

**Child Protection Accountability  
Commission  
("CPAC")**

**CASELOADS/WORKLOADS  
SUBCOMMITTEE**

**FINAL REPORT**

**April 8, 2008**

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# MISSION

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The mission of the CPAC Caseloads/Workloads Subcommittee (“Subcommittee”) is to evaluate the caseloads and workloads of the Division of Family Services’ (“DFS”) workers and provide recommendations for change to CPAC, as appropriate. In so evaluating these caseloads and workloads, consideration should be given to the workloads of the Courts, the Attorney General’s Office (“DOJ”), the Office of the Child Advocate (“OCA”) and others. The Subcommittee should look at the following issues: (1) a local workload study; (2) DFS’ portal of entry for acceptance and investigation of cases; and (3) DFS’ transfer of cases for treatment services with special consideration given to the differences between low/moderate risk, high/very high risk and foster care cases.

This mission was developed by CPAC at its January 2006 meeting and reiterated and adopted again by both CPAC and the Child Death, Near Death and Stillbirth Commission (“CDNDSC”) at their joint meeting in May 2006. When using the term “caseload”, the Subcommittee is referring to the number of cases each DFS worker should have. When referring to the term “workload”, the Subcommittee is referring to the concomitant work generated by each case.

# EXECUTIVE SUMMARY

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Caseloads/Workloads<sup>1</sup> have historically impacted the work of child welfare systems across the nation. In response to child deaths and near deaths in Delaware as well as mounting expectations both at the state and national levels, Senate Bill 142 (“SB142”) was enacted in 1998. SB142 for the first time codified the caseload standards of 14 investigation cases per Division of Family Services (“DFS”) caseworker plus 10%, 18 treatment cases per DFS caseworker plus 10%, one supervisor for every five workers and 140 cases per licensing specialist plus 10%. Despite these standards, additional caseload/workload reduction was deemed necessary and Senate Bill 265 (“SB265”) was introduced and passed in 2004. SB265 removed the “plus 10%” and required caseloads be calculated by regions and fully functioning workers.

Despite these changes, caseloads/workloads have continued to impact the safety of children as demonstrated by child death and near death reviews, and by feedback from the DFS frontline workers. In January 2006, the Child Protection Accountability Commission (“CPAC”) agreed to reconvene the SB142 Subcommittee, renaming it the CPAC Caseloads/ Workloads Subcommittee, and charged it with the mission outlined on the previous page.

The CPAC and its Caseload/Workload Subcommittee, through multidisciplinary collaboration, research, and discussion, makes the following recommendations to CPAC:

- 1. CPAC recommends that the DFS treatment caseload standard be eventually lowered from 18 to 12 through a phased-in implementation of these standards beginning with Fiscal Year 2009. Legislation and a fiscal plan have been drafted in the form of SB180.**
- 2. CPAC recommends that the Subcommittee provide feedback to the Family Court regarding opportunities for improvement which the Court will then internally review.**
- 3. CPAC recommends that the portal of entry for the screening and investigation of suspected child abuse and neglect in Delaware remain as it is, and that the child protection community continue to educate professionals and the public on the reporting of suspected child abuse and neglect.**
- 4. CPAC’s Caseloads/Workloads Subcommittee recommends that concurrent with a reduction of DFS treatment caseloads from 18 to 12, the Division of Family Services, along with its stakeholders and system partners, foster its Public/Private Community Partnerships with the goal of contracting out all the intact family treatment cases to the private sector. In order to effectuate this change, the Subcommittee recommends once the fiscal climate improves which will enable funding of this recommendation, that a workgroup be convened, comprised of child welfare system stakeholders and those with relevant expertise, to establish the guidelines by which the PPCP will operate in Delaware.**

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<sup>1</sup> When using the term “caseload”, the Subcommittee is referring to the maximum number of cases each DFS worker should have. When referring to the term “workload”, the Subcommittee is referring to the concomitant work generated by each case.

The conclusions and recommendations reached by the Subcommittee are a result of in-depth examinations of the impacts on caseloads/workloads, both current and anticipated; the various components of the child welfare system; the workloads of child protection partners; the DFS workload study of 2004 as well as those conducted by other states/agencies; the DFS portal of entry and how treatment cases are handled both in Delaware and around the country.

### *Impacts on Caseloads/Workloads*

There have been numerous changes within child welfare over the past decade, all having a positive impact on the outcomes for children and their families. However, with these federal, state, and policy changes, has come with ever-increasing expectations of child protection staff.

Federal laws that have impacted the child protection system include the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Adoption and Safe Families Act of 1997 (“ASFA”). The Child and Family Service Review (“CFSR”) also impacts casework as recommendations for change come forward as has the ICPC Act of 2006, described on page 12. Statutory changes impacting caseloads/workloads include the McKinney Vento Act and the Child Protection Registry.

New and expanded Department of Services for Children, Youth, and their Families (“DSCYF”) policies also impact the caseloads and workloads of caseworkers. For instance, both System of Care Partnerships and DSCYF Policies 201 and 209 (described on page 13 and 14) have the capacity to increase workload.

Concurrently, Court expectations have increased for children in DFS custody and children in their own homes for which a custody investigation is requested.

Finally, the various quality assurance mechanisms in place, DFS’ quality assurance system, child death and near death reviews and recommendations, and root cause analyses, all create additional caseload and workload issues.

The Subcommittee also took into account the future impacts on child protection caseloads and workloads. Child Death Near Death and Stillbirth Commission (“CDNDSC”) recommendations and changes, both effectuated and proposed, to Delaware Code have the potential to impact caseloads and workload. In addition to these future impacts, the federal Child and Family Services Improvement Act of, the federal Child and Family Services Review which has generated DFS’ Performance Improvement Plan, intact family policy considerations, mental health needs of children in foster care, mixing recommendations, and Title IVE candidacy all carry implications for caseworker caseloads and workload.

### *Components of the Child Welfare System*

Given the impact that the above-mentioned changes have on how child protection cases are handled civilly by the Court, the Subcommittee found it important to also describe the role of each component of the child protection system. Knowledge of the DSCYF, Family Court, DOJ, OCA, the Court Appointed Special Advocate Program (“CASA”), and Contract Counsel for Indigent Parents will enable all to comprehend how DFS legal custody cases move through the legal system, and facilitate the understanding of how any change to DFS workloads will impact the other core components of the legal system.

### *Workload of System Partners*

How Delaware's child protection partners are faring with their own workloads, and how their involvement and action in DFS legal custody matters impacts the workloads of DFS and vice versa is critical to any evaluation of the child protection system. With resources so precious, it is important to ascertain how proposed changes may impact the system partners. However, it is also critical to remember that results from the death and near death reviews indicate that the shortage of time by workers, and the priority court cases take, has created increased risk to children in intact families. **In light of the Subcommittee's review of the workload of system partners, CPAC recommends that the Court continue its participation on the Subcommittee and bring those suggestions regarding workload back to the Court. The Court would then like an opportunity to internally review processes and procedures and provide feedback.**

### *Division of Family Services Workload Study*

Building on the knowledge gleaned from the Action for Child Protection Forum, the Subcommittee began by reviewing workload studies and standards from across the country. Initially, the Subcommittee contemplated conducting a workload study in Delaware, but then determined it could employ the studies done by other states, use the information gleaned from the 2004 DFS time allocation study, and conservatively calculate the time required to handle investigation and treatment cases in Delaware.

**In doing so, the Subcommittee recommended that the caseload standard for DFS investigation workers be lowered from 14 to 11 cases per worker.** This was effectuated in July 2007, by Senate Bill 113 ("SB113"). **Furthermore, the Subcommittee recommends the caseload standard for DFS treatment workers be lowered from 18 to 12 cases per worker.** Senate Bill 180 ("SB180") has been drafted and introduced. While a caseload reduction for DFS investigation caseworkers does not require additional staff to implement, the recommended caseload standard for DFS treatment workers does.

Based on the conservative proposed caseload standard of 11 cases per investigation worker and 12 cases per treatment worker, DFS would need **31** additional treatment positions statewide. Given the extreme nature of such a request, the Subcommittee is pursuing a phased-in implementation of this standard beginning with Fiscal Year 2009.

### *Portal of Entry Analysis*

In order to potentially mitigate the need for 31 additional DFS caseworkers, the Subcommittee examined whether or not the portal of entry for child maltreatment reports needed to be adjusted.

Virtually all states screen child maltreatment referrals. In fact, only the District of Columbia reports that they investigate all child maltreatment allegations.

While the Subcommittee looked at a variety of options and considered the benefits and risks of narrowing Delaware's portal of entry, i.e., what cases it screens and investigates for possible abuse or neglect, the Subcommittee was uncomfortable with narrowing the portal of entry, **recommending that the portal of entry for the screening and investigation of suspected child abuse and neglect in Delaware remain as it is, and that the child protection community continue to educate professionals and the public on the reporting of suspected child abuse and neglect.**

## *Treatment Triage*

Given that narrowing the portal of entry was not an option and DFS caseworkers have an increasingly complex and expanding workload, the Subcommittee next looked at how DFS cases transferred for treatment services could be handled differently in order to lessen the need for 31 DFS caseworker positions and continue to strengthen the ability of the child welfare system to meet the needs of Delaware's children and families.

The Subcommittee began its review of how and what cases DFS transfers from investigation to treatment. DFS began by apprising the Subcommittee that based upon a manual review of every case being transferred from investigation to treatment for a 90 day period in the Spring of 2006, there were very few low risk cases. The Subcommittee, therefore, concluded that there was not a need to explore the elimination of low risk treatment services.

The Subcommittee then focused on how states around the country are handling their child protection treatment cases, and whether or not the possibility of partnering with the private sector to deliver child protection services is an avenue that Delaware should explore. The Subcommittee learned that 39 states across the country have made attempts to contract child welfare services, ranging from pilot projects to complete privatization. Furthermore, the United States Department of Health and Human Services, Administration for Children, Youth, and Families conducted a survey of states (n=46) in 2000 which found that 90% of responding states use private providers to deliver child welfare services.<sup>2</sup>

In the context of the potential benefits and disadvantages of contracting out child welfare services and the array of services DFS currently contracts with the private sector to provide, the Subcommittee examined all the child welfare functions offered by DFS. Intake, Investigation, Intact Family Treatment, Foster Care Treatment, Foster Care Coordination, Adoption, and Another Planned Permanent Living Arrangement ("APPLA") were assessed using the following variables: best practice, public expectations and beliefs, which states have created PPCPs to deliver the function, what are the outcomes in those states, Court involvement, CFSR outcomes, after-hours involvement, and staffing considerations.

**Ultimately, the CPAC Caseloads/Workloads Subcommittee recommends that concurrent with a reduction of DFS treatment caseloads to 12, the Division of Family Services, along with its stakeholders and system partners, foster its Public/Private Community Partnerships with the goal of contracting out all the intact family treatment cases to the private sector. In order to effectuate this change, the Subcommittee recommends that a workgroup be convened, comprised of child welfare system stakeholders and those with relevant expertise, to establish the guidelines by which the PPCP will operate in Delaware. A fiscal plan will be provided as appropriate.**

Acknowledging the financial constraints currently facing Delaware, the Subcommittee puts forth these recommendations as a blueprint for the remediation of the caseloads and concomitant workloads of Delaware's child welfare system. The dedicated support and involvement of Delaware's child welfare system partners has helped to strengthen the response to children and families in need in the past and will continue to do so as the first state evolves its system in a creative and fiscally prudent manner.

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<sup>2</sup> United States Department of Health and Human Services, Administration of Children, Youth and Families. 2001.

With the recommendations set forth in this document, the hope is that all children and families touched by the child welfare system will be better served and those serving them will be better supported as they do so.

# BACKGROUND

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## Prior Legislation Regarding DFS Caseloads/Workloads

The Subcommittee began its work by briefly discussing the history of Senate Bill 142 (“SB142”) and Senate Bill 265 (“SB265”). Senate Bill 142 was enacted in July of 1998. SB142 for the first time codified the caseload standards for DFS workers, child care licensing specialists and DFS supervisors. SB142 was the result of the 1997 death of Bryan Martin, and caseload issues were again recognized in the 1998 death of Tytyana Kennedy. SB142 provided for 14 investigation cases per worker plus 10%, 18 treatment cases per worker plus 10%, one supervisor for every five workers and 140 cases per licensing specialist plus 10%. After several more reviews of child deaths and near deaths, as well as reports from frontline workers on caseloads/workloads, in 2003 CPAC convened the CPAC SB142 Subcommittee to review caseloads of frontline workers. Led by Senator Blevins, the Subcommittee’s work ultimately resulted in the passage of SB265 in 2004. SB265 removed the plus 10% and required caseloads be calculated by regions and fully functioning workers. Actual caseload standards remained at 14 for investigation and 18 for treatment. The bill, now law, also moved the previously established caseworker career ladder into statute. During the work of the SB142 Subcommittee, a rudimentary time allocation study was completed by DFS to enable the Subcommittee to better understand how workers were spending their time.

## Action for Child Protection Forum – December 2005

In December of 2005, four Delaware representatives attended a national forum in New Mexico wherein 20 states had stakeholders present. The members attended 14 general sessions from 9 a.m. to 4:00 p.m. each day. The presentations in these sessions focused on child protective workload studies, state and federal budget funding, caseload management, reduced paperwork, the concept of child protection verses child welfare, class action lawsuits to establish manageable workloads and the “portal of entry.”

All four attendees shared a renewed sense that Delaware is on the cutting edge of many of these issues and were surprised when Delaware asked other states representatives how the Court Improvement Project process had impacted their workloads, only to find that many had not implemented this program of judicial review at all.

The forum discussed the reality that unlimited funding will never be available in child protection and that, on some level, DFS may be staying in cases where, statistically, child protection intervention does not make a difference. Quotes included “We make promises that we cannot keep to ourselves and our legislators;” “We need to seriously consider the intrinsic social work “need” to help everybody and target those that statistics show you can help;” “If we can’t meet the current demand, don’t open the door to families never previously served.”

Additionally, at the forum there was much discussion about a Wisconsin study. Specifically, the study found that for cases at the conclusion of a DFS investigation which were determined to be low or moderate risk (and for which no grounds to obtain custody were present), transferring the case to treatment was a waste of time and resources. Specifically, even for families who wholeheartedly and readily agreed to engage in the services provided by treatment, there were no statistical outcome differences – i.e., it did not reduce the percentage chance of a family returning to child protection for

another investigation. The deduction that can be drawn is that it is most effective to target the high risk and very high risk cases where families are left intact, and load those families with services. Statistics show that outcomes are improved where contacts are increased. Additionally, many states have statutes which permit the state to take legal custody of children as the consequence for high risk and very high risk families who fail to cooperate.

The forum suggested that workload studies can be very helpful in determining portal of entry, workload numbers and caseload numbers. Based on the three to four workload studies presented as part of the conference, Delaware realized that its rudimentary time allocation study did not evaluate case best practices. Given this new information, a preliminary calculation was done for a DFS treatment worker as described below which showed the vast discrepancy between current expectations and practical realities:

A treatment worker works 131 hours/month. Without actually looking at the time, the team guesstimated that 86% of that time was spent on casework – which is likely grossly overestimated as most states average 60-65%. [The Subcommittee learned that, according to the 2004 DFS time allocation study, only 59% of a worker’s time is spent on casework]. If a treatment worker has 18 cases in a given month (and they usually have more), he/she has 6.25 hrs to spend on each case using the 86% figure.

$$131 \text{ hours/month} \times 86\% = 6.25 \text{ hours per case}$$

Now looking at one case: The treatment worker goes to a court hearing – scheduled for one hour, waits a half an hour for it to start, goes in for 1.5 hours and travels to and from the Court for one-half hour, spending 3 hours total. At that hearing, the judge orders visits between parents and child 2 times per week for an hour. For four weeks, that is 8 hours in actual visiting. If the worker has to do transport of child, that could result in an additional 16 hours. So for one case, the worker has spent 11-27 hours on it for the month and only has 6.25 allotted. This does not include the meetings, e-mails, placement issues, etc. This results in workers not making the necessary contacts and providing the necessary interventions for intact families.

<b>Travel to Court</b>	<b>0.5 hours</b>
<b>Court Hearing</b>	<b>1.5 hours</b>
<b>Travel from Court</b>	<b>0.5 hours</b>
<b>Visitation</b>	<b>8.0 hours</b>
<b>Transport of Child</b>	<b>16.0 hours</b>
<b>TOTAL (not all inclusive)</b>	<b>27.0 hours</b>

Despite the changes made to DFS caseload standards, caseloads/workloads have continued to impact the safety of children as demonstrated by child death and near death reviews, and by feedback from the DFS frontline workers. After a few of CPAC’s members presented their experiences regarding the Action for Child Protection National Forum on Child Welfare Workloads to CPAC, the Commission agreed to reconvene the SB142 Subcommittee, renaming it the CPAC Caseloads/ Workloads Subcommittee, and charged it with the mission outlined on page 1.

# IMPACTS ON CASELOAD/WORKLOAD

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After reviewing the history of caseload standards in Delaware, the Subcommittee then began the task of identifying the numerous changes in Delaware's child protection system since 1998 with particular emphasis on the last several years. The Subcommittee discussed that many of these positive changes are regarding families whose children are in the legal custody of DFS with the resulting involvement of the Family Court, the Attorney General's Office and the Office of the Child Advocate and Court Appointed Special Advocate programs. As of October 31, 2006, those children in the legal custody of DFS totaled 1,062, and had climbed to 1,125 by December 31, 2006.

However, those changes have had the greatest negative impact on the quality and depth of services for intact families. Intact families are families for whom DFS is providing services to while children remain in the home with their families. As of October 31, 2006, DFS was serving 5,433 children, 4,371 of those children in intact families representing about 80% of the DFS caseload. These intact families are those that have been the subject of several child death and near death reviews. Below is a comprehensive list and description of each change that the Subcommittee believes has impacted the caseloads and workloads of DFS (as well as its system partners) resulting in increased risk, particularly to intact families.

## Federal Mandates Affecting the Child Protection System

### **Health Insurance Portability and Accountability Act ("HIPAA") of 1996**

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, included "Administrative Simplification" provisions that required HHS to adopt national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.

In response to the HIPAA mandate, HHS published a final regulation in the form of the Privacy Rule in December 2000, which became effective on April 14, 2001. This Rule set national standards for the protection of health information, as applied to the three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct certain health care transactions electronically. By the compliance date of April 14, 2003 (April 14, 2004, for small health plans), covered entities had to implement standards to protect and guard against the misuse of individually identifiable health information.

Areas where client protections are identified: Access to Medical Records; Notice of Privacy Practices; Limits on Use of Personal Medical Information (Identification of Protected healthcare information, Minimum disclosure necessary, Authorization for release of information, Recording of disclosures); Prohibition on Marketing; Confidential communications; Complaints.

### *Impact on DFS Caseworkers*

- Access to medical records- Clients may request to review those parts of a case record that contain personal medical information. Clear documentation of client's request and review/redaction of case record is required.
- Notice of Privacy Practice (NPP) - Presentation of NPP brochure and explanation of Department/ Division plan to protect information. Clear documentation of presentation of NPP is required.
- Ensure client's authorization of release of medical information. Cautions about the release of minimal information when necessary.
- Ensure all communication surrounding the disclosure or receipt of personal medical information is confidential (i.e. e-mail, Fax machine, etc.).

### **Adoption and Safe Families Act ("ASFA") of 1997**

ASFA was signed into law to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. The law made changes and clarifications in a wide range of policies established under the Adoption Assistance and Child Welfare Act (P.L. 96-272), the major federal law enacted in 1980 to assist the states in protecting and caring for abused and neglected children.

Areas of emphasis in the law:

- Continues and Expands the Family Preservation and Support Services Program.
- Continues Eligibility for the Federal Title IV-E Adoption Assistance Subsidy to Children Whose Adoption Dissolves.
- Authorizes Adoption Incentive Payments for States.
- Requires States to Document Adoption Recruitment Efforts.
- Expands Health Care Coverage to Non-IV-E Eligible Adopted Children with Special Health Care Needs.
- Authorizes New Funding For Technical Assistance to Promote Adoption.
- Addresses Geographic Barriers to Adoption.
- Establishes Kinship Care Advisory Panel.
- Establishes New Time Line and Conditions for Filing Termination of Parental Rights.
- Sets New Time Frame for Permanency Hearings.
- Modifies Reasonable Efforts Provision in P.L. 96-272.
- Requires States to Check Prospective Foster and Adoptive Parents for Criminal Backgrounds.
- Requires Notice of Court Reviews and Opportunity to be Heard to Foster Parents, Pre-adoptive Parents and Relatives.
- Requires Assessment of State Performance in Protecting Children.

### *Impact on Caseworkers*

- Increases required documentation and adherence to timeframes for efforts to seek permanency for children.
- Additional activities are required to meet "reasonable efforts" standards.
- Preparation for and attendance at Court review hearings is required on a more frequent basis.

- Preparation for and attendance at Permanency review hearings and meetings is required.
- Completion of Criminal History background checks is required.
- Concurrent planning efforts must be made and documented.
- Provision and monitoring of subsidies is more structured.
- Case workers must ensure foster parents', pre-adoptive parents' and relatives' "right to be heard".

### **Child and Family Services Review (“CFSR”)**

The Child and Family Services Review process was the result of a 1994 congressional mandate that was included as amendments to the Social Security Act (P.L. 103-432). That law required the U.S. Department of Health and Human Services (HHS) to review state child welfare programs to ensure "substantial conformity" with state plan requirements in Titles IV-B and IV-E of the Social Security Act. That law requires that state child welfare programs be measured or judged in certain areas or standards. Over the next several years, HHS and the states worked to develop this review process according to the dictates of the law. The planning for CFSRs was completed in 2000. Delaware was the first state to participate in the first round of the review process in 2001. The second round is set to begin in 2007 and again, Delaware will be the first state to participate.

During CFSRs, the federal government determines: (1) if a state child welfare agency's practice is in conformity with Title IV-B (Promoting Safe and Stable Families and Child Welfare Services) and Title IV-E (Foster Care and Adoption Assistance) requirements; (2) if children and families are achieving desirable outcomes; and (3) if a state needs assistance with its efforts to help children and families achieve positive outcomes.

The CFSR process has three major parts:

1. **Statewide Assessment:** Prior to the scheduled review, a state completes a self-assessment addressing specified topics in the areas of safety, permanency and well-being and several systemic factors that impact the child welfare system.
2. **On-site Review:** Conducted by an interdisciplinary review team, the on-site review focuses on hard copy records and computer documentation and interviews with children, family members, state staff, and other professionals that are serving the family. Seven outcomes and seven systemic factors are measured during the review. Following the on-site review, the Children's Bureau prepares a final report containing the review outcomes.
3. **Program Improvement Plan (PIP):** Following the final report phase, a state is required to submit a Program Improvement Plan to address non-compliance with any of the seven outcomes or seven systemic factors subject to review. The Children's Bureau must approve the plan. A state has two years to satisfy the goals described in the PIP. Financial penalties can be imposed for failure to achieve PIP objectives.

The way states are measured can almost be thought of as a pyramid. At the top of the pyramid are three general categories, or “domains,” within these three domains are seven outcomes, and within these seven outcomes are 25 data indicators or measures. The three “domains” are: (1) Safety, (2) Permanency, and (3) Child and Family Well-Being.

Under the three domains are more seven specific measures:

Safety:

- a) Children are, first and foremost, protected from abuse and neglect.
- b) Children are safely maintained in their homes whenever possible and appropriate.

Permanency:

- a) Children have permanency and stability in their living situations.
- b) The continuity of family relationships and connections is preserved for children.

Child and Family Well-Being:

- a) Families have enhanced capacity to provide for their children's needs.
- b) Children receive appropriate services to meet their education needs.
- c) Children receive adequate services to meet their physical and mental health needs.

Within these seven outcome measures are twenty-five data collection outcomes, such as timeliness of investigations, services to families to protect children, incidence of children re-entering foster care, and placement of children in foster care with their siblings.

DFS underwent its latest CFSR review March 5 – March 9, 2007.

### **Interstate Compact for the Placement of Children (“ICPC”)**

On July 3, 2006, the President signed H.R. 5403, the Safe and Timely Interstate Placement of Foster Children Act of 2006 into law. The purpose of the bill is to encourage and reward States that quickly place children across state lines for foster care and adoption. States are required to conduct, complete, and report the results of a home study within 60 days of a request. Additionally, the law includes a new requirement that on-going visitation occur at least every 6 months (instead of every 12 months) in interstate cases. The bill requires states to provide foster children aging out of the system with a copy of their health and education records free of charge. The amendments in this legislation apply to payments made under IV-B and IV-E beginning October 1, 2006, regardless of whether regulations to implement the amendments have been promulgated by then.

### **State Law Mandates Affecting Delaware’s Child Protection System**

#### **Child Protection Registry (16 Del. C. §§ 921 – 929)**

On February 1, 2003 the laws governing Delaware’s improved Child Protection Registry became effective. The Child Protection Registry contains the names of individuals who have been substantiated for incidents of abuse or neglect since August 1, 1994. The primary purpose of the Child Protection Registry is to protect children and to insure the safety of children in childcare, health care and public education facilities.

Upon completion of an investigation of child abuse or neglect by the Division of Family Services, there are three ways an individual can be placed on the registry: 1) by not requesting a substantiation hearing in Family Court; 2) by order of Family Court after a substantiation hearing has been held and; 3) by plea or conviction of a criminal offense on the same incident of abuse or neglect investigated by DFS.

Each individual substantiated for abuse or neglect is identified by DFS as being on one of four levels related to risk of future harm:

- Level I- These cases do not appear on the registry.
- Level II- These cases remain on the registry for three years.
- Level III- These cases remain on the registry for seven years.
- Level IV- These cases remain on the Registry permanently.

Each level includes a list of findings and definitions which supports the placement of an individual within any Level.

The Child Protection Registry outlines for individuals notified of their impending placement on the registry, the opportunity to request a Substantiation Hearing in Family Court. In addition, after all avenues of appealing the initial finding results in an individual remaining on the registry, the law also identifies steps some individuals can take in order to be removed from the registry early. Removal from the Child Protection Registry means only that the person's name will no longer be reported out to employers. Notwithstanding removal from the Registry, the person's name and other case information remains in the Division's internal information system as substantiated for all other purposes necessary.

### **McKinney Vento Act (14 Del. C. § 202)**

Delaware's McKinney-Vento Act (House Bill 279) was an act to amend Title 14 which relates to school attendance of children in foster care. The statute reflects the practices and procedures of the Department of Education and the Delaware Children's Department to ensure that all children in foster care have the protections and provisions of the federal McKinney-Vento statute. This provision allows foster care children to remain in their school until the end of the school year, and the Department of Education provides transportation funding which aligns with the goals of safety, permanence and well-being of children. This provision requires the DFS worker to work closely with school administration to facilitate children's stability and best opportunity for academic success.

### **New DSCYF Policies/Expansion of DSCYF Policies**

#### **System of Care Partnerships**

A system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates case planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels. The System of Care philosophy utilizes a team approach. The teams can be as small as the child, parents/caregiver, case managers, and an informal support, or as large as the child, parents/caregivers, multiple case managers and formal supports (school staff, mental health providers, GALs/CASAs, support services, etc. Per Department of Services for Children, Youth and their Families (DSCYF) Policy 201, the DFS worker assumes the role of primary case manager whenever there is more than one department service division open with the youth and family.

#### **DSCYF Policy 201**

The intent of Policy 201 is to ensure the integration and coordination of all services and resources available with DSCYF, the family, and the community. The policy is based on a "System of Care"

philosophy which holds that the best care and protection for children can be achieved when the strengths of the families are aligned with community and DSCYF supports. The purpose of Policy 201 is to clarify planning requirements and dispute resolution when a child is active with more than one division.

Every child and family active with more than one service division of DSCYF shall have in place a comprehensive, coordinated Service Plan which designates a primary case manager. The primary case manager will facilitate team meetings and the development/review of the Integrated Service Plan (“ISP”) that coordinates both formal and informal supports to support the child and family.

If there is an active DFS treatment case, DFS will be designated the primary case manager.

#### *Impact on Caseworkers*

- Ascertain which divisions are involved and initiate preliminary discussions
- Coordinate all meetings (divisions, family, clergy, friends, other service providers)
- Ensure the SENSS (risk assessment tool) and/or PCIC has been completed
- Obtain all appropriate consent forms
- Conduct ISP meetings and develop the plan on schedule (within 6 weeks of the opening of the second division’s case)
- Develop group consensus on the goals and interventions to ensure the delivery of the appropriate services to the family.
- Enter the ISP into the FACTS system
- Initiate a face-to-face or teleconference every 90 days or more often if there is a significant change in the child’s situation

#### **DSCYF Policy 209**

The purpose of this policy is to ensure that youth in the care of DSCYF are placed in appropriate, safe settings. DSCYF believes that DFS should provide placement and primary case management for all dependent youth. Policy 209 applies specifically to youth who:

- Have successfully completed residential treatment but parents are unable or unwilling for the youth to return home, or
- Are 13 years of age or younger whose parents are unable or unwilling to provide care for the youth and pursuant to Del. C., Title 10, §936, should not be detained pending adjudication, or
- Are currently in a detention center or detention alternative and whose parents refuse to plan for the youth, and

These youth will be considered DSCYF youth and case planning will be coordinated and resources shared. Under Del. C., Title 29, §9006, DFS is responsible for the provision of child protective, placement, treatment, prevention, adoption, and related services; CMH is responsible for the provision of prevention, outpatient and residential mental health, and drug and alcohol treatment services for children and youth; and YRS is responsible for the provision of detention, institutional care, probation, aftercare, and prevention services for children and youth.

The policy directs that divisional funding streams and contracts will not be used as barriers to accessing the most appropriate placement resource which will be determined by a DSCYF Placement Resource Team.

*Impact on Caseworkers*

- DFS will accept for investigation Child Abuse and Neglect report Line calls from CMH and YRS when a youth cannot return home
- DFS will convene the interdivisional planning meeting per policy 201
- DFS must petition Family Court for custody when appropriate
- DFS must find appropriate placement so a child under 13 years old does not remain in a detention facility.
- When the situation calls for it, DFS will attend bail hearings.

## Family Court Expectations

### **Children in DFS Custody Cases**

If the Division caseworker and supervisor find that the child/ren are at significant risk of maltreatment and out-of-home placement is necessary, then immediate legal action will be taken to obtain court-ordered placement. The Division caseworkers must attend and testify at the Preliminary Protective Hearing, Adjudicatory Hearing, Dispositional Hearing, Review Hearings, and Permanency Hearings. As a result of these hearings, the court issues an order which details the court's expectations for the Division while the children remain in DFS custody. There is much more required of a caseworker for a "placement" case, than for an intact family case, thereby demanding more of the caseworker's time and attention.

*Impact on Caseworkers:*

- Provide a summary to the assigned DAG in advance of hearing.
- Obtain a list of relative placement options.
- Conduct home safety assessments for all relatives.
- Publish for absent parent(s).
- Conduct visitations twice weekly with each parent.
- Conduct visitations at Correctional facilities.
- Conduct visitations between the siblings.
- Conducting visitations for large sibling groups.
- Provide children with transportation.
- Provide parents with transportation
- Provide parents with assistance for housing and employment.
- Refer parents for a substance abuse evaluation.
- Refer parents for a mental health evaluation.
- Refer perpetrator for anger management counseling.
- Refer victim for domestic violence counseling.
- Refer parents for counseling.
- Obtain information from the substance abuse evaluator and mental health evaluator.

- Treatment workers request and obtain updates for each hearing regarding ongoing services from substance abuse evaluators, counseling services, and mental health services. Also criminal background check updates are completed prior to each hearing.
- Obtain report cards.
- Discuss the school's failure to pursue legal action for truancy issues.
- Complete an Educational Surrogate Referral.
- Complete a referral to Child Development Watch.
- Complete a timely referral for counseling for child.
- Ensure that child support application has been filed in Family Court.
- Enroll the child in school.
- Provide tutoring.
- Schedule appointments with specialist, doctors and dentists.
- Provide the court with updated addresses.
- Provide the courts with the current Plan for Child in Care and Family Service plan.
- Complete an Integrated Service Plan (departmental policy 201). DFS is the primary case manager.
- Referrals from Family Court re dependent youth (departmental policy 209)
- Court orders are not received by DFS for several weeks.
- CASA/GAL contact and collaboration re replacement.
- DFS provides lengthy testimony despite stipulation to dependency.
- Attend hearings for children scheduled on the juvenile criminal calendar.
- FACTS documentation pertaining to hearings.
- Concurrent planning efforts

### **Intact Family Cases**

The Division accepts referrals from Family Court when a petitioner files a Custody, Guardianship, or Protection from Abuse petition against a respondent and alleges that the respondent has maltreated the child or placed the child at risk. In addition, the Division also accepts cases where the non-relative has petitioned the court for guardianship.

#### *Impact on Caseworkers:*

- Family Court makes frequent referrals to DFS.
- At times, allegations are not clearly defined or do not rise to the level of abuse, neglect, or dependency.
- DFS is required to be present for the scheduled court hearings without representation.
- DFS is not given sufficient time to conduct an investigation between the time the report is accepted and the hearing is scheduled.
- If the investigation is not complete prior to the first hearing, then DFS is required to participate in subsequent hearings and/or provide a court report by the close of the investigation.
- DFS is required to investigate the petitioner and respondent's households.
- DFS is asked to give recommendations to the court.
- DFS is often required to investigate situations where the parents are unable to be located and the court has already decided to award the relative custody.

## Multi-Disciplinary Collaboration for Physical/Sexual Abuse Cases

Abuse, as defined by Title 16, Chapter 9 of the Delaware Code means any physical injury to a child by those responsible for the care, custody, and control of the child, through unjustified force as defined in Title 11 of the Delaware Code.

Upon receipt of a report of abuse or neglect, the Division caseworker will assess the allegation to determine if the police should be contacted. The caseworker will contact the police when a report indicates a crime may have been committed against a child by a person responsible for the care, custody, and control of the child. The Division will provide the appropriate law enforcement agency with a detailed description of the report received. The appropriate law enforcement agency shall assist the Division in the investigation or provide the Division, within a reasonable time, an explanation detailing the reasons why it is unable to assist. Notwithstanding any provision of the Delaware Code to the contrary, to the extent the law enforcement agency with jurisdiction over the case is unable to assist, the Division may request that the Delaware State Police exercise jurisdiction over the case and upon such request the Delaware State police may exercise such jurisdiction.

### *Impact on Caseworkers:*

- On average, caseworkers wait 2 or more hours for the police to arrive. Police are dissatisfied if, after waiting several hours, the workers leave the scene. Their expectation is for DFS to re-respond.
- Police officers often fail to charge the perpetrators when a crime has been committed.
- Police discuss the crime with the Attorney General's office and DFS is not notified of the outcome.
- Police officers issue warrants but fail to follow up to make the arrest.
- Police officers are sometimes the first responders. They often leave the scene prior to DFS arrival.
- Bail conditions that require DFS supervision, etc.
- Bail conditions are modified and DFS is not given notice to plan for the children.
- Medical examinations at AI DuPont Hospital or Christiana Care are time consuming.
- Child Advocacy Center Interviews are scheduled for days or weeks later. The police are scheduling the appointments. DFS is responsible for transporting the victims.
- Police officers and detectives are difficult to reach.
- Police officers and detectives also try to dictate what steps DFS takes in their investigation, i.e. safety planning.
- Police officers conduct the majority of the interviews for sex abuse and serious injury cases. DFS contact is limited.

## Insufficient Foster Care Resources

### **Lack of Available/Appropriate Foster Homes**

There are times when it is necessary to place children in foster homes that are at their capacity or not equipped to handle the presenting behaviors. Such decisions are made due to the high demand for placement attributed to the increase in dependency-related placements for the teenage population, the increase in placements in the 0-6 age range, and the increased difficulty of issues the children and their

families exhibit. The supply does not meet the demands for a number of reasons including foster home closure due to deteriorated standard of care; closure of foster homes due to adoption; and a lack of foster care providers trained to handle complex needs, particularly of the growing teenage population within DFS.

Placements and re-placements require an exorbitant amount of time for the caseworker. Additionally, the child who moves from one placement to another is re-victimized with each move, making it increasingly difficult to find an appropriate and stable placement.

### **Lack of Behavioral Specialists for Foster Homes**

One of the pressures on caseloads which is related to foster home replacements is the lack of mental health intervention services available to a child in crisis. Foster children may have a crisis any time of the day or any day of the week. Foster parents must have the support of a mental health intervention team that is available around the clock. There is a huge gap between CMH's crisis intervention criteria and the level of incident which will cause a home to discharge a child. Many replacements could be avoided by having a continually available team dedicated to addressing and resolving mental health crises in DFS foster homes, such as the behavioral specialists recommended by the Governor's Task Force Report on Foster Care and re-addressed by the CPAC Foster Care Subcommittee at the January 2007 CPAC meeting.

### Quality Assurance

#### **DFS Quality Assurance**

The Division of Family Services has an extensive quality assurance system which reviews random cases each month, examining the areas of intake, investigation, treatment, and placement. These review findings are shared with Division supervisors and managers in order to guide changes in practice, policy and service delivery. The case review tools are aligned with the Administration for Children and Families safety, permanency, and well-being compliance expectations.

#### **Child Death, Near Death and Stillbirth Commissions ("CDNDSC") and CPAC Near Death Reviews and Recommendations**

The Legislature created the Child Death, Near Death and Stillbirth Commission to review deaths of children under age 18, and those who were near death due to abuse and neglect as certified by a medical professional, in order to provide recommendations to diminish processes or practices which impact the mortality and safety of children. As the recognized Citizen Review Panel in the state, the Child Protection Accountability Commission's Near Death Subcommittee also reviews near death cases to effectuate systemic changes and to make recommendations to safeguard the health and safety of children. Recommendations from these reviews influence some of the policy and procedural changes that affect frontline caseworkers' workload. The Children's Department has a Safety Committee which reviews critical incidents and conducts case reviews.

#### **Root Cause Analyses**

The Department of Services for Children, Youth and their Families (DSCYF) adopted root cause analysis (RCA) as a tool to evaluate critical incidents in its system. Root cause analysis is a systematic

process for looking at an event that occurred and evaluating why the event occurred. The purpose is to reach the systemic issues which may have allowed or caused the event to happen and to recommend improvement plans that will assure future child safety and positive outcomes.

# ANTICIPATED IMPACTS ON CASELOADS/WORKLOADS

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## CDNDSC and CPAC Recommendations from Death and Near Death Reviews

Several concerns identified in the CDNDSC recommendations impact DFS' workload. Changes in contacts for intact families and services to the 0-6 population have been part of early discussions, in addition to balancing current priorities and mandates for DSCYF against future recommendations from the Commission.

### CPAC Definitions Subgroup

Changes in definitions of care, custody, and control, abuse, neglect and other terms have the potential to expand the number of cases accepted for investigation by DFS. Non-related persons who previously were not found to have care, custody, and control may now be included under the revised definition.

### CPAC Extended Jurisdiction Subgroup

Extended Jurisdiction will result in additional services for youth aging out of foster care. The population served by DSCYF would increase from children under the age of 18 to young adults up to the age of 21. Youth who exit care would also have the option of seeking extended jurisdiction within six months of their exit. It is anticipated that 32% of children aging out of foster care would continue to receive services beyond the age of 18.

## Child and Family Services Improvement Act of 2006 (Public Law 109-288)

President Bush signed this Act into law on September 28, 2006. The new law makes changes to Title IV-B, subparts 1 and 2, of the Act, and reauthorizes the Promoting Safe and Stable Families Program (PSSF) and the basic grant under the Court Improvement Program. A major change that will impact the workload of caseworkers includes a provision requiring Monthly Caseworker Visit Data and Performance Measures for States. To receive FY 2008 funding under these funding streams, the law requires the State to submit FY 2007 data on:

- The percentage of children in foster care under the responsibility of the State who were visited on a monthly basis by the caseworker handling the case of the child; and
- The percentage of the visits that occurred in the residence of the child (section 424 (e) (1) of the Act).

States, in consultation with the U.S. Department of Health and Human Services (HHS), are required to establish by June 30, 2008, an outline of steps to be taken to ensure that 90 percent of children in foster care are visited by their caseworkers on a monthly basis by October 1, 2011, and that the majority of the visits occur in the residence of the child.

*Impact on Caseworker:* Full assessment and impact to be determined as a part of the planning and implementation design

## Intact Family Policy Considerations

Services being offered to intact families are under consideration. Any service revision may impact the number of contacts required for each family member by specifying contacts for individuals within the family unit. For example, requirements could be made to see each child in the family during a specific timeframe which could have a major impact on the Treatment workload.

## Child and Family Services Review – March 2007

The federal Child and Family Services Review identified several areas needing improvement in Delaware's child welfare system. In response, the pending Program Improvement Plan builds improvement across five domains: safety, permanency planning, engaging families and youth, service array and quality documentation. Corrective actions are monitored for two years by the Administration for Children and Families. Achievement of action steps and data measurement goals are required to be released from federal monitoring.

## CPAC Mental Health Assessments for Foster Children Subcommittee

Within the past year, children entering foster care have started to receive mental health assessments. Now that the process is underway, we have begun to review the needs associated with those assessments and have found a requirement for increased follow-up at the worker level. Additionally, since more children are being assessed for mental health, the number of children identified as requiring additional services will also be increasing. These services will be coordinated by front-line workers and primary case managers.

## CPAC Mixing Subgroup

Consideration has been given to the inclusion of a foster family's own children in the determination of mixing. Instead of mixing being an issue for only delinquent children in placement with non-delinquent children in placement, changes may occur which would require mixing of delinquent DSCYF children with non foster care children in the home.

## Title IV-E Foster Care Candidacy

To meet federal requirements to document foster care candidacy, the Children's Department designed a new proposed family case plan that documents likely candidates for foster care. Under the proposed process, caseworkers will determine whether a client is, or is not, a likely foster care candidate based on the selection criteria. The worker will record their decision, and the factors supporting it. Supervisors will be required to review the candidacy decision as part of each client's Family Service Plan Review. The worker will be required to access the foster care candidacy status every six months. Family and Child Tracking System (FACTS) is scheduled to be updated Spring, 2007 to be followed by a staff-training curriculum.

*Impact on Caseworker* : Increases required documentation

# COMPONENTS OF THE CHILD PROTECTION SYSTEM

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Given the impact that the changes have on how child protection cases are handled civilly by the Court, the Subcommittee found it important to also describe the role of each component of that system. This will enable all to understand how DFS legal custody cases move through the legal system, and enable the Subcommittee to complete its mission by looking at how any change to DFS workloads will impact the other core components of the legal system. A chart based on data from January 31, 2007, is enclosed as an exhibit to this report. The Subcommittee acknowledged that there are countless community service providers also involved in this process and that service gaps exist which prevent the most efficient use of time. The Subcommittee, however, declined to include those providers and gaps in its core analysis.

## Department of Services for Children, Youth, & their Families

Also known as the Children’s Department, the Department of Services for Children, Youth, & their Families was created in 1984, and is enabled statutorily by 29 Del. C., Ch. 90. The Department is within the executive branch of government and is primarily comprised of three divisions: The Division of Family Services (“DFS”), the Division of Youth Rehabilitative Services (“YRS”), and the Division of Child Mental Health (“CMH”).

The Division of Family Services is the agency charged with caring for abused, neglected, and dependent children.

The Division of Child Mental Health provides voluntary mental health and substance abuse treatment services to children up to age 18 who have mental health or substance abuse problems and their families.

The Division of Youth Rehabilitative Services provides services to youth who have been adjudicated delinquent and ordered by the court system to receive services in the State of Delaware. DYRS serves approximately 5,000 youth per year, ranging from probation to secure care incarceration.

## Family Court

The Delaware Family Court is now a constitutional court that has original exclusive jurisdiction over abused, neglected, and dependent children. The Court’s criminal and civil jurisdiction is set forth in 10 Del. C. §§921 and 922. The Family Court assigns one judge to a case from the day a child enters foster care. That judge remains with the case until permanency is achieved, either by reunification with the family, termination of parental rights and adoption, or some other permanent plan. Currently, there are four judges in New Castle County, three judges in Kent County, and three judges in Sussex County that handle these cases.

## The Court Improvement Project

The Court Improvement Project (“CIP”) was implemented in August 1998 in Sussex County, in October 2000 in New Castle County, and in January 2001 in Kent County in order to improve how

courts within the state handle cases involving children in foster care, termination of parental rights, and adoption. The recommendations of the CIP include assigning one Judge to conduct all the hearings for the life of a case. Additionally, a revised schedule of hearings was recommended which generated more frequent hearings on those cases involving children in foster care. Discussions about those children are often extensive and are held at every hearing.

### The Department of Justice/Attorney General's Office – The Family Division

The Delaware Department of Justice's Family Division houses both criminal and civil matters affecting families, such as domestic violence, juvenile delinquency, child support, and child physical abuse and neglect. This includes the Deputies who represent DSCYF. There are currently nine deputies statewide who represent DSCYF (5 in NCC, 2 in Kent, 2 in Sussex). In addition, there is one deputy assigned as general counsel to DSCYF. DFS is represented by a DAG in every court proceeding.

### Office of the Child Advocate

The Office of the Child Advocate ("OCA") was created in 1999. In the wake of the numerous child abuse deaths in Delaware, the OCA was designed to safeguard the welfare of Delaware's children. In addition to policy reform, legislative advocacy, and training, OCA was charged with securing legal representation for children's best interests in child welfare proceedings. Three OCA Deputy Child Advocates and 350 volunteer attorneys, provide legal representation to approximately 700 children in the legal custody of the Division of Family Services ("DFS"). The scope of the representation is the child's best interests. As an attorney for the child, the attorneys are involved in every legal proceeding regarding the child as well as responsible for ensuring that the child's needs are met while in the legal custody of DFS.

### Court Appointed Special Advocate Program

The Court Appointed Special Advocate Program ("CASA") was created by statute in 1981. It is managed by the Family Court and is comprised of citizen volunteers who have agreed to represent the best interests of abused, neglected, and dependent children in child welfare proceedings. It is governed by 31 Del. C., Ch. 36. The CASA program has a statewide program director as well as nine CASA coordinators. The coordinators provide oversight, guidance, and training to the citizen volunteers. In addition, for any court proceeding wherein the CASA must appear, the CASA is represented by a contracted attorney. Currently, there are four contracted attorneys statewide that represent the CASA program.

### Contract Counsel for Indigent Parents

Currently, there is no absolute constitutional mechanism in place to ensure that parents have legal representation from the day their children are removed from their custody. The United States Supreme Court has held that there is no absolute constitutional right to representation in termination of parental rights proceedings. *Lassiter v. Dept. of Social Svcs.*, 452 U.S. 18 (1981). The Delaware Supreme Court has followed that holding in *Matter of Carolyn S.S.*, Del. Supr., 498 A.2d 1095 (1984) and extended that holding to all dependency/ neglect proceedings involving DFS in *Watson v. DFS*, No. 18, 2002 (Del. 2002). However, the Delaware Supreme Court has been clear that in applying *Lassiter*, most indigent parents will be entitled to counsel. Furthermore, the new Family Court Rules require

the appointment of counsel for indigent parents in matters where DFS is a party. (See Family Court Civil Rules 206 and 207). As a practical matter, all indigent parents involved in proceedings where DFS is a party receive court-appointed counsel. Currently, 8 attorneys are contracted statewide – 4 in New Castle, 2 in Kent and 2 in Sussex.

# WORKLOADS OF CHILD PROTECTION PARTNERS

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## Research

Another area of focus for the Subcommittee was how the other child protection partners are faring with their own workloads, and how their involvement and action in DFS legal custody matters impacts the workloads of DFS. The Subcommittee agreed that the other partners include the Child Placement Review Board, the Family Court, the Attorney General's Office, the Office of the Child Advocate and the Court Appointed Special Advocate Program. While each of these agencies are described above in the legal components section of this report, the common denominator between them all are the children in DFS legal custody who fall under the Adoption and Safe Families Act and court-managed by Delaware's Court Improvement Project.

The Subcommittee has determined that the Family Court process of the Court Improvement Project ("CIP") has added to the workload of all involved systems, including its own. Statistics shared by the OCA/CASA database show caseloads of not just the child representatives but those of the DAGs and the Family Court Judges. The Subcommittee expressed concerns that CIP has been overused, with the result that precious few resources are being further depleted. The Subcommittee is also unsure if this system is enhancing the safety and well-being of children in the legal custody of DFS. However, it can conclude from the death and near death reviews that the shortage of time by workers, and the priority court cases take, has resulted in increased risk to children in intact families.

## CPAC Recommendation

CPAC, and the Family Court in particular, provided guidance to the Subcommittee indicating that it was open to suggestions for improvement by the Subcommittee. The Court would participate on the Subcommittee and bring those suggestions back to the Court. This was done at the January 2007 Subcommittee meeting. The Court would then like an opportunity to internally review processes and procedures and provide feedback.

# DIVISION OF FAMILY SERVICES

## WORKLOAD STUDY

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### Research

Building on the knowledge gleaned from the Action for Child Protection Forum, the Subcommittee began by reviewing workload studies from across the country. Specifically, in addition to the Wisconsin study, the Subcommittee reviewed standards and studies employed by Arkansas, Virginia, Nevada and Alaska. Initially, the Subcommittee contemplated conducting a workload study in Delaware which would be a sampling of cases and employing best practices on same using the standards employed by other states.

The Subcommittee then determined it could employ the studies done by these other states, use the information gleaned from the 2004 DFS time allocation study, and conservatively calculate the time required to handle investigation and treatment cases in Delaware. The study would not be empirically validated and may be conservative in its conclusions, but would still give Delaware a much more accurate picture on current expectations versus practical realities.

### Calculations and CPAC Recommendations

DFS calculated that a worker has approximately 143 hours per month to work. The 2004 DFS time allocation study revealed that 38% or 54 hours per month are consumed with administrative duties (15%), training (5%) and leave. This provides approximately 89 hours per month for a worker to provide client-specific services.

$$143 \text{ hours/month} \times 62\% = 89 \text{ hours/month for client service provision}$$

The Subcommittee then used the workload studies of the other states to conservatively conclude that:

- the workload of a DFS investigation case requires **8.4 hours per month**; and
- the workload of a DFS treatment case requires **8.3 hours per month**.

Given the current caseload standards and adopting the conservative workload figures outlined above, a DFS investigation worker currently needs 117.6 hours per month (8.4 x 14) to handle the workload of 14 investigation cases while currently having only 89 hours per month. As such, a caseload standard of 14 investigation cases per worker is 3 cases too high.

$$14 \text{ investigation cases} \times 8.4 \text{ hours/month} = 117.6 \text{ hours/month}$$

**The Subcommittee is therefore recommending that the caseload standard for DFS investigation workers be lowered to 11 cases per worker.**

In employing the conservative treatment workload standard of 8.3 hours per month, a DFS treatment worker currently needs 149.6 hours per month (8.3 x 18) to handle the workload of 18 treatment cases while currently having only 89 hours per month.

$$18 \text{ treatment cases} \times 8.3 \text{ hours/month} = 149.6 \text{ hours/month}$$

As such, a caseload standard of 18 treatment cases per worker is 7 treatment cases too high. While this calculates to 11 treatment cases per worker, **the Subcommittee is recommending the caseload standard for DFS treatment workers be lowered to 12 cases per worker.**

### Proposed Staffing Needs

Based on the conservative proposed caseload standards of 11 cases per investigation worker and 12 cases per treatment worker, DFS would need **31** additional treatment positions statewide. The chart below details the calculation for October of 2006. A review of cases from January 2006 – November 2006 essentially mirrored these numbers indicating consistency in the request. The Subcommittee does however caution CPAC that the number of children entering the legal custody of DFS has risen by 63 children in the last quarter. This increase, if it continues, may impact the eventual number of positions needed.

<b>Treatment</b>	<b>Caseload Total</b>	<b>Current # of Staff</b>	<b>Recommended # of Staff</b>	<b>Positions Needed</b>
NCC1	447	26	37	+11
NCC2	250	18	21	+3
Kent	334	17	28	+11
Sussex	294	18	24	+6
<b>Statewide</b>	<b>1325</b>	<b>79</b>	<b>110</b>	<b>+31</b>
<b>Investigation</b>	<b>Caseload Total</b>	<b>Current # of Staff</b>	<b>Recommended # of Staff</b>	<b>Positions Needed</b>
NCC1	129	14	12	-2
NCC2	214	18	19	+1
Kent	141	11	13	+2
Sussex	156	15	14	-1
<b>Statewide</b>	<b>647</b>	<b>58</b>	<b>59</b>	<b>0</b>

Facing the realities that 31 new state positions in FY08 would be an unworkable request as well as being uncertain as to whether or not some of these positions/responsibilities can be contracted out (see Treatment Triage section), the Subcommittee agreed over the next several months to develop years one and two of a three year plan to lower caseloads, and to provide fiscal calculations regarding same.

As such, the Subcommittee recommended and CPAC accepted its recommendation to lower caseloads to 11 for investigation and 12 for treatment, and to pursue the phased-in implementation of these standards beginning with Fiscal Year 2008. The Subcommittee will draft legislation and provide fiscal documentation of at least years one and two of the three year plan at the April CPAC Quarterly Meeting. Draft legislation is attached as an exhibit to this report.

# PORTAL OF ENTRY ANALYSIS

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## Research

“Child Protective Services agencies face a large volume of reports, increasingly complex cases, and strained resources”<sup>3</sup>.

Each week, Child Protection agencies across the country receive 50,000 reports of child abuse and/or neglect. In 2002, 2.6 million reports concerning the welfare of approximately 4.5 million children were made. 67% of those reports were investigated.

In Delaware, during FY06, 7,548 reports of child abuse, neglect, and/or dependency were made to the Child Abuse Report line. Of those, 5,829 reports were investigated, representing a 77.2% acceptance rate for hotline calls. This rate is above the national average of 61.7%.

## **The Process**

A child welfare agency, such as DFS, receives a report of child abuse, neglect, and/or dependency and must assess and determine how to best respond. Reports are screened, allowing the child welfare agency to determine which families are investigated and which are not.

Virtually all states screen child maltreatment referrals. In fact, only the District of Columbia reports that they investigate all child maltreatment allegations. However, few states have explicit guidelines outlining the types of reports that should be screened out and even fewer states use formal instruments to guide the screening process.<sup>4</sup>

Of the 40 states surveyed, 26 had single-review screening processes and 14 used multiple-review screening. Approximately half of the states using a single-review process relied on one worker to make screening decisions; while the multiple-review states utilized an intake worker and supervisor to make the determination.

## **Statistics**

Delaware DFS accepted 77.2% of reports made to the hotline in FY06. Conversely, Delaware DFS rejected 22.8% of the reports made to the hotline. There are 3 states that accept more hotline reports for investigation than Delaware according to federal fiscal year 2006 (FFY06) data. They are:

Arizona	98.9%
District of Columbia	90.0%
Texas	82.9%
Delaware	80.1%
Georgia	80.1%

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<sup>3</sup> U.S. Department of Health and Human Services. 2005. Alternative Responses to Child Maltreatment: Findings from NCANDS.

<sup>4</sup> Tumlin & Geen. 2000. The Decision to Investigate: Understanding the State Child Welfare Screening Policies and Practices.

## Definitions

While CAPTA provides minimal standards for the definition of abuse and neglect that states must incorporate into their statutory definitions, the standard for what constitutes abuse, neglect, or dependency varies among states.

**All** states and territories provide definitions for physical abuse, neglect, sexual abuse. Substance abuse is an element of those definitions in **some** states, but not all. Emotional maltreatment is incorporated in to every state's definitions of abuse or neglect except Georgia and Washington. **22** states provide specific definitions of emotional abuse or mental injury to a child.<sup>5</sup>

**18** states and the District of Columbia include abandonment in their definition of neglect while **13** states and **4** territories provide separate definitions for establishing abandonment.<sup>6</sup>

In addition to defining the acts or omissions that constitute child abuse or neglect, **several** states, including Delaware, provide specific definitions of the persons who are reportable under civil child abuse reporting laws as perpetrators of abuse and neglect.

**Six** states and the District of Columbia exempt the financial inability to provide for a child from the definition of neglect. **14** states do not constitute reasonable physical discipline of a child that does not cause bodily injury as abuse<sup>7</sup>.

## Analysis and Implications

There are both benefits and risks to screening reports made to the child abuse hotline. For example, child welfare agencies can save time and money by using the screening process as a triage function. Money is of issue because funding for child welfare services has not kept pace with the increasing responsibilities child welfare agencies have undertaken over the past decade.

Screening enables child welfare agencies to prioritize its response to reports of abuse, neglect, and dependency. Screening also helps with allocation of agency resources so that the children and families that need the resources most, get them. For inappropriate reports of maltreatment, screening can reduce unnecessary intrusion into families' lives.

The risks of screening include the screening out of cases of true maltreatment and the lack of information about what becomes of the screened-out cases. Also, screening occurs at the earliest point in a case where the least amount of information is known.

Despite the fact that the benefits, risks, and best practices for effective screening are still open to debate, screening data in any assessment of child welfare caseloads/workloads must be taken into account.

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<sup>5</sup> Child Welfare Information Gateway. 2005. Definitions of Child Abuse and Neglect: Summary of State Laws.

<sup>6</sup> Child Welfare Information Gateway. 2005. Definitions of Child Abuse and Neglect: Summary of State Laws.

<sup>7</sup> Child Welfare Information Gateway. 2005. Definitions of Child Abuse and Neglect: Summary of State Laws.

## Alternatives

1. Multiple-track response models offer different responses depending on the needs of the family and the risk to the child. Washington is providing community supports to families screened out. In California, a network of community services is being used as part of an alternative response system to serve low- to medium-risk child welfare clients.
2. Structured Decision Making (SDM) is used to provide clearly defined standards and instruments for reliable, immediate, and long-term safety decisions.<sup>8</sup>
3. Alternative response has been defined as “a formal response of the agency that assesses the needs of a child or family without requiring a determination that maltreatment has occurred or that the child is at risk of maltreatment”<sup>9</sup>. Twenty states offer both alternative response and traditional investigation. A survey of six of these states (Kentucky, Minnesota, Missouri, New Jersey, Oklahoma, and Wyoming) found that alternative response is more likely to be used in situations when reporters are non-professionals and school sources; for cases with less pressing safety concerns; and for reports that did not include allegations of sexual abuse. Children previously referred to alternative response do experience subsequent reports and are not at greater risk for subsequent reports than those who received an investigation<sup>10</sup>.

Alternative response was employed when factors suggested that the child was at lower risk of harm or that the family would benefit from community-based services. The possible outcomes options of alternative response include no further action, referral to voluntary services, or returning a case to an investigation unit<sup>11</sup>.

4. Additional caseworkers to manage all cases of child maltreatment that come to the attention of DFS.

## CPAC Recommendation

While the Subcommittee looked at a variety of options and considered the benefits and risks of narrowing Delaware’s portal of entry, i.e., what cases it screens and investigations for possible abuse or neglect, the Subcommittee was uncomfortable with narrowing the portal of entry. When considering Delaware’s trend that the number of reports received has gone down while the number of investigations has gone up, it seems to indicate that Delawareans are making better quality reports of suspected child abuse and neglect. Several subcommittees and agencies in the child protection field are looking at how to further educate professionals and the public on making reports of abuse and neglect. It seems counterproductive to the Subcommittee to be working on improving and increasing reports of abuse and neglect to protect children, and then to narrow the scope of cases which DFS would investigate.

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<sup>8</sup> The Urban Institute. Running to Keep in Place: The Continuing Evolution of Our Nation’s Child Welfare System.

<sup>9</sup> U.S. Department of Health and Human Services. 2003.

<sup>10</sup> U.S. Department of Health and Human Services. 2005. Alternative Responses to Child Maltreatment: Findings from NCANDS.

<sup>11</sup> U.S. Department of Health and Human Services. 2005. Alternative Responses to Child Maltreatment: Findings from NCANDS

As such, the Subcommittee recommends and CPAC has accepted that the portal of entry for the screening and investigation of suspected child abuse and neglect in Delaware should remain as it is, and that the child protection community should continue to educate professionals and the public on the reporting of suspected child abuse and neglect.

# TREATMENT TRIAGE

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## Research on National Child Welfare Reform Efforts

The Subcommittee began its review of how and what cases DFS transfers from investigation to treatment, and whether those cases, based upon the Wisconsin study described in the Background section, can be closed without treatment services.

DFS began by apprising the Subcommittee of its manual review of every case being transferred from investigation to treatment for a 90 day period in the Spring of 2006. DFS concluded that there were very few low risk cases. The Subcommittee concluded from these representations that since so few low risk cases are transferred, there was not a need to explore the elimination of low risk treatment services.

The Subcommittee then focused on how states around the country are handling their treatment cases, and whether partnering with the private sector to deliver child protection services is an avenue that Delaware should explore. Public/private partnerships have existed since the early 1800s and were the prevailing form of child welfare service delivery until government involvement increased dramatically over the latter half of the 20<sup>th</sup> century.<sup>12,13,14</sup> Government interest took many forms, the most significant being the amount of federal funding allocated for the continuum of child welfare services. Recognizing the importance of the community context, federal and state governments have called for broad community participation through Public Law 103-66 (Family Preservation and Support Services Program) which has yielded new state and local partnerships for the purpose of service provision and continuing development of family-centered services.<sup>15</sup>

Further research revealed that the U.S Department of Health and Social Services recently awarded funding to support a Quality Improvement Center on Child Welfare Privatization with the intent to build a knowledge base about effective public/private partnership practices. This resource may prove itself useful going forward as well as the Casey Foundation which provides consultation free of charge.

From the wealth of research reviewed in addition to a teleconference with child welfare reform expert, Madeline Freundlich, the Subcommittee learned that 39 states across the country have made attempts to contract child welfare services, ranging from pilot projects to complete privatization. The Child Welfare League of America (“CWLA”) has examined many of these states’ efforts, including Arizona, Kansas, Texas, and Florida. Approaches include complete privatization (with the exception of hotline and initial investigation functions); diverting low-risk (Arizona and Iowa); contracting deep-end children (Massachusetts); contracting out complex cases involved with multiple agencies (Missouri); and diverting traditional foster and relative care (Kansas, Illinois and Michigan).

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<sup>12</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

<sup>13</sup> Rosenthal. 2000. Public or Private Children’s Services? Privatization in Retrospect.

<sup>14</sup> Snell. 2000. Child Welfare Reform and the Role of Privatization.

<sup>15</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

Furthermore, the United States Department of Health and Human Services, Administration for Children, Youth, and Families conducted a survey of states (n=46) in 2000 which found that 90% of responding states use private providers to deliver child welfare services.<sup>16</sup>

In concert with these efforts, child welfare contracts have moved from per diem or fee for service to incentive-based or performance-based payment schedules.<sup>17,18,19</sup> The performance measures include safety of the child, minimal number of placements, maintenance of family and community ties, placement with a sibling, decrease in placement disruptions, increase in adoptions, and caseload reduction. Many of the performance based measures closely track the federal requirements for state child protection agencies set forth in the Child and Family Services Reviews as well as other federal audits and tracking mechanisms.

## Assessment

Incorporating both self and independent evaluations of the various public/private partnership efforts, the Subcommittee explored the potential benefits and disadvantages of increasing Delaware's public/private community partnerships ("PPCP") within the child welfare system and examined each child protection function with respect to its amenability to a PPCP in Delaware.

Generally, public/private partnerships have both strengths and drawbacks which must be considered prior to embarking on such a venture. More specifically, it is clear that PPCPs will not save money.<sup>20,21,22</sup> Costs will likely be similar to supplementing DFS' workforce by 31 positions. However, the investment being made in a PPCP represents an investment in the community and may lessen the time to engagement of families requiring child welfare intervention and, thereby, increasing participation and positive change.<sup>23,24</sup>

Careful attention also needs to be paid to potential duplication of effort as this distinct possibility can undermine a PPCP's aims, administration, and funding.<sup>25,26</sup> In order to avoid this pitfall, PPCPs need to have clearly defined roles and responsibilities.

Once roles and responsibilities are defined, PPCPs seem to generate increased innovation and greater responsiveness to consumer needs. Private agencies have more flexible funding streams and have opportunities to increase their funding through fundraising efforts.<sup>27,28,29</sup> Additional funding sources,

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<sup>16</sup> United States Department of Health and Human Services, Administration of Children, Youth and Families. 2001.

<sup>17</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

<sup>18</sup> Lee, Allen, & Metz. 2006. Literature Review on the Privatization of Child Welfare Services.

<sup>19</sup> McCullough and Associates. 2005. Child Welfare Privatization.

<sup>20</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

<sup>21</sup> Lee, Allen, & Metz. 2006. Literature Review on the Privatization of Child Welfare Services.

<sup>22</sup> McCown. 2005. Privatization of Child Protective Services.

<sup>23</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>24</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

<sup>25</sup> Lee, Allen, & Metz. 2006. Literature Review on the Privatization of Child Welfare Services.

<sup>26</sup> McCullough and Associates. 2005. Child Welfare Privatization.

<sup>27</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

<sup>28</sup> Rosenthal. 2000. Public or Private Children's Services. Privatization in Retrospect.

however, will not ameliorate increases in reports of child maltreatment or a lack of community resources to address presenting issues. What private agencies have shown they are able to do is enlist community commitment, support, and ownership to develop services or service delivery mechanisms to meet community members' needs.<sup>30,31,32</sup>

In Delaware, the private sector has experience delivering child welfare services in partnership with DFS, so enhancing these relationships will provide opportunities to strengthen the first state's already existing collaborative service delivery practice. Additionally, the Quality Improvement Center on the Privatization of Child Welfare reports that with the private sector responsible for service management, a higher percentage of children remain in in-home placement settings and experience a reduced length of stay in restrictive settings.<sup>33,34</sup>

In the context of the potential positive and negative aspects of contracting out child welfare services, the Subcommittee examined all the child welfare functions offered by DFS. Intake, Investigation, Intact Family Treatment, Foster Care Treatment, Foster Care Coordination, Adoption, and Another Planned Permanent Living Arrangement ("APPLA") were assessed using the following variables: best practice, public expectations and beliefs, which states have created PPCPs to deliver the function, what are the outcomes in those states, Court involvement, CFSR outcomes, after-hours involvement, and staffing considerations.

### *Intake*

Only two states have fostered PPCPs for the delivery of child protection intake services (Arizona and Michigan). Best practice dictates that the intake function should be centralized with one agency to help ensure consistency, convenience, and proper coordination with other child protection system partners. In addition, the community feels that the intake function is a "state" responsibility. Therefore, contracting with private agencies to handle reports of child abuse and/or neglect would not fulfill the needs or the expectations of children, families, and the community.

### *Investigation*

The investigation of allegations of child abuse and neglect has also always been considered the responsibility of the state child protection agency. The public holds the state accountable for responding to allegations timely, thoroughly, and accurately. While two states have contracted this service out to the private sector, the CWLA research indicates contracting out the investigation function is not desirable. Issues arise when consideration is given to the mandates states are under to investigate child abuse and neglect as well as the performance measures, outcomes, and reporting requirements connected to those activities. Additionally, the level of court involvement is relatively high, creating an impact and repercussions on other systems if the investigation function was delivered by the private instead of public sector.

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<sup>29</sup> Combs. 2002. The Dual System.

<sup>30</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>31</sup> McCullough and Associates. 2005. Child Welfare Privatization.

<sup>32</sup> McCown. 2005. Privatization of Child Protective Services.

<sup>33</sup> Lee, Allen, & Metz. 2006. Literature Review on the Privatization of Child Welfare Services.

<sup>34</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

## *Intact Treatment*

A key assumption regarding family preservation programming is the idea that children should remain with their families whenever possible.<sup>35</sup> For families where abuse or neglect has occurred or the risk thereof is high, and the children remain in their homes, intact family treatment services can be provided. For this population, compliance with family service plans is voluntary with the greatest motivation for compliance being the possibility of foster care placement. As such, it follows that engaging with the same agency that has the power to take a child away may be more difficult than engaging with a private agency within one's community. Many child welfare experts argue that it is a true challenge to balance the competing priorities of protecting children and supporting and preserving families; of policing and helping. Using community-based services via the private sector is one strategy to address such a dilemma as well as to strengthen communities.<sup>36</sup>

In a scenario where intact family treatment services would be provided by the private sector, the case would be referred to the contracted agency upon completion of DFS' investigation (see flowchart - Appendix 4). Such a plan would impact approximately 470 families or 60% of DFS' treatment caseload. While this plan would not save money, it would decrease the caseloads of DFS caseworkers significantly and may reduce new incidents of child abuse and neglect, thereby achieving more positive outcomes. Additionally, the investment in the community will create growth, responsibility, and commitment.

Another factor considered is that DFS has fewer data reporting requirements for intact family treatment cases. Generally, the child welfare agency must report initial treatment contacts and on-going treatment contacts.

Following the proposed process, if increased risk is perceived by the contracted agency or new allegations arise, the private contractor would alert DFS via the hotline and the contract manager. The case would be investigated, as appropriate, by DFS and if placement was deemed necessary, DFS would take over the case. At this point, the case would remain with DFS until the child achieves permanency.

In line with System of Care principles, individualized, child-centered, family-focused, and community-based care represents best practice in providing treatment services to families. Furthermore, in light of increasing demands, decreasing resources, and a limited capacity to respond to a broad range of needs, embracing the concept of engaging communities to care for their children is a step towards long-term partnerships which foster protection, flexibility, and adaptive programming for children and their families.<sup>37</sup> Creating ownership of family and child protection and well-being within the community increases the likelihood of successful treatment outcomes. Additionally, stronger relationships with community providers creates better linkages with parents and community members, thereby helping to assure that services are appropriate and will enhance the safety and well-being of children and families, as well as build community.<sup>38,39</sup>

A number of states have privatized intact family treatment services with positive outcomes. For example, in Michigan, the percentage of out-of-home placements was significantly less for the

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<sup>35</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>36</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>37</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>38</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>39</sup> Lee, Allen, & Metz. 2006. Literature Review on the Privatization of Child Welfare Services.

community-based agency than the state agency for each time period spanning from three months to 30 months. Similarly, Kansas reported that 93.8% of the cases served in the community had no placement during participation and 94% had no placement six months after case closure while Arizona's Family Builders program had only 1.12% children served placed in out-of-home care.<sup>40,41,42</sup>

These results are consistent with research indicating that families are more likely to become engaged with community-based or faith-based agencies than the state child welfare agency.<sup>43</sup> When treatment is child-centered and family-focused, it is more likely to effectuate the desired changes. Increasing this likelihood is the availability of services to the family, both in proximity and culturally.

An additional factor to contemplate when considering contracting out intact family treatment cases is the lack of Court involvement in the majority of intact family treatment cases. Growing public/private community partnerships to serve these families would have a minimal impact on our system partners.

### *Foster Care Treatment*

Unlike intact family treatment, foster care treatment involves numerous system partners and as such, creating additional contractual arrangements with the private sector to deliver these services would have a tremendous ripple effect, especially for Family Court and the Department of Justice. Delineating responsibility and accountability for service provision and case management may prove difficult as it has in other states.<sup>44</sup> An additional concern is the inability, due to statute, of the Department of Justice to represent a non-state entity/employee. The risk private agencies would shoulder may be significant depending upon the level of risk-sharing or risk-shifting that such a plan would incorporate.

The level of Court involvement in cases with children in foster care is tremendous. The Court Improvement Project has brought about a level of trust among the child protection system partners. Equally important, CIP has created an atmosphere of investment in those children in the legal custody of DFS that may be at risk if a new set of providers were handling their cases. Consistency among providers would be difficult, although not impossible to ensure. However, numerous states have contracted foster care treatment services out to community and faith-based agencies, albeit with mixed results. The states that have chosen to build PPCPs around foster care treatment service provision use varied outcome measures making it difficult to ascertain the level of success attained. Along those lines, the data driven nature of the child welfare system places increasingly burdensome reporting requirements on state agencies. If PPCPs were providing this function, issues regarding data gathering, reporting, and quality assurance could arise.

### *Adoption*

Contracting out adoption services has been the most successful and least controversial child welfare reform effort thus far. In this context, private agencies focus all of their efforts on locating adoptive families for children with a goal of termination of parental rights ("TPR") and adoption. These PPCPs

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<sup>40</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

<sup>41</sup> McCullough and Associates. 2005. Child Welfare Privatization.

<sup>42</sup> Lee, Allen, & Metz. 2006. Literature Review on the Privatization of Child Welfare Services.

<sup>43</sup> McCroskey & Meezan. 1998. Family-Centered Services: Approaches and Effectiveness.

<sup>44</sup> Freundlich & Gerstenzang. 2003. An Assessment of the Privatization of Child Welfare Services: Challenges and Successes.

are particularly effective when the payment structure is created to reward expeditious and appropriate adoptive placements.

However, in Delaware, DFS often recommends a goal change from reunification to TPR and Adoption long before it is approved by Family Court. The process includes the assignment of two caseworkers, one to continue reunification efforts until otherwise judicially relieved, and one to focus on adoption efforts. For community-based agencies to deliver adoption services, a decision-point would need to be identified as the appropriate time to refer the case to the private sector. The decision-point could be at the time DFS recommends the goal change or after the Permanency Hearing where the goal of TPR and Adoption is approved by the court. Still another option would be to refer the case to a contracted agency once TPR is granted. The legal ramifications of each of these scenarios were considered, particularly in light of the desire to avoid the duplication of effort. Such duplication, in the form of assigning both a DFS caseworker and a private sector caseworker, was difficult to avoid in any of the proposed adoption plans.

#### *Another Planned Permanent Living Arrangement (“APPLA”)*

While the public is beginning to establish expectations for children with an APPLA plan, primarily only the federal government and the child welfare system have outcome measures in this area. Improvement in how APPLA cases are managed is part of DFS’ federal Performance Improvement Plan which is in response to the 2007 CFSSR and substantial changes have been proposed, evaluated, and implemented.

More specifically, however, APPLA plans can be considered part of the continuum of foster care treatment services, making the consideration of PPCPs for APPLA cases quite similar, if not identical, to those for foster care treatment. System partner involvement is the same, if not greater for this population and there is an increased scrutiny placed upon these cases as youth are prepared for independence and exit from the foster care system.

A potential plan for an APPLA PPCP involves the private sector assuming service management responsibilities upon a youth’s fourteenth or sixteenth birthday depending upon the applicable guidelines. DFS would retain court and goal review responsibilities. One hesitation to propose PPCPs for APPLA cases is that this cohort’s permanency goals tend to fluctuate which may result in an increased amount of duplicate effort in addition to frequent caseworker changes.

These concerns combined with the efforts already underway within DFS to more optimally serve this population, make growing PPCPs for APPLA cases a less practical option.

#### *Foster Care Coordination*

Foster Care Coordinators currently recruit, train, and support DFS foster parents. While there are not many of these positions, contracting out this function was considered. Community-based agencies, in a PPCP, would recruit, train, and support all foster parents in Delaware. DFS would no longer have a foster home pool of its own. The perception that DFS foster homes are not regulated in the same manner as private agency foster homes would be addressed. Additionally, there would be little duplication of effort between the state agency and the private sector. However, private agencies, as stated previously, vary considerably in their training requirements, level of support, and philosophies. These discrepancies may create inequalities among foster parents with different agencies and, therefore, inconsistent foster care provision to children.

## Next Steps

Regardless of which child welfare treatment function is recommended for delivery by PPCPs, a workgroup will be needed to address the details of such a venture. The workgroup should be comprised of all the child welfare system stakeholders as well as those with relevant expertise. An inclusionary process will help to ensure that the details of increasing DFS' private sector contracts is done thoroughly, with the utmost commitment, and with the best interests of children and families at the center of the discussions.

The workgroup will need to address every aspect of how the PPCP will function in Delaware. For instance, an assessment of the private sector's capacity and the need for capacity-building, if applicable, will be necessary. Also, details of the referral process and payment structure will need to be decided upon. Other areas requiring careful attention include training needs, setting uniform standards for accountability, and spelling out the roles and responsibilities of both the state and private agencies. A Request for Proposals ("RFP") will need to be created with clear performance-based contract requirements coupled with sufficient flexibility to allow for innovation. Following from the RFP, contract monitoring and evaluation procedures will need to be developed which, in turn, lead to information technology needs including solid baseline data.

Data requirements, while less in some child welfare functions than others, are a crucial component of any PPCP. Currently, DFS must report to the federal government on numerous aspects of its work with children and families. DFS will continue to be required to provide this information and, as such, the manner by which the data is gathered from and/or provided by the private agencies needs to be determined.

Consideration should be given to altering the way in which data can be uploaded into Delaware's Statewide Automated Child Welfare Information System ("SACWIS"). For instance, a two-way data flow into and out of SACWIS may be beneficial. Database accessibility is critical to increasing efficiency and avoiding duplication of effort. Perhaps movement to a web-based system would allow for more uniform access to all users.

## Treatment Triage Recommendation

The Caseloads/Workloads Subcommittee recommends that concurrent with a reduction of DFS treatment caseloads to 12, the Division of Family Services, along with its stakeholders and system partners, foster its Public/Private Community Partnerships with the goal of contracting out all the intact family treatment cases to the private sector. In order to effectuate this change, the Subcommittee recommends once the fiscal climate improves which will enable funding of this recommendation, that a workgroup be convened, comprised of child welfare system stakeholders and those with relevant expertise, to establish the guidelines by which the PPCP will operate in Delaware.

# FINAL RECOMMENDATIONS

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## Caseloads

CPAC championed legislation in Fiscal Year 2007 which lowered DFS investigation caseloads from 14 to 11. CPAC recommends that the DFS treatment caseload standard be eventually lowered from 18 to 12 through a phased-in implementation of these standards beginning with Fiscal Year 2009. Legislation and a fiscal plan have been drafted in the form of SB180.

## Workloads of Child Protection Partners/CIP Impact on Workloads for all Partners

CPAC recommends that the Subcommittee provide feedback to the Family Court regarding opportunities for improvement which the Court will then internally review.

## Portal of Entry

CPAC recommends that the portal of entry for the screening and investigation of suspected child abuse and neglect in Delaware remain as it is, and that the child protection community continue to educate professionals and the public on the reporting of suspected child abuse and neglect.

## Treatment Triage

The Caseloads/Workloads Subcommittee recommends that concurrent with a reduction of DFS treatment caseloads from 18 to 12, the Division of Family Services, along with its stakeholders and system partners, foster its Public/Private Community Partnerships with the goal of contracting out all the intact family treatment cases to the private sector. In order to effectuate this change, the Subcommittee recommends once the fiscal climate improves which will enable funding of this recommendation, that a workgroup be convened, comprised of child welfare system stakeholders and those with relevant expertise, to establish the guidelines by which the PPCP will operate in Delaware.

**Figure 1: Children in the Legal Custody of DFS**

	July	August	September	October	November	December	January	February	March	April	May	June
<b>Children Aged Out</b>			<b>14</b>	<b>12</b>	<b>8</b>	<b>16</b>	<b>9</b>	<b>8</b>				
Kent			2	3	2	3	1	2				
New Castle			8	7	6	12	4	5				
Sussex			4	2	0	1	4	1				
<b>Ages of Children in DFS Custody</b>												
<i>By County</i>												
<b>Kent</b>			<b>206</b>	<b>216</b>	<b>215</b>	<b>217</b>	<b>218</b>	<b>220</b>				
0-4			46 22%	47 22%	42 20%	44 20%	45 21%	46 21%				
5-9			39 19%	45 21%	45 12%	47 22%	47 22%	49 22%				
10-13			40 19%	46 21%	47 22%	47 22%	43 20%	44 20%				
14-17			81 39%	78 36%	81 38%	79 36%	83 38%	81 37%				
<b>New Castle</b>			<b>674</b>	<b>685</b>	<b>680</b>	<b>653</b>	<b>647</b>	<b>659</b>				
0-4			206 31%	215 31%	212 31%	199 30%	188 29%	194 29%				
5-9			138 20%	141 21%	138 20%	127 19%	123 19%	124 19%				
10-13			121 18%	117 17%	113 17%	116 18%	122 19%	123 19%				
14-17			209 31%	212 31%	217 32%	211 32%	214 33%	218 33%				
<b>Sussex</b>			<b>190</b>	<b>194</b>	<b>205</b>	<b>198</b>	<b>193</b>	<b>184</b>				
0-4			49 26%	51 26%	54 26%	55 28%	53 27%	54 29%				
5-9			30 16%	32 16%	34 17%	30 15%	28 15%	22 12%				
10-13			32 17%	30 15%	31 15%	31 16%	33 17%	28 15%				
14-17			79 42%	81 42%	86 42%	82 41%	79 41%	80 43%				
<b>All Counties</b>			<b>1070</b>	<b>1095</b>	<b>1100</b>	<b>1068</b>	<b>1058</b>	<b>1063</b>				
0-4			301 28%	313 29%	308 28%	298 28%	286 27%	294 28%				
5-9			207 19%	218 20%	217 20%	204 19%	198 19%	195 18%				
10-13			193 18%	193 18%	191 17%	194 18%	198 19%	195 18%				
14-17			369 34%	371 34%	384 35%	372 35%	376 36%	379 36%				

SPONSOR: Sen. McDowell & Reps. Maier & M Marshall  
Sens. Amick, Blevins, Cloutier, Connor, Henry,  
Marshall, Peterson, Sokola, Sorenson, Still;  
Reps. Brady, Ennis, Hall-Long, Hudson, Keeley,  
Kowalko, Longhurst, McWilliams, Mulrooney, Plant,  
Schooley, Valihura, Viola

DELAWARE STATE SENATE  
144th GENERAL ASSEMBLY

SENATE BILL NO. 180

AN ACT TO AMEND TITLE 29 OF THE DELAWARE CODE RELATING TO THE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES

WHEREAS, the Division of Family Services' ("DFS") frontline caseworkers provide direct services to Delaware's abused, neglected and dependent children and their families in an effort to remedy those issues, and provide support to strengthen these families;

WHEREAS, as a result of several child abuse deaths in the late 1990s, Delaware's General Assembly implemented statutory caseload standards for DFS workers;

WHEREAS, Governor Minner's Executive Order No. 7 directed child safety as the first priority of the Delaware Children's Department;

WHEREAS, since those standards were implemented, DFS has been impacted by countless federal and state mandates which have focused on increasing safety, permanency and well-being for Delaware's children, but which have significantly increased the workloads and responsibilities of DFS frontline workers;

WHEREAS, four reviews of Delaware child death and near death cases since December of 2004 have cited caseloads/workloads as a contributing factor to the child's death or near death;

WHEREAS, the Child Protection Accountability Commission ("CPAC") once again created a subcommittee to study this issue which has resulted in a comprehensive report recommending statutory caseload reductions;

WHEREAS, CPAC concluded that workers have approximately 89 hours per month to provide direct services to Delaware's children and families;

WHEREAS, CPAC concluded that DFS treatment workers need a minimum of 8.3 hours per month to work each treatment case; and

WHEREAS, under current DFS statutory requirements of 18 cases per treatment worker, DFS treatment workers need 149.6 hours per month to provide treatment services to 18 families and have only 89 hours, resulting in children being left at serious risk, thereby requiring treatment caseloads to be reduced to 12 cases per treatment worker;

NOW THEREFORE:

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Section 9015(b)(2) of Title 29 of the Delaware Code by striking the number “18” and inserting the number “12” in its place.

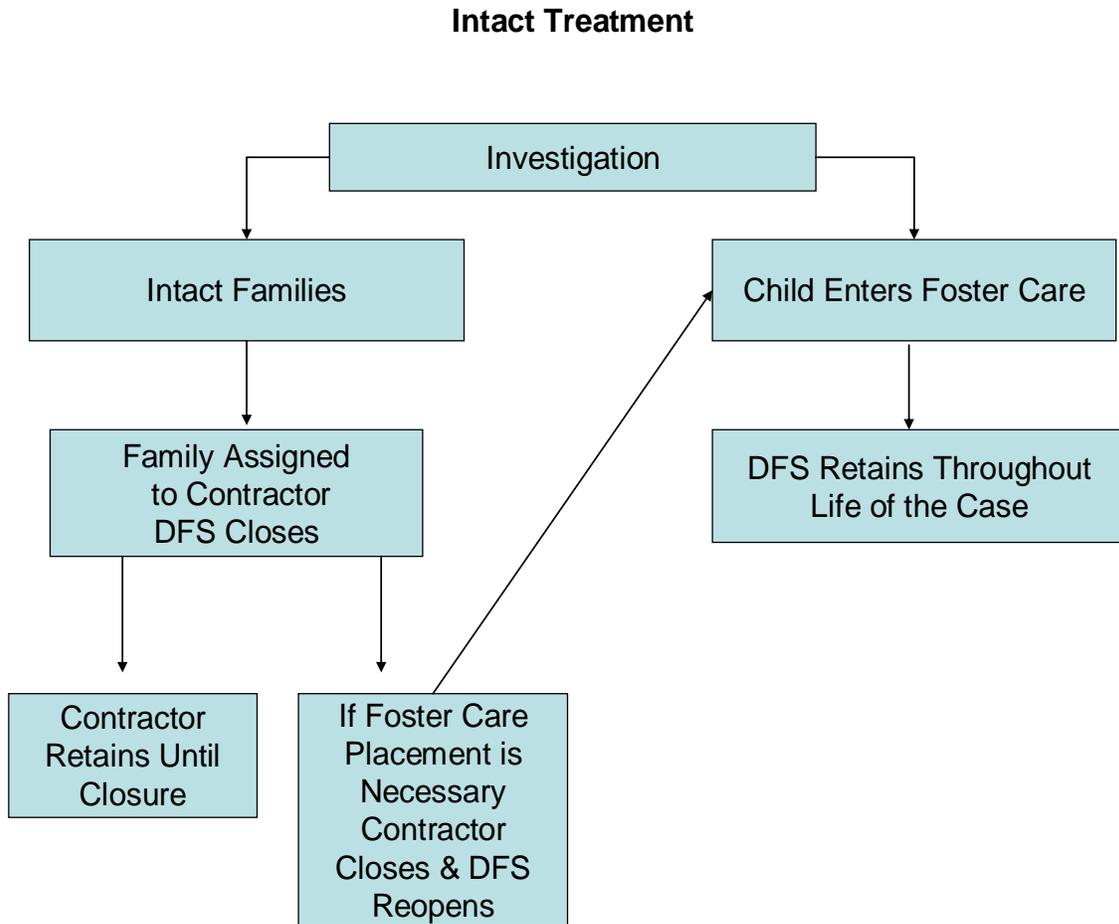
Section 2. In so appropriating funds and positions to comply with the reduction of treatment caseloads from 18 to 12, a three year fiscal plan shall be developed with a first year reduction of treatment caseloads to 15, with the ensuing years’ reductions to be accompanied by the consideration of federal and state mandates for safety, permanency and well-being of Delaware’s children.

SYNOPSIS

This bill reduces treatment caseload standards of Division of Family Services’ caseworkers. It reduces treatment caseloads from 18 to 12 with a fiscal impact. As a result of the fiscal impact, the bill provides for a three year fiscal plan for phasing in the reduction which is consistent with federal and state mandates for safety, permanency and well-being for Delaware’s children.

Author: Senator McDowell

**Figure 2: DFS Intact Treatment Proposed Flowchart**



## Glossary of Acronyms

<b>APPLA</b>	Another (Alternative) Planned Permanent Living Arrangement
<b>ASFA</b>	Adoption and Safe Families Act of 1997
<b>CAPTA</b>	Child Abuse, Prevention and Treatment Act
<b>CASA</b>	Court Appointed Special Advocate
<b>CDNDSC</b>	Child Death Near Death Still Birth Commission
<b>CFSR</b>	Child and Family Service Review
<b>CIP</b>	Court Improvement Project
<b>CMH</b>	Child Mental Health
<b>CPAC</b>	Child Protection Accountability Commission
<b>CWLA</b>	Child Welfare League of America
<b>DAG</b>	Deputy Attorney General
<b>DFS</b>	Division of Family Services
<b>DOJ</b>	Department of Justice
<b>DSCYF</b>	Division of Services for Children Youth and their Families
<b>GAL</b>	Guardian Ad Litem
<b>H.R. 5403</b>	Safe and Timely Interstate Placement of Foster Children Act of 2006
<b>HIPPA</b>	Health Insurance Portability and Accountability Act of 1996
<b>ICPC</b>	Interstate Compact for the Placement of Children
<b>OCA</b>	Office of the Child Advocate
<b>P.L. 96-272</b>	Adoption Assistance and Child Welfare Act of 1980
<b>PIP</b>	Program Improvement Plan (CFSR)
<b>Policy 201</b>	DSCYF policy established to ensure the integration and coordination of services and resources; establishes the DFS worker as the primary worker if a child is active with DFS and another Division of the Department.
<b>Policy 209</b>	DSCYF policy that established the DFS worker as the primary case manager if the parents refuse or are unable to fulfill their responsibilities for a child involved with Delaware's juvenile justice system.
<b>PPCP</b>	Public/Private Community Partnership
<b>PSSF</b>	Promoting Safe and Stable Families
<b>SB113</b>	Passed in 2007, Senate Bill 113 lowered the DFS investigation worker standard from 14 to 11 cases.
<b>SB180</b>	Introduced in fiscal year 2008, Senate Bill 180 proposes lowering the treatment worker caseload from 18 to 12.
<b>SB142</b>	Senate Bill 142 was enacted in 1998 and codified the caseload standards for Division of Family Services workers.
<b>SB265</b>	Passed in 2004, Senate Bill 265 clarified that caseload standards must be calculated by regions and fully functioning workers.
<b>SOC</b>	System of Care
<b>RCA</b>	Root Cause Analysis
<b>Title IV-B Title IV-E</b>	Sections of the federal Social Security Act that regulates placement of children in foster care.
<b>YRS</b>	Youth Rehabilitative Services