ample time to evaluate the progress regarding new practices.

Finally, in this section administrators were also asked for feedback regarding the structure of recommendations that come to their agencies. They all had excellent suggestions for how to craft recommendations that are clear, understandable, useful and feasible for the agencies.

Washoe County's administrators said that it would be helpful to tie the recommendations to a desired outcome and make that clear in the recommendation. Also he said that prioritized recommendations would be helpful, so they know where they are expected to place focus immediately. Clark County's administrator pointed out that he feels recommendations should be material in terms of agency performance and there should be a clear link to the system before something is viewed as a system wide problem and not just an anomaly. In response to the same question, DCFS administration also said that the recommendations should have clear goals and be specific. Also these administrators asked that recommendations not request the creation of another advisory group. "There are so many as it is - issues should be able to be addressed using existing groups. DCFS also stated that recommendations should have the ability to tie into existing practices and federal rules and regulations, and also identify which recommendations are tied to funding, where the funding is coming from and which do not require funding for implementation.

Laws and Policies

Administrators were also asked some questions regarding their procedure for notifying staff of changes in agency policy, as well as the procedures for staff if they want to recommend a change. Participants were also asked to discuss any changes that they would like to see at the legislative level.

First the administrators addressed the question about their agency procedure for making a policy change. In Washoe County they have a policy specialist that is tasked with monitoring and working with different groups to develop new policies. Supervisors are told about new policies in weekly meetings and they are given any documentation that accompanies them and they are supposed to bring the information back to the workers. Information is also sent out via e-mail, and a policy manual that is updated regularly is kept on their agency intranet system. In certain circumstances the policy specialist will schedule trainings and the units will be trained on the policy and have the ability to ask questions. Additionally he mentioned that they do also attend the state sponsored trainings when those policies change. He said that keeping up with all the changes can be challenging, especially when things are sent over email and they get ignored or being able to get everyone out to the group trainings in a timely manner.

In Clark County the administrator discussed the new training unit that has been established, and assistant managers, as well as managers are responsible for scheduling training for their unit. This is a change from the previous practice where policy changes were sent out via e-mail and management staff were responsible for administering the change to all personnel.

DCFS discussed the process for changing policy at a statewide level. Administrators said that at the administrative level a policy charter is written and given to the child welfare agency directors. Then people are designated to participate in drafting policy, language, research, etc and this policy is then sent to the policy approval committee for recommendations or any changes. Then the DMG (Decision Making Group) approves the policy and it is disseminated to the agencies and trainings are scheduled.

In Washoe County the administrator also discussed the procedure if a need for change is identified at the local agency level. Supervisors in this agency have weekly meetings with management and can voice opinions there, but he was not sure about a set process for line level staff to make suggestions.

In Clark County the administrator discussed the process for the agency making recommendations for policy change to the state. He indicated that the process is that his agency makes recommendations to DCFS and they decide what to move forward with in terms of recommended legislation changes. He was concerned about the counties' ability to provide feedback or be involved in these decisions, stating "the whole process at the state level isn't well coordinated. There is no time when the state asks the county what is needed. There is zero engagement by the state in the process."

Administrators were also asked in this section to discuss any changes that they see as necessary at the legislative level. Each had their own responses to this question, but they did overlap in some areas. Administrators from all three agencies mentioned in one form or another that the statutes governing child welfare have become too confusing and muddled with as many times as the laws have been amended. It was recommended that all of NRS 432B be reviewed and essentially rewritten. Washoe County's administrator suggested that the definition of who is a viable placement in terms of foster

care be revisited along with adding a licensing provision to include agencies that provide foster care, and reviewing the NRS to clarify and recognize fictive kin as available placements for children. Clark County's administrator echoed his requests for allowing fictive kin as placements.

DCFS administrators echoed the recommendations to improve NRS 432B, while also mentioning other recommended changes at the legislative level. They said that they have a large list of funding needs, but at the same time stated, "agencies need to stop continually doing more with less and finally just cut programs that we do not have funding for. The state needs to take a critical look and decide what the priorities are and fund them." In addition they noted that the state needs to be more outcome based and really fund programs that are successful.

The Clark County administrator discussed the need for clarity in statutes requiring reviews of child deaths even when abuse or neglect wasn't a factor. He also mentioned a need for more structure in terms of getting standards for determining which cases are investigated from the hotline. He also expressed a problem with requiring an investigation for all children under the age of five because this prohibits them from using differential response in those situations. He also discussed the broader issue of funding providing several recommendations for improvement. "The legislature needs to discuss the role of the state office in a county administered child welfare system" and recommends that the state look at other similar states for guidelines in how to make this work. He also expressed that the state should not only serve a role of oversight and making the counties accountable but also provide guidance and leadership, but questions the states ability to provide guidance and expertise to the counties.

Other Information

In this final section participants were simply asked if they had anything else to add or anything they would like to communicate to the legislature. Reponses were varied but all three agencies had something additional to add.

DCFS wanted to "remind legislators that we cannot raise children in a bureaucratic system – there needs to be flexibility – unique issues arise and those may need emergency funding." While Washoe County's administrator wanted to note that child welfare is evolving and he feels moving in the right direction. "We clearly have significant hurdles to overcome, but the capacity to meet community needs will not be sufficient for some time, but we are moving forward and the agencies have demonstrated a commitment to that."

The administrator in Clark County expressed that there "is a strong need for a policy research entity funded to do research that child welfare needs. Some examples include the University of Illinois where there is a university based research entity that helps with policy practice development in the state."

CONCLUSION – ADMINISTRATOR INTERVIEWS

Overall agency administrators seem to be hopeful in terms of improvement and change. They have some differing views in terms of the best ways to improve UNITY and what's important. However, they all discussed some new practices, policies and procedures that each agency has moved forward with to improve services for families involved in child welfare. A similar theme was heard in discussing these improvements and recommendations and this was a look toward child welfare as a whole system and seeing these agencies as a piece of the child welfare system. These agencies have a role to play, but rely heavily on other organizations to provide services to create successful outcomes for children and families and this should be kept in mind when working on recommendations for improvement and directing those toward the most appropriate organization in the child welfare system.

CONCLUSIONS AND RECOMMENDATIONS

Assembly Bill 629, section 5 of the 74th Legislative Session in Nevada mandated that a performance audit of Nevada's child welfare agencies be conducted in an effort to provide an unbiased view of the overall functioning of the agencies, as well as to address several specific aspects of child welfare which members of the Legislature identified as areas needing improvement by the agencies. The mandate specifically provides that the consultant conducting the performance audit must review, evaluate and make determinations in seven individual areas.

In an effort to appropriately address each issue identified, the UNLV Research Team developed data collection tools, conducted both electronic and paper reviews of a random sample of cases opened and closed in each jurisdiction in the 2007 calendar year, conducted interviews and/or focus groups with caseworkers, supervisors, managers and administrators, and reviewed all applicable agency policies and procedures provided to the team by each entity. Findings in each of these areas are reported in various sections of this report. Specific recommendations are noted throughout the report. Provided below is an overall conclusion and recommendations, as appropriate, for each priority area identified in the legislation.

CONCLUSIONS

1. Review the manner in which the agencies which provide child welfare services document, respond to and report cases of child abuse or neglect.

Appropriate documentation was an area of concern throughout the audit. Although agency policies and procedures specify that documentation in specific areas must be included, both in UNITY and in the paper case files, auditors consistently found that documentation was either severely inadequate or missing altogether. This finding was consistent among all three agencies in the State. Focus groups and interviews with caseworkers, supervisors, and managers revealed that child welfare agency workers are aware of their own shortcomings in regard to documentation and cite lack of time due to high caseloads as a primary reason for inadequate or missing documentation.

Overall, the agencies respond in a timely manner to reports of abuse and neglect as identified in the case review process. Policies and procedures clearly indicate response criteria and timelines, however recommendations to enhance these policies have not yet been formally adopted by all agencies. Slower response times in the rural areas are often the result of geography and state policy restricting the use of vehicles.

2. Review the procedures used by the agencies which provide child welfare services to determine whether to close a case.

For the most part, the child welfare agencies, particularly DCFS and WCDSS, are in substantial compliance with incorporating federal and state law in their policies and procedures in regard to case closure. Recommendations from the Expert Panel and Blue Ribbon Panel still need to be incorporated, as appropriate. CCDFS is missing half of the mandatory laws in their policies and procedures. Specific guidelines for case closures are lacking and seem to be interpreted differently among caseworkers,

supervisors and administrators, indicating the need for enhanced policies and procedures, as well as training related to case closure guidelines and best practices. Documentation, or lack thereof, was a primary factor in the research team's inability to accurately account for case closure practices among agencies, particularly in regard to reasons for case closure.

3. Determine whether the agencies which provide child welfare services are complying with federal and state laws in the manner in which they carry out their responsibilities with respect to child abuse or neglect.

A review of each agencies' policies and procedures indicates that Washoe County Department of Social Services has included approximately 82% of all state and federal laws in their policies and procedures. Nevada DCFS comes in at under half (43%) of all state and federal laws included and Clark County Department of Family Services only included 37% of all state and federal laws in the policies and procedures that were provided to the research team. In reviewing the policies and procedures of each agency, the reviewers only included those policies and procedures that were specifically provided by the agency for review. It is noted that there may have been some missing information from agencies which did not provide a comprehensive set of policies and procedures. It is also noted that in general, policies and procedures were not organized and specific details were often very difficult to locate. Case reviews indicated several areas where agencies failed to comply and/or appropriately document compliance (<50%) with federal and/or state laws. Those included: conducting safety assessments at the appropriate intervals; notification to non-custodial or joint custodial parent not living in the home; giving preference to relative placements; efforts to place the child in close proximity to his/her home; quarterly reports from out of state placements; proximity of school as a placement factor; case plans updated every 6 months; follow up risk assessments; copies of school records in case file; lack appropriate documentation in court reports; identification of family strengths and resources in assessment documents; and caseworker visitations with children in foster homes.

4. Evaluate the effectiveness and availability of appropriate intervention services.

Services were offered to families more often if a child had been removed from the home (80.6%) or if the case was a permanency case (84.6%) compared to an investigation case (47%). Of the children identified as possibly needing mental health services, approximately 80% were referred for services and 60% were documented as having received services. Just over half (56.7%) of required cases had a documented EPSDT (Health Screening). Educational services were more difficult to determine since only 22.4% of school age children had school records in their files. Documentation of services through case notes makes assessment of service delivery and use very difficult to track and may be an underestimate of the efforts made. It is suggested that a new system of tracking service referrals and use is developed that will provide more accurate information. In this system it will also be important to note whether lack of use is due to waiting lists or unavailability of needed services.

5. Determine the frequency with which agencies which provide child welfare services have direct contact with children placed in foster homes or emergency shelters.

AB 629 required the audit not only to determine the actual frequency of visits, but also to determine if the frequency of visits were in compliance with established policies and were appropriate for each child. State and federal law require caseworkers to conduct at least monthly visits with children in

foster care, with visits taking place in the placement at least once every 60 days. Additionally, a portion of each visit must be alone with the child and the caseworker must meet alone with the foster parent if requested. All three agencies have successfully included these state and federal requirements into their policies and procedures. However, practice, as documented in the case files, indicates that policies and procedures regarding visitation are not being followed. Overall, less than 40% of applicable cases included documentation that the child received a visit from their case worker at least monthly. Caseworkers did slightly better at conducting in placement visits at least once every 60 days, at 65%, but lacked significantly in demonstrating that at least a portion of the visit was spent alone with the child (18.2%).

Although it is possible that caseworkers are making appropriate visits and are just failing to appropriately document those visits, based on the information available, it is the determination of the auditors that, overall, the frequency of visits to children are not appropriate for the needs of the child or carried out in accordance with agency policies and procedures, or state and federal law. Documentation is likely a strong factor in these results, however, these numbers indicate a strong need for enhanced training, supervisory oversight and reduced caseloads to meet state and federal requirements. It is also noted that all cases deemed "concerns" by the audit team were due to inadequate documentation that the child had been seen in a timely manner by the caseworker.

6. **Determine whether the agencies which provide child welfare services have successfully incorporated the recommendations set forth in the Report of the Clark County Blue Ribbon Panel for the Review of Child Deaths and of the Northern Blue Ribbon Panel for the Review of Child Deaths, as applicable.**

Overall, there were 178 recommendations included in the final report, 106 of which were included in the analysis to determine agency responsiveness. Clark County DFS was determined to have: substantially completed 6% (3) of the recommendations; not completed 67% (35) of the recommendations; and 27% (14) were unable to be determined based on the information provided and/or collected for this audit. Washoe County DSS was determined to have: substantially completed 20% (5) of the recommendations; not completed 56% (14) of the recommendations; and 24% (6) were unable to be determined based on the information provided and/or collected for this audit. DCFS was determined to have: substantially completed 14% (4) recommendations; not completed 45% of the recommendations; and 41% (12) were unable to be determined based on the information provided and/or collected for this audit.

7. **Evaluate the progress and efforts made towards meeting the requirements set forth in the federally approved Performance Improvement Plan (PIP) and Corrective Action Plan.**

A review of the Statewide Collaborative Policies indicated that the State has substantially accomplished 11 of the 12 identified action steps included in the PIP analysis. The only element which was not identified in the audit was a standardized intake-screening instrument. However, policies provided to the research team for the purposes of this audit did include a Collaborative Policy on Intake which includes components of tracking response times and response criteria. Therefore, it is concluded that the State is substantially in compliance with the action items identified by the Children's Bureau as not having met the performance measures identified as of June 2007.

Four of the eleven objectives of the Corrective Action Plan have been self identified by DCFS as not completed. The primary reason cited for incomplete objectives was a need to pass legislation during the 2007 Legislative Session. The case review process and interviews conducted as a part of this audit indicate that increased attention to Objective 2 (related to enhanced documentation) is needed, since lack of appropriate documentation at all levels was identified as a primary concern throughout the audit period.

RECOMMENDATIONS

1. Stronger investments and enhancements in human resources.
All agencies need to make a stronger investment in their human resources, to include comprehensive training (initial and ongoing) for new and existing staff, support in continuing education, competitive salary rates as well an appropriate overload system, and smaller caseloads. This strategy would improve worker morale and may help to reduce turnover in the case worker positions. New solutions should be examined and policies restructured to maximize work time and productivity as well as incorporate a more thorough system of accountability.

2. Improve documentation practices and electronic data management systems.
Child welfare agencies should focus efforts in implementing change in their case work documentation practices and use of the existing electronic data management system. Agencies should work toward implementing a system that is more complete, accurate and user friendly for both line workers and administration. This data entry system should be created to produce reports that will allow for frequent analysis of policies, procedures, and state and federal laws. This would improve documentation of ICWA, placement efforts, services offered and provided, and ease supervisory oversight. The new system should also include a clear tracking of supervisor involvement which was also found lacking across the state. This report should be available at the county and the state level. Without proper documentation, meaningful conclusions and recommendations are challenging and this is one area that was lacking throughout all stages of the current investigation. By implementing a new system, more time should be available to ensure that all children are visited as appropriately outlined by federal, state, and agency guidelines.

3. Improve supervision of caseworkers.
Supervision is an important role in this process and supervisors should be properly trained and make sure to have time to monitor case worker compliance and assist when needed. Policies and procedures should clearly specify the roles and responsibilities of supervisors, including when caseworkers need supervisor approval, the frequency of case reviews by supervisors, and specific mandatory components of cases that supervisors should be checking for in all cases. Supervisor qualifications should be reviewed to ensure that all supervisors have the knowledge and expertise to properly supervise and advise caseworkers.

4. Update policies and procedures – statewide and agency specific.
Policies and procedures at all agencies need to be updated to include all mandatory provisions of state and federal law, as well as to incorporate best practices and recommendations as deemed appropriate by the State and local agencies. Policies and procedures should be developed in a user friendly manner – including simplification of policies, elimination of contradictory policies, and available in electronic

format – that is consistent with ethical guidelines and takes into consideration the practical application of caseworker and supervisory functions, and appropriate training of all staff. Agencies need appropriate funding to provide administrative support to update policies and procedures and provide adequate training to staff.

5. Stronger investments in the child welfare system.
Many of the recommendations suggested may have a financial commitment. The state and individual agencies should consistently work to seek out additional grant funding and/or philanthropic partnerships to support improvements within the child welfare system and to supplement existing services and increase the capacity to serve more clients. By investing in improving the components listed above, the cost to benefit ratio will prove to be very cost efficient as the need for services may decrease and this will also help with the sustainability of federal dollars.

6. Continue to monitor child welfare agencies and develop sustainable best practice models.
Child welfare agencies need to be continually monitored to ensure compliance with state and federal laws, as well as with the design and implementation of best practice models. Service delivery systems should also be monitored to identify available resources and service needs to enhance the child welfare system in the community. Oversight of the child welfare agencies should be streamlined and administered in collaboration with the agencies to ensure coordinated efforts to improve services for children and families in Nevada.

APPENDIX A
Case Review Data Collection Tool

Performance Audit of the State of Nevada's Child Welfare Agencies
Case Review Data Collection Form

This form is designed to collect information for each case that was selected.

UNITY auditor's name:	**Date of UNITY review:**
Paper case file auditor's name:	**Date of paper case review:**
Date Paper file located:	

Case Information

Case name:	**Office where Site Visit will occur:**
Case number:	**Case worker from case list:**
Child's Name:	**Agency unit as listed on case list:**
Child's person ID:	**Case status on case list:** 1. Open 2. Closed
Type of file: 1. CPS 2. Permanency	**Case status in UNITY:** 1. Open 2. Closed

General Demographics

For all questions that ask about a specific child – choose the child whose first name is alphabetically first. If this child had no involvement in the case chose the child whose name is alphabetically next until you find a child involved in the case.

Child's birth date: ______

Child's gender:

1. Male 2. Female

Child's race:

1. Caucasian
2. African-American
3. Asian
4. Pacific Islander
5. Native American (specify tribe)_____
6. Declined to Answer
7. Child Abandoned

Child's ethnicity:
1. Hispanic 0. Non-Hispanic 6. Declined to Answer

How many other children are living in the home (other children listed in UNITY case)**?** _____

Date of birth of other children in the home *(Indicate in the box the birthdates of all the children living in the home. If there are more than five children, use the blank space beside the table.)*

Child 1		Child 4	
Child 2		Child 5	
Child 3		Child 6	

Does the child have a medical passport? (either in UNITY or paper file)
1. Yes 0. No

Current placement: 1. Parent(s)/caregiver(s) 2. Foster Parent 3. Relative/Fictive Kin

4. In their home – child never removed 5. Other (specify) _____

Child's most current address on file:	

Is the child currently missing from this placement?
1. Yes 0. No

Caregiver's name and Phone number:	

Mother's name:	**Father's name:**
Address: ☐ **Same as child's listed above**	**Address:** ☐ **Same as child's listed above**
Phone:	**Phone:**

Please answer the following questions for the entire documented history of this child:

Total number of substantiated claims for this child: _____

Total number of unsubstantiated claims regarding this child: _____

Date of report	Date assigned to investigator	Date of initial face-to-face contact*	Date of determination	Determination	Allegation	Location/Home Placement	Perpetrator (relationship to child)
				S U			
				S U			
				S U			
				S U			
				S U			
				S U			
				S U			
				S U			

** This is the first date that the worker attempted to make face to face contact, not necessarily the date it actually happened.*

Total number of information only claims regarding this child: _____

Date of report	Allegation

Indicate cause of the agency's most recent involvement with this child or family. Include parent(s)/caregiver(s) factors related to involvement (i.e. substance abuse, mental health issues): *(Include a brief narrative including allegations)*

Report/Investigation

Was the person responsible for the child's welfare immediately notified of the investigation?
1. Yes 0. No 99. Unknown

Was the manner in which the investigation was initiated documented?
1. Yes 0. No

Was the information obtained during the investigation recorded in writing?
1. Yes 0. No

Is there documentation that a safety plan was completed to address the immediate safety concerns of the child?
1. Yes 0. No 77. N/A

Is there documentation that a safety assessment was EVER conducted? 1. Yes 0. No
(If no to question above select "N/A" for all questions in the table below)

Was a safety assessment of the child conducted at the milestones listed below?				
a. at the initial intake for protective services?	1. Yes	0. No	99. Unknown	77. N/A
b. at the initial face-to-face with the child?	1. Yes	0. No	99. Unknown	77. N/A
c. during consideration of removing the child from the custody of his/her parent(s)/caregiver(s)?	1. Yes	0. No	99. Unknown	77. N/A
d. before any unsupervised visits between the child and his/her parent(s)/caregiver(s)?	1. Yes	0. No	99. Unknown	77. N/A
e. before returning the child to the custody of his/her parent(s)/caregiver(s)?	1. Yes	0. No	99. Unknown	77. N/A
f. due to a significant event or change that affects the household of a parent, foster parent, or other care provider?	1. Yes	0. No	99. Unknown	77. N/A
g. before each court review?	1. Yes	0. No	99. Unknown	77. N/A
h. after reunification of the family with the child?	1. Yes	0. No	99. Unknown	77. N/A
i. before closure of the case?	1. Yes	0. No	99. Unknown	77. N/A

Is there a safety assessment in the paper file? 1. Yes 0. No
If Yes – List the dates of the assessments: _____
_____

If the child was taken into protective custody, is there documentation that the agency asked, or attempted to ask, a parent, legal guardian or relative of the child (if available) whether the child is an Indian child?
1. Yes 0. No 77. N/A – Child not taken into protective custody

Placement

Was the child ever removed from the home?
1. Yes 0. No

*** If the child was NEVER removed from the home then skip to page 7***

If Yes, date of most recent removal from home: _____

List reasons for removal:

_____

_____

_____

_____

_____

_____

If applicable, date child returned to home (following most recent removal): _____

Refer to the child's most recent removal from the home- If the child was removed from the home, is there documentation that the agency:				
1. developed a safety plan to ensure the safety of all other children remaining in the home/facility?	1. Yes	0. No	99. Unknown	77. N/A
2. immediately made reasonable efforts to inform the person responsible for the child's welfare that the child had been placed in protective custody?	1. Yes	0. No	99. Unknown	77. N/A
3. gave preference in placement to a relative who was suitable and able to provide care/guidance, regardless of whether the relative resided within the State?	1. Yes	0. No	99. Unknown	77. N/A
4. submitted a plan to the court designed to achieve placement in a safe setting as near the residence of the parent(s)/caregiver(s), as is consistent with the best interests and special needs of the child, including a description of where the child should be placed?	1. Yes	0. No	99. Unknown	77. N/A
5. conducted a diligent search to find relatives?	1. Yes	0. No	99. Unknown	77. N/A

Was a hearing conducted within 72 hours after being taken into custody (excluding weekends and holidays) to determine whether the child should remain in protective custody?

1. Yes 0. No 99. Unknown 77. N/A

If both parents were not living in the home, was the non custodial or joint custodial parent notified of the initial protective custody hearing, foster care, out of home placement or court hearing?

1. Yes 0. No/Not documented 77. N/A

If Yes, how?

1. Telephone 2. Letter

Does the most recent "Permanency and Placement" court report address the following items:

Documented reasonable efforts	1. Yes	0. No	
Conditions of the child's residence	1. Yes	0. No	
School Records	1. Yes	0. No	77. N/A
Mental health background	1. Yes	0. No	77. N/A
Physical health background	1. Yes	0. No	
Social background of the family	1. Yes	0. No	77. N/A
Financial situation of the family	1. Yes	0. No	77. N/A
Whether or not the child was sent to an emergency medical provider	1. Yes	0. No	77. N/A

Was the child placed in a facility, other than under an emergency admission, WITHOUT a court order?

1. Yes 0. No 99. Unknown

If temporary placement was necessary, is there documentation that efforts were made to place the child as close to home as possible? (find this in the Permanency and Placement report)
(NAC 43B.220)

1. Yes 0. None documented 77. N/A

If temporary placement was necessary, is there documentation that immediate plans were made to return the child to their home?
(NAC 43B.220)

1. Yes 0. None Documented 77. N/A

Out of Home Placement

If the child was never removed from their home skip to page 7

In what types of homes was the identified child placed?
In the space below write in the UNITY placement codes for each placement – Indicate the dates for each stay at each location

If the child has siblings, were they EVER separated in an out of home placement?

1. Yes 0. No 77. N/A – No siblings

If Yes, list all reasons for sibling separation in out of home placement.

_____

_____

Number of times a child changed placements: _____

Regarding the child's most recent removal, was the child placed in a home out of state or out of the agency's jurisdiction?

1. Yes 0. No 77. N/A – child never removed

If Yes, are the quarterly update reports documenting child well-being in the case file?

1. Yes 0. No 77. N/A – child not placed out of agency jurisdiction

Provision of Services

Was the Family Risk Assessment Protocol (FRAP) used?

1. Yes 0. No 99. Unknown m- No documentation of FRAP in UNITY or paper file

If No, what was used? _____

_____

Were any services offered to the child's parents?

1. Yes 0. No

If no services were offered then select "No" for all elements in the table below

Services Offered to the Child's Parents: (Not Foster parents, or Relatives)			
Service	**Referral**	**Direct assistance**	**Utilization**
Substance abuse treatment	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Housing	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Parenting classes	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Daycare	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Homemaker services	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Domestic violence counseling	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Mental health counseling	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Emergency fund grants (Cash)	1. Yes 0. No 99. U/K Please indicate what the payment was intended for:	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Welfare agency *(Food stamps, TANF)*	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Health care – Parent(s)/caregiver(s)	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Health care - Child	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Anger management training	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Public Health Nurse	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Transportation	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Job training	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K	1. Yes 0. No 99. U/K
Other service (specify)			

Were the services utilized linked to the FRAP?

1. Yes 0. No 99. Unknown 77. N/A

Were there follow-up risk assessments done?

1. Yes 0. No 77. N/A 99. Unknown

Is there documentation of a semi-annual assessment (court report) for the most recent period of custody?

1. Yes 0. No 99. Unknown 77. N/A

Does the most recent Permanency and Placement court report include the following:

a. the current level of functioning of the child's family?	1. Yes	0. No	99. Unknown	77. N/A
b. an update of the history of the family as it pertains to the risk which prompted placement of the child into foster care?	1. Yes	0. No	99. Unknown	77. N/A
c. the current risk to the child if s/he were returned to the custody of his/her parents or legal guardians?	1. Yes	0. No	99. Unknown	77. N/A
d. the services required to meet the child's needs?	1. Yes	0. No	99. Unknown	77. N/A
e. the strengths and resources of the family of the child?	1. Yes	0. No	99. Unknown	77. N/A
f. reasonable efforts?	1. Yes	0. No	99. Unknown	77. N/A

Are there demonstrated reasonable efforts to finalize adoption?

1. Yes 0. No 99. Unknown 77. N/A – Child not being adopted

If the child's permanency goal is adoption, is there a current social summary on file?

1. Yes 0. No 99. Unknown 77. N/A – Goal is not adoption

Health of the Child

Were any mental health needs identified through the FRAP?

1. Yes 0. No 99. Unknown 77. No FRAP used

Were mental health needs identified through any other means other than the FRAP?

1. Yes 0. No 77. N/A 99. Unknown

If Questions #1 and #2 are Yes, was a mental health screening performed?

1. Yes 0. No 99. Unknown 77. N/A

Was the child referred for mental health services?

1. Yes 0. No 99. Unknown 77. N/A

Did the child receive recommended mental health services?

1. Yes 0. No 99. Unknown 77. N/A

Was an EPSDT (well check) done?

1. Yes 0. No 99. Unknown 77. N/A

Is there documentation of the child's prescription medications?

1. Yes 0. No (if No – skip next table)

List any medications the child has been prescribed and the date of prescription: ***(If there are more than 5 prescriptions, please document those on another sheet of paper and attach.)***

☐ **No prescriptions listed in the file**

Prescription	**Date of prescription**

What types of documentation are included in the case file to indicate that the agency is engaging the parent(s)/caregiver(s) regarding their child's health care?

Letter	1. Yes	0. No	99. Unknown	77. N/A
Phone Call	1. Yes	0. No	99. Unknown	77. N/A
In Person	1. Yes	0. No	99. Unknown	77. N/A
Transportation Provided	1. Yes	0. No	99. Unknown	77. N/A
Other (please specify)	1. Yes	0. No	99. Unknown	77. N/A
Consent Obtained	1. Yes	0. No	99. Unknown	77. N/A

Education Services

If child is not of school age skip to page 11

Are copies of the school records in the case file?

1. Yes 0. No 77. N/A – Child not of school age

Is there documentation in the case file that an educational assessment was requested and/or completed?

1. Yes 0. No 77. N/A

If yes, is a copy of the assessment in the case file?

1. Yes 0. No 77.N/A

If the child was in an out of home placement, was the child enrolled in multiple schools as the result of being in out of home placement?

1. Yes 0. No 99. Unknown 77. N/A

If yes, how many times has the child changed schools since the initial removal? _____

Is there evidence in the case file that the agency made efforts to keep the child enrolled in his/her original school OR indicated specific reasons why the child should not remain at his/her original school?

1. Yes 0. No 77. N/A

Case Planning

Is there a case plan in the file?

1. Yes 0. No 99. Unknown 77. N/A – Investigation Only

(Skip to page 12- "Case Consistency")

If Yes, does the case plan include:

a. identification of barriers to providing a safe environment for the child?	1. Yes	0. No	
b. identification of strengths of the family?	1. Yes	0. No	
c. clarification of responsibilities to address barriers?	1. Yes	0. No	
d. overall goals and objectives of the case?	1. Yes	0. No	
e. step-by-step proposed actions/activities of all persons?	1. Yes	0. No	
f. description of services offered/provided to prevent removal or to reunify the family of the child?	1. Yes	0. No	
g. description of the type of home/institution in which the child is placed, including safety and appropriateness of placement?	1. Yes	0. No	
h. description of efforts that will be made to place siblings together?	1. Yes	0. No	
i. plan for family visitation, including visiting siblings if siblings are not residing together?	1. Yes	0. No	
j. (if goal is adoption or placement in another permanent home) description of steps to finalize including recruitment of adoptive parents?	1. Yes	0. No	77. N/A goal is not adoption or placement in another permanent home
k. statement indicating the proximity of the school in which child enrolled at the time was considered a factor?	1. Yes	0. No	77. N/A
l. health records, if available?	1. Yes	0. No	77. N/A
m. education records, if available?	1. Yes	0. No	77. N/A
n. specified timeline for completing goals, objectives and activities?	1. Yes	0. No	
o. approval by the case worker's supervisor?	1. Yes	0. No – not signed by supervisor	
p. updates at least every 6 months?	1. Yes	0. No	

What are the objectives identified in the most recent case plan? Please list below:

_____
_____
_____
_____
_____
_____
_____

Is there a separate case plan written for each parent/caregiver ? 1. Yes 0. No 99. UK

What is the child's current (last) permanency goal?

1. Maintain in Home	2. Reunification
3. Guardianship	4. Adoption
5. APPLA	6. Other (specify)

How long has the current permanency goal been in place (in months)? _____

Is there evidence that the parent(s)/caregiver(s) was(were) encouraged to and/or participated in the development of the case plan?

1. Yes 0. No 99. Unknown 77. N/A

If reasonable efforts were waived, was a judicial review held within 30 days of removal?

1. Yes 0. No 99. Unknown 77. N/A

Did the agency document a plan for the permanent placement of the child within 12 months of when the child was removed (or within 30 days of removal if reasonable efforts were not required)?

1. Yes 0. No 99. Unknown 77. N/A

Is there documentation that the permanency plan was reviewed annually?

1. Yes 0. No 77. Not Applicable

Was the (first) case plan completed within 45 days after the date the child was removed from his/her home?

1. Yes 0. No 77. N/A 99. Unknown

Is there a concurrent plan?

1. Yes 0. No 77. N/A 99. Unknown

If so, is there documentation that both plans are being worked simultaneously?

1. Yes 0. No 99. Unknown 77. N/A – no concurrent plan

If the child is age 16 or older, is there documentation that the case worker provided services designed to prepare the child to live successfully and independently as an adult?

1. Yes 0. No 99. Unknown 77. N/A – Child under 16

Case Consistency

Transition between workers:

Case worker's name	Worker Type (Investigator/Permanency)	Dates the caseworker had the case

In the most recent 12 month period, how many monthly one-on-one supervisory meetings were held?
Indicate the number of meetings and the total number of months the case has been open (if less than 12 months).

_____ (# of meetings) **_____ (total # of months)** **☐Case open less than 1 Month**

Is there documentation of other supervisory oversight (i.e. case staffing)?

1. Yes 0. No

For the most recent 12 month period, identify visits between the worker and the child. *In the table below, please indicate the location of visit, and the date.*

Date	Location of Visit (in placement, school, doctor, etc)

Please answer all of the following questions for the most recent 12 month period:

Did the child receive a visit from their case worker at least monthly?

1. Yes 0. No

Did the child receive a visit, in their placement, from their case worker at least every 60 days?

1. Yes 0. No

Did the case worker document that s/he spent at least a portion of the visit alone with the child?

1. Yes 0. No

Indicate the number of meetings between the worker and the child and the total number of months the case has been open (if less than 12 months).

_____ (# of meetings) **_____(total number of months)**

In the case file, is there evidence of the case worker's attempts to contact the primary parent(s)/caregiver(s)?

1. Yes 0. No 99. Unknown 77. N/A

If Yes, what type of contact? (Choose all that are indicated.)

1. Telephone 2. Face to face 3. Letters
4. E-mail 5. Other (specify) _____

Identify visits between the case worker and the primary parent(s)/caregiver(s). *In the table below, please indicate the location of visit, and the date.*

Date	Location of Visit (in home, school, doctor, etc)

Total # Visits with Parents _____ **Total # of Months _____**

In the case file, is there evidence of the case worker's attempts to contact the foster parents?

1. Yes 0. No 99. Unknown 77. N/A – no foster parents

If Yes, what type of contact? (Choose all that are indicated in the notes.)

1. Telephone 2. Face to face 3. Letters
4. E-mail 5. Other (specify) _____

For Closed Cases (if case is open skip to page 15)

Date case closed: _____

What criteria were used for case closure? (include a brief narrative – what were the reasons for case closure)

_____

_____

_____

_____

_____

_____

COMPLIANCE OF AGENCY ACTIONS WITH FEDERAL/STATE LAWS AND AGENCY POLICY

If the case is closed, was a safety assessment conducted at case closure?

1. Yes 0. No 99. Unknown 77. N/A – Open case

Has the child's permanency goal been achieved?

1. Yes 0. No 99. Unknown 77. N/A – Investigation Only

Has the child's adoption been finalized within 24 months of the most recent entry into foster care?

1. Yes 0. No 99. Unknown 77. N/A

If the child has been in foster care less than 24 months, are steps in place to finalize the adoption within the 24 month time frame?

1. Yes 0. No 77. N/A – Plan is not adoption 99. Unknown

If the child is 14 years of age or older, have they signed a consent for adoption?

1. Yes 0. No 99. Unknown 77. N/A

If the child was in foster care for 14 or more of the preceding 20 months, was the termination of parental rights to the child initiated?

1. Yes 0. No 99. Unknown 77.N/A

If the child had NOT been placed into an adoptive home within 90 days after termination of parental rights, did the Agency:

Identify and document the obstacles to placement of the child?

1. Yes 0. No 77. N/A

Specify the steps that will be taken to find an appropriate home for the child?

1. Yes 0. No 77. N/A

NOTES

On the page below include any narrative clarification necessary to understand the facts of this case

APPENDIX B
Supervisor Interview Questionnaire

Performance Audit of Nevada's Child Welfare Agencies
Pursuant to AB 629
Supervisor Interview

Demographics

Office Location: _____

Title within the Agency:_____
Length of time with the Agency:_____

Length of time in current position:_____

Length of time in child welfare:_____

Procedures

How many workers do you supervise? _____

How many cases does each caseworker have? _____

As a supervisor how do you supervise the work of the caseworkers?
What do you look for?

How do you make determinations about opening or closing a case?

Feedback/Recommendations

What do you feel that your unit does really well?

What are some of the barriers you see to providing services to families?

Do you have any suggestions or recommendations for how to improve the child welfare system in Nevada?

Is there anything else that I haven't asked you that you think we should know?

Thank you for your time and participation!

APPENDIX C
Focus Group Questionnaire

Focus Group Questions

1. What do you feel that your agency does really well? What are some of the strengths?

2. What are some of the problems you encounter on a regular basis in providing quality service to your clients?
    a. Are there specific problems that are caused by the way your agency operates? (such as high turnover rates, difficult policies & procedures, high caseloads, etc)
    b. Are there specific problems that are caused by the way the child welfare system operates here in Nevada? (such as difficult communication between agencies, transience, etc)
    c. Are there problems with community agencies that cause difficulties for you? (such as waiting lists for services, limited availability of community services, problems with the court system, poor communication and follow-up, etc)

3. Do you have any suggestions or recommendations for how to overcome these barriers?

4. What are some of the problems you encounter using UNITY as a case management tool?

5. What kind of needs or interests do you personally have for professional development training?

6. What kinds of training opportunities are needed for your department or agency?

7. What recommendations for improvement to the child welfare system do you have?

APPENDIX D
Case Worker Survey Instrument

Case Worker Survey
Performance Audit of the State of Nevada's Child Welfare Agencies Pursuant to AB 629 (2007)

You are invited to participate in a research study because you are a direct practice worker in the one of Nevada's three child welfare agencies. Your participation in this study is completely voluntary. If you agree to participate in this study, you will be asked to complete a brief anonymous survey addressing specific issues in child welfare which will take approximately 15-20 minutes of your time and return it by confidential mail to NICRP. Your name will not be associated with your responses in any way. No reference will be made in written or oral materials that could link you to this study. The survey will contain questions regarding organizational/community/system barriers to service delivery; caseload issues; training needs; and impediments to effective child welfare practice in Nevada. You will also be asked to suggest possible recommendations for improvement. All completed surveys will be stored in a locked facility at UNLV for at least 3 years after completion of the study. After the storage time the information gathered will be destroyed. If you have any questions or concerns about the study, you may contact Denise Tanata Ashby at (702) 895-1040. By completing this survey, you are agreeing to participate in the project.

Demographics

Are you: □ Male □ Female

Your title within your Agency: _____

Are you: □ CPS Investigator □ Permanency Caseworker □ Licensing Caseworker □ Other _____

How long have you been with your Agency? _____

How long have you been in your current position? _____

How long have you been working in the child welfare field? _____

What is your level of education?

□ Bachelor's Degree □ Some Graduate □ Graduate Degree

What is (are) your degree(s) in? _____ □ N/A

Caseworker Questions

Please indicate on the scales provided whether you agree or disagree with the statements below:

I feel that I am able to adequately serve the families I work with.

□ Strongly Agree □ Agree □ Neither Agree Nor Disagree □ Disagree □ Strongly Disagree

I feel that I have enough time to manage all of the cases on my current caseload.

□ Strongly Agree □ Agree □ Neither Agree Nor Disagree □ Disagree □ Strongly Disagree

I feel that my agency supports me in my job as a caseworker.

□ Strongly Agree □ Agree □ Neither Agree Nor Disagree □ Disagree □ Strongly Disagree

I think concurrent planning is a useful tool for child welfare practice.

□ Strongly Agree □ Agree □ Neither Agree Nor Disagree □ Disagree □ Strongly Disagree

I think that UNITY is a user-friendly data management system.

□ Strongly Agree □ Agree □ Neither Agree Nor Disagree □ Disagree □ Strongly Disagree

How often do you feel unsafe when conducting home visits with your clients?

□ Always □ Often □ Sometimes □ Rarely □ Never

How often would you say that you refer to the agency's policy & procedures manual?

□ Daily □ Weekly □ Monthly □ I have never referred to the policy manual

How important is it to you to enter case information into UNITY in a timely fashion?

□ Extremely Important □ Important □ Somewhat Important □ Unimportant □ Extremely Unimportant

How many cases do you currently have on your caseload? _____

Is that number: □ More than Usual □ About Average □ Less than Usual

How many children do you currently have on your caseload? _____

Is that number: □ More than Usual □ About Average □ Less than Usual

What are your top three most time consuming case management activities?

1. _____

2. _____

3. _____

Suggestions and Recommendations

If you had an unlimited budget, what are the top three things you would do to improve the child welfare system in Nevada?

1. _____

2. _____

3. _____

Is there anything else that you think the auditors should know about working in the child welfare system in Nevada?

APPENDIX E
Administrator Interview Questionnaire

Performance Audit of Nevada's Child Welfare Agencies (AB 629)
Administrator Interview

You are invited to participate in this research study because you are an administrator in the one of Nevada's three child welfare agencies. Your participation in this study is completely voluntary. If you agree to participate in this study, you will be asked to complete a brief interview addressing specific issues in child welfare which will take approximately between one and two hours of your time. Your name will not be associated with your responses in any way. However, we may reference the agency you represent. The interview contains questions regarding organizational/community/system barriers to service delivery; and impediments to effective child welfare practice in Nevada. You will also be asked to suggest possible recommendations for system improvement. All completed interview forms will be stored in a locked facility at UNLV for at least 3 years after completion of the study. After the storage time the information gathered will be destroyed. If you have any questions or concerns about the study, you may contact Denise Tanata Ashby at (702) 895-1040.

Community relations/issues

- What are some of the recent agency successes in terms of the community you serve? Is there anything in particular that has been especially positive in terms of child welfare in your community?
- What do you see as the specific areas for improvement in terms of community relations? Do you have suggestions for improvement in these areas?

Staffing

- What are some specific strengths in your agency staff?
- What kind of barriers does your agency face in terms of staffing?
- Do you have specific recommendations for ways to overcome some of these barriers? If so, what are the recommendations?

UNITY

- How do you feel about your agency's ability to properly maintain documentation for case files?
- What are some of the primary challenges with regard to UNITY?
- Do you have any ideas for how to improve UNITY as a documentation system?

Outstanding practice

- Has your agency recently implements any new or cutting edge practices?
- How do you feel your agency has been able to respond to the multiple recommendation reports that have been out in the last few years?
- Are there ways that recommendations could be crafted to be most effectively implemented in your agency?

Laws and Policies

- What are your agency's procedures for notifying staff of a change in agency policy or pertinent laws or regulations?
- Are there any changes you see necessary at the legislative level?
- If a need for change is identified, what is the procedure for policy change in the agency?

Other

- Is there anything else that we have not asked you about that you would like to express to the legislature? What are the major areas where you feel that child welfare in Nevada needs improvement?

APPENDIX F
Recommendations from Action Plans and Blue Ribbon Panel Report

Highlighted recommendations indicate items that could be attributed to action by the child welfare agencies.

Clark County

Recommendations	Evaluation Notes
A3. Develop interagency coordinated investigation protocols for deaths involving abuse and neglect.	Marked as complete - Child Fatality Task Force Protocols
A4. Provide direct access to the reporting hotline for hospital emergency departments, labor and delivery units and the child protection units; and for all law enforcement agencies.	Marked as complete – not evident in policies and procedures provided to auditors.
B5. Persons associated with a child's death (witnesses & caretakers) in all coroner child death cases should have a full law enforcement and CPS history review.	Marked as complete – unable to determine based on information provided for this audit.
B6. Establish a protocol and utilize available forensic interviewing resources, such as the county child advocacy center, for child witness interviews.	Marked as complete – interview protocol is not specific to this recommendation.
B7. Work to establish a coordinated investigation protocol with CPS, hospital child protection and the Coroner's Office.	Marked as complete – unable to determine based on information provided for this audit.
C1. Establish a county based MD committee meeting quarterly to discuss policy and procedure relating to the scene, autopsy and circumstantial investigation of all fatalities, and to discuss issues related to law enforcement & district attorney disposition of cases.	District Attorney
C9. Acknowledge & utilize CPS as a routine & vital contributor to infant and child death investigation, & utilize their case information in death certification. Include CPS info. in Coroner's investigative report.	Coroner/ME
C10. Require input from CDR agencies…prior to Coroner death certification in infant & child fatalities for cases involving suspicious circumstances, drug exposure & other high risk factors.	Coroner/ME
C11. Ensure mandatory reporting by Coroner's staff to CPS of deaths relating to CAN…	Coroner/ME
C12. Work with hospital community to ensure appropriate referrals to the coroner's office & that a minimum of external examination, or autopsy, of decedents of infants and children who are developmentally delayed or medically challenged.	Coroner/ME
D14. Coroner & law enforcement records should be obtained & referenced in the CPS file on CPS investigations of deceased children and their families.	Progress unclear – practice not evident in case review process.
F5. Require supervisor &/or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, parenting classes ore domestic violence treatment services.	Marked as complete – not specifically evident in policies provided.
G5. DA should hold the dependency judge accountable for following state laws.	District Attorney

H1a. [See C1]	District Attorney
H1f. Each agency should designate one unit to conduct all of the child death investigations and then adequately fund, staff & train these units together. (CPS 0-3 unit and Metro CAN detail)	Marked as complete – not evident in agencies' policies & procedures.
H2a. Convene a statewide joint task force of [experts]…to meet and reach agreement on state laws, policies & standards related to the investigation & prosecution of infants born drug exposed, infants who die from drug exposure, children who die from egregious acts of neglect, and children who die in situations of DV.	State Legislative Issue
H4b. Conduct case audits of CPS cases to address other agency perceptions that CPS under-substantiates cases; & develop multi-agency CAN team to help in the development of Services Plan. Develop strategies to improve communication, collaboration, cooperation and coordination.	Marked as complete – unable to determine based on information provided for this audit.
I1. County CDR team chair convene a meeting of key value to the county and state to assess and re-define membership, agency responsibilities at the meetings, and records that will be shared…	Child Death Review Team responsibility
I2. Coroner and CDR team meeting to improve rapport…	Coroner/ME and Child Death Review Team
C7. Adequately fund the Coroner's Office….	Coroner/ME
D7. Train all CPS investigators so that they understand that a law enforcement &/or coroner investigation does not abrogate CPS responsibility for its own investigation.	Marked as complete – not evident in agencies' policies & procedures.
D11. Specialty medical exams should be mandatory for unexplained injuries on children. Exams should be required before a case can be unsubstantiated and the state should develop a system to fund these exams in full.	Marked as complete – not evident in agencies' policies & procedures. Funding needs identified.
H1e. The CCDFS CAC should be funded and utilized for coordinated forensic interviewing of surviving siblings.	Marked as complete – not evident in agencies' policies & procedures. Funding needs identified.
H3a. Completely assess and overhaul the Hotline system, adequately fund the proposed improvements, develop back door methods for mandatory reporters & develop paper reporting system for follow-up, tracking & quality assurance.	Progress unclear – unable to determine based on information provided for this audit.
H4a. Conduct comprehensive analysis of resource allocations & funding relative to the pressing needs of the entire CW system & push for additional funding, staffing & training. Community forums to garner public support & to highlight needs of county's children.	Marked as complete - unable to determine based on information provided for this audit.
J1. 11 child deaths in out of home care should be reviewed by DHHS or other identified entity.	DHHS
J2. Solicit opinions from case workers involved with the 79 children's cases.	Marked as complete - unable to determine based on information provided for this audit.
J3. Evaluate the qualifications of current staff & hiring requirements.	Marked as complete - unable to determine based on information provided for this audit.
J4. Need additional resources from management. What is happening at the leadership level?	Unclear recommendation

A5. Reform and staff the Hotline to eliminate all waits over 3 minutes.	Progress unclear - not evident in agencies' policies & procedures.
B1. Develop a countywide policy for law enforcement that clarifies when & how fetal & infant deaths due in part to drug intoxication will be investigated.	Law enforcement
B4. Obtain screens and BAC's on all suspicious persons and/or witnesses to a child's death when evidence of illicit drug or alcohol use is present.	DA, Law enforcement
C4. Develop systematic approach to the death certification of fetuses, infants & children. Utilize "undetermined" cause and/or manner of death when appropriate, and cause of death statements with disclaimers such as "undetermined, cannot exclude overlay"…	Coroner/ME
C6. Replace the use of the phrase "no history of SIDS in the family" from the Coroner's investigative report, with "no history of sudden unexplained death."	Coroner/ME
C8. Utilize qualified forensic neuropathologist for the examination of formalin fixed brains of infants…	Coroner/ME
C13. Obtain full body, postmortem x-rays of all fetal deaths, and all unexplained deaths in infancy and childhood.	Coroner/ME
C14. Require that all in-hospital child deaths signed out by hospital physicians are reported to Coroner's Office, and then ensure that a Coroner supervisor and pathologist review all of these "medical sign outs."	Coroner/ME
D1. Create clear standards on what constitutes a child death case that must be open for investigation, and ensure that supervisors are unable to code down any case that meet these criteria.	Marked as complete – not evident in agencies' policies and procedures.
D5. All child deaths and all reports on surviving siblings previously known to CPS that are called into the Hotline should be screened in for at least a preliminary investigation.	Progress unclear – not evident in agencies' policies and procedures.
D8. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.	Marked as complete – not evident in agencies' policies and procedures.
D9. Utilize research based safety assessment tools & ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires 3 days, but as reported earlier most were done months later.	Marked as complete – not evident in agencies' policies and procedures.
D13. Supervisors should ensure that due diligence is followed in locating out of state CPS records at least five years prior to the death in suspicious cases, including identifying prior addresses, contacting states, and reviewing and incorporating out of state information into the case file.	Marked as complete – not evident in agencies' policies and procedures.
E1. Very specific guidelines should be developed and training provided to intake and caseworkers to define substantiation criteria in cases involving child deaths and surviving siblings. Supervisor sign off should be required in these cases.	Marked as complete – not evident in agencies' policies and procedures.
F1. Revise the Case Reporting System for CPS (UNITY) to clearly delineate intake, investigation and services. Current reports from the UNITY system are difficult to read.	DCFS Technical Action
F2. Require a written service plan for all cases that are substantiated.	Progress unclear – agency policy

	requires a "case" plan for all cases.
F3. Create a way to more clearly log all CPS contacts with the families in the UNITY system.	Marked as complete – DCFS/UNITY item; practice not evident in case review process.
F4. Disallow relative placements without going through the formal, legal system, especially when safety assessments are not conducted for those relatives.	Marked as complete – not evident in agencies' policies & procedures.
F6. Require tracking follow-up and written documentation on all referrals for services.	Progress unclear – not evident in agencies' policies & procedures or through the case review process.
F7. Require that when a death occurs on open cases, a new investigation/case record be created.	Progress unclear – not evident in agencies' policies & procedures.
F8. Require that all cases being closed have complete documentation in the case record describing the justification for closing the case.	Progress unclear – not evident in agencies' policies & procedures or through the case review process.
F9. Open cases should not be closed on current children with a mother who is pregnant.	Progress unclear – not evident in agencies' policies & procedures.
G1. Revise the practices established by former chief prosecutor to a pro active pursuit of prosecution.	District Attorney
G3. Re-open the 2002 Shaken Baby Syndrome case and evaluate the cause of death.	District Attorney
G4. Resubmit the probable murder allegedly caused by the toddler for thorough investigation.	District Attorney
H1d. CPS needs to be an active participant in investigation of possible abuse or neglect, and not defer their investigative responsibilities to the coroner or law enforcement.	Marked as complete – not evident in agencies' policies & procedures.
J5. Evaluate the training available to child welfare workers.	Included in PIP action steps – unable to determine based on information provided for audit.
J6. Evaluate the supervision requirements/job duties in child welfare offices.	Marked as complete - unable to determine based on information provided for audit.
K9. Share the Safety Assessment findings with NRC CPS.	Unclear recommendation
A2. Clarify and if necessary strengthen state law & policy to require mandatory reporting to CPS when a child dies due in part to neglect or abuse, even though there are no surviving siblings, and provide training on this to mandatory reporters.	State Legislative Issue
B2. Develop policy to ensure that law enforcement is notified by either the coroner or hospitals and then conducts complete investigations in natural deaths that have elements of suspicion or in which an infant was in a high risk setting.	Coroner/ME, Law enforcement
B3. Develop countywide law enforcement policy to ensure that all child death autopsies are attended by law enforcement.	Coroner/ME, Law enforcement

C2. Appoint a chief medical examiner to set policy and procedure for the forensic division of the office, to assist in the development of office philosophy and the development of consistency amongst the pathologists in the certification of cause and manner of death for fetal, infant and child fatalities.	Coroner/ME
C3. Revise current investigative and autopsy protocols for the evaluation of infant and child fatalities, based on the new SUIDI form set forth by the US Centers for Disease Control.	Coroner/ME
C5. Exclude Sudden Infant Death Syndrome for cases with "disconcerting" red flags in the history, including a significant threat of maternal or other adult overlay with the presence of intoxication, obesity, relatively small bed, or other significant competing unnatural causes of death.	Coroner/ME
D2. Implement a policy that decisions to initiate an investigation when a child dies in made within 24 hours.	Progress unclear – not evident in agencies' policies and procedures.
D3. Consider amendments to state policy so that all infants born positive for illicit drugs or with evidence of fetal alcohol are substantiated and remain open for at least 6 months.	State Legislative Issue
D4. Revise CPS policy so that a CPS full on-scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision and on all deaths designated as undetermined by the Coroner's office.	Marked as complete – not evident in agencies' policies and procedures provided for audit.
D10. A forensic interview protocol should be developed for surviving siblings and siblings should be interviewed according to forensic techniques, separately from other siblings and potential perpetrators; consider using the CCDFS CAC for all of these sibling interviews.	Progress unclear – not evident in agencies' policies and procedures provided for audit.
D12. A formal policy and procedure should be developed and utilized when parents or potential perpetrators cannot be contacted, following the death of a child. This should include filing of a petition for pick up if the death was due to potential abuse or neglect and automatic substantiation if the potential perpetrators have disappeared.	Marked as complete – not evident in agencies' policies and procedures provided for audit.
E2. Create a separate category of "unable to locate".	DCFS – Legislative Issue
G2. Institute a policy that all cases investigated by law enforcement, the coroner and CPS be brought to the DA for review.	Progress unclear – not evident in agencies' policies and procedures.
H2b. Revise CPS policy to always fully investigate the safety of surviving siblings in potential child abuse and neglect fatalities, and change policy so that in the event of a child abuse death, a case is investigated and substantiated even when there are no siblings.	Marked as complete – not evident in agencies' policies and procedures provided for audit.
H2c. Consider establishing a New Birth Match program, modeled after the state of Michigan's. This program results in notification to CPS of new births from parents with a prior history of CPS when termination of parental rights and/or history of child fatality has occurred.	DCFS – not a feasible recommendation for NV at this time
I3. Revise state statute to permit public meetings to be closed at the state team level when needed to discuss confidential child specific cases.	State Legislative Issue
I4. Revise state statute to combine Executive Committee to Review Child Deaths and the Administrative Team to one state level review team.	State Legislative Issue
K2. Add to statute a new section defining maternal substance misuse.	State Legislative Issue

K7. Educate mandatory reporters that they are required to report suspected child abuse and neglect when a child dies.	Progress unclear – unable to determine based on information provided for this audit.
K8. If maternal substance misuse observed as a contributing factor on a child's death, this should be grounds for substantiation. Change statute and policy so that substantiation requirements are clearer on this issue. Reorganize all substance abuse statute information into on section in NRS.	State Legislative Issue
K12.New legislation should include illegal drugs and alcohol. Propose legislative language revisions to NRS432B to expand prenatal illegal drug use to include alcohol misuse.	State Legislative Issue
K13. Safety assessments must be preformed on surviving siblings within 24 hours of the fatality or near fatality.	Marked as complete – not evident in agencies' policies and procedures provided for this audit.
K14. Add to diligent search policy a requirement for CPS records requests to other sates for families residing in Nevada for less than 5 years.	Marked as complete – not evident in agencies' policies and procedures provided for this audit.
K15. If one child dies, substantiate on all of the children due to emotional abuse of surviving siblings.	Marked as complete – not evident in agencies' policies and procedures provided for this audit.
K16. Substantiated cases should all have a case plan unless it is determined unnecessary by a supervisor.	Marked as complete – agency policy indicates that this is required.
K17. A child death must be entered into UNITY as a new report. This should be added to the intake policy.	Marked as complete - not evident in agencies' policies and procedures provided for this audit.
Ensure correct child fatality data is obtained by CCDFS caseworkers or other identified staff and recorded into the statewide data system (ie: name spellings, dates of death, and causes of death).	Practice not consistent in case review process.
Ensure complete case information and proper case closures (incomplete or missing data elements, lack of detail in case notes, substantiation errors & improper case closures noted).	Practice not consistent in case review process.
Increase internal data integrity by establishing a system of cross-checks between UNITY, Child Neglect Systems (CANS), the county courtesy notifications database, and CDR team data.	Progress unclear – unable to determine based on information provided for this audit.
Link child fatality data with other DCFS systems of care (CPS, juvenile justice services, mental health).	Progress unclear – unable to determine based on information provided for this audit.
If CCDFS workers are not seasoned social workers then the appropriate ratio should be less than 1:5 due to the need for additional supervisory oversight. Caseload ratios must be examined by a team of external & internal experts to apply best practices in accordance with local needs & national standards published by	Progress unclear – not evident in agencies' policies and procedures. Practice not evident through case

CWLA. Including management to supervisor to caseworker ratios.	review, interview or focus group process.
CCDFS should recruit and hire staff with degrees in social work.	Progress unclear – not evident in agencies' policies and procedures. Practice not evident through case review, interview or focus group process.
Clark County must improve and streamline the licensing and recruitment processes and provide ongoing support for foster parents, in accordance with the Safe Futures document.	Progress unclear – unable to determine based on information provided for this audit.

Washoe County

Recommendation	Evaluation Notes
A1. Clarify and if necessary strengthen state laws and policies regarding definitions for abuse and neglect in fetal and infant deaths caused in part by maternal drug use or other lifestyle issues that could cause harm to infants.	State Legislative Issue
A2. Clarify and if necessary strengthen state law & policy to require mandatory reporting to CPS when a child dies due in part to neglect or abuse, even though there are no surviving siblings, and provide training on this to mandatory reporters.	State Legislative Issue
A3. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting guidelines.	Progress unclear – unable to determine based on information provided for this audit.
A4. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Child Advocacy Center model.	Progress unclear – unable to determine based on information provided for this audit. Funding needs identified.
A5. Identify funding for and recruit a trained forensic pediatrician.	Progress unclear – unable to determine based on information provided for this audit. Funding needs identified.
B1. The state should adopt, provide training on and enforce utilization of the new national guidelines for Sudden and Unexplained Infant Death Investigation & provide training throughout the state to law enforcement and death investigators.	Coroner/ME, Law enforcement
B2. Two cases of possible abuse and/or neglect should be submitted to the DA for review and further investigation conducted.	District Attorney
B3. Law enforcement should establish a policy to notify CPS on every child death they investigate,	Law enforcement

regardless of cause and manner.	
C1. Establish a state level study group & consult with experts from the national Association of Medical Examiners & the CDC to explore the feasibility of abolishing the state's county-based coroner system and replacing it with a state medical examiner system.	DCFS, State of NV
C2. All children in state custody should have full death investigations through the coroner's office, regardless of suspected cause of manner.	Coroner/ME
C3. Cause of death statements should always be listed by forensic pathologist on autopsy reports, prior to review by the coroner's office.	Coroner/ME
C4. Coroner should not change cause/manner statements from forensic pathologists without first meeting with pathologists to address scene circumstances & autopsy together prior to certification & consider a mechanism to also have a deputy coroner available to "sign off" on all cases.	Coroner/ME
C5. Establish improved communication & collaboration between the coroner & pathologists, and between coroner & CPS and law enforcement. Recommend that all deputy coroner investigative reports to the pathologists include mention of CPS and law enforcement involvement, as this information must be provided to the pathologist prior to death certification.	Coroner/ME
C6. Allot time and money to allow death investigators to attend local, regional and state and national trainings and meetings.	Coroner/ME
C7. Comprehensive toxicology testing and metabolic studies should be conducted rather than the basic panel tests currently being conducted, on most infants and children under age 18.	Coroner/ME
C8. Neuropathology consultation on formalin fixed brains should be obtained especially on potential abusive head injury deaths and for instances of hypoxic/ischemic encephalopathy.	Coroner/ME
C9. Consider using terms on death certificate other than SIDS, such as "sudden unexplained death in infancy/undetermined" when intense petechiae, CPS issues, co-sleeping or other unsafe sleep environment issues are present.	Coroner/ME
C10. Re-open for investigation at least one case.	Coroner/ME, Law enforcement, District Attorney
C11. Establish a policy and procedure with reference to organ procurement, and involve law enforcement and the DA.	Coroner/ME, Law enforcement, District Attorney
D1. Create clear standards on what constitutes a child death case that must be open for investigation, and ensure that supervisors are unable to code down any case that meets these criteria.	Included in agency policies and procedures.
D1a. CPS must investigate subsequent reports on cases where another child in the family had died.	General provisions included in agency policies and procedures.
D1b. CPS should investigate all reports of possible medical neglect, regardless of if the death occurs in a hospital.	Progress unclear – not evident in agencies' policies and procedures.
D1c. A full CPS on-scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision.	Included in agency policies and procedures.

D1d. All deaths designated as undetermined by the Coroner's Office must be investigated by CPS.	Included in agency policies and procedures.
D1e. All deaths with prior CPS substantiations or at least three prior reports must be investigated by CPS.	Progress unclear – not evident in agencies' policies and procedures.
D2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.	Progress unclear – not evident in agencies' policies and procedures. Funding needs identified.
D3. CPS should not defer their investigations to law enforcement and should immediately assess safety of surviving siblings. Train all CPS investigators so that they understand that a law enforcement and/or coroner investigation does not abrogate CPS responsibility for its own investigation.	Progress noted in action plan – unclear in agencies' policies and procedures.
D4. Implement a policy that decisions to initiate an investigation when a child dies is made within 24 hours.	Progress unclear – not evident in agencies' policies and procedures.
D5. Consider amendments to state policy so that all infants born positive for illicit drugs or with evidence of fetal alcohol are substantiated and remain open for at least 6 months.	DCFS, State Legislative Issue
D6. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.	Unable to determine status based on information provided for audit.
D7. Utilize research based safety assessment tools and ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires 3 days.	Progress unclear – not evident in agencies' policies and procedures.
D8. A forensic interview protocol should be developed for surviving siblings & siblings should be interviewed according to forensic techniques, separately from other siblings & away from parents & potential perpetrators; consider using a CAC model for all of these sibling interviews.	Progress unclear – not evident in agencies' policies and procedures. Funding needs identified.
D9. Supervisors should ensure that due diligence is followed in locating out of state CPS records at least five years prior to the death in suspicious cases, including identifying prior addresses, contacting state, and reviewing and incorporating out of state information into the case file.	Progress unclear – not evident in agencies' policies and procedures.
E1. Very specific guidelines should be developed & training should be provided to intake and caseworkers to define substantiation criteria in cases involving child deaths and surviving siblings. Supervisor sign off should be required in these cases.	Progress unclear – not evident in agencies' policies and procedures.
E2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.	Unclear recommendation
F1. Revise the CPS Case Reporting System including the UNITY system so that intake, investigation, case plans, referrals and services are clearly delineated and can be categorized on a time scale.	DCFS, UNITY
F2. Require a written service plan for all cases that are substantiated.	Required in agency policies and procedures.
F3. Create a way to more clearly log all CPS contacts with the families.	Unable to determine status based on information provided for audit.
F4. Require supervisor and/or judicial approval prior to allowing reunification of parents who do not	Progress unclear – not evident in

complete required substance abuse treatment, mental health treatment, or domestic violence.	agencies' policies and procedures.
F5. Require tracking and follow up on all referrals for service.	Progress unclear – not evident in agencies' policies and procedures.
F6. Require that when a death occurs on open cases, a new investigation/case records be created.	Progress unclear – not evident in agencies' policies and procedures.
F7. Require that all cases being closed have complete documentation in the case file describing the justifications for closing the case.	Progress unclear – not evident in agencies' policies and procedures. Case review process identified room for improvement in documentation.
F8. Establish a high level, independent review (separate from licensing and CPS) of all deaths and serious injuries occurring in any licensed foster home and/or in adoptive home that have more than one special needs and/or medically fragile child.	Unable to determine status based on information provided for audit.
G1. Institute a policy that all child death cases investigated by law enforcement, the coroner and CPS are brought to the DA for their review.	Progress unclear – not evident in agencies' policies and procedures.
G2. Reinstate the position of a dedicated DA for child abuse and neglect cases on a 24/7 basis.	District Attorney
G3. Reinvestigate cases described above and consider for prosecution.	District Attorney
G4. Require mandatory training on domestic violence laws and policies for attorneys.	District Attorney
G5. Review and utilize NV Evidence Code Section that allow for prosecution in corpus delicti cases.	District Attorney
G6. DA's office should take leadership in aggressively pursuing establishment of a child advocacy center for multidisciplinary, coordinated child abuse investigations and in hiring a county-funded forensic pediatrician.	District Attorney

Rural Nevada - DCFS

Recommendations	Evaluation Notes
A1. Clarify and if necessary strengthen state law & policy to require mandatory reporting to CPS when a child dies due in part to neglect or abuse, even though there are no surviving siblings, and provide training on this to mandatory reporters.	State Legislative Issue
A2. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting guidelines.	Progress unclear – unable to determine based on information provided for this audit.
A3. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Child Advocacy Center model.	Progress unclear – unable to determine based on information provided for this audit.
B1. The state should adopt, provide training on and enforce utilization of the new national guidelines for Sudden and Unexplained Infant Death Investigation & provide training throughout the state to law enforcement and death investigators.	Coroner/ME, Law enforcement

B2. One case of possible abuse and/or neglect should be submitted to the multidisciplinary team for possible neglect or abuse charges.	District Attorney
B3. State should provide rural law enforcement with training on mandatory reporting and need to notify CPS on every child death they investigate, regardless of cause and manner.	Progress unclear – unable to determine based on information provided for this audit.
C1. Establish a state level study group & consult with experts from the national Association of Medical Examiners & the CDC to explore the feasibility of abolishing the state's county-based coroner system and replacing it with a state medical examiner system.	Coroner/ME, State of NV
C2. Allot time and money to allow death investigators to attend local, regional and state and national trainings and meetings.	Coroner/ME
C3. Comprehensive toxicology testing and metabolic studies should be conducted rather than the basic panel tests currently being conducted, on most infants and children under age 18.	Coroner/ME
C10. Re-open for investigation at least one case.	District Attorney
D1. Create clear standards on what constitutes a child death case that must be open for investigation, and ensure that supervisors are unable to code down any case that meets these criteria.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D1a. CPS must investigate subsequent reports on cases where another child in the family had died.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D1b. A full CPS on-scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D1c. All deaths designated as undetermined by the Coroner's Office must be investigated by CPS.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D1d. All deaths with prior CPS substantiations or at least three prior reports must be investigated by CPS.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D3. CPS should not defer their investigations to law enforcement and should immediately assess safety of surviving siblings. Train all CPS investigators so that they understand that a law enforcement and/or coroner investigation does not abrogate CPS responsibility for its own investigation.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
D4. Implement a policy that decisions to initiate an investigation when a child dies is made within 24 hours.	Included in agencies' policies and procedures.

D5. Re-open a possible homicide case.	District Attorney
D6. Review policies regarding contact with other states and develop a quality improvement plan to address out-of-state referrals and notification.	Progress unclear – unable to determine based on information provided for this audit.
D7. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.	Progress unclear – unable to determine based on information provided for this audit.
D8. Utilize research based safety assessment tools and ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires 3 days.	Safety assessment tool included in policies and procedures; policy on surviving siblings not evident in agencies' policies and procedures provided for this audit.
D9. A forensic interview protocol should be developed for surviving siblings & siblings should be interviewed according to forensic techniques, separately from other siblings & away from parents & potential perpetrators; consider using a CAC model for all of these sibling interviews.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
E1. Very specific guidelines should be developed & training should be provided to intake and caseworkers to define substantiation criteria in cases involving child deaths and surviving siblings. Supervisor sign off should be required in these cases.	Substantiation criteria included in policies and procedures; specifics of this recommendation unclear.
E2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.	Unclear recommendation
F1a. Have specially trained CPS staff who are familiar with the risk factors of abuse among children with disabilities. These staff should also have training in best practice of communicating with children with disabilities and importance of interviewing these children separate from their caregivers (professional or family).	Progress unclear – unable to determine based on information provided for this audit.
F1b. Children with disabilities placed in foster care should be visited frequently to assess safety and well-being. Foster parents should be required to have a special care training before children with disabilities are placed with them.	Progress unclear – unable to determine based on information provided for this audit.
F1c. Any reports of child abuse, physical or sexual, should be thoroughly investigated with interviews that support the child's communication abilities.	Progress unclear – unable to determine based on information provided for this audit.
F2. Revise the Case Reporting System for CPS to clearly delineate intake, investigation, case plans, referrals and services.	Progress unclear – unable to determine based on information provided for this audit.
F3. Require a written service plan for all cases that are substantiated.	Agency policy requires written case plans.
F4. Create a way to more clearly log all CPS contacts with the families.	Progress unclear – unable to

	determine based on information provided for this audit.
F5. Require supervisor and/or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, mental health treatment, or domestic violence.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
F6. Require tracking and follow up on all referrals for service.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
F7. Require that all cases being closed have complete documentation in the case record describing the justifications for closing the case.	Case closure policies require documentation; case review process indicates that improvements in documentation are needed.
The state's UNITY data system must be examined by a team of internal and external experts to determine the necessary changes to ensure it is user-friendly, streamlined, produces adequate hard copy documents in order to analyze the flow of the case, and produces management reports that can be used effectively as a management tool.	Progress unclear – unable to determine based on information provided for this audit.
State standards must be set regarding the recruitment, staffing, caseload levels and training required for child welfare workers. Funding must be provided.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
The state must ensure that all child welfare workers successfully complete core child welfare training followed by ongoing advanced practice skills development such as the establishment of a statewide certificate of completion in Child Welfare Core Training.	Progress unclear - not evident in agencies' policies and procedures provided for this audit.
A workload study must be completed to determine the actual number of workers needed to provide quality intensive services and to determine the actual amount of activity and intensity of work required to engage families that is fueled by best practice expectations.	Progress unclear – unable to determine based on information provided for this audit.

APPENDIX G
Program Improvement Plan
Outcome Measures and Items Not Achieved by June 2007

CP = Statewide Collaborative Policy approved by the DMG (all three child welfare agencies)

Safety Outcome 1 – Item 1: Timeliness of initiating investigations of reports of child maltreatment	
Action Steps	Evaluation Notes
1.1: The State will have a standardized CPS intake-screening instrument that ensures that reports of child maltreatment are accurately and timely dispositioned by tracking response timelines and developing categorized response criteria.	No standardized intake-screening tool evident in Audit; CP on Intake includes components of tracking response times and response criteria.
1.2: The State will have standardized Statewide policy and practice guidelines on responding to reports of abuse.	CP on Intake includes minimum response criteria and explanations of "present danger" and "foreseeable danger".
Safety Outcome 1 – Item 2: Repeat Maltreatment	
2.1: The State will revise and implement standardized criteria and practice guidelines for substantiation of reports of maltreatment.	CP on Substantiation (9/05) (the CP references addressing this PIP item)
2.2: The State will have in place a mechanism for analysis of multiple reports of maltreatment on a family.	CP on Intake includes brief note on including multiple reports.
2.3: The State will review, revise and enhance the use of a Statewide, standardized safety assessment tool.	CP on Safety Assessment and CP on Assessment Process; NV Safety Assessment Tool included in policies.
2.4: The State will have standardized risk assessment criteria and a risk assessment tool.	CP on Family Risk Assessment Protocol (FRAP)
2.5: The State will have standardized criteria regarding case closure.	CP on Case Closure includes criteria and guidelines for case closure.
Safety Outcome 2 – Item 4: Risk of Harm	
4.1: The State will review, revise and enhance the use of a Statewide, standardized safety assessment tool. (See Item 2, Action Step 2.3)	CP on Safety Assessment and CP on Assessment Process; NV Safety Assessment Tool included in policies.
4.2: The State will have standardized risk assessment criteria and a risk assessment tool. (See Item 2, Action Step 2.4)	CP on Family Risk Assessment Protocol (FRAP)
4.3: Develop policy for the following definitions: immediate, timeliness, face to face contact, new reports, initiating investigations and appropriate criteria for case closure. (See Item 1, Action Step 1.2 and Item 2, Action Step 2.5))	All definitions, except "immediate" are found in CP on Intake, additional reference to "face to face" found in CP on Caseworker Contact; CP on Case Closure includes criteria and guidelines for case closure.
Permanency Outcome 1 – Item 7: Permanency Goal for Child	
7.1: Establish a Statewide case planning process to increase the appropriate use of concurrent case planning.	CP on Case Planning, includes Concurrent Planning Practice Guidelines; NV Concurrent Planning Guide 2007 also included in policy documents.
7.2: The State will strengthen policy and practice on early identification, diligent search efforts and assessment of parents, non-custodial parents, relatives, and other placement resources for the purposes of placement, adoption, or other planned permanent arrangement.	CP on Diligent Search and Placement Decisions (references a "Diligent Search Resource Handbook" – not provided in policy documents for audit), includes assessment of suitability; CP on Kinship Care.