State of Delaware – Child Welfare Caseloads Report

A Collaborative Report Issued by the Child Protection Accountability Commission Caseload/Workload Committee and Delaware State University

Committee Co-Chairs:
Susan Murray, Deputy Director, Division of Family Services &
Rachael Neff, Director of Special Court Programs, Family Court

Committee Members: Rosalie Morales, Trinette Redinger Ramsey, Moira Dillon, Monica Morris, Christine Lemanski, Deborah Colligan, Jennifer Perry, Maureen Monagle, Brittany Willard, JoAnn Santangelo

Table of Contents

Preface by the Co-Chairs: Rachael Neff & Susan Murray

It is with a deep commitment and respect for the social work and child welfare profession that we submit this report about child welfare caseloads in Delaware. We believe children should grow up in families that can appropriately care for them in all of the neighborhoods and communities throughout Delaware. We also recognize that some families need additional support during times of crisis. When vulnerable children and families come to the attention of our child welfare system, we want them to receive timely, supportive and therapeutic services. The work that is required to respond to families in a time of crisis must be individualized, thorough, driven by assessment and entail comprehensive case planning. This work can only be done when manageable caseload standards exist for child welfare workers.

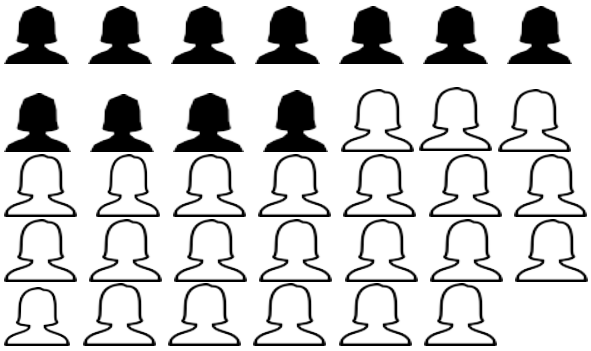
The Division of Family Services caseworkers in Delaware are burdened by caseloads that make it difficult to successfully carry out their jobs. Ultimately, the individuals negatively impacted by this are children and families who do not receive the services. This is a worrisome practice in Delaware that prompted our Child Protection Accountability Commission to take a closer look at the current state of caseloads and potential changes. Our Caseload/Workload Committee has engaged in work over the past year and a half that has revealed that we must change our approach to managing caseloads in Delaware. We recommend lowering caseload standards for our child welfare workforce so they achieve the results that children and families need and deserve. We need a child welfare workforce that can sit with children and families in need, identify their struggles, partner with them in reaching out for critical support and ensuring that services are provided. This is work that requires adequate time and attention.

We are also encouraged by the work that has been done around the country to examine caseload standards in other jurisdictions. As a result of time studies and caseload analyses, states have challenged the way they historically structured caseloads and found ways to reduce them for workers. Furthermore, we appreciated the guidance from the Child Welfare League of America who synthesized best practices to consider when creating caseload standards. The field and practice of child welfare over the past 15 years has changed and we must consider these practice changes as we set forth reasonable caseload standards in 2019.

We encourage readers to think about what our most vulnerable children and families who appear at our Department of Services for Children Youth and Their Families deserve. We believe they deserve a caseworker who will be responsive to their needs and take the time to work with their family to ensure necessary supports are in place so that children can grow up in safe and supportive families. We believe child welfare caseworkers need a manageable caseload size that allows them an opportunity to help their families stay together and safe. This is an opportunity for the leaders of Delaware to take action and we are confident that this report will make a compelling argument to move forward with reducing caseload standards.

Executive Summary

The State of Delaware is experiencing a child welfare caseload crisis; this report demonstrates how high caseloads are impacting treatment and permanency staff. Child welfare caseloads in our state are over statutory standards. The workload is unmanageable and impacts the Department of Services for Children, Youth and Their Families (DSCYF) from consistently meeting the safety, permanency and well-being needs of children and families. Without adequate resources, this Department will struggle to meet its mission and mandate of providing for the safety and well-being of children that it is expected to serve.



(11 children out of 34 received a face-to-face contact)

This report provides an overview of the caseloads findings from the work of the Child Protection Accountability Commission's Caseload/Workload Committee that convened in 2017 and 2018. The state launched a comprehensive time study analysis to capture current caseload information. The time study analysis revealed that treatment workers, who statutorily have their caseloads set at 18, are unable to perform all of the activities for that number of cases. Specifically, the analysis indicated that there was an average caseload size of 17 that served an average number of 34 children. During the four week time study period, for cases where time surveys were submitted, face-to-face contact with a child or family occurred 32% of the time. We learned that families that are intact, who may present some of the more serious safety risks, are not receiving the services at the same rate as placement cases.

The data further revealed that due to the restriction in the amount of time workers can spend on critical case activities that they are unable to provide their cases with quality case work reflective of best practice. For example, leading practices such as family search and engagement efforts, creating safety agreements, engaging in safety organized decision-making and participating in team decision making meetings were all areas where workers dedicated the least amount of time. This was valuable information that was learned in the analysis as it demonstrated that while best practices have been introduced, they are not yet prioritized and being incorporated as routine aspects of case management practice, simply due to the lack of time in a day.

While the report will highlight time study data, it will also provide direct feedback from the Division of Family Services (DFS) caseworkers. Speaking directly with caseworkers was a critical component to providing an accurate assessment of casework practices. "I've got cases sitting there where I haven't seen these people in over a month because I physically do not have time to do it, because I have five cases that are going crazy. . . ." (FG 2018, p. 12, line 323.) This direct quote summarizes a theme that will be shared throughout the report: children and families are not receiving services due to unmanageable caseloads. There is an opportunity to change this worrisome practice and this committee recommends immediate action.

Finally, this Committee makes strong recommendations for responsive caseload standards at the conclusion of this report. We recommend lowering the caseloads for treatment workers to 12 cases. We respectfully submit this final section of the report. These recommendations, if not acted upon, are a serious warning that continuing as 'business as usual could result in additional tragedies and harm to our most vulnerable children.

Delaware's Child Welfare System

The Division of Family Services (DFS) investigates child abuse, neglect and dependency, and offers treatment services, foster care, adoption, independent living and childcare licensing services in accordance with the state mandate. Services are provided across the state and DFS works closely with our sister divisions, other state and federal agencies and community child welfare partners to ensure the lives of children and families who need our services are transformed for the better. The mission for the Division of Family Services is "to promote safety and well-being of children and their families through prevention, protection and permanency." https://kids.delaware.gov/fs/fs.shtml).

The Division of Family Services manages the Child Abuse Report Line, which is the entry point for services and intervention by the agency. Reports of abuse, neglect and dependency are screened through the DFS Report Line using an evidence based Structured Decision Making® screening tool. Reports accepted for intervention are then assigned to investigation case managers across the state. Once investigations have been completed, some children and families are assigned for ongoing case management services and assigned under the Division's Treatment program area. The Division's treatment cases encompass working with both intact families and families where the children have been removed from their care and are in foster care or other out of home care settings. The primary focus in these cases is assessment and case planning. For intact families, primary activities include initial and ongoing assessment of the family and children's strengths and needs and developing and monitoring family service plans. The focus with intact families is engagement that leads to strengthened skills and building a support network for the family to reduce the risks to the children thereby reducing the likelihood of family disruption and out of home placement. The engagement of family in assessment and case planning is accomplished through

frequent and meaningful face-to-face contacts and communication amongst the family, support system and any external professionals or community supports working with the family.

For placement cases, primary activities include all of the activities administered with intact families as well as an extensive list of additional responsibilities for treatment workers. The focus in these families is on initial and ongoing assessment of the family and children, developing a family service plan with the family with the goal of reunification and a plan for each child in care that addresses their needs while in placement. These cases are often more time consuming and demanding of a worker's available time. This is because these cases require additional activities that become part of the assigned worker's workload for these cases.

In addition to added responsibilities, there is also more oversight of these cases by the courts, the agency and external stakeholders involved in the case. There are more parties to manage and communicate with on these cases. These factors drive activities on placement cases to take precedent over activities associated with intact families. This demand significantly compromises the workers available time for all of their children and families. Some of these additional activities include managing the child in placement and attending to their well-being needs; extensive court activity; arranging and facilitating visitation with the children in care and their parents, siblings and extended family; and coordinating services for both the child(ren) in care and their parents. Again, these responsibilities are accomplished through frequent and meaningful face to face contacts and communication with the child(ren) in care, their parents or guardians as well as the care providers with whom the child(ren) are placed. These cases require additional case documentation and travel.

For some families reunification is not successful. The agency, court and supporting parties change focus and goals shift to working towards effectuating adoption or other permanent placement for the child. The children in these cases are transitioned to our Permanency and

Adoption Case Management track where case activities are primarily focused on the child and supporting, or recruiting a permanent resource while managing the child and his or her well-being needs during placement. While these cases typically do not require engagement or planning with parents or family, they still include all of the activities associated to placement cases such as court activity and coordination of services for the child. In addition, permanency and adoption cases have some specialized activities such as adoption recruitment activities and pre-placement visitation activities done with potential adoptive resources and the child.

Nationally states have continued to see high numbers of children in foster care. It is clear and statistics support that it is becoming increasingly difficult each year to meet the needs of the children and families served by DFS. Children in foster at the end of 2017 totaled 443,000 across the nation (AFCARS, 2018)[1]. While foster care numbers have experienced a slight decrease in Delaware, the number of children contributes to the growing workload for DFS workers. Often these families and children have far more complex and multifaceted challenges that need to be managed and overcome. As the needs and complexity of the families we serve increases so does the workload responsibilities for case managers. In FY18, the average monthly placement (DFS out-of-home care) population was 759 with a decrease to 661 in FY19. [2] In cases where there is placement, the demand on time and the additional oversight has led to struggles in sharing time with intact families. It has created a demand of placement case activities over intact family case activities. This is concerning, given that nearly half of the families we serve are intact yet workers struggle to find time to effectively serve these families given their workload demands of placement cases. It is critical for readers to understand that a significant part of DFS's work is to be directed at maintaining and providing services for children and families who are living together. The goal is to preserve families

[1] AFCARS Report/ACF/2018
[2] DFS FACT SHEET FY2018 &FY2019

whenever possible and ensure child safety and well-being. The Division's ability to provide adequate services in this area is significantly compromised by the activities directed towards managing cases with children in placement.

The Division of Family Services provides treatment and permanency case management services in each of its three counties. In total, the Division has 77 treatment and permanency positions across the state. Those staff are assigned to units located in each of the regional offices. Each unit is typically comprised of five or six caseworkers, one unit support worker, and a supervisor. The chart below shows the breakdown of staff in each county. New Castle County includes two regional offices (NCC1-Beech Street and NCC2- University Plaza), both with their own compliment of treatment and permanency workers. In the NCC1 regional office, there are 25 treatment and permanency workers. There is a subset of those workers (5 workers/one unit) that manage only adoption cases. In the NCC2 office, there are 15 treatment and permanency workers. In the Kent County office, there are 20 treatment and permanency workers, with one unit (6 workers) primarily handling all permanency and adoption cases. In our Sussex County offices, there are 17 treatment and permanency workers. In that county, there is also one unit (5 workers/one unit) that handles permanency and adoption cases.

Figure 1.1- Caseworkers Type by Region

Region	Treatment Workers	Permanency Workers	Total
NCCI	20	5	25
NCC2	15	0	15
Kent	14	6	20
Sussex	12	5	17
Statewide	61	16	77

The Division of Family Services case managers spend approximately 75% of their time on case related activities. The other 25% of their time is spent on administrative activities, such as training and leave. DFS case managers work 37.5 hours a week or 150 hours a month. If 75% of that time is spent on case related activities, then caseworkers have 112.5 hours each month to work with children and families. The current caseload standard in Delaware is 18 cases for treatment and permanency workers. Given this standard and the percentage of time spent a month on case related activities, workers would only have 6.25 hours per case a month available for each case. Although the caseload standard in Delaware is 18 and the statewide average typically hovers at or just above 18, there are workers that are managing much higher caseloads at any given time, particularly in our NCC1/Beech Street and Kent County regional offices. The chart below shows the caseloads at Beech Street in June 2018, one of the months during the Caseload/Workload time study. Workers in the Beech Street office are managing higher caseloads; some more than double the standard. There is simply not enough time to adequately and effectively serve a family.

Figure 1.2 -Caseload Report for NCC1/Beech Street – June 2018

UNIT A	CASES	UNIT B	CASES	UNIT C	CASES	UNIT D-Permanency	CASES	UNIT E	CASES
Worker 1A, SFSS	12	Worker 1B, SFSS	15	Worker 1C, FCT	**23**	Worker 1D, FCT	**48**	Worker 1E, FSS	18
Worker 2A, FCT	18	Worker 2B, FSS	14	Worker 2C, FCT	**28**	Worker 2D, FCT	**48**	Worker 2E, FSS	vacant
Worker 3A, MFSS	12	Worker 3B, FSS	8	Worker 3C, FCT	**25**	Worker 3D, FSS	**24**	Worker 3E, FSS	18
XWorker 4A, FSS	15	Worker, 4B, MFSS	15	Worker 4C, FSS	19	Worker 4D, FCT	**27**	Worker 4E, FSS	10
Worker 5A, SFSS	13	Worker 5B. FSS	6	Worker 5C, SFSS	**31**	Worker 5D, FCT	16	Worker 5E, FSS	17

In addition, it is important to understand what a *case* means for DFS. For the Division of Family Services, a case is assigned for a family not an individual child. That means that a treatment case

includes all of the significant participants associated to that family- the mother, father, other guardians or caregivers, all children and any other related or unrelated adults and minors living in the identified household. Remember, treatment cases can be both intact families and families who have children in placement. That means that one treatment case could have multiple children in placement that need individualized yet coordinated services. One case could include multiple children that are still in their own home and also need individualized yet coordinated services for themselves and their parents or caregivers. Therefore, the case number or caseload number alone is not an accurate depiction of the workload associated with any given case. The true workload of a case is dependent on many factors including the characteristics and risk factors of the family, the number of members in the family, the number of children in care and the stage of the case. While permanency cases are technically "child only", meaning the child in placement is the primary client, the workload associated to permanency cases is similar to that of a treatment case as they are still working with multiple parties on behalf of the child. The primary difference is the goal or focus of the a permanency case is on working towards the best permanency outcome for the child and in a treatment case the goal is primarily preservation or reunification of the family. The Division of Family Services serves between 2,000 and 2,500 cases annually in the Treatment and Permanency Program areas. In FY18, approximately half of those cases are placement cases. In those two thousand plus cases, approximately 5,000 children are served. While the number of children in care may fluctuate slightly each year, the number of families serviced in the Division's treatment and permanency program areas has not decreased but has remained steady over the last 4 years.

Child Protection Accountability Commission Caseload/Workload Committee

The Child Welfare League of America (CWLA) recommended a caseload standard of 12 constitutes an acceptable caseload size to allow a caseworker to conduct their work. CWLA also

recognizes the importance of differentiating between the amount of time it takes to service a family where a child has been removed from their home as opposed to working with a family that is intact. The unique circumstances will be discussed more fully later in the report.

Delaware's child welfare system and the Child Protection Accountability Commission have been monitoring caseloads for decades and has long been concerned about the impact that high caseloads have on the families we serve and on our child welfare system. Delaware recognized this concern over a decade ago and convened a Caseloads Committee through its Child Protection Accountability Commission (CPAC.) The Committee met for two years and presented its final report to CPAC in April 2008. During that time, legislation was passed lowering the DFS investigation caseload standard from 14 cases to 11 cases in July 2007. A separate bill was introduced recommending that the DFS treatment caseload standard be lowered from 18 cases to 12 cases; however, the bill never made it out of committee due to the fiscal climate.

Over the next several years, CPAC continued to monitor caseloads at its quarterly meetings. Additionally, when statutory authority to investigate and review deaths or near deaths of abused or neglected children was transferred to CPAC, the CAN Panel began to track individual cases above the caseload standards for investigation and treatment. As a result, in FY17, CPAC recommended the Caseloads/Workloads Committee be reconvened in response to a recommendation that arose from the Joint CPAC/Child Death Review Commission Retreat in September 2016. The charge of the Committee was to evaluate caseloads and workloads of the DFS treatment workers and provide recommendations for change to CPAC.

Additionally, CPAC's Executive Director wrote to Governor Carney last year highlighting the concern of child welfare caseloads. In letters sent on August 8, 2018 and November 14, 2018, the findings from reviews of the child deaths and near deaths due to abuse or neglect raised

concerns about frontline workers carrying high caseloads. It was repeatedly seen that DFS frontline workers are over the statutory caseload standard at the time of these near fatal or fatal incidents. These findings will continue to be made if frontline staffing resources are not made available to DFS.

One of the critical pieces of the Caseload/Workload Committee is to conduct a time study analysis of Division of Family Services treatment workers. In an effort to strategically gain information about this work, the Committee entered into a partnership with Delaware State University to accomplish a time study and structured focus groups with DFS. The study would be one critical part of understanding how treatment workers are spending their time and provide a closer view of workloads for child welfare workers. The results of this time study are summarized in this report and are one critical component for justifying why caseloads must be lowered to 12 cases.

Time Study & Purpose, Scope and Methodology of the Study:

The Federal Child Welfare Information Gateway issued a Caseload and Workload Management Issue Brief in July 2016 indicating that the most comprehensive approach to assessing caseload and workload is a workload study. Other states (Colorado, Alaska) have taken on similar workload studies and Delaware decided to follow the approach recommended by best practice experts in the field. DFS and the CPAC Caseloads Committee collaborated with Delaware State University (DSU) to conduct a time study with the goal of evaluating Treatment and Permanency caseloads and the workload associated with those cases.

The purpose of the time study was to determine how much actual time workers spent performing the various activities when providing services for children and families. Gathering that data from practicing caseworkers would allow DFS to make more appropriate caseload/workload decisions, including whether additional resources are required. This study was planned and

conducted over a four-week period. The participants, all treatment/permanency workers in the state, recorded how much time they spent on each activity, each day, for four weeks. The survey was adapted from one selected by DFS that was used in another state (Colorado) for a similar time study. Once that basic tool was selected, the focus group of DFS workers was convened to review the survey and determine if the survey in fact represented the work and activities they perform. One of the focus group sessions was held confidentially and was facilitated by the DSU partners. It was an opportunity to get direct feedback and information vital to understanding the workload and caseload issues that workers are challenged with every day. Another meeting was convened that included more workers and supervisors to receive direct feedback on the survey tool. The workers believed significant work needed to be done to adapt the survey for their use. The Division captured those comments and made revisions.

The survey was initiated in June 2018 and continued for four weeks. The protocol established called for staff to complete a daily survey and submit the surveys to an electronic mailbox set up for collection. The Division also collected demographic information about the workers and their caseloads prior to the launch of the survey phase. This information included the type of worker (treatment vs permanency), how many cases they were assigned, years of service/experience workers had with the agency, and if the cases were classified as intact family cases or placement cases and some information about placement cases. The workers were assigned a project identification number that they entered on each submitted survey. The survey tool required staff to select activities that they did that day and to indicate the project case number and the start and stop time for the completed activity. Once the survey phase was complete, all of the surveys were entered in to an Excel workbook and shared with DSU. DSU partners, together with the CPAC Data Analyst, used SPSS (Software Package for the Social Sciences) to conduct the data analysis. The results of the time study will be discussed later in this report.

Focus Group Feedback

The second component of our engagement with Delaware State University was the use of focus groups to engage staff in the survey tool development and get firsthand feedback from frontline staff. The focus group that convened in April 2018 with caseworker representatives from across the state provided very valuable contextual information regarding workers caseload, workload, and work experiences. This type of information could not be gleaned from simply conducting a time study. This group also provided valuable insight into the final development of the survey tool and survey process. This feedback allowed us to obtain first-hand information about what we had suspected for decades: that caseloads and, more importantly, the workload associated with them are unmanageable. It was clear that workers also share this concern as evidenced by their comments. For example, one worker remarked : ". . . it's like a mine field, because everybody's at 20 to 25 cases, and then [another worker] leaves, their whole unit goes up to 30 cases for a couple of months. Then [another] person has a baby, their whole unit goes up to 35 for a month".[3]

Further, workers shared concerns that the workload cannot be managed within normal working hours. DFS case managers have a 37.5 hour work week to complete all of their tasks, activities and case related responsibilities. While DFS does not require "on call" work, the workers talked about numerous phone calls, texts, and emails that needed attention while they were off work and while on vacation. One worker who attended the focus group was, in fact, "on vacation" the day of the focus group, but attended nonetheless because of the importance of having her voice

[3] Focus Group Transcript 2018

heard. While there is overtime pay, the workers are never off the clock, and generally do not receive overtime pay for phone calls that add up to a significant amount of time during any given month.

Caseworkers shared they are sometimes called on to handle cases for another worker while he or she is on leave, in addition to their own caseload. The coworker on leave could be out short or long-term. As a result, this study found one worker had as many as 51 cases due to unit vacancies or unit mates being out on leave. We also learned that other workers had more than 20 cases at any given time. For participants in the focus group who are dedicated to their job and providing safety for children and families, this condition is untenable. Workers stated: "Unexpected medical leave, unexpected mental health leave. . . you're still getting these cases. . . you're just kind of frazzled and I often times end up sitting just . . . waiting for the phone to ring. . ." to fix something on the coworker's case," (FG 2018, p. 12, line 336). While coverage for your coworkers cases may be necessary, it impacts a worker's ability to manage the needs of their own existing caseload.

All of these issues impact the skill needed, resources required, and most importantly, the time it takes to serve families. The workers are the bridge to safe and appropriate care for families in need and in crisis. The treatment and permanency workers are dedicated to their work but it is clear that they do not have enough time to successfully manage the responsibilities of cases assigned and need fewer cases to devote more time to each family. One worker remarked: "I've got cases sitting there where I haven't seen these people in over a month because I physically do not have time to do it, because I have five cases that are going crazy. . . .".[4] The importance of the workers' attitudes, beliefs, and values about their work cannot be underestimated. The treatment and permanency workers go above and beyond every day. They are committed to their work and spoke openly about their frustrations, struggles and commitment. During the focus group, one worker commented:

[4] Focus Group Transcript 2018

"No matter how many hours we spend doing this job, we're never caught up on our work, we're never focusing on all of our cases. We cannot serve our families the way that we need to, and the way that they deserve and that these kids deserve, with our case numbers being so high".[5]

Best Practices: Caseloads vs. Workloads Discussion

The information in this report can provide insight into services provided, but also a method to move forward in the development of a standard whereby treatment workers can be assigned workloads that allow for a family and child focused approach. In addition it must take into account all of the responsibilities that are required to bring a case to resolution, consistent with legal and industry standards. The research by the CWLA regarding workload perspectives is an important consideration. It is also important to understand the definition of caseload and workload. The CWLA conducted, and is conducting considerable research in the area of workload assignment. A recent report, *Caseload & Workload: A Synthesis of the Evidence Base Current trends, and Future Direction* (2018) found that there are many variables that must be reviewed when looking at caseloads or workloads. CWLA cites empirical research that makes the distinction between "workload" and "caseload" as follows:

> Caseload – All individuals (usually counted as children or families) for whom a worker is responsible, as expressed in a ratio of clients to staff members (CWLA, 2005, p. 225, as cited in CWLA 2018, p. 105).

> Workload – The amount of work required to successfully manage a case and bring it to resolution. It is based on the responsibilities assigned to complete a specific task, or set of tasks, for which the social worker is responsible (CWLA, 2005, p. 215, as cited in CWLA 2018, p. 105).

[5] Focus Group Transcript 2018

Although there is no universally tested standard that has come from CWLA, there has been extensive research for the use of a specific criteria to assign the number of caseworkers to needed families (CWLA 2018). Further, it is unlikely that one standard will be applicable to every state and region, given the differences in state requirements, geography, population, etc. However, consideration as to the "workload" associated to a case may be a more accurate reflection of the work because it takes into account the different responsibilities required and unpredictability of events during the duration of the case. It also captures the various characteristics of each case that can change at any time and can significantly impact the amount of time and effort involved. There appear to be very few predictors of the amount of time or effort a case will require at the point of initial assignment to a caseworker. The workload associated to a case is different for each case type. Considering the workload associated to certain case types, family characteristics or stage in the system could provide greater understanding related to the time needed to successfully manage that case.

There are various methods to establish best practice recommendations with caseloads but as stated above, there is no universally accepted method to establish a quality caseload. It was critical for DFS to determine which areas of casework require the most attention from a best practice perspective. There are certain essential areas where caseworkers should be spending their time which include engaging the family in assessment and planning for safety, permanency and well being, which is primarily done by face to face contact, regular and frequent communication and coordination of services.

There are enhanced practice activities that, while not always required, result in better ability to assess, plan and meet the needs of the family. We also know that best practice results in better outcomes for families. Some of those activities are Safety Organized Practice tools and strategies,

enhanced family search and engagement, group supervision and critical thinking exercises and techniques. It is important to remember that reasonable caseloads with manageable workloads coupled with best practice strategies have many benefits for both families and systems. Manageable caseloads allow workers the time they need to invest in both essential and best practice strategies, which is time intensive, but if done well, result in better outcomes.

Achieving better outcomes for children and families also results in better performance on the Federal Child and Family Services Reviews (CFSR) and demonstrates desired outcomes for safety, permanency and well-being. Also, "manageable workloads may help agencies retain workers who would otherwise opt to leave as the result of feeling overloaded."[6] Retaining workers allows the agency to continue to meet the needs of families and children and fulfill their mandate and requirements when servicing families. When workers have manageable caseloads and workloads, their performance is more likely to be consistent and committed and they are better able to handle the direct and secondary stressors of the job. High performance also results in better outcomes for children, families and systems. The time study conducted in Delaware hopes to gain a better understanding of how workers in Delaware are spending time in relation to essential case related activities and best practice activities. This information will be useful for DFS to continue to evaluate the use of best practices and the associated outcomes, and reducing the barriers to improve outcomes. One large barrier is the current caseload status and caseload standard.

What We Learned: Data Findings

All Division of Family Services treatment workers (N=76) were invited to participate in the time study project. Each worker was assigned a unique identifier for themselves and for each of

[6] Caseloads and Workloads Issue Brief, July 2016, Child Welfare Information Gateway

their cases. Most workers did not submit a survey for every day of the study and some workers did not submit any reports. One contributing factor to the inconsistent participation rate and survey submissions could be due to the time study occurring during a time frame that included a holiday and popular vacation time (July 4th holiday). However, 78% of workers participated during the study time some submitting surveys for as few as four days and others submitting as many as 21 days within the study period.

Figure 2.1 – Participation of Workers (Note: 1 worker only submitted only 3 hours of time and therefore was coded as a non-participant)

Region	# Workers	# Participants	Participation Rate	# Days Submitted	Total time documented (in hours)
Kent	20	18	90%	184	1197.2
Beech	24	15	63%	141	1167.8
Univ. Plaza	14	12	86%	153	1199.3
Sussex	18	14	78%	218	1366.8
Statewide	76	59	78%	696	4931.1

Figure 1.4 – Caseloads for All Workers (N=76)

Region	Avg. # Cases	Avg. # kids	Avg. # Placement Cases	Avg. # Placement Kids	Avg. # Intact Cases	Avg. # Intact Kids
Kent	17.4	37.3	7.5	10.8	9.9	26.5
Beech	19.6	38.4	11.8	15.9	7.8	22.2
Univ. Plaza	14.6	30.8	7.4	14.1	7.2	16.6
Sussex	13.4	26.2	8.5	12.2	5.4	14.0
Statewide	16.6	33.9	9.1	13.3	7.7	20.4

Figure 2.2 – Caseloads for Treatment Workers (N=62)

Region	Avg. # Cases	Avg. # kids	Avg. # Placement Cases	Avg. # Placement Kids	Avg. # Intact Cases	Avg. # Intact Kids
Kent	17.1	41.9	4.7	8.8	12.4	33.1
Beech	15.9	39.7	6.1	11.4	9.8	28.0
Univ. Plaza	14.6	30.8	7.4	14.1	7.2	16.6
Sussex	11.5	29.5	4.5	9.7	7.6	19.8
Statewide	15.0	36.2	5.7	11.1	9.5	25.1

Figure 2.3 – Caseloads for Permanency Workers (N=14) – permanency workers are only assigned to placement cases and therefore only placement number are represented here

Region	Avg. # Placement Cases	Avg. # Placement Kids
Kent	18.8	18.8
Beech	33.4	33.4
Univ. Plaza	-	-
Sussex	18.2	18.2
Statewide	23.8	23.8

Non-Participating Workers

With workers expressing burnout from the current workload, it is to be expected that some workers would not be able to set aside the time each day to participate in the time study. When specifically examining the workers that did not participate, over 50% of the workers that did not participate were from the Beech region, which has the highest average caseload and the largest average number of children within each caseload (see Figure 1.2). Additionally, 71% of the workers that did not participate maintained a caseload of 13 or more cases – or greater than the proposed caseload standard (see Figure 2.2)

Figure 3.1 - Non-Participating Workers

Region	# Workers	Avg. # Cases	Avg. # kids	Avg. # Placement Cases	Avg. # Placement Kids	Avg. # Intact Cases	Avg. # Intact Kids
Kent	2	16.5	45.0	4.5	9.5	12.0	35.5
Beech	9	20.9	36.6	14.6	18.9	6.3	17.7
Univ. Plaza	2	10.0	21.0	8.0	17.0	2.0	4.0
Sussex	4	15.3	40.3	6.3	12.8	9.0	27.5
Statewide	17	17.8	36.6	10.6	16.1	7.1	20.5

Figure 3.2 – Non Participating Workers, Caseload Number Breakdown

Caseload Size	# Workers
0-12 Cases	5
13+ Cases	12

Intact vs. Placement Cases of Participating Workers

The breakdown of Intact vs. Placement cases for the workers that participated in the time study is listed in Figure 4.1. When comparing the number of placement cases assigned to each worker by region and the breakdown of placement cases worked (Figure 4.2), we can see that placement cases were worked on at a higher rate than intact cases. Statewide, while placement cases comprised 52% of the caseworker's caseload, placement cases made up 57% of the total cases worked. A smaller portion of cases than should be expected were recorded as being worked on.

Figure 4.1 – Intact vs. Placement Cases Percent Worked for All Workers

Region	Total # Cases	# Intact Cases	% Intact Cases of Total Cases	# Intact Cases worked	% Intact Cases Worked	# Placement Cases	% Placement Cases of Total Cases	# Placement Cases worked	% Placement Cases Worked

Kent	315	174	55%	126	72%	141	45%	119	84%
Beech	282	130	46%	91	70%	152	54%	135	89%
University Plaza	185	97	52%	69	71%	88	48%	100	113%
Sussex	175	55	31%	55	100%	120	69%	107	89%
Statewide	962	456	48%	341	75%	501	52%	461	92%

Figure 4.2 – Intact vs. Placement Cases Percent Worked for Participating Treatment Workers

Region	Total # Cases	# Intact Cases	% Intact Cases of Total Cases	# Intact Cases worked	% Intact Cases Worked	# Placement Cases	% Placement Cases of Total Cases	# Placement Cases worked	% Placement Cases Worked
Kent	240	174	73%	126	72%	66	28%	65	98%
Beech	202	130	64%	76	58%	72	36%	71	99%
University Plaza	185	97	52%	69	71%	88	48%	100	113%
Sussex	84	55	65%	49	89%	29	35%	31	107%
Statewide	681	439	64%	320	73%	242	36%	267	110%

Figure 4.3 –Placement Cases Percent worked of Participating Permanency Workers

Region	Total # Cases (All Cases)	# Placement Cases worked	% Placement Cases Worked
Kent	75	55	73%
Beech	80	67	84%
University Plaza	-	-	-

Sussex	91	77	85%
Statewide	246	199	81%

Figure 4.4 – Intact vs. Placement

Region	Total Cases Worked	Intact Cases Worked	% Intact worked of total worked	Placement Cases Worked	% Placement worked of total worked
Kent	245	126	51%	119	49%
Beech	226	91	40%	135	60%
University Plaza	169	69	41%	100	59%
Sussex	162	55	34%	107	66%
Statewide	802	341	42%	461	58%

Figure 4.5 – Intact vs. Placement – Placement cases disproportionately worked on (Treatment)

Region	Total Cases Worked	Intact Cases Worked	% Intact worked of total worked	Placement Cases Worked	% Placement worked of total worked
Kent	191	126	66%	65	34%
Beech	147	76	52%	71	48%
University Plaza	169	69	41%	100	59%
Sussex	80	49	61%	31	39%
Statewide	587	320	55%	267	45%

Figure 4.6 – Time spent on Intact vs. placement cases (regions added together do not add up to the statewide total due to rounding)

Region	Time spent on Intact Cases (hours)	Time spent on Placement Cases (hours)	Times more Time spent on Placement than Intact

Kent	347.9	640.0	1.8
Beech	275.4	706.0	2.6
University Plaza	372.2	740.4	2.0
Sussex	341.8	796.5	2.3
Statewide	1337.2	2882.9	2.2

Statewide, over twice as many hours were recorded as being spent on placement cases than intact cases, despite each region having more intact cases than placement cases. The Beech Street region has the highest overall caseload average, along with the highest average number of placement cases and placement kids. (Figure 1.4). This is also the region that had the most significant difference in time spent on intact and placement cases. It can be inferred that since these cases have court oversight, the workers prioritize those cases. If the placement caseload is too high, the workers will run out of time to spend on intact cases. Case response should be proportional to the risk. Since intact cases represent the cases with the highest levels of risk, ideally, the majority of the workers' time would be spent with intact cases.

Caseload Size

The participation rate for workers with a smaller caseload is higher than that of workers with larger caseloads. It can be inferred that since the workers with larger caseloads are participating at a lesser rate, these are the workers with less time to fill out the daily surveys. Workers reported spending an average of 30 minutes filling out the survey each day, which is valuable time that could be spent tending to one of the many cases on a workers' caseload. Thirty minutes may not be time that can be set aside for a worker with a larger caseload.

Figure 5.1 – Participation rate by Caseload level

Caseload Size	# Workers	# Participants	Participation Rate	# Days Submitted	Total time documented (in hours)	Avg Days Submitted	Avg Time Total Submitted (in hours)
0-12 Cases	27	22	81%	267	1816.4	12.1	82.6
13+ Cases	51	37	73%	428	3110.9	11.6	84.1

Figure 5.2 –Cases Worked of Participating Workers by Caseload Level

Caseload Size	# Intact Cases (of participating workers)	# Intact Cases worked	% Intact Cases Worked	# Placement Cases (of participating workers)	# Placement Cases worked	% Placement Cases Worked
0-12 Cases	91	98	108%	88	126	143%
13+ Cases	365	259	71%	413	354	86%

When looking at the cases worked breakdown by caseload size (see Figure 4.2), the percent of intact and placement cases are both over 100%. This means that these workers are helping with cases assigned to other workers. For example, in Kent, 2 workers left just before the project began. The 47 cases and 51 kids assigned to those 2 workers needed to be covered by other caseworkers.

Primary Activities, Placement Activities and Best Practice Activities

Once results were received regarding the amount of time actually spent on certain activities, it was important for us to examine more closely the different activity types accounted for in the study. Prior to launching our time study in Delaware, we researched other states who had conducted similar studies. Some of those states, such as Colorado, Washington and Alaska, had included in their time study work, an analysis of the actual time spent vs the expected or needed time in accordance with industry standards and best practices. For Example, The *Colorado Child*

Welfare County Workload Study (2014), used the outcomes of their survey to determine the discrepancies between the actual time measured in the time study and how much time is needed to be in compliance with industry standards and best practice. This helped them determine what supports their workers and their system needed. Delaware decided to conduct a similar analysis.

Like Colorado, we conducted a series of meetings with subject matter experts who worked together to estimate the amount of time activities would require if they are to be considered up to industry standards and in line with best practices. This group determined that there are a set of activities that are essential to all cases and case types and are considered primary activities. The group also examined the differences in additional activities on placement cases and estimated how much time those activities should take to be considered in line with industry standards. Finally, the group also determined a set of activities that we consider solely best practice activities applicable to any case type and designed to enhance practice and outcomes for children and families.

There are certain activities conducted by Treatment and Permanency workers that are essential to all cases and are considered primary activities for both case types. Those activities are reflected in the chart below, Figure 6.1. When we looked at these essential case activities in relation to the time estimated and the time reported in the time study, we learned that workers who participated in the study reported less time, indicating that they were unable to spend the best practice estimated time for that activity type. We know from the time study results that Face to Face Contacts, Communication and Case Documentation were three of the most frequently occurring activities and averaged the most time reported. However, in considering the best practice estimated time for these activities, it is clear that although workers really are spending much of their time on these activities, they are still not able to spend adequate time on these activities. For example, in the activity categories of Face-to-Face Contacts workers reported spending less than half (4.8 hours) of

the estimated/needed time of 12 hours each month. The time study indicated that face to face contacts that reported on cases where surveys were submitted was low, at 32%. The agency has expectations and measurements set for face to face client contacts at 95% of contacts should be made on time. In FY2018, face to face client contacts measurement for DFS was at 84% , again and indication that while workers are spending a considerable amount of time on this critical activity they are still unable to reach the goal.

Not having enough time to engage in meaningful and frequent contacts with clients and parties associated to the cases compromises a workers ability to accurately assess and ensure safety of the children. It further impacts their ability to engage the family, care providers and others in goal planning and ongoing assessment of needs and strengths, as well as progression on service plans. Reducing caseload sizes to manageable levels will allow for more thorough and meaningful case contacts.

Fig. 6.1-Primary activities for Intact and Placement Cases

Activity Category	Actual Reported Hours for the activity per Time Study results	Estimated hours for the activity
Face to Face Contacts	4.8	12
SDM/Assessments	2.1	8
Communication	5.3	10
Goal Planning	2.4	6.5
Administrative Functions	10.16	18

Travel	10.8	11
Case Assignment Activities	6.3	10
Safety	1	5
Case Documentation	5	7.5

Placement Cases require additional activities and therefore expand the workload of the treatment or permanency worker. The activities in the chart below (Fig. 6.2) show the activities that are required in placement cases- Custody, Placement, Court Involvement, and Visitation, Child Well Being Activities, Permanent Guardianship or Adoption specific activities, older youth activities and missing children activities. These are not activities associated with an intact family case with some infrequently occurring exceptions such as court involvement to accompany a parent or child to a court proceeding. As with the primary activities, each of these activity areas captures multiple sub-activity types that were reported in the Time Study. While the actual time reported for some of the activity categories associated to placement cases is closer to the best practice estimated time, we still see significant differences in the categories of Custody (5.9 reported hours vs. 10 estimated hours) and Visitation (4.1 reported hours and 8.5 estimated hours). It is important also to recognize that these activity categories are essentially required activities on placement cases. All placement cases require court activities and visitation between the child or children in care and their parents and families. We must also remember that these are activities in addition to primary case activities that are essential to all cases managed by a worker.

Fig. 6.2-Additional Activities for Placement Cases- Figure

Activity Category	Actual Reported Hours for the activity per Time Study Results	Estimated hours for the activity
Custody	5.9	10
Placement	10	14

Court Involvement	14.7	19.25
Visitation	4.1	8.5
Child Well Being	10.5	14.5
Permanent Guardianship/Adoption specific	6.4	8
Older Youth Activities	4.5	5
Missing Children	4.6	6

This chart (Fig. 6.3) highlights some of the case related activities that are considered Best Practices in the field of child welfare. These activities when completed are known to result in better engagement and better outcomes for children and families. As you can see below, these activities are some of the least reported activities in terms of frequency and time reported and show the greatest percentage change between hours reported and hours estimated. Workers simply can not get to these activities due to the pull of additional activities/duties associated with placement cases and the primary activities on both their placement and intact family cases. For example, Safety Organized Practice, which is a practice model that DFS adopted as part of their Outcomes Matter Initiative Package that began in 2013, has the smallest amount of actual reported time of all the activity categories in the time study. It therefore has the largest difference between the reported time and estimated time. Safety Organized Practice (SOP) is a practice model designed to help child welfare staff use critical thinking and build good working relationships with families to improve child safety and improve outcomes for children, families and systems. When workers are unable to invest time in these strategies and practices the children, families and our system suffer.

Fig. 6.3-Best Practices Activities- Figure

Activity Category	Actual Reported Hours for the activity per	Estimated hours for the activity

	Time Study Results	
Family Search and Engagement	1.7	5
SOP (Safety Organized Practice)	.83	5
Case specific meetings	7.3	11.25

As a result of the comparison of the time study with the best-practice estimates to complete the work as outlined above, DFS can make recommendations regarding the number of full-time positions that are needed to be able to successfully manage the workload and meet industry standards related to best practice. The largest percentage of increase in the activities between actual and estimated time will provide information about the largest areas of needed resources. Depending on where DFS determines the need is greatest, such as with child and worker contact, they can then determine where additional resources are best applied. In addition, with the increase in caseworkers, there is a mandated ratio of supervisor to worker staffing. Supervisors will also be required with additional workers.

Summary

This study revealed information that DSCYF can utilize to inform its practice with children and families. Again, as stated throughout the report, the limitations of this point-in-time-snapshot should be considered. Replicating the study or allowing for a longer duration of time for future caseload studies to be completed may yield different information for DSCYF. However, the committee would like to highlight main findings from the data.

The first is that workers are spending more time on placement cases than intact family cases. The data revealed that treatment workers spend 2.5 times longer on placement cases than intact cases. On a practice level, this means that there are children and families with some level of risk

associated with their cases, where children are still residing in the home, and their cases are receiving less attention. One of the main goals of DFS is to keep families together and prevent removing children. However, the data revealed that workers are providing less time with families who may be at greater risk of entering out of home care. There should be considerations made as to how additional support can be provided to these families and what specific types of support are most needed to keep families together.

During the time study, the data revealed that less than half of the cases with recorded activities received a fact to face contact during the reporting period. As noted throughout the report, meeting in person with children and families is a critical component to quality case management. It allows for accurate assessments to be completed; it allows for individualized service planning to occur and it allows time for a worker to build a trusting and helping relationship with children and families who need support. Recognizing the challenges of the work study such as not all cases being reported on during the study and not all workers participating, the face to face contact data shows a much lower than desired amount of time being spent on this critical case activity. It should however be noted that face to face contacts was one of the top three activity categories where workers recorded time spent. Therefore, we learned that although workers are spending a considerable amount of their time completing face to face contacts, they are still not able to see children and families frequently or consistently enough. It is clear that resources are needed that allow more time for workers to meet with children and families face-to-face.

DFS adopted a variety of best practices to implement several years ago as part of their Outcomes Matter Initiative. These practices were strategically adopted by DFS because they are found to be effective evidence based practices aimed at prevention efforts and keeping families together while improving outcomes for children and families. However, the data revealed that the

least amount of time was spent on Family Search and Engagement, Safety Organized Practice and Safety related activities that are part of the Outcomes Matter Initiatives package. These are activities that did not happen with significant frequency throughout the study; however, when completed they did take significant time to properly complete. In order for DFS to be even more successful in strengthening practices related to Outcomes Matter initiatives, resource considerations must be made that allows for ample time to use these best practices. Without the necessary resources, it will be impossible to for DFS to support children and families in ways that help strengthen them and prevent placements.

CPAC Recommendations

This report was intended to provide a strong recommendation to the State of Delaware surrounding the unsustainability of current caseload standards for child welfare workers, how they present safety risks to underserved children and families and the need to re-evaluate the current caseload situation. There are recommendations for the General Assembly as well as implications and further consideration points for the leadership at DSCYF.

Recommendations for the General Assembly:

1. Lower the treatment caseloads to 12 cases for DFS treatment workers. This will require a change in the current caseload mandate of 18.
2. Support increased funding for DSCYF/DFS to allow for necessary resources so that DFS can come into compliance with the new mandated caseload standard of 12. DFS would consider additional staffing and/or expanded or new contractual services as the resources needed.

DFS Implications and Further Considerations:

DFS recognizes that even with the right resources, effective case management is achieved through ongoing consideration, implementation and monitoring of multiple strategies and practices. DFS will consider evaluating the implementation of the following strategies:

1. Consider changing the calculation formula for caseload reports to more accurately reflect the workload. One change could be counting cases by child not by family.

2. Currently caseload calculations include only fully functioning staff and their assigned cases. Fully functioning workers are those who have completed the new worker training, are not on leave, and therefore are on full rotation for case assignments. Consideration should be given to including all workers regardless of their fully functioning status. This would include workers are on leave or otherwise off rotation but still carrying cases. To accomplish this, we will consider supplemental or tiered caseload reporting.

3. Consider a case weighting strategy that may assist supervisors in decision making around case assignments.

4. Explore best practices in case in assignment and specialization once staffed appropriately, such as intact only or placement only caseloads.

References

Collins- Camargo, C., Collins, J., & Wilfong, J. (2018). Child Welfare League of America Caseload & Workload. A Synthesis of: The Evidence Base, Current Trends, and Future Directions. Washington, D.C.: CWLA Press.

ICF International, Inc. (August, 2014). Colorado Child Welfare County Workload Study

Retrieved from: https://leg.colorado.gov/sites/default/files/documents/audits/1354s_-_colorado_childrens_welfare_workload_study_report_august_2014.pdf

Department of Service for Children Youth and Families (2018). Family Services.

Retrieved from https://kids.delaware.gov/fs/fs.shtml

Langley, T. R. (2010). Child Protection, The Courts and Social Workers. New York

State of Delaware 2015-2019 Child and Family Services Plan. Retrieved

from https://kids.delaware.gov/pdfs_archive/fs/fs-CFSP-2015-2019.pdf

State of Delaware Child Protection Accountability Commission Fiscal Years 2004 and

2005 Annual Report. Retrieved from.

https://courts.delaware.gov/forms/download.aspx?id=39128

State of Delaware, CPAC. (February 26, 2007). Caseload/Workloads Subcommittee Interim

Report.

APPENDIX A – Copy of Survey

APPENDIX B – Time spent by Category and Activity (NOTE: CAN BE REORGANIZED TO MATCH ACTUAL SURVEY)

Category	Activity	Count of Occurences	Total Time	Average Time (in Minutes)
Administrative Functions	Focus Issues	75	4857	65.6
	IT Issues/Complications	8	193	24.1
	Mandatory & ongoing trainings	21	3965	188.8
	Mentoring/Interns	45	2470	54.9
	Other HR-related expectations	48	1830	38.1
	Records request and redaction	12	645	53.8
	Staff meetings	13	1067	82.1
	Supervision	113	3200	28.3
	Unit Meetings	6	372	74.4
Administrative Functions Total		**341**	**18599**	**610.1**
Case Assignment	Coverage of Colleagues cases	67	4730	71.7
	Framework (prior to assignment)	3	150	50.0
	Initial Contact	28	2402	89.0
	Mine the File/Review Case	235	8753	37.2
	Treatment Response to new hotline	22	1893	90.1
	Warm Handoff	13	477	39.8
Case Assignment Total		**368**	**18405**	**377.8**
Case Documentation	Criminal Background Checks	85	1356	16.1
	FACTS/FOCUS Work	301	16237	54.3
	History Notes	27	1055	39.1
	Ongoing case notes	665	26301	39.7
	Referrals/Applications	76	2862	38.2
	Social Summaries	6	570	114.0
Case Documentation Total		**1160**	**48381**	**301.4**
Case Specific Meetings	CAC Related Activities	2	245	122.5
	Coordinating meetings	32	1000	31.3
	Family Team Meetings	25	1817	72.7
	FIRST Meetings	1		
	Framework Meetings	1	15	15.0
	MDT Meetings	1	120	120.0
	Team Meetings (child specific)	49	3540	75.3
Case Specific Meetings Total		**111**	**6737**	**436.7**
Child Well Being	Best Interest Meetings	21	1088	51.8
	Coordinating appointments	72	2641	37.2
	Crisis Planning (placement disruption, out of medication, CPR, inpatient hospitalization)	10	490	49.0
	Dental appointments	12	950	79.2
	Doctors appointments	25	1940	80.8

	IEP/504 meetings	10	600	60.0
	Mental Health Appointments	31	2517	83.9
	Paternity testing	1	20	20.0
	PBH Referrals	8	465	58.1
	Purchases for child and/or family	22	1018	46.3
	School/Extracurricular Activities	20	895	44.8
	Signing consents	29	547	18.9
Child Well Being Total		**261**	**13171**	**629.9**
Communication	Communication Regarding Medical/Medicaid	55	1655	30.6
	Communication Related to Adoptive Activities	22	860	41.0
	Contact with family interventionalist	177	4098	23.4
	Contact With OCA	88	1587	18.0
	Contact with various workers involved in the case	377	11539	32.1
	Emails / Letters	871	20818	25.2
	Phone calls/texting collateral	177	4535	25.9
	Phone calls/texts with Bio-Parent/s	464	8769	20.0
	Phone calls/texts with foster parents	271	5590	22.6
	Phone calls/texts with Relatives	200	5039	25.7
	Phone calls/texts/ with child/ren	61	1218	24.4
	Written Request of Collaterals	39	1074	27.5
Communication Total		**2802**	**66782**	**316.5**
Court Involvement	Child Support	1	60	60.0
	Court appearances - Adult criminal	2	126	126.0
	Court appearances - civil - closed (private custody/guardianship)	7	793	113.3
	Court appearances - Criminal - Child	21	2495	118.8
	Court appearances – in Court - Civil - DFS (DFS/custody/guardianship/private custody)	73	6939	97.7
	Documentation for Court	55	3319	61.5
	Filing court documents	9	205	22.8
	Mediation	4	360	90.0
	Notification of Court	17	540	31.8
	Preparation for Court	186	10638	57.5
	Publications	2	27	13.5
	Substantiation Hearing	1	30	30.0
	Truancy	1	60	60.0
Court Involvement Total		**379**	**25592**	**882.8**
Custody	Filing a Petition	7	220	31.4
	Referral / Attending TDM	5	630	126.0

	Removal Activities	10	573	57.3
	Writing the Petition	15	2055	137.0
Custody Total		**37**	**3478**	**351.7**
F/F Contacts	Face-to-face in the community	90	6558	74.5
	Face-to-face in the foster home	67	3166	50.3
	Face-to-face in the home	148	6787	46.8
	Face-to-face in the office setting	29	1798	69.2
	Face-to-face with parent/s	212	10701	50.7
F/F Contacts Total		**546**	**29010**	**291.5**
Family Search and Engagement	FSE activities (mine record, use of tools)	14	810	57.9
	Monitor social media	15	266	17.7
	Relative Notification Letters	2	55	27.5
Family Search and Engagement Total		**31**	**1131**	**103.1**
Goal Planning	Case Transfer to Permanency	9	430	47.8
	Family Service Plan Review	56	2682	47.9
	PPC	17	800	50.0
Goal Planning Total		**82**	**3912**	**145.7**
Leave	Holidays/Sick/Personal Time	152	59522.5	399.5
Leave Total		**152**	**59522.5**	**399.5**
Missing Children Activities	Documentation of efforts	5	130	26.0
	Efforts / leads to locate child	10	315	31.5
	Interview of a child upon return	2	45	22.5
	Medical exam	1	120	120.0
	Police/Special Investigator/NCMEC contacts/communication	8	125	15.6
	Runaway Events / Reports (NCMEC)	8	490	61.3
Missing Children Activities Total		**34**	**1225**	**276.9**
Older Youth	Board Extension	3	60	20.0
	Exit Meetings	2	65	32.5
	IL Assessments (14/15 year olds)	3	75	37.5
	IL Referrals	2	70	35.0
	Plan for Adulthood (Medicaid, scholarships)	1	60	60.0
	Steps Meetings	1	90	90.0
Older Youth Total		**12**	**420**	**275.0**
Perm Guardianship/Adoption Specific	Child Profile Review / Edit	4	250	62.5
	Perm. Guardianship / Adoption Selections	2	160	160.0
	PPC Presentation	11	340	37.8
	Pre-Placement visits/coordination	2	115	57.5

	Review home study reports	3	125	41.7
	Review TPR / Adoption/Guardianship Pet	7	165	23.6
Perm Guardianship/Adoption Specific Total		**29**	**1155**	**383.0**
Placement	5 Day Plan	11	565	51.4
	Child Plan Review	10	295	29.5
	Child Plan	28	1575	56.3
	Completing the LOC	35	1330	38.0
	Coordinating/Waiting for Placement	51	3170	63.4
	Gather information (Birth Certificates, SS Card, Birth records, etc.)	27	1260	46.7
	Home Safety Assessment	7	345	49.3
	Ice Breaker	1	30	30.0
	ICPC	9	305	33.9
	Out of State Placement Activities	7	345	49.3
	Physical Placement of Child	16	1695	121.1
	Placement Paperwork	40	1414	37.2
Placement Total		**242**	**12329**	**605.9**
Safety	Assessment	28	820	29.3
	Creating of Safey Agreement	21	700	33.3
Safety Total		**49**	**1520**	**62.6**
SDM	Child Strengths and Needs	28	975	34.8
	Family Strengths and Needs	43	1905	44.3
	Reunification Assessment	5	115	23.0
	Risk Re-assessment	26	672	25.8
SDM Total		**102**	**3667**	**128.0**
SOP	Circles of Support	2	40	20.0
	Genograms/Ecomaps	1	30	30.0
SOP Total		**3**	**70**	**50.0**
Times	Time Taken to Complete Survey	388	12945	33.5
	Time Taken to Eat a Non-Working Lunch	285	9881	34.7
Times Total		**673**	**22826**	**68.2**
Travel	General Transportation to appointments (child)	95	6577	72.3
	General Transportation to appointments (parents)	19	1055	58.6
	Out of State Travel	5	1050	210.0
	Transportation to/from visits	62	3522	57.7
	Travel to court	93	3908	42.9
	Travel to visit child	167	8505	51.5
	Travel to visit collateral contacts	1	60	60.0
	Travel to visit foster parents	26	1240	49.6
	Travel to visit parent/s	184	8341	45.6

Travel Total		**652**	**34258**	**648.3**
Visitation	Coordinating visitation with parent/s	69	2092	31.7
	Coordinating visits with contracted provider agency	55	1930	35.7
	Coordinating visits with foster parents	36	910	26.8
	Coordinating visits with relatives	49	1713	35.0
	Coordinating visits with siblings	6	115	19.2
	Supervision of visits of siblings	1	10	10.0
	Supervision of visits with parents/relative	22	1980	90.0
Visitation Total		**238**	**8750**	**248.3**
Grand Total		**8304**	**380941**	**7592.9**