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Audit Report

**DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
DIVISION OF FAMILY AND
YOUTH SERVICES
FOLLOW-UP**

January 26, 1999



Audit Control Number:

06-4595-99

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

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January 26, 1999

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF FAMILY AND YOUTH SERVICES FOLLOW-UP AUDIT

January 26, 1999

Audit Control Number

06-4595-99

In April 1998 we issued an audit report that discussed various aspects of the operations of the Division of Family and Youth Services (DFYS). In that report we discussed many of the problems faced by DFYS, which contributed to the agency not being able to respond to all of the reports of harm (ROHs) received regarding the abuse and neglect of children. This report is a follow-up review of the current status of the recommendations made in the prior report.

Our central conclusion is that at this time, it is too early to see significant impacts on either number of cases worked, or on how the cases are worked by DFYS. So far in FY 99 (through October 1998) the agency is investigating fewer reports of abuse and neglect than it had for the same months in each of the prior two years. It again appears management decisions have contributed to the agency not making any progress towards investigating all ROHs it receives. We also discuss in the report improvements such as better recruitment and more timely hiring of social workers as well as better training provided to the newly-hired social workers.

The audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in developing the conclusions and recommendations presented in this report are discussed in the Objective, Scope and Methodology section.

A handwritten signature in cursive script that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we conducted a review of various aspects of management and casework related to the child protective services function within the Division of Family and Youth Services (DFYS). The agency is organizationally located in the Department of Health and Social Services (DHSS). Our audit was designed to review the issues previously identified in a prior DFYS audit (Audit Control No. 06-4586-98) released in April, 1998.

Objectives

Specifically, the objectives of our follow-up review are as follows:

1. To evaluate how effectively DFYS management has utilized FY 99 personal services appropriations in maintaining agency-staffing levels to adequately address and respond to reports of child abuse and neglect received by the agency.
2. To identify the factors and circumstances, if any, which inhibit the agency's readiness to effectively respond to reports of child abuse and neglect.
3. To identify the degree to which DFYS is unable to respond to reports of harm and how the agency deals with such reports.
4. To assess the impact of recent changes in federal and state law on the State's child protection system.
5. To determine the status and effectiveness of the newly established Family Services Training Academy.

Scope

Our audit focused primarily on determining the current status of recommendations from our prior audit. Data analyzed was primarily from the first four months of FY 99, with comparisons to the same four months in prior years. As of the date of this review, comprehensive statistics past October 1998 were not available.

Methodology

In carrying out our follow-up audit we:

1. Interviewed DFYS child protection staff across the State including investigators, supervisors, and regional children services managers.
2. Reviewed reports from the agency's case management system, known as PROBER.

3. Reviewed other child protection system reports including various publications from the Child Welfare League of America.
4. Analyzed expenditures for DFYS personal services in FY 98 and FY 99 using agency budgets and state payroll information.
5. Performed a review of various aspects of the legal system and its affects on the State's child protection system. Our review included obtaining an understanding of current state and federal laws, the impact of recent Alaska Supreme Court decisions, and recent changes to federal law (the Adoption and Safe Families Act of 1997). We also attended training that discussed the impact of the new state and federal laws on the way cases are worked.
6. Attended a multi-agency meeting regarding the impact on services to children of the new federal and state laws.
7. Attended a meeting of regional children services managers.
8. Interviewed the coordinator for the DFYS/University of Alaska-Anchorage Training Academy.
9. Reviewed course evaluations completed by individuals receiving the training offered.

ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services with responsibility for providing a range of services designed to remedy or prevent abuse, neglect, and exploitation of children and youth. To meet these statutory responsibilities, the department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the youth section of the Division of Corrections.

The Family Services section of DFYS is responsible for providing child protection and welfare services, licensing of child care facilities, and the recruitment, selection, and training of foster parents. The other major section of DFYS, Youth Corrections or Youth Services is responsible for supervising adjudicated youth offenders. In FY 99, the agency budgetarily separated family services functions from youth corrections activities.

The focus of this audit was Family Services. Specifically, the audit concentrated on child protective services (CPS). The goal of CPS is to identify, treat, and prevent child abuse and neglect, as well as to ensure reasonable efforts are made to protect and maintain children in their own homes. DFYS provides protective services for children by investigating reports of harm, referring families to community resources, initiating legal intervention if children are unable to remain safely in their own homes, and providing out-of-home placements and permanency planning when necessary.

When children are taken into physical custody they are placed either in foster care or in an emergency shelter facility. DFYS also contracts with residential care facilities to provide assorted levels of care and treatment of youth.

Each provider is subjected to licensure and periodic review to assure children are provided with reasonable care in a safe environment. Responding to complaints of abuse and neglect for children in out-of-home care is also the responsibility of DFYS social workers.

In 1991, the Hickel administration comprehensively reorganized DFYS. The Family Services section was scaled down (from five) to three regions: Southeast, Southcentral, and Northern. The Southcentral region has recently been divided into two regions: Anchorage and the rest of Southcentral. The administrator for each region headquartered in Juneau, Anchorage, and Fairbanks, respectively, currently reports directly to the division director.

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SYNOPSIS OF PRIOR REPORT CONCLUSIONS

As discussed in the Objectives, Scope and Methodology section, the objective of this review is to assess the current status of the findings from our previous Division of Family and Youth Services (DFYS) audit released in April 1998. In this section we summarize conclusions from that report. In that audit we also presented recommendations that addressed such case management topics as workload prioritization, personnel utilization, personnel training, and new child protective services legislation. These are summarized in the Findings and Recommendations section.

Personnel and caseload

A central issue of our prior review was the utilization of personnel resources. Up until the time of the previous audit, DFYS had faced a growing caseload. Although the workload has leveled off over the past year, the agency reports cases are becoming more complex. The growth in caseload and its increasing complexity limited the agency's ability to carry out investigations effectively and efficiently. Not all reports of harm (ROHs) involving abuse or neglect of children can be investigated. Of those reports that are assigned, many investigations were delayed. Though DFYS was unable to effectively carry out much of its work, the agency attempted to address the most serious problems through a system of prioritization of ROHs. By doing so, the agency tried to identify and address the needs of children most at risk.

In this context, we reported in our previous audit the following conclusions:

1. In FY 97 DFYS could not investigate more than 3,700 ROHs that were within the agency's jurisdiction. DFYS is required, by statute, to take and investigate all ROHs of suspected child abuse and neglect. For the last complete fiscal year at the time of our prior audit, the agency was unable to meet this statutory responsibility.
2. The agency's triage response to ROHs is risk based but leaves some children at risk. As discussed previously, to manage an increasing workload, DFYS has developed an informal policy to delay or never investigate ROHs determined to be lower risk. The use of this practice, referred to as workload adjusting, varies between district offices. Some agency offices workload adjusted as many as two-thirds of the ROHs received. Though it appeared to us DFYS was generally triaging ROHs in ways consistent with a risk-based approach, we remained concerned that the agency's inability to investigate many cases leaves some children at risk.¹

¹ The agency's Child Protective Services (CPS) manual, which provides guidance for prioritizing ROHs, comments that children younger than 6-years-old are more vulnerable to harm than older children. Of the workload adjusted reports we reviewed, 56 (19%) involved children under the age of 6. This vulnerable group represents children that are the least able to care for or protect themselves. These children are also more likely to be isolated from public view and mandatory reporters than children of school age.

3. Most ROH investigations that are started are completed within two months. In our prior review we discussed the length of time it took DFYS to investigate ROHs. As measured by the first report of contact compared to the last report of contact, we determined that while the average case took about 35 days to investigate, most (83%) were completed within 60 days. We also noted, the cases that were ultimately substantiated typically were investigated longer than cases determined to be unconfirmed or invalid. In a review of 412 cases, we found that on average, substantiated cases took nearly 45 days to investigate, while unconfirmed cases took only 29 days.²
4. DFYS was unable to consistently provide ongoing services to some children and families. Whenever a decision is made to continue with a case beyond the investigation phase, DFYS policy requires ongoing services to be provided to the family. The minimum casework service to be provided to the child and family are determined by an agency risk assessment which consists of evaluating several factors. In general, the higher the assessed risk to the child, the more contact is required by the DFYS social worker.

The Southcentral Region developed and implemented an internal supervisory review process for ongoing cases. The reviews were carried out over the last nine months of calendar year 1997. These reviews, in total have indicated that in the Southcentral Region about two-thirds (67.5%) of the ongoing cases did not meet the required contact standards.

5. DFYS did not fully utilize appropriation funding for personnel during FY 97. A standard practice in most executive branch agencies is to leave some authorized, funded positions vacant in order to be sure operational expenditures are within established budgets. Although DFYS received a relatively small reduction in the requested funding for staff, agency managers left 21 positions vacant for all of FY 97. Of these, ten were case carrying social worker positions, one was a social worker supervisory position, while six others provided support, both administrative and programmatic, to line social workers.

Our analysis indicates that child protective services, particularly in-the-field social worker positions, absorbed a disproportionately greater number of these empty positions, ostensibly kept vacant to cover the agency's imposed vacancy and turnover, or V&T, factor. This practice was particularly pronounced in the agency's Northern Region (NRO). Of the ten case-carrying social workers positions kept vacant statewide, five were in NRO.

The combination of the positions left vacant (or forced vacancy factor), combined with the other positions that went vacant for shorter periods time (the natural vacancy rate

²Lack of timely and thorough investigations can actually increase the risk of abusive or neglectful behavior. According to a 1990 report issued by the U.S. Advisory Board on Child Abuse and Neglect, unresolved investigations create and sustain uncertainty in the family about the future. This uncertainty causes anxiety within families, and may stall children's development. Further, mandated reporters (i.e. teachers, doctors, etc.) may begin to doubt the system and fail to continue to report suspected cases of abuse, thus placing children at greater risk of continued abuse or neglect. The risk is even greater for families who are not offered or do not accept services following an investigation.

generated by employee turnover), allowed DFYS to come in well under (just over \$1 million) the agency's FY 97 personal services budget. DFYS utilized this funding to cover retirement incentive program costs not only for staff within the agency's appropriation, but for other agencies within the Department of Health and Social Services.

Most of the excess authorization funding (just over \$880,000) was used to fund a reimbursable services agreement (RSA) with the Division of Retirement and Benefits for retirement incentive program (RIP) costs. The RSA essentially prepaid RIP costs for FY 98, FY 99, FY 00, and FY 01. In addition, the RSA funds were used not only to cover the RIP costs for DFYS employees, but also for some of the RIP costs of participating staff of the Alaska Psychiatric Institute.

Other Issues

In addition to the personnel and caseload issues discussed in the previous report we also discussed other issues that had an impact on the operations of DFYS. These other issues discussed in the report included:

1. Child protection statutes. State law also affects the functioning of the agency, and how it is interpreted and applied by the courts. We concluded that a lack of specificity in the statutes as they existed, limited the agency's authority to terminate parental rights.³
2. DFYS staff training efforts have suffered from lack of coordination, consistency, and funding. In the previous audit we discussed how DFYS training had been reduced in past years, primarily due to changes in administration, decisions by management, and/or use of available funding. This has resulted in untimely "CORE" training which provides child protection orientation to new employees. Prior to February 1998, CORE training had not been held since early 1995.

Discussion of prior report conclusions in current report

These various conclusions were reflected, to varying degrees, in the Findings and Recommendations presented in the previous report. We used those Findings and Recommendations as a basis for setting the scope of this follow-up audit. Accordingly, the current situation, practices, and our perspective on the issues summarized in this section are reflected in the Findings and Recommendations of this report.

³We often saw cases where parents repeatedly failed to take appropriate action or change their personal conduct to alleviate the living conditions that posed a threat to the safety of their children. Included in the cases we selected for review were two cases where DFYS moved to terminate parental rights. In both instances there were numerous children involved and the parents had an extensive history of failure in complying with the case plan developed by DFYS. The case plan attempted to reunify the children in state custody with their parents while providing some assurance of safety and care. The children's case files involved sequential case plans, filled out over numerous years, which called for the parents to enter substance abuse treatment. The parent(s) involved were given multiple opportunities to make minimal changes needed to forestall termination of parental rights, but their efforts were repeatedly insufficient to fully resolve the problems involved.

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BACKGROUND INFORMATION

The following brief description of new federal and state laws is intended to provide the reader with a better understanding of some of the more significant technical changes in those laws.

New federal law promotes limiting time children may be kept in out-of-home care

On November 19, 1997 the president signed into law the Adoption and Safe Families Act of 1997. The primary focus of this law is to improve the safety of children, promote adoption and other permanent homes for children who need them, and support families. The new law made numerous changes and clarified a wide range of federal policies that had been in place since the 1980 Adoption Assistance and Child Welfare Act. The new law provides for the following:

1. **Set-aside funding is provided for continuing support of the Court Improvement Project.** The Alaska Court System (ACS) continues its efforts at streamlining and promoting consistency in the adjudication of child-in-need-of-aid (CINA) cases. ACS has received federal funding under the 1997 act to assist in this effort. ACS is in the process of formally reviewing how the system handles CINA hearings in various jurisdictions and has issued a 1996 report that identified many significant areas of differences and made numerous recommendations for improvement.
2. **Adoption incentive payments provided for states.** The legislation provides \$20 million in federal fiscal years 1999 through 2003 for payments to eligible states which exceed the average number of adoptions the State completed between 1995 and 1997. Essentially the program provides for paying states a bonus for each foster child adopted.
3. **New time line and basis for filing for termination of parental rights.** Previously, under federal law the length of time a child spent in out-of-home care was not necessarily a singular factor for states to initiate termination of parental rights. Under the new law, states must file a petition to terminate parental rights on behalf of any child, regardless of age, who has been in foster care for 15 out of the most recent 22 months. For children already in foster care, states are required to phase in the filing of termination petitions beginning with children for whom the permanency plan is adoption or have been in care the longest.
4. **New, shorter time frame for permanency hearings.** The prior federal law required a disposition hearing within 18 months of a child's placement into out-of-home care. The new law establishes a permanency planning hearing for children in care to occur within 12 months of a child's entry into care. At the hearing, the law requires a determination be made whether and when: (1) the child will be returned home; (2) the child will be placed for adoption and a termination of parental rights filed; (3) the child will be referred for legal guardianship; or, (4) another planned permanent living arrangement is made if other options are not appropriate.

5. Further definition of "reasonable efforts" to reunite families. As required by the 1980 law, states must continue to make reasonable efforts to preserve and reunify families. However, currently the "reasonable efforts" requirement does not specifically apply to cases in which a court has found:
- The parent has subjected the child to an "aggravated circumstance" as defined in state law (including, but not limited to abandonment, torture, chronic abuse, and sexual abuse).
 - The parent has committed murder or voluntary manslaughter or aided or abetted, attempted, conspired or solicited to commit such a murder or manslaughter of another child of the parent.
 - The parent has committed felony assault that results in serious bodily injury to the child or another one of their children.
 - The parental rights of the parent to a sibling have been involuntarily terminated.
6. Foster parents, pre-adoptive parents, and caretaking relatives are allowed access to court reviews and are allowed to speak at judicial proceedings. Under the new law a foster parent, any pre-adoptive parent, or relative caring for a child must be given notice of and an opportunity to be heard in any review or hearing involving the child.
7. Established outcome measures. The U.S. Department of Health and Human Services will develop, in consultation with governors, state legislatures, state and local public officials, and child welfare advocates, a set of outcome measures to be used to assess the performance of states in operating child protection and child welfare programs. Also to be developed is a system for rating the performance of states with respect to the outcome measures.

In many respects it is this new federal law, in addition to the recent Alaska Supreme Court decisions, and recent casework setbacks, which have contributed to the administration seeking a substantial revision to the State's CINA statutes. As with much federal legislation, the State has both "stick" and "carrot" incentives to conform with the law. Perhaps most significant is the prospect of losing federal funding used to support various aspects of child protection services in the State.

REPORT CONCLUSIONS

Our prior audit identified several areas needing improvement in the case management process followed by the Division of Family and Youth Services (DFYS). A central aspect of our prior review involved the agency's capability and capacity to investigate all the reports of harm (ROHs) made to DFYS concerning the abuse and neglect of children. Although to a degree, the insufficiency of staff was a problem of the agency's own making, we recommended DFYS receive funding for additional social worker positions. The legislature responded with funding to hire 28 more positions.

As discussed in the Findings and Recommendations section, the division has, over the last eight months since the audit report was issued, made efforts to resolve some of the problems set out in the previous report. The effects of these efforts, however, have not yet been fully realized in the short time period between that audit and this review.

Two key management decisions have contributed to a decrease in investigated ROHs

DFYS made two key management decisions during the first four months of FY 99 (July-October of 1998) that contributed to a drop in the number of ROHs the agency assigned for investigation. As shown by figure 1 on the top of the following page, there was a 4% drop, statewide in the rate of investigated ROHs over the first four months of FY 99 compared to the same four months in FY 98.

The two decisions made by DFYS officials that contributed to a curtailing of agency activity, as measured by assigned ROHs, were:

1. **Managerial decisions related to promotions and transfers contributed to an inexperienced staff manning the Anchorage intake units.** The new positions DFYS received set off a chain reaction within the agency. The establishment of new positions along with both regular turnover and a new agency policy not to keep any positions intentionally vacant, provided opportunities for promotion and transfer within the agency. DFYS allowed such transfers and promotions to take place, even though it may have had a negative impact on the agency's short-term readiness to respond to ROHs.

DFYS management reports that new hires typically require at least 70 to 90 days of orientation before they are able to carry full intake caseloads. The combination of new employees, regular turnover, and internal promotion resulted in an increasingly inexperienced intake unit⁴ that reduced the division's ability to effectively maintain its readiness to respond to ROHs despite addition of front line workers. Presumably, this is a short-run factor, which will lessen in impact on ROH investigations as new workers gain work experience.

⁴ One DFYS report shows that, beginning in May 1998, only 1 intake worker out of 20 in the Anchorage intake units was tenured beyond their probationary period. Turnover statistics in Fairbanks are similar.

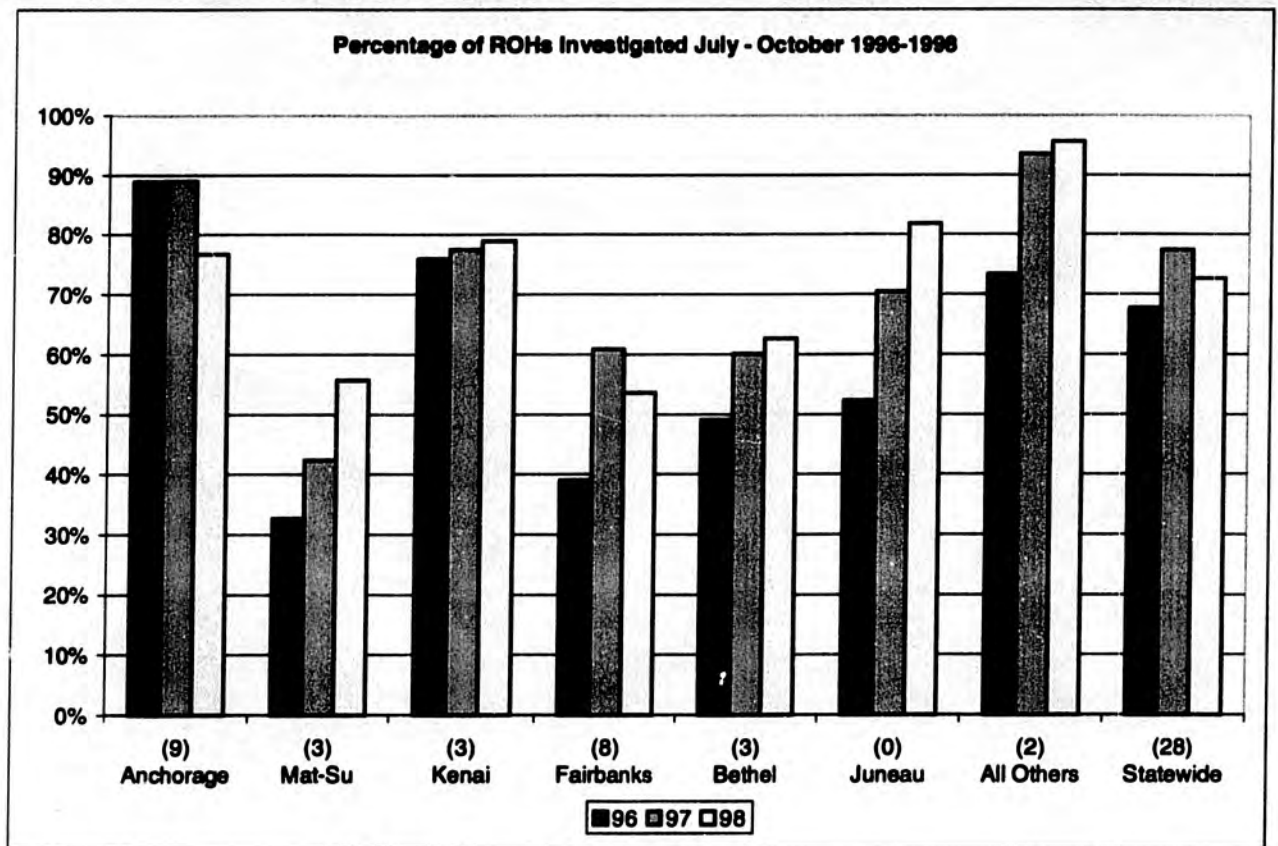


Figure 1.

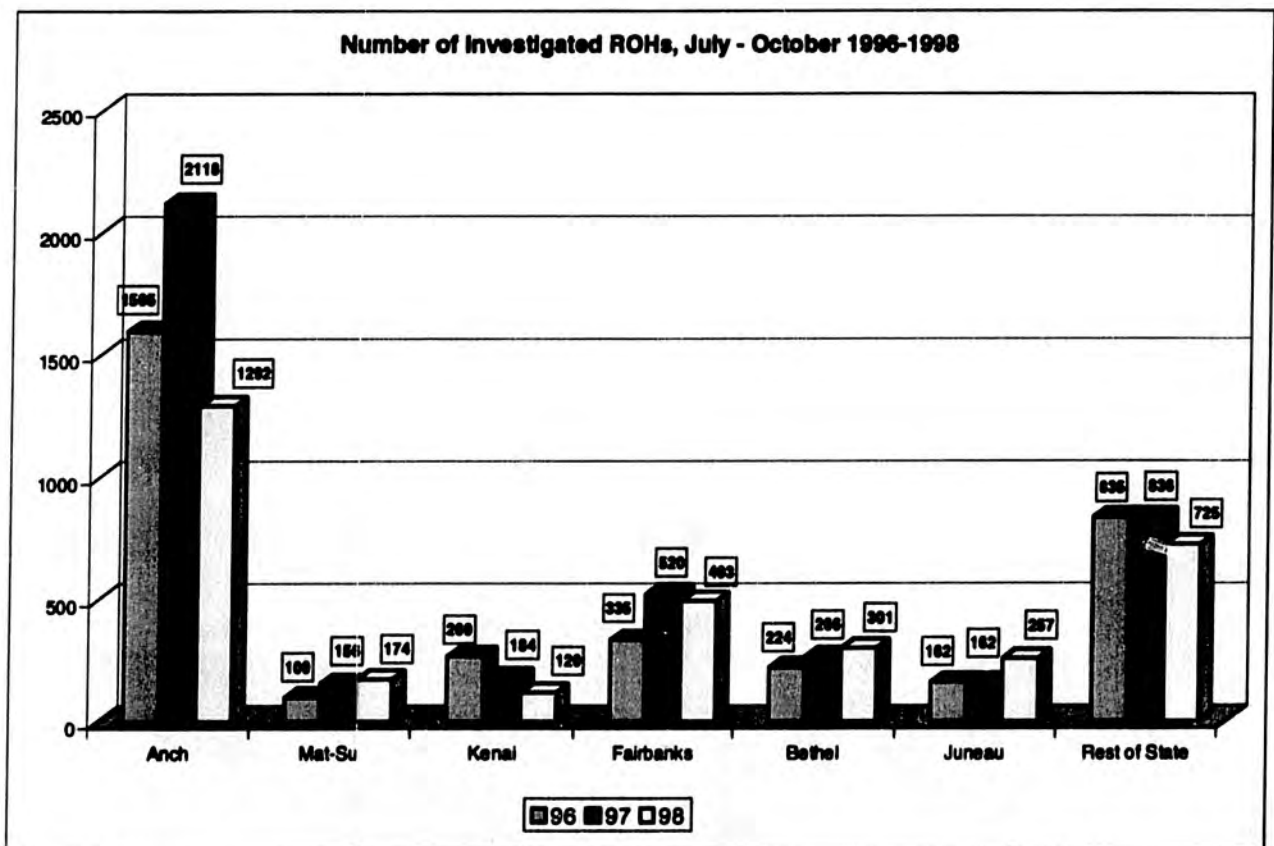


Figure 2.

2. More aggressive use of workload adjusting in Anchorage intake units. Besides the start-up and employee dislocation factors faced by DFYS in the first few months of FY 99, the agency also made a significant change in the way the Anchorage intake unit operated. Previously, the Anchorage intake unit investigated over 85% of the ROHs it received, and "workload adjusted" relatively few.⁵

In the early part of FY 99, the policy followed by Fairbanks and many other DFYS offices essentially was fully adopted in Anchorage. With the explicit approval of DFYS management, Anchorage began workload adjusting significantly more ROHs than the intake units previously had done. According to DFYS management this was done to improve the investigative casework that the agency did do – while at the same time it lessened the stress on relatively inexperienced social worker staff beginning work in the intake units. As a result, because the Anchorage intake unit accounts for over a third of all ROHs statewide, this change in policy resulted in a decrease in the overall number of ROHs assigned for investigation.

Given the time constraints of our follow-up review, we could not evaluate if the ROH investigations being carried out by the Anchorage intake unit, were qualitatively better than those done prior years. It may be that children, in the aggregate, are better protected by having DFYS conduct investigations that consistently meet an established minimum standard for more serious ROHs rather than doing more investigations, but in a less comprehensive way. However, such an approach is not consistent with claims the agency has historically made and leaves children, who are the subject of uninvestigated ROHs, at risk.

From our perspective, such decisions and the accompanying results, seemingly send a contradictory message to state policymakers. In testimony before the legislature and materials made available to the public, DFYS has pointed to the large number of uninvestigated ROHs as being indicative of the agency's need for more staff. After receiving funds for more staff, the agency adopted policies and made decisions that resulted, at least in the short run, in fewer ROHs being investigated. DFYS representatives established the percentage of ROHs investigated as a critical measure of agency operations. Accordingly, the agency should carefully consider what impact its decisions will have on that measure in order to maintain its credibility with the public and state lawmakers.

Additionally, in our view it is too early to see the impact of the staff hired into the newly authorized positions. While DFYS has made reasonable attempts to fill these positions in a timely manner, most were not filled until September or October. New hires typically require at least 70 to 90 days of orientation before they are able to carry full caseloads. As a result the impact of these new positions is not reflected in the July - October 1998 data included in this report.

⁵ By comparison, in recent years, the intake unit in Fairbanks utilized a distinctly different policy which resulted in only 54-61% of its ROHs being investigated, due to low priority or lack of staff availability. Other offices in the State also workload adjusted many of the ROHs received, for example the Mat-Su set-aside referred over 58% of the ROHs it received in FY 98. The Anchorage unit was the exception rather than the rule in the number of ROHs that it assigned for investigation, when compared to other DFYS offices.

New legislation strengthened child protection statutes, but impact so far on casework is minimal

In May 1998, the legislature passed a new child protective services statute, described by some as one of the most aggressive in the nation. Some petitions have been amended to reflect both old and new statutory criteria. However, social workers have been backlogged with old cases and new statutory requirements have effected few cases that predate the new statute. For the cases to date that have been affected by the new law, the most significant impact has been on social workers that now face additional paperwork as they file amended adjudication petitions.

In response to provisions of the federal Adoption and Safe Families Act and similar provisions in the new statute, DFYS has begun to research alternative methods to move children through state custody. As discussed in the Background Information section, one of the primary provisions of both the federal and the state legislation was to force the agency to more promptly develop permanency plans for children in out-of-home care more promptly. The legislation focuses specifically on children that have been in out-of-home situations for the longest periods of time with emphasis on those that have been in state custody at least 15 of the most recent 22 months.

On November 17, 1997 when the federal Adoption and Safe Families Act became effective, DFYS had identified more than 600 children that had been in out-of-home care for 15 of the most recent 22 months. The list of these children, referred to as the transition list, has now been reviewed and worked. The result of this review has been the identification as of December 15, 1998 of just over 300 children for whom the State still needs to take action. Most of the children pending removal from the list are currently scheduled for termination proceedings, adoptions, or guardianships. Though some of the children initially on the transition list have now returned home, it is possible that many of the children still on the list will never be reunited with their parents. The size of the list has forced DFYS to consider options for permanently placing these children more quickly.

Placement with relatives, guardianships, and adoptions are all possible permanent resolutions. Permanency can be achieved through a variety of routes including voluntary relinquishment of parental rights, negotiations with parents, or, the most extreme and time-consuming method, termination of parental rights (TPR). Obtaining a TPR requires more preparation and court time than other methods and generally results in these cases taking much longer to complete. Because permanency plans that are negotiated and agreed to with the parents are more expedient than termination proceedings, DFYS prefers to pursue these options when possible.

To help DFYS avoid protracted termination proceedings, the division is currently in the process of establishing a pilot mediation program to help reconcile the objectives of the agency and the wishes of the parents so that children can be permanently placed without the delays typically associated with TPR hearings. Typically, the objective of negotiations will be that parents will voluntarily relinquish their parental rights or permit their children to be placed with legal guardians.

Management information systems still need improvement

To date, the division has not repaired or replaced its case management system, PROBER. The system continues to reflect more than 5,000 investigations open longer than 90 days. The research analyst responsible for the data believes these open cases primarily reflect data problems rather than actual open cases. It does appear, however, that the agency has, for data entry purposes, more consistently defined ROHs that are not being assigned for investigation. Problems previously identified with uninvestigated Child Protective Service's reports being inconsistently labeled on PROBER appear, based on system data available (for the first four months of FY 99), to be more consistently entered as workload adjusted reports.

The DFYS workload measurement model has not been improved since the last audit. As a result, the actual case workload remains understated and the model is rarely used for caseload management decisions.

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FINDINGS AND RECOMMENDATIONS

This review of the Division of Family and Youth Services (DFYS) was designed as a follow-up of a previous audit (Audit Control No. 06-4586-98) released in April, 1998. Each of the recommendations addressed below reflects our evaluation of the current status of the prior recommendations made in that report.

Prior Recommendation Nos. 1 and 2

1. **The legislature should consider authorizing and funding additional social worker positions in order for the Division of Family and Youth Services within the Department of Health and Social Services (DHSS) to better meet the agency's statutory mandates.**
2. **If the legislature appropriates additional funding for child protection services for FY 99, the commissioner of DHSS should report the effects of those increases to the legislature.**

In our previous audit, we recommended that the legislature consider authorizing funding for additional social worker positions. We concluded more positions would improve the agency's ability to investigate reports of harm (ROHs) and meet contact standards for children taken into and remaining in state custody. In the prior audit we also noted that because of previous management philosophy in one region and bureaucratic barriers to hiring, the division had not effectively used the personal services funding it had received in the past. To promote accountability for any funding increase, we suggested that DFYS report to the legislature how increased staffing was being utilized to help the agency carry out its statutory responsibilities.

Current status of prior recommendations: The legislature authorized 28 new social worker positions⁶ for FY 99. Funding for these positions was staggered, with some funded for a full 12 months beginning July 1, 1998, while others were funded for only 9 months.

At the time the new social worker positions were authorized, non-supervisory social workers were hired from state personnel registers only. Reportedly, the registers for social workers contained few viable candidates. In response, the agency embarked on several recruitment efforts to expand the pool of potential applicants for the new positions. One of the more successful of these efforts was a job fair conducted at the end of August, during which DFYS personnel spoke to applicants and helped them complete state employment applications. This effort resulted in expanding the register by as many as 40 prospective social worker candidates.

Though DFYS hired social workers in a timely fashion, the increase in the number of social workers has not yet been reflected in casework statistics. In large part, the lack of impact on agency statistics is presumably a function of time. Because most of the social workers were hired in September 1998 and will spend their first 70 to 90 days in orientation, the full effect of these additional resources will not be reflected in the casework statistics presented in this report.

⁶ The positions authorized included social workers, social services associates, community care specialists, and administrative positions.

It is probably too soon to determine how the additional positions will eventually affect case management.

On a statewide level, DFYS data shows that, though available staff has increased, fewer cases were assigned for investigation during the first four months of FY 99, compared to the same time frame in previous years (see Figure 2 on page 12). For Anchorage, which receives more than a third of all reports of harm, at least two factors have impacted the ability of the agency to investigate reports of harm (see discussion in the Report Conclusions section):

1. High personnel turnover in the social worker ranks. Both newly created positions and turnover in existing positions resulted in most intake workers in the Anchorage and Fairbanks offices being relatively inexperienced. Internal position juggling intensified generally high levels of turnover typical in social work as new positions provided social workers opportunities to transfer or seek promotion.
2. A revised managerial philosophy for workload adjusting reports. In an attempt to better manage caseloads, DFYS decided to delay investigation on a number of lower priority cases in Anchorage. As discussed in the Report Conclusions section, in the first few months of FY 99, DFYS expanded the use of workload adjusting in the Anchorage intake units.

In addition to investigating fewer reports, caseworkers in the permanency planning unit also report that they are consistently unable to meet contact standards for children in state custody. As of November 1998, the State had custody of more children than at any point over the last 12 months. Though the division's child protective services manual nearly always requires at least one face-to-face contact every three months with each child in state custody, some workers carry caseloads that include 70 to 80 children and admit that they have not seen some of the children under their supervision in more than nine months.

The Division of Legislative Audit's current position on prior recommendations: DFYS has investigated fewer reports of harm in the first four months of FY 99 even with an increase in funding for social worker positions. When this is considered along with the increase in Child-in-Need-of-Aid (CINA) petitions we are concerned that the agency is still not able to consistently meet its various statutory mandates and casework policy requirements.

The expanded use of workload adjusting in Anchorage seems to be more of a reactive, perhaps short-term measure, rather than part of an overall strategy to efficiently and effectively address reports of abuse and neglect. Additionally, when considering workload adjust policy, we believe DFYS should be mindful of public policy pronouncements of "zero tolerance" and be sure that whatever policy is adopted can be reconciled to such stated policy. While workload adjusting has merit, we continue to believe it should be coupled with a valid workload measurement device (see discussion under Prior Audit Recommendation Nos. 5 and 8).

DFYS made reasonable efforts to hire for the newly authorized positions in a timely manner. Accordingly, most of the positions authorized in July were filled before October. However,

promotional and transfer opportunities provided by these positions may have temporarily reduced the agency's ability to respond to reports of harm, as staff turnover increased significantly. We recognize that as the new positions were only authorized in July and most new personnel have been employed with the agency for a maximum of two or three months, it is still very early to attempt to evaluate the effect of the new hires on casework statistics. In light of the division's apparent reduced capacity to respond to reports of harm however, we believe DFYS, in making future hiring and promotion decisions, should evaluate the overall effect such decisions will have on the division's ability to respond to ROHs.

Prior Recommendation No. 3

The legislature should consider amending relevant child protection statutes in order to provide a basis for better and more consistent casework.

Our previous review recommended the legislature consider amending child protection statutes to provide a basis for better and more consistent casework. In that recommendation we noted two areas where court interpretations of the current statute had weakened the statute significantly. Additionally, the Kempe Children's Center, a nationally recognized organization in the child protection field, commented that Alaska Statutes were among the weakest child protection statutes in the country.

Current status of prior recommendation: An amended child protective services (CPS) statute became effective on September 14, 1998. The new statute changes some of the requirements for finding a child in need of aid and provides timelines under which social workers should consider terminating parental rights. At this early date, the new statute appears to have had only a minimal impact on actual casework. Some social workers report they have prepared amended CINA petitions for children in state custody and sometimes draft new petitions to include criteria under both the new and old law.

We noted two provisions of the prior statute in our last review that were particularly weak: one for abandonment and one for neglect. For a child to be found in need of aid before the change in statute, the child had to be "...habitually absent from home or refusing to accept available care, or having no parent, guardian, custodian, or relative caring or willing to provide care."

Under the prior statute, the ability to provide care was not examined nor was inability to care for a child a factor in determining if a child warranted a CINA determination. This weakness appears to be remedied by new statutory language that defines abandonment as "...a conscious disregard of parental responsibilities toward the child by failing to provide reasonable support, maintain regular contact, or provide normal supervision, considering the child's age and need for care by an adult." The improved specificity of the statute for a CINA determination will potentially allow for earlier intervention from DFYS through better identification of parental behaviors that constitute neglect.

The previous statute related to child neglect required the child to have suffered or be at imminent and substantial risk of suffering physical harm before the child could be declared in need of aid. The amended statute allows the court to find neglect if:

the parent, guardian, or custodian fails to provide the child adequate food, clothing, shelter, education, medical attention, or other care and control necessary for the child's physical and mental development, though financially able to do so or offered financial or other reasonable means to do so.

In part, the Knowles administration proposed statutory changes to promote compliance with the requirements of new federal laws. Under the federal Adoption and Safe Families Act of 1997, states must file a petition to terminate parental rights and concurrently, identify, recruit, process, and approve a qualified adoptive family on behalf of any child, regardless of age, that has been in foster care for 15 out of the most recent 22 months. Though there are some specific exceptions to this requirement, the amended state law also discusses termination of parental rights for children in custody for 15 of the last 22 months.

At the inception of the federal law in November 1997, DFYS had identified more than 600 children that had been in custody for more than 15 of the most recent 22 months. Since that time, the list has been updated to reflect changes in each child's status. The latest estimate is that just over 300 children remain in this long-term out-of-home-status. In addition to the children on the transition list when the federal law became effective, more children have been added to the long-term out-of-home-care category over the last 14 months.

One of the changes precipitated by new state and federal laws is concurrent case planning. To be prepared to more rapidly move children into permanent care, social workers must now plan both for the success and the failure of the family in reunification efforts. While encouraging parents to seek treatment and overcome whatever situation caused their children to be removed from the home, social workers must also develop a permanency plan for the child that includes alternatives to returning home. Though northern region offices had been practicing concurrent planning prior to the new legislation, this practice was not as formalized in other regions of the State.

When children cannot be returned to their parents, the most permanent and extreme alternative permanency plan is termination of parental rights. As of the date of this report, no termination of parental rights has been attempted under the new law. The public defender has warned, however, that cases begun under the old law and carried to termination proceedings under the new law will be appealed. In the view of the public defender's office, the attempt by the Department of Law to retroactively apply state laws as they pertain to termination proceedings may be unconstitutional.

At this time, DFYS staff estimates there are only a small number of previous cases that could be brought to termination only under the new law. In part, this is because social workers have been so busy with backlogged cases, that they have not yet had time to identify old cases that could not have gone to termination under the former law.

The agency's compliance with the law requiring earlier permanency plans for children in state custody may be hindered by factors beyond the control of DFYS. Social workers are most concerned about the time limits imposed by the new law because their caseloads do not seem conducive to meeting the timelines. Other agencies are reportedly equally overburdened. The Attorney General's Office is responsible for representing the agency in court whenever termination of parental rights is sought, guardians ad litem are responsible for representing the children, and public defenders are often responsible for representing the rights of the parents. Each of these agencies, however, has expressed concerns about not having the staff to handle a large influx of cases.

In addition to the backlogs in state agencies, private agencies offering treatment programs for substance abusing parents typically have waiting lists for admission. Consequently, children linger in state custody while their parents wait for limited slots in treatment programs. If the parents subsequently fail in one treatment program, the waiting period for both parent and child may begin all over again. The timeline requirements of the new law make each one of these treatment failures even more critical.

In recognition of some of the systematic problems associated with terminating parental rights, DFYS is developing a pilot mediation program to work with families that can not be reunited. One purpose of mediation is to provide the agency and the parents an opportunity to avoid protracted termination hearings while still acting in the best interests of the children involved. DFYS hopes that much less time will be spent in mediation than would be spent in termination hearings.

The Division of Legislative Audit's current position on prior recommendation: In our view, the amendment strengthens the statute by describing parental behaviors that may be considered abandonment or neglect rather than requiring the social worker to determine whether the child is in imminent danger of substantial physical harm. Social workers, however, comment that the new statute seems to have little effect on emergency custody decisions, but pertains more to adjudication hearings.

Though we recognize the value of statutory time limits for children in state custody, we are also aware that there are certain system-wide factors that may impede the agency's compliance with the statute. We encourage DFYS to continue creative efforts to reduce the length of time children spend in non-permanent settings.

Prior Recommendation No. 4

The DHSS director of administrative services should ensure expenditures for the retirement incentive program (RIP) are made in accordance with legislative appropriations.

Our previous audit noted that DHSS utilized \$880,000 of authorized DFYS personal services funding to fund other divisions as well as the agency's RIP costs for three years. We have found no large dollar transactions for FY 98 or 99 to suggest that similar funding transfers have been

made in the previous fiscal year or so far in FY 99. Our analysis to date indicates that virtually all personal services funding has been used in payroll related costs.

Prior Recommendation Nos. 5 and 8

5. The director of DFYS should develop and implement a clear and consistent policy regarding when ROHs can be left uninvestigated.
8. The director of DFYS should develop an updated, accurate, and relevant workload measurement model.

In the past, DFYS had a policy of workload adjusting reports of harm based on certain workload measurement criteria. Because the workload measurement model that was used to make these decisions is severely flawed, it was disregarded by agency managers as a method to regulate assigned or workload adjusted cases. Previously, we recommended that DFYS refine or replace the workload measurement model and develop a clear and consistent policy for workload adjusting ROHs.

Current status of prior year recommendation: The issue of the workload measurement model has not been addressed. Additionally, no clear workload adjusting policy has been established. The availability of community resources and each local DFYS office's working relationship with these agencies has been cited as a critical factor that has an impact on workload adjusting ROHs. DFYS has encountered some difficulties with the establishment of a uniform policy on a statewide basis as both types of cases and available resources vary greatly from community to community.

Some of these differences were highlighted by a review of Anchorage workload adjusted ROHs performed by the Mat-Su office manager. Because the Mat-Su office workload adjusts many of the ROHs it receives, the manager was asked by Anchorage managers to review a small sample of ROHs received by the Anchorage office to provide feedback on the Anchorage office's workload adjusting practices compared to those of the Mat-Su office. His review found that most cases he reviewed in Anchorage should not be workload adjusted.

In large part, his assessment was based not so much on the severity of the cases involved, but rather on the lack of suitable alternative community resources in Anchorage. The availability and working relationship with community resources are only one factor limiting the uniformity of workload adjusted reports. Additionally, there are some philosophical differences between managers related to workload adjusting. Some managers reject the idea that workload adjusting will remain a necessity and strive to investigate all CPS related ROHs, while other managers recognize workload adjusting as necessary and prefer not to investigate a case unless there is enough time to do the work adequately.

The Division of Legislative Audit's current position on prior recommendations: Because DFYS finds that it is still unable to investigate each report of harm and the resultant need to allocate available resources responsibly, we continue to recommend that DFYS develop a

usable and reliable workload measurement system. While we understand that community resources vary significantly, we continue to believe that DFYS should strive for more consistency in report prioritization and the resultant assignment of cases.

In addition, any expansion or further implementation of an agency-wide, consistently applied workload adjusting methodology should be coupled with a valid workload measurement device. The expanded use of workload adjusting in Anchorage seems to be more of a reactive, perhaps short-term measure, rather than part of an overall strategy to efficiently and effectively address reports of abuse and neglect.

Prior Recommendation No. 6

The director of DFYS should continue efforts to develop an integrated professional development and training program in conjunction with the University of Alaska and pursue Title IV-E funding.

In our prior audit we discussed the need for, and the recent events involving, an ongoing training program for DFYS social workers. As we discussed in the prior recommendation, a well-trained workforce is essential for the effective functioning of a child welfare program. Effective, ongoing training is also a way to combat high turnover rates among DFYS social workers. We noted that DFYS was pursuing federal training funds that were available, and we encouraged the agency to seek the federal funding necessary to upgrade its training program.

Current status of prior recommendation: Previously, we recommended that DFYS develop an integrated professional training program in conjunction with the University of Alaska. The agency has made progress in the development of such training. Since that audit, the agency, in conjunction with the University of Alaska - Anchorage, has begun teaching CORE classes to new social workers and has established an ambitious schedule of more advanced CORE classes. The first of these classes, offered at the beginning of November 1998, received very positive evaluations from the class participants. In addition, a class for new supervisors, generally more tenured social workers, was scheduled for mid-January 1999.

Additionally, DFYS has offered stipends to students currently in the social work bachelor's program and to some current employees seeking master's degrees in social work. The conditions of the stipend are that recipients are committed to work for the agency for at least a year after their education is completed. At this point, the agency has about ten bachelor degree students and four master degree students in the stipend program.

The Division of Legislative Audit's current position on prior recommendation: DFYS has made significant progress in its efforts to establish consistent and well-funded training. We encourage the agency to continue these efforts and to aggressively pursue federal funding sources to maximize and ensure the stability of the agency's training efforts.

Prior Recommendation No. 7

The director of the Division of Family and Youth Services should ensure accurate and timely entry of child protection case information into its management information system.

During our last review, we identified several deficiencies in the agency's case management system. PROBER and recommended that the agency take action to remedy these problems.

Current status of prior recommendation: Among the problems we discussed previously was lack of consistent practice with regard to case closure within the system. As of December 1, 1998 PROBER showed more than 5,000 investigations open longer than 90 days. According to the agency's data analyst, many of these cases reflect data problems rather than actual open investigations.

Additional problems we noted with PROBER were related to specific inconsistencies in how data was recorded. Though a review of statistical data provided by DFYS suggests that some of these problems have been resolved, DFYS supervisors continue to comment that the system is neither user friendly nor totally dependable.

The Division of Legislative Audit's current position on prior recommendation: We continue to recommend that DFYS correct, upgrade, or replace the current case management system.

DEPT. OF HEALTH AND SOCIAL SERVICES

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March 8, 1999

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LEGISLATIVE AUDIT

Pat Davidson, Legislative Auditor
Division of Legislative Audit
Legislative Budget and Audit Committee
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Juneau, Alaska 99811-3300

RE: Legislative Audit Control Number 06-4595-99
Follow Up Audit on Division of Family and Youth Services (DFYS)

Dear Ms. Davidson:

Thank you for the opportunity to comment on findings of your recent review conducted in follow-up to the audit of the Division of Family and Youth Services (DFYS) released last year.

That report, released April 2, 1998, contained two critical findings: 1) that changes were needed in Alaska's child protection laws; and 2) that without additional staff, DFYS could not meet the mandates of either existing or proposed child protection laws. It was clear that changes were needed in Alaska's laws to allow earlier, more effective intervention to protect children and to speed the process of placing abused children in safe, permanent homes. It was equally clear that DFYS could not improve its ability to carry out these mandates without additional staff.

In responding to that report, I cautioned that the real effects could be measured in a meaningful way only in the long term. Your follow-up review reflects the difficulty and limits of such an early assessment of broad-scale system change. Drawing meaningful conclusions about the impact of new staff is difficult to accomplish while those staff are being hired and trained and while workload continues to fuel staff turnover. Similarly, few meaningful conclusions can be reached by assessing the impact of such a sweeping new law at such an early date.

While I believe it is far too soon to draw definitive conclusions about the many recent changes to Alaska's child protection system, I also understand the keen interest and responsibility you and I have in assessing these changes. With this in mind, a few general comments are appropriate in response to some conclusions emphasized in your report.

Staffing

A key finding of your current report is that DFYS remains unable to meet its statutory mandates and casework policy requirements. This finding is, unfortunately, only too predictable. In seeking

achieve "zero tolerance" – a full response to all credible and legitimate reports of harm and the ability to implement appropriate interventions when warranted. The Legislature authorized an even smaller number. It was clear that we would not achieve the "zero tolerance" mandate.

In assessing the impact of new staff, your report focuses primarily on the number of reports of harm investigated. This is certainly a critical measure – if a report is not investigated, children are left at risk and many will be harmed as has been amply demonstrated by those cases discussed publicly and in prior audits. However, the agency must not only investigate reports of harm, but also intervene effectively when necessary and provide services to the child and family to achieve a permanent positive outcome for the child. Doing this does not allow us to focus on a single measure of performance, however important. Focusing solely on increasing the number of investigations conducted would, as your report suggests, have been politically expedient in quickly demonstrating the impact of additional staff. It would not, however, have been responsible in meeting our other statutory obligations to children and families with whom we have intervened.

Auditors noted that the past year has seen an increase in the number of cases resulting in formal intervention and agency custody – something your recent review of DFYS custody decisions indicated was warranted. Because of this, the number of children in agency custody has increased by 400 from January 1998 – January 1999 and is now at an all time high. Responding to cases involving formal intervention, conducting thorough investigations, and implementing appropriate services in these more complex cases requires substantially greater amounts of time than responding to reports of harm where formal intervention is not required. Coping with the workload related to these additional formal intervention cases means less time is available to respond to other reports of harm. Because of this the number of investigations that can be assigned and completed has been reduced. This factor alone precludes precise comparisons of the impact of new staff with staff efforts in prior years.

As your report notes, our concerted efforts have been successful in recruiting and hiring new social work staff and fully utilizing funding for personnel. The new positions authorized for FY 99 were established in July, far in advance of normal timelines, and largely filled by September. However, again following prior recommendations of auditors, we have been careful not to overwhelm new staff by assigning full and complex caseloads before they are trained and experienced. New staff cannot be expected to carry full caseloads and function at the journey level for approximately six months after being hired. This prudent and necessary practice also contributes to reductions in the number of investigations that can be conducted.

We agree that the impact of turnover in existing positions has also affected overall agency capacity. When experienced staff are lost, there is inevitably a reduction in work capacity while new staff are recruited, hired, trained and gain experience. As noted in your report, the division has been experiencing an "high personnel turnover" in social work positions in some offices or units. While there has been some predictable impact from promotions associated with the five new supervisory and other new social worker positions, the primary impact of turnover has been loss of experienced staff to other employment opportunities, something not controllable by agency

managers. This has occurred primarily in the intake and investigation units of the two largest offices where the workload continues to be greatest and where there is greater competition with private organizations for qualified staff. These units experienced almost a complete turnover. High and stressful caseloads led most of these workers to leave the agency while some transferred to other units.

Improved administrative action made it possible to assign and investigate more reports of harm in FY 98 than in FY 97. In FY 98, the division assigned 1,400 more reports of harm than were assigned the previous year, a fact that is not mentioned in the narrative of your report. (Furthermore, the fact that the agency assigned a record number of cases in FY 98 should be taken into account when drawing comparisons to the current fiscal year.)

The division was able to respond to an increased number of cases in FY 98 by better utilizing existing positions and aggressively assigning investigations. However, this accomplishment came at a cost – we lost many experienced staff.

We know from experience and from responses to surveys of staff that the two best ways to deal with turnover are to improve training and reduce workloads to manageable levels. The results of two job satisfaction surveys recently conducted by DFYS – one of current social workers and another of social workers who left the agency during the past six months – clearly explain these important factors affecting turnover. Over 60 percent of the workers responding to the survey indicated that their workload is unmanageable. Lack of sufficient and specialized training also contributes greatly to stress and turnover.

The need for training is being addressed directly through orientation and "core" training of all new workers at the Family Services Training Academy developed in partnership with the University of Alaska. The Academy has begun a full schedule of social worker training and all new social workers have been attending training sessions. Though the training reduces the initial capacity of newly authorized staff, they will ultimately be better prepared to perform work at a higher level.

We remain concerned about staff turnover and vacancy rates for obvious reasons. Staff vacancies are tracked weekly, hiring managers have been directed to fill all social worker vacancies as quickly as possible, and with the assistance of special initiatives the division has lowered the vacancy rate significantly. We anticipate increases in the level of response to reports of harm throughout this fiscal year as new staff complete training and gain experience. Our most recent data, unavailable at the time auditors completed their report, indicates that we are, in fact, beginning to realize the benefit of the new positions as the real work capacity of new staff reaches journey level. The overall response to reports of harm is beginning to reflect that increased capacity.

What seems clear is that, although the Legislature approved 28 of the 30-40 new positions recommended by auditors last year, these positions alone cannot reduce caseloads to manageable levels or enable the agency to fully meet its statutory obligations. We cannot resolve the overall workload problem, which may be the most significant factor affecting staff turnover, without

increased staffing to bring down caseloads. We have developed a model to project staffing needs to achieve "zero tolerance" by moving toward national caseload standards over a several year period. We have based our request for an additional 26 positions in the Governor's FY 00 budget on the basis of that model.

Child Protection Law Changes

Changes in Alaska's child protection laws passed by the last Legislature strengthen protection for children by: 1) making the health and safety of children paramount in child protection decisions; 2) establishing clear timelines requiring prompt action by agencies, courts, and parents in resolving child protection matters; and 3) establishing greater accountability for agencies and parents to act in the best interests of children. The new law also provides improved guidance by better defining actions and circumstances that constitute child abuse and neglect. Finally, the new law does much to promote coordination and teamwork on behalf of children and families.

We believe, as we think you do, that a true assessment of the impacts of our new law can only be accomplished over the long term, certainly not within a few months of its effective date. However, recognizing the constraints inherent in assessing the impact at this early date, we believe several notable changes have occurred.

First, massive efforts were made by all agencies involved in the child protection system to train staff in preparation for implementing the law. From June through September, all DFYS social workers and staff from partner agencies attended training sessions at more than 15 different training locations throughout the state. DFYS' Child Protection Services Manual was also rewritten to reflect changes required by the new law.

Second, our courts are enforcing the new 120-day timelines for adjudication in child in need of aid (CINA) cases. This means that children taken into state custody are no longer routinely experiencing lengthy delays before critical decisions are made and parents are prompted to address the issues that place children at risk. Judges must consider the effects of delays on the children and the result has been strict limits on delays. Earlier adjudications are prompting quicker action on permanent plans for children – permanency hearings are being scheduled at the time of adjudication. This increases the demands on all parts of the child protection system, but may ultimately prove beneficial once existing case backlogs are resolved.

Third, foster parents and relatives are attending court hearings. Judges hear first-hand from caretakers who are with the children every day and this assists them in making decisions that are in the best interests of the children.

Fourth, actions have been filed in some cases that would not have been possible under the old law – CINA adjudication and termination actions not possible under the old law are now proceeding to resolution.

Another important result of Alaska's new law and the federal Adoption and Safe Families Act is the enormous effort to move a backlog of longstanding cases to permanency while simultaneously adhering to the new deadlines for action imposed by HB 375. Alaska has 631 children who must be moved to permanency within 18 months of the date the federal law was enacted (November 19, 1997.) High caseloads for DFYS and our partner agencies has and will impede our ability to accomplish this as well as meet the requirements as additional children reach this threshold. The full impact of the new law will not be realized until no backlog of cases exists and certainly cannot be measured within four months of its effective date.

To meet its responsibilities, DFYS has begun training of social work staff to implement concurrent planning, which is specifically authorized under our new law. Concurrent planning provides for family support services to strengthen or treat the conditions that led to the child being removed while simultaneously developing an alternative plan, in case it is needed.

Together with the Alaska Court System, Office of Public Advocacy, Public Defender Agency, and the Department of Law, DFYS is also working to develop voluntary mediation services to assist in resolving some of the longstanding cases. Obviously, it is too early to assess even the short-term impact of this effort, as it is with the new law.

Workload Adjusting and Workload Measurement

The issue of workload measurement model has, in essence, been resolved. DFYS replaced the workload accounting system of the 1980s by adopting the Child Welfare League of America recommended caseload standards to measure workload. Like many other states, the division has elected to use the CWLA recommended caseload standards to measure workload and to plan, organize, and administer services, and as goals for continuing improvement of services. The ratios of client to staff offer guidance based upon the study and consensus of national experts determining what constitutes best practice. The standards, simplified, are below.

**Child Welfare League of America's
Recommended Caseload/Workload Standards**

Intake Investigation	12 active cases per month, per 1 social worker
On-going Cases	17 active families per 1 social worker, and no more than 1 new case assigned for every 6 open cases
Family Foster Care	12-15 children per 1 social worker
Combined Investigation and On-going	10 active on-going cases and 4 active investigations per 1 social worker
Supervision	1 supervisor per 5 social workers

We agree that a new policy based on the CWLA caseload standard is needed to guide managers in different offices and circumstances to appropriately allocate limited staff resources and best protect children. Risk assessment must remain a central element of this policy as it is in all aspects of child protection casework. Clearly, expertise from outside DFYS will be necessary to develop a new risk-based system for prioritizing reports of harm and appropriately allocating staff time to achieve the best outcomes. We have been unable to seek the necessary assistance of national experts this fiscal year because of insufficient funds. Basic program operating costs such as office leases and client-related travel must take priority over even important program development this year. We had to postpone this purposely but hope to proceed with this project next fiscal year.

Staff Training

We have, as your report notes made substantial progress in developing an integrated training and professional development program in partnership with the University of Alaska. We are continuing to aggressively pursue federal funding to extend this program.

Management Information

We concur with your recommendation that DFYS correct, upgrade, and ultimately replace the current management information system. We are pursuing improvements through all these approaches – training staff and changing processes to improve data quality in the existing system, upgrading to wide area network connections to maintain functionality in the face of technology obsolescence. The bottom line, we need approximately \$7 million to completely replace the system with improved technology. All these actions are necessary to assure vital information is available to support daily casework activities and to support effective management and policy decisions.

Much has been done to change Alaska's child protection system since the release of your audit report last April. While it is far too early to draw definitive conclusions about the full impact of these changes, it seems clear that legislative action taken last year has improved protections for Alaska's children. Much remains to be done in the future.

I appreciate your efforts and those of your staff to objectively review these critical issues.

Sincerely,



Karen Perdue
Commissioner

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



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March 9, 1999

Members of the Legislative Budget and Audit Committee:

We have reviewed the response of the Department of Health and Social Services to our audit report. We have the following comments regarding the department's discussion regarding how we assessed the impact of new social worker positions on agency performance.

The department notes that our report focuses primarily on the number of reports of harm (ROH) investigated by the Division of Family and Youth Services (DFYS). The department also states that there are other important aspects of child protection which DFYS must focus on, possibly at the expense of ROH investigation statistics.

We agree that investigation statistics alone, while significant, do not completely reflect the full scope of DFYS child protection responsibilities. We would encourage the agency to identify and report on additional performance measures that reflect other qualitative aspects of child protection. These measures would enhance an evaluation of the agency's operations.

A handwritten signature in cursive script that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor

Audit Report

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**DEPARTMENT OF HEALTH AND
SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES
CHILD PROTECTIVE SERVICES
CUSTODY AND TERMINATION DECISIONS
FOR SELECTED CASES**

August 11 , 1998



Audit Control Number:

06-4573-98

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

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August 11, 1998

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES
CHILD PROTECTIVE SERVICES
CUSTODY AND TERMINATION DECISIONS FOR SELECTED CASES

August 11, 1998

Audit Control Number

06-4573-98

This audit reviews casework practices, emergency custody decision making, and the procedures followed and considered when the State seeks termination of parental rights. In the report we discuss the broad discretion exercised by state social workers in taking children into state custody, the nature and extent of judicial reviews, and how certain, selected cases were handled by the Division of Family and Youth Services and the Department of Law.

The audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section.

A handwritten signature in cursive script that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with a Legislative Budget and Audit Committee request and Title 24 of the Alaska Statutes, we conducted a review of casework related to Division of Family and Youth Services (DFYS) custody decisions. DFYS is organizationally located in the Department of Health and Social Services.

Objectives

The specific objectives of our review were as follows:

1. For selected cases, we assessed the reasonableness and legal basis of the agency's child custody decisions. In making our assessment we wanted to develop a better understanding of how DFYS applies the child-in-need-of-aid (CINA) statutes in carrying out day-to-day case work.
2. For selected cases, we assessed if DFYS made reasonable efforts to prevent removal of children from the home as required under the CINA statutes.
3. For selected cases, we reviewed case files to better understand how the agency made and documented reasonable efforts to reunite parents and children.
4. For selected reports of harm (ROHs), where DFYS did not take custody we reviewed the circumstances involved. This was done to better understand the factors that distinguish ROHs where the agency took emergency custody from situations where custody was not sought. We compared the various situations in order to assess the reasonableness and consistency of casework decisions. In addition, from this review, we evaluated the actions taken by the agency to provide appropriate services to protect children from further harm in circumstances where custody was not taken.

Scope and Methodology

To understand and evaluate circumstances involved in which DFYS takes custody of children from those in which the agency does not seek custody, we reviewed 72 case files. We selected these 72 cases three ways. Most were from a sample of substantiated ROHs received by DFYS between July 1, 1997 and March 15, 1998. Additionally, we reviewed a variety of cases brought to our attention by advocacy groups and legislators responding to specific constituent concerns. Some of these cases involved ROHs that pre-dated July 1, 1997 .

In addition to reviewing agency files, we also discussed some of the cases with various involved parties such as social workers, social worker supervisors, guardians ad litem,¹ grandparents, and the parents involved. We also reviewed DFYS policy and procedures, Alaska Statutes, and

¹ The guardian ad litem (GAL) serves in court as an advocate for the child in a child-in-need-of-aid case. The GAL is generally appointed as soon as a child is adjudicated CINA.

CINA court rules to develop a better understanding of the basis for casework decisions and adjudications related to children in need of aid.

We reviewed the Kempe Children's Center Report on five selected cases and a report issued by the Alaska Judicial Council addressing what was termed the Court Improvement Project Report as related to CINA proceedings. To obtain an overview of the custody decision-making process, we attended several meetings, including permanency planning meetings and a court hearing.

In addition we reviewed amendments to the CINA statutes made by the 1998 legislature, in order to develop a better understanding of how the statutes were applied by the courts and prospective impact the new legislation may have on case work decisions. We also reviewed the recent state Supreme Court Decision, *In the Matter of J.A.* issued August 7, 1998.

Included in the cases selected on the basis of legislative referral, were numerous cases involving the Kenai and Homer field offices. For these particular cases, we reviewed both the DFYS files and interviewed the parent(s), and sometimes the grandparent(s), of the children involved. Such interviews were arranged for us by the Guardians of Family Rights, an advocacy group that supports and advises parents that become involved with DFYS. From our interviews and review of case files we developed specific questions for the agency in order to understand the basis for its custody decisions.

ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services with responsibility for providing a range of services designed to remedy or prevent abuse, neglect, and exploitation of children and youth. To meet these statutory responsibilities, the department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the youth section of the Division of Corrections.

The Family Services section of DFYS is responsible for providing child protection and welfare services, licensing of child care facilities, and the recruitment, selection, and training of foster parents. The other major section of DFYS, Youth Corrections or Youth Services is responsible for supervising adjudicated youth offenders.

The focus of this audit was Family Services. Specifically the audit concentrated on child protective services (CPS) and the decision making process related to custody of children. The goals of CPS are twofold: (1) to identify, treat, and reduce child abuse and neglect; (2) to ensure reasonable efforts are made to protect and maintain children in their own homes. DFYS provides protective services for children by: (1) investigating reports of harm; (2) referring families to community resources; (3) initiating legal intervention if children are unable to remain safely in their own homes; and, (4) providing out-of-home placements and permanency planning when necessary.

When a child is taken into physical custody they are placed either in foster care, or perhaps in an emergency shelter facility. DFYS also contracts with residential care facilities to provide assorted levels of care and treatment of youth.

Each provider is subjected to licensure and periodic review to assure children are provided with reasonable care in a safe environment. Responding to complaints of abuse and neglect for children in out-of-home care is also the responsibility of DFYS social and licensing workers.

According to the agency's FY 99 budget documents, the three DFYS regions had 328 permanent, full-time authorized positions during FY 97. Including Central Office and Youth Facility Services, DFYS had 570 permanent, full-time authorized positions. During that same period, DFYS' three regions had a combined operating appropriation in excess of \$22 million. The total DFYS operating appropriation was \$69.8 million. Included in the appropriation was funding for three regional offices, Central Office, Purchased Services, and Youth Facility Services.

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BACKGROUND INFORMATION

As discussed in the Organization and Function section of this report, the Division of Family and Youth Services (DFYS) is charged with protecting children from neglect and abuse. To assist social workers in meeting this mandate, the agency has developed procedures to manage caseloads through screening and prioritizing reports of harm (ROH). DFYS has also developed procedures to assess, record, and mitigate the risks of continued child abuse and neglect. Central to these procedures are a risk assessment tool, a case assessment form, and, for ongoing cases, a case plan.

DFYS prioritizes response to ROHs based on perceived risk to child

DFYS screens each ROH received to determine whether to initiate an investigation.² Despite being required by statute to respond to all ROHs, DFYS has developed a process that has resulted in some reports not being investigated. DFYS delays responding to some lower priority reports until workload permitted. This process, termed "workload adjusting" was originally intended to delay investigating ROHs until workload permitted. However, workload rarely did, and the ROHs typically went uninvestigated. The screening process involves ascertaining the current status of the child, the potential for immediate and/or future danger, and the location of the child and parents. To accurately assess the degree of risk to the child, the screener elicits additional information about the alleged victim and the family.

Additional information helpful for the screening assessment includes: prior history with child protection, substance use or abuse by parents or caregivers, domestic violence, history of concerns, and family strengths and resources. Although the screener may be able to determine the need and immediacy of intervention on the basis of a brief contact with one reporter, it may also be necessary to contact several collateral sources to acquire the needed information. If the report of harm does not meet the criteria for investigation, the case is closed.

As mentioned, to manage an increasing workload, DFYS has developed an informal policy to delay or defer investigations on ROH determined to be lower risk. The use of this practice, referred to as workload adjusting, varies between district offices, with some offices workload adjusting as many as 67% of their reports of harm.

² AS 47.17.030 (a) requires DFYS to investigate all reports of harm. The statute reads as follows:

If a child, concerning whom a report of harm is made, is believed to reside within the boundaries of a local government exercising health functions for the area in which the child is believed to reside, the department may, upon receipt of the report, refer the matter to the appropriate health or social services agency of that local government. For cases not referred to an agency of a local government, the department shall, for each report received, investigate and take action, in accordance with law, that may be necessary to prevent further harm to the child or to ensure the proper care and protection of the child. [Emphasis added.]

FAMILY ABUSE/NEGLECT ASSESSMENT

Worker _____

Date: _____

Case Name: _____

Case Number: _____

RISK ASSESSMENT

ABUSE		Score	NEGLECT		Score												
A1	Number of prior reports of abuse None (0) One (1) Two (2) Three or more (4)		N1	Number of prior referrals for neglect None (0) One or two (2) Three or more (4)													
A2	Number of prior placements outside of family residence None (0) One or more (1)		N2	Number of prior placements outside of family residence None (0) One or two (1) Three or more (3)													
A3	Number of abuse/neglect types noted in current referral One (0) Two or three (2) Four or more (3)		N3	Either caretaker neglected as a child No (0) Yes (2)													
A4	Number of adults in home (18 yrs of age or older) Two or less (0) Three or more (2)		N4	Single caretaker home at time of referral No (0) Yes (1)													
A5	Number of children in home Two or less (0) Three or more (2)		N5	Caretakers history of drugs/alcohol abuse None (0) One or both caretakers are abusers (3)													
A6	Either caretaker abused as a child No (0) Yes (2)		N6	Age of youngest caretaker at time of referral 26 or older (0) 25 or younger (1)													
A7	Caretakers history of drug/alcohol abuse None (0) One caretaker (1) Both caretakers (3)		N7	Number of children in home Two or less (0) Three or four (1) Five or more (2)													
A8	One or both caretakers previously convicted of a criminal act No (0) Yes (1)		N8	Caretaker(s) primarily involved in negative social relationships No (0) Yes (2)													
A9	Caretaker(s) primarily involved in negative social relationships No (0) Yes (2)		N9	Motivation for change demonstrated by perpetrator(s)/ caretaker(s) Not applicable (0) Motivated & realistic (0) Motivated, not realistic (1) Unmotivated (2)													
A10	Caretakers history of depression None (0) Significant, long-term episodes by either caretaker (1) Episode(s) include a suicide attempt by either caretaker (3)		TOTAL NEGLECT RISK SCORE														
A11	Cooperation with agency demonstrated by perpetrator(s)/ caretaker(s) Not applicable (0) Cooperative (0) Uncooperative (1) Hostile / Threatening (3)		GENERAL INSTRUCTIONS 1) Complete both risk scales (abuse & neglect) on the family during the intake process for all intakes. 2) Calculate the total score for each scale. 3) Assign the family's service level based on the highest score in either scale; use the following chart: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Risk of Abuse Scale</td> <td style="text-align: center;">-2 → 4</td> <td style="text-align: center;">5 → 7</td> <td style="text-align: center;">8 or above</td> </tr> <tr> <td style="text-align: center;">Service Level</td> <td style="text-align: center;">☐ Low</td> <td style="text-align: center;">☐ Medium</td> <td style="text-align: center;">☐ High</td> </tr> <tr> <td style="text-align: center;">Risk of Neglect Scale</td> <td style="text-align: center;">0 → 3</td> <td style="text-align: center;">4 → 10</td> <td style="text-align: center;">11 or above</td> </tr> </table>			Risk of Abuse Scale	-2 → 4	5 → 7	8 or above	Service Level	☐ Low	☐ Medium	☐ High	Risk of Neglect Scale	0 → 3	4 → 10	11 or above
Risk of Abuse Scale	-2 → 4	5 → 7				8 or above											
Service Level	☐ Low	☐ Medium	☐ High														
Risk of Neglect Scale	0 → 3	4 → 10	11 or above														
A12	View of abuse by non-perpetrator(s) / caretaker(s) Not applicable (0) More serious than agency (-2) Consistent with agency view (0) Less serious than agency (2)																
TOTAL ABUSE RISK SCORE																	

Risk of Abuse Scale

-2 → 4

5 → 7

8 or above

Service Level

☐ Low

☐ Medium

☐ High

Risk of Neglect Scale

0 → 3

4 → 10

11 or above

OVERRIDES: Note: Override to High. Circle appropriate reason.

- 1) Substantiated sex abuse.
- 2) Child required medical treatment subsequent to abuse or neglect.
- 3) At least one sibling is in DFYS placement
- 4) Suspicious death of sibling.
- 5) Other: _____

FINAL ASSIGNMENT LEVEL _____

Supervisor's Review/Approval _____

Date _____

Risk assessment tool quantifies risk factors for abuse and neglect

In 1989 DFYS contracted with the National Council on Crime and Delinquency (NCCD) to construct a rating procedure, or "instrument," to better assess risk of continued maltreatment of children in certain situations. The instrument, known as the risk assessment tool (RAT) was the product of research by the NCCD and a cross section of DFYS rural and urban social workers.

In addition to assessing the risk of continued harm to children, the tool was designed to also provide guidance as to suggested level of service that should be provided to the families involved. RAT scores are also intended to form the foundation for case planning and action.

The RAT consists of a series of numerically evaluated indicators for abuse and neglect (See prior page for sample of RAT form currently used).

The sum of the RAT indicators dictate required service levels of low, medium, and high. RAT scores can be overridden by supervisors and **must** be overridden in certain situations described in inset at right.

RAT forms are typically completed near the end of an ROH investigation. RAT scores are theoretically used to determine whether a case will be forwarded for continuing service and are central to the case assessment form which summarizes, in a narrative form, the status of the case. Since 1989, the RAT has been neither reevaluated nor revised.

Case assessments used to close cases or forward them to ongoing units

DFYS uses case assessment forms to summarize the findings of an ROH investigation. These forms are designed to support the decision to close or continue a case into the ongoing unit. If the outcome of an investigation results in the state taking custody of a child, DFYS must show that reasonable efforts were made to prevent the removal of the child from the home. The documentation of these efforts on the case assessment form includes summaries of the presenting problem, intervention and progress made, a social summary, recommendations, and an intake determination. A supervisor reviews each case assessment to ensure that the situation supports the investigation determination and the eventual disposition of the case.

Figure 1

Risk Assessment Tool (RAT) Scoring

	Low*	Medium	High
Abuse	-2 to 4	5 to 7	7 or more
Neglect	0 to 3	4 to 10	11 or more

RAT scores must be overridden to show a need for high service levels if any of the following has occurred:

1. Substantiated sex abuse
2. Child required medical treatment subsequent to abuse or neglect.
3. At least one sibling is in DFYS placement.
4. Suspicious death of sibling.

*As shown above, risk scores for abuse as calculated on the RAT can actually sum to a risk level at less than zero. If there are no other risk factors for abuse and the caregiver views the report of abuse more seriously than the agency, a total risk of abuse score could conceivably sum to -2.

Case plans form framework for reunification or termination of parental rights

If a case is transferred to the ongoing services unit, the social worker, in conjunction with the family, develops a case plan to outline necessary corrective measures. Many times these measures include substance abuse assessment and treatment, anger management counseling, and parenting skills instruction. Generally cases transferred to the ongoing unit are for children in state custody. The case plan is designed to address the issues that initially brought the children into state custody. In nearly all cases, the ultimate goal of the case plan is to reunify the child with the parents or the original caregiver.

This goal has both social work and legal ramifications. The case plan must, under social work guidelines, be reasonable in that it addresses the areas that have caused children to be at risk and sets attainable goals for the caregivers. In a legal sense, the agency must document that it has made "reasonable efforts" to reunify the family before termination of parental rights can be considered. Historically, DFYS has interpreted reasonable efforts to include making available to caregivers a wide variety of family support services. Such services have typically included establishing a workable visitation schedule, helping with childcare problems, developing safety plans for children, and assisting caregivers in finding substance abuse assessment and treatment.

Number of parties contribute to complexity of custody cases

Custody decisions are not made by DFYS alone. When DFYS takes emergency custody of a child, the agency is required to show probable cause for its actions at a court hearing within 48 hours. When non-emergency custody is taken, the agency is required to show cause within a "reasonable time." For each case in which temporary custody is granted (the court finds probable cause), the parties to the action include not only the parents and children, but also an assistant attorney general (AAG), a guardian ad litem (GAL)(see footnote on page 1), and the parent's attorney.

Because the Attorney General's Office is charged with representing DFYS in custody cases, the AAG is often involved early in a case by helping the agency determine whether or not legal grounds exist to take custody. The AAG then often participates in determining when custody of the children may be returned to the parents.

If the agency's petition for temporary custody is granted, the court appoints a GAL as a representative for the child. The GAL is charged with representing the best interests of the child in court proceedings and often with reporting to the court before adjudication takes place.

In many cases, attorneys are also party to the case as representatives of the children's parents. In some of these cases, the attorneys are court appointed public defenders.

New federal and state laws will force changes in custody and termination decisions

Under new federal laws, DFYS should generally move for termination of parental rights in cases of children that have been in state custody for the last 15 of the most recent 22 months. New state laws passed during the last legislative session give DFYS more authority to effect these terminations. As of May 1, 1998, there were 566 children that had already been in custody for more than 15 months; 248 of those have been in custody longer than 38 months.

One the most significant changes to current casework will be the implementation of concurrent planning for children in custody. Current casework generally involves only one case plan, which as discussed previously, has generally been designed to return children to their parents. The new federal law will require social workers to plan for both family reunification and termination of parental rights.

If, at the end of 15 months, the family can not be reunified due to noncompliance with case plans, the alternative permanency plan – termination of parental rights – should be pursued. In some situations termination is not mandated at the end of 15 months. These situations include potential relative placements, instances when support services have not been offered to the family, and any other situations that social workers can demonstrate termination is not in the best interest of the child.

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REPORT CONCLUSIONS

As set out in the Objectives, Scope, and Methodology section we reviewed selected cases involving custody decisions made by the Division of Family and Youth Services (DFYS). From this review of selected situations where DFYS either sought, or did not seek, custody, we have developed the following conclusions.

DFYS exercises extensive discretion in making decisions to take and maintain custody

When considering taking custody of a child, DFYS social workers have extensive discretion. From our review of many reports of harm (ROH), done in conjunction with both this and the prior recently completed DFYS audit (Control No. 06-4586-98), we often found it difficult to recognize a standard, consistent response to the reports. From our review of ROHs and subsequent case work decisions, we could not develop a definitive standard that would allow us to predict when DFYS would take custody.

We attempted to understand and evaluate decisions using such quantitative measures as the agency's risk assessment tool (RAT) scores. However as discussed in Recommendation No. 4, we found the RAT was not completed consistently by the social workers, and even adequately documented RATs were not necessarily indicators of the eventual custody decisions.

For example in Case A on page 21, we found it difficult to understand why DFYS left the children in the home situation described through such a multiplicity of ROHs and generally high RAT scores. In other cases we reviewed, the agency took custody in seemingly less pervasively bad circumstances (for example, see discussion on page 21 of a case where the agency took custody though RAT scores were relatively low). In discussions with agency personnel, the central rationale was that DFYS is required to make reasonable efforts, perhaps what may appear as extremely reasonable efforts to both avoid taking custody of children.

In Case B-Part I on page 22, DFYS did not seek custody for a boy for which it received numerous ROHs. Despite knowing of the case for some time, the agency was seemingly reluctant to take custody. DFYS acted only after the father had been taken away to a detoxification center, was being evicted from his home, and his electricity was being shut off. DFYS sought custody, after the care-giving grandparents involved had gone to court to obtain temporary custody. As with the situation in Case A this case suggests that in some instances there is seemingly quite a high threshold to the agency's probable cause to take custody of children being abused and neglected.

Another situation where DFYS took custody much sooner is illustrated in the fact situation in Case C on page 24. In Case C, the mother involved expressed puzzlement over DFYS taking emergency custody because of a physical altercation between the mother and daughter. Given the circumstances, as set out in the opening paragraph of the case, it would seem unclear why custody was taken – especially compared to the circumstances involved in Cases A and B as previously cited. Evaluating the decision simply on the information set out

in the original ROH, the agency's decision to seek custody would seem suspect. However, the agency action seems justified in the full context of the girl's circumstances discovered in the course of DFYS responding to the original ROH.

Legal advice regarding "making of a case" also influences custody and termination decisions

When making case work decisions, social workers are also guided by the advice of assistant attorneys general (AAG) working in the Department of Law. DFYS social workers must "make their case" not only to obtain custody, but to maintain custody in subsequent adjudications, and especially when seeking to terminate parental rights. In most instances, the advice and perspective of the AAG working with the agency directs these case work decisions. One primary example is the situation discussed in Case B-Part II on page 23. In this case, not only did the agency resist seeking termination of parental rights primarily on the advice of the AAG involved, it also decided to dismiss the child-in-need-of-aid (CINA) classification based on the AAG's advice. Again, although the AAG's advice and DFYS actions may be consistent with statute, it is inconsistent with agency decisions in seemingly similar cases.

Courts, on occasion, do make rulings that limit the discretion of the agency

In the course of this and past reviews, we have consistently heard complaints from parents and parent advocate groups that the court system does not provide an independent, impartial review of DFYS actions. Both groups typically assert that the courts do not afford them a full chance to be heard and confront the testimony and opinions of agency social workers. While rare, we did note there were occasions when the courts took exception to the custody recommendations made by agency social workers.

For example, in Case D on page 25, the judge decided to allow the young step-daughter to return to her home, against the recommendation of DFYS. The agency had concluded that the girl, had had inappropriate contact with her step-father and was opposed to her return home.

The girl, like the one in Case C had recanted her account of the relationship with her step-father. Again, DFYS had reason to disbelieve the recant, and wanted to continue custody of the girl, until her mother took action that would provide for the safety of her daughter. Essentially this involved separating from, and perhaps ultimately divorcing the stepfather. However, at the adjudication, the court decided that the girl could return home, although DFYS was allowed to maintain custody. It appears a contributing factor to the court's decision was that the step-father was incarcerated and, as a result, would not be present in the home in the near future.

In another case, the court left a young 5 year-old boy with his mother, while giving DFYS supervisory custody. In Case E on page 26, the mother appeared to have difficulty supervising her son, due to her use of prescription painkillers. These instances suggest that the court does exercise independent judgement, but that DFYS consistently prevails, in large part because of experience, by both the social workers and the AAGs about what is necessary to make a CINA case. We have also noted cases where the agency has not pursued custody

due to being advised by an AAG that the circumstances involved would not permit the agency to take custody or, if circumstances change during the time the State has custody, would not allow the agency to retain custody. Case E on page 26 is one such example.

Investigations associated with ROHs impact custody decisions

It sometimes appears that DFYS is responding in a disproportionate manner when the agency seeks custody. In many cases it appeared that the ROH circumstances that triggered the agency's investigation would not warrant DFYS seeking custody. When we interviewed parents and heard how they related the circumstances leading up to DFYS taking custody it often seemed the agency's actions were disproportionate to the situation set out on the original ROH.

However, custody decisions often seem more reasonable when other information is developed from the ROH investigation. For example, in Case C, the circumstances that led to the girl being brought to DFYS by law enforcement, would, in and of itself, not necessarily rise to the level where the agency would seek custody. But as reflected by the other facts set out in Case C, the custody decision is more reasonable. Given the horrific report by the girl, the circumstances seem to be consistent with the provisions set out in law for declaring a child to be a child-in-need-of-aid (CINA). Considering these factors, the agency appears to have appropriately exercised its discretion.

The circumstances of a case involved in a recent State Supreme Court ruling illustrates how DFYS does, at times, evaluate investigations in the full context of a child's situation rather than the isolated circumstances that may have brought the child to the agency's attention. In an August 7, 1998 decision the court discussed a case where DFYS sought extended custody of a child that was involved, as a passenger, in a minor automobile accident³ where the father was arrested for driving while intoxicated (DWI).

In this decision the State Supreme Court advised lower court judges hearing abuse and neglect cases to weigh the "totality of circumstances" that put a child at risk, even though the child may not face imminent harm. A slim majority of the court (in a 3-2 decision) set out the position that the judges making CINA decisions are obliged to examine all of the circumstances involving a child and not focus only on isolated incidents that trigger state involvement.

Essentially, although such an incident which led to DFYS intervention may not rise to the level of a CINA adjudication, it may be indicative of an aggregation of factors which suggest more substantial risk to the child. According to the court record, the father of the boy involved had two DWI convictions since 1992 in addition to a history of alcohol abuse and domestic violence.

The majority opinion observed that the *"state's evidence tended to show that [the boy], only 9 years old, lived in a chaotic home where everyday life was dominated by his parents'*

³ The court decision stated that the father "...backed his car into a neighbor's vehicle while attempting to leave his apartment complex."

longstanding alcohol abuse and domestic violence," and as such the child "stood in constant jeopardy of physical harm, either from his parents' actions or from their failure to provide adequate supervision." This situation is similar to many of the cases we were asked to review, where the individual circumstances when considered in isolation may not have supported a CINA finding, but led to an investigation that identified other factors to support the State seeking custody. In light of the recent ruling, the circumstances such as those set out in Case A on page 21 would presumably require the agency to move for CINA status earlier in the case.

DFYS custody decisions are generally supportable but not obviously consistent

In general, when DFYS takes custody of children, the decision is supported by numerous risk factors. Risk factors recorded on the risk assessment tool (RAT) most often reflect substance abuse and/or domestic violence issues. These risk factors, when combined with the absence of responsible relatives willing to care for the children, seem to be the most common reason children are taken into custody. In a review of 21 cases in which DFYS took custody of children and risk assessments were completed, RAT scores were high for abuse, neglect or both in 17 of the cases.

One case was for substantiated sexual abuse, and though the RAT abuse and neglect scores were both only 4, substantiated sexual abuse requires an override to a high-risk level. Another case with unusually low RAT scores (abuse score of 3, neglect score of 7) is described in the inset at right. The other two cases showed more moderate risk factors, but involved circumstances that suggested increased risk to the children.

DFYS is required to make "reasonable efforts" to prevent children from being removed from their parents. While these efforts often include assisting parents with daycare, transportation, and substance abuse treatment programs, they also may involve empowering one parent to protect the child against the other parent who may be abusive.

While, as described in the case in the inset above, DFYS may petition to take custody of a child to protect it from one parent, the agency sometimes advises the protective parent to seek domestic violence restraining orders against the abusing parent. In these cases, the protective parent maintains a legal basis to keep the abuser away from the children and the State is not forced to take custody of the children

DFYS Takes Custody with Low RAT Scores

The report of harm concerned three children of divorced parents. The children, who usually lived with their mother, had been staying with their father while their mother was out of town attending to a sick relative.

DFYS became involved when two of the children ran out of the house, flagged down a cab driver and asked him for help because their father was beating their brother. The children stayed with the cab driver that night. When the mother returned the next day, DFYS told her they would petition for temporary custody of the children, but place them with her. According to the case assessment the mother was considering reconciliation with the father and the agency petitioned for temporary custody to protect the children from their father. The agency subsequently released custody when the mother and children left the State.

The files we reviewed indicated that DFYS generally made reasonable efforts to avoid removing children from their parents. Though the agency makes reasonable efforts to keep children with their parents, sometimes these efforts are not successful.

Even in cases where children cannot reside with their parents, DFYS still attempts, when possible, to avoid taking custody of the children.

In general, cases in which DFYS takes custody are distinguishable, by the RAT scores involved, from cases that are substantiated and closed. Occasionally, however, cases with high RAT scores are closed without further action.

Of the 51 non-custody cases we reviewed, 11 had relatively high RAT scores, but custody was not considered an option. Case A is an example of a case with extremely high RAT scores that did not result in DFYS immediately seeking custody or monitoring the family by any other means.

Though this case is atypical in its closure with such high RAT scores, the results of such a closure, continued reports of concern and escalating problems within the family, are all too common.

Most case plans reflect efforts toward reunification, but don't require total compliance

DFYS is required to make "reasonable efforts" not only to prevent removal of children from the home, but also to reunify children in custody with their families. In each of 12 custody cases

Alternatives to custody include placements with relatives, monitoring by other agencies

When parents are unable to care for their children or pose a threat to their child's safety, DFYS is often able to avoid taking the children into physical custody by placing them with relatives or neighbors.

In one case we reviewed, a single mother had left her children with a teenaged babysitter for a few days while the mother was out of town. The babysitter decided she didn't want the responsibility for the children and left them with their maternal aunt, who called DFYS for help. A letter to the mother described a relatively common situation:

You are very fortunate your relatives were willing to help you out when you were away. This created a hardship for (name deleted) and I would hope that you would go out of your way to thank her. If not for her, the Department of Health and Social Services would have petitioned the court for custody of your children.

Placement with relatives is often the best alternative for both the State and for the children. The State benefits by minimizing the costs of foster care. The child is generally also happier and less traumatized by being placed with relatives.

In addition to minimizing both state cost and trauma to children, placement with relatives also allows the State to comply with Indian Child Welfare Act regulations, which pertain to Alaska Native children. These regulations require DFYS to place Native children, who comprise nearly 40% of DFYS' ongoing caseload, with relatives if possible.

Other agencies are also sometimes used as a resource to monitor and assist families so state custody does not become necessary. When DFYS can rely on agencies such as Family Advocacy, Healthy Families, the Public Health Nurse and various tribal organizations to help monitor and assist the family, the likelihood of the State taking custody of the children is reduced.

Some of these agencies assume only a monitoring role to ensure that the risk of harm to the children remains low, while other agencies provide in-home observation and education in parenting skills.

we reviewed in depth, the initial permanency plan was for the children to return to the biological parents. Reasonable efforts to reunify are to be documented through the case plan, which describes what parents must do to regain custody of their child. For the cases we reviewed, each of the case plans required regular visitation with the children. Most of the plans also required drug or alcohol abuse assessment and/or treatment as well as maintenance of drug-free and violence-free homes.

The case plans we reviewed appeared to be reasonable in that they generally addressed the issues that initially brought the family to the agency's attention. However, in most of the cases we reviewed, the parents did not immediately make significant progress toward goals outlined in case plans (see Case A for an example of a custody case with resistant parents). In most cases, return of the children to the parents is apparently not contingent upon total completion of steps outlined in the case plan. In many cases, either the parents only partially complied with the requirements of the case plan, or only one of the parents complied with the requirements. In some cases, the return of the children to their parents seemed driven more by the children's displeasure with foster care than with any real progress made by the parents in carrying out their case plan.

The agency's inability or unwillingness to insist that parents comply completely with case plans may be driven in part by a desire to reunify families as quickly as possible. A report by the Alaska Judicial Council, *Improving the Court Process for Alaska's Children in Need of Aid*, comments: *'The child-in-need-of-aid process often focuses, in fact, upon the parent in need of aid.'*⁴ The report also notes: *"Research has shown that the longer a child remains in foster care, the less likely family reunification becomes, with a particularly significant drop between the first and second years in foster care."*

Termination of parental rights impeded by reasonable effort requirements, establishment of paternity, and parent's promises

As discussed above, DFYS efforts to reunify parents and children must be documented in case plans. In one case, when the agency considered terminating the parental rights of a mother who appeared disinterested in reunification, a supervisor determined that termination would not be immediately possible. For medical reasons, the child had been placed in a different region of the state than where the mother lived. The mother, through a combination of her own and DFYS' problems had not visited the child in months. Though she was making little progress toward any case plan goals, the supervisor's position was that the mother had to be provided the opportunity to visit the child before the agency would be able to demonstrate reasonable efforts to reunify the family. The supervisor's advice reflected ongoing concerns she had heard expressed from the AAG involved. This AAG impact on case decisions is discussed in our Report Conclusions on page 11.

Another difficulty in terminating parental rights arises when the paternity of the child is unknown. For the agency to terminate parental rights, both parents must be notified. If a father can not be identified, an advertisement in the local newspaper advises that termination will take place unless someone shows reason the action is not in the best interest of the child.

⁴ Alaska Judicial Council, *Improving the Court Process for Alaska's Children in Need of Aid*; October 1996; p. 92.

If a father is located during the notification proceedings, DFYS must also make reunification efforts with the father and his family.

When DFYS begins to discuss termination proceedings, it is not uncommon for parents to make some effort to comply with case plans. The Alaska Judicial Council also comments on this phenomena: *"Eleventh hour conversions by parents who began treatment at the last minute caused problems in some of the cases reviewed by the (Citizen's Foster Care Review) panel."*

While, as discussed above, we believe that DFYS is well supported when it takes children into custody, we are not so convinced that custody is not taken as often as is necessary. Some of the cases shown in the Case Studies section seem to represent cases where custody would have been warranted. We address our concerns about the safety of children further in the Findings and Recommendations section of this report.

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CASE STUDIES

This section discusses the circumstances involved in various selected cases we considered in the course of this review. The cases are presented to provide examples of the different, and often difficult and conflicting factors that the Division of Family and Youth Services (DFYS) must take into consideration when making decisions about taking or retaining custody of abused or neglected children. Cases were selected to illustrate the various aspects of the agency's casework decision making.

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Case A

Situation demonstrates problems with taking and keeping custody of children

In one case reviewed for this report, DFYS had received 28 reports of harm (ROH) on one of the four children in the family. Numbers of ROHs on the other children varied from 23 to 25. Initial reports concerning neglect of the children began in 1993. According to various reporters, the neglect was the result of drug and alcohol abuse by the parents.

DFYS contacted the parents on some of these reports; others were workload adjusted. By 1994, the reports concerned domestic violence and physical abuse as well as neglect. In April of 1994, the social worker discussed the possibility with the parents of removing the children from the home if reports continued. The mother promised to obtain drug treatment and placed the children with her parents. By the end of July, 1994, the mother had dropped out of her rehabilitation program and was again living with the children. DFYS closed the case because, in its view, there was nothing else it could do with the family.

In August 1994, the mother threatened suicide and the police took the mother and children to a women's shelter. The shelter made several reports that the mother neglected her children and one report that she hit them. In December 1994, the mother became angry with the social worker and claimed she no longer wanted or needed her help. DFYS closed the case with risk assessment scores of 20 for abuse and 16 for neglect (RAT scores are discussed in the Background Information section). The closing documents commented that if the division received more reports, a straight petition (a non-emergency custody petition) should be discussed with the supervisor and Department of Law. The supervisor agreed to close the case but noted:

"High risk case – due to worker shortage and caseload, unable to intervene effectively."

After several more reports of neglect and abuse in early 1995, DFYS finally took emergency custody of the two oldest children in April, when the parents were arrested as a result of a domestic violence incident. In July, the children were released to the parents, though there were indications that the mother continued to use drugs throughout the three-month period the children were in state custody. Throughout the rest of 1995 and most of 1996, the children continued to live with their mother who was, by this time, separated from the father. During this time, DFYS received 9 reports of harm, mostly for neglect. Of those, each of the 6 that were investigated were substantiated.

In October 1996, DFYS took emergency custody of the two youngest children when the mother, who was inebriated, tried to leave town with the children. The children were placed with the father, who was reportedly in active recovery. A case plan outlining the terms of this placement requires that the father is to maintain a drug-free, nonviolent household. The father's signature is not on the plan.

In early 1997, DFYS received new reports of harm that the father was again drinking and using drugs. He was subsequently arrested for driving while intoxicated. In August, DFYS again took emergency custody of the children when the father's girlfriend overdosed on heroin. As of early April 1998, three of the children remained in foster care. One was with her mother. The permanency plan, last updated when the children were placed in foster care, is to return the two youngest children to the father and the oldest to the mother.

Case B-Part 1

DFYS TAKES NON-EMERGENCY CUSTODY AND LEAVES 7 YEAR OLD WITH GRANDPARENTS

One case reviewed involved a child's grandparents as caregivers. The paternal grandparents had a history of voluntarily caring for their grandson on occasions when their son, acting as a single parent, was unable, often due his drug/alcohol addiction, to care for the child. Since 1990, when he was 2 years old, DFYS had received several ROHs involving the child. The agency generally found them unsubstantiated and did not petition for custody.

Though DFYS could not prove most of the allegations of neglect and sexual abuse, by early January 1995, the risk assessment score for the child (see Background Information for discussion of how cases are scored for risk) associated with the most recent ROH was high for both neglect and abuse. The case, however, was closed with a recommendation that the father seek drug and alcohol abuse assessments. Over the next several months, DFYS received more ROHs, but each was closed as unsubstantiated.

In October of 1995 the father was reported to Anchorage Community Patrol. This local agency picked up the father in an inebriated condition and admitted him to a community detoxification center. The grandparents were summoned to take the 7 year old boy. DFYS received an ROH from the grandparents' attorney. In response to the ROH, the agency apparently decided since the child was with the grandparents and not at any imminent risk of harm, DFYS would not seek custody. The grandparents, as result of court action they initiated, obtained a domestic violence restraining order against the father and also received temporary legal custody of the child. At the same time, DFYS responded to a report from the grandparents that the boy was willing to talk about sexual abuse by his father.

During November, 1995 DFYS worked with the Anchorage Police Department (APD) and therapists to investigate various allegations of sexual abuse involving the father and the son. Through various interviews with APD and social workers, the child denied that he had been sexually abused. During this time, the child remained with his grandparents, and DFYS while keeping the case "open" had no custody of the child.

By December 1995, the father had left one treatment program and was beginning another. He had also taken a polygraph in which he denied molesting his son. The polygraph indicated that he was not being truthful. Medical evidence was inconclusive. APD dropped the sexual abuse investigation, believing it could not substantiate a case against the father. The child, who continued to deny any sexual abuse, remained with the grandparents. DFYS filed a non-emergency petition to adjudicate the child as a child-in-need-of-aid (CINA). Under the CINA order, issued December 11, 1995 temporary placement was granted to the grandparents. The CINA order superseded the temporary custody order the grandparents had obtained in October.

CASE B-Part 2

DFYS RELINQUISHES CUSTODY, APPARENTLY AS MUCH FOR LEGAL ADVANTAGE AS CHILD PROTECTION CONCERNS

At the beginning of 1996 the father continued in various treatment programs. There was some dispute between the father and the grandparents over the conditions under which he could have visitation with his son. In February 1996 the Alaska Supreme Court agreed to hear the grandparents' motion to intervene in their grandson's CINA case.

In April 1996, the child's guardian ad litem recommended that the boy remain in the legal custody of DFYS and continue to be placed with his grandparents. A June 1996 case plan stated the problem as being the father's chronic alcohol and drug dependency that endangered the welfare of his son. The plan set as a goal successful completion of an in-patient intensive care substance abuse treatment program. The father was also to continue in therapy after completing this program. The plan noted the sexual abuse allegations made against the father were unsubstantiated. At this time, the case social worker also noted in the file that she should confer with her supervisor regarding termination of parental rights.

By late August 1996, however, DFYS notified the grandparents the agency intended to dismiss the CINA case involving the boy. By that time the district attorney had filed weapons misconduct charges against the father. Since the child was with the grandparents, and in the view of DFYS the agency still had not met its requirement of "reasonable efforts" to reunify the child with his father, no effort was made to terminate parental rights.

DFYS took this approach despite both the guardian ad litem and the therapist favoring termination of parental rights as being in the child's best interest. In September 1996 the assistant attorney general (AAG) wrote DFYS that he could no longer see any further child protection issues involved in the case. He also commented that the Department of Law was too busy to go through an unnecessary termination trial, which would only allow the grandfather to promote his own private custody interests at the expense of the State. Some two and half weeks later he wrote the grandparents' attorney. He stated that if the attorney would drop his appeal to the Alaska Supreme Court, that "the department may be willing to commit to a termination proceeding." After the grandparents' attorney refused to do so, the AAG did file with the court to dismiss the CINA petition. The court dismissed the boy's CINA case.

Case C

GIRL TAKEN INTO CUSTODY AFTER FIGHT WITH MOTHER DUE TO FACTORS OUTSIDE REPORT OF HARM

Initial Action - A 13-year girl came into DFYS custody after a police officer picked her up following a physical altercation with her mother. The officer was responding to a call from the mother, had been to the house, heard the mother's description of the fight, and caught up with the teen-ager as she left the house in anger. The officer brought the girl to DFYS.

In discussions with the mother, she believed the police response was inappropriate and disproportionate. She expressed dismay at the actions of the officer. She had contacted the police with the expectation that they would talk to the girl, tell her to obey her mother, and that would be the end of the altercation. The mother commented that if she knew the police would end up transferring her daughter into custody, she never would have made the call.

In Custody - Once in custody the child reported that her mother had allowed a man to have sexual intercourse with her in exchange for drugs. She reported that upon complaining of such treatment to her mother, she was told "Get over it... ." The record also indicated that this was not the first incident where this mother had been involved with DFYS. There were numerous ROHs over the years involving the daughter and her siblings.

DFYS sought emergency custody under provisions of AS 47.10.010 (a)(1)(3)(6) which provide for a minor being determined to be a child-in-need-of-aid (CINA) under the following circumstances, where the child ...

(a)(1) ... is habitually absent from home or refusing to accept available care, or having no parent, guardian, custodian, or relative caring or willing to provide care,

(a)(3) ... having suffered substantial physical harm or if there is an imminent and substantial risk that the child will suffer such harm as a result of the actions done by or conditions created by the child's parent, guardian, or custodian or the failure of the parent, guardian, or custodian adequately to supervise the child;

(a)(6) ... having suffered substantial physical abuse or neglect as a result of conditions created by the child's parent, guardian, or custodian.

Recant - Subsequently, the girl recanted her story of being traded for her mother's drugs. DFYS considering the circumstances of recantation, and consistent with the professional literature on sexual abuse, discounted the girl's recant. In this particular case, DFYS believed it had reason to believe the daughter was being pressured to recant the story. However, eventually DFYS returned the child to the mother, even though the mother had refused to cooperate in carrying out the case plan.

Case D

GIRL RETURNED HOME BY JUDGE OVER DFYS OBJECTIONS

Initial Action - A 13-year girl came into DFYS custody after reporting to her aunt that her step-father sexually molested her. The agency, in conjunction with law enforcement officials interviewed the daughter and the step-father about the allegations. According to the notes in the case file, the step-father told of encounters with his step-daughter that were consistent with her allegations and initial report. DFYS sought, and received from the courts, custody of the girl.

The mother involved denied all allegations. In her view her daughter made up the entire story in order to seek retribution against her and her husband for disciplining the girl. Subsequently, the girl recanted her allegations. As in case C, DFYS believed it had reason to reject the recantation due to the circumstances of the case. It sought to maintain custody outside the home of the mother and step-father, but the court ruled that the girl could return home. It was speculated that the court felt more comfortable about the decision because the step-father would be out of the home for the next few months due to being incarcerated.

Case E

SMALL BOY LEFT IN HOME WITH MOTHER BUT SUPERVISED BY DFYS WORKERS DUE TO SAFETY CONCERNS

Initial Action – Numerous neighbors reported to DFYS that a young 5-year-old boy was crying and screaming so loudly that they could hear him through the walls of their adjoining apartments. The boy was trying to get the attention of his mother to assist him in going to the bathroom, since he was in a full body cast. According to the report of harm the neighbors had tried to arouse the boy's mother by phoning the apartment repeatedly, but to no avail. One reporter was recorded as stating that a neighbor had banged on the apartment's door so hard that a clock had been knocked off the wall inside the mother's apartment, but again raised no response.

The DFYS social worker along with law enforcement officials finally gained access to the apartment. Apparently, the boy's mother was heavily sedated by prescription painkiller medication. DFYS was concerned about the mother's ability to adequately supervise her son. Adding to this concern were the circumstances included in the boy being in the body cast. This was a result of the boy jumping out a second story window, while his mother was asleep because of the medication she was using.

In Custody - DFYS filed for custody of the child after emergency placement, but the court ordered supervision only following a lengthy and highly contested hearing. An adjudication hearing is scheduled in September 1998, but DFYS contemplates that it may withdraw if the home remains stable. The boy is receiving child protection daycare services, both as respite for the mother and so the agency may monitor the child's condition.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The director of the Division of Family and Youth Services (DFYS) should improve the relevance of the forms utilized to assess risk to children, and institute procedures to provide for more consistent, ongoing supervisory review of the risk and case assessments.

DFYS received 15,547 reports of harm (ROH) in FY 97. As discussed in the Report Conclusions section, the agency has established procedures to manage this caseload. Managing the caseload includes not only identifying and investigating the highest priority ROHs, but also supervising those cases to ensure appropriate resolutions. DFYS has developed procedures to assess risk of harm and determine which service level will best reduce risk to families under investigation. Forms summarizing the facts of each investigation are central to caseload management as they serve as a means by which line social workers communicate to their supervisors the results of ROH investigations.

DFYS uses two forms to document and assess the risk of continued harm to children of parents under investigation. The risk assessment tool (RAT) is used to quantify potential continued risk to the child. The results of the RAT are designed to form the basis for recommendations for how the case should be resolved. RAT scores ostensibly establish the level of service that should be provided to families under investigation. This service level is recorded on a case assessment form. The case assessment form is used to document, in a summarized manner, the situation that brought the family to the agency's attention, the outcome of the investigation, and any recommendations for resolution of the situation.

RAT form design and usage has been criticized by outside consulting organization

The Kempe Children's Center, in a report published in December 1997,⁵ made the following comments about the design of the RAT:

Many of the risk factors in the instrument are demographic or historical, and as such, they will not change. The only 'dynamic' variables are substance abuse, depression, perception of abuse by non-caregivers, motivation for change, and actual change in psychological or life circumstances. Given the amount of research on individual, familial, and environmental variables influencing child maltreatment, dynamic factors should be added to the assessment. The limited number of dynamic variables to be considered leaves the worker without a clear indication of what must be controlled in order to assure safety.

The Kempe Children's Center report also made the following observations about how social workers complete the RAT and DFYS' decision making process as it pertains to RAT scores:

⁵ Kempe Children's Center: Report by the Review Panel, December 1, 1997.

- *There is great inconsistency and apparent inaccuracy in the use of the existing risk assessment scale in the categories on depression, negative social relationships, and cooperation.*
- *The use of the risk assessment tool varied considerably in the cases reviewed indicating the need for training to increase inter-rater reliability and validity.*
- *...discrepancies suggest that training is manifest in the efforts and accomplishments of some caseworkers and supervisors, and not others.*

Our review found RAT forms and case assessments are inconsistently completed

In addition to the deficiencies noted by the Kempe Children's Center, in our review of 66 RATs, we found the forms were often incomplete. A comprehensive family history is critical to completing these forms. Incomplete information understates the risk to children and may impact decisions related to services to be provided for the family. In many cases, it appeared that completion of the RAT form was a mere paperwork exercise rather than the comprehensive assessment tool that we understand was the intent behind the document when it was originally developed.

Case assessment forms are used to summarize the initial situation, progress and recommendations on a case. In our review of 51 case assessments, we found that most were completed and reviewed by a supervisor. We were not, however, convinced that the assessments were comprehensive. In 10 cases (just under 20%), the assessment did not explicitly address the issues described in the report of harm. In 42 (almost 82%) cases where the family had had previous interactions with the division, there was no mention of these previous cases in the case assessment or the pattern of abuse or neglect they represented. This inclination to view each report of harm as an isolated incident was discussed by the Kempe Children's Center: *"It is crucial that investigations and assessments be based on more than just the current incident/report."* As discussed in the Report Conclusions section, the Alaska Supreme Court has recently endorsed this position with a recommendation that judges review the "totality of circumstances" surrounding child-in-need-of-aid (CINA) cases.

In addition to case summaries that appear incomplete, recommendations for resolving cases were not consistently persuasive. These case assessment recommendations range from lists of potential services for the family to simply "close case." We were unable to determine from the case files whether the decision to discontinue intervention with the family was supported by additional factors not shown in the file or whether the decision was, as it appeared on the case assessment, unsupported. When a case with high-risk levels is closed, the reasons for the closure should be shown on the case assessment form. As discussed in Recommendation No. 2, in cases where the State does not take custody, yet high-risk to the child remains, it does not seem to us that "close case," with no further commentary, is an appropriate recommendation.

In our view, DFYS social workers do not consistently complete RAT forms because they perceive the forms as having limited relevance to line social work. Besides often having little training on what the forms mean and how they should be completed (see Recommendation

No. 4), workers realize that for most cases, the agency will provide services only if the decision is made to take custody. As discussed in Recommendation No. 2, all too often, services are not available, even if needed, for children not in state custody. Accordingly, if the custody drives the service level rather than the "scored risk" faced by a given child, the RAT form really is reduced to a hollow paperwork exercise.

The deficiencies noted in DFYS' assessment and summary forms may have far reaching effects. Because these forms are used by supervisors to help determine whether the line social worker has made appropriate case recommendations, the validity, accuracy, and completeness of these forms is central to good casework. DFYS should review the entire risk assessment and case closure system. This analysis should include an evaluation of whether factors currently used to assess risk actually provide social workers with enough information to make valid case recommendations. The agency should also ensure that social workers are appropriately trained and supervised in the use of the risk assessment tool and the related case assessment forms.

Recommendation No 2

DFYS should develop alternatives to closing cases where services are indicated but custody is not taken.

Resolution of reports of harm where custody is not taken varies widely. One consistent element, however, is that, regardless of perceived continued risk to children, there is little follow-up with the family. Of 45 cases with completed RATs where custody was not taken, 11 cases (24%) had risk assessment scores considered high under the current scale. As discussed in Recommendation No. 1, risk assessment scores tend to understate actual risk to the child. This suggests that more children are at higher risk than the assessment tool indicates. Each of the 45 cases was closed without further action, regardless of RAT scores.

The Kempe Children's Center also commented on this situation:

"...it appeared that cases were closed even if the risk assessment revealed high risk. What is the purpose of the tool if one can find high risk and close the case?" The Center then recommended "...that DFYS' responsibilities include follow-up in all investigated cases in which there has been a substantiation. If DFYS has recommended that the client do something, then DFYS needs to check to see if it's been done. If DFYS puts a safety plan in place, there needs to be a role for DFYS to monitor and evaluate its effectiveness."

We concur with the Center's recommendation. For FY 99 DFYS will be receiving increased funding for more social worker positions. In our view, the use of some of these positions to provide follow-up services to families not currently served will help to ensure the safety of children for which the agency is responsible.

Recommendation No. 3

DFYS should document the involvement, or lack thereof, of parents in the development of case plans.

In our review of 12 cases in which custody was taken, we found case plans for only 8. Of the eight case plans we found, only four were signed by both the social worker and the parents. Typically the social worker and the social worker's supervisor sign case plans, but parents often do not. In some files, it is unclear whether the absence of a parental signature suggests disapproval of the case plan, the absence of discussion about the case plan, or administrative oversight.

DFYS is required to make "reasonable efforts" to reunify families. The case plan is generally the document that sets out those efforts. Documentation that the parents involved accepted the plan, or at least some documented acknowledgement that efforts that were made to include them in the case plan is important. DFYS must be able to demonstrate that the parents were aware of the plan's requirements. The agency may find it difficult to prove that reasonable efforts have been made when the time comes to terminate parental rights if signed case plans can not be produced.

Occasionally, the absence of parental signature on the case plan does indicate the parent's reluctance to sign a plan with which they disagree. DFYS should ensure that caseplan forms including a signature line for parental disagreement with the caseplan are consistently utilized in all regions. With such a signature on file the parents will find it difficult to claim, as they often do, that they are not aware of any case plan requirements to explain their failure to comply with the reunification plan of the agency.

Recommendation No. 4

DFYS should ensure that all line social workers receive appropriate training

To some degree, each of the prior findings reflect our observation that many DFYS social workers do not receive enough training to adequately protect children. In addition to the pressures generally associated with the dynamic nature of families, new state and federal laws will soon substantially change casework methods for children in long-term state custody. Some line social workers have expressed concern that they are not fully prepared for these changes. These concerns are supported by some of our own fieldwork experiences.

During the course of our fieldwork, we observed the effect of inadequate training during our attendance at permanency planning meetings. Over the course of two days, three cases in which the social worker recommended termination of parental rights were brought to the meetings. Each of the cases was presented to a permanency planning committee that included the guardian ad litem, tribal representatives, social workers and their supervisors, and the permanency planning coordinator. The committee forwarded none of the cases to the Department of Law to begin termination proceedings, however, due to oversights in fundamental casework necessary to successfully pursue the terminations.

As discussed in the Report Conclusions section, social workers have discretion and the related responsibility for initial custody decisions. Social workers have told us that they are often ill prepared to make custody determinations, especially in cases of alleged sexual abuse. We have found that these cases are some of the most challenging for DFYS. Sexual abuse cases are often the most difficult and lengthy cases and may present the largest liability to the State. One of the cases we reviewed seems to illustrate line social workers' contention that they have not always been provided appropriate training for working these cases.

The case involved a child and her mother alleging that the child's father, who has shared custody of the child, had sexually abused her. The father denied the allegations, claiming that the mother was simply trying to obtain sole custody of the child. The social worker involved in the case, who concedes that she has no specific training in interviewing sexual abuse victims, believes that the child has now been interviewed so often that any potential anecdotal evidence that the child may have been able to provide has been irreversibly contaminated.

The details of this case were submitted to the Kempe Children's Center for review and advice. The Center commented: *"It is unclear why this case is being dismissed merely because the alleged perpetrator is denying."* The report also recommended only supervised visits with the father stating as the reason: *"[The child] remains in emotional and psychological conflict in the relationship with the father when there is ongoing contact without adequate supervision."* Subsequently, DFYS and the Attorney General's Office dropped the CINA case with a recommendation that the Kempe Center report be reviewed during a divorce-related custody hearing currently scheduled for December, 1998. It seems possible that a more timely resolution of this case may have been realized if the involved social workers had been better trained in interviewing sexual abuse victims.

Over the last several years, DFYS funding for training has been sporadic. Though there have been trainers in each of the three regions, funding for training has been very limited. Many social workers that began work within the last few years had not had basic CORE⁶ training. The agency has recently made efforts to ensure that all social workers have had CORE 101 and 102 classes. The social workers, however, find these classes of limited use after they've been on the job for a few years. Social workers frequently comment that the training they most need has been provided only to supervisors and is rarely presented to line workers. DFYS hopes to remedy some of the training problems through partnering with University of Alaska Anchorage to establish a training academy. While the academy seems to enjoy wide support from supervisory and line social workers, line social workers out of the Anchorage area are concerned that very little funding appears to remain for social workers to take advantage of any community-based educational programs within their own regions.

Given the broad discretion afforded social workers and the subjective nature of casework, adequate and timely training for line social workers is essential. In the agency's restructuring

⁶ CORE training is a series of courses in basic child protection services to be provided to all staff. Topics covered include, but are not limited to, the history of child welfare, DFYS mission and mandate, personal safety, assessment of child abuse and neglect, intake, investigation, confidentiality, ethics, cultural sensitivity, family centered services, safety issues, and stress and time management.

of the training system, DFYS has a unique opportunity to offer its workers the tools they need to better protect children. In the development of new training programs, the agency should seek and carefully consider line workers' perceptions of what training they believe would provide them with the tools to better protect children.

Recommendation No. 5

The commissioner of the Department of Health and Social Services (DHSS) should develop a non-judicial process to provide recourse and consideration to parents and other interested parties that become involved in child protective services disputes.

By the nature of the agency's responsibility it often creates controversy. When DFYS makes the decision to take physical custody of a child in order to assure they are protected from neglect or abuse, such action often generates protest from the parents involved. Likewise, as has been unfortunately the case in some recent instances when DFYS decides not to take custody, and subsequent harm comes to the child, the agency's decision making process is also subject to public criticism.

In instances when a child is taken into custody, it has been the position of the agency that the court system provides due process and protection for the children's parents. Within 48 hours of taking a child into custody, DFYS must appear in front of a judge to obtain concurrence with the agency's decision. If the DFYS custody action is not supported by the circumstances involved then the judge can order the child be returned to the home. As discussed in the Report Conclusions section, parents often feel they are not afforded appropriate due process in many of these hearings.

Parents and other interested individuals often feel judicial system unresponsive

In many of the individual cases we were asked to review, parents and other parties such as grandparents and foster parents often expressed frustration with the way the judicial review process worked in conjunction with their child-in-need-of-aid case. Various parents repeatedly voiced their frustration that the court process did not provide them with an adequate forum to tell their side of the story.

They often complained that they were afforded limited opportunity to speak at judicial proceedings while social workers were allowed to repeat what in the parents' view was hearsay and second hand gossip. Then the assistant attorney general (AAG) representing the agency characterizes their actions in the worst possible light, as advocates are wont to do in order to make the strongest case possible. In our view, much of this perception is fostered by the procedural rules followed by the court system when considering CINA cases. The inset on the following page discusses these rules and application.

Proposed legislation and related testimony reflects much of the frustration with established process

An extensive revision to the CINA statutes passed during the 1998 legislative session, gave DFYS what is generally acknowledged as new, expanded authority to intervene on behalf of children. Much of the opposition to this revision of the CINA statutes was initiated by individuals and organizations suspicious and concerned about giving DFYS broader, more expanded authority.

In our view, the nature of these concerns was reflected in some sentiment to set up a separate process to adjudicate children and juveniles. Evidence of this sentiment was legislation introduced during the 1998 legislative session establishing such a process. This legislation was given limited consideration and did not pass. However, testimony at hearings related to the legislation was that such an entity was necessary to develop a countervailing authority to the perceived wide, and from a practical perspective unchecked, authority of DFYS.

Options to consider to provide some further recourse for involved parties

Considering these perceptions, whether valid or not, we suggest the DHSS commissioner consider establishing an alternative means of recourse for parents and others involved in child custody decisions involving DFYS outside of the formal judicial process. We suggest the commissioner consider the following possible remedies:

1. Improved public notification and staff awareness of existing DFYS complaint resolution process. Currently DFYS has an informal procedure in place to respond to various complainants, the review is done internally by agency staff. There is a complaint form that can be made available to parents upon request. However, in Kenai, it was reported to us, that the DFYS office was unaware of the procedure and could not provide the appropriate form to the individual from the public making a request. While this process would likely be criticized as lacking independence, it may be a place to start.

We suggest the agency develop informational posters and require various state DFYS offices to display them prominently. Such posters should inform parents of the existence of a complaint procedure, along with instructions about how to contact the appropriate agency personnel to make a complaint. The agency should develop a clear complaint review and resolution procedure, which would include formal notification to the complainant of the result of the reviewer's investigation and decision.

2. Funding a specialized position in the Office of the Ombudsman. DFYS should consider utilizing some of its funding to contract with the Office of the Ombudsman to provide a position to respond to complaints of how specific cases are handled. Such a position, set up in an agency outside the Department of Health and Social Services could provide an ongoing, independent presence to assess on behalf of the public how the agency is responding to the concerns and rights of parents while acting on reports of neglect and harm to their child(ren).

3. Development of a community-level mediation process. Mediation is becoming increasingly popular as a method of conflict resolution. Mediation is a conflict resolution process in which one or more impartial persons intervene to help negotiate a mutually acceptable agreement between two parties. The mediator does not take sides or decide how a dispute should be resolved.

One promoter of mediation, in talking about the mechanics of a particular process commented that mediation sessions could provide substantial catharsis in emotional situations such as child custody. Sessions held in conjunction with mediating a dispute could provide a time that parties can speak at length and be heard without interruption. A session with a mediator can be more freewheeling, and informal rather than constrained by the formalities of a court room.

A full day of mediation can serve to bring emotions under control. This may result in a better understanding of the issues involved, communication of the actions DFYS wishes to pursue, and set the stage when such issues are discussed before the next court date, when emotions may surge again. In such a setting a trained non-lawyer layman mediator may often help make the process a much less stressful and unpleasant one for the parents involved.

We urge the department and DFYS to consider how to address this very real frustration that many parents have with the child protection system. We realize that DFYS workers themselves may often be frustrated with the attitude and response of the parents and see any sort of outreach effort as being counterproductive to effective child protection. In our view, the interlocking structure and roles of DFYS, the Department of Law, and the Alaska Court System leave many parents with a feeling, either real or perceived, that they are not being heard.

Parents are frustrated with all aspects of the system. They complained of the service their public defender attorney can provide. They expressed dismay to us upon discovering their child has separate "confidentiality rights" from them (see Recommendation No. 6). They resent being branded as the worst kind of parents in the strongly worded, adversarial language that is employed by the State's advocates from the Attorney General's Office and being silenced by the formalities of the process employed by the Alaska Court System. In general, they feel the full weight of the State is unfairly being brought to bear on them. It seems to us that such frustration over not being heard and not having a chance to tell their story, sets up a process that makes parents less willing to participate in effective case planning and contributes to extending the time children spend in state custody. For these reasons we encourage the Department of Health and Social Services' commissioner to explore ways to provide some non-judicial avenue to addressing these concerns.

**CINA Court Rules, based on civil standards
rather than criminal, are often viewed as unfair**

In many of the individual cases we were asked to review, the parents involved did not feel they received due process and fair consideration under the CINA court process. In our view, this was often due to the nature of some of the Alaska Court System's CINA rules. These rules, primarily designed to protect and benefit the child, are applied in a manner where the parents involved believe they are not being afforded due process, especially when compared to procedural safeguards available in criminal trials. Specifically, some of the rules that contributed to the complaints we heard were:

1. **Exclusion of parties.** The court may exclude a parent during the child's testimony in order to protect the child from material psychological harm. The parents may listen to a recording of the testimony to prepare for further examination and rebuttal, but we heard numerous complaints that access to, and availability of, tapes was inconsistent and intermittent on the part of the courts. [Rule 3 (c)]
2. **Exclusion of witnesses.** Witnesses may be excluded from any hearing at the discretion of the judge. Parents we spoke to complained repeatedly they were not availed of what they felt was adequate opportunity to rebut DFYS claims with witness testimony. [Rule 3 (d)]
3. **Admission of hearsay evidence.** According to CINA Rule 10 (b)(4) "*[t]he court may admit hearsay evidence which would be otherwise inadmissible under the Evidence Rules if the hearsay is probative of a material fact, has circumstantial guarantees of trustworthiness, and the appearing parties are given a fair opportunity to meet it.*" Many parents we interviewed felt the court "let in" and considered only hearsay evidence presented by the DFYS social worker. From our limited review of selected cases, it seems that this complaint had merit – the testimony of social workers, repeating the reports and complaints of others was often the central aspect of the State's presentation.

The court has adopted these rules to both expedite the CINA hearing process and provide protection for the best interests of the child. Currently, the Alaska Court System is reevaluating the way in which it handles CINA cases. A review was completed in October 1996, titled *Improving the Court Process for Alaska's Children-in-Need-of-Aid*, presenting analysis that indicated that the Alaska Court System was inconsistent in how it handled the cases. The study found jurisdictions varied in the amount of time they set between required adjudications, and how this variance contributed to children remaining in state custody for inordinately long periods.

Recommendation No. 6

The director of DFYS should reevaluate the scope and application of the agency's confidentiality requirements, giving due consideration to the impact they may have on promoting more cooperation with parents in the development of case plans for their children.

Much of what DFYS does with various cases must remain confidential. It is our observation that this need for confidentiality often gets in the way of the agency's effectiveness in carrying out case work. When DFYS refuses to disclose information about a child's psychological evaluation, or counseling sessions to parents, it contributes to mistrust between the parents and the agency. Accordingly, such mistrust often contributes to parents not cooperating in a satisfactory manner with DFYS in developing, much less carrying out, case plans designed to reunite the parents with their children.

A common complaint about the case plans developed by DFYS was that they often included more subjective rather than objective measures of accomplishment, and that when it seemed to parents the objectives of one case plan was accomplished, another was developed. Another complaint was that case plans often seemed to be dictated by the social worker rather than developed jointly on a more cooperative basis with the parents. As discussed further in the next recommendation, oftentimes parents seemed to have limited involvement in developing a case plan.

DFYS procedure permits a parent to bring an attorney to case plan meetings, but it seems this courtesy extends only to the attorney. If an attorney sends a representative in their stead, the agency closes the meeting rather than permit the representative's participation. This is done, say DFYS officials, to protect the confidentiality of the child. The parent is perceived as being uncooperative, while at the same time DFYS seems to be acting in somewhat arbitrary manner. It is not clear to us what confidentiality interest a 10-month old child enjoys separate from their parents that limits outside assistance in case planning. Although we could see where a 15 year old child may have separate confidentiality interests.

DFYS should consider seeking more cooperation with case plans by utilizing outside third parties to assist and advise the parents as they go through the case plan conferences. Such parties could be required to receive training so they could provide assistance and support to parents in case plan meetings. Such counselors could advise parents of the procedure involved, perhaps advocate, to some extent, on the parents' behalf with the social worker involved, and contribute to a better developed case plan, which the parent has "bought into." The primary obstacle to such an approach is DFYS' concerns regarding confidentiality. Accordingly, we suggest that DFYS reconsider the necessity and value of all its confidentiality requirements.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

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November 24, 1998

Pat Davidson, Auditor
Division of Legislative Audit
Legislative Budget and Audit Committee
P.O. Box 113300
Juneau, Alaska 99811-3300

Re: Department of Health and Social Services
Division of Family and Youth Services
Child Protective Services
Custody and Termination Decisions for Selected Cases
Audit Control Number 06-4573-98

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LEGISLATIVE AUDIT

Dear Ms. Davidson:

Thank you for the opportunity to review and respond to the preliminary report on the audit referenced above. Thank you also for extending the time for a response to allow thorough consideration of the report and coordination with Department of Law staff in responding to it.

Decisions by social workers to take emergency custody or seek non-emergency custody to protect children from parental abuse and neglect have obvious and important ramifications for children and families. And there are clearly no more important decisions to parents and children than decisions to seek termination of parental rights or to actually sever legal ties between children and parents.

Because of their impact, these decisions are inherently controversial and evoke intense and enduring emotions among those affected by them. The decisions understandably result in strongly held beliefs about the fairness and responsiveness of the persons and processes involved in such decisions, particularly when the outcomes are perceived as unfavorable or unsatisfactory, as they inevitably will be at times.

It is entirely understandable that these earnest beliefs result in frequent and impassioned complaints about the individuals and processes involved in such decisions. These persons and processes are often perceived by complainants as the cause of either catastrophic family disruption or disastrous failure to protect a child. It is no surprise, then, that dissatisfaction with these decisions and their results are the cause of more complaints about social workers, attorneys, judges and court processes than any other actions taken in child protection cases.

As auditors have noted in previous reports, complaints about these decisions may and do come from conflicting and sometimes directly opposing perspectives. It is not uncommon at all for the state to receive diametrically opposed complaints about the same custody decision – on one hand, that the decision was premature and too intrusive; and on the other hand, that it was too late and did not adequately protect the children involved. In fact, the audit upon which this report is based was, I believe, conducted to respond to complaints made to legislators from both perspectives.

These extremes of perspective about the child protection system reflect the difficulty we experience as a society in attempting to balance fundamental but sometimes conflicting goals and rights. We seek to support and maintain the integrity of families and preserve the rights of parents. At the same time we strive to assure the safety of children and protect them from abuse, neglect and exploitation sometimes perpetrated on them by those whose most basic responsibility is to nurture and protect them.

Child protection decisions involve interpreting, judging and sometimes predicting complex human behavior. Thus, they are often neither simple nor exact. They do not lend themselves to mechanistic formulas or prescriptive blueprints that can be followed by rote. Consequently, these decisions are always subject to differing interpretations of the facts and both legitimate and baseless criticism. It is not always easy to distinguish between legitimate criticisms and those that are simply self-serving or driven by misguided emotion.

Complaints from widely divergent perspectives may be largely unavoidable, given the nature of child protection issues and the balancing act our child protection system is required to perform. Decisions will clearly not satisfy all those with interests in the outcome. But I believe we must work to minimize the basis for justifiable complaints and answer unjustified complaints by helping resolve the emotions that prompt them.

Because I recognize the difficulty of interpreting and comparing custody decisions, particularly in the face of conflicting descriptions and accounts of events long past, I appreciate the obvious effort you and your staff put into researching these important, sensitive and difficult decisions. I also appreciate your effort to bring a balanced, objective perspective to your report and to develop constructive recommendations that might help improve future decisions and their acceptance by those affected by them.

Before responding to your recommendations, I want to comment on the overall framework of the child protection system and some of your observations and conclusions leading to those recommendations.

Background

Decisions to take emergency custody or to seek non-emergency custody of children are, as they should be, relatively infrequent events. In the most recent 12-month period for which data is available, fewer than 8% of child protection investigations resulted in emergency removal of

children from their homes. Termination of parental rights are far more rare events, involving less than 1% of the open cases in this same period.

These critical decisions occur within a legal framework established to protect children, while providing safeguards against unnecessary government intrusion into family life, primarily in the form of laws and court rules that safeguard the rights of parents. Children can be removed from parental custody only when specific criteria are met and demonstrated in impartial court proceedings at which parents are represented by their own counsel. These proceedings are governed by rules of evidence and procedure that are the same as or parallel to those that govern criminal and other civil proceedings. The Child In Need of Aid Rules are designed to "...to promote fairness; accurate fact-finding; the expeditious determination of children's matters; and the best interests of the child, including individualized care and treatment in the least restrictive placement, and the preservation of family life." The burden to prove that removal from parental custody or termination of parental rights is necessary and justified rests with the state agency. Children are provided with separate advocates precisely because their interests may differ from those of their parents or the agency.

The description of processes on page 8 of your report requires clarification. In attempting to differentiate between emergency and non-emergency custody processes, your report states, "When non-emergency custody is taken, the agency is required to show cause within a 'reasonable time'." A more accurate statement would be "When non-emergency custody is sought, the agency is required to show cause within a 'reasonable time'." When the division seeks custody on a non-emergency basis, it must first file a petition for adjudication, prove at trial that the child is a Child In Need of Aid (CINA), and then provide evidence to demonstrate in a subsequent disposition hearing that custody is necessary.

Minor clarification of the method for prioritizing reports of harm and workload adjusting might be useful. First, the process of prioritizing reports involves assessing the degree of immediate danger posed to a child and the urgency of the response required by DFYS, rather than assessing risk of subsequent harm at some future date. This distinguishes between the process of establishing the priority of a report of harm and the later use of the risk assessment tool to establish level of service. In addition, the process of workload adjusting is established in a formal, rather than informal, policy, and some of the variance between offices is due to both the number and the nature of reports of harm received compared to the number of staff available to respond.

Key Observations and Conclusions

Several important observations and conclusions reached in your report deserve specific comment.

Exercise of discretion and the effect of legal advice in custody and termination decisions

Your report notes that social workers have significant discretion in making decisions to take emergency custody, seek non-emergency custody, or maintain custody once it is granted. You point out, however, that this discretion is neither exercised in isolation nor unchecked. DFYS

does not make these decisions alone or without safeguards that provide both legal oversight and checks on DFYS decisions and actions.

Emergency custody decisions must meet strict statutory standards (AS 47.10.142) and are subject to court review and the challenge of parents, supported by their attorneys, within 48 hours. Non-emergency custody cannot be obtained without court order, which again can be contested by parents and their counsel at trial. Custody orders are time limited and the necessity of continued custody is subject to annual court review. Parents or the children's advocates may seek a judicial review and challenge the need for department custody at any time.

You observed that, in deciding to seek custody, social workers are guided by the advice of assistant attorneys general who represent and advise them. It is both prudent and appropriate that they seek such advice. This is a key reason why your report is able to conclude that "...DFYS is well supported when it takes children into custody..." and is a reason that judges also consistently rule in favor of the department in child protection cases.

The advice of assistant attorneys general helps to prevent social workers from taking custody when facts of the case do not support doing so. Their involvement and counsel serves to assure that formal legal action is pursued only when it is necessary and supported by the facts and circumstances of the case. It is an important means of preventing errors and deterring unnecessary or unsupportable disruption of family life.

Independence and impartiality of judiciary

Your report identifies consistent complaints voiced by some parents and parent advocate groups that the court process does not provide an independent, impartial review of DFYS actions. This complaint seems to arise primarily from the fact that judges rule in favor of the DFYS in most child protection cases and from obvious dissatisfaction of parents with the outcomes of court proceedings. However, your report found both that DFYS custody decisions are generally supported by facts and that judges do not always follow department recommendations.

The fact that the department is consistently able to prove to the court that facts support its actions does not indicate that judges or court processes are biased in favor of the department or against parents. Nor should it lead to the conclusion that the department has some other advantage that enables it to prevail. Instead, it demonstrates that the department does not pursue formal legal action to intervene in family life without good grounds for doing so and does not pursue legal action frivolously or punitively.

Assistant attorneys general are ethically bound to advise against and to refuse to litigate cases they believe are frivolous or not supportable. In fact, citizens should be alarmed if judges consistently found that the department had *failed* to prove a basis for its child protection actions, just as they would be alarmed if prosecutors consistently pursued criminal cases against citizens on inadequate grounds.

It is true that the child protection legal proceedings can be complex and adversarial. It is also true that these complexities exist to protect the rights of parents and children against unnecessary and unjustified government intrusion. It is precisely because of this that parents are accorded the right to legal representation from the outset of such proceedings.

Custody decisions

Parent and parent advocates often complain that social workers are overzealous and act too intrusively or with insufficient factual grounds in taking custody, seeking non-emergency custody, or pursuing termination of parental rights. Conversely, parents involved in custody disputes, grandparents, concerned relatives, foster parents, and child advocates sometimes express concern that social workers do not take custody early enough, return children to parents too soon, and do not act decisively to terminate parental rights.

The cases reviewed by auditors seem to have led you to conclude that the latter criticism may be more accurate. Your report notes what seems to be "quite a high threshold to the agency's probable cause to take custody of children being abused and neglected" and concludes "that custody is not taken as often as is necessary." Similarly, you noted not only that social workers generally make required reasonable efforts to avoid removing children from their parents but that sometimes their efforts to avoid taking custody may seem "extremely reasonable" and were perhaps more than was warranted.

Your conclusions are consistent with much of the testimony received during consideration of significant changes in Alaska's child protection laws (HB 375) during the last legislative session. Your case reviews seem to indicate that if there is a pattern of error in DFYS decisions it may be in the caution social workers have demonstrated seeking custody of children or termination of parental rights.

This is obviously influenced by many factors. Among these are Alaska's laws, workload and staffing levels in DFYS, poorly implemented agency policy focusing on "family preservation," individual judicial decisions in specific locations which influence future actions in similar cases, and uncertainty of staff based on lack of adequate training as well as many other factors.

As you know, a recent review by the Kempe Center found that the restrictive nature of Alaska's laws limited intervention and focused custody decisions on the single incident under investigation and the immediate risk to children. These laws and their interpretation in case law restricted social workers and courts from effectively considering "cumulative risk" or the totality of circumstances. Passage of HB 375 and the recent Supreme Court decision discussed in your report will significantly affect future practice. In fact, there is a clear trend in the number of children being taken into custody which indicates that practice is already changing to better consider the total risk to children.

Changes in law and court decisions will clearly impact decisions in custody cases. They will not necessarily eliminate misunderstandings such as those noted in your report. These cases clearly

point out the importance of thorough investigations and the need to consider the "totality of circumstances" when making custody decisions.

Predicting custody actions

You noted that, though DFYS custody decisions are supportable, they are not always obviously consistent. The difficulty auditors encountered in developing a "definitive standard" for predicting case conditions that trigger DFYS custody actions is an issue child protection agencies struggle with throughout the nation. The complexity of these decisions makes it difficult to develop definitive or prescriptive tools or standards to guide or interpret custody decisions.

For these very reasons, the Risk Assessment Tool (RAT) was not designed to drive the decision to take custody of a child or to open or close a case for services. In fact, national concerns against using a risk assessment tool for such purposes were extremely strong when Alaska's RAT, the first empirically based model for use in child protection, was developed. In particular, the RAT was specifically not developed to serve in making the decision on whether to assume emergency custody. Insufficient information is available, particularly in new cases, to complete the tool at the time an investigation is begun and the decision regarding emergency custody must be made on the basis of statutory criteria. As you have indicated in your report, much of the key risk information is acquired throughout the investigative process, and that process can continue for some time after the decision to assume custody has been made.

The RAT does predict the risk of subsequent harm to a child in the current living situation absent intervention or mitigating circumstances, but it is focused on a limited number of factors and is not used to dictate the nature of the intervention. It is, as you know, used to determine the level of agency interaction with a family according to the level of risk identified, i.e. High, Medium, or Low, with contact standards prescribed in policy for each level of risk. Further discussion of the RAT will be offered in response to your Recommendation No. 1.

The complexity of the factors influencing custody decisions and their interaction in individual cases do not lend themselves to ready comparison in a few cases. The small number of cases you reviewed or the fact that some of the cases were picked based on complaints arising from them may make them less than representative and may have contributed to the difficulty in developing a common standard. However, it is more likely that the unique interplay of factors in each case make them difficult to compare. Nonetheless, we certainly agree that there should be consistency in custody decisions and that training is critical to achieving consistency, particularly in such important and complex decisions.

Reunification after removal

Your report observed that case plans reflect reasonable efforts to reunify children with their parents and that the plans were focused on the issues that present risk to children. However, you noted that return of children to parental custody was not necessarily contingent on the parents' completion of all steps in a case plan. This is true because completion of the case plan is not the standard for returning a child to parental care.

Return of children to the parental care is governed by a legal standard at all times. To sustain an out-of-home placement, the department must demonstrate that leaving a child with the parent is "contrary to the welfare of the child" (or, for cases subject to the Indian Child Welfare Act, "necessary to prevent imminent danger of physical harm or damage to the child.") Parents must demonstrate the ability to provide care and safety for their children, but are not legally required to fully comply with all aspects of a case plan before a child can be returned home. Clearly, there should be a high correlation between progress on key elements of a case plan and return of children to parental care, but absolute completion of all parts of a case plan is not the required test.

Termination of parental rights

Your report accurately presents some of the problems inherent in terminating parental rights. This has been, partly by design, a difficult undertaking. In the case you mentioned of the mother not visiting, DFYS would, I believe, need to make efforts to encourage and assist visitation between the mother and child rather than leaving the responsibility completely to the mother.

You note that recent changes in federal and state law (the federal Adoption and Safe Families Act and Alaska's HB 375) may expand DFYS' "authority to effect" terminations or to take custody of children. It is important to clarify the effect of the new federal and state laws. While commonly perceived and frequently characterized as expanding DFYS authority to act, these laws do not give DFYS broader authority. They do give DFYS and others in the child protection system better guidance and set clear expectations for early movement toward permanency. They also specify certain situations in which DFYS is not required to make "reasonable efforts" to prevent removal or reunify children with their parents before proceeding toward alternative permanent plans. And the new laws *do* hold both DFYS and parents accountable to more quickly resolve the conditions that put children at risk. But they do not diminish the legal safeguards that protect parents' rights.

Specific sections of the new federal and state child protection laws provide for the filing of a petition for termination of parental rights when a child has been in out-of-home placement in the custody of the division for 15 of the most recent 22 months. That provision does not extend to children in custody but placed at home during that time, and it does extend to children in placement for any 15 of 22 months rather than for "the last 15 of the most recent 22 months" as stated in your report. In addition, concurrent planning need not include the termination of parental rights but may include other permanent plans such as placement with a relative or a particular foster parent or independent living plans for an older child.

Relative placements

In the section on "Organization and Function", you mention that children in custody are placed in foster care, emergency shelter, or residential care, and that each provider is subject to licensure. It is important to emphasize that children are frequently placed with relatives who may or may not become licensed providers. In fact, Alaska law provides a preference for placement with relatives, and over one third of children in agency custody as a result of abuse or neglect (more than 600) currently live with relatives.

You also commented that the state benefits from relative placement by minimizing the cost of foster care. This is sometimes true, but it is not the policy reason prompting placement of children with relatives. The statutory preference for placement with relatives is based, I believe, on the goal of maintaining family ties and providing emotional stability for children. Any financial benefit to the state is obviously secondary and is more limited than auditors may have understood. Some relatives are able to care for their related children without financial assistance. However, over one third of relatives providing care for children in department custody are licensed as foster parents and receive foster care payments to enable them to care for related children. Many others must apply for temporary assistance benefits through the Division of Public Assistance in order to be able to support a relative child in their home.

Case Studies

Your report discussed some case examples that illustrate the complexity of some custody decisions. Some additional information about these cases may help readers understand the cases, events, and decisions.

Case A: This is a difficult case to compare to others because it is an extreme anomaly. The case was handled by a succession of three troubled workers: one was demoted for lack of competence as a journeyman social worker; the next suffered from terminal cancer; the third was terminated for incompetent work. Many of the reports of harm were workload adjusted because of staff shortages, but many were investigated as a composite rather than individually. Sometimes when custody was contemplated it was not taken because, although the case was considered problematic, the evidence to sustain custody was marginal or there was someone available to appropriately care for the children. Custody was taken from April, 1995, until December, 1996; then again in August of 1997 and continues to date. While there have been many changes in policy, law, and recently in staffing levels since this case first came to the attention of DFYS in the early 1990s, it should not be reflective of normal practice. It does, however, provide cause for concerned action to improve practice.

Case B: This case involved a heated custody battle between the grandparents and the father. The grandparents were the primary source of reports of harm. It was extremely difficult to obtain evidence to substantiate the reports. In addition, the grandparents were readily available to care for the child and the parent readily sought their assistance to assure the child received appropriate care. There was no clear indication that the child was at risk. The grandfather requested that DFYS intervene and terminate the father's parental rights, but was unwilling to work with the department. The department, by law, was required to work toward reunification with the father if the department took legal custody of the child. The grandfather already had physical custody of the child, had filed for a legal guardianship of the child, and had obtained an order that restrained the father from contacting the child. The department dismissed the CINA petition when the grandfather obtained full legal custody of the child.

Case C: As you point out, the initial report of harm did not appear to present serious circumstances. The department took custody mainly because the child's mother refused to have the child in her home after an altercation and requested removal of the child from the home. The statutory grounds were AS 47.10.010(a)(1), "no parent willing to provide care." As often happens, however, much more information surfaced as the investigation proceeded, raising the level of identifiable risk to the child. You assessed that we acted appropriately to take custody, but the mother adamantly disagrees. But the mother, who was represented by counsel at all times in the proceedings, did agree to state's custody in a written stipulation to adjudication. She also agreed that she could not provide needed services to the child. The child was recently returned home because she desperately wanted to return home and was running away from alternative placement. The mother had begun to work on the case plan. The counselor for the mother and the child recommended return home as long as the mother continues to work on the case plan.

Case D: There does not seem to be any question regarding DFYS action to take custody in this case. As auditors noted DFYS sought to maintain custody outside the home. The court found at an adjudication trial that the child had been sexually abused by her stepfather and continued to be at risk in the home. The judge allowed the child to live in the home, conditioned on the stepfather being required to leave the home and having no contact with the child. Those orders remain in place. The stepfather is required to participate in sex offender treatment. The mother continues to deny that her daughter was sexually abused.

Case E: As your report notes, the court refused to grant the state legal custody of the child. The parties are attempting to negotiate a resolution without further litigation.

The case described on page 31 merits additional clarification since it represents some of the complexity of cases in which DFYS becomes involved and the need for special training to deal with the complexity. The mother in this case repeatedly alleged that her young daughter's father had sexually abused the child. In attempting to gain evidence to support this claim, the mother tape-recorded herself insisting to the child that the child was sexually abused by the father. The mother, on tape, repeatedly insisted that the child say that her daddy hurt her "tush." The child did not say that her father sexually abused her.

The father tape-recorded phone messages from the mother in which she threatened him with losing contact with the child. The judge who presided over the custody dispute between the parents ordered DFYS to get involved. DFYS had experts interview the child. The experts reported that the child did not report sexual abuse by her father, but only said that her mother had told her to report that her father touched her inappropriately. DFYS sent the case to the Kempe Center for review. The Kempe Center could not testify that there was a "preponderance of the evidence" that the child was sexually abused by the father. Because of the failure of legal proof, the AG recommended dismissal of the case.

Though your report seems to leave the impression that the worker's inept interviewing skills hampered a resolution of the case, it was the mother's conduct that contaminated the evidence. She completed multiple inappropriate interviews with the child and even tape-recorded herself

prompting specific answers in those interviews. This would clearly have been a challenging case under any circumstances and one that would, as auditors conclude, require a highly trained and skilled staff person.

Recommendation No. 1

The director of DFYS should review the format and implementation of forms used to assess risk to children.

The department concurs. The RAT form is a risk assessment tool that was developed and empirically validated to measure indicators of subsequent risk to a child in the environment assessed at the time absent any intervention. It was the first such tool developed in the child protection field nationally. When the RAT was developed, there was recognition that it would need to be refined and revalidated to reflect newly gained knowledge and experience. Much work has been done in the area of risk assessment in the years since this tool was originally developed and it represented a "state of the art approach." The division is committed to 1) reviewing the RAT and either empirically revalidating it or adopting a different tool that better serves our purpose; and 2) developing a valid tool for measuring progress and evaluating the continuing risk of harm in a family based on changes made and current circumstances. In the meantime, staff will be trained on the appropriate use of the RAT and reassessment procedures.

Recommendation No. 2

DFYS should develop alternatives to closing cases where services are indicated but custody is not taken.

The department concurs. Fundamentally, however, we simply do not have the resources to routinely devote to staff cases where we have no legal authority. The increased funding received in FY99 is certainly helpful, but even with the additional staff those funds provided, we cannot investigate all reports of harm or adequately serve those children and families for which we have legal and custodial responsibility. We cannot justify devoting staff resources to cases in which we have no legal authority and no means to compel parental involvement in services.

We have been able to increase the grants to agencies providing family preservation and family support services. We believe that these types of voluntary services – coordinated with our own efforts – offer the best response in cases where risk exists but legal intervention is either not necessary or not possible. We will explore the possibility of addressing this issue through existing grantee services.

Recommendation No. 3

DFYS should document the involvement, or lack thereof, of parents in the development of case plans.

The division concurs. Parental involvement in developing case plans is important, as is documenting that involvement or the lack of involvement. In fact, DFYS' case planning form provides a line for parents to sign indicating that they were involved in the planning process but disagree with the case plan. Unfortunately, parents' attorneys often insist that their clients not participate in the planning process until after a court decision has been made on the petition seeking adjudication of the child as a child in need of aid.

In any case, parents participate or not, documentation is essential. Steps to assure improved documentation will be accomplished through the increased training efforts and through the supervisory review process.

In addition to basic documentation of parental involvement, federal regulations require the division to document its attempts to elicit parental involvement in the case planning process.

It is interesting to note that Alaska is one of the few states that arranges for parents – including those to are incarcerated – to participate telephonically in the case planning and review process. This presents some unique documentation issues.

Recommendation No. 4

DFYS should ensure that all line social workers receive appropriate training.

We concur. As you know, the division signed a contract last July with the University of Alaska to establish the Family Services Training Academy under a partnership between DFYS and the UAA Social Work Department. The Academy will provide training to all social work staff. It offers orientation and training in a core child welfare curriculum for Family Services social workers and licensing workers and specialized training for Family Services supervisors.

In addition, the academy will develop and present specialized training on a number of child welfare practice areas. Plans call for all new social workers to receive two weeks of orientation and core training before being assigned a caseload, and for experienced workers and supervisors to receive several days of specialized training each year.

The academy will be able to respond quickly to emerging needs for specialized training. Training can be delivered at the academy site in Anchorage and at sites in hub cities around the state as needed. In addition, the Family Services Training Academy will develop curriculum materials and technology for self-study and remote delivery of training throughout the state.

The Family Services Training Academy will facilitate the work of two advisory bodies: the Training Advisory Board and the Training Work Group. At this writing, recruitment for members of these bodies is underway.

The Training Advisory Board will consist of representatives of numerous agencies and organizations that have responsibilities or interest in child protection issues. The Board will advise DFYS and the University on broad issues and related training needs for the various stakeholders.

The Training Work Group will consist primarily of DFYS and University employees. Both rural and urban supervisors, social workers, and licensing workers will be represented. The Work Group will be charged with identifying the specific training needs of DFYS workers and supervisors and recommending training to meet those needs. The Work Group may recommend training be secured locally or provided statewide by the Academy.

Recommendation No. 5

The commissioner of the Department of Health and Social Services (DHSS) should develop a non-judicial process to provide recourse and consideration to parents and other interested parties that become involved in protective services disputes.

I understand and agree with the intent of this recommendation – that the department should do all we reasonably can to eliminate perceptions of unfairness and develop processes that facilitate effective resolution of child protection issues. However, I disagree with those who believe our court processes do not provide them with a fair, impartial forum.

Clearly I cannot, as commissioner, establish a process that substitutes for the judicial process. Nor can I resolve the dissatisfactions various parties have with that process. I can, however, work with the court and other parts of the child protection system to educate and inform the public about the child protection system and the judicial process to overcome some of the gross misunderstandings and misperceptions and any legitimate shortcomings that prompt dissatisfaction with the process.

I am not so naïve that I believe any action we take will be able to satisfy those whose complaints are fundamentally expressions of frustration with the outcome of child protection processes. And I am wary of making wide-scale changes based on the perceptions of a limited and select sample of persons dissatisfied with the outcome of their particular case. Nonetheless, there are legitimate reasons to attempt to understand and address all concerns in order to improve both the real outcomes and the perceptions of those affected by the processes.

You have included some additional recommendations within this broader recommendation.

1. Improved public notification and staff awareness of existing DFYS complaint resolution process.

I agree that increased public and staff awareness and utilization of the grievance resolution process already in place would assist in resolving complaints and concerns. I believe, however, that this process, which is adopted in agency regulations, should be streamlined. As it exists, the process can be cumbersome for both citizens and burdensome to the agency. Despite this, it has been a successful vehicle for satisfactorily resolving complaints and could be used more frequently if streamlined.

Although other projects will necessarily take precedence, I will consider revising these regulations to make the grievance process a more effective mechanism for resolving complaints as work plans allow. We will also ensure staff are knowledgeable about this avenue for resolving complaints, advise complainants of the process, and have the complaint forms available.

2. Funding a specialized position in the Office of the Ombudsman.

I do not agree that contracting with the Office of the Ombudsman is an appropriate means to resolve child protection concerns and complaints received by the department. While I fully support the Office of the Ombudsman and the work it does, I do not believe a position external to the department would provide the rapid response needed to resolve most complaints we receive. I also believe it is most appropriate for the Legislature to adequately support the Ombudsman to perform its critical role.

Instead, I have established a position within DFYS to assure a rapid, knowledgeable response to complaints. Rather than providing an oversight role, the position will focus on troubleshooting problems and concerns, implementing substantive solutions whenever possible, mediating and assisting in resolving problems, and providing information and follow-up. DFYS' inability to respond in a timely manner to the many issues raised concerning the thousands of investigations and custody decisions made by agency staff each year has hindered timely resolution of these issues and detracted from perceived responsiveness of the agency. Rapid, sensitive and substantive response to concerns will do much to improve public perception and satisfaction with agency responsiveness. Of course, not all persons can be satisfied with the

3. Development of a community-level mediation process.

I agree that mediation can be an excellent tool for resolving differences between parents and the agency. The CINA subcommittee of the Court Improvement Project, of which DFYS is a member agency, is establishing a mediation project, to be piloted first in Anchorage and then expanded in other areas of the state. This project will provide a means of reaching agreement on custody cases and avoiding the formal adversarial, and sometimes lengthy and emotional, court proceedings. DFYS will be a full participant in this effort, but the department obviously cannot develop such a process alone.

In the meantime, key parties in the child protection system (the court system, Public Defender, Office of Public Advocacy, Department of Law, and Department of Health and Social Services) are moving forward to increase use of mediation in custody and termination cases under Civil

Rule 100. Agreed to as part of joint planning efforts related to implementation of HB 375, agencies are identifying candidate cases and will be pursuing this alternative resolution approach this fiscal year, even before the mediation project is fully developed.

Recommendation No. 6

The director of DFYS should reevaluate the scope and application of the agency's confidentiality requirements, giving due consideration to the impact they may have on promoting more cooperation with parents in the development of case plans for their children.

The division must, of course, follow the confidentiality requirements established in law by congress and the legislature. We have, however, twice within the past three years requested and received, legislative changes to reduce the confidentiality restrictions in Alaska laws. In part these changes were specifically made to allow sharing of information with legislators to assist them in understanding the full context of complaints and concerns brought to them and to aid in their resolution.

In addition, within the past year Governor Knowles appointed the Task Force on Confidentiality of Children's Matters to study the issue of confidentiality in child protection cases and to recommend changes that could assist in informing the public and providing agency accountability. The Task Force did not specifically address the primary issue that I believe generated this recommendation – allowing lay advocates and persons without a specific role as a party in a case to participate in hearings and case conferences in which confidential information about children are discussed. However, the Task Force did recommend opening CINA hearings to the public, which would allow advocates to attend, so long as they were not witnesses in the case. The Task Force recommendations were released for public comment last summer. Task Force members are meeting next month to review comments. Proposals for additional changes in state law may well result from this effort.

Sharing information about a child with the child's parents is fundamental to working with parents and has always been required with rare exceptions established in law to protect a minor's independent right to privacy. If a child is not in custody, a parent has the right to the information available to the division. If a child is the subject of a CINA proceeding, the parents, through their attorney, are provided with all reports and evaluations through the discovery process. Misunderstanding about these issues may stem from DFYS' inability to provide information that is not even available to the division because of privacy issues safeguarded in patient/doctor/therapist communications. The division cannot independently circumvent or control those confidentiality provisions.

Court Rules and Processes

Because many of the conclusions and recommendations in your report center on parents' misperceptions of the standards and processes employed by the court in CINA cases, these deserve some discussion. Your report describes some of the rules that are regarded by parents as unfair to them.

For example, parents complained that they were not given an adequate forum to tell their story and were given limited opportunity to speak at hearings.¹ Parents may be witnesses at any proceeding. At the very first hearing, parents are advised of their right to testify and to present witnesses - CINA Rule 10(b)(2). Parents must take the stand under oath and be cross-examined, the same as any other witness. No rule limits the ability of a parent to testify at any proceeding. However, they often choose not to testify or accept the advice of their attorneys that they should not do so. This, of course limits their opportunity to relate their views. Some parents may feel that the process of testifying in response to questions posed to them by attorneys limits their ability to fully express themselves.

Exclusion of parties

CINA Rule 3(c) is cited as a rule that is viewed by parents as unfair because it allows children to testify outside of the presence of their parents. Invoking this provision requires that a hearing take place and that the state prove that the parent must be excluded from the courtroom in order to protect the child from "material psychological harm." The parent participates in the hearing by phone or by videolink, and is allowed to consult with counsel between direct and cross-examination of the child.²

It is important to note that the same procedure is available in criminal trials as well. Alaska Statute 12.45.046 allows the court to make special accommodations for child witnesses in criminal trials. The statute allows the court to use closed-circuit television, one-way mirrors, and any other procedure that would assist the child in meaningfully communicating in court. The U.S. Supreme Court has addressed the issue in several opinions and decided that in some cases, special accommodations may be made for child witnesses. (See, Maryland v. Craig, 497 U.S. 836 (1990), which requires the state to demonstrate that the child witness would be traumatized by the presence of the defendant and that confrontation would pose a threat of serious emotional harm to the child before a special procedure may be authorized by the court).

¹ There was one probable cause hearing in Kenai where the judge accepted the testimony of a parent through an "offer of proof," rather than calling the parent to the stand. The decision was reversed on appeal.

² No AAG could recall a case where parents were required to listen to tapes after the hearing and then prepare for cross-examination. The parents participate in the hearing while it is occurring, but from a different room, or the child's testimony may be prerecorded, with defense counsel present to cross-examine, and presented at trial on videotape.

The procedure in CINA Rule 3(c) was employed during the summer of 1997. DFYS was adjudicating a Child In Need of Aid case based upon ongoing sexual abuse of a child by her stepfather.³ Prior to the trial, the child's mother repeatedly threatened the child with how gruesome the cross-examination was going to be at trial. Two days before trial, the child was admitted to the psychiatric unit at Providence Hospital due to an overdose, in an attempt to commit suicide. The medical providers concluded that the mother had pressured the child into feeling responsible for the case going to trial. The child's mother had pressured, coerced, and threatened the child to recant her statements of fear of her stepfather, immediately prior to trial. On the day of trial, a psychiatric nurse accompanied the child to court.

The AAG asked the court to have the stepfather/offender participate in the hearing by telephone from a neighboring courtroom, based upon CINA Rule 3(c). The court first required that the psychiatric nurse testify about the level of psychological harm that would occur to the child if she had to testify before her abuser. The nurse testified that the child was not eating, had lost a lot of weight, was suicidally depressed, and would probably attempt suicide again if forced to face the man who molested her. The court ruled that the evidence met the burden of proof in CINA Rule 3(c) as "material psychological harm." The stepfather/offender participated in the hearing by phone from a conference room in the courthouse while the child testified. The child's mother was in the courtroom during the child's testimony. The teenage babysitter victim had to testify before the offender because the rule does not offer the same protection to a child victim who was molested by a non-family member. The state successfully adjudicated the case.

Exclusion of witnesses

CINA Rule 3 (d) is called the "exclusionary rule" because the rule does not allow witnesses to listen to each other testify. The basis of the rule is found in Evidence Rule 615. Both state and federal evidence rules follow the practice in all cases, civil and criminal. The rule is enforced so that witnesses cannot change or alter their testimony based upon hearing the testimony of another witness. The rule does not exclude parties from the hearing, and parents are parties to a CINA action, therefore parents are never excluded from a hearing based upon this rule.

Witnesses for the parents and for the state will be excluded from listening to other witnesses testify.⁴ The purpose and function of the rule and the protections it provides to them have obviously not been made clear to parents.

³The stepfather had sexually abused two younger sisters of an ex-wife in another state. He was fired from the police force in another state for providing liquor to teenagers and for dating teenage girls. In Alaska, he was criminally convicted of molesting a teenage babysitter. The state took legal custody of his two stepdaughters after one child reported that he had molested her since she was eleven years old. Nevertheless, her mother stood by the offender and insisted that the child was lying.

⁴ The complaint from Guardians of Family Rights is that the witnesses for the parents are not allowed to hear the state social worker testify. The Guardians claim that if their own witnesses could hear the worker testify, then their own witness could testify that the worker lied. Nothing in the rules prevents a witness from taking the stand for the parents it only prevents witnesses from tailoring their testimony on the basis of the testimony of others.

Admission of hearsay evidence

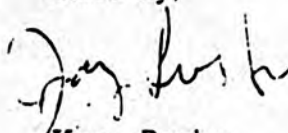
CINA Rule 10(b)(4) is perceived by parents as unfair because they believe it was unfairly applied to admit hearsay evidence presented by social workers but not them. Hearsay evidence is admissible at trial, both criminal and civil, in the specific identified circumstances where hearsay evidence has been determined to be reliable. Evidence Rules 801, 802, 803, 804 and 805 govern the admissibility of hearsay evidence at all times in trial, both civil and criminal.

CINA Rule 10(b)(4) is a special exception that only exists at a "probable cause" hearing for the limited purpose of establishing probable cause before a judge. CINA Rule 10 (b)(4) does not govern the presentation at evidence at adjudication trial or termination of parental rights trial. A similar provision exists in criminal law. At the grand jury presentation, where probable cause is established, specific exceptions allow prosecutors to use hearsay evidence for the limited purpose of establishing "probable cause" before the grand jury. (See AS 12.40.110 which allows hearsay evidence to be presented to the grand jury in limited and conditional circumstances for child abuse cases).

Court proceedings can certainly be intimidating and difficult to understand. They are also easy to misinterpret, particularly when the issues at stake are so important to the participants and so emotionally charged. Procedures that are highly technical and poorly understood can certainly lead to perceptions of unfairness, especially when the outcome is dissatisfying. That is why legal counsel is essential for all parties in those child protection cases that unavoidably involve formal legal processes. It is also why I agree with many of your suggestions for resolving complaints and issues outside those formal legal processes whenever possible. I recognize, however, that there will always be instances in which alternative processes cannot be applied because of the risk to children and the unwillingness or inability of those whose behavior endangers children to recognize that danger.

Again, I recognize the difficulty auditors faced in reviewing and interpreting controversial custody decisions. I appreciate the effort and professionalism of your staff during the course of their work on this audit and your indulgence in allowing me additional time to respond to your report.

Sincerely,



Karen Perdue
Commissioner

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ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



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November 27, 1998

Members of the Legislative Budget and Audit Committee:

We have reviewed the Department of Health and Social Services' response to our audit report. We have the following observations and comments regarding various aspects of the department's response:

Number of cases reviewed

On page 42, the department comments that it is difficult to fully capture the varied and complex factors that have an impact on custody decisions from looking at a limited number of cases. We believe that certain commonalities among the 72 cases included in this review validate the comparisons we made. For this review, we selected cases where DFYS had investigated and substantiated reports of harm.

Many of the cases had initially been ranked as top priority for investigation and the situation subsequently assessed as high risk. Though some of these cases were brought to our attention by complaints arising from the manner in which they were investigated and resolved, they shared many of the same characteristics of the cases we selected more randomly. While we agree with the commissioner's comments on the individuality and uniqueness of each specific case, it is our position that similar case circumstances should lead to similar casework decisions.

Concerns about social worker training in handling sexual abuse cases

In this and in previous reports on DFYS, we have recommended that social workers receive comprehensive training. In this report, we discuss a case which seemingly illustrates this concern, where lack of training of a social worker may have hampered timely and appropriate resolution of a case involving the alleged sexual abuse of a small girl. In this case, the Kempe Children's Center, the experts with whom the State contracts for advice on child protection issues, questioned both the interviewing techniques used and the outcome of the case.

On pages 45-46, the commissioner comments that the case involved additional complications:

"Though your report seems to leave the impression that the worker's inept interviewing skills hampered a resolution of the case, it was the mother's conduct that contaminated the evidence. She completed multiple inappropriate interviews with the child and even tape-recorded herself prompting specific answers in those interviews. This would clearly have been a challenging case under any circumstances and one that would, as auditors conclude, require a highly trained and skilled staff person. [emphasis added]"

We were aware of the extenuating circumstances as set out by the commissioner. Our intent in describing this case was to illustrate and support Recommendation No. 4 regarding the need for better and more specialized training of social workers. Though, the commissioner concedes that a highly trained and skilled staff person would have been needed to resolve this case in the appropriate manner, social workers have told us, as we state on page 31 of the report, they are *"often ill prepared to make custody determinations especially in cases of alleged sexual abuse."* Because most social workers will, at some point in their careers, be required to investigate sexual abuse allegations, we believe that they should be adequately trained to perform these duties as efficiently and effectively as possible.

In summary, we reaffirm our conclusions and findings that similar case circumstances should lead to similar casework decisions. Additionally, we remain convinced that social workers would benefit from more comprehensive training.

Sincerely,



Pat Davidson, CPA
Legislative Auditor

**DEPARTMENT OF HEALTH AND
SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES
RESIDENTIAL CHILD CARE PROGRAM**

February 13, 1991

06-4388-91

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
P.O. BOX W
JUNEAU, ALASKA 99811-3300

March 21, 1991

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska
Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES
RESIDENTIAL CHILD CARE PROGRAM

February 13, 1991

Audit Control Number

06-4388-91

The audit mainly addresses issues related to the rate structure for paying providers of residential child care services. In addition, we analyzed staffing levels, turnover rates, and salary levels for some grantees and summarized the funding sources of some providers' operations. The scope of the review was developed from a special request of the Legislative Budget and Audit Committee.

The audit was conducted in accordance with governmental performance auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope and Methodology section of this report.

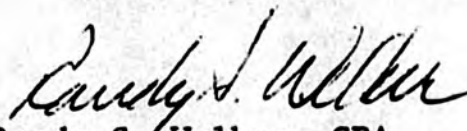

Randy S. Welker, CPA
Legislative Auditor

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OBJECTIVES, SCOPE AND METHODOLOGY

In accordance with a Legislative Budget and Audit Committee special request and the provisions of Title 24 of the Alaska Statutes, a review was conducted on various issues relating to the purchase of residential child care (RCC) services by the Department of Health and Social Services, Division of Family and Youth Services (DFYS).

Objectives

The objective of the review was to answer specific questions asked by the Committee, with minor modifications. The specific issues in the request were analyzed under three topics: (1) Rate Structure, (2) Staffing Ratios, Turnover Rates, and Salaries, and (3) Provider Profile. The Audit Issues and Analysis section of this report details the questions under these topic areas with our responses.

Scope and Methodology

Audit resources focused primarily on grants administered from FY 89 through FY 91, with emphasis placed on FY 90 activity.

Fieldwork procedures utilized during the course of the audit included analytical review of a wide variety of materials:

1. The request for proposals for FY 89 residential child care services.
2. Responses to the request for proposals submitted by grantees.
3. A study prepared by Banerjee Associates entitled: "Children's Residential Services Rate Study, Final Report, July 30, 1988."
4. Various grantees' budgetary data, quarterly cumulative fiscal reports, and audited financial statements.
5. DFYS and grantee correspondence related to RCC services.
6. Professional literature and newspaper articles relating to residential treatment services.

In addition to document review and analysis, interviews were conducted with selected grantees and various DFYS personnel.

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ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services (DHSS) with responsibility for providing a range of services designed to remedy or prevent abuse, neglect and exploitation of children, youth, and adults. To meet these statutory responsibilities, the Department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the youth section of the Division of Corrections.

Residential child care services are purchased under grants to facilities licensed by the State to provide 24-hour care or day treatment for one or more children. Regulations define a child as a person under 18 years of age who has not been judicially emancipated, or a person under 20 years of age who is in the custody of the department. Grant awards are based on the purchase of a specified number of beds for the level of care requested in specific areas of the State. According to DFYS, a total of 212 beds for emergency shelter and residential treatment and 28-day treatment slots were purchased from 17 grantees in FY 90. Payment rates for emergency shelter and residential treatment ranged from \$95 to \$185 per bed per day.

Payment Rate Structure

In June 1982, the Legislature suspended the operation of the "full cost of care" payment rate structure provided for under AS 47.40.040, and AS 47.40.050 from July 1, 1982 to June 30, 1984. During this time frame DHSS was ordered to conduct a study of alternatives to the method of establishing payment rates under AS 47.40.

A committee of five appointed by the commissioner of DHSS was formed to conduct the study. Three members of the committee were employees of DHSS and two members represented RCC providers. The committee addressed various issues including the rate setting mechanism, methods of reimbursement for capital costs, sources of funding, allowable expenses, service providers, cost comparisons among facilities, accreditation, and appeal procedures.

The committee issued a report to the Legislature on their findings in January 1984. The report recommended that the payment for services move from a "full cost of care" methodology to a granting process. However, the report was deficient in that it failed to establish or define a methodology for setting rates.

The current rate structure for paying RCC providers was initiated in FY 89. DFYS instituted the new rate structure as a systematic method of calculating grant awards to

providers. Grants awarded to providers are based on a payment rate per day multiplied by the number of beds being purchased from that provider. The payment rate structure as described in the request for proposal for FY 89 RCC services is multi-layered for additional services provided. Generally speaking, providers of Category II through IV treatment services are granted a basic rate of \$90 per bed per day increased by \$15 for emergency shelters. Providers of day treatment, Category I, are paid at 70% of the basic rate.

A facility may receive incremental additions to the basic rate for additional services provided. For example, the basic rate is increased by a predetermined rate for night supervision, psychological counseling, and individual and group therapy.

Service Categories

The FY 89 request for proposal for RCC services describes the categories of services purchased by DFYS as follows:

Category I: Day Treatment Programs

An intensive daytime program with services designed for the individual. The emphasis of each program is on counseling for the child, family members and foster parents, development of interpersonal, living and problem solving skills, physical and academic education, and positive recreation.

Category II: Emergency Shelter

A temporary residential care facility for children who are in immediate danger in their present environment or who are not committable to Alaska Psychiatric Institute or a juvenile detention center but no other alternative is currently available.

Category III: Specialized Residential Care

A highly structured program providing 24-hour care, supervision, and treatment services for children with moderate to severe emotional and behavioral problems who require an integrated program of specialized treatment and residential care. Specialized residential care includes: (a) programs for emotionally disturbed children, (b) sex offender treatment programs, (c) programs for dysfunctional behavior, and (d) emancipation/transition programs.

Category IV: Intensive (Staff Secure) Residential Treatment

Intensive treatment programs provide 24-hour interdisciplinary, psychotherapeutic treatment for children who have severe emotional disorders and require secure residential

treatment. These emotional problems include conduct, anxiety, affect and adjustment disorders, and poor impulse control. Intensive treatment programs must provide a safe environment for children who have a combination of treatment needs and are a danger to themselves and/or others as evidenced by suicidal or homicidal threats or attempts or are chronic runaways.

The RFP also identified three levels of care and supervision as follows:

Level 1. Basic Care/Structured Supervision.

Level 2. Controlled Supervision.

Level 3. Staff Secure.

The level of care dictates the staff-to-client ratio required of a provider.

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AUDIT ISSUES AND ANALYSIS

Included within the special audit request were questions on various issues related to the residential child care (RCC) program. In response to those areas of interest, we formatted our analysis of questions under three topics: Rate Structure; Staffing Ratios, Turnover Rates, and Salaries; and Provider Profile. The following summarizes our response to each question.

RATE STRUCTURE

1. What are rates of reimbursement for RCC grants based on? Are the rates based on the cost of service provided? If not based on the cost of service, why not?

As discussed further in Recommendation No. 1 on page 15 of this report, the current rate structure used by the Division of Family and Youth Services (DFYS) to reimburse providers for RCC services has deficiencies. Costs unique to each facility are not taken into account in the rate structure. Generally, a standard rate is applied to all facilities. The following describes the development of payment rates.

The rate structure for reimbursing providers, as described further in the Organization and Function section of this report, was designed by DFYS. Providers are awarded grants based on a fixed rate for a predetermined number of beds as specified in the request for proposal. The fixed rate includes, but is not limited to, a basic rate which reimburses providers for the cost of food, clothing, shelter, daily supervision, social services, and administrative oversight. Supplemental rates are available for enhanced services above and beyond services already provided under the basic rate.

The basic rate was taken from a rate study prepared by Banerjee Associates in July 1988. This study used information based on actual costs of residential care providers. According to the study, some of the techniques used to develop the proposed rate system included: (1) data provided by facilities for the 1987 Annual Cost Report (IVE) [Non-Voluntary Foster Care federal program], (2) the development of theoretical models to provide a framework for the rate system, and (3) the collection and review of extant materials on rates, in professional literature and from other jurisdictions.

The rates for category III services (residential treatment) were broken down by facility size as follows. Maximum ranges were calculated for higher intensity levels of treatment.

<u>Facility Size</u>	<u>Basic</u>	<u>Maximum</u>
Family Size (less than 6)	\$ 79.57	\$102.47
Small (6-9)	\$ 71.32	\$109.38
Medium (10-14)	\$ 78.66	\$119.44
Large (more than 15)	\$109.23	\$137.56

DFYS originally used the minimum rate for a family size facility of \$80 (rounded) as the basic rate. Negotiations between a previous DFYS director and RCC providers resulted in a rate increase to \$90 per bed per day. Generally, the day treatment rate was calculated at 70% of the original basic rate. (This percentage approximates the time spent by each youth per 12-hour day at the treatment facility.)

The study also suggested that the base rate be increased by incremental rates for added services, however, no amounts were suggested.

According to DFYS, incremental rates were generally calculated for each service based on what it would cost to add that staff person on a per day basis. As stated in the body of Recommendation No. 1, documentation supporting the development of these cost components is not available. Examples of incremental rates are as follows:

Individual Therapy (\$10 per bed per day)
 Awake Night Staff (\$5 per bed per day)
 Psychological Consultation (\$5 per bed per day)
 Controlled Supervision (\$20 per bed per day)
 Secure Supervision (\$70 per bed per day)

2. Were geographical cost differentials included in the rate structure?

The FY 89 request for proposal for awarding grants to RCC providers included a 25% cost of living differential to be applied to the basic rate. The geographic cost differential was only to be applied to grants awarded to facilities located in Bethel and Nome. Three providers' rates included the geographic cost differential - the Bethel Receiving Home, the Bethel Group Home, and the Nome Receiving Home. The amount of the cost differential added was arbitrarily set at 25% of the basic rate of \$90. Incremental increases were not adjusted by the arbitrary 25% cost differential. For further discussion, see Recommendation No 1. d. on page 16 of this report.

3. Have providers received adequate increases in their funding to cover the effects of inflation?

The current rate structure for awarding grants to RCC providers was implemented in FY 89. Rates have not been adjusted since then. Therefore, any increases in costs due

to the effects of inflation have been absorbed by the facility. For further discussion, see Recommendation No 1. c. on page 16 of this report.

STAFFING RATIOS, TURNOVER RATES, AND SALARIES

4. What is the proper staff-to-client ratio for the service being provided?

Staff-to-client ratios required of the RCC facilities are based on standards for levels of supervision which are outlined in the FY 89 Request for Proposal (RFP). The three levels of supervision and their ratios per the RFP are as follows:

<u>Level of Supervision</u>	<u>Staff/Client Ratio</u>	
	<u>Waking Hours</u>	<u>At Night</u>
Structured	1:6	1:12
Controlled	1:5	1:10
Staff Secure	1:3	1:6

The RFP identifies the level of supervision required at each location.

We did not evaluate the adequacy of the staff-to-client ratios shown above. It is our belief that the issue of proper staff to client ratios should be addressed by qualified DFYS field staff. See Recommendation No. 3 on page 19.

A facility must be licensed by DFYS to operate as an RCC facility. DFYS requires a minimum staff-to-client ratio for basic care of 1:6 during waking hours and 1:12 at night (structured supervision). DFYS Licensing Section believes these minimum staffing level requirements provide proper supervision to care for and protect children placed in RCC facilities. No documentation is available to support the ratios required.

Controlled and staff secure supervision staff-to-client ratios were initially established by DFYS in the RFP at 1:4 and 1:2 during waking hours, and 1:8 and 1:4 at night, respectively. DFYS based these two ratios on their individual understanding and expertise in the field. However, a teleconference between the director of DFYS at that time and interested providers resulted in a change to these staffing levels. The ratios were decreased to the levels specified in the RFP. Again, no supporting documentation exists for either set of ratio requirements.

Six providers' facilities were visited during the course of the audit - Juneau Youth Services, Inc.; Alaska Baptist Family Services; Alaska Children's Services, Inc.; Alaska Youth and Parent Foundation, Inc.; Booth Memorial Youth and

Family Services, and Mat-Su Community Mental Health Services, Inc. These six providers represent 59% of the RCC grants awarded and 56% of the total beds and day treatment slots purchased by the State in FY 90. All of these facilities indicated that the required staffing levels are insufficient to properly care for the level of intensity of disturbed children that DFYS is placing in their facilities.

In December 1990, The Child Welfare League of America published its new regulations for basic care staffing levels. A ratio of 1:5 during waking hours and 1:10 at night was recommended. According to the league, the higher staffing level requirements are in response to the higher intensity level of children's problems seen today.

5. What are staff turnover rates of RCC providers?

Historically, the social worker/counseling field has been known to have a high rate of turnover. Our analysis of staffing patterns at six RCC facilities showed a high level of turnover, especially in the entry level positions. The turnover rate for these positions averaged 58%. Providers believe the reason for staff leaving includes employees seeking job opportunities available with the State of Alaska and employees experiencing a high level of job burnout.

There appears to be a direct correlation between salary levels and the turnover rate. Generally, as discussed below in question six, salary levels in positions at RCC facilities are lower than in comparable state positions. This is particularly true in the entry level positions.

6. How do salaries paid by RCC providers compare with salaries paid by the State of Alaska for similar positions?

We compared salaries paid by RCC providers with salaries of similar state positions. We used education and experience requirements of positions as the basis for our comparison. Duties performed within the job classifications were not considered as a basis for comparison purposes. Also not included in the salary comparison amounts were fringe benefits, housing, or subsistence paid by either the RCC providers or the State.

Our comparison showed that salaries paid by RCC providers averaged 82% of the salary paid by the State of Alaska for similar positions. Entry level staff salaries have the largest deviations. These salaries averaged 64% of the salary paid by the State for similar entry level positions. Many providers believe this contributes to the high turnover rate noted in response to question five.

PROVIDER PROFILE

7. Are RCC providers properly classified based on the intensity of services provided?

In FY 89, grant awards were made to providers based on the criteria established in the request for proposal (RFP). In that proposal, DFYS identified the number of beds being requested for the four service categories - Day Treatment, Emergency Shelter, Specialized Residential Care, and Intensive Residential Treatment - in specific locations throughout the State. For each category and location, the levels of supervision and treatment being requested are also identified. Respondents to the RFP specify which service they intend on providing.

As discussed in Recommendation No. 3 on page 19, monitoring providers by DFYS is lacking. The department does not have a system for monitoring to ascertain that the providers are providing the services requested in the RFP. Monitoring procedures could include evaluating the adequacy of placements to ensure that the level of intensity required by clients is compatible with the provider's abilities.

8. Are there providers receiving funds that are not in full operation?

According to DFYS, the number of beds licensed for each facility and the number of beds purchased by the state RCC program during FY 90 are as follows. Beds not purchased by the RCC program may be funded by other sources.

<u>Provider</u>	<u>Licensed Number of Beds</u>	<u>Number of Beds Purchased by State</u>
Alaska Baptist Family Services	12	10
Alaska Children's Services - Residential Care	40	32
Intensive Residential Treatment	20	18
Booth Memorial Youth and Family Services - Residential Care	18	10
Day Treatment (Slots)	N/A	13
Kenai Peninsula Community Care	23	15
Kodiak Baptist Mission	12	11
Mat-Su Community Mental Health Services	5	5
Alaska Youth and Parent Foundation	25	15
North Slope Borough	12	12
North Star Children's Home	8	8
Presbyterian Hospitality House	15	15

<u>Provider (cont.)</u>	<u>Licensed Number of Beds</u>	<u>Number of Beds Purchased by State</u>
Gateway Center for Human Services -		
Residential	5	5
Emergency Shelter	5	5
Ketchikan Youth Services (Day Treatment Slots)	N/A	10
Juneau Youth Services -		
Residential Care	16	14
Emergency Shelter	8	6
Day Treatment (Slots)	N/A	5
Youth Advocates of Sitka	5	5
Bethel Group Home	8	8
Bethel Receiving Home	16	8
Nome Receiving Home	6	6

During FY 90, one provider, Gateway Center for Human Services located in Ketchikan began providing residential care services in October 1989 and emergency shelter services in March 1990. Emergency shelter services were discontinued in September 1990. Funds granted were adjusted for the reduction in service. Grantees awarded FY 90 RCC funds have been operating as follows:

<u>Years of Operation</u>	<u>Number of Grantees</u>
2 years or less	1
3-5 years	1
6-10 years	0
11-19 years	8
More than 20 years	7

9. Are other state, federal, or private funds being used to fund residential treatment services?

Providers receive funds from sources other than the DFYS, RCC grant award to operate their program. Analysis of five providers' available FY 90 audited financial statements showed that the percentage of funding received from other sources ranged from 9% to 20%. Current regulations do not require providers to match internally generated funds with the state grant. Individual policies on fund raising activities vary from provider to provider. However, most agencies do receive some federal funding and United Way contributions. In addition, some providers operate other programs which help fund a portion of administrative costs.

A review of FY 90 RCC providers' financial statements showed the following examples of other revenue sources:

- a. State of Alaska, Division of Mental Health and Developmental Disabilities.
- b. State of Alaska, Department of Education.
- c. Federal School Lunch Program.
- d. Municipal/Borough Funding.
- e. Private Contributions.
- f. Interest Income from Investments.
- g. United Way.

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FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Department of Health and Social Services, Division of Family and Youth Services (DFYS) should reevaluate the current payment methodology used to reimburse residential child care (RCC) providers and then, in accordance with AS 47.40.011(b), adopt regulations implementing the payment process.

Regulations have not been adopted by DFYS to define the methodology of setting RCC rates. During our review of the rate structure which is used to reimburse providers, we identified several weaknesses. The current structure does not ensure that providers will be reimbursed for allowable costs.

Generally, grants to facilities are based on a fixed rate per bed per day. The fixed rate is comprised of a basic rate and may include supplemental rates for additional services provided. During our review of the rate structure, we noted the following deficiencies:

- a. Basic Rate Was Not Predicated on Facility Size. The basic rate, a major component in the rate structure, was derived from a study entitled: "Children's Residential Services Rate Study, Final Report, July 30, 1988." Components of the basic rate include the costs of providing: shelter, food, daily supervision, clothing, liability insurance, and administrative oversight.

The study prepared by Banerjee Associates computed basic rates for four sizes of facilities ranging from 6 beds or less to more than 15 beds. However, DFYS selected the basic bed rate of \$80 for residential treatment, family size facility (6 or less residents), as the foundation for the rate structure. This base rate, increased to \$90, was used as the basic rate for all grantees, no matter how many beds were licensed for the facility. Therefore, a facility that had 32 beds would have the same basic rate as a 5 bed facility.

- b. Applying Fixed Rates to All Facilities Does Not Take Into Consideration Differing Operations. Not all facilities are alike. Facilities have differing operating costs. Consequently, applying a standard rate to all providers does not ensure providers will be equally reimbursed for allowable costs. Some providers have to pay for facility rent while others have no rent obligations. In addition, some providers, usually the older organizations, have large endowments that provide

substantial other income to supplement program operations while others are relatively new and do not have this resource.

- c. Cost of Living Allowances Were Not Incorporated in the Rate Setting Process. The rate structure for awarding RCC grants has not been adjusted since the development of the rate structure in FY 89. Consequently, cost increases due to the effects of inflation have not been covered by the rate setting process. Therefore, the potential exists that providers with increasing costs may not be fully reimbursed for their operating costs.
- d. Geographic Differentials Were Arbitrarily Established and Applied. The FY 89 request for proposal for awarding grants to RCC providers included a 25% cost of living differential to be applied to the basic rate. However, the geographic differential was only to be applied to grants awarded to facilities located in Bethel and Nome - the Bethel Receiving Home, the Bethel Group Home, and the Nome Receiving Home. Studies exist that show costs may differ for facilities located in other regions of the State. However, rates established for those facilities in other locations of the State were not adjusted by a geographic differential.

Furthermore, the percentage of the geographic differential added was arbitrarily set at 25% of the basic rate of \$90. Incremental increases were not adjusted by the 25% cost differential.

According to the Banerjee Study (the original source for the basic rate), geographic differentials should be adjustments to the basic rate. The Study stated: "It is recommended that the Basic Rate be . . . adjusted for geographic differences in accord with Alaska standard practice."

- e. Documentation Does Not Exist to Support Changes Made to the Basic Rate or Incremental Additions to the Basic Rate. Facilities receive a basic bed rate per day plus incremental rate levels added for services provided in excess of the basic level of care. (See Organization and Function section of this report for further information). A basic rate of \$80 was taken from the Banerjee Study. However, DFYS adjusted this amount to \$90 per bed per day. Justification for the \$10 increase was not available. In addition, the source for incremental level rate adjustments to the basic rate was not supported by computations. Accordingly, we are unable to determine the reasonableness of the rate increases due to the lack of documentation.

- f. Incomplete Data Was Used to Compute Basic Rates. The report, prepared by Banerjee Associates, contained several qualifications. For example, the report included qualifications on the completeness of data used to derive cost figures:

The twin restraints of limited time and resources allocated to the study precluded both the collection of primary data and significant follow-up efforts to extend the secondary data available through the IVE [Non-Voluntary Foster Care federal program] reports and other extant documents. In addition, the providers did not make available figures on certain cost items as a group of them had proposed doing. The IVE data were difficult to analyze for several reasons. The figures were incomplete in a number of instances and they were predicated on different premises or it was impossible to determine the premise on which a specific item was based.

AS 47.40.011 (b) states:

The department shall adopt regulations . . . establishing the procedures to be followed in awarding grants, the types of services for which payment may be made, costs that may be paid with grant money, and the method of payment. [Emphasis added.]

Title 7 AAC 50.965 states:

Payment. (a) The department will reimburse a grantee for the allowable costs incurred by the grantee in performing its duties under the residential child care facility grant. The department will, however, pay a grantee no more than the total amount awarded in the residential child care facility grant.

This regulation does not specifically address the method of payment.

Because no regulations that outline the methodology that would assure adequate reimbursement of costs have been promulgated, the quality of care may be affected for homes where payment rates do not meet operating costs. Facilities that are unable to provide staff with sufficient salaries will tend to have a higher rate of turnover. A high rate of turnover is believed to adversely affect treatment of residents. Social bonding between staff and residents is thought to be an integral part of the treatment process, especially for severely emotionally disturbed children.

In addition, facilities are unable to provide formal input into the rate structure by not having the methodology addressed in regulation. Consequently, providers may become dissatisfied with the method of reimbursing them for operating costs and decide to no longer respond to requests for proposals.

We realize the development of a payment methodology is a difficult and complex task. We do not anticipate an adequate payment methodology will be developed overnight. Many variables will have to be considered in designing a methodology that will reimburse grantees for the fair share of providing RCC services. Recognizing that no two providers are alike, the rate structure should ensure that providers are reimbursed for the net cost of operations to the fullest extent possible. Ultimately, regulations that are adopted should promote both efficient operations and quality of care and include incentives for cost containment.

Recommendation No. 2

DFYS should develop an accounting policies and procedures manual to assist providers in reporting financial information.

Title 7 AAC 50.955(a)(2) and (3) requires RCC grantees to submit to DFYS quarterly expenditure reports and a final expenditure report. Review of these reports and discussions with some providers showed that reporting of financial information is not consistent between providers. The following are examples of inconsistencies:

- a. Some facilities do not report all costs associated with the RCC grant. They only report costs up to the amount of the grant.
- b. Not all agencies report the value of donations received as revenue or as in-kind costs.
- c. Facilities that operate more than one program do not allocate costs and report them similarly. Some facilities allocate administrative costs to all grants while others do not. In addition, some allocations are based on judgements and are not supported.

As a result of the above, for some providers, we are unable to determine the actual cost of providing RCC. Comparing costs between facilities is not meaningful based on quarterly financial status reports submitted by facilities.

Much of the inconsistency in reporting is caused by the lack of accounting and reporting instructions to act as guidelines for facilities to use in reporting fiscal data.

According to RCC providers, DFYS has not provided instructions or training to assist providers in preparing quarterly financial status reports.

To be useful and comparable, accuracy and uniformity in financial reporting should be pursued for providers of RCC services.

Recommendation No. 3

DFYS should maintain documentation to justify staffing levels being requested of RCC providers and monitor the providers.

DFYS has no documentation to support staffing level requirements requested in the FY 89 RCC request for proposal (RFP). The draft RFP for FY 89 services was published with staff-to-client ratios for structured, controlled, and intensive supervision at 1:6, 1:4, and 1:2, respectively. After a teleconference between the previous DFYS director and providers, the ratios were changed to 1:5 for controlled supervision and 1:3 for intensive supervision. However, no justification for the revision was available.

According to some providers, the current required staff-to-client ratio is insufficient to meet the needs of the children. DFYS admits that the level of disturbance of children being placed into residential care has been increasing, thus requiring more sophisticated treatment or supervision.

Furthermore, at present, no policy for monitoring providers is in place to ensure compliance with levels of supervision and treatment specified in the RFP or that present levels are adequate. DFYS awards grants to facilities to provide for the care and treatment of children placed in their facility. For some facilities, the payment rate consists of a basic rate plus incremental increases for higher levels of services. According to division staff, the rate of some incremental level increases is based on higher staffing levels. Without monitoring, DFYS is unable to evaluate the adequacy of those staffing levels established. In addition, understaffing at the facilities could jeopardize the safety of children and staff.

Alaska Statute 47.10.230(b) states:

. . . A child under the care of the department may not be placed in a family home or institution that does not maintain adequate standards of care.

Increased monitoring efforts would result in DFYS knowing what staffing level is appropriate at each facility and for the level of intensity of children placed in the facility.

Developing RFPs based on the results of periodic monitoring would provide acceptable justification for the levels being requested. Therefore, DFYS should develop and implement a plan to monitor facilities. DFYS should also maintain documentation of the decision making process.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

WALTER J. HICKEL, GOVERNOR

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RECEIVED
MAY - 6 1991

LEGISLATIVE AUDIT

Michael J. Deegan, CPA
In-Charge Auditor
Division of Legislative Audit
P O Box W
Juneau, AK 99811-3300

Dear Mr. Deegan:

Re: Audit Control Number 06-4388-91
Special Audit on Division of Family and Youth Services,
Residential Child Care Grant Program
February 13, 1991

Thank you for the opportunity to respond to the report on the residential child care grant program within the Division of Family & Youth Services. We believe your analysis of the issues will assist the Division in improving the payment system for residential child care. Our specific comments to your recommendations follow:

Recommendation No. 1

The Department of Health and Social Services, Division of Family and Youth Services (DFYS) should reevaluate the current payment methodology used to reimburse providers of residential child care (CC) and then, in accordance with AS 47.40.011(b), adopt regulations implementing the payment process.

We agree that the payment methodology needs to be reevaluated and that there are weaknesses in the rate structure. The current system is designed so that the Department specifies the services needed for which it will reimburse. However, limitations in funding preclude the Division from covering all allowable costs.

We basically agree with the deficiencies in the current structure you have noted, and will comment on each as follows:

- a. Basic Rate was Not Predicated on Facility Size. The current rate structure was based on the Banerjee study, which had a number of inadequacies, including the size breakdowns used. We agree that facility size affects operating costs and

believe that there is an economy of scale that operates so that facilities of fewer beds will cost more per child than large facilities. The Banerjee study came to an opposite conclusion, but failed to provide adequate evidence to support higher rates for larger facilities. Thus, DFYS was faced with an inadequate study and no time to initiate a new study. As a result, using some of the Banerjee data, a rate structure was developed that would allow residential care providers an increase, and would be as fair as possible. DFYS selected the middle payment range as the fairer of the options available at the time.

- b. Applying Fixed Rates to All Facilities Does Not Take Into Consideration Differing Operations. We agree that there should be a way to differentiate between costs that some facilities have to incur that other facilities do not. The issue of facility rent costs is certainly one that needs attention. Some facilities are paying rent to individuals or organizations not connected to the facility operator; others pay rent to an umbrella agency; others have received state capitol grants to build facilities and now own those facilities outright, although they may have repair and replacement costs. In some communities, we have been unable to negotiate operating grants, because there are no facilities available for rent or purchase that will accommodate the needed services. We believe part of this problem could be solved by the state owning the buildings and the Division granting only for operation of the programs delivered at the facility and facility repair and upkeep.

You have also referred to some programs having endowments that allow those programs to supplement program operations. DFYS wants to have a system that will reward, not penalize, facilities that are able to raise funds which can enrich the basic programs the state can fund.

- c. Cost of living Allowances were Not Incorporated in the Rate Setting Process. DFYS has requested funding of Cost of Living Allowances through the budget process but requested increases have consistently been either not funded or vetoed. DFYS agrees that the potential exists for providers with increasing costs to not be fully reimbursed for operating costs which are associated with the level of services required

by DFYS. AS 47.40.041 establishes a contingency procedure if legislative appropriation does not cover the costs required: "If insufficient money is appropriated to fund all grants awarded, the department shall prorate grant amounts, reduce the number of beds contracted for, or otherwise adjust grants to the extent of the appropriated funds." However, DFYS consistently confronts the fact that there are an insufficient number of beds, and therefore DFYS cannot afford to reduce the number of beds in order to increase cost reimbursement to grantees.

d. Geographic Differentials Were Arbitrarily Established and Applied. DFYS has established a geographic differential payment system for foster care which could be used for the residential care system as well. (This system is found in 7 AAC 50.720(c).) However, to implement such a system would create a significant cost increase which could not be implemented unless significant additional funding were appropriated. To apply a geographic differential in the absence of increased funding would mean that other funded programs would be reduced, which would also be unfair.

e. Documentation Does Not Exist to Support Changes Made to the Basic Rate or Incremental Additions to the Basic Rate. We concur that the documentation is unavailable.

f. Incomplete Data was Used to Compute Basic Rates. We concur that incomplete data was used in the original rate computation. Part of the difficulty, as noted in the Banerjee quote, is that "providers did not make available figures on certain cost items." Lack of information on all costs incurred by grantees will continue to affect the ability of DFYS to improve the rate system. We expect considerable opposition from some providers to providing complete costs data. In FY92, agencies receiving residential care grants will be required to submit financial reports that include all sources of funding for each budget category. This should then give DFYS complete information on total funding.

Recommendation No. 2

DFYS should develop an accounting policies and procedures manual

to assist providers in reporting financial information.

DFYS agrees that the development of an accounting policies and procedures manual would be useful to all concerned. DFYS proposes to establish a working group to include residential child care providers, DFYS staff, and staff from the Department's Accounting Section which would be charged with development of more appropriate reporting forms, accompanying instructions, and a policy and procedures manual.

Recommendation No. 3

DFYS should maintain documentation to justify staffing levels being requested of RCC providers and monitor the providers.

It is our understanding that the staffing levels requested were based on a review of staffing requirements then being recommended by national groups such as the Child Welfare League of America, the Residential Child Care Consortium, and licensing requirements. Ultimately, the ratios were a professional assessment, based on the state of the art at that time. It would certainly be useful to reassess the current thinking in the field to determine whether higher staffing ratios are needed because of the levels of disturbance that are being exhibited by children going into out of home care today. Review of current national standards and a project currently underway to assess children in foster care on the severity of problems and needs for supervision may be of assistance in determining staffing levels.

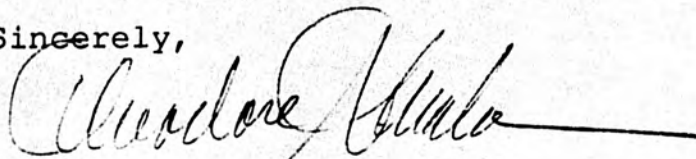
We recognize that monitoring of providers for compliance with requirements in the RFP, including staffing levels, is important. However, there are no funds in the proposed FY92 budget for grant compliance monitoring. It will be impossible to assess some areas of grant compliance without conducting on-site reviews and thorough analysis of written reports. DFYS does not have the capability in either staffing or travel budget to perform this function at the current time. Projected budget reductions will make it even more unlikely that adequate monitoring will occur in the future.

We appreciate the efforts of your staff to analyze all the issues that have led to the current situation we encounter in the residential care grant program. Your auditors have raised important questions, and have been both objective and professional

Michael J. Deegan, CPA
dit Response
Page 5

in their approach. Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in dark ink, appearing to read "Theodore Mala", followed by a horizontal line extending to the right.

Theodore A. Mala, MD, MPH
Commissioner

Audit Report

**DEPARTMENT OF HEALTH AND
SOCIAL SERVICES
DIVISION OF FAMILY AND
YOUTH SERVICES
SELECTED ISSUES AND CONCERNS**

February 11, 1992



Audit Control Number:

06-4407-92

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

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DIVISION OF LEGISLATIVE AUDIT

The Legislative Budget and Audit Committee is a permanent interim committee of the Alaska Legislature. The bipartisan committee is made up of five senators and five representatives, with one alternate from each legislative chamber. The chairmanship of the committee alternates between the two chambers every legislature.

The committee is responsible for providing the legislature with audits of state government agencies. The programs and activities of state government now cost more than \$4 billion a year. As legislators and administrators try increasingly to allocate state revenues effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by the Division of Legislative Audit helps provide that information.

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February 21, 1992

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF FAMILY AND YOUTH SERVICES SELECTED ISSUES AND CONCERNS

February 11, 1992

Audit Control Number

06-4407-92

As set out in the Objectives, Scope, and Methodology section of this report, this audit addresses various selected issues of concern involving the operations of the Division of Family and Youth Services. Of major concern was the impact of impending agency reorganization on service delivery, agency compliance with the requirements of the federal Indian Child Welfare Act, and the agency's consistency in following their own standards when taking emergency custody of children.

The audit was conducted in accordance with generally accepted government auditing standards. Audit scope and methodology are discussed further in the Objectives, Scope, and Methodology section. As discussed in the report, we are unconvinced that the benefits purportedly to be realized through agency reorganization are supported. Other results of our audit are summarized in the Report Conclusions and the Findings and Recommendations sections of the report.

A handwritten signature in cursive script, reading "Randy S. Welker".

Randy S. Welker, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with a Legislative Budget and Audit Committee request and Title 24 of the Alaska Statutes, we have reviewed selected Division of Family and Youth Services (DFYS) issues and agency reorganization plans. The objectives, scope and methodology of our review were as follows:

Objectives

The objectives of the audit addressed selected issues developed from the special requests of the Legislative Budget and Audit Committee. These objectives are summarized as follows:

1. To assess the impact of division reorganization on the provision of services.
2. To assess the current status of DFYS' compliance with the federal Indian Child Welfare Act (ICWA).
3. To determine if DFYS applies child protection criteria consistently to both native and non-native clients when making emergency custody decisions.
4. To determine if DFYS applies foster care licensing standards on a consistent basis.
5. To evaluate the extent that foster care providers are complying with training requirements.
6. To evaluate the effectiveness of agency social worker training.
7. To determine the extent to which agency social workers meet DFYS' training policy.

Scope and Methodology

For most of the objectives listed above, we reviewed pertinent documentation related to DFYS activities carried out during 1990 and 1991. Likewise, our interviews with selected individuals, particularly representatives of native community service organizations generally addressed DFYS operations over the past two years.

To address objectives one through four, we reviewed a sample of the following DFYS documents: (1) Emergency custody client files, (2) foster home licensing files, (3) foster parent training files maintained through the contracted foster parent training center, and (4) various staff training records.

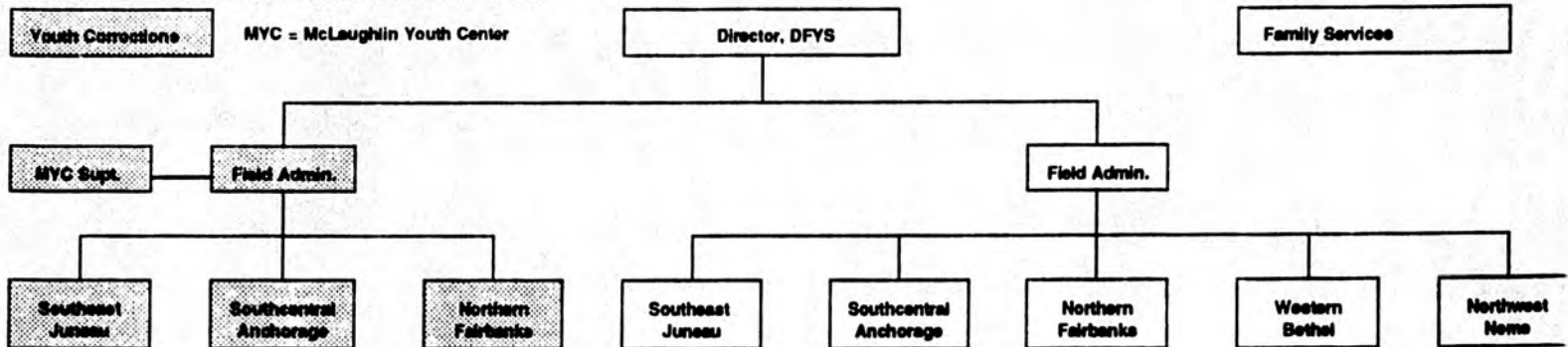
In addition to reviewing these documents, we interviewed social workers, native community members from rural and urban areas, a rural Superior Court judge experienced in child custody cases, and the DFYS staff trainer.

In order to assess the impact of reorganization, we reviewed caseload information, past and prospective organization charts, internal cost savings reports, DFYS management review contracts, and an Office of Management and Budget preliminary evaluation of the system. We also researched social service delivery models in other states and interviewed several DFYS management team members.

DFYS UPPER MANAGEMENT STRUCTURE

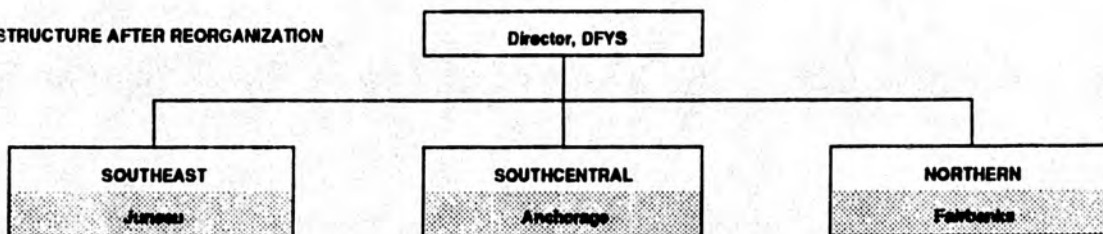
BEFORE

TOP MANAGEMENT STRUCTURE PRIOR TO REORGANIZATION



AFTER

TOP MANAGEMENT STRUCTURE AFTER REORGANIZATION



ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services with responsibility for providing a range of services designed to remedy or prevent abuse, neglect, and exploitation of children, youth, and adults. To meet these statutory responsibilities, the department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the youth section of the Division of Corrections. Since this organizational combination, DFYS has administratively been divided into two major sections - Family Services and Youth Corrections.

The Family Services section of DFYS is responsible for providing child protection and welfare services, licensing of child and adult care facilities, the recruitment, selection, and training of foster parents. Youth corrections is responsible for supervising adjudicated youth offenders. A major aspect of the youth corrections section is the operation of five facilities for adjudicated youth located in Juneau, Anchorage, Fairbanks, Bethel, and Nome.

DFYS' management is primarily structured on a regional basis

As illustrated by the organizational chart on the opposite page DFYS agency management is primarily structured on a regional basis. Prior to reorganization (or the BEFORE structure on the opposite page chart), the separation of Youth Corrections and Family Services was maintained in the line organization starting just below the division director.

The Youth Corrections section was divided into three regions, each managed by a regional administrator. Each regional manager reported to a field administrator responsible for Youth Corrections. With the exception of the McLaughlin Youth Center in Anchorage, the superintendent of each youth facility reported to the regional administrator responsible for the part of the State where their facility was located.

The Family Services section was divided into five regions. Similar to Youth Corrections, each of the regional managers reported to a field administrator responsible for the Family Service section of the agency. Essentially, the top management of the agency involved a total of eleven positions, with overlapping regional responsibilities, albeit with different service delivery functions.

A major directive of the Hickel administration was to comprehensively reorganize DFYS. A central aspect of the reorganization has been the realignment of management of the agency's Family Services and Youth Corrections sections. In an August 1991 memorandum to the Division of Budget Review, Department of Health and Social Services Commissioner Mala commented that the existing structure, which had evolved over a number of years, had made DFYS

...a top heavy agency resulting in a cumbersome, redundant, and inefficient administrative structure which is unresponsive to staff needs. Public monies are being wasted; clients of the Division are not receiving badly needed services as a result of the ineffectual structure.

As a result of this, the current administration has ordered a reorganization of the Division of Family and Youth Services.

Reflecting his view of the management structure, Commissioner Mala in turn directed the division to

...consolidate and merge the eight Youth and Social Services Regions into a three-region structure with Juneau, Anchorage, and Fairbanks as the regional offices. The perspective I have ... is that additional layers of administrative staff are not productive or cost effective enough to justify the expenditures we are now incurring. My goal is to have a "leaner" and more productive organization by deleting a number of "mid-level management" positions, while at the same time improving the quality of service to the public by improved service delivery coordination and the funding of additional line social worker and probation staff.

DFYS Director Price, cited this directive along with other benefits that would result from reorganization. In his view, the reorganization would provide more on-line social workers, better service delivery, and was necessary to implement a new "family preservation" service delivery model. In turn, the new family preservation philosophy would result in DFYS being less intrusive on the family and allow the State to reduce foster care costs.

Accordingly, the Hickel administration reorganized DFYS' management structure. As shown on page 2 (labeled as the AFTER structure) the agency created three regions below the director level, with administrators responsible for **both** Youth Corrections and Family Services functions in each particular region. The administrators in each region, headquartered in Juneau, Anchorage, and Fairbanks respectively, report directly to the division director.

In FY 91, DFYS had an operating budget of almost \$60.5 million. Of that total, almost \$26 million was for "purchased services" which provides funding for receiving homes, emergency shelters for youth, and foster care. The remaining \$34.5 million in operational funding is generally evenly split between family service and youth correction sections. The family services section has 310 authorized full-time positions while the FY 91 youth services budget authorized 288 full-time positions.

Licensing of Out-of-Home Care Providers

When children are taken into state custody they are placed in foster care, or into an emergency shelter facility. Out-of-home placement providers, whether foster parents or institutions, are reimbursed on a daily rate which varies based on the level of supervision, custody, and treatment that they provide to the youth in custody.

Each provider is subject to licensure and review on an ongoing basis to assure that they are providing reasonable care in a clean and safe environment or facility. Complaints of abuse and neglect of children placed in out-of-home care are also the responsibility of staff, DFYS' social workers, and licensing workers.

**CALCULATED ON A POSITION-BY-POSITION BASIS
RECLASSIFICATION ELIMINATES TEN LINE SOCIAL WORKERS**

<u>PCN</u>	<u>PRE-RECLASS TITLE</u>	<u>WORKER TYPE</u>	<u>POST-RECLASS TITLE</u>	<u>WORKER TYPE</u>
06-2243	Mental Health Clinician	A	Grants Administrator II	A
06-3881	Publications Specialist I	A	Program Officer	A
06-3900	Clerk Typist III	C	Social Worker IV	A
06-3014	Social Worker IV	S	Social Worker V	A
06-3770	Clerk Typist III	C	Social Worker IV	A
06-3954	Data Processing Clerk I	C	Social Worker IV	A
06-3089	Social Worker IV	S	Social Worker V	A
06-3063	Clerk IV	C	Accounting Clerk III	C
06-3085	Social Worker IV	S	Social Worker V	A
06-3114	Administrative Assistant II	A	Administrative Assistant III	A
06-3863	Clerk Typist III (PPT)	C	Clerk Typist III (PPT)	C
06-3878	Social Worker IV	S	Social Worker V	A
06-3925	Clerk Typist III	C	Analyst Programmer I	A
06-3186	Social Worker V	A	Social Worker IV	S
06-3357	Social Worker IV	S	Probation Officer IV	S
06-3617	Youth Facility Superintendent I	A	Youth Facility Superintendent II	A
06-3633	Unit Leader	S	Probation Officer IV	A
06-3482	Administrative Assistant I	A	Regional Administrator	A
06-3034	Social Worker III	L	Social Worker III (PFT)	L
06-3215	Social Worker III	L	Regional Administrator	A
06-3076	Social Worker III	L	Social Worker IV	S
06-3713	Social Worker III	L	Social Worker IV	A
06-3871	Social Worker III	L	Program Officer	A
06-3218	Social Worker III	L	Regional Administrator	A
06-3889	Social Worker III	L	Program Officer	A
06-3874	Social Worker III	L	Probation Officer IV	A
06-3201	Social Services Associate III	L	Social Worker V	A
06-3866	Probation Officer II	L	Probation Officer IV	S
06-3573	Youth Counselor II	L	Probation Officer IV	A

Key to "Worker Type" Column:

A - Administrative position
C - Clerical position

S - Supervisory position
L - Line Worker

REPORT CONCLUSIONS

REORGANIZATION CONCLUSIONS

As reflected in the Objectives, Scope, and Methodology section of this report, the objectives of our review were varied. One of the major objectives of the review was to evaluate the impact that reorganization of the agency (as discussed in the Organization and Function section) had on the division's ability and effectiveness to deliver services. Specifically, there were concerns regarding the rationale behind the reorganization, the impact that reorganization had on the number of available line social workers, and the extent that the agency realized any administrative cost savings.

Lack of savings and reduction in line social workers clouds necessity for reorganization

The immediate necessity of reorganizing the Division of Family and Youth Services' (DFYS) management structure to accomplish the administration's change in service delivery focus and philosophy appears to us to be unconvincing. Though a family preservation philosophy may be adopted by the agency at any time, the actual provision of services by DFYS' social workers will be delayed until extensive training has taken place. In the interim, some family preservation services will be contracted to outside providers.

The professed benefits of reorganization were to be cost savings, an increase in the number of line social workers, and transition to a family preservation service delivery philosophy. These benefits have not been realized. The number of case carrying line social workers has been reduced; cost savings, if any, are negligible and; the agency's ability to offer family preservation services is not imminent. In our view, the reasons given for the urgency with which DFYS has pursued the reorganization effort are unconvincing and the resultant disruptions in service delivery are insupportable.

Reorganization has reduced the number of line social workers

Reorganization was primarily accomplished through the elimination of 11 administrative positions, and the reclassification of another 29 positions. DFYS' management felt that this reorganization would save funding which could be used to increase the number of line social worker positions. Using various and differing calculations and definitions of line social workers, the reorganization resulted in a net reduction of 5 to 10 line workers.

The table on the opposite page shows the effect of the 29 reclassifications on line staff. The table reflects our view that Social Worker IVs (SW IVs), typically the first line of supervision within DFYS, **cannot** be considered as line social workers. Since SW IVs carry either less than a full or no caseload they should not be considered as line staff. Likewise, the analysis in the table assumes that Probation Officer IVs are supervisory positions and that Probation Officer IIs are considered as line workers.

As reflected by the table on page 6 (note the shaded line for PCN # 06-3034), only 1 of the 11 reclassified line positions remained so after reorganization. By this comparatively simple calculation, reorganization resulted in a reduction of 10 line social worker positions.

Using caseload hours from the agency's management information system, we calculated that more than 8 full-time equivalent line worker positions were lost after the elimination or reclassification of the 40 positions involved in reorganization. The detail of our calculation of the impact on full-time equivalent line staff is presented in the inset below.

In calculating the effect that reorganization had on line services, we analyzed the impact on caseload carrying capacity. Under DFYS standards a full-time social worker is defined as having a 112.5 monthly caseload of hours. Using this standard, we calculate that the reorganization of positions resulted in the equivalent of more than eight full-time social workers being eliminated.

As illustrated below, the ten caseload carrying positions affected by reclassification represented just over 1,000 monthly caseload hours. After the shuffle of positions, that total dropped to the equivalent of one full time worker - 112.5 hours. This reduction of 923 casework hours represents the equivalent of 8.21 line social workers.

PCN	Position Title Before Reclassification	Position Title After Reclassification	Before Case Hours	After Case Hours	Difference in Case Hours
3034	Social Worker III	Social Worker III	56.3	112.5	56.20
3076	Social Worker III	Social Worker IV	112.5	-0-	(112.50)
3713	Social Worker III	Social Worker IV	112.5	-0-	(112.50)
3871	Social Worker III	Program Officer	112.5	-0-	(112.50)
3889	Social Worker III	Program Officer	112.5	-0-	(112.50)
3874	Social Worker III	Juvenile Probation Officer	112.5	-0-	(112.50)
3089	Social Worker IV	Social Worker V	79.8	-0-	(79.80)
3666	Probation Officer II	Probation Officer IV	112.5	-0-	(112.50)
3215	Social Worker III	Regional Administrator	112.5	-0-	(112.50)
3218	Social Worker III	Regional Administrator	112.5	-0-	(112.50)
Total Caseload Hours			1,036.1	112.5	(923.60)
Decrease in equivalent line Social Workers			923.60 ÷ 112.5 = 8.21		

Reorganization was implemented with little evidence of comprehensive planning

Each administration has an extensive prerogative to structure and organize agencies as necessary to accomplish program and policy goals. Despite this wide latitude, any large, significant change to an organization's structure should be adequately planned and evaluated.

In our view, DFYS did not adequately plan for, nor evaluate the need for, agency reorganization. While citing numerous advantages -- more line social worker positions, better supervision, fewer central office personnel, cost savings, and the need to emphasize family preservation services -- these factors were never comprehensively addressed in any singular, directed planning document.

DFYS' realignment of regional management was done independently of a comprehensive statewide evaluation of executive branch management, which was being conducted by both the Office of Management and Budget and the Lieutenant Governor's office. Rather, the former director implemented reorganization based on his previous experience as director and the findings of two reports prepared by former DFYS managers under contract with the agency. These reports criticized the agency's existing management structure, although the amount of original and recent research involved in the reports appeared to have been limited.

Within DFYS, lead agency personnel were designated in each region to develop new regional management structures. Designation of these groups appeared to be a consensus building exercise, aimed at eliciting widespread support for reorganization. However, our observations and discussions indicated that input from the designated staff was limited.

Anticipated cost savings of reorganization have not been realized

DFYS' management maintained that, through the elimination and reclassification of positions, reorganization would streamline management structure and provide for savings in personnel costs. However, an internal analysis prepared by DFYS' administrative staff projects that savings will not be realized. Rather, it was projected that the net result of the reclassification and elimination of positions would result in slightly greater personal services costs. Two factors contribute to negating any anticipated personal services savings:

1. Many eliminated positions were vacant - Many of the positions that were eliminated were necessarily kept vacant due to budgetary constraints. Accordingly, no actual personal services costs savings were realized from eliminating these positions.
2. Many of the reclassified positions were upgraded - The three regional directors for the blended Youth Corrections and Family Services functions were classified as Range 23 while the previous regional managers had pay ranges of 19 to 21 on the State's salary scale. In total, of the 29 reclassifications, 25 involved upgrades on the State's salary scale.

Reorganization's impact on family preservation service delivery remains to be seen

According to the former director, a third benefit of reorganization was the facilitation of family preservation services. Under his directorship and consistent with the Hickel administration's policy, he wanted to redefine the scope of child protective services. Under this redefinition the scope of services would expand from a focus only on the protection of

the abused and neglected child, to also include new family services emphasizing the preservation and maintenance of the child's family.

The director also anticipated that this change in scope and focus would allow DFYS to reduce the agency's reliance on foster care. By doing so, the agency could stop the growth in foster care costs incurred in recent years. Further, it was anticipated that the foster care expenditures could be either reduced and/or reallocated to promote both child safety and preservation of the family.

Consolidation of Youth Correction and Family Service functions within the agency may provide an opportunity to reduce foster care costs. The change in program focus and the accompanying reorganization of the agency has been patterned after a reputedly successful program implemented by Idaho. The consolidation of Family Services and Youth Corrections, under the Idaho model, contributed significantly to the smooth transition to the family preservation delivery approach and subsequent realization of foster care cost savings. As discussed previously, however, DFYS is not yet prepared to offer the family preservation services that are expected to reduce foster care costs.

ADDITIONAL REPORT CONCLUSIONS

In addition to an analysis of the impact of DFYS' reorganization efforts, we reviewed several other selected DFYS management practices. These included: (1) the agency's compliance with the Indian Child Welfare Act (ICWA), (2) the application of child protection criteria (3) the consistency with which foster care licensing and training standards are applied, and (4) the social worker training program. Our conclusions regarding these reviews are summarized below and are discussed in the Findings and Recommendations section of this report.

Compliance with the ICWA is hampered by lack of native foster homes

To help preserve the culture of the native child while the child is in state custody, the federally mandated ICWA provides criteria, or preferences, for foster care and preadoptive placements. Due to lack of native foster homes, native children are often placed out-of-preference. Social workers generally recognize that compliance with ICWA is simply good social work and place native children in out-of-preference homes only after all other options have been exhausted.

Regions in which recruitment of native foster homes has been comparatively successful have established close working relationships with native community service organizations. Regions in which the cooperative effort does not exist, however, tend to have more problems recruiting native foster homes. Recommendation No. 1 in the Findings and Recommendation section of this report further discusses DFYS' ICWA efforts.

ASSESSMENT OF RISK DETERMINES DFYS' PRIORITIES AND DOCUMENTS RATIONALE FOR EMERGENCY CUSTODY

By necessity, child protection services and intervention decisions are risk driven. In order to formally evaluate and document the risk that a child may be exposed to abuse or neglect, social workers complete a Risk Assessment Tool (RAT). Each RAT (illustrated and discussed further in Appendix A) requires that each social worker assign a score to factors that have been shown to be related to abuse and neglect of children.

The RAT is used to prioritize service levels for cases. Children assessed with the highest risk levels are served first. Because DFYS suffers chronic casework overload, generally only the highest priority cases are provided services.

Many high priority cases require DFYS to assume emergency custody of the child. The decision to assume emergency custody is based on the assessment that there is risk or potential for further risk to the child if left in the home without immediate action by DFYS to protect the child. Alaska Statute (AS 47.10.142) requires that at least one of the following criteria be met before emergency custody may be assumed:

1. The minor has been abandoned, or
2. The minor has been grossly neglected and the division determined that immediate removal is necessary to protect the child's life, or
3. The minor has been abused and the division determined that immediate removal is necessary to protect the child's life, or
4. The minor has been sexually abused.

For each child remaining in emergency custody for more than 12 hours, DFYS must file a petition with the court alleging that the child is a child in need of aid. If, within 48 hours, the child remains in emergency custody, a DFYS representative must plan to appear in court to show probable cause for removing the child from the home.

In evaluating the consistency with which DFYS made emergency custody determinations, we reviewed and compared RAT scores for children taken into state care. Further, we reviewed individual children's cases to verify that the circumstances of the case were reflected on the child's RAT.

In general, child protection criteria is applied consistently

One objective of our review was to determine if child protection criteria was applied consistently to native and non-native clients. From our review of selected DFYS emergency custody client files, we concluded that DFYS does consistently apply agency-established criteria when deciding on taking emergency custody of children. Children assessed on the risk assessment tool (RAT) (see inset at top of the opposite page) at high risk of abuse or

neglect were uniformly removed from the home. Furthermore, the RAT scores in client files were generally found to support the decision to assume custody.

Community standards may compromise safety requirements of foster care licensing

Before licensure, each prospective foster home must undergo an investigation to ensure that the home meets certain regulatory standards. Licensing workers are allowed some flexibility in this evaluation, and, as a practical matter, use what are termed "community standards" as a guide for acceptability in some situations. The community standard flexibility, while useful in some cases, should not be applied to fundamental safety standards. In our view, these include the storage of firearms, medicines, and fire safety. We noted, through review of foster home licensing files, that safety standards, while generally applied in urban areas, are less likely to be enforced in rural areas. See Recommendation No. 2 in the Findings and Recommendation section of this report for further discussion of our concerns in this area.

Foster parents do not consistently meet the 15 hour training requirement

State regulations require that foster parents complete a minimum of 15 hours of foster parent training annually. Only 17% of the foster parent training files we reviewed indicated that the foster parents had received the minimum required training. Though the Alaska Foster Parent Training Center (AFPTC) presently offers correspondence courses through which foster parents may obtain training credits, all on-site courses have been eliminated as a result of reduced funding. See Recommendation No. 3 in the Findings and Recommendation section of this report.

Most foster homes do not receive foster care orientation

State regulations require each prospective foster parent to receive an orientation in which the details of foster parenting are explained. The purpose of the orientation is to inform the prospective foster parents of the level of commitment required and to explain the regulations relating to foster care. Of the files we reviewed, most foster homes had not received this orientation prior to licensure. See Recommendation No. 4 in the Findings and Recommendations section of this report.

Staff training program improves social worker skills but is not fully used

DFYS has developed a social worker training program consisting of orientation and core competency courses. The courses receive good to excellent evaluations from social workers and appear to be effective. Our review of tests given before and after training showed that trainees' knowledge of basic aspects of social work increased markedly. The pre-service orientation packet, also an important part of the training program, however, is often not completed in the timeframe specified by internal policy. See Recommendation No. 5 in the Findings and Recommendation section of this report.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

Division of Family and Youth Services (DFYS) should take measures to improve agency compliance with the Indian Child Welfare Act (ICWA).

ICWA is aimed at preserving the culture of native children while they are in state custody. To help ensure that a child remains connected to their native culture, the Act provides criteria, or preferences, for foster care and preadoptive placements. These criteria include, in order of preference:

- a. A member of the native child's extended family.
- b. A foster home licensed, approved, or specified by the native child's extended family.
- c. A foster home licensed, approved, or specified by the native child's village or tribal organization.
- d. A native foster home licensed or approved by an authorized non-native licensing authority.
- e. An institution for children approved by a native tribe or operated by a native organization which has a program to meet the native child's needs.

Due to lack of foster homes, native children are often placed out-of-preference

Native children in Alaska are often placed in non-preference, non-native homes because too few native foster homes are available. DFYS' social workers generally acknowledge the importance of placing native children in a culturally compatible setting. However, due to the shortage of native foster homes, DFYS is unable to do so on a consistent basis. Native communities as well as primarily non-native areas have had difficulties recruiting native foster homes. Barrow, for example, has had a particularly difficult time recruiting foster homes for pre-school age children. As a result, most children of this age that cannot be placed with relatives are placed at a local receiving home. The receiving home, which employs primarily non-native workers, is considered an out-of-preference placement.

DFYS has enjoyed some recruitment successes in smaller, more rural areas. The Association of Village Council Presidents recently commended the Bethel DFYS office for their success in recruiting native foster homes. In general, in areas where the agency has been successful in placing native children in preference homes, DFYS and the local native organizations work well together. Regions where there is little contact with native organizations tend to have less success in placing native children.

One supervisory social worker describes the procedures required by ICWA as "just good social work" and commented that the removal of children from the native culture is akin to the systematic elimination of a political body through the removal of its members. Of the

files we reviewed on native children in out-of-preference homes, most were placed only after all relative placement options had been exhausted.

Southcentral region does have difficulties in complying with ICWA requirements

**MANY NATIVE GROUPS RESIST
SIGNING STATE'S STANDARD
ICWA AGREEMENT**

The ICWA State Tribal Agreement, as authorized by Alaska Statute (AS 47.10.230(g)) is a procedural document. The intent of the agreement is to establish the powers and responsibilities of tribes and the State when a native child is taken into state custody.

The drafting of the standard agreement was a collaborative process. State agencies met with representatives from Alaska's native organizations to develop the agreement. Accordingly, the agreement does not address all the issues that the various organizations necessarily wanted to be recognized in a standard agreement. In the interest of reaching some consensus and developing a workable agreement, some salient issues were intentionally left unaddressed. Most prominently, these issues pertained to (1) tribal courts, (2) jurisdiction, and (3) state funding for social services.

Because the agreement does not specifically address or recognize these issues some tribes have refused to sign the agreement. Most prominently, the Tanana Chiefs Conference (TCC), a large Native organization, has advised virtually all of its members against signing the agreement because TCC believes the tribes gain too little through the agreements.

As of December 31, 1991, the State had developed fourteen tribal agreements, covering the following twenty-six villages.

Craig	Circle	Elwuk
Haines	Hoonah	Hydaburg
Juneau	Kasaan	Kanaitza
Ketchikan	Klawock	Klukwan
Kotzebue	Ninilchik	Pellana
Petersburg	Port Graham	Saxman
Scammon Bay	Sitka	Tanana
Tenassee Springs	Tokeook Bay	Unalaska
Wrangell	Yakutat	

Many villages may still be considering whether or not to sign the agreement. As a result, the list of covered villages may continue to grow.

While it is clear that a cooperative effort between DFYS and native organizations yields more positive results in case planning and native child placement, this cooperative effort does not exist in all regions. The Southcentral DFYS office is perceived by many native organizations to be culturally insensitive. Although it was reported to us that often there is a difference in opinion between native organizations and DFYS over case plans in most regions, the Southcentral DFYS office was the only office repeatedly mentioned by the native community as unreceptive to the need for the native child to remain in touch with his/her culture.

Native organizations from outside as well as inside the Southcentral region suggest that the Southcentral office has preconceived notions about village life. Two native corporation social workers report that DFYS' social workers are reluctant to place native children in villages. One village representative's remarks illustrate the native community's view of DFYS. He said that he thinks workers in the Southcentral office "feel like village life is not good." Our limited review of native children in foster care in the Southcentral region bore out these concerns. Of the six files reviewed, only one file indicated the child was in a preference placement.

Large caseloads and high turnover rates for social workers may be factors that

contribute to the perception that DFYS' Southcentral office is culturally insensitive. Due to overwork and rapid turnover, social workers are less likely to be adequately trained about the Alaska native culture than their less overworked counterparts in other regions.

DFYS' staff trainer recognizes the importance of cultural issues but has not yet designed a course, aside from ICWA training, to emphasize cultural sensitivity. Once the course has been established, DFYS' staff trainer would like to add it to the basic training already required of social workers. Given the Southcentral region's poor working relationship with the native community and resulting perception of cultural insensitivity, training aimed at increasing levels of cooperation between the Division and the native community should be considered.

Since our last audit in February 1990, DFYS has improved notably in documenting attempts to comply with ICWA, for which we commend them. The division must, however, continue to address, through education of social workers and cooperative efforts with the native community, the necessity of recruiting native foster homes in both rural and urban areas.

Recommendation No. 2

When applying community standards in licensing foster homes, DFYS must not unduly compromise established safety standards.

As a practical matter, DFYS must make some allowances for what are termed "community standards" when licensing foster homes. DFYS is given discretion to make these allowances under regulations that permit the agency to

...waive [licensing requirements] if an alternative method of satisfying the intent of the requirement is consistent with community, ethnic, and cultural standards, and the safety and well being of children are not endangered.

Licensing workers are often faced with the dilemma of too few homes for too many children needing foster care. The problem is further complicated by the need to comply with ICWA preferences. We recognize the difficulties of simultaneous compliance with regulatory and ICWA requirements. Given the chronic shortage of homes and the central role that foster care placement plays in ICWA compliance, there are compelling reasons to be flexible in licensing decisions. However, DFYS should still be cautious not to unduly compromise the safety of children in foster care.

Application of community standards has compromised regulations pertaining to safety

As acknowledged in the regulations, DFYS should not compromise foster home safety standards when applying community standards. Safety standards are those standards that relate to the storage of firearms and ammunition, medicines, and fire safety. We are

concerned that these safety standards are applied differently in rural areas than in urban areas of the State.

State regulations [7 AAC 50.570 (h)] require that:

A foster parent shall ensure that firearms are unloaded and stored in a locked place reasonably inaccessible to all children, that firearms are equipped with trigger guard locks and that ammunition is stored separately in a locked place, reasonably inaccessible to children.

In our review of foster home licensing files we identified an instance where firearm safety standards were not consistently applied to both rural and urban communities. In rural communities, DFYS licensing workers do not consistently require that foster homes unload and store all firearms in a safe locked place, purchase and use trigger guard locks, or that ammunition be stored in a locked place. One foster home, which had been licensed and relicensed since June of 1988 and was revisited in July of 1991, had the following notation in its licensing file:

I talked to them about their firearms and the necessity of being equipped with trigger locks, being locked in a separate storage space, and that the ammunition needed to be stored and locked in a separate storage space.

The foster father stated that they are to be used for hunting, or for his own use. He talks to the children about gun safety, and guns are nothing to play with. He went on to state he would not purchase any trigger locks and the guns would continue to stay in his entryway along with the ammunition.

Licensing workers felt that since rural communities rely extensively on firearms for subsistence hunting of, and protection from, animals, this justified exceptions for community standards. However, in our view, these exceptions unduly compromise safety standards.

Recommendation No. 3

DFYS should ensure that all foster parents have satisfied the required 15 hour minimum of foster parent training before relicensure.

According to state regulations (7 AAC 50.433):

(b) A foster parent shall participate in training provided or approved by the agency to develop and enhance the foster parent's skills. A foster parent shall annually participate in a minimum of 15 hours of agency-approved ongoing education. The hours may be shared between two foster parents in a two-

parent foster home. However, each foster parent in a two-parent home shall and the total training hours for the home must be at least 15 hours.

Only 17% of the 29 foster parent licensing files we reviewed showed evidence that the minimum training requirements were met. Another 10% of those foster parent licensing files reviewed had received some training during the past year, but they had not met all the training requirements.

Foster parents need the training to develop and enhance their foster parenting skills. By developing these methods through training, foster parents will be able to enhance their relationship between the foster parents and foster children. Licensing workers have not been enforcing the training requirements prior to relicensure. Many foster parents reported they were not aware of the foster parent training center. The training courses are not difficult, and they provide foster parents with an additional resource to help them confront difficult foster parenting issues.

DFYS has reduced commitment to foster parent training

Recently, DFYS has reduced the Northwest Resource Associates, Alaska Foster Parent Training Center (AFPTC) one year contract by 40% and made the contract renewable on a quarterly basis. Reduction of the contract from \$600,000 a year to a renewable \$90,000 quarterly contract suggests DFYS has reduced the agency's commitment to meeting the training needs of foster parents. In order for foster parents to obtain the necessary training, DFYS needs to renew their commitment to foster parent training.

This contract reduction has had a major impact on the training AFPTC offers foster parents. Given the new contract AFPTC can only offer training by mail. Before the contract reduction, AFPTC offered on-site training to foster parents. This gave foster parents an opportunity to interact with other foster parents facing similar issues and an opportunity to learn different techniques to deal with these issues.

Foster parents who attended on-site training favorably evaluated the courses presented. Trainers were also afforded the opportunity to interact with foster parents and monitor how foster parents were adjusting to foster care responsibilities.

Recommendation No. 4

DFYS should ensure that all foster homes receive the approved foster care orientation before children are placed in the home.

State regulation [7 AAC 50.433(a)] requires each prospective foster parent to complete an approved foster care orientation *before* accepting children for foster care. The orientation is aimed at ensuring that foster parents fully understand the regulations and resultant level of commitment associated with foster care. Prospective foster parents must not continue to

be permitted to make this commitment without the knowledge necessary to make an informed decision.

The foster parent files we reviewed did not provide documentation that foster parents consistently received orientation prior to placement. Twenty-one of the twenty-nine files reviewed represented homes that should have had orientation. Of these, only five contained documentation that the orientation had been received prior to licensure.

Some foster homes have received no orientation because they were licensed before the orientation requirements became effective. If these foster parents are to be "grandfathered in" or excused from the orientation, this determination should be reflected in the licensing file. Other foster homes have not received a documented orientation because licensing workers sometimes consider a discussion of regulations at the time of the standard-by-standard evaluation as orientation.

In our view, this does not constitute orientation as neither the content nor the occurrence of these discussions is documented. To retain foster parent accountability for compliance with the regulations, DFYS must be able to show that the standards were explained and understood.

Recommendation No. 5

DFYS should fully comply with all training standards established in the division's November 1989 policy statement.

DFYS' staff work in a changing environment which requires that they maintain an appropriate level of knowledge and skill to function effectively. To ensure that social workers attain this level, DFYS must renew their commitment to social worker training.

In November 1989, the director of DFYS issued a policy statement on training. One aspect of this statement required that newly hired Family Service employees complete a three week orientation period. This includes completion of the pre-service orientation packet (PSO) and one week of internship with an experienced social worker. During this time the newly hired employee receives no case assignments.

Only 40% of the new employee files we reviewed indicated that the employee had completed the PSO. The low completion rate seems to be attributable to high caseloads. Though supervisors are generally supportive of the training effort, few are willing or able to cover the caseload of the social worker in training.

Social worker training has improved in recent years. Social workers have been receptive to the training. The course evaluations we reviewed generally rated the training between very good and excellent. Pre- and post-tests to measure the effectiveness of the training show a marked increase in knowledge considered necessary to perform social work services. The

PSO is also an important part of the DFYS training effort. The DFYS management team should ensure that social workers are provided the full benefits of the agency's training program.

(Intentionally left blank)

Risk Assessment Tool (RAT) Used to Determine Service Levels and Measure Caseloads

Assessment that the child's father abuses alcohol. Accordingly, the risk has been given a value of one.

FAMILY ABUSE / NEGLECT ASSESSMENT

Worker: Marg Jones
Case Name: Miller

Date: 4/12/88
Case Number: 123456

ABUSE			NEGLECT		
	SCORE			SCORE	
A1	1	Number of prior reports of abuse (None, One, Two or more)		0	Number of prior reports of neglect (None, One or Two, Three or more)
A2	0	Number of prior placements outside of family residence (None, One or more)		0	Number of other placements outside of family residence (None, One or Two, Three or more)
A3	0	Number of substance abuse problems in current report (None, One or more)		2	Other caretaker designated as a child (Yes/No)
A4	2	Number of adults in home (18 yrs or age of death) (One or two, Two or more)		0	Other caretaker living in home or reports (Yes/No)
A5	0	Number of adults in home (18 yrs or age of death) (One or two, Two or more)		3	Caretaker history of drug/alcohol abuse (None, One or two, Two or more)
A6	2	Number of children in home (One or two, Two or more)		0	Age of youngest caretaker at time of report (18 or older, 18 or younger)
A7	1	Other caretaker designated as a child (Yes/No)		0	Number of children in home (One or two, Two or more, Three or more)
A8	0	Caretaker history of drug/alcohol abuse (None, One or two, Two or more)		2	Caretaker's primary source of negative social relationships (Yes/No)
A9	0	One or more caretakers providing discipline of a child (Yes/No)		2	Substance use change demonstrated by perpetrator/caretaker (Not applicable, Moderate & Positive, Moderate, Not Positive, Moderate Plus)
A10	2	Caretaker's primary source of negative social relationships (Yes/No)		9	
A11	0	Caretaker history of depression (None, Significant, long-term episode by other, Significant, long-term episode by other, Significant, long-term episode by other)			
A12	1	Cooperation with agency consultation by perpetrator (Not applicable, Cooperation, Uncooperation, Hostile / Threatening)			
A13	0	View of abuse by non-perpetrator/caretaker (Not applicable, More serious than agency view, Consistent with agency view, Less serious than agency view)			
TOTAL ABUSE RISK SCORE			TOTAL NEGLECT RISK SCORE		

GENERAL INSTRUCTIONS

- 1) Complete both risk scales (abuse & neglect) on the family during the intake process for all intakes.
- 2) Calculate the total score for each scale.
- 3) Assign the family's service level based on the total score in either scales use the following chart:

Social Worker Judgement. Although not intended to be used in place of social worker judgement, the RAT guides the social worker in evaluating the level of child protective services that should be provided. The agency's Child Protective Services manual instructs social worker Jones that when assessing factor A9 to judge "the degree to which the social relationships detracts from the strength of the family. An example would be a parent who has a substance abuse problem yet continues to socialize with others who use alcohol or drugs."

GENERAL INSTRUCTIONS

- 1) Complete both risk scales (above & right) on the family during the intake process for all intakes.
- 2) Calculate the total score for each scale.
- 3) Assign the family's service level based on the highest score in either scale; use the following charts

OVERSIGHT: Notes Overdue to High. Circle appropriate reason.

1) Substantiated case abuse.

2) Child required medical treatment subsequent to abuse or neglect.

3) AS focus on sibling is in DYS placement.

4) Sibling's death of sibling.

5) Others _____

FINAL ASSIGNMENT

Sara Grant

06-9703 CFS 4/89

Service Level Contact Standards. Service levels are assigned for cases based on the highest score on either scale. The Miller case would be assigned a high service level because of the total of the neglect factors. Based on the service level assigned, DFYS has established minimum contact service standards for casework. If this high risk case was in a community served by a local DFYS office, the assigned social worker would be required to make 4 face-to-face contacts per month, 2 of which must be in the home. If the case was in a community served on an itinerant basis, the worker would be required to make 1 face-to-face contact and 5 phone calls per month. Lower risk cases require fewer social worker contacts.

Case Load Measures. Service levels and casework standards are used to measure each social worker's case load. For each service level and its associated casework standards, DFYS has estimated how many hours should be involved to provide the minimum amount of service to each case. For a high service level case, requiring 4 face-to-face monthly contacts and other services, 8.1 hours are allotted. In order to meet minimum casework standards for the same case, DFYS allots 9.5 hours (for the 5 phone calls and 1 face-to-face monthly contact). The lower the service level assigned to a case, the less time is allotted to provide minimum services.

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STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

WALTER J. HICKEL, GOVERNOR

THEODORE A. MALA, COMMISSIONER

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030

March 31, 1992

Randy S. Welker, Legislative Auditor
Division of Legislative Audit
Legislative Budget and Audit Committee
P.O. Box W
Juneau, Alaska 99811-3300

MAR 31 1992

LEGISLATIVE AUDIT

Re: Preliminary Audit Report
Division of Family and Youth Services
Audit Control Number 06-4407-92

Dear Mr. Welker:

Thank you for the opportunity to review and respond to the preliminary audit report on the Division of Family and Youth Services. We do not dispute many of your findings. They reflect a widely shared opinion that the Division of Family and Youth Services has had its share of problems. We are working hard to address those problems and to earn a more positive public perception.

However, we feel compelled to respond to two basic issues which we believe result from incomplete information. First, we are concerned about the sample size of foster care records upon which some of your findings were based. Second, we continue to disagree with the report's conclusions on the DFYS reorganization.

Foster Care Record Sample Size

We are concerned about the sample size of foster care records upon which some of the findings are based. A review of 2% sample (only 29 of approximately 1,400 foster parent files and only 6 Anchorage custody files) may not provide an adequate base. In certain instances, the report may not include enough information to assure the accuracy of some of the findings. More detailed comments follow in response to Recommendations 3 and 4.

DFYS Management Changes

The bulk of your report offers comments critical of the recent management restructuring accomplished by the Division of Family

and Youth Services. Last November, the Division consolidated eight regions with two separate lines of authority (Family Services and Youth Corrections) into three regions, each under a single Regional Administrator and a single line of authority. In the process, we eliminated eight former regional manager/administrator positions and the three field administrator positions through whom they and central administrative staff reported. They were replaced by the three Regional Administrative positions reporting directly to the Division Director. We thus eliminated one layer of management (eleven positions) and further unified the Division's two main functions.

The savings realized by eliminating these eleven positions totaled \$688,700. Additionally, Governor Hickel vetoed \$229,800 in the FY92 operating budget in anticipation of the reorganization, also contributing to savings. Additional detail is shown in the memorandum dated January 3, 1992, from Fred E. Schmitz which accompanies this letter. Mr. Schmitz's memorandum and its attachments also identify how this money was spent.

All of the savings are being spent on personnel who either deal directly with clients or who have supervisory responsibility for those who have direct contacts with clients. See in particular the second page of Mr. Schmitz's memorandum and the two-page attachment to his memorandum. Also attached is a copy for your information of Mr. Schmitz's earlier memorandum dated December 13, 1991. The reorganization has not resulted in any "net reduction" of line social workers. Our records show that the budgeted V&T would have caused forced vacancies of over 45 positions. Reorganization savings have reduced that number by 10 positions to a forced V&T of 35 positions.

The report stated that there was no planning for or evaluation of the need for agency reorganization. We disagree. There is extensive support and preparation for the management streamlining which predates the actual organizational re-alignment. Over the course of several years, the Division of Family and Youth Services came to be perceived as an agency which was not doing very well. This perception is reinforced by numerous recent studies, audits and analyses, both internal and external. These examinations included a Legislative Audit Report dated February 27, 1990, entitled: "A Special Report on the Department of Health and Social Services Division of Family and Youth Services." Also included is a 1987 internal review and report. The Division also received prominent attention in the 1991 report by the Senate Family Law Review Task Force.

It is generally agreed within the Division that the time for a more cooperative effort between Youth Corrections and Family Services functions was long overdue. We believe the structural changes we

have made will assist the shift to the "Family Centered" approach in both parts of the agency. The consolidation ensures a consistent family centered approach by both sections logically leads to a reduction in placements.

We concur with your comment that the "Reorganization's impact on family preservation service delivery remains to be seen". Whether the structural changes which have been made are effective will only be seen over the course of time. At present, the Division is only a few months beyond the time the reorganization plan went into effect. It will be at least another year before the effectiveness of these changes can be judged. The results of any such change are not 100% predictable, but failure to change in this instance certainly had all the appearance of continuing problems.

We must, therefore, reject each of the major criticisms of the organizational changes made regarding the Division of Family and Youth Services. Given all the circumstances, certain organizational changes were warranted. The changes made did in fact result in a savings of personnel costs, calculated as \$688,700, and the entire savings is being spent on line personnel throughout the organization which is enhancing the delivery of services.

Recommendation No. 1

Division of Family and Youth Services (DFYS) should take measures to improve agency compliance with the Indian Child Welfare Act (ICWA).

We agree that DFYS should strive for a better level of ICWA compliance. It is agreed that more Native foster homes are always needed and that working with the tribal organizations usually results in successful recruitment efforts. The positive comments regarding the degree of improvement are appreciated, especially the comment that the files reviewed indicated that most non-preference placements occurred "only after all relative placement options had been exhausted." We question your statement that native children are "often" placed out-of-preference since the number of cases reviewed was so small. In addition, we believe that the statement that the Barrow receiving home is an out-of-preference placement is incorrect. While that facility may have difficulty recruiting Native staff, the facility is operated by the Native corporation in Barrow, is therefore approved by the tribe, and certainly falls within the order of preference.

We would like some clarification of your comments regarding what you term as "the State's standard ICWA agreement." We use a standardized ICWA agreement format for the beginning of a

collaborative planning process with tribes. The resultant State Tribal Agreement has formalized already existing coordinated planning and services with DFYS. For other tribes, the Agreement created the opportunity to develop joint working relationships. Although the Agreement is standard in format, several sections require the individualized completion of tribal-specific information, such as contact persons and expert witnesses. Cooperative efforts with Alaskan tribes in the placement of Native children is the only successful method of implementing the ICWA.

In response to concerns expressed regarding the approach of the Southcentral region to ICWA, the region has the majority of the caseload of children in out-of-home care, so it can be expected to have the majority of the problems and require the greatest effort to show improvement. The Southcentral Regional office must address problems with children from tribes across Alaska. This perplexing task makes an equitable and culturally sensitive implementation of the tribal specific ICWA provisions difficult. We acknowledge that there have been problems and that DFYS staff have not always reacted with sensitivity. Efforts are being made to improve our performance, and the current Regional Administrator is a strong advocate for cultural awareness and appropriate care for all children. The office has been in contact with Native organizations in the area to identify problems, develop solutions, and begin meeting on a regular basis. Further, negotiations continue toward additional State/Tribal agreements.

Finally, each of the DFYS core training sessions includes a segment on cultural issues. Recent adoption training included a full day of cultural child-rearing practices offered by respected Native elders. All adoption cases require full documentation of relative search and tribal participation.

Recommendation No. 2

When applying community standards in licensing foster homes, DFYS must not unduly compromise established safety standards.

The concerns expressed here present a dilemma. DFYS is criticized for having too few Native foster homes. There is also a perception that the application of community standards is leading to safety violations in rural areas and that homes in villages may not be appropriately licensed. While the letter cites only one example of a firearm safety violation and no other safety standards violations, we will conduct a more extensive internal review to get a better understanding of the extent of the problem.

To clarify, DFYS has no policy which allows a differential application of safety standards in rural areas than in urban areas.

Rather the Division utilizes a waiver process in both areas when a legitimate alternative for meeting a safety standard is present. This agency will be revisiting some of the safety regulations to address some of the concerns for increased sensitivity to local community standards, while at the same time ensuring the safety of our children in placement.

Recommendation No. 3

DFYS should ensure that all foster parents have satisfied the required 15 hour minimum of foster parent training before relicensure.

While DFYS appreciates this part of the audit report, including the number of files reviewed and the percentage of noncompliance findings for the training requirement, the Foster Parent Training Center Summary Sheets for last fiscal year give a comprehensive picture of foster parent training. The Training Center tracks all training provided by the center, as well as other training that a foster parent sends to them for documentation. Every new foster home is mailed introductory information on the training center. This training requirement was enacted by the Legislature in 1990. Of 1,777 homes in the training center's database, 496 homes had training recorded and 208 homes completed the 15 hours during the year.

Training was one of eight areas identified by the DFYS regulation implementation committee in the Spring of 1990 that would need special emphasis and support. DFYS knew that the requirement was ambitious and that it would be difficult to deliver training in both urban and rural settings over such a vast geography. Many foster parents resisted attending training due to the missing of work, and on-site training is very expensive. DFYS agrees that the continued training needs of foster parents should be addressed. It is satisfying to see that the new self-study courses are being well-received. Some foster parents have invited other foster parents to their homes to view foster care videos and follow the viewing with a discussion.

The training requirements must be balanced against the state's need for foster parents and continuity of care for children in foster homes. License revocation resulting from a lack of training should be viewed with extreme caution. Licensing workers receive copies of the training center reports for their foster homes. The licensing policy is for the licensing worker to note any noncompliance on the standard-by-standard evaluation and require a plan of corrective action by the foster parents.

Both the training center report and the findings would indicate that further training of licensing workers is necessary. DFYS intends to continue the emphasis on the foster parent training requirement within budgetary constraints.

Recommendation No. 4

DFYS should ensure that all foster homes receive the approved foster care orientation before children are placed in the home.

DFYS agrees that an "approved" orientation is desirable before children are placed in a foster home. DFYS regulations require that the orientation be provided in all but emergency licensure and placement situations. The regulations do not require the "approved" orientation be provided in emergency circumstances; however, a brief orientation has historically been provided, even in emergencies. DFYS believes the concern raised by auditors may be a licensing file documentation problem, rather than any pervasive lack of a foster parent orientation.

An "approved" orientation is provided in a variety of ways. As a practical matter, orientations are more sophisticated in urban areas than in rural ones. DFYS "approved" orientations range from several pre-licensing training meetings in Anchorage to a licensing worker's one-on-one discussion of regulations with an applicant during the licensing review in a rural community. In addition, every licensed foster home in the state has been mailed a copy of an "approved" self-instructional orientation. Each quarter the Foster Parent Training Center mails it to all new foster parents and to each foster parent who does not have training in their data base for that year. Not all foster parents are responding to the self-instructional questionnaire. Those who respond receive five hours of training credit. Finally, foster parents are commonly given the "Foster Parent Handbook", published by the Division. The handbook also serves as an "approved" orientation.

DFYS believes that foster care orientation is adequately addressed by the Division. Licensing staff will be informed of the variety of "approved" orientations that may be documented in the licensing file of a foster home.

Recommendation No. 5

DFYS should fully comply with all training standards established in the division's November 1989 policy statement.

There exists within this agency a continuing commitment to social worker training. Admittedly, given the high caseloads and vacancy

Randy S. Welker
March 31, 1992
Page 7

rate in some areas, new staff are not always given the protected time to complete the orientation packet. It is still the intent of the Division that all new social workers complete the Pre-Service Orientation before receiving any case assignments. A memo will be distributed to all Family Service supervisors reiterating that policy. The positive comments regarding improvements in the Division's training are appreciated.

The Department of Health and Social Services appreciates the opportunity to respond to your letter, and would welcome further discussion on any of these issues, should you wish.

Sincerely,

A handwritten signature in dark ink, appearing to read "Ted Mala", with a long horizontal flourish extending to the right.

Theodore A. Mala, MD, MPH
Commissioner

Enclosures

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF FAMILY AND YOUTH SERVICES

WALTER J. HICKEL, GOVERNOR

P.O. BOX H-05
JUNEAU, ALASKA 99811-0630
PHONE: (907) 465-3170

MEMORANDUM

DATE: January 3, 1992

TO: Gene Shaffer, Acting Director
Division of Family & Youth Services

FROM: Fred E. Schmitz, *Fred* Acting Accountant IV
Budget Section

SUBJECT: Management Restructuring Analysis

This memorandum and the attached worksheet is a further refinement of my analysis of December 13, 1991 memorandum regarding, among other things, the cost savings are a result of the recent management restructuring and how the cost savings is being spent. Please keep in mind that while the figures and the information have been further refined from several weeks ago, further refinements will still be made as I am relying on hurriedly prepared information from field offices. Based, however, upon the latest information, and the attached worksheet, there is a net administrative position savings of \$688,700, all of which and more is being spent on reclasses and filling previously vacant line positions throughout the state. This savings figure has a high degree of confidence and likely will not change. It appears that a total of eleven such positions will be filled from the savings. See page two of the attached spreadsheet under the section titled "Line Position V&T (Vacancy & Turnover) Costs".

Due to the length and complexity of the spreadsheet, I have decided to summarize the spreadsheet for clarity purposes as follows:

ADMINISTRATIVE POSITION SAVINGS

SAVINGS:

Deleted 11 Administrative Positions	\$ 893,000
2 Positions Held Vacant	<u>121,200</u>
Total	<u>\$1,014,200</u>

COSTS:

Reclassified -13 Administrative Positions	<u>\$ 325,500</u>
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NET ADMINISTRATIVE POSITION SAVINGS

\$688,700

NET ADMINISTRATIVE SAVINGS SPENT ON LINE STAFF

Line Supervision Position Costs:

Reclassified 7 Supervision Positions	<u>\$ 42,500</u>
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Line Position Costs:

Reclassified 9 Line Positions	<u>\$ 176,000</u>
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V&T Position Costs:

11 Vacant Positions to be filled	<u>\$ 470,800</u>
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NET ADMIN. SAVINGS SPENT ON LINE STAFF

\$689,300

DIFFERENCE

(\$ 800)

Due to the estimated amount that each filled V&T position would cost, the filling of these positions resulted in overspending of savings by \$800.

As part of the management restructuring, two revised programs (RP#0620091 and RP#0620189) were completed to reclassify the effected positions. As requested I have analyzed the effect of these RPs on the position count for Administrative, Line Supervisor and Line Staff. The results were as follows:

<u>Three Reclassed Administrator Positions</u>	<u># of Positions</u>
<u>Administrative to Administrative</u>	1
<u>Line to Administrative</u>	2
 <u>Twenty Six Reclassed Positions</u>	
<u>Line to Administrative</u>	3
<u>Administrative to Administrative</u>	7
<u>Line Supervisor to Line Supervisor</u>	3
<u>Line Staff to Line Supervisor</u>	4
<u>Administrative to Line Staff</u>	2
<u>Line Staff to Line Staff</u>	7
<u>TOTAL POSITIONS RECLASSED</u>	<u>29</u>

If you have any questions or notice any discrepancies please notify me. I hope this is of assistance.

Attachments: December 13, 1991 Memo from Fred Schmitz
1/2/92 Management Restructuring Analysis Spreadsheet

ADMINISTRATIVE POSITIONS SAVINGS & COSTS**ADMINISTRATIVE POSITIONS SAVINGS****Eleven Deleted Administrative Positions**

PCN	Position Title	Component	Savings \$	Subtotal	TOTAL
06-3123	Regional Social Services Manager III	SCRO	\$69,700		
06-3124	Regional Social Services Manager II	NRO	\$78,400		
06-3017	Regional Social Services Manager I	NWRO	\$92,700		
06-3076	Regional Social Services Manager I	WRO	\$89,600		
06-3013	Regional Social Services Manager II	SERO	\$71,100		
06-3009	Social Services Field Administrator	Central Office	\$77,600		
06-3701	Social Services Field Administrator	Central Office	\$80,200		
06-3470	Juvenile Probation Officer V	Probation Services	\$81,000		
06-3602	Juvenile Probation Officer V	Probation Services	\$86,400		
06-3641	Juvenile Probation Officer V	Probation Services	\$75,600		
06-3467	Social Services Field Administrator	Probation Services	\$90,700		
Total Saved - Deleted Positions			\$893,000	\$893,000	

Two Positions Held Vacant as Part of Management Restructuring

* 06-3421	Social Worker IV	SCRO	\$84,600		
* 06-3954	Data Processing Clerk I	NRO	\$56,600		
Total Saved - Vacant Positions (12 months Funding)			\$121,200	\$121,200	
* PCN3421 \$ @ Pre-Manage. Restruct & PCN3954 @ Post-Manage. Restruct					
both positions held vacant for 9 months savings, see below for 3 months costs					
TOTAL ADMINISTRATIVE SAVINGS				\$1,014,200	\$1,014,200

ADMINISTRATIVE POSITIONS COSTS**Three Reclassified Regional Administrator Positions**

* 06-3215	Regional Administrator	SCRO	\$82,600		
* 06-3218	Regional Administrator	NRO	\$85,600		
* 06-3482	Regional Administrator	SERO	\$82,600		
Total Cost - Regional Administrators			\$250,800	\$250,800	
*Costs Before Reclassification, (\$154.6) plus Reclassification Costs (\$94.4)					

Eleven Reclassified Positions

Reclassified Line to Administrative					
06-2243	Grants Administrator II	Central Office	(\$15,700)		
06-3871	Program Officer	Central Office	\$12,600		
06-3889	Program Officer	Central Office	\$10,800		
Total Line to Administrative			\$7,700		
Reclassified Administrative to Administrative					
06-3881	Program Officer	Central Office	\$21,300		
06-3900	Social Worker IV	Central Office	\$20,000		
06-3063	Accounting Clerk III	SCRO	\$1,900		
06-3114	Administrative Assistant III	SCRO	\$1,600		
06-3925	Analyst Programmer I	SCRO	\$7,900		
06-3617	Youth Center Superintendent II	NRO	\$0		
* 06-3863	Clerk Typist III	SCRO	\$14,300		
Total Administrative to Administrative			\$67,000		
*Part Time to Full Time					
Total Cost - Reclassified Administrative Positions			\$74,700	\$74,700	
TOTAL ADMINISTRATIVE COSTS				\$325,500	(\$325,500)

NET ADMINISTRATIVE SAVINGS**\$688,700**

NET ADMINISTRATIVE SAVINGS SPENT ON LINE POSITIONS AS FOLLOWS:

Page #2

LINE SUPERVISION POSITION COSTS

Reclassified Supervision to Supervision

PCN	Position Title	Component	Cost \$	Subtotal	TOTAL
06-3089	Social Worker V	NRO	\$5,200		
06-3085	Social Worker V	SCRO	(\$8,400)		
06-3878	Social Worker V	SCRO	\$0		
Total Supervision to Supervision			(\$3,200)	(\$3,200)	

Reclassified Line to Supervision

06-3076	Social Worker IV	SCRO	\$3,700		
06-3713	Social Worker IV	SCRO	\$0		
06-3573	Juvenile Probation Officer IV	SCRO	\$30,900		
06-3866	Juvenile Probation Officer IV	SCRO	\$11,100		
Total Line to Supervision			\$45,700	\$45,700	

Total Line Supervision Position Costs **\$42,500**

LINE POSITION COSTS

Reclassified Administrative to Line

06-3770	Social Worker IV	NRO	\$24,000		
* 06-3954	Social Worker IV	SCRO	\$14,200		
Total Administrative to Line			\$38,200	\$38,200	
* Position Held Vacant - Three Months Costs					

Reclassified Line to Line

06-3014	Social Worker V	NRO	\$5,800		
06-3357	Juvenile Probation Officer IV	SERO	\$3,800		
06-3201	Social Worker V	NRO	\$39,800		
06-3633	Juvenile Probation Officer IV	NRO	\$8,800		
06-3789	Social Worker III	SCRO	\$0		
* 06-3034	Social Worker III	SCRO	\$26,900		
* 06-3874	Juvenile Probation Officer IV	SERO	\$52,700		
Total Line to Line			\$137,800	\$137,800	
* Part Time to Full Time					

Total Line Position Costs **\$176,000**

LINE POSITION V&T (VACANCY & TURNOVER) COSTS

06-3014	Social Worker V	NRO	\$59,200		
06-3770	Social Worker IV	NRO	\$34,700		
06-3766	Social Worker III	NRO	\$51,600		
06-3034	Social Worker III	SCRO	\$24,800		
06-3789	Social Worker III	SCRO	\$56,600		
06-3644	Juvenile Probation Officer III	SCRO	\$59,900		
06-3204	Social Worker III	SCRO	\$54,700		
06-3048	Social Worker III	SERO	\$49,800		
06-3065	Social Worker III	SERO	\$49,800		
06-3084	Social Services Associate I	SERO	\$13,800		
* 06-3421	Social Worker IV	SCRO	\$16,100		
Total V&T Costs			\$470,800	\$470,800	
* Position Held Vacant - Three Months Costs					

TOTAL LINE POSITION COSTS **\$689,300**

NET ADMINISTRATIVE SAVINGS LESS LINE POSITION COSTS DIFFERENCE **(\$800)**

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF FAMILY AND YOUTH SERVICES

WALTER J. HICKEL, GOVERNOR

P.O. BOX H-05
JUNEAU, ALASKA 99811-0630
PHONE: (907) 465-3170

MEMORANDUM

DATE: December 13, 1991

TO: Michael L. Price, Director
Division of Family & Youth Services

FROM: *fd* Fred E. Schmitz, Acting Accountant IV
Budget Section

SUBJECT: Management Restructuring Analysis

Per your request I have completed an analysis to determine the impact of the Management Restructuring as it relates to funding and positions. The following is the results of that analysis.

COST SAVING AS THE RESULT OF MANAGEMENT RESTRUCTURING

A total of eleven administrative positions were deleted resulting in a savings of \$893,000. Three existing positions were reclassified to administrative positions, costing an additional \$94,400. The net savings of \$798,600 was used to pay for reclassifying twenty nine line positions and fund six vacant line positions throughout the Division.

DFYS ADMINISTRATION				TOTAL
11 DELETED ADMINISTRATION POSITIONS COST SAVINGS				\$893,000
06-3123	RSSMIII	SCRO	(\$89,700)	
06-3124	RSSMII	NRO	(\$78,400)	
06-3017	RSSMI	NWRO	(\$92,700)	
06-3078	RSSMI	WRO	(\$89,600)	
06-3013	RSSMII	SERO	(\$71,100)	
06-3009	SSFA	CENTRAL OFFICE	(\$77,600)	
06-3701	SSFA	CENTRAL OFFICE	(\$80,200)	
06-3470	JPOV	PROBATION SVCS	(\$81,000)	
06-3602	JPOV	PROBATION SVCS	(\$88,400)	
06-3641	JPOV	PROBATION SVCS	(\$75,600)	
06-3487	SSFA	PROBATION SVCS	(\$80,700)	
TOTAL			(\$893,000)	
3 RECLASS REGIONAL ADMINISTRATOR POSITIONS - ADDITIONAL COST				(\$94,400)
06-3215	REGIONAL ADMINISTRATOR - SCRO		\$28,800	
06-3218	REGIONAL ADMINISTRATOR - NRO		\$24,900	
06-3482	REGIONAL ADMINISTRATOR - SERO		\$39,900	
TOTAL			\$94,400	
NET ADMINISTRATIVE SAVINGS AS THE RESULT OF REORGANIZATION				\$798,600
DFYS LINE STAFF				
29 RECLASSIFIED LINE STAFF POSITIONS				\$488,200
6 LINE STAFF POSITIONS				\$340,400
TOTAL			\$798,600	
TOTAL SAVINGS SPENT				(\$798,600)
DIFFERENCE				\$0

Prior to management restructuring, the Divisions FY92 vacancy and turnover (V&T) was at 6.9%. This V&T is the result of a \$2,204,000 authorization shortfall requiring that the Division leave approximately forty line positions vacant for entire year. \$440,000 of this authorization shortfall is due to IVE federal funds which will not be received. After management restructuring, the Divisions shortfall was reduced by \$340,400 resulting in a 5.8% V&T. This V&T requires that the Division only leave open thirty four line positions for entire year, a net savings of six line positions.

As mentioned above, twenty nine positions were reclassified. Below you will find listed each position reclassified as a result of management restructuring:

<u>PCN</u>	<u>Position Title</u>	<u>Location</u>
06-3666	Juvenile Probation Officer II	Kenai

Position was vacant since June of 1991 at the time of the reclassification and relocation. This position was reclassified to a Juvenile Probation Officer IV and relocated to Anchorage. Workload in Kenai did not support filling the position and thus the position was reclassified to provide line supervision of field positions.

06-3573	Youth Counselor II	Anchorage
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Position was vacant since August of 1991 at the time of the reclassification. This position remains in Anchorage and was reclassified to a Juvenile Probation Officer IV in order to create program audit capabilities.

06-3085	Social Worker IV	Anchorage
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Position was not vacant at the time of the reclassification. This position remains in Anchorage and was reclassified to a Social Worker V due to incumbent working out of job class.

06-3034	Social Worker III (Part Time)	Homer
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Position was not vacant when time status classification was changed to full time. The incumbent position remains in Homer and was changed to full time to reflect actual workload.

06-3713	Social Worker III	Anchorage
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Position was vacant since December of 1990 at the time of the reclassification. This position remains in Anchorage and was reclassified to a Social Worker IV in order to create program audit capabilities.

06-3954 Data Processing Clerk I Fairbanks

Position was vacant since December of 1991 at the time of the reclassification and transfer. This position was reclassified to a Social Worker IV and transferred to Anchorage in order to enhance line supervision.

06-3878 Social Worker IV Anchorage

Position was not vacant at the time of the reclassification. This position remains in Anchorage and was reclassified to a Social Worker V due to incumbent working out of job class.

06-3076 Social Worker III Anchorage

Position was vacant since June of 1991 at the time of the reclassification. This position remains in Anchorage and was reclassified to a Social Worker IV due to incumbent working out of job class and to enhance line supervision.

06-3063 Clerk IV Anchorage

Position was not vacant at the time of reclassification. This position remains in Anchorage and was reclassified to an Accounting Clerk III due to incumbent working out of job class.

06-3925 Clerk Typist III Anchorage

Position was not vacant at the time of reclassification. This position remains in Anchorage and was reclassified to an Analyst Programmer I due to incumbent working out of job class.

06-3863 Clerk Typist III (Part Time) Dillingham

Position was vacant since August of 1991 when changed to full time and transferred. This position was transferred to Anchorage in order to balance clerical work load between districts.

06-3114 Administrative Assistant II Anchorage

Position was not vacant at the time of reclassification. This position remains in Anchorage and was reclassified to an Administrative Assistant III in order to reflect duties to be assigned to incumbent following reorganization.

06-3789 Social Worker III Homer

Position was not vacant at the time of transfer. This position was transferred to Kenai in order to adjust workload between districts.

06-2243 Mental health Clinician III Juneau

Position was vacant since April of 1991 when transferred and reclassified. This position remains in Juneau and was transferred from the Division of Mental Health in FY91 and reclassified to a Grants Administrator II in order to reflect current job duties.

06-3881 Publication Specialist I Juneau

Position was vacant since June of 1991 at the time of reclassification. This position remains in Juneau and was reclassified to a Program Officer to oversee statewide programs for Youth Services.

06-3871 Social Worker III Anchorage

Position was vacant since October of 1990 at the time of transfer and reclassification. This position was transferred to Juneau and reclassified to a Program Officer to oversee statewide programs for Family Services.

06-3889 Social Worker IV Anchorage

Position was vacant since December of 1990 at the time of transfer and reclassification. This position was transferred to Juneau and reclassified to a Program Officer to oversee the newly created program audit unit statewide.

06-3900 Clerk Typist III Fairbanks

Position was vacant since September of 1991 at the time of transfer and reclassification. This position was transferred to Juneau and reclassified to Social Worker IV in order to serve as a public relations contact for public and media on child protective services issues.

06-3014 Social Worker IV Fairbanks

Position was vacant since November of 1990 at the time of reclassification. This position remains in Fairbanks and was reclassified to a Social Worker V to reflect current job duties.

06-3770 Clerk Typist III Fairbanks

Position was vacant since November of 1990 at the time of reclassification. This position remains in Fairbanks and was reclassified to a Social Worker IV in order to create program audit capabilities.

06-3089 Social Worker IV Nome

Position was not vacant at the time of reclassification. This position remains in Nome and was reclassified to a Social Worker V in order to supervise the Nome and Kotzebue districts.

06-3357 Social Worker IV

Juneau

Position was not vacant at the time of reclassification. This position remains in Juneau and was reclassified to a Juvenile Probation Officer IV in order to reflect reallocated work duties.

06-3874 Social Worker III (Part Time)

Ketchikan

Position was vacant since November of 1990 when changed to full time, transferred and reclassified. This position was transferred to Juneau and reclassified to a Juvenile Probation Officer IV in order to reflect reallocated work duties.

06-3201 Social Services Associate III

Bethel

Position was vacant since February of 1991 at the time of reclassification. This position remains in Bethel and was reclassified to a Social Worker V in order to bring job class in line with work duties.

06-3617 Youth Center Superintendent I

Fairbanks

Position remains in Fairbanks and was reclassified to a Youth Center Superintendent II. This reclassification was necessary to reflect reallocated work duties.

06-3633 Unit Leader

Fairbanks

Position remains in Fairbanks and was reclassified to a Juvenile Probation Officer IV. This reclassification was necessary to reflect reallocated work duties.

06-3215 Social Worker III

Anchorage

Position was vacant since November of 1990 at the time of the reclassification. This position remains in Anchorage and was reclassified to Regional Administrator. This reclassification was necessary to implement the management restructuring plan.

06-3218 Social Worker III

Fairbanks

Position was vacant since November of 1990 at the time of the reclassification. This position remains in Fairbanks and was reclassified to Regional Administrator. This reclassification was necessary to implement the management restructuring plan.

06-3482 Administrative Assistant I

Juneau

Position was vacant since June of 1991 at the time of the reclassification. This position remains in Juneau and was reclassified to Regional Administrator. This reclassification was necessary to implement the management restructuring plan.

As a side note it should be pointed out that bargaining unit affiliation changes also occurred. A net of seven General Government Unit members will become Supervisory Unit members.

If you need any further information or have questions feel free to contact me.

Alaska Foster Parent Training Center Training Summary Sheet

July 1, 1990 to June 30, 1991

Region	Geo. Location	Training Type	Homes Trained	People In Homes	Hours Trained	Training Type	Homes Trained	People In Homes	Hours Trained	Training Type	Homes Trained	People In Homes	Hours Trained
SouthCentral	Village	AFPTC Self-Study	1	2	4.00	AFPTC On-Site	17	34	626.00	Non-AFPTC	3	6	26.50
	Village Hub		5	10	52.00		4	7	90.00		13	25	112.50
	Service Cntr		15	29	73.00		35	69	1179.00		18	36	131.50
	Urban		41	70	352.00		31	51	634.50		64	110	732.50
Southeast	Village	AFPTC Self-Study	0	0	0.00	AFPTC On-Site	4	7	67.00	Non-AFPTC	0	0	0.00
	Village Hub		6	11	51.00		3	6	105.00		3	5	32.00
	Service Cntr		6	11	38.00		10	20	300.00		3	6	93.00
	Urban		6	9	46.00		7	12	126.00		18	29	166.00
Northern	Village	AFPTC Self-Study	0	0	0.00	AFPTC On-Site	5	9	126.00	Non-AFPTC	1	2	12.00
	Village Hub		8	14	76.00		5	9	135.00		6	11	200.50
	Service Cntr		0	0	0.00		1	1	21.00		1	2	30.00
	Urban		14	27	130.00		8	15	164.00		17	32	347.75
NorthWestern	Village	AFPTC Self-Study	0	0	0.00	AFPTC On-Site	4	8	147.00	Non-AFPTC	0	0	0.00
	Village Hub		0	0	0.00		1	2	21.00		0	0	0.00
	Service Cntr		1	2	21.00		1	1	15.00		0	0	0.00
	Urban		0	0	0.00		0	0	0.00		0	0	0.00
Western	Village	AFPTC Self-Study	1	1	4.00	AFPTC On-Site	11	18	222.00	Non-AFPTC	3	5	134.00
	Village Hub		0	0	0.00		0	0	0.00		0	0	0.00
	Service Cntr		1	1	5.00		2	3	36.00		1	1	15.00
	Urban		0	0	0.00		0	0	0.00		0	0	0.00
			105.00	167.00	854.00		149.00	272.00	4,014.50		151.00	270.00	2,033.25

Homes = All Homes Trained in that area

People In Homes = Number of people listed on license, but not necessarily trained

Hours Trained = Hours that a home has recorded for the fiscal year

Alaska Foster Parent Training Center Training Summary Sheet

July 1, 1990 to June 30, 1991

Region	Geo. Location	Total Homes In Database	Total People in Homes In Database	Total Homes Trained	Total People In Homes	Total Hours Trained	Total of Homes completed 15hrs in Fiscal Yr.
SouthCentral	Village	88	155	31	58	656.50	18
	Village Hub	106	194	25	47	254.50	9
	Service Cntr	261	472	86	164	1383.50	41
	Urban	464	771	117	196	1719.00	55
Southeast	Village	34	58	7	13	67.00	3
	Village Hub	64	107	19	34	188.00	5
	Service Cntr	152	246	35	63	431.00	11
	Urban	99	167	34	57	338.00	13
Northern	Village	40	68	11	20	138.00	5
	Village Hub	65	117	19	35	413.50	9
	Service Cntr	18	32	5	9	51.00	2
	Urban	120	203	39	71	641.75	16
NorthWestern	Village	47	86	22	41	147.00	4
	Village Hub	3	4	1	2	21.00	1
	Service Cntr	51	89	9	17	36.00	2
	Urban	0	0	0	0	0.00	0
Western	Village	97	171	22	34	360.00	11
	Village Hub	8	15	2	4	0.00	0
	Service Cntr	58	97	12	20	56.00	3
	Urban	0	0	0	0	0.00	0
		1,777.00	3,054.00	496.00	887.00	6,901.75	208.00

Total Homes In Database = Total number of licenses/homes in the current AFPTC database, with training and without training

Total People In Homes In Database = Total number of people listed on license in the current AFPTC database, with training and without training

A SPECIAL REPORT ON THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES

February 27, 1990

Audit Control Number

06-4351-90-S

Commissioner, Department of
Health and Social Services

Myra Munson

Deputy Commissioners, Department of
Health and Social Services

Karen Perdue
Eileen Lally

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
P.O. BOX W
JUNEAU, ALASKA 99811-3300

March 30, 1990

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska
Statutes, the attached report is submitted for your review.

A SPECIAL REPORT ON THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES

February 27, 1990

Audit Control Number

06-4351-90-S

The audit addresses a variety of programs, operations, selected practices and casework procedures of the Division of Family and Youth Services. The scope of the review was developed from a special request of the Legislative Budget and Audit Committee and from a subsequent memorandum from an individual Committee member.

The report reviews agency casework practices, foster parent licensing investigations, placement of youth in residential care facilities, contracting procedures, training, morale problems, operations and management of agency contractors, and an evaluation of an associated program: the Alaska Youth Initiative.

The audit was conducted in accordance with governmental performance auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section of this report.


Randy S. Welker, CPA
Legislative Auditor
Division of Legislative Audit

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with a Legislative Budget and Audit Committee special request and the provisions of Title 24 of the Alaska Statutes, a review was conducted of selected policies and practices of the Department of Health and Social Services, Division of Family and Youth Services (DFYS).

Objectives

The objective of the review was the critical examination of ten selected issues and concerns identified by the Committee. The selected items of concern involved a wide variety of operating programs and procedures administered by DFYS.

After fieldwork began, additional issues were added to the scope of the review in response to concerns raised by an individual Committee member. These additional issues involved management policies associated with the Juneau district office.

Due to the diverse nature of the issues for the special request, discussion of audit objectives can be found in the Audit Issues and Analysis and Juneau District Office sections of this report.

Scope and Methodology

Audit resources were focussed primarily on program activities of the two most recently completed calendar years (1988 and 1989). Where appropriate, such as in the case of evaluating contract procurement procedures, 1987 activities were also reviewed. The review excluded the activities of DFYS' Youth Services section, which is responsible for supervision and treatment of youth with criminal convictions.

Various management practices utilized by the Juneau district office were examined for the period beginning March 1989 to the present.

Fieldwork procedures utilized during the course of the audit included analytical review of a wide variety of materials:

1. Case files of children in state custody.
2. Curriculum and training evaluations for both social worker and foster parent training offered in FY 89 and FY 90.
3. Selected foster parent licensing and associated investigation files.

4. Documentation of residential care placement decisions.
5. Documentation in procurement files for selected professional services contracts, including program reporting documentation for DFYS subcontractors.
6. Audit reports prepared by other agencies, internal DFYS management reviews, and results of various foster parent surveys.
7. Alaska Statutes, currently proposed legislation, regulations pertaining to DFYS operations and the agency's child protective services manual.
8. Professional literature and newspaper articles relating to child protection and development issues.
9. Attorney General memorandums of advice related to child protection issues.
10. Closed Ombudsman investigations involving DFYS.
11. Selected correspondence and memorandums written by both DFYS and the agency's contractors.
12. A recent judicial decision involving child protection and adoption issues.

In addition to document review and analysis, interviews were conducted with foster parents, social workers, guardian ad litem, DFYS contract service providers, DFYS central office personnel, and administrators of other state programs. Fieldwork also included observing training provided to both foster parents and social workers.

ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services with responsibility for providing a range of services designed to remedy or prevent abuse, neglect and exploitation of children, youth, and adults. To meet these statutory responsibilities, the Department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the youth section of the Division of Corrections.

In addition to the agency's role in supervising adjudicated youth offenders, DFYS' range of responsibilities include a wide variety of activities classified as Family Services.

Family Services

The Family Services section of DFYS is organized into five regions: Southcentral with the Regional Office in Anchorage; Northern - Fairbanks; Western - Bethel; Southeastern - Juneau; and Northwestern - Nome. Each regional office is responsible for providing services through various field offices. Communities without a field office are served on an itinerant basis. In addition to child protection and welfare services, each regional office is responsible for the licensing of child and adult-caring facilities, the recruitment, selection and training of foster parents, as well as for the operation of an adoption program for that region.

Each region is administered by a Regional Social Services Manager (RSSM) stationed in the regional office. Each RSSM reports directly to the Social Services Field Administration (SSFA) in the agency's central Juneau office. The SSFA reports to the DFYS director. Program and budget information is available to all levels of field staff from the Central Office.

There are three central points to the philosophy underlying DFYS' provision of child protection services:

1. Children have the basic right to safety and normal development.
2. Children have the right to a permanent and safe home environment.
3. The most desirable plan of service to be implemented by the agency for a child in danger is to make the family home a safe environment.

In addressing these philosophical service goals, DFYS has established three service priorities:

1. First priority of the agency is to protect children (and adults as necessary) from further harm through informed intervention.
2. Second priority of the agency is to provide services which will prevent the removal of a child from his family. In many respects, this has been one of the more controversial aspects of DFYS operations. The agency makes every effort, some critics claim too extreme of an effort, to prevent removal of the child from their family; and failing that, reunifying the child with the family as soon as it is safely possible.
3. Third priority of the agency is to provide services which assure permanent placement for all children who are in DFYS custody. Permanency planning is a process which begins when the agency first comes into contact with the child and family.

Licensing of Out-of-Home Care Providers

When a child is taken into physical state custody they are placed either in foster care, or perhaps into an emergency shelter facility. In addition to emergency shelter providers, DFYS also contracts with residential care facilities to provide assorted levels of care and treatment of youth. Out-of-home placement providers, whether foster parents or institutions, are reimbursed on a daily rate which varies based on the level of supervision, custody, and treatment that they provide to the youth in custody.

Each provider is subject to licensure and review on an ongoing basis to assure that they are providing reasonable care in a clean and safe environment or facility. Complaints of abuse and neglect of children placed in out-of-home care are also the responsibility of staff DFYS social workers and licensing workers.

AUDIT ISSUES AND ANALYSIS

The audit primarily focuses on ten issues raised by the Legislative Budget and Audit Committee's special request. Subsequent to the start of fieldwork the scope of the review was expanded to include particular concerns involving DFYS' Juneau district office.

Issues 1 and 2: Case File Documentation.

Specifically, the Legislative Budget and Audit Committee's interest involved allegations that social workers were forging the signatures of natural parents and foster parents on various case file documents. In a related issue, concerns were raised regarding how social workers completed medical reports that characterized the condition of children taken into state custody.

In order to assess these concerns our audit analysis primarily focused on case plan reviews, the primary casework document that requires, to the extent possible, the signatures of both the natural and foster parents. Based on interviews with foster parents the alleged incidents of forgery took place in Anchorage; and, accordingly, audit review for forgeries was limited to files in that office. Although no indications of possible forgery were noted, the extensiveness of the review was limited by the incompleteness of the case files.

Twenty-four cases were reviewed. Only 10 of 24 files even included the required case review. Of those 10 only 3 had parental signatures that could be reviewed for possible forgery. Our experience was consistent with the file deficiencies identified in the numerous reviews cited in Recommendation No. 2 in the Findings and Recommendation section of this report. Due to the general disarray of file documentation, the review of medical reports involving alleged misstatements by social workers also limited any comprehensive review that could be done in a timely manner.

Issue 3: Training of social workers.

Committee concerns involved the use of federal funding for the training of social workers. DFYS has funded much of the new training effort by appropriately utilizing federal reimbursements available under the Title IV-E program. These funds have been used to implement a training program designed to establish a base level of competence in the provision of child welfare and child protection services. The agency's current training program is discussed further in the Prior Audit Recommendations section of this report.

Issue 4: DFYS contracting procedures.

DFYS procedures for evaluating proposals and awarding contracts were reviewed to determine if the agency complied with applicable legal and regulatory requirements when issuing professional service contracts.

Review of contracting practices did raise numerous concerns. Deficiencies and recommendations for improvements are discussed further in Recommendations No. 3 and No. 7 in the Findings and Recommendations section of this report.

Issue 5: Division statistics and Management Information.

Concerns regarding technical status definitions of youth when in state custody were reviewed. In addition, we reviewed, to a limited degree, the current status of the agency's management information system.

We have no findings in this area although the implementation of the agency's new Prober management information system is discussed in the Prior Audit Recommendations section of this report.

Issue 6: Retribution and blacklisting.

The review examined allegations that DFYS either retaliated or blacklisted selected foster parents who criticized the agency. DFYS foster parent licensing and investigation files were reviewed to determine the existence or practice on the part of the agency of "blacklisting" foster parents. Blacklisting is an imprecise term but for the purposes of this review it was defined as a situation whereby a licensed foster parent is selected for investigation on arbitrary or unreasonable grounds, investigated in an inconsistent manner, and are excluded from receiving placements without formal cause or notice despite no substantiated investigation findings.

Evidence reviewed in the course of the audit does not suggest that DFYS engages in arbitrarily suspending placements as a retaliatory measure against foster parents who criticize the agency. However, DFYS does occasionally place foster parents in an informal suspended status, whereby placements are put "on hold" without formal notification to the licensees. Our findings in this area are discussed further in Recommendation No. 5 in the Findings and Recommendation section of the report.

Issue 7: Alaska Foster Parents Association (AFPA).

We reviewed the current relationship between DFYS and AFPA. Although the relationship between AFPA and DFYS may be currently strained, the preliminary results of a foster

parent survey conducted by DFYS' training contractor indicates that there is a relatively high degree of cooperation and satisfaction between DFYS and "rank-and-file" foster parents. Our analysis and results of the foster parent survey are presented in the Prior Audit Recommendations section of this report.

Issue 8: Residential Care Placements.

Procedures used to assure that children in state custody are placed in the least restrictive setting were examined. Agency procedures for reviewing placements to residential care facilities were evaluated to determine their effectiveness in assuring that children are placed in the least restrictive setting and that the most cost effective placement is utilized. Our findings in this are discussed further in the Residential Placement section of this report.

Issue 9: Response to Past Audits.

The Legislative Budget and Audit Committee directed that the review determine the extent to which recommendations made in past audit reports have been implemented. DFYS has responded in part, if not completely, to all past audit recommendations. The current status of prior audit recommendations are discussed more extensively in the Prior Audit Recommendations section of this report.

Issue 10: Alaska Youth and Parent Foundation (AYPF).

A financial grant audit and a limited programmatic review of AYPF operations was conducted as part of the audit review. AYPF is an Anchorage private nonprofit organization that provides residential care services under contract to DFYS. Results of the review are discussed further in the Alaska Youth and Parent Foundation section of this report.

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JUNEAU DISTRICT OFFICE

In an expansion of the audit scope made subsequent to the beginning of fieldwork, audit staff was directed to address five specific questions regarding service delivery by the Juneau District Office. Comments below summarize the findings for each of the questions involved in the audit scope expansion.

1. How has the poor morale of the social work staff affected the service delivery of the Juneau office?

It is generally acknowledged that there is poor social worker morale in the Juneau district office. Recognizing that service delivery is hard to quantify, certain instances and trends were identified that may reflect poor morale or suggest that local Juneau social workers are not providing the communities they serve with adequate or fully effective social work services.

Use of sick leave and extensive absences. The use of sick leave by Juneau workers rose significantly during 1989 compared to 1988. Although this difference was in large part attributable to extended leave of absences by two workers, interviews with those individuals indicated that their extended absences were in part a reaction to the poor morale situation in the Juneau office.

Staffing of the Haines office. The regional social services manager (RSSM) believes that the potential case workload in the northern Lynn Canal communities of Haines and Skagway area is such to justify opening a one-person satellite office in Haines. In early 1989 a worker was transferred from DFYS' Seward office to open and staff the Haines office. However, due in part to a dispute regarding the transfer and storage of her personal goods and in part because of her attitude toward what she felt was intransigence on the part of the regional management, the relocation of that individual to Haines fell through.

Subsequently, the Haines position was filled by another social worker. The newly hired social worker resigned in October 1989, after only six months in the position. During her time in the position, agency statistics indicated that she carried a relatively small case load, made extensive use of leave, and was not provided adequate support and training by her supervisor. The supervisor repeatedly resisted directives from regional management to provide training and support for the Haines worker, and the antagonistic relationship between the supervisor and regional management contributed to the Haines office not receiving its full measure of services.

Some Juneau district office workers feel that the relatively minimal case load in Haines coupled with extended vacancies in local social worker positions, results in a misapplication of available social worker resources. The Haines staffing problems and the position's small case load contributed to the case load burden on Juneau workers. Workload management statistics substantiate this assertion, with the Haines-Skagway case load continually calculated as being little more than one-half of a standard case load.

Management should reevaluate the necessity for the Haines satellite office and consider if the region as a whole might not be better served by returning the Haines position back to Juneau. Service delivery, as necessary, could be provided on an itinerant basis, and the addition of the worker to the Juneau district office could shoulder a greater portion of the office's case load.

Recruitment of non-agency personnel to provide services. In the summer of 1989, a mother of 10 absconded with her children while they were in legal custody of the State, and was subsequently located in California. Regional management and the ongoing case supervisor disagreed on how the State should respond to the situation.

The regional manager decided that staff should be assigned to travel to California to retrieve the children, while the supervisor opposed this decision. The decision was reached during mid-week. It was determined that two staff members who were most knowledgeable about the case would travel the next week and escort the children back to the State. Staff members wanted to travel to California over the weekend to accomplish the tasks, even though regional management did not feel the weekend trip was necessary and would not authorize per diem reimbursement for the weekend days.

Although their support for their supervisor's position and disagreement with management's plan of action may have contributed to their decision, when informed that they would not receive per diem for the weekend travel days, staff involved refused to make the trip. When other staff also refused to go or were otherwise unavailable, a counselor at the Alaska Youth Village (a DFYS contractor) and a social worker from Sitka were finally recruited to make the trip. Essentially, the Juneau district office was reduced to asking non-office, and in the case of the counselor, non-state personnel to render services and carry out case decisions.

2. Can the current workload be handled by existing staff? Additionally, how have duty assignments and reassignments affected workload?

Our review of CMS monthly statistics indicates that even though the Juneau office workload as whole is reasonable, the office's load is not evenly distributed between workers. It's likely that certain workers who consistently carried a heavier case load than others each month, would perceive that the office as whole is understaffed although that perception is not supported by CMS statistics.

The schedule below was developed from CMS statistics, and shows how case loads are typically distributed among Juneau office social workers. Two factors contribute to this maldistribution of cases between social workers: (1) The continued commitment to staffing a Haines office despite small case loads and difficulties in effectively filling the position, and (2) lack of effective utilization by the former ongoing unit supervisor of CMS to more equitably distribute case loads between workers and analyze client service needs.

**CASELOAD DISTRIBUTION, BY HOURS
JUNEAU DISTRICT OFFICE**

	Social Worker 1	Social Worker 2	Social Worker 3	Social Worker 4	Social Worker 5	Social Worker 6	Social Worker 7	Social Worker 8	Social Worker 9	Social Worker 10	Haines Worker 11
January 1989	162.90	155.30	123.50	115.80	41.90	107.60	65.40	43.40	111.40	67.00	61.30
February 1989	147.40	145.50	122.00	120.90	5.70	96.50	77.80	60.30	102.50	59.10	55.10
March 1989	144.10	142.30	118.40	104.20	150.40	101.50	66.40	82.50	86.70	83.10	61.90
April 1989	106.40	102.30	92.20	97.70	143.60	96.30	108.20	115.40	85.40	87.00	70.30
May 1989	102.60	86.90	98.00	91.50	177.00	102.70	98.90	66.20	70.90	39.00	34.60
June 1989	119.40	91.70	109.30	129.00	143.90	108.90	124.90	113.30	10.30	83.90	76.00
July 1989	140.30	150.70	135.20	129.80	121.00	111.50	129.50	125.40	21.50	36.60	54.60
Six Month Total	923.10	874.70	798.60	788.90	783.50	725.00	669.10	606.50	488.70	455.70	413.80
Six Month Average	131.87	124.96	114.09	112.70	111.93	103.57	95.59	86.64	69.81	65.10	59.11
Indexed Workload	1.17	1.11	1.01	1.00	1.00	.92	.85	.77	.62	.58	.53

Standard Caseload in Hours = 112.47

**STATEWIDE CASELOAD/STAFFING COMPARISONS
JUNE 1989**

	<u>Workload in Hours</u>	<u>Time Available</u>	<u>Under or (Over) Staffing in Hours</u>	<u>June 89 Under or (Over) Staffing in FTEs *</u>	<u>Jan-June 89 Under or (Over) Staffing in FTEs *</u>
<u>Southcentral Region</u>					
Anchorage Total	5,614	5,571	43	.38	18.59
Kodiak	164	225	(61)	(.54)	(.23)
Naknek	135	192	(57)	(.60)	(.19)
Dillingham	113	96	17	.18	.43
Homer	455	315	140	1.25	1.34
Kenai	862	450	412	3.67	3.16
Saint Paul	52	61	(9)	(.10)	.43
Valdez	32	96	(64)	(.66)	(.12)
Sand Point	162	96	66	.69	.58
Mat-su	668	562	106	.94	2.41
Copper Center	158	96	62	.64	.33
Cordova	128	96	32	.33	(.06)
Seward	153	96	57	.59	.67
Unalaska	175	96	79	.82	.69
McGrath	15	61	(46)	(.47)	(.13)
Eagle River	<u>362</u>	<u>337</u>	<u>25</u>	<u>.22</u>	<u>.93</u>
Regional Totals	<u>9,248</u>	<u>8,446</u>	<u>802</u>	<u>7.34</u>	<u>28.83</u>
<u>Western Region</u>					
Aniak	740	169	571	5.94	2.69
Bethel	1,637	1,036	601	5.34	4.93
Kwillingok	134	112	22	.22	.11
Mountain Village	<u>202</u>	<u>112</u>	<u>90</u>	<u>.93</u>	<u>1.08</u>
Regional Totals	<u>2,713</u>	<u>1,429</u>	<u>1,284</u>	<u>12.43</u>	<u>8.81</u>
<u>Southeast Region</u>					
Sitka	242	225	17	.16	.86
Petersburg	111	97	14	.15	.92
Wrangell	115	97	18	.19	.25
Ketchikan	836	787	49	.43	.23
Juneau	<u>986</u>	<u>1,012</u>	<u>(26)</u>	<u>(.23)</u>	<u>(.69)</u>
Regional Totals	<u>2,290</u>	<u>2,218</u>	<u>72</u>	<u>.70</u>	<u>1.57</u>
<u>Northwestern Region</u>					
Nome	516	434	82	.73	1.09
Kotzebue	<u>350</u>	<u>350</u>	<u>0</u>	<u>.00</u>	<u>.08</u>
Regional Totals	<u>866</u>	<u>784</u>	<u>82</u>	<u>.73</u>	<u>1.17</u>
<u>Northern Region</u>					
Minto	289	96	193	2.01	1.10
Nenana	155	193	(38)	(.40)	(.20)
Galena	198	192	5	.06	.02
Delta	469	385	84	.87	(.02)
Fort Yukon	82	96	(14)	(.14)	.26
Barrow	316	192	123	1.28	1.99
Fairbanks	<u>1,491</u>	<u>1,350</u>	<u>141</u>	<u>1.26</u>	<u>3.54</u>
Regional Totals	<u>3,000</u>	<u>2,504</u>	<u>496</u>	<u>4.94</u>	<u>6.69</u>
Statewide Totals	<u>18,117</u>	<u>15,381</u>	<u>2,736</u>	<u>26.14</u>	<u>47.07</u>

Juneau totals have been adjusted by auditors to correct data deficiencies and inconsistencies as discussed in Recommendation No. 4 of the report.

* FTEs = Full Time Equivalent Social Workers

Although the statistics fluctuate on a month-to-month basis, recent analysis of DFYS' Case load Management System (CMS) statistics generally indicates that the Juneau office is slightly understaffed to handle the workload. Relative to the rest of the State, Juneau's workload is not extreme given the office's resources. The schedule on the opposite page compares workloads for the various DFYS statewide offices for June 1989 and the six-month period of January 1989 - June 1989. As the schedule indicates, at that time the Juneau office was slightly overstaffed.

3. How effectively has CMS been implemented by DFYS? What level of training has been afforded staff in its implementation?

The effectiveness of CMS implementation in the Juneau district office is discussed extensively in Recommendation No. 4. In general, CMS has not been consistently used, nor completely understood by line staff or their supervisors. However, with the selection of two new supervisors, and a more committed approach, regional management has made organizational changes to promote more effective implementation.

The director of DFYS acknowledged that training funds were not available to provide extensive and consistent training in the use of CMS. To a large extent, training involved supervisors "comparing notes" at periodic supervisory staff meetings. The proximity of the Juneau district office to DFYS' central office also could have allowed local office supervisors, if they were so inclined, to consult with appropriate central office personnel to permit them to better understand and apply CMS.

4. How has management's demand for increased work documentation impacted service delivery?
5. What steps has DFYS taken to address concerns and problems highlighted in audits completed last March by OMB and Northwest Resources Associates?

Since they are inter-related the last two questions of the audit scope extension are addressed together. The reviews cited in question 5 pointed out, among other things, the consistent lack of required documentation in Juneau case files (see discussion in Recommendation No. 2). In response to those audit findings, management has made a concerted effort to improve case file documentation, even to the extent of suspending a social worker, due in part to poor case file documentation.

Documentation demands are increasing, although in large part the recent demands made of Juneau workers are not "increased

work documentation," but rather an attempt to encourage them to complete that which is required by established agency procedures. We have received reports that the medicaid eligibility documentation has become increasingly complex and burdensome for social workers. Having social workers complete such forms points to the urgent need, as identified repeatedly in internal agency reviews and the current DFYS budget request, for more clerical support for social workers.

Certainly, if social workers are filling out documents they are limiting the amount of direct service they can provide. As acknowledged in Recommendation No. 2, each piece of case file documentation should be evaluated to be certain that it is necessary and relevant.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

DFYS should support pending legislation to clarify the abuse/neglect status of newborn infants who test positive for controlled substances.

During the latter part of 1989, an infant less than a year old died in Fairbanks of a cocaine overdose. The child had been born addicted to cocaine and was known to DFYS authorities. Although the agency had obtained legal custody of the child, they were unable to obtain the necessary legal system approvals for physical custody. In the view of the court, the newborn's addiction to cocaine was not sufficient evidence in and of itself to demonstrate that the child was at risk of being abused or neglected to such an extent that physical custody was warranted.

The child remained in the care of the mother. In an attempt to quiet the disruptive child the mother allegedly resorted to inducing the infant to ingest cocaine. Apparently the attempt resulted in a lethal overdose. Had DFYS been able to take physical custody of the child the agency would have better served its mandate to protect children who are being abused or neglected.

In Anchorage, the judiciary has been more supportive of DFYS' approach and decisions regarding newborns who test positive for narcotics. The agency has been able to obtain physical custody in instances it has felt it was necessary and as such has been able to afford better child protection. Likewise, subsequent to the death of the Fairbanks child, the legal system in that community has given DFYS more support.

The relevant issue remaining however is the degree of discretion that statutes should allow the court in such circumstances. Currently AS 47.17.070 defines child abuse or neglect as

the physical injury or neglect, sexual abuse, sexual exploitation, or maltreatment [Emphasis added.] of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate the child's health or welfare is harmed or threatened.

At the time of this report, SB 450 is pending action before the House of Representatives, specifically the House Health, Education, and Social Services Committee. The proposed legislation amends AS 47.17.070 by expanding the definition of maltreatment of infants. In part the legislation proposes maltreatment be further defined as "conduct that

results in a controlled substance . . . being found in a newborn child's blood or urine"

We concur with DFYS' support of this legislation clarifying the agency's child protection responsibilities for newborn infants. According to an internal DFYS report the number of newborns in the Anchorage area that test positive for controlled substances is alarming. Although the two largest jurisdictions in the State appear to be acting consistently in supporting DFYS for the present, such statutory language serves to promote continued consistency on the part of the judiciary in allowing DFYS to better protect children.

Recommendation No. 2

DFYS must take steps to improve the documentation of social worker case files.

The organization and documentation of many DFYS case files is inadequate. During 1989 four reports or reviews were either issued or completed by a variety of sources that repeatedly cited incomplete casework files. The various reports and reviews identified the following documentation problems:

Northwest Resources Associates (NWRA). In March 1989 NWRA reported on a case file review conducted under a contract with DFYS. NWRA reported deficiencies in the Juneau district office case files such as:

1. Lack of documentation necessary to demonstrate compliance with the provisions of the Indian Child Welfare Act (ICWA).
2. Lack of critical documentation and inconsistent format of files.
3. Social worker contacts and service provision that were inconsistent with the case's documented plan.
4. Inconsistent use of several DFYS forms. A large number of forms that were used were incomplete and not signed or dated by DFYS staff.

HIGH RISK UNIT MOVING FOR CUSTODY OF ADDICTED NEWBORNS

Prior to August 1989, rather than moving for legal custody immediately when there were signs of controlled substances in a newborn's blood or urine, DFYS was assessing each case separately. After August 1989 these children were identified as "uniquely vulnerable," and the agency began seeking custody immediately.

For FY 90 DFYS received funding for a newly created High Risk Unit for the Anchorage area. Among other duties, this unit concentrated on identifying and treating infants born testing positive for controlled substances. There is an alarming need for such a unit. According to DFYS records, there were 23 cases of "cocaine babies" reported in the Anchorage area alone, over the last four months of 1989. As of mid-January 1990, the High Risk Unit had 65 cases of cocaine-addicted infants in their caseload.

Regional DFYS agency personnel report that the substance abuse reporting requirement is necessary to effectively identify, isolate, and address this increasing problem. Reportedly, one doctor was sued by the parents after reporting a cocaine-addicted infant to DFYS. Since currently there is no clear statutory duty for the doctors to report, they are subject to claims that such reports are a violation of patient confidentiality.

U.S. Department of Health and Human Services (USHHS) review. An April 1989 report issued by USHHS, stated that documentation in 55 of 150 case files reviewed did not meet federal program standards. Because the error rate exceeded 20%, the State was found ineligible to receive FY 88 Title IV-B funds. DFYS was advised that USHHS wished to recover more than \$160,000 in federal funds from the State due to the degree of noncompliance.

The largest areas of noncompliance involved the lack of case plans and evidence of documented periodic case review. The report also noted that it is difficult for the agency to identify all children who have been in foster care for more than six months by using DFYS' current management information system.

OMB management review. The Governor's Office of Management and Budget (OMB) issued a management review of DFYS' Southeast Region Out-of-Home Care program in March 1989. The report stated that accurate and complete case files were not being consistently maintained. OMB cited the lack of consistent use of standard forms, inconsistent structure of files, missing or undated report of contacts, lack of documented supervision, and inconsistent development of case plans.

Specifically, the report stated that less than half of the 147 cases examined contained a six-month case review as required. Only 93 of the 147 files contained required placement reviews. Statutorily required annual court reviews were present in only 78% of the cases.

Internal review. Between May 15 and June 15, 1989 DFYS' Juneau district office hired, on a temporary basis, an experienced social worker to conduct an internal review of worker case files. Utilizing a checklist, the individual reviewed various files and, in general, noted many of the same deficiencies identified in the NWRA and OMB reports.

Consequences of Deficient Documentation

The lack of adequate case file documentation, besides putting federal funding in jeopardy, increases the chance for social worker error and potentially leaves children at risk. Consistent file organization is critical to the effective implementation of the agency's recently developed Case Load Management System (CMS).

An integral part of CMS is the accurate completion of the Risk Assessment Tool (RAT) (See illustration on next page for illustration of RAT and how it is used) for children who are taken into state custody. For recidivist children, completion of the RAT requires ready access to the child's previous case file. Disorganized or incomplete files lead

Risk Assessment Tool (RAT) Used to Determine Service Levels and Measure Caseloads

Risk Assessment Factors used in evaluating referrals have been developed based on results of research conducted in Alaska. The 12 factors used for abuse and the 9 factors used for neglect correlate with how much "risk" a particular child faces. For example, factor A7 addresses the relationship between alcohol/drug abuse on the part of parents or "caretakers" and risk to the child. In the example, social worker Jones has made an assessment that the child's father abuses alcohol, but the mother does not. Accordingly, the risk has been given a value of one.

Date: 4/12/88
Case Number: 123456

Worker: Mary Jones
Case Name: Miller

RISK ASSESSMENT		NEGLECT	
	Score		Score
A1 Number of prior records of abuse: None One Two Three or more	1	N1 Number of prior referrals for neglect: None One or two Three or more	0
A2 Number of prior placements outside of family residence: None One Two Three or more	0	N2 Number of prior placements outside of family residence: None One or two Three or more	0
A3 Number of abuse/neglect types noted in current referral: None One Two or three Four or more	0	N3 Either caretaker neglected as a child: No Yes	2
A4 Number of adults in home (18 yrs or age or older): One Two or three Four or more	2	N4 Single caretaker home at time of referral: No Yes	0
A5 Number of children in home (18 yrs or age or older): One Two or three Four or more	0	N5 Caretakers' history of drug/alcohol abuse: None One or both caretakers are abusers	3
A6 Either caretaker abused as a child: No Yes	2	N6 Age of youngest caretaker at time of referral: 26 or older 25 or younger	0
A7 Caretakers' history of drug/alcohol abuse: None One caretaker Both caretakers	1	N7 Number of children in home: Two or less Three or four Five or more	0
A8 One or both caretakers previously convicted of a criminal act: No Yes	0	N8 Caretakers primarily involved in negative social relationships: No Yes	2
A9 Caretakers primarily involved in negative social relationships: No Yes	2	N9 Motivation for change demonstrated by perpetrator(s): Not applicable Motivated & realistic Motivated, not realistic Unmotivated	2
A10 Caretakers' history of depression: None Significant, long-term episodes by either caretaker (episode(s) induces a suicide attempt by either caretaker)	0	TOTAL NEGLECT RISK SCORE	
A11 Cooperation with agency demonstrated by perpetrator(s): Risk applicable Cooperative Uncooperative Hostile / Threatening	1	GENERAL INSTRUCTIONS 1) Complete both risk scales (abuse & neglect) on the family during the intake process for all intakes. 2) Calculate the total score for each scale. 3) Assign the family's service level based on the highest score in either scale; use the following chart:	
A12 View of abuse by non-perpetrator(s) / caretaker(s): Not applicable More serious than agency view Consistent with agency view Less serious than agency view	0		
TOTAL ABUSE RISK SCORE		9	

Social Worker Judgement. Although not intended to be used in place of social worker judgement, the RAT guides the social worker in evaluating the level of child protective services that should be provided. The agency's Child Protective Services manual instructs social worker Jones that when assessing factor A9 to judge "the degree to which the social relationships detracts from the strength of the family. An example would be a parent who has a substance abuse problem yet continues to socialize with others who use alcohol or drugs."

Risk of Abuse Scale
Risk of Neglect Scale
Service Level

06-9703 CPS 4/89

OVERIDES: Note: Override to High. Circle appropriate reason.
 1) Substantiated sex abuse.
 2) Child required medical treatment subsequent to abuse or neglect.
 3) At least one sibling is in DFYS placement.
 4) Suspicious death of sibling.
 5) Other: _____

Supervisor's Review/Approval: Sara Grant

FINAL ASSIGNMENT LEVEL: High

Date: 4/14/88

Service Level Contact Standards. Service levels are assigned for cases based on the highest score on either scale. The Miller case would be assigned a high service level because of the total of the neglect factors. Based on the service level assigned, DFYS has established minimum contact service standards for casework. If this high risk case was in a community served by a local DFYS office, the assigned social worker would be required to make 4 face-to-face contacts per month, 2 of which must be in the home. If the case was in a community served on an itinerant basis, the worker would be required to make 1 face-to-face contact and 5 phone calls per month. Lower risk cases require fewer social worker contacts.

Case Load Measures. Service levels and casework standards are used to measure each social worker's case load. For each service level and its associated casework standards, DFYS has estimated how many hours should be involved to provide the minimum amount of service to each case. For a high service level case, requiring 4 face-to-face monthly contacts and other services, 8.1 hours are allotted. In order to meet itinerant casework standards for the same case, DFYS allots 9.5 hours (for the 5 phone calls and 1 face-to-face monthly contact). The lower the service level assigned to a case, the less time is allotted to provide minimum services.

to inaccuracies in RAT and could contribute to a child receiving less service than their case may actually merit.

Compliance with the provisions of ICWA is difficult, but it must be done. Improved documentation is necessary to demonstrate compliance and keep the agency focused on the needs of the native child. In December 1989, the State completed extensive unsuccessful legal action over the adoption of a Tlingit child largely because DFYS did not appropriately follow ICWA requirements during the early stages of the child's case.

Besides these child protection concerns, lack of adequate case file documentation may be prohibiting the State from collecting additional federal funds. A May 1987 consultant report estimates that by taking a more aggressive approach toward identifying allowable federal reimbursement costs, DFYS could increase its federal claim by at least \$5,000,000 annually.

Although we are skeptical about the contractor's cost recovery estimate, federal reimbursement could be substantial. In order to increase federal reimbursement, the consultant states that DFYS must put in place a system to define activities that meet federal eligibility standards and provide adequate proof that costs associated with those activities also meet applicable standards. An implicit assumption of the consultant's analysis was that DFYS casework documentation would also meet the necessary federal requirements.

Response of Management

DFYS has taken steps to improve case file management and organization. Guidelines have been established that set out how case files should be setup and organized. Previously, file organization was largely left to the discretion of the individual social workers resulting in a variety of file organization schemes.

Case file documentation can be overemphasized. Completing the required paperwork should not be so onerous as to hinder the performance of good casework and child protection. Required forms and documents should be scrutinized on an ongoing basis to be sure that they are succinct, purposeful, and nonduplicative. However, the lack of documentation and the general disarray of DFYS' files has become so acute that it is jeopardizing federal funding participation, the State's ability to document its cases in court, the State's ability to comply with ICWA, and is hampering effective implementation of CMS.

Recommendation No. 3

DFYS should document the agency's rationale in instances where a professional service contract is not awarded to the highest rated responsive proposer.

In October 1988 DHSS' commissioner approved the awarding of the FY 89 (subsequently renewed through FY 90) foster parent training contract for \$280,000 (renewed at \$510,000), to Northwest Resource Associates (NWRA). The contract recipient was the second highest rated respondent to the professional services request for proposals (RFP).

After notifying DFYS that they intended to file a protest of the award, the highest rated proposer, Alaska Management Technologies (AMTECH) withdrew their appeal in a letter of October 24, 1988. In the letter AMTECH's president states that DFYS' previous director related that "three of the five Proposal Evaluation Committee members had indicated a preference for an award of the contract to NWRA." We do not know what documentation of that claim Director Chase may have shared with AMTECH but the review of the proposal scoring show the opposite to be true, that three evaluators gave AMTECH the higher scores.

NORTHWEST RESOURCE ASSOCIATES (NWRA) RECEIVES CONTRACT DESPITE COMING IN SECOND

NWRA's proposal to provide foster parent training received an evaluation score of 188.2 out of a possible 250 evaluation points. AMTECH was the highest rated respondent with a score of 225 (AMTECH's score included 25 extra points for being an in-state contractor). Even though AMTECH received a higher score, NWRA was awarded the contract because DFYS's director claimed that "three of the five Proposal Evaluation Committee members had indicated a preference for an award of the contract to NWRA." As discussed in Recommendation No. 3, DFYS procurement documentation did not support this assertion.

An analysis of the rating scores given by each evaluator indicates that AMTECH not only received the most points on an overall basis, but also were favored by a majority of the evaluation committee:

AMTECH Evaluators

Totals

MH	10	12	22	22	8	32	20	10	10	4	18	25	9	202
MK	9	14	23	23	8	35	20	10	10	4	18	28	9	211
K	8	13	15	10	10	30	20	10	10	4	18	25	8	181
KS	10	11	22	25	5	25	20	10	10	2	20	20	10	190
DS	10	12	25	25	10	30	20	10	10	4	20	30	10	216

NWRA Evaluators

Totals

MH	9	15	25	22	9	32	17	7	6	4	20	25	5	196
MK	10	14	25	25	9	35	19	7	7	5	18	28	9	211
K	10	13	20	23	8	30	18	8	8	4	15	22	10	189
KS	10	11	22	25	5	30	18	6	6	2	20	15	8	178
DS	10	10	25	25	5	30	15	5	5	2	15	15	5	167

Evaluators giving AMTECH higher score (MH, KS, DS)..... 3

Evaluator giving NWRA higher score (K)..... 1

Evaluator giving both proposals same score (MK)..... 1

AS 36.30.250 requires that for such competitive solicitations the contract should be awarded to the respondent "whose proposal is determined in writing to be the most advantageous to the State taking into consideration the price and the evaluation factors set out in the request for proposals." In the view of the auditors, by virtue of receiving the highest total score and the higher score from a majority of the evaluation committee, AMTECH's proposal best addressed the criteria factors listed in the original RFP.

In her letter of notice to AMTECH, the director stated that NWRA's proposal "clearly demonstrates the best understanding of the programmatic needs of the Division and the implementation strategies that are needed to meet those needs." If this was the case, it would indicate that the RFP evaluative criteria either did not adequately include or appropriately weigh the agency's programmatic needs and implementation strategies.

AMTECH was passed over for award of the contract due to misgivings that DFYS staff, particularly evaluation committee members, had with the performance of the firm under the previous contract. The president of AMTECH confirmed that the former DFYS director contacted him and spoke about the agency's concerns. He was unable to respond to the agency's requests for personnel changes and, accordingly, accepted their decision to award the contract to NWRA.

Apparently, the RFP criteria was not structured in such a way that these misgivings or criticisms could be reflected in the scoring of the proposals. From the documented record, it is unclear why DFYS recommended award of the contract to NWRA. The reason alluded to in the letter to AMTECH is not supported by any documented justification. Scores based on the criteria set out in the RFP favor award to AMTECH. DFYS' award to NWRA in the face of the evaluation results should have been better documented to satisfy professional service contracting statutory and regulatory requirements.

Recommendation No. 4

The Juneau district office Case Load Management System (CMS) summary reports should be accurately completed and summarized in order to enhance their usefulness to DFYS management.

Beginning in 1988, DFYS implemented a system for weighting and tracking social worker case loads. Cases are assigned a

value based on identified risk factors associated with the child involved. Depending on the risk level assigned, certain fieldwork standards are required to be met. Based on these standards CMS sets the number of hours that are estimated to be involved in servicing the case. The risk assessment document used in setting service levels is illustrated and annotated on page 18.

Each month every social worker fills out a ledger listing their cases, associated risk levels, and the CMS established hours involved in servicing each case. Hours are totaled for each worker and are indexed based on the standard workload per month of 112.47 hours. If a worker's index exceeds 1.25, the supervisor is required to review the cases on the ledger for possible ways of reducing the workload. There are three methods that supervisors can use to reduce workloads: (1) reevaluate risk levels assigned to cases and identify which cases may be able to be assigned a lower risk, (2) determine if some low-risk cases can be closed, and (3) reassign cases to other workers.

In the Juneau district office, CMS documentation is incomplete, inaccurate, and inconsistent. Many monthly worker ledgers and aggregate reports are missing or were never completed. Summary reports and social worker ledgers consistently contain mathematical errors. Social workers completed their ledgers differently, some recording activity that others did not. The ledgers and reports were not filed consistently in one place.

When CMS was first implemented, social workers were assured that they would not be required to complete the monthly worker ledgers. This was to be the responsibility of their immediate supervisor. To date in the Juneau office, this has been the responsibility of each social worker, which in turn has resulted to widespread inconsistencies between the various case load ledgers.

Also hampering the effective implementation of CMS has been the resistance of the former ongoing unit supervisor. Numerous meetings were held between the regional manager, the supervisor, and his union representative concerning application of CMS requirements. The supervisor has expressed to us that he believes that the CMS has limited value to actual casework, and he does not believe it accurately reflects service delivery time and effort.

Presumably, CMS was designed to provide an objective, systematic method of measuring and evaluating a social worker's case load. Completion of aggregate reports are necessary for supervisors to develop a full view of the nature and extent of their social worker's case loads. On a

regional level, RSSMs and regional staff managers need accurate aggregate case load information to make allocative decisions concerning positions within the region. At present, because of the deficiencies in application of CMS in the Juneau district office, social workers view completing their CMS forms as an empty exercise, which serves only to create another piece of paper to deal with that offers them no tangible benefit.

Recommendation No. 5

DFYS should develop and implement procedures to formally notify foster parents who are placed in an "on hold" or suspended status.

From the 95 files reviewed (selected on the basis discussed below at right) 40 had associated investigations or an inconsistent foster child placement history. In 4 of these 40 cases there was evidence that:

1. DFYS licensing staff had advised that placements be suspended or placed "on hold" with no documented notification to the foster parents themselves or.
2. Licensees received no placements for an inordinate period even after investigative results were indeterminate or unsubstantiated.

In three of the four instances, the investigations did appear to have been started in response to legitimate reported incidents involving foster children. However, no subsequent foster care placements were made for extended periods after inconclusive investigations had been completed. In only one of the four situations did it appear that placements were arbitrarily suspended with no formal notice to the licensee.

Examples of Informal Sanctions

In a case involving a Matanuska Valley foster parent license, a complaint dated March 11, 1986 was filed with DFYS. The agency issued a letter of finding dated April 7, 1986

HOW FOSTER PARENTS WERE SELECTED FOR "BLACKLIST" REVIEW

The licensing files and associated investigation files involving 95 foster parents were reviewed for evidence of retribution or possible blacklisting by DFYS. Foster parents' files were selected for review based on the following criteria:

1. The foster parent was recorded as either attending or testifying at legislative hearings involving child protection issues.
2. The foster parent was a leading member of the State's foster parent association.
3. The foster parent had filed a grievance with DFYS.
4. The foster parent's license status was part of an internal review conducted by DFYS's field administrator.
5. The foster parent had otherwise been identified to us as having been a victim of

stating that the complaint was unsubstantiated.

However, no children were placed with the investigated foster parents from April through September 1986 when their license expired.

Under a renewed license, a May 1989 complaint was received regarding the same foster parent home. A DFYS investigation found the complaint to be unsupported. Although the license was renewed on May 26, 1989 no placements had been made as of late November 1989.

Another noted instance involved a Fairbanks foster parent listed in legislative committee minutes as testifying or attending a hearing regarding DFYS. The licensee's file contained no formal complaints, but a DFYS licensing worker noted after a visit that she "just did not feel that these people are up to providing the care the kids need." No documented notice was made to the licensee that the visit by the licensing worker was anything but routine, but there have been no placements with the foster parent since June 1989.

Communication of Status is Important

While individuals are being investigated, DFYS licensing workers oftentimes do not communicate to foster parents the status of their investigation. While an investigation is being conducted, placements are generally suspended. A recent internal DFYS report recognized the need for more formal license notification procedures within the agency. A December 1987 internal review task force report identified a need for improving due process afforded foster parents by observing:

Currently there is a DFYS policy that, rather than suspending the license of a [foster care] provider for alleged violations, a "hold" is placed on making placements in that facility while an investigation is conducted. DFYS should develop a policy on holds, and these criteria should be made known to all parties. . . . the provider should be notified within 48 hours of the "hold" on placements in that facility.

LICENSING WORKERS HOLD PLACEMENTS EVEN AFTER INDETERMINATE INVESTIGATIONS

Licensing workers reported they often had mixed feelings about the results of their foster parent license investigations. Even when investigations resulted in an indeterminate or non substantiated finding, licensing workers continued an informal suspension of placements.

Licensing workers comment that even though their investigation resulted in no finding of cause, they could not in good faith endorse the placement of children in the homes. Often, the worker talks with the investigated foster parents and attempts to "counsel them out" of foster care. Failing that, the workers may continue to advise social workers to avoid placing children with the foster parents until the foster care license expires.

DFYS management is aware of, and supports, this approach. Director Webb commented to the auditors that qualifying for a foster parent license does not entitle the holder to receive placements. If a licensing worker has concerns regarding a foster parent's capabilities, even if the worker cannot substantiate or prove them, they have a professional responsibility to restrict placements in that home.

DFYS should proceed with this recommendation. Given the level of mistrust that exists between many foster parents and the division, DFYS should develop and follow formal foster care license review procedures and clearly communicate to the provider the status of their license whenever any sort of investigation or license review is being conducted by the agency.

Recommendation No. 6

The Southeast regional office should reevaluate personnel management practices in order to promote improved employee morale and enhance communication between employees.

Since March 1989 the Southeast regional office has taken a series of personnel actions that have contributed to a reduction in employee morale, appear to be capricious in nature, and has officiously limited social worker communications. The actions often interfere with effective service delivery and perpetuate previously identified personnel communication problems within the agency.

Promotions and Transfers

In May 1989, DFYS' Southeast regional supervisor (RSSM) decided to transfer a line social worker from the Juneau district office to the regional office. The position was to assist in permanency planning and compliance with federal case file requirements. Staff in the district office were given short notice of the transfer. No opportunity was provided the district office social workers to apply for the position. Rather, the social workers were informed that an individual had already been selected for the transferred position. When asked how the selection decision was made, workers were informed that the name had been randomly drawn "out of a hat."

Since the background and interest of the person selected had been in the area of permanency planning, the actual randomness of her selection challenged the RSSM's credibility. Line social workers felt both that they had not been given fair consideration for the position, and they would adversely be affected by the elimination of a position that carried part of the district office's case load. The transfer decision was grieved through the union agreement process and eventually the RSSM reversed her decision to transfer the position.

When the Social Worker IV staff position at the regional office became vacant a memorandum was circulated to line social workers (Social Worker III positions) encouraging the staff to be sure that they were on the appropriate personnel register and that their application was complete and up to date. Soon after the memorandum was circulated, the RSSM

decided to transfer the ongoing unit supervisor into the position, even though he opposed the transfer. Although subsequent hires were made from line staff to the two Social Worker IV supervisory positions in the Juneau district office, line social workers felt the actions of the RSSM contradicted her implicit promise to hire for the regional office position from their ranks.

Intradivisional communications

Since March 1989 directives have been issued by the Southeast regional staff manager prohibiting supervisors from communicating with DFYS central office or upper division management without permission. Recognizing the necessity and the prerogatives involved with a formalized chain of command, such directives appear to us to be unnecessarily confrontational, overly restrictive, and counter to recommendations previously made by a DFYS internal task force.

The aforementioned December 1987 internal review task force report stated:

In some locations, there is a history of closed communication connected to low worker morale and self-esteem. This may lead to workers "back-biting" and negatively assessing each others' workload and job performance. Lack of leadership and value orientation at all levels can engender suspicious and close-minded worker attitudes which lead to burnout and poor performance.

Although taken from the section of the report dealing with worker-to-worker communication, the report's concern over closed communications should be heeded. If DFYS' central office staff or upper management deems direct inquiries from line social workers inappropriate they can take the initiative to direct that comments be made through the chain of command. Emphatic directives denying direct access to upper management by regional management contributes to poor worker morale and promotes the sense that line workers must be circumspect and secretive in the communications within the agency.

Suspension of Social Worker

In early July 1989 the Southeast RSSM suspended a Juneau district social worker for three days. The basis for the suspension was developed from an internal review of social worker case files by a temporary hire Social Worker IV. Utilizing a document check list, the reviewer noted missing documentation required by the agency's child protective services manual and evaluated how certain cases were worked.

The RSSM and regional staff manager met with the social worker and his supervisor on May 31, 1989. According to the supervisor and the social worker their impression was that the issues and criticisms raised were resolved with a verbal reprimand and discussion. The supervisor felt that the meeting was the first of several that management was going to have with each social worker to discuss the findings of the internal review.

The social worker involved was given no indication that the meeting was to form the basis for suspending him. He was not afforded the opportunity to have his union representative present. Further, the supervisor and social worker both felt that the issues that prompted the conference were resolved within a few days after the meeting and no further action was to be taken. No communication occurred between either the RSSM or the staff manager and the social worker between May 31, 1989 until the July 5th letter of suspension. At that time, the supervisor had left on vacation further giving the appearance that the suspension had been timed to coincide with her absence.

Social workers must be held responsible for the condition of their case files and conduct of their cases. However, it does not appear to us that the concept of progressive discipline was applied in this instance and that the worker may not have been afforded appropriate due process.

We recognize that the Juneau district office has developed a reputation for resisting management change and not providing the type of service expected from line social workers. Its location in the Capital city gives the office a high degree of visibility. It is important, from both a service delivery and public relations point of view that DFYS make the district office operate in a most competent, professional manner possible. However, regional management should not become so focused on changing operations in such a manner as to adversely affect employee morale to such a degree that service delivery itself suffers.

Recommendation No. 7

DFYS should improve compliance with established contract procurement requirements related to professional service contracts.

Professional service contracting is required to be carried out in a very structured, well-documented manner. Requirements relating to professional service contracts are numerous and complicated and compliance requires a good understanding of statute, regulation, and the state administrative manual. Documentation of procedures,

necessary approval requirements, and reporting all vary depending on the nature of the procurement and the size of the anticipated contract award.

Since January 1987 DFYS has not consistently complied with the variety of requirements involved in professional service contracting. Twenty (20) procurements (11 informal solicitations, 5 sole source, and 4 competitive sealed proposals) were reviewed. From this review the following procurement deficiencies were noted:

1. Evaluation criteria not the same as listed in RFP. AS 36.30.250(a) prohibits the use of evaluation factors and criteria in the consideration of professional service proposals that were not included in the agency's original request for proposals (RFP).

When considering proposals for both the FY 89 - FY 90 homemaker services contract and a contract to study residential care rates, DFYS used evaluation criteria contained in a standard grant review form which differed from the criteria that had been listed in the respective RFPs.

2. Proposal cost element not assigned the appropriate value. For two of four competitive sealed procurements reviewed, the proposal with the lowest cost factor did not receive the highest number of evaluation points available for that factor as required by 2 AAC 12.260(d) of the Alaska Administrative Code.
3. Lack of clear and convincing evidence for sole source procurement. For FY 89 the Alaska Foster Parents Association (AFPA) was awarded a \$20,000 sole source contract for planning and implementing a foster parent training conference. Although AFPA may be qualified, DFYS did not present clear and convincing evidence that the organization was the only source for this service as required by AS 36.30.300(a).
4. Lack of required documentation for sole source awards. State regulations (2 AAC 12.420) require that for each sole source procurement, the agency must submit to GSS a procurement report form listing the contractor's name, amount of award, and service provided. DFYS did not complete or had not retained, the required procurement report for four of the five sole source solicitations reviewed.
5. Lack of documentation that at least three bidders/contractors were informally solicited. For three of the informal solicitations reviewed, there was no documentation in the procurement files that three firms or persons were contacted for proposals as required by state regulations [2 AAC 12.400(c)(1)].

In addition to the deficiencies listed above, we have concerns regarding the degree to which DFYS seeks to bargain with contractors receiving sole source contracts. For sole source procurements, AS 36.30.300(c) requires the procurement officer to "negotiate with the single supplier, to the extent practicable, to obtain a contract advantageous to the state." None of the five sole source procurements reviewed contained any documentation that indicated DFYS conducted any negotiations. Even if it was determined that negotiations were not practicable, the rationale for that assessment should be documented in the contract file.

We recommend that DFYS' contracting officer review the various types of professional services procurement methods along with the myriad of regulations, reporting and documentation requirements associated with each method. It is necessary to maintain well organized, sufficiently documented procurement files to support the numerous awards DFYS makes each year.

RATES AND PROGRAMS FOR OUT-OF-HOME PLACEMENTS

The schedule below provides the current daily rate that DFYS pays for different types of care and services. Rates for both foster and residential care vary from community to community based on cost of living differentials.

	Daily Reimbursement Rates	
	Minimum	Maximum
Family Foster Care	\$ 18.63	\$ 24.61
Specialized Foster Care	31.00	102.00
Group/Residential Facilities		
Day Treatment	23.45	56.25
Emergency Shelter	105.00	127.00
Residential Care- Level 1	95.00	127.50
Residential Care- Level 2	105.00	147.84
Residential Care- Level 3	185.00	185.00

Program Descriptions:

Family Foster Care - Most children in out-of-home placement are placed in family foster care. Foster care is suitable for a majority of children who cannot be placed with relatives but who can attend local schools and live in the community without danger to themselves or others.

Specialized Foster Care - Children formally assessed as having special needs; out-of-home placement in specialized foster care may be made. Foster parents are also screened and assessed to determine if they have the skills necessary to serve the child's special needs. Although it has been utilized on a limited basis by programs such as Alaska Youth Initiative, DFYS's program is still under development. The agency expects to have its program in place by July 1, 1990.

Day Treatment - Children in their own homes, relative care, or foster care may be placed in an intensive day program which offers structured rehabilitative activities. The goal of day treatment is to maintain children in a less restrictive setting rather than resorting to residential placement.

Emergency Shelter - In cases of emergency or for brief periods, children may be placed in emergency shelter residential facilities. Placements are designed to last until the child can be returned home or placed in a residential facility offering longer term care. Ideally, placements in an emergency shelter should not exceed 60 days.

Residential Care - Children with emotional problems which require ongoing counseling from on-site staff may be placed in a residential care facility. DFYS identifies and contracts for three different levels of residential care. Higher care levels reflect programs involving more supervision and treatment.

More specifically, the different levels of residential care are as follows:

Level 1 - Basic Care/Structured Supervision: requires planned, structured supervision by professionally trained staff for 24-hours a day.

Level 2 - Controlled Supervision: requires adult supervision to protect children or youth, others, or the community and/or maintain the treatment environment.

Level 3 - Staff Secure: constant control and adult supervision is required because the children or youth may be a danger to themselves and/or others as evidenced by suicide threats/attempts, homicidal threats/attempts, and chronic running away along with a combination of other treatment needs.

RESIDENTIAL PLACEMENT

As discussed in the Audit Issues and Analysis section of the report, the review evaluated procedures used by DFYS to assure that children in state custody are appropriately placed in the least restrictive setting. As discussed at right, DFYS has formally established procedures, with some regional differences, that subject each individual to special review prior to placement in a residential care facility.

These placement review procedures were evaluated to determine their effectiveness in making sure that children are placed in the least restrictive setting as required by state and federal law. Additionally, since more restrictive placements are also more expensive (as illustrated in the schedule and discussion on the opposite page) the State has further incentive to make sure children are placed appropriately.

Results of Review

Seventy-nine (79) residential placement care "staffings" conducted in DFYS' three major regional offices: Juneau, Anchorage, and Fairbanks were reviewed. The associated case files for each staffing were reviewed in order to assess if the placement committee critically reviewed each child's circumstances prior to approving or recommending placement in a residential facility and if the committee considered if the child could have successfully been placed in foster care.

In 58 of the cases reviewed (73%), staffing information indicated that the individual child had failed in at least one previous foster care placement. The remaining 21 cases dealt primarily with children who had previously been in one level of residential care, had failed, and now consideration was being given to transferring them to a more restrictive, treatment-oriented setting.

COMMITTEES SCREEN RESIDENTIAL PLACEMENTS

In each region of the State, DFYS utilizes residential placement committees (RPC) of social work professionals to evaluate proposed placements in residential care facilities. Before a social worker can begin arranging for placement of child in a specialized residential treatment setting, they must go before the committee in their region and justify their recommendation. In Juneau and Fairbanks, placement committees are made up entirely of DFYS personnel, while in Anchorage outside child care and development professionals also sit on the committee.

Another function of each region's RPC is to provide a forum for discussing the case history of the child, possible treatment options, and the availability of alternatives, such as specialized foster care. A second level review is provided by many of the residential care facilities, who also evaluate the appropriateness of the referral for their program. This is done because oftentimes there are waiting lists for the programs at the facility, or the child may not fit into the current treatment offered.

Moreover, of the 58 cases cited above, 39 had at least 2 reported failed foster home placements, and in 22 of these 39 cases the child had at least 4 failed foster home placements. Such statistics suggest that few, if any, of the children approved for placement in residential facilities would have succeeded in a foster home placement.

It was also observed that the residential placement committees, particularly in the Fairbanks region, functioned as designed. The committees actively "staffed" the case, and oftentimes recommended a less restrictive level of care than that originally recommended by the involved social worker. In Fairbanks, 19 cases involving specific recommended social worker placements were reviewed. Although the placement committee concurred with the recommended placement in 13 instances (68%), in the other 6 cases, the committee disagreed with the social worker and recommended foster home placement.

ALASKA YOUTH INITIATIVE

An analytical review of the Alaska Youth Initiative (AYI) March 1989 Status Report was conducted to assess the performance of this specialized treatment program. One aspect of this report of particular interest was the outcome's analysis. By identifying and objectively measuring certain client behavior, an individual's progress can be more objectively assessed and monitored (see discussion on the next page of "outcome measures").

AYI has been generally successful in providing effective, alternative treatment for youth with significant emotional problems. AYI is still a pilot program, with no formally established regulations. As a result, the program has the flexibility to more readily adjust treatment plans to respond to changing needs of the clients. The number of clients served are relatively limited, generally less than 50, ranging in ages from 7 to 20. At any one time, approximately a third of AYI clients are DFYS referrals.

Based on program indicators, as confirmed by our analytical review, DFYS referral clients have made progress in that they are better able to live in family-like, non-institutional environments in their local communities. The case files for 12 DYFS referred AYI clients were reviewed in late 1989 - early 1990.

From the audit review of either the completed AYI monitoring instrument or anecdotal information gathered from case files, our observations of the client's current status using AYI's rating scale were as follows:

1. Five of the clients' overall well-being was rated as either good or excellent (42%).
2. Four of the clients' overall well-being was rated as either fair or stable (33%).

AYI: DESIGNED FOR IN-STATE, INDIVIDUALIZED TREATMENT FOR TROUBLED YOUTH

The Alaska Youth Initiative (AYI) is a joint program of the Alaska Departments of Health and Social Services and Education. The program is designed to develop individualized services for the State's most troubled youth. Historically, most of these youth have been institutionalized outside of Alaska, often at great expense. AYI was designed as an alternative to outside placement, with program costs that range between one-third and one-half of those involved with outside placement.

Youth are referred to the program by school districts, DFYS, the Alaska Psychiatric Institute, and Community Mental Health Centers. All referrals to AYI are reviewed by an inter-departmental team made up of senior staff members from the participating agencies.

After acceptance into AYI, a process of individualized case planning and implementation begins. This involves the use of "dollars follow the child" funding and what is referred to as "wrap around services." This funding methodology is contrasted to group-type programs such as the Miller House or the McLaughlin Youth Center where dollars are expended on general programs for a group population rather than individualized services.

Under the group-type of funding, the historical way of serving youth is to admit them to a group program hoping that they will adapt to the program and have their needs met. If the youth does not fit the program he or she is referred to another program. This leads to the youth potentially experiencing multiple placement failures, often five or six per year. The AYI method of serving youth is to identify the needs of the youth, custom design a program to their needs, and modify the program rather than reject the child from the program if the needs of the youth change.

3. Three of the clients' overall well-being was rated as either marginal, poor, or in a crisis (25%). The individuals in this category were either in runaway status at the time of review, or were in youth detention facilities.

Performance Indicators

As discussed at right, AYI is in the process of developing a system to identify and measure the impact that the program's treatment approach is having on clients. On page 9 of Appendix A, AYI lists the preliminary results of the limited tracking system that has been piloted over the last three years.

The outcomes discussed in the status report, are based on information involving only AYI clients in the Fairbanks region. The information as reported is encouraging. According to the report, school attendance has increased significantly, alcohol/drug abuse/possession has been significantly reduced, and suicide attempts have been virtually eliminated.

Based on the review of AYI's data gathering system and information summary procedures, we conclude that the outcomes discussed in the status report does reflect improvement in the behavior of AYI clients.

AYI should continue to refine and expand their system for monitoring client outcomes. Such information is necessary for public policymakers to make effective and reasonable funding allocation decisions.

AYI USES PERFORMANCE INDICATORS TO MEASURE TREATMENT SUCCESS

Since 1986-1987, AYI has attempted to develop an objective way to identify and measure the behavior of individuals in their program. By developing objective measures of individuals' behavior, AYI can determine the effectiveness of their treatment approach.

To date, ten measures of behavior have been identified for use in evaluating treatment success:

1. Use or possession of alcohol/drugs
2. Running away
3. School attendance
4. Involvement with natural family
5. Assaultive Behavior
6. Incidence of property damage
7. Amount of time in a secured facility
8. Willingness to take prescribed medication
9. Incidence of police reports
10. Suicide attempts

The individual primarily responsible for the day-to-day supervision completes a daily data sheet recording the client's behavior for each of the ten performance indicators. For each youth, a yes/no response is entered daily for each of the performance indicators. Daily data sheets are summarized each month and the results are compared with previous months' data. Such comparisons provide one way to analyze the individual's progress, or lack of it, in treatment.

As discussed in the report, AYI has limited use of the process for recording, gathering, and analyzing to clients in the Fairbanks region. While this pilot project offers a viable way to monitor and assess AYI's program effectiveness, the labor-intensive aspect of processing the daily data sheets makes use of the process statewide problematical.

Pro-active Client Tracking

AYI maintains another system, used statewide, called pro-active client tracking, for monitoring how clients in the program are doing. Pro-active client tracking involves the use of a structured interview format, used by AYI staff to obtain information from "key informants." These key informants are people who interact with the youth on a regular, routine basis. Information obtained from these interviews are compiled into a monthly report that provides a "snapshot" of the youth's life at that time.

In assessing the progress of DFYS referrals to AYI for this report, performance indicator and/or the pro-active client tracking information was reviewed.

DFYS Support

Originally, AYI expected that each participating agency would dedicate equal funding and staff time for each individual referred to the program. However, AYI has not received the necessary level of commitment and support for DFYS referrals. On page 10 of the status report (Appendix A) AYI notes that "due to huge case loads, DFYS caseworkers are typically unable to devote significant time to the youth [in the program]."

AYI is experimenting with new treatment approaches that would not require an undue amount of DFYS caseworker time and attention. The status report further comments that this new approach has been working in the Fairbanks region and consideration is being given to using it statewide. AYI workers interviewed confirmed the historical difficulties with DFYS referrals. The Fairbanks AYI worker reports improvement in DFYS' referrals which he attributed to AYI's ability to demonstrate success using a treatment approach which requires a minimum amount of participation on the part of the DFYS social worker.

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ALASKA YOUTH AND PARENT FOUNDATION

The Alaska Youth and Parent Foundation (AYPF) is a private nonprofit organization in Anchorage that provides residential care services under contract to DFYS. The largest contract between AYPF and DFYS is for what is termed Level I, or emergency shelter beds. This level of service is designed to provide residential care and supervision for not more than 60 days for youths in state custody. AYPF complied with all financial reporting and expenditure requirements of the emergency shelter grant for the past two fiscal years.

The program portion of the review focused on AYPF's provision, and DFYS' utilization, of emergency shelter beds. These placement beds are not designed to provide treatment but rather are primarily used to provide relatively short-term safe shelter for youths in custody. Because AYPF provides counseling services under other aspects of their operations, they are able to offer a limited amount of treatment to DFYS' emergency shelter placements.

Use of Emergency Shelter

DFYS is often faced with a dilemma because it is often difficult to place particularly troubled or emotionally disturbed youth in the right type of treatment setting, or appropriate treatment is just not available. In such instances, social workers resort to using emergency shelter beds as a place to warehouse difficult youth.

AYPF, and other emergency shelter providers are required to notify DFYS if a youth is in placement for more than 60 days. Twenty-three case files were reviewed for youths placed at AYPF by DFYS. Of the 23 cases reviewed, 7 involved youths who were placed at AYPF for more than 60 days. In each case, AYPF acted appropriately by notifying DFYS when a resident reached their 60th day of stay. For these 7 cases, DFYS files indicated that little case planning had been done on the individuals' behalf, and the agency had made little active effort in working on the case.

All youths involved did present a difficult set of circumstances for DFYS social workers. Four of the seven cases had had numerous foster placement failures. One of the individuals was still in the shelter at the time of our review, two had run away from the shelter, two were discharged to the Job Corps training program, and the remaining two youths were subsequently placed in foster care.

All seven of the cases involved situations where the individual had been either abused by their natural parents, originally brought to the shelter by their foster or natural

parents, or were runaways with no family support network with which DFYS could develop a case plan aimed at reunification.

The circumstances of such cases, and the extended use of emergency shelter beds, suggest that DFYS needs to reexamine the nature and type of purchased residential care services in the Anchorage area. For a large number of cases, AYPF is being asked to provide services beyond what should be required from an emergency shelter contractor.

PRIOR AUDIT RECOMMENDATIONS

The Division of Legislative Audit's (DLA) last comprehensive audit report for the Division of Family and Youth Services (DFYS) was issued in August 1986. That report included four broad ranging recommendations (numbered 1, 2, 3, and 5) regarding the administration and operational family service programs within DFYS (a fourth recommendation pertained to only youth services). One of the objectives of this review was to examine and report on the current status of those prior audit recommendations.

Prior Audit Recommendation No. 1

The Division of Family and Youth Services (DFYS), in conjunction with the Legislature, should review statutes governing the agency's responsibilities and duties. The goals of such a review should be twofold:

- A. The determination of the extent of the State's role in child protection.
- B. Restructure DFYS' funding and statutes to better provide child protection services at the determined level.

DFYS social service offices are struggling to keep up with the reports of neglect and abuse of children and comply with related statutory investigation requirements. In attempts to meet the 72-hour statutory requirement for initial investigation of child abuse reports, ongoing case loads suffer. DFYS often must overlook the needs and care of children already in state custody in order to respond to new reports of abuse and neglect.

Statutes establish the limits of the State's responsibilities to intervene and protect children. Accordingly, the Legislature will have to play an active role in implementing statutory changes and/or increasing funding levels in order that the State's responsibilities for child protection are better aligned with the resources allocated for that purpose.

Auditor Comment on Recommendation

The prior audit recommendation reflected DLA concerns that the combination of the agency's statutory mandate and funding levels was putting DFYS in a position where in order to protect children at risk in the general population, it was not providing children already in custody with necessary services. The recommendation reflected audit concerns about inadequate permanency planning, shuffling of children between foster homes, and the provision of effective social work on an ongoing basis.

Current Status

Currently, there appears little prospect for reducing the demand for services from DFYS. Recent actions in this area all point to expanding the statutory role of the agency in child protective services. The proposed legislation discussed in Recommendation No. 1; continued concerns about how the State should respond to prospective mothers who expose the unborn children to Fetal Alcohol Syndrome; and the rapid legislative action addressing statutes pertaining to sexual contact between teachers and their students, all expand or would expand the scope of DFYS authority and responsibility.

Some staff social workers have expressed concerns regarding the need to more clearly define the role and responsibility of DFYS. Social worker comments reported in a recently completed internal management review of the Anchorage office reflect concerns over whether DFYS is a child protection agency or a child welfare agency. From comments in the report, some social workers appear to believe that the functions are, to some degree, incompatible. DFYS management response which we believe reflects widespread public sentiment is: the agency must be both.

In the areas of funding, the Legislature has provided the agency with additional resources. Since FY 87 the agency has added 26 new positions, 17 of which are front-line case carrying social workers (the balance made up of licensing workers and screening/compliance positions). Six of the new positions have been used to develop a special unit in Anchorage which specializes in children in "high-risk" situation. With the advent of these new workers, case loads have moderated, but as the schedule of page 12 indicates, the agencies statistics indicate that many areas of the State still are chronically understaffed.

The development and implementation of the risk-based Case Management System (CMS) (discussed elsewhere in the report) provides staff with a clearer sense of direction and priorities. Use of CMS provides staff with a more objective assessment about which cases should be worked first and which children are at greater risk of abuse and neglect. By doing so, management has provided often overworked social workers a sense of what cases should be given priority rather than setting them in a situation where all cases in an overwhelming case load are worked to a limited degree.

Prior Audit Recommendation No. 2

DFYS should develop a management information system to replace its current computerized payment system.

Auditor Comment on Recommendation

DFYS' management information system (MIS) has been a long standing DLA concern. DFYS has struggled for years not only to pay its numerous foster parents in a timely manner, but also to provide useful, accurate information on the children and families that the agency serves. Besides hampering long range planning for program and operations development, the lack of a reliable MIS also interfered with the day-to-day provision of services. Social workers often had to stop what they were doing to conduct hand tallies of various information from case files they were working on, in order to develop and report statistical information to management.

Current Status

DFYS has developed a new MIS to replace the computerized payment system presently being used. The new software system, called Prober, is a relational database program which will store 120 different types of information about each DFYS client. The system will be able to supply useful, accurate information to management about the children served by the State, and virtually eliminate the practice of labor-intensive hand tallies. At the time of this report, DFYS is installing the necessary hardware and software in each office, training social workers on how to use the system, and is entering client information in the data base.

The hardware consists of personal computers throughout the state and 150 megabyte hard-drive located in the Central Office in Juneau. As of March 26, 1990, 55 of the prospective 61 sites (90%) statewide have received the necessary hardware and software configuration. Sites without an active system generally lack a necessary part of the system. In particular, the need for dedicated phone lines has hampered full implementation. For example, four locations in the Southcentral Region still need to have phone lines installed.

Some "bugs" are still being worked out of the system's software, and the payment aspect of the system will not be operational until some time after July 1, 1990. Besides installation of the necessary hardware and software, the other two Prober implementation components are training and data entry.

The bulk of the Prober training was accomplished in November 1989 with the training of staff in Anchorage, Fairbanks, and Juneau. A cross section of regional office staff received this training. It is planned that these staff will serve as trainers for personnel in the outlying offices in the State. As of the date of this report, Dillingham, Naknek, Homer, and Unalaska are the only offices remaining to receive training. DFYS staff anticipates that training for these offices will be accomplished by April 20, 1990.

Data entry for information on new clients is being accomplished as they come onto DFYS' case load. Data entry for information on existing clients is being done as time permits. As of the date of this report some offices in the State (Fairbanks, Eagle River and Sitka) have completed data entry for all clients being served.

Recommendation No. 3

DFYS should develop standardized foster care procedures and encourage compliance through improved training and supervisory review. In addition, DFYS should continue working toward improved relations with foster parents in order to sustain a more viable foster care program.

Auditor Comment on Recommendation

Foster parents have historically been among the biggest critics of DFYS. The prior report included four particular continuing foster parent concerns that we recommended should be further addressed by DFYS:

1. Licensing investigation procedures (see Recommendation No. 5 in the Findings and Recommendation section of this report for discussion of DLA's current concerns).
2. Specialized foster care rates.
3. Foster parent training.
4. Oftentimes adversarial relationship between foster parents and DFYS.

Current Status

In 1989 Northwest Resource Associates (NWRA), DFYS' foster parent training contractor conducted a survey of foster parents statewide. Among the topics addressed in the survey was the relationship with DFYS. Just over a third of the responding foster parents said that getting help from a DFYS caseworker was a significant problem. Just less than a third reported "moderate" problems with DFYS while 30% responded with financial and reimbursement concerns.

More specifically, foster parents complained that social workers did not provide them enough information about the children placed with them. Foster parents we spoke to felt that social workers tended to treat them as glorified baby sitters rather than as an active participant in the planning and implementation of a treatment approach for the child in their care. The survey analysis bore this sentiment out, when it noted that "fully 63% [foster parents] expected to have at least moderate involvement in the case planning when they began [as foster parents]. However only 44% noted that moderate involvement in planning occurred."

Other survey response rates pertaining to the relationship between DFYS staff and foster parents were:

- 41% were dissatisfied with caseworker availability.
- 39% were dissatisfied with caseworker services provided to the children in their care.
- 44% were dissatisfied with foster parent support services.
- 30% were dissatisfied with local or regional foster parent associations.
- 26% were dissatisfied with payment amounts.
- 30% were dissatisfied with the timeliness of foster parent payments.

In NWRA analysis of these responses, with which we fully concur, was as follows:

Empirically, these dissatisfactions reflect the opinion of less than half the respondents and could be viewed as a majority being satisfied with caseworker services. Clinically, the number of foster parents expressing dissatisfaction with caseworker availability and services should be viewed as significant and serious. Dissatisfaction with professional services can be due to many reasons - some of which may be unfair or even inaccurate. However, this level of dissatisfaction is important regardless of the reasons. It should become the basis for further study to determine how it arises and how it can be reduced - either through improved service delivery, worker-foster parent communication, or evaluation of expectations.

Foster Parent Training

Under their contract with DFYS, NWRA established the Alaska Foster Parent Training Center in Fairbanks. Between March and November 1989, NWRA through the center, has provided 24 foster parent training sessions at 12 different sites in the State. More than 160 licensed foster parents attended the training, and although NWRA was disappointed by the turnout, evaluations of the sessions were generally very favorable.

Audit review of the training evaluation forms confirmed that the training had been well received by attending foster parents. In addition, NWRA was able to make curriculum materials available for audit review. In our view, the materials were well organized and relevant to the day-to-day problems of foster parenting.

Prior Audit Recommendation No. 5

DFYS should take steps to improve and increase training of social workers and personnel working youth detention facilities.

Auditor's Comment on Recommendation

The prior report observed that between FY 81 and FY 86, DFYS' training budget was reduced 80%, from \$500,000 to \$100,000. Previously, much of the larger training budget was afforded by the receipt of federal funds.

Current Status

DFYS has implemented an ambitious training effort utilizing in large part Federal Title IV-E funds. The new training program has been designed to establish a base level of competence in the provision of child welfare and child protection services. The program is based on a "core-curriculum" of entry-level training which has been recently endorsed by the Child Welfare League of America. The curriculum is designed to ensure a base level of knowledge of the concepts and theories underlying child protective services as well a specific information pertaining to service provisions in Alaska.

Use of such an entry level program provides a base curriculum which ensures that all staff are similarly grounded in theory and specific practice. It can also serve as the basis for a "certification" program for agency social workers, assist the agency in effectively handling the 25% turnover rate for social workers, and provides a firm base from which higher level training can be developed.

Social workers have generally responded favorably to the new training program. Training session evaluation forms give high marks to the materials, relevance of information, and presentation. The primary criticism reflected on the evaluation forms and from our interview with social workers is that the curriculum is too basic for their background. Some social workers also expressed an interest in receiving more "administrative" training in skills such as how and when to complete the myriad of forms required for casework documentation.

To date, DFYS' internal training effort has focused almost exclusively on the curriculum needs of social workers. It is our understanding that as the core-curriculum program becomes more established, the attention of DFYS' training personnel will turn toward the needs of youth detention staff.

APPENDIX

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THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

STATUS REPORT: THE ALASKA YOUTH INITIATIVE (AYI)

March, 1989

The original AYI concept paper included the following statement:

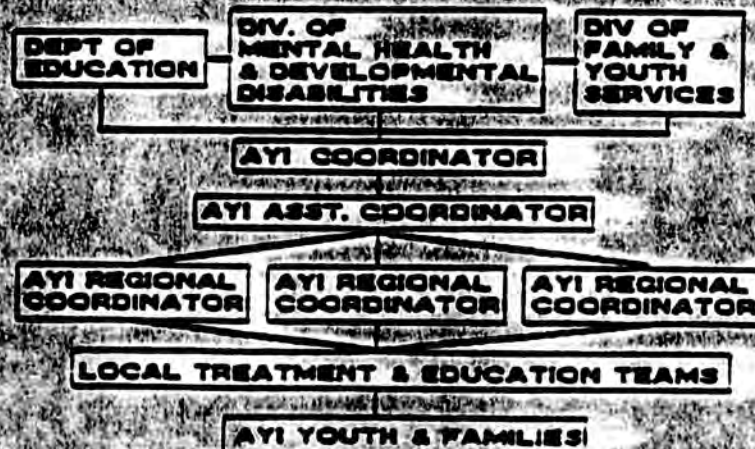
The Departments of Education (DOE) and of Health and Social Services created the Alaska Youth Initiative (AYI) to demonstrate that all State departments, school districts, and community human service organizations can work together to accomplish the following goals:

1. Limit further inappropriate institutional and out-of-state placements.
2. Transition back our youth who have been placed out-of-state.
3. Develop the necessary culturally appropriate in-state programs that will meet the needs of our most troubled youth.
4. Provide special individualized case planning, monitoring, program development and funding for youth and their families.
5. Eliminate confusion around client responsibility and funding for youth and their families.
6. Evaluate the strengths and gaps in the continuum of services within communities.

MANAGEMENT OF AYI

The AYI is managed by the Inter-Departmental Team (IDT), consisting of senior staff from the Department of Education, the Division of Mental Health and Developmental Disabilities, and the Division of Family and Youth Services. An AYI Coordinator and an Assistant Coordinator report to the IDT. There are three Regional Coordinators, one each in Anchorage, Juneau, and Fairbanks. These positions coordinate local treatment and education teams, which devise individualized service plans for each youth.

INTERDEPARTMENTAL TEAM



FUNDING OF AYI

Current funding of the AYI for FY 89 is as follows:

DOE: \$835,000.

DMHDD: \$603,000.*

DFYS: \$250,000 plus add-ons through residential and foster care.

Total: \$1,688,000 plus add-ons through residential and foster care. The total amount obligated is approximately \$2,000,000.

CHARACTERISTICS OF THE YOUTH IN THE AYI AS OF MARCH 1, 1989

1. Location

The 45 active AYI youth (seven youth are on inactive status) are located in the following general areas:

Anchorage/Mat-Su.	15
Kodiak.	2
Kenai	1
Northwestern Alaska	1
Western Alaska	
(Y-K Delta).	2
Fairbanks	11
Juneau.	9
Southeast Alaska	
(other than Juneau). . . .	4

2. Age

The average age of AYI youth is 15.8 years. The range is from seven to 20 years old.

3. Sex

55 percent of AYI youth are male; 45 percent are female.

Y

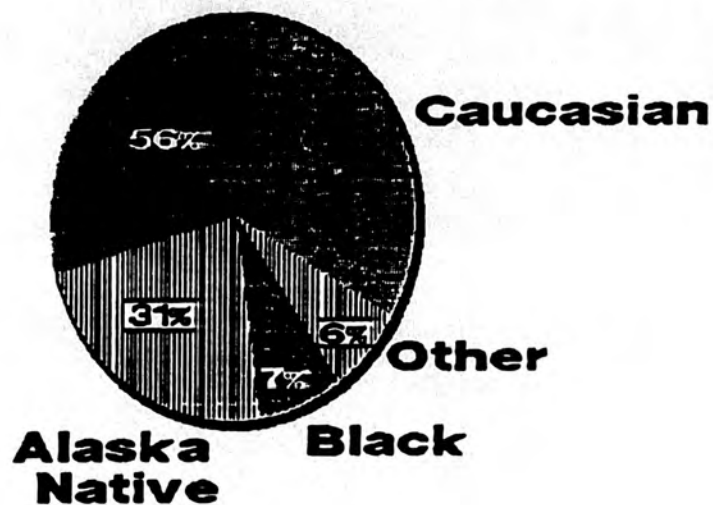
4. **Race**

56 percent are Caucasian.

31 percent are Alaska Native (Alaska Natives represent 14% of the State's population).

7 percent are Black.

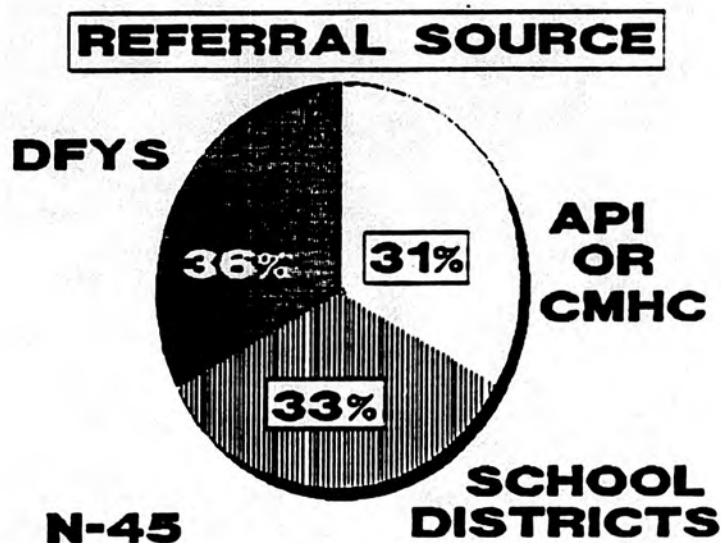
4 percent are other (Southeast Asian or Hispanic).

5. **Cost**

The current per child average yearly cost is \$40,562, which includes direct service/education costs and direct program administration costs. For AYI youth with two full years in AYI, the average second year costs are 24% less expensive than first year costs. The projected average third year costs for all youth with three full years in AYI is 36% less than first year costs.

6. Source of Referrals

Alaska Psychiatric Institute.	9%
Community Mental Health Centers	22%
Division of Family and Youth Services	36%
School Districts.	33%



7. DSM III-R Primary Diagnosis

100% of the youth meet the State definition of major mental illness for children and adolescents.

Breakdown by primary diagnosis:

Psychosis/Schizophrenia	40%
Behavior Disorder	31%
Borderline Personality Disorder	12%
Major Depressive Disorder	10%
Bi-Polar Disorder	6%
Other	1%

8. Functional Impairments of One Year or More

<u>Impairment *</u>	<u>Percentage of AYI Youth</u>
A. Self Care.	31%
B. Social Relationships (ability to establish satisfactory relationships with peers and adults).	91%
C. Self Direction (behavioral controls, decision making, judgement and value systems).	60%
D. Family Life (capacity to live in family or family-like environment).	60%
E. Learning Ability (ability to learn academic skills for other than behavioral reasons).	60%

* A youth may have more than one impairment.

9. Symptoms

<u>Symptom *</u>	<u>Percentage of AYI Youth</u>
A. Persistent psychotic symptoms of more than one year in duration.	46%
B. Suicidality: Attempt in past three months; significant ideation within past month.	24%
C. Violence: has caused injury to persons or significant damage to property.	44%
D. Severe depression or emotional trauma due to being a victim of abuse situation(s). 'Must have persisted for more than one year.	60%
E. Multiple severe physical disabilities and/or medical anomalies of more than one year in duration	13%

* A youth may have more than one symptom.

10. Interagency Cooperation

The average number of agencies represented on individual treatment/education teams is 4.3. The range is from three to seven agencies.

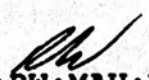
11. Custody/Non-Custody

42 percent of the youth are in the custody of Health and Social Services.

58 percent are in the custody of their parent(s) or themselves.

Mr. Randy S. Welker

- 27 -


MMM:RW:MAH:NK:mjh

WP/H:\ADM\LTR\#167.SSP/F#774

FYS#167

12. Living Arrangements

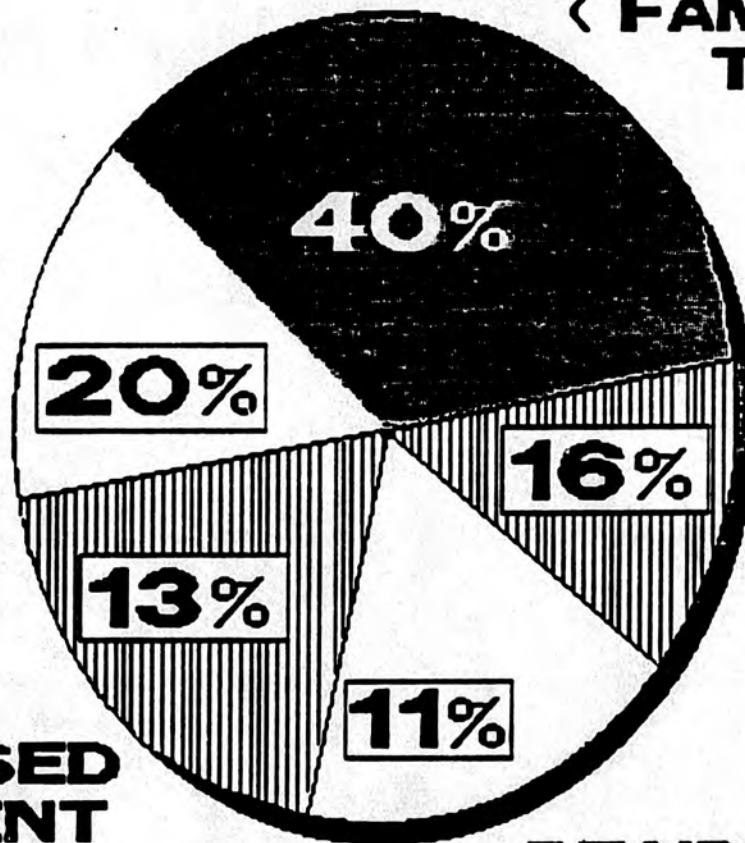
Percentage of AYI youth in home with family of origin (or adoptive)	20%
Percentage of AYI youth in staff secure teaching family homes	16%
Percentage of AYI youth in family treatment homes . . .	40%
Percentage of AYI youth in supervised apartment living	13%
Percentage of AYI youth in group residential care . . .	11%

N=45

**THERAPEUTIC
FOSTER CARE**

**(FAMILY
TREATMENT
HOMES)**

**IN
FAMILY
HOME**



**TEACHING
FAMILY
HOMES**

**SUPERVISED
APARTMENT**

**RESIDENTIAL
CARE**

13. History of Abuse

51 percent of AYI youth have been substantiated as being victims of sexual, emotional, or physical abuse.

14. Special Education Status

91 percent of AYI youth are classified as Special Education Students by their school districts.

15. Community Mental Health Center Involvement

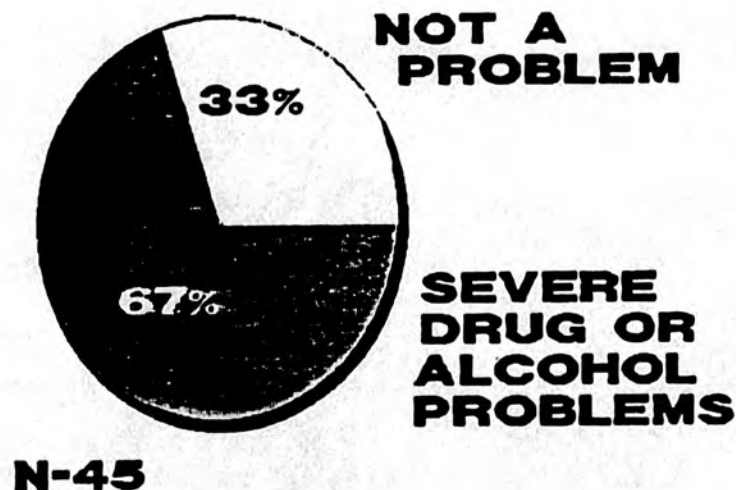
Local community mental health centers have had significant involvement in 73 percent of the treatment plans for AYI youth.

16. Living in Community of Origin

71 percent of AYI youth are being served in their community of origin.
27 percent of AYI youth are served in Alaska, but outside of their home communities.
2 percent are currently being served outside of Alaska.

17. Drug and Alcohol Abuse

67 percent of AYI youth have had substance abuse problems.



18. Characteristics of Family of Origin

50 percent were from two parent households.
50 percent were from one parent households.

19. Failed Placements Before AYI / After AYI

The average number of failed placements per youth who have been placed out of the family home prior to admission to AYI was 5.8. The average number of failed placements per youth after admission to AYI is .20 (unequal amounts of time compared). The range is from 38 failed placements to no failed placements.

20. Current Months in AYI

The current average length of participation in AYI is 11.8 months.
The longest length of participation as of March 1, 1989 was 31 months.

RESULTS FROM THE FIRST AND SECOND YEARS OF AYI

1. As of March 1, 1989, forty-nine AYI youth have been diverted from proposed out-of-Alaska placement or have been returned to Alaska. Two AYI youth have required placement in out-of-state care, one on a short term basis only.
2. Over 75 new jobs have been created for Alaskans as a result of this project. These jobs were formerly in other states.
3. Collaborative planning and shared funding of individual treatment and education plans continues for all 45 active AYI youth.
4. An unconditional care approach sticking with the youth "no matter what" has been working. The traumatic occurrence of failed placements has been stopped in almost every case.
5. Continuing performance indicator outcome evaluation shows that:
 - A. The amount of time the youth spend with their natural families or in family-like care as opposed to institutional care has been dramatically increased.
 - B. Alcohol and drug use/possession for AYI youth who have substance abuse problems has been significantly reduced.
 - C. The incidence of runaway episodes for AYI youth has been reduced by over 75 percent, based on occurrence of runaway incidents for six months prior to AYI involvement and for six months after AYI involvement.
 - D. School attendance by AYI youth has significantly increased as a result of AYI involvement.
 - E. Parental involvement with AYI youth has been greatly increased by involvement with AYI.
 - F. Assaultive behavior by AYI youth has been significantly reduced.
 - G. Property damage by AYI youth has been significantly reduced.
 - H. Voluntary medication compliance has been increased.
 - I. The incidence of contacts with police has been significantly reduced.
 - J. Suicide attempts have been almost eliminated as a result of AYI involvement.

PROGRESS ON PREVIOUS PROBLEMS WITH AYI: PROGRESS IS BEING MADE

The last status report identified several problem areas. In this section, each is listed with descriptions of progress made since the last status report in spring of 1988.

1. Problem:

"Procedures were developed for AYI that seem to work well for Education and Mental Health referrals. However, they do not seem as effective for clients referred through the Division of Family and Youth Services. Efforts are now underway to revise these procedures."

Progress:

Originally, AYI called for equal amounts of funds and local staff time from DMHDD, DFYS, and school districts. However, due to huge case loads, Family and Youth Services case workers are typically unable to devote significant time to the youth. In Fairbanks, Karl Brimmer, AYI Regional Coordinator, has been experimenting with new ways to work with DFYS around AYI/DFYS youth and has made significant progress. Karl has asked the local DFYS office to commit to initial treatment and education team involvement to configure a case plan which will reduce the DFYS workload for an AYI/DFYS youth to a level comparable to the workload requirements for a youth in out-of-state placement.

AYI is currently considering the application of Karl's model to AYI statewide. The current judgement of AYI staff is that this approach works and is a valuable process development. AYI will likely add a requirement that the worker/probation officer respond to a weekly telephone call about the youth.

2. Problem:

"The Inter-Departmental Team structure is being reexamined. Two levels of the IDT will be formed. One will be a general IDT focusing on more general systems issues. The other will be specific to AYI and will serve as an AYI screening team."

Progress:

The general IDT was not formed. Instead, a "Joint Efforts Team" consisting of the Deputy Commissioner of Health and Social Services, the Directors of both DFYS and DMHDD, and the Coordinator of Child and Adolescent Mental Health Services was formed to address more general systems issues. The IDT has been serving as an effective screening team for AYI.

3. Problem:

"It is clear that a greater focus on case management is needed during the initial stages of case planning, particularly when community agencies have not worked together extensively in the past. On several cases, the length of time to put a plan into action has been unacceptable."

Progress:

A much greater focus on individualized assistance (case management) has been instituted. Now, when needed, each new AYI youth gets an assigned individualized assistance coordinator (IAC). The overall length of time needed to put a plan into place has been greatly reduced, but is still unacceptably high. The Southeast Alaska AYI Coordinator has been effectively training and using undergraduate students as IACs.

4. Problem:

"In addition, the AYI was originally structured as a very small (5 to 10 youth) demonstration project. The need for the individualized services has been so great that the project had to be made larger. Unfortunately, due to budget limitations, AYI staff have not been added to match the increased workload. This must be rectified to ensure the quality of the program."

Progress:

Legislative approval was obtained to hire an assistant to the AYI Coordinator in Juneau. This individual came on staff by March 1, 1989. Regional AYI staff now in place in Anchorage, Fairbanks, and Juneau, have greatly increased the quality of AYI services. There is a need for an AYI Coordinator to serve the Nome/Bethel areas. Currently, program quality for children in these areas is suffering due to increased referrals and lack of designated staff.

ADDITIONAL AYI ISSUES AND SOLUTIONS

As expected in an evolving program, other pressing issues have come to the attention of the IDT and the AYI staff. These are as follows:

1. Criteria for Admittance into AYI

AYI has had the luxury of having more funds than appropriate referrals. Unfortunately, this is no longer the case, and all participating agencies are short on funds. More detailed criteria have been developed and are now being tested.

2. Lack of Regulatory Control

AYI needs to be "institutionalized" through state regulation. A draft set of regulations has been written and has been circulated to key policy makers in HSS.

3. Lack of Organized Client Review

The severe level of the disturbance of these youth dictates that care will be intensive and dynamic in nature. Although monthly summaries of care were prepared, youth's plans have not been tracked as closely as they should have been. Further, in part due to the very rapid expansion of AYI over the last 24 months, periodic assessment of overall progress towards goals has not been completed in a reliable and systematic manner.

4. Lack of Inter-Agency Agreement Around Youth

Careful analysis of what occurs when AYI youth do not do well points to an overall failure to obtain up-front and ongoing interagency and parent agreement on treatment and education plans. This last year, Jacqueline Rummel, AYI Coordinator for Southcentral Alaska, has been experimenting with use of core treatment and education teams for each AYI youth. The results and overall improvement in getting through crisis points have been remarkable for youth with these teams. Ms. Rummel's model has been adopted statewide and has greatly improved program quality.

5. Lack of Adequate Assessment of the Youth

Acceptance into the AYI can produce a significant positive life change for the youth and family but may involve the expenditure of large amounts of state funds over a number of years. For example, the total multi-year cost to the State for individualized treatment and education of a 13 year old youth suffering from severe mental illness can exceed \$400,000 if the youth stays in services through age 21. At this time, funds are available to serve a maximum of only fifty youth at a yearly per youth funding level of approximately \$40,000. Therefore, the review team faces a responsibility to do everything possible to ensure that only the most needy youth get into the program.

However, traditional diagnostic information is not always helpful in obtaining a comprehensive, ecological assessment of the youth. AYI has drafted an environmental assessment instrument that is currently being tested. This assessment involves direct interviews in the natural environment of the youth with persons knowledgeable about the youth's strengths and needs. Completion of the environmental

assessment typically involves a three day process. This on-site assessment is expensive and labor intensive to administer, especially considering the vast distances and high travel costs in Alaska. However, it is a necessary step to obtain the best possible information about the needs of the referred youth. The instrument will be carefully developed and tested over the next 12 months. The instrument was developed by Dr. Chuck Lester of Alaska Pacific University.

6. Lack of Reliable and Valid Client Outcome Data

Like any large scale restructuring, AYI has been difficult to implement. All too often, restructuring of this type gets bogged down in red tape and controversy around administrative issues, and client outcomes are not even mentioned. However, improving client outcomes is why AYI exists. AYI decided to focus on producing accurate client outcome data as a way to demonstrate that the restructuring was in fact working in spite of the anticipated administrative problems.

In 1986 and 1987, a system of measuring client outcomes was tested. After satisfactory testing of the system, efforts were made to make the outcome data as scientifically reliable and socially valid as possible. In collaboration with the University of Alaska Anchorage Mental Health Services Training Center, an expert in these aspects of data collection was hired to train statewide children's mental health staff in techniques of behavior definition and data collection. This was accomplished during the summer of 1988. These efforts have been implemented effective November, 1988 and will be tested through spring 1989 to ensure adequate reliability and overall integrity of the data. The current goal is to systematically produce accurate client outcome data on each severely emotionally disturbed child being served through new HSS/DMHDD funded programs and AYI by June, 1989.

A detailed description of this new effort is available upon request to the AYI Coordinator in Juneau. The analysis of the 1986-87 pilot of the client outcome measurement system is also available upon request.

7. Lack of Generic Training of Staff Working in AYI

Again, due to very rapid growth in AYI, staff have been individually trained only, around specific needs of individual AYI clients. However, recent problems point to a need for systematic, generic training of all AYI staff in such areas as medication issues, restraint procedures, and other skills involved in serving youth with severe mental illness. Development of these training packages is the highest priority for AYI at this time.

ANALYSIS OF AYI YOUTH WHO HAVEN'T SUCCEEDED IN AYI

As of March 1, 1989 four youth out of 54 have not made significant progress in AYI. Although to protect client confidentiality, individual case issues cannot be discussed in this report, the AYI staff has identified several themes that should be addressed. In the cases of these youth, "lack of significant progress" is defined as a failure of the program to make major changes in the targeted goals of the youth. In each case, these youth are in a locked setting (juvenile detention, adult detention, psychiatric care) for an indefinite period of time and, therefore, on inactive status. "Inactive Status" means that AYI will honor its unconditional care commitment as soon as the youth are able to begin transition back to the community. In the cases of four additional AYI youth who have become adults and removed themselves from the program, "Inactive Status" means that the IDT will consider them for re-referral under strict conditions (up to the 22nd birthday).

Several of the themes were discussed earlier in this report under "Previous Problems". In particular, length of response time; lack of case management; lack of inter-agency consensus; and lack of organized client review and lack of organized treatment and education teams. All of these are major issues which affected the three youth. In addition, the following themes are present:

1. **Lack of effective locked back-up**

If there is one thing we know about serving our most difficult AYI youth in the community, it is that they almost always will go through from five to 20 major crisis episodes before they realize that they will not be thrown out of the program. During these crisis episodes, if they are exhibiting criminal or emotional behaviors that are dangerous to themselves or others, they need to be exposed to natural consequences, such as placement in Alaska Psychiatric Institute (API) or in McLaughlin Youth Center for brief periods of time. Then they need to be brought right back to their programs. However, in the case of McLaughlin, the court may not allow the youth to be in the community due to having them under an institutional order. At the present time, AYI is working well with API and is designing effective backup plans for youth who are committable to the inpatient setting.

2. **AYI was not sufficiently developed at the time they were being served**

All of the individuals involved with AYI were initially faced with little established technology except for the Kaleidoscope Program in Illinois. One model, which is a local agency model, proved to be only partially valuable as a model for AYI. Therefore, AYI was faced with "making it up as we went along". Over time AYI has become more skilled at performing tasks which are required to successfully serve AYI youth and their families. A good measurable indication of this is the almost total lack of youth failures in the program within the last year.

RECOGNITION

The success or failure of any demonstration effort depends on the competence of the individuals who implement the programs. In the case of the Alaska Youth Initiative, those persons who work directly with AYI youth as their jobs, as part of their jobs, or as parents are the "heart and soul" of the program. They deserve special recognition. These very special people and their roles are listed in the following section.

The ultimate efforts in most cases have been made by the parents of AYI youth. The IDT and the AYI staff offer special thanks to each of the parents, even though their names are not listed here in order to protect confidentiality.

<u>Name</u>	<u>Position</u>
Allen Anderson	Family Treatment Home
Karen Anderson	Family Treatment Home
Richard Arts	Individualized Assistance Coordinator
Linda Augustine	Teacher
Marvin Bergeson	Pediatrician
Nichole Bevis	Youth Counselor
Paula Bond	Therapist
Dennis Boyer	Teacher
Connie Boyton	Family Treatment Home
Ron Boyton	Family Treatment Home
Carl Brice	Family Education Consultant
Julie Britton	Teacher
Karl Brimmer	AYI Regional Coordinator
Steve Brooks	Training Consultant
Jerry Brown	Individualized Assistance Coordinator
Edith Browne	Family Treatment Home
Vincent Browne	Family Treatment Home
Karen Bumpas	Individualized Assistance Coordinator
Rudy Campos	Psychiatrist
Patty Carlson	Family Treatment Home
Jessica Carvalho	Individualized Assistance Coordinator
Phyllis Chavis	Respite Care Worker
Frankie Clyde	House Manager/Recreational Aide
Sandra Collins-Jackson	Therapist/Consultant
Mary Cragan	Therapist
Paul Craig	Neuropsychologist
Chris Datton	Psychiatrist
Bonnie Dickinson	Family Treatment Home
Cathy Donadio	Individualized Assistance Coordinator
Steve Emerson	Individualized Assistance Coordinator
Ken Fisher	Family Treatment Home
Sharon Fisher	Family Treatment Home
Linda Fraini	Psychologist
Joe Gertsen	Respite Provider

<u>Name</u>	<u>Position</u>
Mary Guilas	Teaching Family Home
Anita Henry	Family Treatment Home
Mary Hogans	Family Treatment Home
Norris Hogans	Family Treatment Home
John Houser	Teaching Family Home
Marilyn Irwin	Individualized Assistance Coordinator
Lucy Jackson	Individualized Assistance Coordinator
Paula Janowiec	Former AYI Regional Coordinator
Connie Kind	Mental Health Counselor
Nina Kocinski	Therapist
Sandra Law	Individualized Assistance Manager
Chuck Lester	Psychologist
Debbi Logan	Respite Care Worker
Joan Lopez	Psychiatrist
Karen MacFarquhar	AYI Assistant Coordinator
Gene Mangiardi	Clinician
Chuck Mailander	Apartment Manager
Tony Mander	Psychologist
Julie Mangold	Individualized Assistance Coordinator
Mike Marder	Teacher/Individualized Assistance Coordinator
Osamu Matsutani	Psychologist
Randy Miller	Apartment Manager
Barb Murray	Therapist
Jack Opgenonth	Individualized Assistance Coordinator
Steve Parker	Psychologist
Anita Parrish	Family Treatment Home
Joe Parrish	Family Treatment Home
Miguel Perez	Family Treatment Home
Ronda Perez	Family Treatment Home
Marianne Piedlow	Individualized Assistance Coordinator
Nancy Pressler	Respite Provider
Lynn Radin	Clinician
Marcy Redmond	Respite Provider
Linda Reimer	Respite Care Worker
Rick Reimer	Respite Care Worker
Cheryl Riggs	Consultant
Mauroen Rily	Individualized Assistance Coordinator
Celia Ringstad	House Manager
Judy Ringstad	On-call Youth Counselor
Fred Robrecht	Teaching Family Home
Jacqueline Rummel	AYI Regional Coordinator
Jerry Schrader	Psychiatrist
Danni Seagren	Youth Counselor
Steve Serr	House Manager/Recreational Aide
Robert Sewell	AYI Regional Coordinator
Dolly Smith	Individualized Assistance Coordinator
Maggie Stanger	Respite Provider
Barbara Stanton	Teacher
James Steele	Teaching Family Home Owner

<u>Name</u>	<u>Position</u>
Susan Steele	Teaching Family Homer Owner
Debbie Stith	Family Treatment Home
Rusty Stith	Family Treatment Home
Debbie Stith	Family Treatment Home
Randy Storrs	Social and Recreational Aide
Sarah Traut	Proactive Client Tracking Worker
Bruce Tillet	Family Treatment Home
Bill Watson	AYI Assistant Program Coordinator
Roger Wharton	Family Treatment Home
Bret Wilson	Teacher
John Wreggit	Psychiatrist
Clyde Vincent	Family Treatment Home
Juliet Vincent	Family Treatment Home

In addition, special recognition is given to the staff of the following State divisions, agencies and school districts who have been involved with AYI.

Advocacy Services of Alaska, Anchorage
 Advocacy Services of Alaska, Fairbanks
 Advocacy Services of Alaska, Juneau
 Alaska Children's Services
 Alaska Mental Health Association
 Alaska Psychiatric Institute
 Alaska Specialized Education & Training Services, Inc. (A.S.E.T.S.),
 Anchorage
 Alaska State Troopers
 Alaska Youth and Parent Foundation, Anchorage
 Anchorage Alliance for the Mentally Ill
 Anchorage School District
 ARCA, Anchorage
 Attorney General's Office, Anchorage
 Attorney General's Officer, Fairbanks
 Behavior & Academic Success in Education, Juneau
 Bering Strait School District, Unalakleet
 Booth Home, Anchorage
 Central Peninsula Counseling Services, Kenai
 Challenge Alaska, Anchorage
 Charter North Hospital, Anchorage
 Chief Andrew Issac Health Center, Fairbanks
 Coho Mental Health Center, Craig
 Convent House, Anchorage
 Delta/Greely Schools
 Denardo Center, Fairbanks
 Fahrenkamp Center ofr Child, Adolescent, and Family Services
 Fairbanks Alliance for the Mentally Ill
 Fairbanks Community Mental Health Center
 Fairbanks Correctional Center

Fairbanks Counseling and Adoption
Fairbanks Native Association Youth Prevention Drug Program
Fairbanks Northstar Borough School District
Fairbanks Youth Facility
Family and Youth Services, Northern Region
Family and Youth Services, Northwestern Region
Family and Youth Services, Southcentral Region
Family and Youth Services, Southeast Region
Family and Youth Services, Western Region
Gateway Community Mental Health Center, Ketchikan
Iditarod Area Schools, McGrath
Juneau Alliance for the Mentally Ill
Juneau Borough Schools
Juneau Community Mental Health Center
Juneau Youth Services
Kenai Care Center
Kenai Peninsula Borough Schools
Ketchikan Gateway Borough Schools
KNA Community Counseling Center, Aniak
Klawock School District
Kodiak Baptist Mission
Kodiak Island Borough Schools
Kodiak Island Mental Health Center
Kuskokwim Native Association
Kuspuk Schools, Aniak
Lower Yukon Schools, Bethel
McLaughlin Youth Center, Anchorage
Maniilag Association, Kotzebue
Mat-Su Borough Schools, Palmer
Mat-Su Community Counseling Center, Wasilla
Mat-Su Services for Children & Adults, Inc.
MEN, Inc., Juneau
Mental Health & Developmental Disabilities, Northern Regional Office
Mental Health & Developmental Disabilities, Southcentral Regional
Office
Mental Health & Developmental Disabilities, Southeastern Regional
Office
Mental Health Services Training Center, Anchorage
Milam Recovery Center, Juneau
North Slope Borough Community Mental Health Center, Barrow
Norton Sound Community Mental Health Center
Office of Public Advocacy, Anchorage
Office of Public Advocacy, Fairbanks
Office of Public Advocacy, Juneau
Presbyterians Hospitality House Residential Program, Fairbanks
Presbyterians Hospitality House Youth Day Program, Fairbanks
Public Defenders Office, Anchorage
Public Defenders Office, Fairbanks
Public Defenders Office, Juneau
REACH, Inc., Juneau
Resource Center for Parents and Children, Fairbanks

SAGA Vocational Program, Juneau
 Sitka Borough Schools
 Sitka Community Mental Health Center
 Sitka Parent Association for Children With Special Needs (PACS)
 Sitka Receiving Home
 Southcentral Counseling Center, Anchorage
 Southcentral Foundation, Anchorage
 Southeastern Regional Health Corporation, Sitka
 Special Education Service Agency (SESA)
 Supported Employment and Living Services, Wasilla
 Tukkivik Group Home, Specialized Foster Care Program, Fairbanks
 University of Alaska, Anchorage
 University of Alaska, Southeast
 Yukon/Koyukuk Schools, Nenana

In addition, special recognition must be given to several individuals outside of Alaska who have provided valuable technical assistance and support.

<u>Name</u>	<u>Program</u>
Mel Breed	Kaleidoscope, Illinois
David G. Born	University of Kansas
Karl Dennis	Kaleidoscope, Illinois
Al Duchnowski	Florida Research and Training Center for Improved Services for SED Children
Robert Friedman	Florida Research and Training Center for Improved Services for SED Children
Barbara Friesen	Research and Training Center for Severely Emotionally Disturbed children, Portland, Oregon
Dr. Ira Lourie	National Institute of Mental Health
Dr. Judith Jacobs	National Institute of Mental Health
Judith Katz-Leavy	National Institute of Mental Health
Christina Kloker-Young	Ohio
James Mason	Research and Training Center for Severely Emotionally Disturbed Children, Portland, Oregon
Dennis Olsen	Washington
Dick Sammons	New York
John Smith	Kaleidoscope, Illinois

A sincere note of special thanks must go to Tom Buckner of the Alaska Department of Education who has been on the AYI Inter-Departmental Team for over three years. Due to an administrative change, he was recently replaced by Richard Smiley. AYI would not have happened without Tom's advocacy and service on the IDT.

In addition, former Commissioners John Pugh (HSS) and Marshall Lind (DOE); former Deputy Commissioner of HSS Connie Sipe; current DOE Deputy Commissioner Steve Hole and current HSS Deputy Commissioner Blanche Brunk; William Mulnix (DOE); former IDT members Martha Holmberg, Jackie Damon, Jody Engleman, and Robert Gregovich; former Public Defender Nancy Grozek; former DMHDD Director, Dr. Mel Henry; current DMHDD Director, Dr. Todd Risley; and Advocacy Services of Alaska attorney Jeff Jesse; former DMHDD staff Dr. Barbara Minton; Sharon Lobaugh of the Alliance for the Mentally Ill; and many others not mentioned were instrumental during the first 18 months of AYI.

The IDT

The current IDT is:

Department of Education: Richard Smiley
Division of Family and Youth Services: Carolyn Frichette
Division of Mental Health and Developmental Disabilities: John VanDenBerg

AYI Staff

The Coordinator of AYI is John VanDenBerg, Coordinator of Child & Adolescent Services, DMHDD
The Assistant Coordinator is Robi Andison

The Regional Coordinators are as follows:

Fairbanks (Northern Region), Karl Brimmer
Juneau (Southeast), Robert Sewell
Anchorage (Southcentral), Jacqueline Rummel

Clerical (Juneau), Cara Peters

Please do not hesitate to contact any of the above for more information about AYI.

STEVE COWPER, GOVERNOR

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**LEGISLATIVE
AUDIT**

Mr. Randy S. Welker
Legislative Auditor
Division of Legislative Audit
P.O. Box W
Juneau, Alaska 99811-3300

Dear Mr. Welker:

Thank you for the opportunity to respond to the preliminary report on the extensive audit of the Division of Family and Youth Services (DFYS) recently conducted by your agency. A thorough understanding of the general context within which DFYS has functioned over a period of years, how that context has shaped the overall direction of the agency, and some of the initiatives underway which reflect that direction would, I think, be helpful in understanding issues leading to the audit and my response to recommendations in the report.

As you know DFYS has a broad scope of responsibility to serve children, families and vulnerable adults and has been chronically short of resources to carry out its mandates over a period of many years. This resource shortage was, during the decade of the 1980's, exacerbated by a number of factors. Chief among these were:

- (1) a growing state population and an increasing need for services;
- (2) an increase in the severity and complexity in the problems experienced by the agency's client population;
- (3) greater formality in the legal and service processes;
- (4) a need for higher levels of accountability;
- (5) a high rate of staff turnover;
- (6) lack of training for staff following loss of the staff training program in 1984;
- (7) a need to provide more and more sophisticated training and support for important provider groups;
- (8) higher expectations of agency performance as a result of a growing public awareness and concern about the problems and needs the agency is mandated to address;
- (9) lack of a clear public understanding of the agency mandates and constraints.

Within the context of this complex and changing environment DFYS has undertaken several important initiatives designed to improve services. The primary goals of agency management in undertaking these initiatives have been:

- (1) to clearly focus staff and other resources on achieving the desired outcomes for each client; and
- (2) to improve the quality of services provided.

Objectives of the initiatives established to accomplish these goals have been:

- (1) to provide clear and consistent direction to staff;
- (2) to improve consistency and increase accountability in the provision of services;
- (3) to increase the skills of staff and important provider groups through training;
- (4) to fund service improvements wherever possible by obtaining the maximum available federal resources; and,
- (5) to allocate resources most effectively.

Primary among the initiatives undertaken by DFYS has been the development and implementation of the agency's risk-based Case Management System (CMS). The Case Management System addresses several critical needs within the agency and complements other initiatives and the overall agency direction. It provides clear direction for staff, ensures a focus on achieving outcomes, provides methods of monitoring services to assure quality, consistency, and accountability; and it provides an exceptional framework for effectively managing resources. In conjunction with development and implementation of the CMS, DFYS has undertaken other equally important though less sweeping initiatives. These include:

- (1) implementation of a competency-based training program for child protection staff with a goal of instituting competency certification for staff (we are also initiating a similar effort for youth corrections staff);
- (2) complete revision of the division's child protection and youth corrections policies and procedures and development of a systematic method for ongoing revision;
- (3) development of performance standards for child protection staff;
- (4) implementation of a program to improve permanency planning for children in state custody;
- (5) implementation of a case review system to assure progress toward a permanent home for all children in state custody;
- (6) increasing federal receipts under Title IV-E of the Social Security Act by nearly \$3 million;

- (7) implementation of a project to achieve accreditation for all detention and treatment facilities operated by the agency;
- (8) implementation of a statewide system of training for foster parents which will provide an opportunity for all foster parents to receive the level of training required by revised licensing regulations;
- (9) adoption of new foster care licensing and payment regulations and regulations establishing a complaint resolution process.

As with any significant change, the necessary changes in DFYS have not been accomplished without some concern and dissatisfaction among both staff and affected constituent groups. Some concerns obviously result from the uncertainty, trepidation, and misunderstanding that accompany any change. Others result from differences in perspective and goals. These are encountered in implementing reforms in any system, even under ideal circumstances.

However, some of DFYS' initiatives have, by necessity, been implemented more rapidly with fewer resources and less advance preparation and training than would have been desirable under more favorable circumstances. It is not surprising that there are misunderstandings concerning the motivations producing change and the effect of that change on staff and constituent groups. Nor is it surprising that these are reflected in concerns such as those leading to the most recent audit.

I believe the changes made within DFYS are positive and have been generally well received. And, I am confident that as these systemic changes are refined and stabilized they will receive increased support. The increased familiarity that will develop over time and the increased understanding provided by training should significantly improve acceptance and reduce resistance. Much remains to be done, of course. However, with what I believe is a firm foundation the nature of future change within DFYS should be steady and incremental, evolutionary rather than revolutionary in nature.

In responding to the specific issues and recommendations in your preliminary report I will follow the format and numbering of the report.

AUDIT ISSUES AND ANALYSIS

Issues 1 and 2: Case file documentation.

Documentation is one of several necessary activities which compete with actual direct service delivery for caseworker time. Effective delivery of services requires a suitable balance between the provision of services and adequate documentation of those

services and other related activities. Achieving a satisfactory balance between case file documentation and other activities has long been a problem for public human service agencies. Doing so has become an increasingly acute problem during the 1980's as the legal and service processes have become more formalized and the need for and expectations of accountability and documentation have become greater.

Much of the increase in documentation requirements are the result of participation in federal programs such as Medicaid, Titles IV-B and IV-E of the Social Security Act which are important sources of funding for client services and program improvements. Changes in these requirements are essentially beyond the control of DFYS management. The only option available to management to reduce the documentation requirements resulting from these programs is non-participation. This is not a realistic alternative. The funding provided through participation in these programs is essential to continued agency operation. Funds obtained through participation in these programs have been the most important source of support for initiatives to improve agency services in recent years and are essential to efforts to consolidate those improvements in the future.

DFYS management has recognized case file documentation as a critical area for improvement and is implementing strategies to correct this problem. The division is incorporating specific training concerning required documentation and the theory underlying documentation into the core curriculum being provided to all social work staff this fiscal year. Greater emphasis is also being placed on monitoring documentation through systematic supervisory audits of casework files and in training of supervisory staff. In addition, as part of a broader plan for improving overall agency functioning, management will begin using the findings of supervisory audits concerning key case documents as one measure of performance routinely monitored each month.

I find little to credit in allegations that signatures on case file documents have been falsified. There are only three (3) forms which require signatures of foster parents, natural parents or both: the case plan, the placement plan and the placement review documents (see enclosed). It is true that such documents are too frequently incomplete or lacking but there is little incentive for department staff to falsify signatures on such documents.

We believe that the most successful interventions on the behalf of children will include participation in development of the case plan by both biological and foster parents and a commitment by all to implementing the plan. A goal during the next fiscal year is to provide joint training to foster parents and casework staff on processes for joint development of meaningful plans for

children in placement as well as how to work jointly with the child's own family. Revised foster home regulations which became effective on April 29, 1990, place emphasis both on planning and working with biological parents. A major effort is underway to revise policies and forms and to train those affected by the new requirements.

Implementation of these regulations and policies and systematic supervisory audits and case reviews should reduce any residual concern that staff are falsifying signatures on case documents.

Issue 3: Training of social workers.

DFYS has indeed developed a training program funded in large part by appropriately utilizing federal reimbursements available under the Title IV-E program. This has occurred with the approval and encouragement of both executive and legislative policymakers. Training of staff has been repeatedly identified by internal and external reviews as critical to improving the quality and consistency of services provided by DFYS. Re-establishment of a training program is the most logical and cost effective response to meet this longstanding need and use of federal funds to do so represents a sound management strategy given the overall state fiscal outlook.

As your report notes DFYS' new training program is based on a state of the art "core curriculum" of competencies for child protection staff. This curriculum represents a fundamental knowledge base that all staff providing those services are expected to master and evidence in the performance of their work. The agency is in the process of developing a similar curriculum for youth corrections staff which will also be unique and state of the art.

Implementation of this fundamental entry-level program for child protection staff as the priority in re-instituting a staff training program was purposeful. An entry-level program provides a base curriculum which can ensure that all staff are similarly grounded in theory and specific practice requirements. Training of child protection staff was chosen as the first step in development of an agency-wide training program for several reasons. Experience has shown that the need for training in child protection work was most critical. The results of insufficient training in child protection can be tragic; child protection practice has changed rapidly and become more complex and formalized; child protection services are the largest part of agency efforts; and staff turnover is greatest in the child protection section of the agency.

The decision was made to have all child protection staff attend this training even though it is designed for the "new" or inexperienced social worker in order to ensure that all child protection staff have exposure to this knowledge base. This is an effective means of promoting consistency, quality, and appropriate accountability. The same approach will be implemented in the Youth Corrections section and should improve the day-to-day performance of DFYS staff. In response to the needs of staff for more focus on specific administrative practices, particularly relating to the case management system, changes have already been made in the content of the core curriculum to provide additional information and guidance on these issues. Revision of the core curriculum will be a continuous process reflecting new information and changes in practice.

In addition to implementation of the CPS core curriculum, training has also been provided for supervisors and mid-level managers in both sections. This training was also focused on providing these staff with the primary knowledge and skills needed to increase their effectiveness. As the training program progresses more advanced and specialized training will be developed and provided for staff in both sections and at all levels of the agency. The content of these advanced courses will be determined by the results of a systematic assessment of staff training needs and will, of course, be dependent on funding availability.

When development and implementation of the Youth Corrections core curriculum is completed in the next two fiscal years we will need to devote fewer resources to the fundamental curriculum because it will be provided for new staff only. This should allow us to place greater focus on development and implementation of advanced courses beginning in FY 93. Work on advanced courses will also occur during the next two fiscal years but at a lower level than would be ideal because we must focus on core curriculum development.

Issue 4: DFYS contracting procedures.

Effective procurement and administration of grants and contracts is recognized by DFYS management as being of critical importance to service effectiveness. The Division issues grants and contracts totalling nearly \$18 million annually. The agency is hindered in managing these funds by limited staffing within the Division's central office. A single staff person is responsible for developing and administering the issuance of RFP's, scheduling and staffing the evaluation of proposals, documenting justification of award recommendations, negotiating the final terms of contracts and grants, and overseeing the performance of contractors and grantees.

One staff person regardless of how well trained or competent cannot ensure that all grants and contracts issued by DFYS will be awarded in full compliance with the complex procedures required by the State's procurement procedures. An additional area of concern to DFYS management not addressed by your report is the lack of a capacity for systematically and routinely evaluating the performance of grantees and contractors.

Issue 5: Division statistics and Management Information.

The Division has long recognized the need for improved information for decision-making at all levels. We have to date utilized information available from DFYS' admittedly limited thirteen-year-old management information system as well as information from manual counts. While we recognize the inherent limitations in the outmoded system and manual counts we believe the information presented has been as accurate as possible.

As you note we are implementing an improved client information system to provide information needed for effective decisions at all levels. We are confident that the information it will provide will be both more accurate and more useful than information previously available. All systems are, of course, subject to human and technical error. However, the design of the new system is more sophisticated than the older system. And, because it is more responsive to the needs of staff it enjoys greater acceptance and support among line and supervisory staff than did the older system. This should make it more accurate and reliable than the older system.

Issue 6: Retribution and blacklisting.

It was encouraging to note that no evidence of "blacklisting" of foster parents was found. The derivation of this issue is a complicated one but seems, as you noted, based largely on the informal suspension of placements in foster homes for legitimate reasons. This informal limitation of placements in foster homes is an unsatisfactory approach and has been identified as undesirable by foster parents, DFYS management, and DFYS field staff alike.

Much of the misunderstanding and mistrust between agency staff and certain individual foster parents and their advocates may well result from failure on the part of staff to make clear findings about the quality of care provided by foster parents and to communicate those findings and concerns openly and effectively to foster parents. This failure was undoubtedly the result of lack of clear management direction in the past and lack of adequate staff training. However DFYS is committed to eliminating the

practice in favor of providing unequivocal information to foster parents concerning reasons for placing or not placing children with them.

Issue 7: Alaska Foster Parents Association (AFPA).

There is no question that there have historically been strains in the relationship between the leadership of AFPA and a succession of DFYS managers and administrators. This results in part, perhaps, from the natural tension between any organized interest group and the public agency for which it is a natural constituent and in part from individual personalities. Only infrequently can agency administrators respond in a way that fully satisfies any constituency. To the degree that constituency groups hold rigid opinions or positions, agency actions not in concert with those opinions or positions will be viewed as unsatisfactory or arbitrary.

DFYS has made a concerted effort to include AFPA members in planning and coordinating programs and activities relating to the foster care program. Involvement of AFPA members has added a valuable perspective but by no means the only valuable perspective to those efforts. DFYS management is committed to responding constructively to find solutions to legitimate issues raised by AFPA and we believe the relationship between DFYS and AFPA is improving and will continue to do so as reforms are made within AFPA by new leaders. However, in any decision or action taken by DFYS, management must give due consideration to the fact that the perspective presented by AFPA may not be representative of the majority of foster parents. Nor is AFPA the only affected or interested constituency on most issues related to substitute care.

Issue 8: Residential Care Placements.

Your analysis of the appropriateness of DFYS use of foster and residential care resources and the decision process was useful. It points out the effectiveness of the regional placement committees as a management tool to assure effective and appropriate use of these important resources.

As the high rate of foster home placements in your sample seems to indicate, the needs of children entering DFYS custody are becoming increasingly complex. It is becoming clear both nationally and in Alaska that children's needs frequently do not readily fit the available resources or structures of care. An important focus of management in the future will necessarily be on the development of a continuum of flexible and creative substitute care services which match needs of children and families. DFYS

central management staff are currently analyzing these issues and will be developing a report identifying these issues and options for changes in the future direction of substitute care. This will include the need for and issues related to home based pre-placement and independent living services.

Issue 9: Response to Past Audits.

As you know DFYS has been the subject of numerous internal, executive, and legislative audits as well as multiple reviews by the Ombudsman and grand jury investigations. Each of these has resulted in a number of substantive recommendations. Of these recommendations there are three primary types: (1) those which can be implemented unilaterally by agency management without additional approval or resources; (2) those requiring executive approval at a level higher than agency management, including requests for additional resources; and (3) those requiring legislative approval, including appropriation of resources and changes in law.

As your report points out DFYS has responded in part, if not completely, to all recommendations of past audits by your agency. It is the impression of agency staff that most recommendations made by your agency and in other reviews of DFYS functioning have been addressed in good faith, though for a variety of reasons not the least of which is resources, not all have been fully realized. However, there has been no formal assessment of agency progress in responding to all of the various recommendations made to the agency nor of the continued relevance of those recommendations to current agency circumstances.

DFYS' director believes that a formal review and analysis of the status of these recommendations would be valuable in assessing agency progress and in planning the future direction of the agency. For that reason DFYS will, during the next fiscal year, undertake an initiative to assess DFYS progress in responding to recommendations of internal and external reviews which have statewide or systemic local application. The scope of this analysis has not been fully determined but may extend to recommendations made in major reviews over the last decade.

The initiatives outlined in my introductory comments are in many respects broad-based agency responses to issues identified by agency management and in recommendations of internal and external reviews over a period of years. Obviously, implementation of substantive changes in an agency as large and complex as DFYS requires significant planning, time, and effort. Those changes requiring additional resources or changes in law require even more time and effort. As your report indicates significant program improvements have been made in important areas such as in the training of foster parents, management information system

development, rejuvenation of the staff training program and in development of the Case Management System. The results of these and other initiatives such as the agency's Permanency Planning Project should become even more apparent in the future.

Issue 10: Alaska Parent and Youth Foundation (APYF).

I agree that DFYS must reexamine the nature and type of residential care services in the Anchorage area. A reexamination of this type must occur statewide as well as in Anchorage and must be performed systematically. Doing so is essential to insure that the funds appropriated for purchase of residential care services are used most effectively to meet the needs of children in DFYS custody.

A limited review of the need for various types of child residential care occurs as an integral part of agency budget development each year. However, a more extensive review and analysis of need occurs only in preparation for the initial year of the multi-year grant cycle for residential care. This is will occur during FY 91 in preparation for solicitation for services beginning in FY 92.

As you noted it is frequently necessary for children to be temporarily placed in a residential care setting not best suited to their needs because all appropriate placements are filled to capacity. This is a resource-related problem long recognized by agency staff and providers and one for which there is no simple or quick solution. It will, as you suggest, require a thorough analysis of the needs of children entering DFYS custody, of the capacity of the residential child care system to meet those needs, and of the ability of DFYS to support the needed capacity with available resources.

JUNEAU DISTRICT OFFICE

1. How has the poor morale of the social work staff affected the service delivery of the Juneau office?

The Juneau District Office and the Southeast Region of DFYS may well have been the subjects of more reviews and audits than other segments of the agency. Low morale and concerns about poor service delivery and quality have been longstanding problems and have prompted previous internal and external reviews. The findings of these audits have confirmed the need for improvements in service delivery and have pointed out specific deficiencies in compliance with agency policy and procedure, state and federal laws, and good social work practice. There is, however, reason to believe that

progress is being made to remedy both service deficiencies and morale problems.

Repeated identification as a poorly functioning office and the necessary management responses to those findings have resulted in feelings of isolation and alienation from management and contributed to an already existing morale problem among staff in the Juneau District Office. This has undoubtedly been exacerbated by the prevailing labor relations climate.

Efforts by agency management to implement reforms and improvements in practice have been viewed as retaliatory and targeted at individuals. Virtually any change not initiated by line staff has been met with suspicion and resistance and has been viewed as an arbitrary attempt to exert management authority. Even long-sought reforms such as efforts to provide clear direction through the revised CPS manual, to equalize workloads through the Case Management System, and to re-institute the staff training program have been disparaged and actively resisted.

Poor morale in the Juneau Field Office has been manifested in numerous ways - such as the outright refusal of staff to perform duties identified by auditors - and others less readily identifiable but perhaps more insidious. Virtually all of these have in some way reduced the effectiveness of services. To the extent that staff attention and efforts have been diverted from service delivery through absences or contention over organizational, supervisory, or labor relations issues service availability and effectiveness have clearly declined.

DFYS management has taken several steps to improve both morale and service delivery in the Juneau District Office. Management consultation has been obtained by Regional management staff through contract. Consultation has focused specifically on identifying improvements which can be implemented in management practices and in field office operations to improve communication and morale and increase the effectiveness of service delivery. Newly appointed supervisors have attended training designed to increase their effectiveness in communicating with, and supporting, and supervising staff.

Difficulties in filling the Haines position and in supervision of the position when it was filled have contributed to perceptions among Juneau District Office staff that placement of the position increased the difficulty in managing the Juneau caseload. However as auditors' analysis of the workload indicates, the workload in the Juneau office was manageable even with the position located in Haines. The Juneau office workload was ineffectively distributed by the supervisor. While one worker had an average workload nearly 20% above the standard and another was 10% above the standard four

had workloads substantially below standard - two were as much as 40% below the standard. Proper distribution of these cases could have resulted in a reduction of the workload of all staff in the Juneau office to a level at or slightly below the standard workload without relocating the Haines position to Juneau.

Problems in supervision of the Haines position when it was filled and vacancy in the position have prevented development of a stabilized workload. Because of this it has not been possible to adequately evaluate the efficacy of the position location. Nor has it been possible to evaluate the likelihood of achieving the goal of increasing services to outlying communities to meet the needs expressed by those communities. Reassignment of the position located in Haines to the Juneau office would obviously impact the workload distribution in Juneau. However, as auditors' analysis indicates doing so is not necessary to reduce all Juneau office workloads to a standard level. Nonetheless, Regional management staff are currently re-evaluating allocation of the Haines position.

2. Can the current workload be handled by existing staff? Additionally, how have duty assignments and reassignments affected workload?

As your letter points out the Juneau office is slightly understaffed according to the workload documented through the Case Management System but not critically so, certainly not in comparison to other agency offices. As your analysis indicates, with all positions filled and proper adjustments and assignments made by the supervisory staff, the workload is manageable. The perception of overload held by some staff is most likely the result of vacancies and poor workload distribution.

Maldistribution in workloads can and should be remedied at the supervisory level. Proper distribution of workloads within a service unit is the responsibility of the unit supervisor. Seriously unbalanced caseloads are never justified even when vacancies exist. With two new supervisors in the Juneau field office there is reason to believe that previous deficiencies in workload assignments will be corrected as supervisory staff become skilled in appropriately assigning cases and adjusting workloads as provided for by the Case Management System.

3. How effectively has CMS been implemented by DFYS? What level of training has been afforded staff in its implementation?

The Case Management System has been implemented with relative effectiveness statewide given the limitations that existed during implementation of the system. Implementation of the CMS occurred at a time when no systematic training program existed within DFYS and no additional resources were available for this special project. Training necessary to implement the CMS was accomplished following a plan designed to make the most of available resources. Staff from each region who were involved in development of the system were utilized as primary trainers in their respective regions.

The initial training for this system was completed in 1987 in each region by "core team" staff from the region. The development and implementation of the system was completed without a training center or training consultation. There were no additional funds available to train new staff as turnover inevitably occurred. These limitations were recognized in development of the training strategy employed by the CMS "Core Team". Ongoing training in the CMS was essentially the responsibility of supervisors in each unit with consultation from "core team" staff from within the region.

There are clearly significant differences in the effectiveness of implementation of the system between regions and offices. Unfortunately the Southeast region is one of those in which the CMS has not been as effectively implemented as we would like. This has resulted from the loss of key training resources when "core team" staff from the Southeast Region transferred to other regions and a deficient understanding and lack of acceptance of CMS concepts by past supervisors in the Juneau Field Office.

DFYS management has recognized the need for more complete and effective implementation of the Case Management System and has developed and is currently implementing a statewide project to improve functioning of the system in all agency offices. The goal of this project is to ensure that all agency staff understand and effectively implement the CMS. This project includes:

- (1) assessing the understanding and performance of staff in implementing the system;
- (2) identifying obstacles to successful implementation and strategies to overcome those obstacles statewide and within each office/region;
- (3) training of specialists in operation of the new management information system which automates the workload accounting portion of the CMS;
- (4) incorporation of training on the CMS into the "core curriculum";

- (5) development of specialized training curriculum for use by supervisors in training staff on the CMS;
- (6) ongoing training of new staff in the CMS and continuous re-assessment of the functioning of the CMS and revision and remediation as needed.

The project portion of the plan is to be completed by December 1990 and the ongoing reassessment, revision and remediation is to be institutionalized as an integral part of agency operation by that time. Southeast regional management staff have already made organizational changes to promote more effective implementation of CMS in the region and in the Juneau office.

- 4. How has management's demand for increased work documentation impacted service delivery?
- 5. What steps has DFYS taken to address concerns and problems highlighted in audits completed last March by OMB and Northwest Resources Associates?

As your report notes DFYS management has made a concerted effort to improve case file documentation and has elevated the importance of documentation in communications to staff and in reviews of staff performance. This was done to ensure adequate documentation of services and to meet requirements imposed from outside the agency as well. As auditors noted, the requirement that documentation be completed and the accountability for doing so may very well be a new phenomenon in some offices. Most of the documentation requirements are not new though some have increased in complexity.

The process of systematically monitoring compliance with documentation and other requirements as part of regular supervisory reviews is one of a number of important new steps being implemented by the agency. These are designed precisely to improve overall performance and respond to concerns and problems identified in such reviews as those conducted by OMB, Northwest Resource Associates, and by the U.S. Department of Health and Human Services.

Management's "demand" for documentation stems from a number of sources. Some are within the authority of agency management to alter and others are not. Proper casework practice requires a minimum level of documentation of case planning and service. Management has some flexibility in establishing these requirements though we are constrained in doing so by the need to comply with federal requirements. The need to meet the requirements established to obtain services for clients or reimbursement for services under such federal programs as Medicaid and Titles IV-B and IV-E generates other specific documentation requirements. The amount of paperwork involved, such as the Medicaid application, can

be formidable.

There is no question that additional clerical and paraprofessional staff would be of considerable help in meeting all case file documentation requirements. The need for such staff is demonstrated in the Juneau field office where the ratio of clerical support to service staff is one to seven and the two clerical staff must also perform receptionist duties. DFYS management has recognized this need and has repeatedly sought additional clerical and paraprofessional staff through the budget process. DFYS' FY 91 budget request included increments providing additional clerical support in each region to help implement the new management information system. Fortunately these were approved by the Legislature.

As suggested, there is continual review of required documentation to ensure that there are not any unnecessary requirements. DFYS has established a manual revision committee to systematically review agency policies and procedures. As part of that process the committee also reviews the forms and documentation attendant to policies and procedures on an ongoing basis.

Recommendation No. 1

DFYS should support pending legislation to clarify the abuse/neglect status of infants who test positive for controlled substances.

DFYS agreed with your recommendation and supported earlier versions of SB 450 which defined presence of a controlled substance in the system of a newborn within the definition of maltreatment to be reported under AS 47.17. The final version of SB 450 did not include this language. However, DFYS has established high risk units in the Anchorage and Fairbanks field offices to address the special issues of investigation and assessment which apply to infants who test positive for controlled substances. There are currently more reports than the Division can effectively address. However, between now and the next session, DFYS will consider whether additional legislative changes are required in order to ensure the protection of this population of infants.

Recommendation No. 2

DFYS must take steps to improve the documentation of social worker case files.

We agree fully with this recommendation. As your report notes DFYS management has been keenly aware of this problem and has taken steps to address it. Unfortunately, efforts to improve documentation have been hindered by staffing limitations and

workload demands. When work demands are beyond the capacity of available staff resources it becomes increasingly difficult to achieve a satisfactory balance between providing and documenting services. Where insufficient staffing levels have been identified as the primary cause of inadequate documentation, efforts have been made to obtain additional staff. However, inadequate documentation has not been entirely attributable to resource limitations however and other actions have been taken to improve documentation.

Management has taken several actions to clearly establish the importance of documentation and to create systems to monitor staff performance in this and in other areas. In addition to seeking additional clerical and paraprofessional staff to perform documentation activities actions taken to improve documentation have included:

- (1) development of clear guidelines for case file organization;
- (2) increased emphasis on the importance of documentation;
- (3) implementation of a manual revision committee which provides for a systematic review of documentation requirements;
- (4) increased monitoring of documentation including creation of a specialized compliance unit in Anchorage;
- (5) implementation of systematic supervisory case audits statewide;
- (6) seeking resources to establish a program monitoring and evaluation unit within the agency Central Office.

Three additional projects currently underway within the agency are designed to improve overall program functioning and case documentation as well. These are: (1) implementation of a plan to ensure uniform and effective use of the CMS throughout the agency; (2) implementation of the agency's new management information; and (3) development of a special unit to systematically monitor and evaluate field operations and other programs and services provided by the agency.

Case Management and Client Information Systems

When properly understood and implemented the Case Management System will make adequate documentation a reasonable and accepted work expectation. It will also help to ensure that the priority assigned to documentation is not left to the discretion of the individual case worker. The Case Management System is designed to accomplish this and to help balance documentation and direct service assignments by providing clear direction and by establishing a framework to objectively define and maintain reasonable workloads through equitable allocation and necessary adjustments.

The CMS service standards for each case type were established on the basis of a time study which included the time required for completion of case documentation as part of the tasks studied in setting standards. The CMS provides the necessary structure for defining reasonable workloads and allowing management to equitably allocate workloads and define resource needs. With reasonable workloads defined management can require accountability in work performance, including satisfactory documentation of case records, commensurate with actual workloads. As requirements change over time the time study must be repeated and standards adjusted. This capacity for adapting to changes in circumstances is one of the most important elements of the CMS which make it a flexible management tool.

Implementation of the new client information system should help reduce the need for some currently existing paperwork such as the monthly workload ledgers, manual monthly intake reports, and similar manually compiled documents making documentation easier for staff.

Program Monitoring and Evaluation Unit

DFYS management is also in the process of developing a capacity within the agency's Central Office to monitor and evaluate field operations and other programs and services provided by the agency on a systematic basis. DFYS sought resources to establish a special unit to perform these functions in its FY 90 budget request but this increment was not funded. However, because the need for a systematic approach to program review and evaluation is critical, DFYS' management is developing a plan to implement a limited system with existing resources during FY 91. Resources will be sought in the FY 92 budget request to support and expand this capacity.

This is being undertaken because many of the inevitable problems within a large agency such as DFYS could be identified and corrected earlier if a systematic review of agency operations was performed regularly. In addition, many problems could be prevented and important program improvements made if information from systematic reviews were available to for planning.

Recommendation No. 3

DFYS should document the agency's rationale clearly in instances where a professional service contract is not awarded to the highest rated responsive proposer.

While I believe that the decision to award the contract in question was appropriate, well supported, and has certainly been justified by the products and performance received under the contract, it is clear that the basis for the decision was not adequately documented. We agree that the Division's rationale for awarding all professional services contracts should be fully documented.

An internal review of the circumstances of the award of the foster parent training contract to Northwest Resource Associates was conducted by DFYS. The resultant finding was essentially the same as the conclusion of your audit: adequate documentation of the decision process was not contained in the file or in tapes of the Proposal Evaluation Committee (PEC).

Contact was made with the former staff person responsible for documenting the decision process - Ms. Barbara McPherson. Ms. McPherson recalled that she had been unable to determine the final recommendation of the PEC from documentation, her recollection of the meeting, or from the audio tape of the meeting. To confirm the recommendation she contacted committee members. Three members of the PEC indicated support for awarding the contract to NWRA despite the scoring of the PEC on the condition that NWRA agree to establishing an in-state office for coordinating the services.

This recommendation was based on perceived performance problems with the then-current contract under AMTECH and the greater experience of NWRA in providing similar services. This preference was communicated by Ms. McPherson in her report to Yvonne Chase, Director of DFYS at that time. It was this preference Mr. Anderson referred to in his letter to Ms. Chase withdrawing AMTECH's appeal of the award. We agree with your conclusion that part of the problem which occurred in this instance is that the evaluation criteria set out in the RFP did not address all the areas the PEC felt should be considered. The Division will try to ensure that evaluation criteria conform to the needs for the service for which a contract is being considered.

DFYS has already made an effort to ensure proper documentation of all contract and grant awards including written recommendations of the PEC, signed by each member, a statement of the reasons for the recommendation, and the writer finding by the Director detailing the rationale for the award recommendation. Efforts will be made by existing staff to ensure that this occurs.

Recommendation No. 4

The Juneau district office Case Load Management System (CMS) summary reports should be accurately completed and summarized in order to enhance their usefulness to DFYS management.

As discussed previously, efforts are underway to assure that proper understanding and implementation of the CMS occurs agency-wide to maximize the usefulness of the CMS, including workload reports. This initiative is considered a critical priority by agency management. An integral part of this effort is implementation of the agency's new management information system. This system will automate the workload accounting system as well as other reports beneficial to line staff, supervisors, and management. Additional clerical staff received in the FY 91 budget will greatly facilitate implementation of the new management information system and the Case Management System as well as increase professional staff time available for provision of direct client services.

As noted in your report implementation of the CMS in the Juneau Field Office has been problematic since its inception. The use of the manual workload ledger to support the workload accounting system was planned as an interim measure pending implementation of a management information system. The original plan called for the supervisors to complete workload ledgers. This approach was not implemented in the Juneau Field Office. Resistance of both supervisory and line staff in that office to the CMS system has clearly been a factor contributing to limited success in implementing the CMS.

With two new supervisory staff in the Juneau Field Office greater support for effective implementation of the CMS is expected. As additional training is provided, effective implementation is achieved, and the system is used to equalize workloads among staff greater acceptance of and support for the system is expected among line staff.

Recommendation No. 5

DFYS should develop and implement procedures to formally notify foster parents who are placed in an "on hold" or suspended status.

DFYS management and I agree completely with this recommendation. Foster parents should be fully informed of agency decisions not to place children in the foster home and of the reasons for those decisions. There should be no concealed process for limiting placements. New foster home licensing regulations more clearly specify requirements which must be met. Licensed foster parents will thus be better equipped to provide good care for children. We are hopeful that there will be no need for putting a "hold" on placements, other than holds requested by foster parents who wish to have a respite. In those limited instances where DFYS thinks it is appropriate to place a "hold", there will be a requirement that foster parents be notified in writing of the reasons for limiting placements.

It is important to keep in mind that it is the Department's responsibility to ensure not only the safety of children in its custody but also the best care possible. Previous regulations did not provide as much protection for children in care. Thus, there were instances in the past when an investigation of a foster home did not result in a finding of substantiated abuse or neglect, yet there was reason to justify limiting further placements of children in the home on the basis of the quality of care provided in the home. Lack of a substantiated finding of abuse or neglect is not a sufficient reason to resume placements when legitimate concerns exist about the quality of care provided by a foster parent; in fact it is the affirmative responsibility of the Department to limit placements in such circumstances.

Foster parents do not have a "right" to receive placements of children in their home simply because they are licensed. Licensure implies only a minimum standard. The Department must evaluate the best interests of children and the quality of care provided by foster parents in making placement decisions. While a foster parent may meet the standard for licensure and has the "right" to a license there is no responsibility on the part of the Department to actually place a child in the home. Placements will be based on the needs of the children needing care and the type of care foster parents can provide. These issues will be fully discussed with foster parents.

Recommendation No. 6

The Southeast regional office should reevaluate personnel management practices in order to promote improved employee morale and enhance communication between employees.

This is already being done as part of a broader process of evaluating the structure and functioning of agency offices in the Southeast region. Management staff in the region have identified limitations and deficits in their management repertoire and have sought professional consultation to improve their own performance and that of other staff in the region. Consultation was sought expressly to aid managers in increasing teamwork and to improve employee morale and overall functioning within the region. They are committed to taking actions necessary to do so. The desired outcome, of course, is improved service delivery.

Managers in the Southeast region are relatively new to management positions within the agency and new to the region though not entirely new to supervisory or management roles. Certainly they were unprepared for the pervasive climate of mistrust, alienation, and resistance to management efforts encountered in the Juneau Field Office. Personal styles and management practices which were appropriate, well-received and effective in other, less rigorous circumstances have, in the context of the Juneau Field Office, been less effective. Many of the actions and motivations of regional management staff have been misinterpreted and misunderstood by staff. Managers efforts have in some instances been actively subverted. Some of the issues that have come to the attention of auditors are the result of poor or confusing communication from regional management staff. Others are the result of long term and more general problems within the Juneau office, perhaps exacerbated by an unfortunate labor relations climate.

Promotions and Transfers.

Regional management staff have taken a number of personnel actions in the last year aimed at improving client services. Transfer of a position to the Regional office to perform permanency planning tasks was initiated specifically to address deficiencies in case file documentation, poor case planning, and failure to comply with case review requirements of federal and state law. All of these problems were identified by previous reviews of performance within the region and required special attention. Inexperience and poor communication by regional management as well as the general climate of the office flawed the process and increased resistance to the plan by staff.

The regional manager clearly did not describe the decision

process well either to staff or auditors. The result was that the decision appeared capricious though it was made in conformance with appropriate personnel practices and after consultation with the agency's personnel officer. When reassignment or reclassification of an existing position is necessary the process of determining the specific position to be reassigned or reclassified must necessarily entail consideration of the skills, abilities and interests of incumbent individuals. Unless a vacancy exists it is not possible to follow the procedures for filling a vacant position including providing staff an opportunity for formal application. Selection of a specific Position Control Number for reassignment could essentially be done on a completely random basis e.g. "drawing a name (or number) from a hat" though this is not routine.

In the instance of the transfer of a position from the Juneau Field Office to the regional office several incumbent staff were considered for the position. Unfortunately, managers did not fully consult with staff under consideration to determine their interest. Although selection of a position for reassignment is a management prerogative and consultation with staff is not required, it is good practice. The unfortunate result of managers' failure to fully and effectively communicate with staff during the selection process was to increase staff alienation. It also allowed staff to focus discussion and energy on the perceived capriciousness of management actions rather than on the real performance issues the action was designed to address. Although the position was ultimately returned to the field office due to staff resistance, the reasons for the transfer remain - permanency planning for children in the Southeast region is not adequate.

The creation of a Social Worker IV position in the Regional office was also accomplished to address specific problems identified in reviews of performance within the region. It was anticipated that this promotional opportunity would be open to all staff. However, a review of historical problems and the strengths and needs of individual staff led to a decision that overall performance within the region could be most improved by utilizing the skills of the supervisor of the ongoing service unit in the newly created regional position. This approach did not eliminate promotional opportunities for other staff but merely made those opportunities available in another unit. In fact, staff from within the Juneau Field Office were promoted to fill two supervisory positions in the office at the same rank as the Regional office position.

It appeared then, as it does now, that this plan offered the best potential for broadly benefitting all staff involved and improving services to agency clients. Unfortunately, the focus of staff was again on the perceived arbitrariness of managers rather than the benefits of managers actions. However, to date this plan

appears to hold a good deal of promise for improving services to clients, improving the performance of staff, and improving the overall climate within the office.

Intra-divisional Communication

Much improvement is needed in communication within the Southeast region. Specific strategies for making needed improvements are being developed with the aid of a management consultant. However, implementation of these strategies will require commitment of all staff in the region. Supervisors and other staff are encouraged region wide and statewide to use appropriate channels of communication as this promotes the most immediate response to the needs of both clients and workers.

Communications problems in the Southeast region are not a new phenomenon created by current managers. Managers' actions, such as directives to staff concerning appropriate channeling of communication, were efforts to solve certain problems, such as failure of staff to keep regional management sufficiently informed to allow for accountability and effective decisions. Unfortunately, the approach taken in attempting to address some problems contributed to others. In a different environment such approaches may have been more productive. They may also have been unnecessary.

The desire of regional management has been to encourage full and direct communication through appropriate avenues within the region and with all other agency offices, including the Central Office. However, there were specifically identified problems in which staff purposefully avoided the appropriate chain of command. One staff person was asked to channel all communication involving policy and/or procedure changes because of this problem area. This is not a region-wide policy but is a response to the unique behavior of this employee. The Regional office has consistently forwarded all correspondence from staff addressed to Central Office to that office. There was one occasion when line staff forwarded two memos directly to Central Office. These were appropriately returned to regional management staff by the Director for information regarding any actions the regional office had taken to address the issues in the memos.

Steps being taken by regional management should, with the cooperation and commitment of all staff, remedy the communication difficulties.

Suspension of Social Worker

This issue is currently being grieved through the appropriate labor relations avenues. For this reason comment is limited to the following:

The issues involved in this case were not limited to poor case file documentation, although there were widespread failures in this area by the employee. Failure to complete case plans in a timely manner or with the participation of all parties (i.e. all case plans were delinquent and were signed by the worker only demonstrating no client participation) and lack of adequate documentation in the case files contributed to the decision to take disciplinary action. However, the primary concerns were the failure to follow intake procedures and to respond in a timely way to reports of harm and the danger to children left at risk by this failure. Investigation of reports of harm and recognition of the critical nature of doing so are fundamental to effective child protection services. The critical nature of the lapse in this case made the suspension necessary.

Had case documentation been the only concern in this particular instance disciplinary measures taken would have been less stringent. There is precedent for such disciplinary actions for similar lapses by other employees. The concept of progressive discipline is based not only on increasing sanctions for repeated failures of a similar nature but also on the application of sanctions appropriate to a particular lapse. Failures to investigate reports of harm are not widespread within the agency and cannot be countenanced if the agency is to carry out its mandates.

The staff person who was subject to the disciplinary action did have an opportunity to have union representation when it became clear that disciplinary action was necessary. Union representation is not necessary or appropriate at all meetings between management and staff. It occurred in this case when it was necessary and appropriate. The staff person was represented at meetings on June 21 and 29, 1989.

The critical issue throughout this process has been the need for the staff person to understand the importance of the error which left a child in danger due to negligence in failing to investigate a report in a timely way and to be prepared to correct this error in the future. Neither the worker nor the supervisor recognized or acknowledged the problems in this worker's caseload and the worker maintained his view that his performance was of "excellent" quality despite the identified problems. It is critical that a staff person with the tenure of this employee fully understand appropriate practice, required procedures, and the

increased danger caused to vulnerable children by failure to follow these practices and procedures.

When a supervisor fails to comprehend the need for disciplinary action and as in this case echoes the lack of knowledge of the staff person it is necessary for higher level supervisory staff to initiate appropriate disciplinary action. As in this case disciplinary action is based upon the situation and may be initiated at any level in the chain of command if necessary.

Recommendation No. 7

DFYS should improve compliance with established contract procurement requirements related to professional service contracts.

We agree with this recommendation and have already taken steps to address some of the issues identified. Efforts have been made to ensure that all solicitations are fully documented and that sole source awards are limited and fully justified. During the upcoming fiscal year DFYS will be reviewing agency procurement procedures for both contracts and grants to identify changes in procedures, such as review sheets, which can be instituted as controls to insure that procurements comply with legal and regulatory requirements. We will also be reviewing agency ability to monitor and evaluate the performance of grantees and contractors and the need for development of mechanisms for systematically monitoring and evaluating grantee and contractor performance.

It seems apparent that limited staffing available to oversee the procurement process severely hinders the agency's ability to fully comply with procurement requirements and to negotiate effectively to obtain contract terms most favorable to the state. Staffing levels also severely limit agency effectiveness in monitoring and evaluating the performance of grantees and contractors. DFYS will be reviewing the adequacy of staffing available for these processes and will be requesting additional staff in our next budget request if warranted. DFYS has already begun the process of reclassifying a clerical position to an administrative assistant level to provide much needed support in administering the award of contracts and grants and in monitoring them once they have been awarded. This should increase DFYS' ability to fully comply with procurement requirements and to administer contracts effectively.

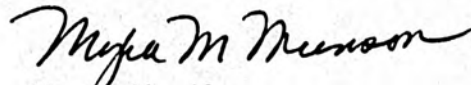
In closing I want to express my appreciation for the opportunity to respond to the audit report and recommendations. As always we have found the audit a rigorous though useful process. We also appreciate the time and effort devoted to the audit process by your staff and the objectivity and professionalism they brought

Mr. Randy S. Welker

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to the process. An objective and systematic review of issues is informative and helpful even when there is not complete agreement on the best solutions.

Sincerely yours,

A handwritten signature in cursive script, reading "Myra M. Munson".

Myra M. Munson
Commissioner

Enclosures

Audit Report

**DEPARTMENT OF HEALTH AND SOCIAL
SERVICES DIVISION OF FAMILY AND
YOUTH SERVICES RESIDENTIAL
PLACEMENT OF YOUTH IN THE YUKON-
KUSKOKWIM DELTA REGION**

August 31, 1995



Audit Control Number:

06-4526-95

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

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August 31, 1995

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF FAMILY AND YOUTH SERVICES
RESIDENTIAL PLACEMENT OF YOUTH
IN THE YUKON-KUSKOKWIM DELTA REGION

August 31, 1995

Audit Control Number

06-4526-95

This audit report reviews the process by which the Division of Family and Youth Services (DFYS) makes placement determinations for youth in the Yukon-Kuskokwim delta region of the State. The audit includes a review of placement committee methodology and statistics of children placed out of the region over the last three fiscal years. The central conclusion of our review is that DFYS placement decisions are reasonable and consistent with the documented treatment needs of the youth involved.

The audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section on page one of this report.


Randy S. Welker, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with a Legislative Budget and Audit Committee request and Title 24 of the Alaska Statutes, we reviewed Division of Family and Youth Services' (DFYS) out-of-home residential placement decisions for children of the Yukon-Kuskokwim (Y-K) District. The specific objectives, scope, and methodology of our review were as follows:

Objectives

The objectives of the audit addressed several issues related to residential child care placement decisions and how they are made. These objectives are summarized as follows:

1. To evaluate the methodology used by the Northern Region Office residential placement committee.
2. To consider how DFYS's assessment of available in-region treatment programs affected placement decisions.
3. To determine the number of Y-K youth placed in foster care, both in and out of the region.
4. To assess the degree to which the Bethel Group Home, the local provider of long term residential treatment, has implemented internal audit recommendations.

Scope and Methodology

For most of the objectives listed above, we reviewed pertinent documentation related to DFYS residential placements made during the period of FY 93 through FY 95. Our interviews with selected individuals also addressed placement decisions made during the last three fiscal years.

To address objective one, we reviewed placement committee residential staffing forms and DFYS client files. To address objectives two and four, we reviewed pertinent reports issued by DFYS and the Department of Health and Social Services (DHSS). We discussed the conclusions and analysis of these reports with site review team leaders, DHSS's internal auditor, and a DFYS residential facility licensing specialist.

Additionally, we discussed with placement committee members the decision making mechanism used by the committee when making residential placements.

To address our third audit objective, we reviewed a listing of children that DFYS had placed in foster care.

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ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services with responsibility for providing a range of services designed to remedy or prevent abuse, neglect, and exploitation of children and youth. To meet these statutory responsibilities, the department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the Youth Section of the Division of Corrections. Since this organizational combination, DFYS has administratively been divided into two sections — Family Services and Youth Corrections.

The Family Services section of DFYS is responsible for providing child protection and welfare services, licensing of child and adult care facilities, and the recruitment, training and selection of foster parents. Youth Corrections is responsible for supervising adjudicated youth offenders. A major aspect of the Youth Corrections Section is the operation of five facilities for adjudicated youth located in Fairbanks, Anchorage, Juneau, Bethel, and Nome.

DFYS management is structured on a regional basis with offices in Fairbanks, Anchorage, and Juneau. Each of the three regions has a residential placement committee comprised of various DFYS personnel, charged with the responsibility of deciding which facility best suits each child needing residential care. The committee responsible for placements of youth from the Yukon-Kuskokwim (Y-K) region is based in DFYS's Northern Region Office (NRO). The NRO placement committee is made up of two psychologists, a licensing specialist, and a probation officer from the Fairbanks area, as well as a social worker and youth facility superintendent from the Bethel area.

In 1992, DFYS reorganized the State's regional administrative structure. The reorganization collapsed five management regions (Anchorage, Fairbanks, Juneau, Nome, and Bethel) into only three larger districts, headquartered in the State's three largest cities. This consolidation effectively eliminated the Bethel and Nome regional offices, leaving field offices in their place.

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BACKGROUND INFORMATION

The Yukon-Kuskokwim (Y-K) region has only one residential treatment¹ program for adolescents, the Bethel Group Home (BGH). According to grant documents, BGH focuses on services for boys from ages 12-18 who have moderate to severe emotional problems. Many of the actual referrals to the program are adjudicated boys on probation within the youth corrections system. There is currently no residential treatment program for girls in the region.

The Jesuit order of the Catholic Church founded BGH more than 20 years ago. The central aspect of treatment provided by the home is a traditional five-step behavior modification approach. During the school year, each of the residents is enrolled in the local school system and attends classes with other Bethel youth. In the summer, BGH runs a fish camp experience in which each of the residents is expected to participate. Historically, BGH has offered little individualized treatment, with each resident expected to adapt to the home's standard program. The treatment staff, or counselors, have little formal education in the behavioral sciences, though some have extensive experience with the BGH program.

BGH has had problems recruiting and retaining treatment directors. The program had been essentially² without a treatment director for more than a year before they hired one in October 1993. The home retained that treatment director for only three months before dismissing her. It was about seven months before BGH could recruit the current treatment director. Recruitment and retention difficulties have been attributed to many factors ranging from location and a non-competitive salary, to the apparent lack of support from the BGH director and staff level for such a position.

On several occasions, there have been disputes between the Division of Family and Youth Services (DFYS) and BGH regarding the suitability of referred youth. In recent years, BGH has rejected some referrals based on the home's evaluation that the client's behavioral problems were too severe for BGH's treatment program. DFYS has asserted that if BGH developed a more individualized treatment approach the disputed referrals would likely be more suitable for the home's program.

BGH's rejection of these applicants has contributed to DFYS's realization that the agency's description of services and expectations lack specificity. DFYS sets out descriptions of services in the agency's request for proposal (RFP) that outlines grantee's responsibilities. Accordingly,

¹A facility known as the Bethel Receiving Home also provides residential services for youth in the Yukon-Kuskokwim region. The program at the receiving home is designed to provide what is termed short-term shelter for youth of both genders whose placement status is in transition. The shelter is designed to provide limited treatment and does not typically keep youth for more than 30 days.

²A treatment director had been hired in August 1993, but lasted only a week before he accepted another position in the community.

DFYS is rewriting the RFP to include more specific descriptions of services to be provided by the grantee. See Recommendation No. 2 for more discussion regarding this issue.

DFYS evaluation reviews have criticized BGH's treatment program and accounting practices

BGH has been the subject of fairly intense scrutiny over the last few years.³ This scrutiny arose, in part, from a letter of complaint filed by BGH's former treatment director alleging both programmatic and financial irregularities. DFYS's response to the complaint was to launch extensive reviews of the facility's treatment program and accounting practices. Both of these reviews were critical of BGH's operations. The report on the treatment program, conducted during February 1994, raised the following concerns:

Staff do not appear to have received basic training in counseling skills to maintain ongoing, programmatic treatment without adequate clinical supervision . . . Staff do not appear to receive adequate clinical supervision to provide basic counseling services to the youth in the home.

The report goes on to comment: "*BGH needs not only a mature, qualified clinical treatment director, but also a program wide commitment to formal treatment. Without this program change, any new "outside" clinical person will be ineffective.*"

DFYS's continuing concern with the BGH treatment team lead to the following recommendation regarding future placements:

If BGH continues to choose their milieu community based treatment philosophy while resisting formal and treatment plan driven treatment, those youth who present with serious mental health, substance abuse or sexual offending treatment needs should be referred elsewhere. . . . Refer all future youth through the Regional DFYS Residential Placement Committee to allow them to determine the appropriate placement for these youth based on their needs and the future BGH program's demonstrated delivery of treatment.

A special purpose financial review conducted during March 1994, contained additional criticisms of BGH. The report concluded, in part, that BGH's accounting system "*is inadequate to the task of recording expenditures and making proper allocation of costs and revenues.*" Additionally, the auditors noted errors in payroll and revenue recording as well as an absence of supporting

³BGH's first critical review of recent years was prompted by concerns raised by DFYS' proposal evaluation committee (PEC). The PEC, in reviewing, BGH's FY 94 program proposal noted substantial deficiencies in the organization's proposed program. DFYS conducted an on-site review in September 1993 and criticized BGH for not developing individualized treatment plans for referred youth on a timely basis nor effectively monitoring treatment progress. The review commented that "*if the Bethel Group Home does not strengthen its therapeutic component, consideration should be given to restricting their admissions.*"

documentation for expenditures charged to the state grant. This report recommended suspending further funding for BGH unless the Home took corrective financial measures.

Downturn in referrals lead to cuts in BGH funding

BGH is licensed for a total of eight beds.⁴ Historically, DFYS has purchased all eight of these beds and made consistent referrals to the program. DFYS, in late October 1994, citing a lack of demonstrated need, announced a decision to fund only five beds and buy additional beds on an as-needed basis. The effect of this decision was to substantially reduce DFYS grant funding available to BGH and, accordingly, to save DFYS money that may have been spent on unfilled beds.

According to DFYS, the decision to reduce the number of compensated beds was based on "*a number of considerations.*" In a letter notifying BGH of the agency's decision, the only considerations specifically discussed were a reduction in the number of referrals made to the facility and the additional costs of paying for unused beds.

During the spring and summer of 1994, following DFYS's site review of the previous fall and the recently completed complaint investigation, the agency made only one referral to the home. BGH rejected this referral, feeling their program was not appropriate to the individual's treatment needs. At the end of June 1994, BGH had only one resident.

After BGH retained a new treatment director in July 1994, DFYS began making referrals to the program. By the time DFYS announced the bed reduction decision in October, BGH again had five residents. Throughout the rest of 1994 and into the first six months of 1995, the BGH census has ranged from six to eight filled beds.

⁴DFYS is responsible for licensing youth residential treatment facilities. The division develops regulations establishing standards that facilities must meet to be authorized to provide residential care. For the most part, the regulations address architectural and design considerations that DFYS requires to be in place prior to licensing a given facility at an established capacity level.

RATES FOR BEDS VARY BASED ON TYPE OF SERVICES PROVIDED AND FACILITY LOCATION

DFYS pays \$170.60 per bed per day for five BGH beds whether or not these beds are filled. Additional beds can be purchased on an as-needed basis at the same rate. The amount paid per bed is calculated as follows:

\$105.00 Base rate
33.60 Geographic differential
22.00 Enhanced Supervision
10.00 Clinical Services t.

\$170.60 Daily rate per bed

The base rate is the rate that is paid to each facility regardless of location, staffing levels, or services offered. The geographic differential is paid to more rural areas where the cost of living is higher than in urban settings. Enhanced supervision is paid to facilities with a 24-hour awake staff and higher staff to client ratio. The clinical services addition is paid to facilities that offer specific treatment programs.

The result of the FY 95 decision to reduce funding for beds was to reduce the BGH budget by $\$170.60 \times 3 = \511.80 per day for the months December through June. The decision to fund only 6 beds for FY 96 had a similar impact.

At the end of June 1995, DFYS announced a decision to fund six of the eight BGH beds and again purchase additional beds on an as-needed basis. The letter conveying this information to BGH cites several reasons for the decision:

First, in a review of your occupancy rate since October, 1994, the need for a full eight (8) beds was not apparent. Six (6) appears to be more appropriate with the option to pay for two (2) additional placements as needed.

Second, we continue to have some concerns about the high turnover in your Treatment Director position. You state in your proposal that the Bethel Group Home provides treatment to youth "who have moderate to severe behavioral and/or emotional problems." In order to adequately meet this objective, we are hoping to see increasing stability in this position and the treatment services you provide.

Finally, we continue to have some concerns about your fiscal accountability, and look forward to working with you during the next year to better evaluate your agencies [sic] financial needs in relation to meeting the needs of Bethel-area boys in DFYS custody.

Placement committee has representation from Fairbanks and Bethel

DFYS, before placing clients in residential treatment programs, reviews their situations and backgrounds. A group of agency professionals referred to as a placement committee performs this review. The Northern Region Placement Committee (NRO), which includes two psychologists, consists of DFYS staff drawn from the Fairbanks and Bethel areas. The committee members meet telephonically once every two weeks to consider potential residential placements. The committee documents these meetings using a residential staffing form on which social workers have listed their recommendations. The committee then completes the form as the members discuss the case with the social worker.

A case generally reaches the placement committee through a previous recommendation for residential placement. In most cases, these recommendations have come from a mental health professional involved in the case. Occasionally, the social worker makes the recommendation based on a history of failed attempts in less restrictive settings. Our observation during one placement committee meeting was that members seemed particularly concerned with placing clients in the least restrictive setting and as close to home as possible. In one case discussion we observed, the committee resisted the social worker's initial recommendation to place the client out of his region and persuaded the social worker to place the youth with a service provider closer to home.

NRO placement committee replaces Bethel-based committee

As discussed in the Organization and Function section, in FY 92 DFYS consolidated the regional office located in Bethel into a region administered out of Fairbanks. Initially, referrals to BGH were not subject to the formal approval of a placement committee. Rather, the decision to send a youth client to BGH was most often a consensus decision reached through negotiation between the probation officer, the client's parents, the public defender, and the local court. In March 1994, partially in response to a complaint that Bethel Probation Officers were boycotting BGH, the NRO placement committee assumed responsibility for BGH as well as all other residential placements. Though the NRO placement committee contains two Bethel residents, some consider it to be primarily a "Fairbanks" team.

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REPORT CONCLUSIONS

It is widely recognized that good social work case management involves an effort to maintain a child in a familiar environment whenever possible. However, there are a variety of reasons why such placements are not always possible. The Yukon-Kuskokwim (Y-K) region has a limited, though growing, array of mental health resources. These services do not presently include long-term residential treatment programs for any girls or for boys younger than 12. Residential substance abuse treatment and sex offender treatment programs are also unavailable in the Y-K region. The absence of these types of treatment programs often necessitates placement in programs out of the region. As discussed in the Background Information section, regional placement committees make these residential placement decisions.

Limited mental health resources in the Y-K region affect placement decisions

Of the 35 Y-K region clients placed in residential programs over the last three fiscal years, 27 were placed out of region. Of these, 13 were girls, 7 were boys requiring a residential substance abuse program, and 3 were boys requiring treatment for sex offenses. Additionally, four boys were placed out-of-region for other reasons.⁵

To determine whether clients needed residential treatment programs, we reviewed placement committee files and client files. In each case where the placement committee recommended a residential program, we found convincing support for that decision. Often, the committee identified the need for residential placement after several unsuccessful attempts in less restrictive settings. We also noted an ongoing concern that a proposed facility be the least restrictive possible given the client's needs.

In cases where the committee recommended substance abuse or sex offender treatment programs, we searched for evidence that those recommendations were warranted. Generally, mental health professionals had recommended the client for a residential substance abuse or sex offender treatment program before the committee reviewed the case. Occasionally, where there was no mental health evaluation on file, a long history of associated identified treatment needs was documented.

We also compared treatment needs as identified in the client file and by the placement committee to services offered by specific residential facilities. We saw only one case in which an identified treatment need may not have been met by the facility to which the client was assigned. In this case, the committee had evaluated the client as needing continuing substance abuse treatment, but sent her to a teaching parent facility not noted for such a treatment

⁵ Of the four boys referred out-of-region for "other" reasons, one was too young for BGH placement, two were rejected by BGH (one because BGH was full and one because the boy was considered too violent), and one required an intensive treatment unit.

program. Further, client progress reports from the facility did not mention substance abuse treatment.

Of the 35 residential placement files reviewed, 27 were based on a mental health professional's recommendation for residential care. Some of these recommendations named specific facilities while others left that decision to the placement committee. Of the eight referrals that were not based on mental health professional's recommendations, the referral decisions were consistent with long client histories.

Foster care clients generally placed in region

In cases where there is no documented need for residential care, children removed from their homes are placed in foster care (see inset at right). Most foster care homes are located near the child's home, though a few are located out of the region.

There are presently no foster care providers in the Y-K region for youth correction clients, resulting in each of these clients being sent out of the region.

Though DFYS must often place Y-K youth needing residential care out of the Y-K region, the agency usually keeps children in foster care within the region. The following reflects DFYS records of clients presently in foster care.

Section	In Region	Out of Region	Total
Youth Corrections	0	4	
Family Services	54	2	56
Total	54	6	60

The vast majority of foster children, however, are family services clients, and are mostly placed within the region.

Placement committee composition, methodology helps to ensure balanced decisions

In our view, the combination of placement committee composition and methodology offer reasonable assurance that placement decisions are well informed and balanced. The inclusion of two mental health professionals on the committee enhances its credibility. The additional reliance on recommendations from mental health professionals outside the Division of Family and Youth Services (DFYS) organization and the frequency with which they concur with DFYS recommendations offer additional support for most placement committee decisions.

Prior to the 1992 reorganization, the placement committee process was less formal, based more on consensus, and entirely local. When the placement committee process was formalized and moved to Fairbanks, Bethel residents may have felt some loss of ownership of the residential placement process. Though Bethel residents may feel that they have little remaining influence over the placement decision making process, two of the six members of the team are Bethel

residents. Both of these residents are high profile DFYS employees⁶ and are active participants in the committee process.

It is our conclusion that out-of-region placements of Y-K youth over the last three years have been justified. We base our conclusion on the credentials and experience of placement committee members, in combination with our own observations of a placement committee meeting and extensive client file support for residential placement decisions.

BGH has complied with some, though not all, of Internal Audit's recommendations

In response to the Department of Health and Social Services (DHSS) Internal Audit's criticisms regarding Bethel Group Home's financial management, BGH contracted with an accounting firm to design and implement a general ledger accounting system for them. BGH has been using this system since April 1995. Other recommendations made by DHSS internal audit included developing a better tracking system for revenues, closing multiple bank accounts, and updating the executive director's employment contract, which had expired. BGH has implemented each of these recommendations.

The internal audit report also found that personnel files were incomplete, BGH needed a travel authorization system, and that BGH's accounting firm chronically submits required single audit reports well past the time they are due. These findings still exist. A recent standard by standard licensing review found that personnel files are still incomplete. As of the date of this report, the FY 94 single audit due by June 30, 1995, has still not been submitted to the Office of Management and Budget.

While BGH's history of accounting difficulties does not seem to have impacted placement decisions, DFYS cites it as one of the reasons that the agency continues to be reluctant to fund the BGH program for a full eight beds. As shown in the Background Information Section, BGH's financial accountability continues as a major concern to DFYS. The agency's correspondence related to FY 96 grant funding reflects this concern.

⁶One is the supervisory social worker for Bethel Family Services, the other is the Bethel Youth Facility superintendent.

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FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Division of Family and Youth Services (DFYS) in conjunction with the Division of Alcohol and Drug Abuse should consider conducting a needs assessment of Yukon-Kuskokwim (Y-K) youth to help establish programs aimed at keeping clients with specific treatment needs in the community.

As discussed in the Report Conclusions section, the Y-K region has a limited array of mental health resources available to adolescents. One result of these limitations is that Y-K region youth requiring either a residential girl's treatment program or substance abuse treatment are sent out of the region to obtain treatment. In fact, nearly 75% of the children that were sent out of the region over the last three fiscal years were girls and/or in need of substance abuse treatment.

The expansion of mental health resources in the delta region will help to ensure that Y-K region children can obtain necessary treatment in or near their communities. The arguments for retaining children in or near their regions are numerous. Most often mentioned are the family and community support that can be offered to the child and the congruence of cultural values. In addition, clients placed in programs outside of their communities during the school year generally miss part of the school program. Reintegration of children back into the community becomes increasingly difficult when they must simultaneously try to establish a drug-free sober peer group and catch up on missed school work.

The most proactive approaches to adolescent substance abuse problems are prevention and early intervention programs. Accordingly, the best way to keep Y-K youth in the region would be to develop such programs. These programs would require the development of a mechanism to identify and involve high-risk children in preventive programs. An effective prevention and early intervention program would help to reduce the number of children needing substance abuse treatment.

Though some of the children sent out of the region clearly need residential treatment, others could probably stay in the community if appropriate support services for adolescents in substance abuse recovery were available. These services would include adolescent Alcohol Anonymous (AA) and Children of Alcoholics (COA) meetings, and probably an outpatient treatment component. With such services available in the community, more youth could be placed at the Bethel Group Home, and have access to such services as an integral part of their treatment plan.

It is our understanding that the DFYS Central Office has contracted for a needs assessment for Y-K girls to be completed by the end of September 1995. The Northern Region Office (NRO) reports that they are also performing a needs assessment aimed at ensuring that needs for its

youth clients are being met. NRO will use this assessment to develop the residential child care and other grantee requests for proposals (RFP) for FY 97. We encourage DFYS to continue these efforts to identify specific needs for the entire region and particularly for the Y-K district.

Recommendation No. 2

DFYS should clarify the definition of services set out in the agency's RFPs for the provision of residential child care.

In funding residential care facilities for youth in its custody, DFYS uses an RFP. This document solicits proposals from local agencies to provide the necessary residential care and treatment. The RFP is the central document designed to define the nature and extent of services expected from residential facilities.

Over the last few years, DFYS has experienced problems with some residential child care providers over the meaning of certain RFP provisions. DFYS reports that while there are few problems with the larger, perhaps more sophisticated, facilities' interpretations of grant language, some smaller facilities have interpreted RFP requirements differently than DFYS intended. The Bethel Group Home (BGH), for example, has been in ongoing conflict with the division over the definition of certain grant requirements.

The FY 94 RFP included standard language related to what DFYS wants from a residential care provider. Specifically, the RFP required a *"specialized program for Emotionally Disturbed and Behavior Dysfunctional boys [and] . . . Clinical Services provided by a master's level therapist."*

BGH and the division have disagreed over the definition of "a specialized program" and clinical services. As discussed in the Background Information section of this report, DFYS has expressed dissatisfaction with BGH's treatment program, suggesting that BGH has not met the intent of the RFP. Disagreements related to the treatment program have had two major ingredients: BGH's non-individualized treatment of clients and the periodic lack of a treatment director. These particular problems have now been at least partially resolved; BGH has a masters level therapist on staff, and it is our understanding that she has taken a leading role in developing more individualized treatment plans for residents.

While on-site reviews for a few years have reflected the view that BGH's treatment program was deficient, DFYS has not taken steps to clarify the RFP requirements or to better define grant terms. If these requirements had been more clearly presented in the RFP, perhaps the resolution of disputed terms would have been a much shorter process. Though some of the past RFP language disputes may now be in the resolution process, others will unquestionably arise unless revisions to the RFP include the addition of clear and detailed expectations.

According to the NRO regional manager, DFYS has not yet developed the RFP for FY 97 grants. The region recognizes that while RFPs have remained fairly static over the years, regional needs have changed. NRO has established a committee to assess youth treatment needs in the region. The regional manager comments that because it is unlikely youth services will receive more grant money in the future, it has become increasingly important to ensure available funding is spent most effectively. We encourage DFYS to continue efforts to both better identify the needs of northern region youth and to define more clearly the methods by which they expect those needs to be met.

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DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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October 16, 1995

Mr. Randy S. Welker
Legislative Auditor
Legislative Budget and Audit Committee
Division of Legislative Audit
P. O. Box 113300
Juneau, AK 99811-3300

OCT 2 1995

Dear Mr. Welker:

RE: Preliminary Audit Report, August 31, 1995
Department of Health and Social Services (DHSS)

This letter is in response to the subject audit. Department response to the Legislative Audit recommendations is as follows:

Recommendation No. 1

DFYS in conjunction with the Division of Alcohol and Drug Abuse should consider conducting a needs assessment of Y-K youth to help establish programs aimed at keeping clients with specific treatment needs in the community.

DHSS concurs with the recommendation. As noted in your preliminary report, DFYS has contracted for a needs assessment specifically targeting the needs of girls in this geographic area. Since this needs assessment is targeted at girls only, DFYS will review it with the Division of Alcohol and Drug Abuse (ADA) to see whether it adequately addresses the need for substance abuse issues for this population. DFYS and ADA will, in addition, pursue the feasibility of conducting a joint assessment of substance abuse prevention and treatment needs for all youth in the region.

It should be noted that the department will also attempt to coordinate any such needs assessment with providers such as schools, health, mental health, public safety and substance abuse. It will be critical to involve the communities in this region in such an assessment. The most appropriate solutions must be

Ms. Diane Burnham
October 16, 1995
Page 2

community based and should come from the community involved, and the community must also help define the scope of the issues to be addressed.

Recommendation No. 2

DFYS should clarify the definition of services set out in the agency's Request for Proposals for the provision of residential child care.

DHSS concurs with this recommendation. DFYS will require staff to describe services requested more clearly in Requests for Proposals, and review will be made to ensure they do provide clarity.

Thank you for the opportunity to respond to this audit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Karen Perdue".

Karen Perdue
Commissioner

Audit Report

**DEPARTMENT OF HEALTH AND SOCIAL
SERVICES, DIVISION OF FAMILY AND
YOUTH SERVICES, SELECTED CHILD
PROTECTION ISSUES**

March 26, 1998



Audit Control Number:

06-4586-98

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

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March 26, 1998

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF FAMILY AND YOUTH SERVICES SELECTED CHILD PROTECTION ISSUES

March 26, 1998

Audit Control Number

06-4586-98

This report summarizes our review of various operational aspects of the Division of Family and Youth Services. Two central aspects of our review were how the agency utilized personnel in FY 97, and how well the agency is doing in responding to reports of abuse and neglect of children, in addition to supervising children in state custody.

This audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section.

A handwritten signature in cursive script that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we conducted a review of various aspects of management and casework related to the child protective services function within the Division of Family and Youth Services (DFYS), which is organizationally located in the Department of Health and Social Services (DHSS).

Objectives

1. To evaluate how effectively DFYS management utilized FY 97 personal services appropriations in maintaining agency staffing levels to adequately address and respond to reports of abuse and neglect received by the agency.
2. To evaluate how effectively and consistently DFYS met timelines, established either in statute or the agency's internal policy and procedures in investigating and responding to reports of child abuse or neglect.
3. To identify the factors and circumstances, if any, which inhibit DFYS' ability to effectively respond to reports of child abuse and neglect.
4. To identify the degree to which DFYS is unable to respond to reports of harm, how DFYS manages these reports, and evaluate the effect of not responding may have on child safety.
5. To assess the impact of recent changes in federal law and proposed state legislation on the State's child protection system.

Scope

Our audit focused primarily on determining the effectiveness of DFYS' investigative practices. Most of our analysis is based upon data related to operations of FY 97. Our fieldwork reviewed casework operations across the state.

Our scope was hindered to a limited degree by the unreliability of DFYS' management information system, which compiles child protection data. These limitations existed primarily due to inconsistent and untimely data entry practices across the State. Where we could not rely on the data, we developed alternative audit techniques to confirm the information that served as a basis of our observations and conclusions. The deficiencies of DFYS' management information system are addressed in Recommendation No. 7.

Methodology

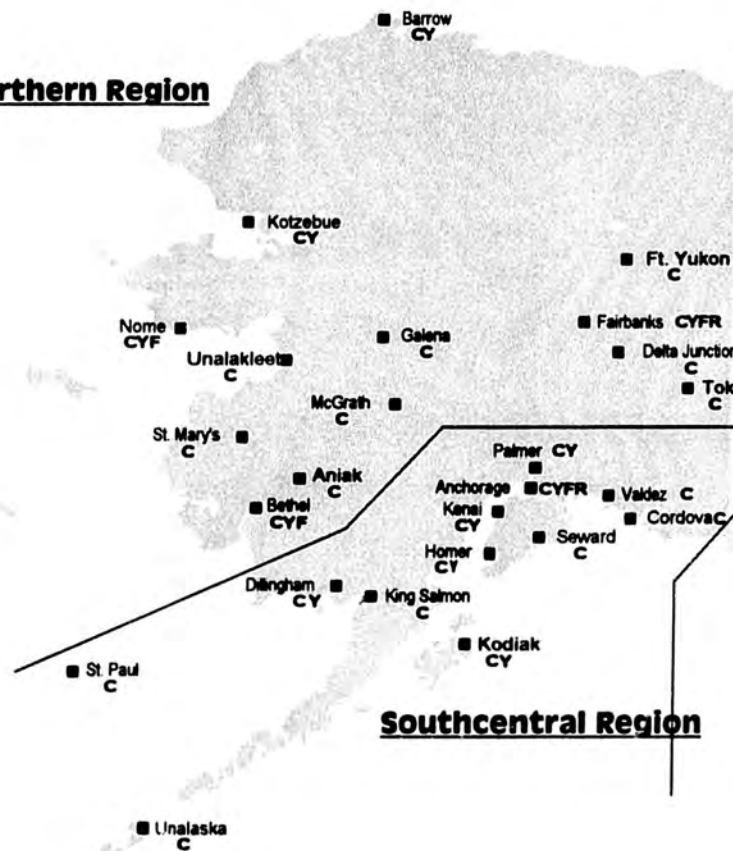
Significant methodologies applied in this audit include the following:

1. Interviews of DFYS child protection staff across the State including investigators, supervisors, and regional managers.
2. Review reports on Alaska's child protection system including the following:
 - *Administrative Review of the Anchorage Family and Youth Services Office*, April 1996.
 - Alaska Judicial Council, *Improving the Court Process for Alaska's Children in Need of Aid*, October 1996.
 - *Anchorage Family and Youth Services Records Review*, November 5, 1996.
 - *Child Fatality Review and Response*, May 27, 1997.
 - *Statewide Case Record Review, Multiple Reports of Harm*, August 1997.
 - *Report by the Review Panel, A review of five child protection cases from the state of Alaska*, December 1, 1997. (a.k.a. Kempe Center Report)
 - *Child Protection Review Team, Report to Governor Knowles*, December 11, 1997.
 - *Protecting Alaska's Children From Neglect: The Appropriate Legislative Response*, *Alaska Law Review – Volume 14*.
3. Review of other child protection system reports including:
 - State audit reports from Washington, Kansas, Arizona, and Minnesota.
 - Various publications from the Child Welfare League of America.
4. Analysis of the use of amounts appropriated for DFYS personal services in FY 97 using agency budgets and state payroll information.
5. Random sample review of 712 reports of harm received by five DFYS offices across the State during FY 97. This review included 412 investigated reports and 300 uninvestigated reports. We reviewed reports received in the Anchorage, Fairbanks, Bethel, Kenai, Mat-Su, and Juneau DFYS offices.
6. Job-shadowed social workers responding to reports of harm in Anchorage, Fairbanks, Bethel, and Mat-Su.

7. Interviewed individuals outside DHSS including employees of the Department of Law, University of Alaska, and Alaskan residents concerned about the State's child protection system.
8. Performed a review of various aspects of the legal system and its affects on the State's child protection system. Our review included obtaining an understanding of current state and federal laws, the impact of recent Alaska Supreme Court decisions, recent changes to federal law (the Adoption and Safe Families Act of 1997), and proposed changes to state law (HB 375 and SB 272).

Department of Health and Social Services Division of Family and Youth Services Offices

Northern Region



C - Family Services Office
 Y - Youth Corrections Office
 F - Youth Correctional Facility
 R - Regional Office
 S - State Office

Southeastern Region

Southcentral Region

ORGANIZATION AND FUNCTION

Title 47 of the Alaska Statutes charges the Department of Health and Social Services with responsibility for providing a range of services designed to remedy or prevent abuse, neglect, and exploitation of children and youth. To meet these statutory responsibilities, the department created the Division of Family and Youth Services (DFYS) in 1980 by combining the Division of Social Services with the youth section of the Division of Corrections.

The Family Services section of DFYS is responsible for providing child protection and welfare services, licensing of child care facilities, and the recruitment, selection, and training of foster parents. The other major section of DFYS, Youth Corrections or Youth Services is responsible for supervising adjudicated youth offenders.

The focus of this audit was Family Services. Specifically, the audit concentrated on child protective services (CPS). The goal of CPS is to identify, treat, and prevent child abuse and neglect, as well as to ensure reasonable efforts are made to protect and maintain children in their own homes. DFYS provides protective services for children by investigating reports of harm, referring families to community resources, initiating legal intervention if children are unable to remain safely in their own homes, and providing out-of-home placements and permanency planning when necessary.

When a child is taken into physical custody they are placed either in foster care, or perhaps in an emergency shelter facility. DFYS also contracts with residential care facilities to provide assorted levels of care and treatment of youth.

Each provider is subjected to licensure and periodic review to assure children are provided with reasonable care in a safe environment. Responding to complaints of abuse and neglect for children in out-of-home care is also the responsibility of DFYS social and licensing workers.

In 1991, the Hickel administration comprehensively reorganized DFYS. A central aspect of the reorganization was the realignment of management within the agency's Family Services and Youth Corrections sections. The Family Services section was scaled down (from five) to three regions: Southeast, Southcentral, and Northern. Under the reorganized structure, regional administrators were responsible for both Family Services and Youth Corrections operations within their particular region. The administrator for each region, headquartered in Juneau, Anchorage, and Fairbanks, respectively, currently reports directly to the division director. The map on page 4 shows the various DFYS offices around the State.

According to the agency's FY 99 budget documents, the three DFYS regions had 328 permanent, full-time authorized positions during FY 97. Including Central Office and Youth Facility Services, DFYS had 570 permanent, full-time authorized positions. During that same period, DFYS' three regions had a combined operating appropriation in excess of \$22 million. The total DFYS operating appropriations were \$69.8 million, which included the three regions, Central Office, Purchased Services, and Youth Facility Services.

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BACKGROUND INFORMATION

The purpose of Child Protective Services is to identify, treat, and prevent child abuse and neglect, through provision of services to children and families. Child Protective Services staff most often become aware of suspected child abuse or neglect from persons referred to as reporters.

Reporters may be concerned individuals in the general public, or mandatory reporters. Mandatory reporters, as defined under AS 47.17.020, are persons who, in the performance of their occupational duties, have reasonable cause to suspect that a child has suffered harm as a result of child abuse or neglect.

The screener receives information on potential harm to a child

The screening phase involves receiving information of potential harm to a child and determining whether to initiate an investigation.¹ Screening involves ascertaining the current status of the child, the potential for immediate and/or future danger, and the location of the child and parents. The screener elicits additional information about the alleged victim and the family in order to most accurately assess the degree of risk to the child.

Additional information helpful for the screening assessment includes: prior history with child protection, substance use or abuse by parents or caregivers, domestic violence, history of concerns, and family strengths and resources. Although the screener may be able to determine the need and immediacy of intervention on the basis of a brief contact with one reporter, it may also be necessary to contact several collateral sources to acquire the needed information. If the report of harm does not meet the criteria for investigation, the case is closed.

Reports of harm meeting criteria for investigation are assigned a priority level and moved into the investigation stage. DFYS has three priority levels (see page 8) with three different response times. Those reports determined to be priority 1 must be responded to within 24 hours from the time the report is received; priority 2 must be responded to within 72 hours, and priority 3 within 7 days.

The figure on page 10 summarizes the screening and intake process and illustrates how the two aspects of screening and investigation fit together.

¹ AS 47.17.030 (a) requires DFYS to investigate all reports of harm. The statute reads as follows:

If a child, concerning whom a report of harm is made, is believed to reside within the boundaries of a local government exercising health functions for the area in which the child is believed to reside, the department may, upon receipt of the report, refer the matter to the appropriate health or social services agency of that local government. For cases not referred to an agency of a local government, the department shall, for each report received, investigate and take action, in accordance with law, that may be necessary to prevent further harm to the child or to ensure the proper care and protection of the child. [Emphasis added]

P1 Assigned to all cases presenting the greatest degree of risk to the child, and requiring an emergency response.

P1 must be responded to within 24 hours.

Priority One (P1)

Death	Abandonment
Brain Damage, Skull Fracture	Failure to Thrive
Subdural Hematoma	Burns, Scalding
Internal Injuries	Wounds
Malnutrition	Bone Fractures
Torture	Venereal Disease
Sexual Exploitation or Molestation	
Lack of Supervision (no caretaker and young child)	

Report of Harm Prioritization

P2 Assigned to all reports which present a lesser degree of risk to the child. Priority 2 designations indicate that while the situation is serious, information available does not indicate the child is in immediate danger.

P2 must be responded to within 72 hours.

Priority Two (P2)

Cuts/Bruises/Welts
Human Bites
Sprains/Dislocations
Tying/Close Confinement
Drug/Alcohol Abuse
Medical Neglect
Excessive Corporal Punishment

P3 Assigned to those referrals which indicate that a delay in responding to the situation will not result in significant additional harm.

P3 must be responded to within seven calendar days from receipt of the report.

Priority Three (P3)

Other Abuse
Inadequate Food (older child)
Inadequate Shelter
Inadequate Clothes
Educational Neglect
Other Neglect (older child)
Emotional Abuse (no observable manifestations)

Source: Child Protective Services Manual, 1998 version.

The DFYS investigator gathers information about the alleged abuse or neglect

The investigation phase involves gathering information about a particular incident or history of incidents with the goal of protecting the child from harm or further harm. In the course of an investigation, the social worker must consider factors that may indicate that risk exists beyond the immediate allegations. Such risk factors include chemical dependency, domestic violence, and if the parents or caretakers were victims of abuse or neglect as children. Social workers are also directed to consider family strengths and resources that can be coordinated to reduce the risk to the child. Such factors include the presence of responsible extended family, neighbors and friends of the family involved, and other potential support structures. The various reports of harm discussed on page 12, which were taken from the sample of reports of harm (ROH) reviewed, illustrate the variety of circumstances DFYS screeners and investigators must address.

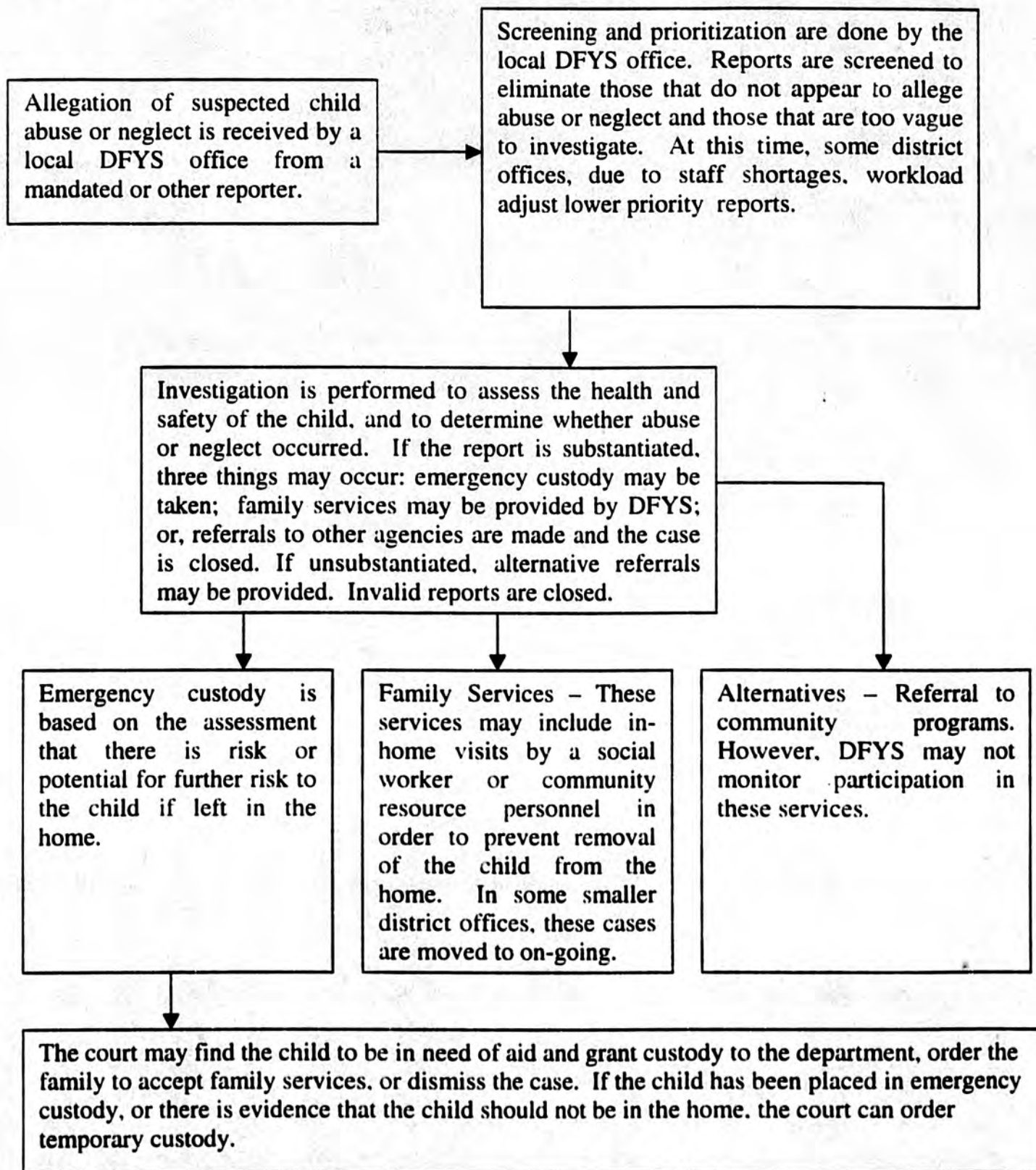
Social workers often have to coordinate interviews with law enforcement agencies to ensure, when both agencies are mandated to respond, trauma to the child is minimized. Regardless of other agency involvement, the social worker retains final responsibility for the direction and resolution of the investigation.

The investigating social worker also prepares a risk assessment. The risk assessment involves a review of the level of danger to the child. Social workers use the facts gained in the investigation, along with the circumstances in a report of harm, to complete the risk assessment tool (RAT). The RAT is intended to measure and quantify the degree of risk for each case. RAT scores determine service level, which in turn dictates the minimum required services to a family. The purpose of these services, which can include family support and referral activities, is to protect the child and to alleviate the risk which originally led to DFYS intervention.

Investigations will be concluded with a finding on the allegation

Investigations will be concluded with a finding on the allegation. Findings are substantiated, unconfirmed, or invalid. If a finding is substantiated, it is determined that the child suffered harm or faces risk of harm as a result of abuse or neglect. If a finding is classified as unconfirmed, the investigator cannot determine whether the child suffered harm through the action or inaction of caretakers. A social worker may make an invalid finding when there are no facts to support the allegation. When a referral is determined to be invalid, the case is closed. When a referral is unconfirmed or substantiated, the situation will be assessed by analyzing the outcome and service level (as determined by the RAT). The investigation will then be terminated by either closing the case or transferring the case to the ongoing caseload (see flowchart on next page).

The Screening and Investigation Process



DFYS social workers provide ongoing services to children and families

Whenever a decision is made to maintain a case open beyond the investigation phase, ongoing services will be provided to the family. At a minimum, ongoing cases represent those cases in which DFYS is legally required to be involved. However, cases in some offices will remain open when it is probable DFYS will take custody of the children if the family does not follow the case plan.

It is the agency's policy is to make reasonable efforts to maintain children in their own home. However, if conditions are unsafe for the child, then removal is warranted. From that point forward, casework services are directed toward permanency for the child, and when possible, through family reunification.

The minimum casework service levels to be provided to the child and family is determined by the family's score (low, medium, high) on the RAT, their location to the DFYS office involved (local or remote), and the progress shown by the family since the initial classification. Changes in service level can be made only after a service level review has occurred. Service level standards represent a minimum level of service to be provided to a family. Certain cases will require higher levels of contact, as determined by risk to the children, client need, and good social work practice.

RAT Level	Service Level Requirements
LOCAL HIGH	Four face-to-face family contacts per <i>month</i> (two of which may be by a collaborative ²). Plus one face-to-face contact with child(ren) individually, if age appropriate, by social worker per <i>month</i> . Social worker must make one of the family contacts in the home.
REMOTE HIGH	One face-to-family contact by social worker in home with family per <i>month</i> . Plus one face-to-face with child(ren) individually, if age appropriate, by social worker per <i>month</i> . Worker must arrange three collaborative contacts per month.
LOCAL MEDIUM	Two face-to-face family contacts with family per <i>month</i> (one of which may be by a collaborative). Plus one face-to-face with child individually, if age appropriate by social worker per <i>month</i> . Social worker must make one of the family contacts in the home.
REMOTE MEDIUM	One face-to-face family contact by social worker in home per <i>quarter</i> . Plus one face-to-face with child(ren) individually per <i>quarter</i> in home. Worker must arrange two collaborative contacts per <i>month</i> .
LOCAL LOW	One face-to-face family contact by social worker in home per <i>quarter</i> . Plus one face-to-face with child(ren) individually, if age appropriate, by social worker per <i>quarter</i> .
REMOTE LOW	One face-to-face family contact by collaborative in home per <i>quarter</i> . Plus one face-to-face with child(ren) individually, if age appropriate, by collaborative per <i>quarter</i> . One face-to-face with family <i>every six months</i> by DFYS.

² Collaborative contact is a contact by a secondary service provider who is involved in the development and implementation of the case plan. If the worker does not designate a collaborative contact worker, all contacts must be made by the social worker.

Sample of Assigned Reports of Harm Received by DFYS

Case One: Paternal grandmother reported that stepmother's long fingernails scratch grandchild (age 11) when stepmother grabs grandchild. Also stepmother has emptied old cat litter into grandchild's bed and made grandchild sleep in it for a week when grandchild forgot to empty litter box. Parents forced other grandchild (age 10) to eat his own vomit. Case assigned as priority 2, investigated, and closed as unconfirmed.

Case Two: Anonymous reporter states that father is under the influence of alcohol or dope. Father has hit the kids (two children under 5) with a flashlight and yelled at kids. Another female in the home is using drugs. Children are inside courtyard (gated area) but parent is not watching them. Neighbors are watching kids according to caller. Case assigned as priority 2, investigated, and closed as unconfirmed.

Case Three: Neighbor reported that parents and children are often heard screaming and hollering at each other as well as someone is being beat and put into the closet (possibly 6 year-old male). This minor has been heard screaming at his parents to stop drinking. Case assigned as priority 2, investigated, and closed as unconfirmed.

Case Four: Counselor at school reported that 14 year-old child was out for two days and when the child returned to school, was hung over. Child told counselor she had been drinking with her mother. Case assigned as priority 2, investigated, and closed as unconfirmed.

Case Five: Anonymous report that teen mom may be neglecting 9 month-old baby. Baby is taken out with mom all night while mom parties. Case assigned as priority 2, investigated, and closed as invalid.

Case Six: Anonymous report that 9 year-old female is left alone after school hours while mother and father neglect her. The child seems to find her own place to stay without the parents making arrangements. Parent's priority seems to be alcohol and bingo. Parents do not make a safe plan for the child after school. The child is not fed regularly. The house is unfit and filthy. Possibly past sexual abuse. Nonspecific concern that the father or older brother may have sexually abused 9 year-old. Case assigned as priority 2, investigated, and unconfirmed.

Case Seven: Medical doctor reports concerns regarding sexual abuse of a 2 year-old girl by father. Mother alleges that her daughter has been using her finger to penetrate herself sexually. Minor alleges that "daddy hurt me." Case assigned as priority 2, investigated, and unconfirmed.

Case Eight: Neighbor called concerning neglect of four siblings. Reportedly the mother leaves her children unsupervised with their 13 year-old brother who is out of control. The 13 year-old has been sexually acting out, assaultive physically as well as verbally to anyone who challenges him with any sense of authority. A neighbor and her two children were assaulted by him, another child was shot in her face with a toy gun, and another child was beat with a broom stick handle. The mother leaves every night and does not return until morning on a regular basis. Case assigned as priority 1, investigated, and unconfirmed.

Case Nine: Police call to report they've taken four children (ages 2-13) into custody because they are unsupervised. Research of the database shows many previous neglect reports on this family. Case is assigned as priority 1, investigated and substantiated. The Assistant Attorney General advises that the history and the latest incident is not enough to gain temporary custody.

Case Ten: Women's shelter calls to report that an 8 year-old child has disclosed sexual abuse by mom's boyfriend. Mom and child are currently living at the shelter because the boyfriend is also violent. Case is assigned as priority 3 (because the child is no longer in contact with the boyfriend) and investigated, but unconfirmed.

In-home, ongoing services address problems that impair the ability of the family to function at a minimally sufficient level. The social worker may enable the parents to remain in charge of their children while periodically assessing whether in-home services are adequate to assure protection of the child. The social worker often utilizes community resources and extended family resources.

Out-of-home services provide structured, time-limited rehabilitation programs for parents to help reunite families as quickly as possible. These services often include planned, regular visitation between parents and child.

In some cases, reunification is not possible. Some parents cannot or will not provide security, affection, and continued care for the child. If reunification efforts have failed, an alternative placement plan must be developed and promptly implemented. Permanency planning choices include long-term foster care, guardianship, and adoption.

The screening, investigations, and ongoing services described on page 10 reflect the agency's child protective services (CPS) manual descriptions of the processes associated with each of those units. These processes were designed under the assumption that the agency would be adequately staffed to carry out the policies and practices outlined in the CPS manual. However, increasing workloads and relatively steady funding levels have reduced DFYS' ability to respond in accordance with CPS manual standard. The agency has developed several strategies to deal with the discrepancies between caseload and resources. Among these is a case prioritization method referred to as workload adjusting.

Original workload adjustments based on workload accounting system and case prioritization

During the mid 1980s, DFYS experienced a steady increase in the demand for child protective services, which resulted in high caseloads. In an effort to *"identify and provide services to those clients with the greatest need and to most effectively allocate resources to enhance service provision to those clients,"* the agency developed a case management system. The case management system included a workload accounting system. This system, intended as a tool for managers to better evaluate caseload distribution among their workers, consists of time standards for each area of the intake³ and ongoing casework process. These standards are based on the results of a DFYS time study conducted in 1989.

DFYS managers have unanimously commented that the hours applied in the workload accounting system significantly understate actual hours required to do the job. Managers attribute this understatement largely to a lack of awareness on the part of social workers regarding the precepts of the study. Because the implications of failing to accurately track the hours required for each task were not emphasized when social workers were assigned these tracking duties, the resultant study was haphazard at best. Furthermore, managers do not believe CPS standards were followed during the time study.

³ The term intake covers different components of case work depending on the size of the DFYS office processing the ROH. In the Anchorage district office the intake function consists of two separate and distinct components—screening and investigations. In other smaller offices, intake covers both screening and investigations with little distinction.

When a memorandum publishing the results of the study was issued in 1989, it was clear that the division was unable to meet the minimum standards of contact with clients or investigate all reports, even with required hours measured by understated time standards. The memorandum describes the problem:

In most work sites, Division employees are faced with the prospect of having a system which defines clients with the highest risk but due to chronic understaffing, are unable to meet with those clients on even the most minimum scale. This results in situations where the quality of service to all clients is diminished. The purpose of [workload adjusting] is to address this systemic deficiency and allow workers to provide enhanced services to those clients at the highest risk of continued harm.

The memorandum goes on to describe situations in which cases may either be closed (for ongoing units) or not investigated (for intake units). The decision to workload adjust investigations was to be based on the workload accounting report. Workload adjusting could take place only in offices where the workload for investigators was above 1.05, a calculation of the ratio of available hours to required hours. Only reports of harm rated as priority 3 were to be eligible for workload adjustment. Additionally, if a third priority 3 report was received for a family that had not been investigated, due to the prior reports, the referral would automatically receive a priority 2 rating and be investigated within priority 2 timelines. Reports of harm not investigated were to be logged and investigated at a later date, when the workload dropped below a 1.05 ratio. All workload adjustments, whether for intake or ongoing services, were to be recorded on a work adjustment report and submitted on a monthly basis to the regional manager.

In the years since the workload adjustment policy was developed, the systematic approach to prioritizing caseloads has deteriorated. Essentially the systematic approach to prioritizing caseloads has been abandoned due to the dramatic increase in reports of harm since 1989 (see chart on page 18). Workload adjusting priority 3 reports has become standard for most offices. In general, intake supervisors make these adjustments with little or no attention to standardized workload reports. Furthermore, where the initial workload adjusting theory was designed only to delay an investigation, currently most workload adjusted ROHs will never be investigated.

New federal law promotes limiting time children may be kept in out-of-home care

On November 19, 1997 the president signed into law the Adoption and Safe Families Act of 1997. The primary focus of this law is to improve the safety of children, promote adoption and other permanent homes for children who need them, and support families. The new law made numerous changes and clarified a wide range of federal policies that had been in place since the 1980 Adoption Assistance and Child Welfare Act. The new law provides for the following:

1. Set-aside funding is provided for continuing support of Court Improvement Program. – The Alaska Court System (ACS) continues its efforts at streamlining and promoting consistency in the adjudication of child-in-need-of-aid (CINA) cases through funding

from this program. ACS had received funding to review how it handled CINA hearings in various jurisdictions and issued a 1996 report that identified many significant areas of difference and made numerous recommendations for improvements.

2. Adoption Incentive Payments provided for states. – The legislation provides \$20 million in federal fiscal years 1999 through 2003 for payments to eligible states which exceed the average number of adoptions the state completed between 1995 and 1997. Essentially the program provides for paying states a bonus for each foster child adopted.
3. New time line and basis for filing for termination of parental rights. – Previously, federal law did not require states to initiate termination of parental rights proceedings based only on a child's length of stay in foster care. Under the new law, states must file a petition to terminate parental rights on behalf of any child, regardless of age, who has been in foster care for 15 out of the most recent 22 months. For children already in foster care, states are required to phase in the filing of termination petitions beginning with children for whom the permanency plan is adoption or have been in care the longest.
4. New, shorter time frame for permanency hearings. – Former federal law required a disposition hearing within 18 months of a child's placement into out-of-home care. The new law establishes a permanency planning hearing for children in care to occur within 12 months of a child's entry into care. At the hearing, the law requires a determination be made whether and when: (1) the child will be returned home; (2) the child will be placed for adoption and a termination of parental rights filed; (3) the child will be referred for legal guardianship; or, (4) another planned permanent living arrangement is made if other options are not appropriate.
5. Further definition of "reasonable efforts" to reunite families. – As required by the 1980 law, States must continue to make reasonable efforts to preserve and reunify families. However, currently the "reasonable efforts" requirement does not specifically apply in cases in which a court has found:
 - The parent has subjected the child to "aggravated circumstance" as defined in state law (including, but not limited to abandonment, torture, chronic abuse, and sexual abuse).
 - The parent has committed murder or voluntary manslaughter or aided or abetted, attempted, conspired or solicited to commit such a murder or manslaughter of another child of the parent.
 - The parent has committed felony assault that results in serious bodily injury to the child or another one of their children.
 - The parental rights of the parent to a sibling have been involuntarily terminated.

6. Access for foster parents, pre-adoptive parents, and relative caretakers to court reviews along with an opportunity to speak. – Under the new law a foster parent, any pre-adoptive parent, or relative caring for a child must be given notice of and an opportunity to be heard in any review or hearing involving the child.
7. Established outcome measures. – The U.S. Department of Health and Human Services will develop, in consultation with governors, state legislatures, state and local public officials, and child welfare advocates, a set of outcome measures to be used to assess the performance of states in operating child protection and child welfare programs. Also to be developed is a system for rating the performance of states with respect to the outcome measures.

In many respects it is this new federal law, in addition to the recent Alaska Supreme Court decisions, and recent casework setbacks, which has contributed to the administration seeking a substantial revision to the State's CINA statutes. As with most federal legislation, the State has both "stick" and "carrot" incentives to conform with the law. Perhaps most significant is the prospect of losing federal funding (some \$10 million in FY 97) used to support various aspects of child protection services in the State.

REPORT CONCLUSIONS

Personnel and Caseload

A central issue of our review involved the utilization of resources. The request for the review was prompted in large part by a request for increased funding. The legislature expected to receive such a request for expanded funding in order that the Department of Health and Social Services' (DHSS) Division of Family and Youth Services (DFYS) could be more responsive to the reports of abuse and harm to children. In various reviews conducted of DFYS in recent months, which grew out of tragic child deaths in the fall of 1997 and winter of 1998, the lack of necessary personnel resources was a common theme.

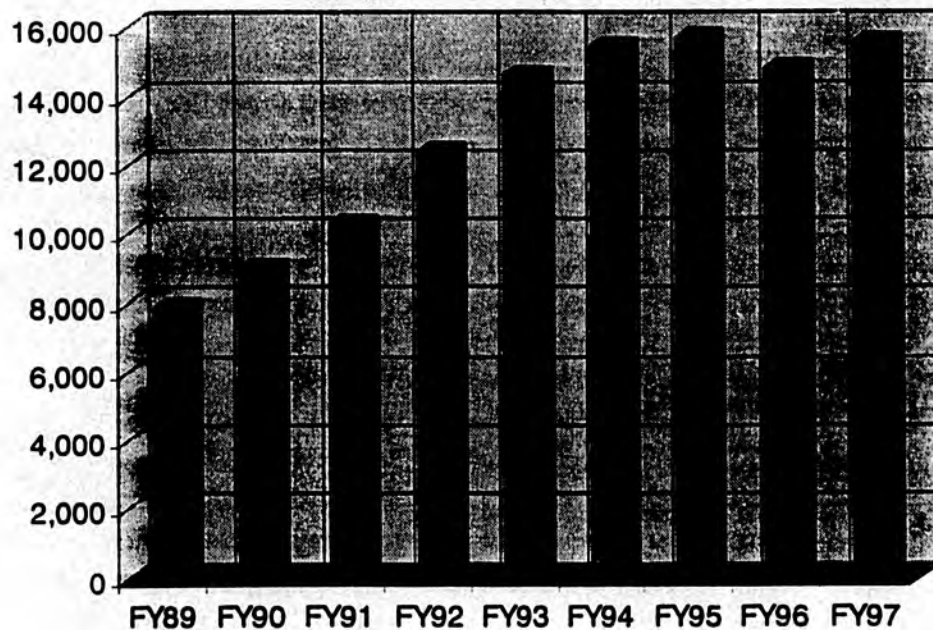
As shown on the graph on page 18, DFYS has, in recent years, faced a growing caseload. This growth has limited DFYS' ability to carry out investigations within the guidelines required by the agency's child protective services (CPS) manual. Specifically, not all reports are investigated. Of those reports that are assigned, many investigations are not begun on time. Though DFYS is currently unable to comply with CPS manual standards, the prioritization of reports of harm reflect the agency's efforts to use limited resources to best protect the children most at risk.

In FY 97 DFYS could not investigate more than 3,700 reports of harm within its jurisdiction

DFYS is required to take and investigate all calls from the public regarding suspected child abuse and neglect. These calls are referred to as reports of harm (ROH). Alaska Statute 47.17.030(a) requires DFYS to respond to every ROH. The statute requires in part that the agency "... *for each report received, investigate and take action in accordance with law, that may be necessary to prevent further harm to the child or to ensure the proper care and protection of the child.*"

DFYS' FY 99 budget documents state, that due to lack of resources, the agency was unable to respond to more than 5,000 reports of harm (ROH) during FY 97. This total represents some ROHs which would not typically be responded to, regardless of availability of staff. Over 1,200 of these reports represent complaints that contain either insufficient information on which DFYS could act, or represent situations that are beyond the agency's jurisdiction. The table on the next page summarizes ROHs, both assigned and uninvestigated, by various DFYS offices statewide.

Reports of Harm



The graph above illustrates the increasing trend in total referrals regarding child abuse and neglect made to the agency. Fortunately, it has not currently been increasing at rates experienced during the early years of the graph.

FY 97 Screening Outcome of all Reports of Harm ⁴					
District Office	Total Reports of Harm	Assigned for Investigation		Not Assigned for Investigation (Workload Adjusted)	
		Number	Percentage	Number	Percentage
Anchorage	5,725	5,090	89%	589	10%
Mat-Su	1,052	343	33%	707	67%
Kenai	881	669	76%	155	18%
Fairbanks	2,534	990	39%	1,403	55%
Bethel	1,361	668	49%	482	35%
Juneau	752	393	52%	182	24%
All Others	<u>3,242</u>	<u>2,376</u>	73%	<u>222</u>	7%
Statewide	<u>15,547</u>	<u>10,529</u>	68%	<u>3,740</u>	24%

⁴ Reports of Harm screened out as non-child protection issues or insufficient information account for the difference between total Reports of Harm, assigned and workload adjusted.

DFYS' triage response to ROHs is risk based but leaves some children at risk

To manage an increasing workload, DFYS has developed an informal policy to delay or never investigate ROHs determined to be lower risk. The use of this practice, referred to as workload adjusting, varies between district offices. Some agency offices workload adjusted as many as two-thirds of the ROHs received.

Though DFYS appears to be generally triaging in ways consistent with a risk based approach, the agency's inability to investigate many cases leaves some children at risk.

The ROH described in the inset at right, one of the reports we reviewed, is an example of a workload adjusted report. From our review of 300 workload adjusted reports of harm, a profile of a typical workload adjusted case emerged. In general, these reports are for neglect of older children from families that have been investigated before. The figures on the following page, graphically summarize the various information about workload adjusted ROHs.

Example of a Workload Adjusted ROH

The report of harm concerned alleged neglect of an 11 year old girl. There had been 9 prior reports of harm, 4 of which had been investigated. The narrative stated the child *"has missed 40 days of school this year, not from illness. She is a very bright 6th grader, but is doing very poorly in school – used to be a straight A student. Child is withdrawn, has frequent somatic complaints, sad affect, poor hygiene."*

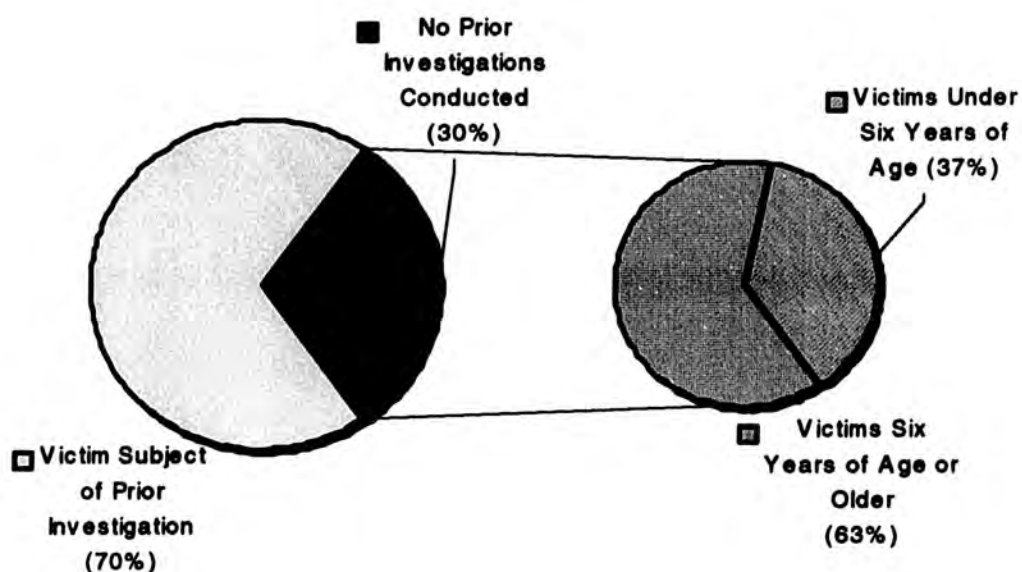
Though this report was not assigned for investigation, another report, received about six weeks later, was assigned. After three more investigated reports, which were substantiated for neglect, the division took custody of the child.

The agency's CPS manual, which provides guidance for prioritizing ROHs, comments that children younger than 6-years-old are more vulnerable to harm than older children. Of the workload adjusted reports we reviewed, 56 (19%) involved children under the age of 6. This group, labeled the most vulnerable by DFYS policy, represents children that are the least able to care for or protect themselves. These children are also more likely to be isolated from public view and mandatory reporters than their school-aged counterparts.

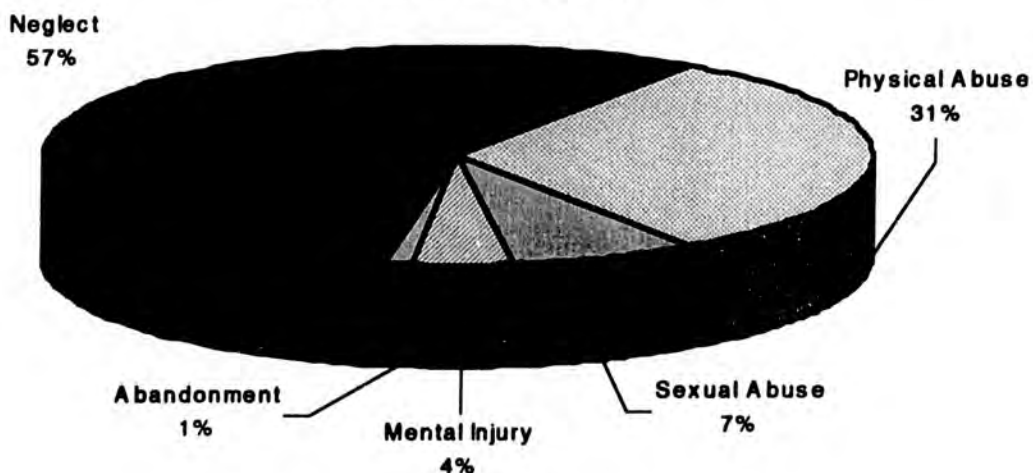
The CPS manual also suggests an evaluation of prior reports of harm as a tool to help determine the prioritization of a report. The Anchorage district office has institutionalized the practice (though not written into policy) of investigating any report on a child that has had the previous two reports workload adjusted. This practice, which is **not** uniform statewide, indicates a recognition that multiple reports often suggest an increased risk to the child. Multiple reports are often indicative of an increased risk to the child. This was borne out in an internal DFYS report that examined and actually "reworked" the cases of children on which the agency had received multiple ROHs. The inset on page 21 further discusses the findings of the agency's multiple ROH report.

We reviewed 300 unassigned Reports of Harm (ROH), of which 116 were categorized as physical or sexual abuse. The remaining 184 were categorized as neglect, mental injury, or abandonment. Of the 116 physical or sexual abuse reports, as the figure below illustrates, 70% involved children that were subjects of prior investigations. The remaining subjects had no prior investigation conducted. Of these reports, 37% of the subjects were children under the age of 6.

Workload Adjusted Reports of Harm



Workload Adjusted Reports by Harm Category



Of the 300 reports we reviewed, 126 involved reports on families that had not been previously investigated. Though a number of prior reports of harm on a family is generally considered to elevate risk, investigated reports provide the agency with knowledge of the child, the family, and the situation. DFYS' knowledge of families that have never been investigated, however, is often very limited. In these cases, the decision to workload adjust a report is entirely dependent on information provided by the reporter. Though mandatory reporters, such as healthcare professionals and teachers are trained to recognize the less obvious signs of child abuse and neglect, many reporters – such as the general public – are less likely to recognize more subtle indicators of abuse or neglect.

Reports of neglect are also more susceptible to being workload adjusted. In general, reports of neglect are assessed as lower risk than reports of physical or sexual abuse. Though the effect of cumulative neglect on children may be as harmful as abuse, the risk of harm associated with each report of neglect, viewed separately, is not usually assessed as significant as an incident of physical or sexual abuse.

Though most of the reports that were workload adjusted were for incidences of neglect or mental injury, 115 of the 300 (38%) were for physical or sexual abuse. Many of these reports concern children that are not immediately exposed to the alleged abuser, but family systems are dynamic, often involving volatile situations. Workload adjusting reports of this nature limits DFYS' ability to ensure the children's continued safety.

In some cases, workload adjusted reports represent ROHs investigated by other agencies. In the Fairbanks and Anchorage district offices, for example, some reports of harm are investigated by military social workers and other on-base officials.

The agency's management information system does not permit us to readily identify these ROHs that are classified as "workload adjusted" but are, presumably investigated by a non-DFYS entity. As a result, we cannot comment on the extent that such reports may "overstate" the number of unassigned ROHs, but our assessment, based on our sample would be that the total would be relatively small.

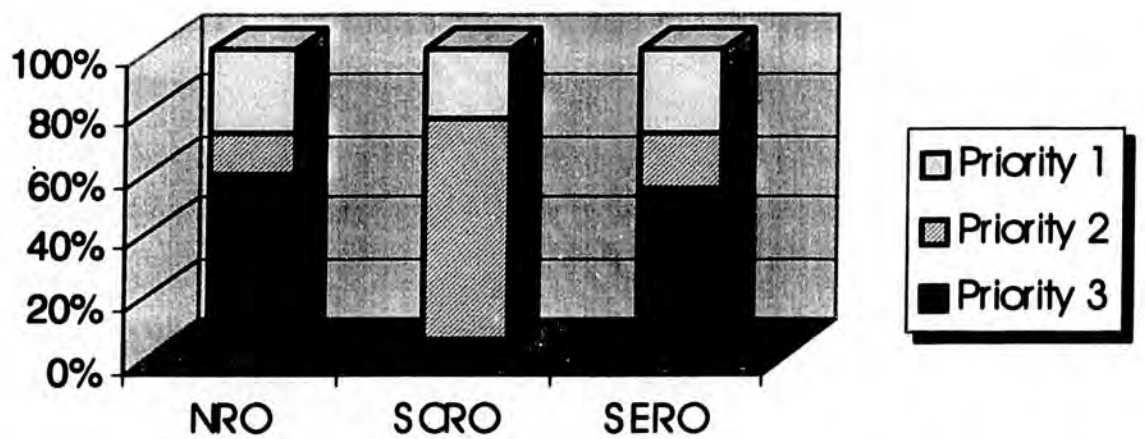
Multiple ROH Report Identified Children at Risk and Key Risk Factors

In response to the failure of DFYS to protect a six year old girl from harm, despite the agency having received 16 ROHs, the commissioner directed an internal review of high risk cases – eventually defined as those with six or more ROHs on record at the agency. The review was undertaken both to ensure the safety of the children in these high-risk situations and to better understand the key risk factors for families with multiple reports.

Of the 475 cases reviewed, 78 (16%) were identified as needing additional casework to ensure the continuing safety of the children involved. Of those, DFYS assumed custody in six cases.

Additionally, through the review DFYS identified two key risk factors related to families with multiple ROHs. In 81% of the cases, substance abuse was involved, while in 59% of the cases, domestic violence was a factor. Some cases involved both factors.

Regional Prioritization

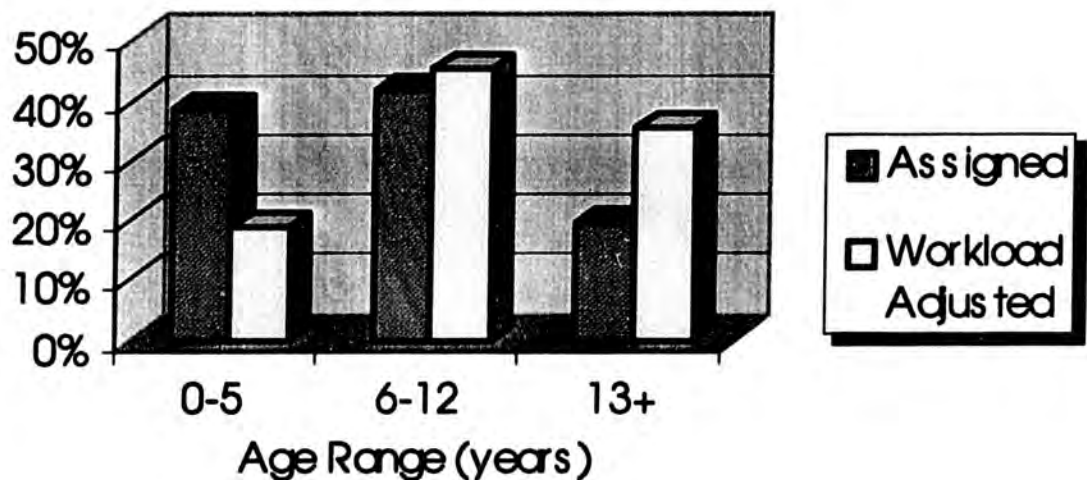


NRO – Northern Region

SCRO – Southcentral Region

SERO-Southeast Region

Referrals by Child's Age



Note—The percentages for the assigned ROHs presented in the above chart represent the summary for all DFYS FY 97 assigned reports (10,529). The percentages for the workload adjusted figures were compiled and summarized from our sample of 300 workload adjusted ROHs.

Many investigations are not initiated as required, but highest priority cases are more timely

As discussed in the Background Information section, DFYS prioritizes investigations based on a supervisor's evaluation of the seriousness of the report. The CPS manual specifies timelines for initiating investigations depending on the priority assigned to the investigation.

For the 401 assigned cases we reviewed, DFYS did not initiate⁵ an investigation within the CPS manual timelines for 174 (43%) reports.

Of these reports with delayed response, most (more than 95%) were priority 2 and 3 reports, but 18 (4.5%) were priority 1 reports, those in which the children appear to be most at risk.

Of the priority 1 cases not investigated within the specified timeline, 7 were for neglect while 11 were for physical or sexual abuse. The average timeline for these delayed cases was more than 5 days compared to the one-day response required by the CPS manual.

Regions Differ in Case Prioritization

Our review found that regions interpret the prioritization process very differently. While consistent percentages across regions suggest that the regions agree on the elements of a report that constitute a priority 1, wide differences in percentages of priority 2 and 3 cases indicate that these cases are treated with less consistency.

For example, cases that may be categorized as priority 2 and investigated through the Anchorage office would possibly be labeled as priority 3 or even workload adjusted in the Fairbanks office. These prioritization differences in conjunction with dissimilar staffing levels result in significant variances between offices in the priorities assigned to reports and in the numbers of reports that are investigated (see the top chart on the opposite page).

Most investigations completed within two months

In a review of the length of time cases take to investigate, as measured by the first report of contact compared to the last report of contact, we found that while the average case took about 35 days to investigate, most (83%) were completed within 60 days. Notably we also found that cases that were ultimately substantiated typically were investigated longer than cases determined to be unconfirmed or invalid. In a review of 412 cases, we found that on average, substantiated cases took nearly 45 days to investigate, while unconfirmed cases took only 29 days.

Lack of timely and thorough investigations can actually increase the risk of abusive or neglectful behavior. According to a 1990 report issued by the U.S. Advisory Board on Child Abuse and Neglect, unresolved investigations create and sustain uncertainty in the family about the future. This uncertainty causes anxiety within families, and may stall children's development. Further, mandated reporters (i.e. teachers, doctors, etc.) may begin to doubt the system and fail to continue to report suspected cases of abuse, thus placing children at greater risk of continued abuse or neglect. The risk is even greater for families who are not offered or do not accept services following an investigation.

DFYS social workers do not consistently meet required ongoing case contact standards

Besides being unable to investigate all ROHs as required by statute, DFYS social workers are unable to effectively supervise the children that are in state custody and other children that require "ongoing" casework. Included in the agency's policy and procedures are what are termed

⁵ By DFYS' definition, a social worker "initiates" an investigation when she/he attempts a face to face contact with the family. This may include school visits or home visits, even if the social worker is unable to actually contact the family due to nobody at the residence or the child being absent from school.

"contact standards." These standards are established based on the severity of the case, and require social workers to make and document their contacts.

The Southcentral Region developed and implemented an internal supervisory review process for ongoing cases. The reviews were carried out over the last nine months of calendar year 1997. These reviews, in total have indicated that in the Southcentral Region more than two-thirds (67.5%) of the ongoing cases did not meet the required contact standards.

These findings appear to be consistent with a 1996 review conducted by the University of Washington of the Anchorage district office case files. The report included the following observations regarding case contacts:

1. Case records did not document required family home visits.
2. Of 322 cases where home visitation should have occurred, 44% documented one or more home visits within the last six months, while documentation of a required visit was lacking in 56% (181) of the cases.
3. Of 271 cases in which home visitation should have been expected in the last year, at least one visitation was documented in only 60% of cases.
4. Visits to foster homes are not occurring as necessary.

Making the necessary contacts with the individuals involved in a particular case is the central aspect of casework. The caseworker must stay apprised of changing dynamics in the child's life, the progress of the parents and children at reunification, and gathering information from involved third parties such as foster parents and counselors regarding the child's case. Essentially, contact and the interaction generated by such caseworker contact is the central aspect of casework. By not meeting, or documenting contact standards, as set out in the agency's CPS manual, DFYS staff is not effectively and consistently fulfilling a central part of its mission.

The lack of consistency with which the agency meets casework contact standards, provides some credence to the information generated by the division's workload analysis report. According to such a statewide analysis developed in November 1997, DFYS needs 15 more caseworkers to adequately address the agency's current caseload.⁶ The estimate likely understates the need for additional workers, since it is widely acknowledged within the agency that the workload measurement model tends to understate work hours actually required to carry out the casework. While recognizing the report may understate the need for workers, we still believe it is significant that the analysis shows the need for more resources. This analysis is consistent with the deficiencies noted by both internal and external reviews.

⁶ The analytical workload report attempts to measure the division's workload in a consistent, objective manner, and identify when, and by how much, the agency becomes short-staffed. The workload analysis report attempts to quantify agency workload by assigning an estimated number of hours to various tasks involved in working a particular case. The hours assigned for each casework task is based on the severity of the cases. More severe cases require more casework contact, which results in a higher number of work hours being required. The merits and drawbacks of workload measurement information is discussed further in Recommendation No. 8.

DFYS did not fully utilize appropriation funding for personnel during FY 97

In FY 97, DFYS' appropriation for child protective services was set out in four different budget components – Central Office, Northern Region, Southcentral Region, and Southeast Region. Funding in these four components supported both child protective services and youth probation activities (youth correction activities related to facilities were funded in other, separate budget components).

As shown in the chart on page 27, these four components comprised a single appropriation within DFYS' budget. For these four components, DFYS received FY 97 appropriations of \$22,560,300 designated for personal services. This total appropriation was slightly less than the governor's request of \$22,788,600. The requested amount reflected a vacancy and turnover (v&t) factor of 4.9%. Since no positions were specifically eliminated by the legislature, the appropriation of the less than requested amount essentially resulted in a slightly increased v&t factor of 5.9%.

DFYS also received additional authorizations for personal service expenditures of \$699,200 for this appropriation. This additional authorization funding was for costs associated with new legislation related to deterring of automobile theft, runaway minors, the State's welfare reform initiative, and cost-of-living pay increases approved by the legislature. The agency transferred a net of \$11,400 by shifting funding from personal services to other account categories — resulting in a total net increase of \$687,800. As shown on the following page, authorizations for the appropriation totaled \$23,248,100.

Barriers to Effective Hiring also had an Adverse Impact on DFYS Service Delivery

In addition to holding positions open to meet v&t requirements, the filling of positions was also adversely effected in FY 97 by the constraints of the state's recruitment and hiring process. During the course of our review we interviewed various DFYS hiring managers who expressed frustration over both the lack of qualified and attractive candidates for vacant positions, and the difficulties involved with hiring within the requirements of the state personnel system.

The Department of Health and Social Services has taken steps to address many, if not all the concerns and problems involved with keeping agency social worker and other positions filled. Below is a listing of the various problems cited by agency hiring managers, and the action that the department and agency are either taking or intending to take to address them.

Problem	Corrective Action
Job classification registers for social worker positions were not kept open continuously. When registers were open, they were opened at times of the year that did not coincide with college graduation dates — a likely source of prospective employees.	DHSS began continuous recruitment for social worker I - IV and social services associate I - III positions during January 1998. In June of 1992, the application examination authority, for all departments, was consolidated within Division of Personnel (DOP), Department of Administration. DOP closed most job classes to open recruitment. Application examining became backlogged at DOP. Authority to examine applications was transferred back to all departments in July 1996. At this time, DHSS addressed backlog of approximately 4,000 applications.
Applicants, despite scoring well against qualification criteria often were not considered desirable candidates by hiring managers, based on past work performance. These individuals and unresponsive candidates hinder the hiring process by filling the upper ranks of the job register.	No corrective action. These candidates cannot be removed from the registers under current personnel rules involuntarily. Workplace Alaska could provide more hiring flexibility to DFYS offices. ⁷ However, the General Government Unit has not "signed off" on having social worker positions recruited through this alternative program.
Most social worker positions are ineligible for the Workplace Alaska, on-line, internet hiring process.	No corrective action in immediate future. Class action lawsuit currently exists between the Unions and the State of Alaska concerning Workplace Alaska. While more hiring responsibility is placed on DFYS offices through using Workplace Alaska, most expressed approval for the process and stated that better candidates are produced than through the traditional register hiring process.
Application rating tool is too cumbersome and time consuming.	DHSS Human Resources section revised application rating tool during January 1998. All people on existing registers were asked to reapply.
Difficulty attracting employees to rural offices.	No direct corrective action. DFYS hopes continuously open registers, improved training, and establishing a relationship with the University of Alaska will provide relief to this problem.

⁷ Workplace Alaska is an alternative state employment procedure which allows state agencies to recruit and hire personnel through advertising of a separate listing, posted on the internet, rather than working the traditional ranked register system. However, as noted above, most line social worker positions remain subject to the standard state hiring process.

FY 97

DFYS Budget ComponentGovernor's
Request
(Personal
Services)Appropriation
(Personal
Services)

1 Delinquency Prevention		
2 Foster Care		
3 Subsidized Adoption and Guardianship		
4 Residential Child Care		
5 Family Preservation		
6 Southcentral Region	\$ 10,188,976	\$ 10,118,000
7 Northern Region	6,958,603	6,878,400
8 Southeastern Region	3,355,049	3,309,400
9 DFYS Central Office	<u>2,285,972</u>	<u>2,254,500</u>
10 McLaughlin Youth Center	\$ <u>22,788,600</u>	22,560,300
11 Fairbanks Youth Facility		
12 Nome Youth Facility		
13 Johnson Youth Center		
14 Bethel Youth Facility		
15 Social Services Block Grant Offset		
Legislation for Additional Personal Services Authorizations		408,000
Cost of Living Allowance Funding		291,200
Net Other Transactions (Transfers to Other Accounts)		<u>(11,400)</u>
Total Personal Services Authorizations		\$ <u>23,243,100</u>

single appropriation

A standard practice in most executive branch agencies is to leave some authorized, funded positions vacant in order to be sure operational expenditures are within established budgets (which are set with a v&t factor "built-in"). Although DFYS received a relatively small reduction in the requested funding for staff, agency managers left 21 positions vacant for all of FY 97.⁸ Of these, ten were case carrying social worker positions, one was a social worker supervisory position, while six others provided support, both administrative and programmatic, to line social workers. Three Central Office positions were kept completely vacant. Only one juvenile probation position was left open for all of FY 97.

Our analysis indicates that child protective services, particularly in-the-field social worker positions, absorbed a disproportionately greater number of these empty positions, ostensibly kept vacant to cover the agency's imposed v&t factor. This practice was particularly pronounced in DFYS' Northern Region (NRO). Of the ten case-carrying social workers positions kept vacant statewide, five were in NRO. Additionally, NRO held vacant a supervisory social worker IV position, in addition to having three of the six administrative support forced vacancies.

The combination of the positions left vacant, (or forced vacancy factor), combined with the other positions that went vacant for shorter periods time (the natural vacancy factor), allowed DFYS to come in well under (just over \$1 million) the agency's FY 97 personal services

⁸ One position included in our count of 21 was filled for two months, and another was filled for only one month. The other 19 were left completely vacant for all of FY 97.

budget. As a result, the agency has sufficient funding to cover retirement incentive program costs not only for staff within the agency's appropriation, but for other agencies within DHSS.

Most of the excess authorization funding (just over \$880,000) was used to fund a reimbursable services agreement (RSA) with the Division of Retirement and Benefits for retirement incentive program (RIP) costs. The RSA essentially prepaid RIP costs for FY 98, FY 99, FY 00, and FY 01. In addition, the RSA funds were used not only to cover the RIP costs for DFYS employees, but also for some of the RIP costs of participating staff of the Alaska Psychiatric Institute. See Recommendation No. 4 for further discussion of these transactions.

Summary of Caseload and Personnel Issues

As discussed in this section, our review of various aspects of FY 97 operations showed DFYS did not consistently meet either its statutory mandates nor the agency's own internal measures of effective casework. In our view, it is clear that the primary reason for the agency's failure to effectively operate is the lack of enough qualified, trained, line social workers.

To some degree, the agency contributed to this lack of resources, by the manner in which it allowed its personnel to be deployed during the year. Despite having vacancies beyond what was needed to meet its budget, it is our conclusion that this factor alone does not completely account for the agency's inability to effectively carry out its mission. We discuss further in Recommendation No. 1 our concerns about personnel resources and the extent that additional positions are needed to remedy the problems involved.

Other Issues

In addition to the personnel and caseload issues discussed in the previous section, there are other issues that have an impact on the operations of the Division of Family and Youth Services. State law also affects the functioning of the agency, and how it is interpreted and applied by the courts. In addition, new federal legislation prospectively will have a substantial impact on the operations, and possibly funding, of DFYS. This legislation will effect the training and casework practices of the agency. Given these issues we offer the following conclusions and concerns.

Lack of specificity in current statutes limits DFYS' authority to terminate parental rights

We often saw cases where parents repeatedly failed to take appropriate action or change their personal conduct to alleviate the living conditions that posed a threat to the safety of their children. Included in the cases we selected for review were two where DFYS moved to terminate parental rights. In both instances there were numerous children involved and the parents had an extensive history of failure in complying with the case plan developed by DFYS. The case plan attempted to reunify the children in state custody with their parents while providing some assurance of safety and care. The children's case files involved sequential case plans, filled out over numerous years, which called for the parents to enter substance abuse treatment. The parent(s) involved were given multiple opportunities to make minimal changes

needed to forestall termination of parental rights, but their efforts were repeatedly insufficient to fully resolve the problems involved.

In the course of our review, we became aware of two recent Alaska Supreme Court decisions that have served to narrow the State's child-in-need-of-aid (CINA) statutes. These decisions appear to be primarily the result of unclear statutory wording and have had an impact on agency casework. The court's interpretation and application of the CINA statute has essentially driven casework practices. This has made it more problematic for the State to seek parental rights terminations and contributes to the ongoing concern about children "lingering" in repeated foster care placements.

The governor's Child Protection Working Group report included the recommendation that stricter guidelines and timelines related to the termination of parental rights be established in statute. The working group observed that current laws do not establish clear and definite timelines nor provide clear guidance establishing the responsibilities of parents to address either the behaviors or conditions which expose their children to harm. As a result, children often linger for years in state custody without a permanent home. The working group stated that *"parents need to take a greater responsibility for getting their children back."* From our review of case files, combined with our historical experience and review of cases in prior audits, we concur with the governor's working group recommendations and observations.

DFYS staff training efforts have suffered from lack of coordination, consistency, and funding

DFYS training has undergone significant transition over past years resulting primarily from shifts in administration, decisions by management, and/or use of available funding. This transition has resulted in untimely "CORE" training which provides child protection orientation to new employees. Prior to February 1998, CORE training had not been held since early 1995. CORE training offered by DFYS is a three-part training course providing:

- an overview of State of Alaska child protection services;
- interviewing techniques; and,
- case management.

Two Alaska Supreme Court rulings in recent years have weakened DFYS' authority to intervene on behalf of children

Alaska Statute 47.10.010 (a) sets out the following six circumstances where a court should find that a child is in need of aid (CINA):

1. The child being habitually absent from home or refusing to accept available care, or having no parent, guardian, custodian, or relative caring or willing to provide care, including physical abandonment [by the child's parent or parents].
2. The child being in need of medical treatment to cure, alleviate, or prevent substantial physical harm, or in need of treatment for mental harm as evidenced by failure to thrive, severe anxiety, depression, withdrawal, or aggressive behavior or hostility toward others, and the child's parent, guardian, or custodian has knowingly failed to provide the treatment.
3. The child having suffered substantial physical harm or if there is an imminent and substantial risk that the child will suffer such harm as a result of the actions done by or conditions created by the child's parent, guardian, or custodian or the failure of the parent, guardian, or custodian adequately to supervise the child.
4. The child having been or being in imminent and substantial danger of being, sexually abused either by the child's parent, guardian, or custodian, or as a result of conditions created by the child's parent, guardian, or custodian, or by the failure of the parent, guardian, or custodian adequately to supervise the child.
5. The child committing delinquent acts as a result of pressure, guidance, or approval from the child's parents, guardian, or custodian.
6. The child having suffered substantial physical abuse or neglect as a result of conditions created by the child's parent, guardian, or custodian.

For the most part, these subsections have not generated much controversy and the courts have applied what is termed their "plain meaning" when interpreting and applying the various clauses. However, the way in which two recent Alaska Supreme Court decisions have applied and interpreted sections one and six of the above list, have had an adverse impact on DFYS' ability to intervene legally on behalf of a child.

In January 1996 the Alaska Supreme Court ruled that under current statute the courts do not have jurisdiction to intervene solely on evidence that a parent is willing but unable to provide for a child's needs (section one above). In September 1997 the court ruled that Alaska courts do not have jurisdiction to intervene to protect a child based solely on evidence that the child has suffered "emotional neglect."

One legal commentator stated, in an *Alaska Law Review* article "[w]hile many children in need of aid remain unaffected by these two decisions because they are protected by other subsections of the [child protection statutes], these decisions decidedly have left children vulnerable in certain cases of neglect."

Case carrying social workers also expressed concern regarding the need for training specific to their job. As an example, investigators were concerned about not receiving training for interview techniques specific to child sexual abuse. It is critical for investigators to receive training relevant to their jobs as they are required to determine whether children should remain in or be removed from their homes, and often must justify, in court, their decision to remove the child.

Some Northern Region social workers and administrative staff filed a class action complaint with their union in October, 1997 which identified their concerns regarding inadequate training. These employees felt that they had not received the training resources necessary to perform the responsibilities of their respective positions. Included in the agency's draft response to the class action complaint, was the following statement:

CORE 101

This is a five day course in basic child protection services to be provided to all staff who have not previously attended core training. Topics covered include, but are not limited to, the history of child welfare, DFYS mission and mandate, personal safety, assessment of child abuse and neglect, intake, investigation, confidentiality, ethics, cultural sensitivity, family centered services, safety issues, and stress and time management.

The reason for the lack of necessary training for social workers has been lack of funding for the training purposes. For example, there is not enough funding available to complete the CORE series in this fiscal year. However, the problem of lack of funding for training of social workers must be addressed at the legislative level.

According to the agency, funding concerns were both travel as well as personal services related. Our review indicates that this is not solely a legislative funding issue however, it is coupled with a management decision not to fill all the regional training positions. Review of funded positions indicates that all three training positions were funded for both FY 97 and FY 98.

We recognize DFYS has intensified its training over the past few months and are now offering the basic CORE training to social workers. Additionally, workers are scheduled to attend job-specific training such as courses related to inhalant and sex abuse, and interviewing children.

Concurrent planning will be important in meeting new federal law requirements

The Adoption and Safe Families Act of 1997, signed into law November 19, 1997, amends the Child Welfare and Adoption Assistance Act of 1980. The new law clarifies that the health and safety of children served by child welfare agencies must be of paramount concern and aims to move children in foster care more quickly into permanent homes. Such federal requirements may require states adopt the practice of concurrent planning.

Concurrent planning allows two plans to be in place at the same time. This will require the social worker devise a permanency plan for an abused or neglected child. The concurrent

plan simultaneously works toward the goal of family reunification with a back-up strategy for an alternative permanency placement. In some cases, the likelihood of a child returning home is slim, but the law requires that reasonable efforts be made to reunify children with the birth families. By having a backup plan in place in case reunification efforts fail, the backup plan can continue once it is decided reunification efforts should end.

Two plans should reduce unnecessary delays that prevent a permanent, stable situation for children and families; minimize the number of out-of-home placements; and save foster care dollars by redirecting funds that are used to sustain homes with little chance of success. Some key elements to concurrent planning will require additional time by the social worker. The social worker will initially need to identify children in need of concurrent planning and provide intensive up-front reunification services. Full disclosures will need to be made to the biological parents and other involved parties.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The legislature should consider authorizing and funding additional social worker positions in order for the Division of Family and Youth Services (DFYS) within the Department of Health and Social Services (DHSS) to better meet the agency's statutory mandates.

As evidenced by the conclusions presented in the previous section, DFYS is unable to respond effectively to either of the two main aspects of its overall mission. The division is not effectively meeting its responsibilities either in the investigations or screening process or in the manner in which the agency monitors children in state custody or otherwise subject to supervision. As set out in the Report Conclusion section:

1. **DFYS cannot investigate all reports of harm (ROH)** – DFYS is required to take calls regarding suspected child abuse and neglect. The agency is required by statute to respond to and investigate all such reports of harm (ROH) that fall within the agency's legal jurisdiction. Without conducting an investigation in every case, DFYS cannot assess a child's safety. DFYS was unable to respond to more than 3,700 ROHs during FY 97. To ensure DFYS can investigate all appropriate ROHs, we believe additional social worker staff is needed.
2. **DFYS cannot meet child protective service (CPS) standards related to supervision of children in state custody** – The frequency of contact between the social worker and the families on their case load provides an objective way to measure the social work being provided to children and families. Both internal and external reviews of ongoing cases indicate the agency is not able to carry out effective, ongoing casework on the children in state custody, or otherwise being supervised by the State. Reviews typically point out a lack of sufficient documentation of required social worker contacts with children.

According to Governor Knowles' Child Protection Review Team's report issued in December, 1997 current caseloads for investigatory social workers at DFYS ranged from 26 to 35 cases per month. Social workers in the agency with ongoing caseloads average between 22 to 24 cases, which is also twice the Child Welfare League of America (CWLA) standard of 12 to 15. The report pointed out that this total was 100% to 200% above the CWLA standard of 12 cases per worker. However, CWLA notes "*virtually no state spends enough to meet basic national child welfare standards.*" In fact, national averages are 15.3 cases per investigations worker and 24 per ongoing caseload worker.

Lack of adequate staff to investigate reports of child abuse and neglect has meant that not all ROHs can be investigated, and lower risk cases are delayed. Besides leaving children at greater risk, these circumstances have also limited early intervention which contributes to problems going unaddressed until they are more severe or chronic. Intervention at that time is typically more difficult and costly.

Higher case loads and understaffing also limits the State's ability to do effective casework and take better care of children who are in its custody. Social workers do not have the time to help families and monitor the safety of children.

DFYS needs more staff to meet its statutory mandate to investigate all ROHs received. Staff shortage problems were brought about partially by the misallocation of personnel resources, particularly in the Northern Region. Despite this factor, we believe the agency needs additional staff in order to meet its statutory responsibility to respond to, and investigate, each ROH within its jurisdiction. Additional staff are also needed for the agency to provide more effective casework to children in state custody.

We have reviewed the agency's budget request increment for the funding of 40 additional staff⁹ and the documentation the agency prepared to justify the number of social worker positions involved. The information we reviewed seems reasonable and does tend to support the social worker positions involved.

Most of the costs of proposed new positions, at least for FY 99, come from federal funding sources. More specifically, the department is proposing to use \$286,900 in Title IV-E funds along with \$1,065,000 from the Social Services Block Grant, which was generated by welfare reform savings. These totals cover over half of DHSS' \$2 million request. Federal authorities are permitting states to shift funding in this manner as an incentive to implement welfare reform measures. When considering whether to fund all or part of these requested positions, we suggest the legislature inquire and satisfy itself regarding funding support for the positions over the next few years.

In our view, DFYS needs new social workers and related support positions to effectively carry out the agency's mission – to protect children from abuse and neglect. The agency has asked for 40 new positions (see Recommendation No. 2). It does appear the agency did consider the social worker positions funded, but left vacant in FY 97, when developing estimates. We also know that the time estimates used as a basis for calculating some of the positions included in the budget request were conservative in that estimates understate the actual time involved to carry out certain social worker tasks (see Recommendation No. 8).

We support the social worker component of the department's budget request. Based on our fieldwork review and observations, and our overall assessment of the agency's needs, while also being mindful of the practical constraints involved in recruitment and hiring, we believe the agency could effectively utilize 30 to 40 positions in addition to the fully funded positions already authorized. Currently, the budget request recognizes hiring constraints. Under the request, DFYS would not receive 12 month funding for all new positions. Specifically, funding is staggered so 26 positions are funded for 12 months, 13 positions are funded for 9.6 months, and 1 position is funded for 10 months. In our view, even these assumptions reflect an overly optimistic estimate of the agency's ability to recruit and fill social worker positions.

⁹ DHSS documentation shows positions are based upon staff shortages indicated by FY 97 assigned investigations and 3,725 ROHs which were workload adjusted during FY 97.

Recommendation No. 2

If the legislature appropriates additional funding for child protection services for FY 99, the commissioner of DHSS should report the effects of those increases to the legislature.

The governor has proposed a \$32 million legislative package called Smart Start to expand public services to Alaska's children. An element of this plan calls for an increase to the child protection system in the amount of \$14 million.

This proposed increase to Alaska's child protection system addresses numerous phases of protection services including expanding resources for Alaska State Troopers, improving the State's foster care system, and, at a cost of \$1.6 million, adding 40 new DFYS staff positions. As discussed in Recommendation No. 1, we believe weighing current workload demands against DFYS' statutory mandate, and considering the impact of recent federal legislation (see Recommendation No. 3), does suggest a need for more DFYS staff.

To ensure accountability for any funds appropriated to address this need, we believe DFYS should measure the impact on child protection services resulting from any additional funding authorized by the legislature. Specifically, we believe this information should be reported to the legislature and include, at a minimum:

- The progress of any funded elements of the governor's Smart Start package for child protective services.
- The impact any additional staff have had on DFYS' ability to respond to uninvestigated reports of harm, to investigate in a timely manner, and to meet contact standards for ongoing cases.
- Vacancy experienced within social worker positions during FY 98 and the first six months of FY 99 and how close that vacancy reflects budgeted vacancy. This analysis should include conclusions regarding whether hiring problems experienced in the past have been remedied.
- Changes made to the child protection system as a result of any audits, management reviews, changes in federal legislation, and, potentially, changes in state legislation.

We believe DHSS management, in order to demonstrate its willingness to be held accountable for the extra funding, should commit to providing the legislature such information, in a formal report by February 1, 1999.

Governor's Smart Start Proposal: Composition of 40 requested DFYS Staff Positions

Southcentral Region

<u>Job Type</u>	<u>Qty.</u>
Social Worker	16
Supervisory Social Worker	2
Licensing	1
Support	5
SCRO Total	24

Northern Region

<u>Job Type</u>	<u>Qty.</u>
Social Worker	7
Supervisory Social Worker	2
Licensing and Eligibility	3
Support	4
NRO Total	16

TOTAL NEW POSITIONS **40**

Recommendation No. 3

The legislature should consider amending relevant child protection statutes in order to provide a basis for better and more consistent casework.

In our review of case files done for this review along with files reviewed in the course of prior audits, we came across numerous children that lingered in state custody due to the irresponsibility of their parents. We often saw cases where parents repeatedly failed to take appropriate action or change their personal conduct to alleviate the living conditions that posed a threat to the safety of their children. During this review, we went through two specific files where the State had moved for termination of parental rights because of the parents repeated failure to effectively comply with the established case plan. In both instances the court did not approve of termination, primarily due to the current interpretation and application of the State's child-in-need-of-aid (CINA) statutes.

As discussed in the Report Conclusions section, Alaska Supreme Court rulings made in recent years have served to undermine the practical enforceability of two sections of the State's central child-in-need-of-aid statutes. Specifically, the courts addressed:

1. Willingness to care – AS 47.10.010(a)(1) states a child may be a child-in-need-of-aid if they have no parent, guardian, custodian, or relative “*caring or willing to provide care . . .*” [Emphasis added.] The court interpreting this language required the parent care or be willing to care, but is not required to do both. The courts found that statute does not “*require ability to care – willingness is enough.*” Given this interpretation, the State's ability to terminate parental rights under this provision is limited as long as the adults involved express a willingness to care for the child, regardless if such willingness is demonstrated by their behavior in meeting the requirements of the DFYS case plan.
2. Neglect must be physical and substantial – AS 47.10.010(a)(6) states a child may be a child-in-need-of-aid if he or she “*...suffered substantial physical abuse or neglect as a result of conditions created by the child's parent, guardian, or custodian.*” [Emphasis added.] Here the court essentially attached the modifier substantial to both the phrases “physical abuse” and “neglect.” Moreover, the court interpreted the law to require physical neglect, as opposed to emotional or other non-physical neglect. Given this interpretation, in any CINA proceeding, such as termination, the State must demonstrate not just neglect, but substantial physical neglect to successfully make its case.

The Kempe Center, one of the outside organizations that reviewed the casework carried out in selected DFYS cases, observed in its report that:

... current Alaska statutory and case law needs to be carefully reviewed. The review should include Alaska statutes, court interpretation of Alaska statutes, and the understanding and behavior of DFYS staff based on current law. . . .

Read narrowly, only if a child is at risk of being sexually abused by the child's parent, guardian, or custodian can parental failure to protect the child be the basis for intervention This language leaves unclear what is envisioned for a

parent who risks his or her child with sexualizing casual acquaintances, no matter how often or with what result. In general, the statutes seem to leave confused the question of a parental incapacity which allows a child to substance abuse, contributes to depression or irreversible developmental delays so long as the parent expresses willingness to keep trying.

The governor's Child Protection Working Group suggested that statutory changes be pursued that, in general, would accomplish the following:

1. Change the philosophical orientation of the statutes – The working group suggested that instead of the current statutory focus of the termination statute on the conduct of the parent, the focus be shifted to the best interests of the child. The working group observed in its report that "the purpose of the statutes is to protect the child; therefore, the basis for terminating parental rights should also focus on the needs of the child.
2. Separate statutory provisions for termination – Currently, termination of parental rights is listed as just one of several "disposition" options available once a child is adjudicated as CINA. The working group recommends that termination be listed separately with its own distinct definitions and specific listing of what will "justify and constitute grounds for terminating parental rights."
3. Establish guidelines for compliance based on the age of the child – The working group noted that many states set guidelines on how long a parent has to comply with a reasonable case plan to regain custody of their children. Usually, the younger the child, the quicker the parent must comply. Adoption of such a system in statute would reduce the number of children lingering in the system.¹⁰

Besides promoting both better casework and long-term care for the child involved, such a change in statute will clarify DFYS' authority and give the agency a better chance of maintaining the federal funding it receives under Title IV-B and Title IV-E of the federal Social Security Act. Funding under these two sections assist states in providing a wide range of child welfare services – everything from subsidizing the cost of out-of-home placements, to training funds for social workers, to funding the development of management information systems. New federal legislation, the Adoption and Safe Families Act of 1997, which became effective in November 1997, ties certain federal funding assistance to the state achieving various requirements related to out-of-home placement of children.

Under the new federal legislation, States must move to terminate parental rights and identify, recruit, and approve a qualified adoptive family on behalf of any child, regardless of age, who has been in foster care for 15 out of the most recent 22 months. These new requirements apply not only to children entering foster care in the future but also to children already in out-of-home placement. For children already in care, states must phase in filing of

¹⁰ The working group's report cites as an example the State of Massachusetts. According to the report, that state gives as a basis that "(if) the child is four years or younger and in out-of-home placement for at least six of the last twelve consecutive months, and the child was prevented from returning to the parent's home due to the parent's failure to accept services to address and correct the conditions that caused the child to be in out-of-home placement..." the state can move to terminate parental rights.

termination petitions starting with the children that already have adoption permanency plans or who have been in out-of-home care the longest.

Additionally, it appears federal authorities will require state officials to certify that state law conforms with certain provisions of the new federal legislation. In particular, the federal government will require state law to:

1. clarify "reasonable efforts" requirements related to termination of parental rights;
2. provide for the State to initiate or join proceedings within a specified time to terminate parental rights; and.
3. clearly state the safety of children be the paramount statutory concern.

To provide incentive for state compliance, the federal government is likely to make some, if not all federal Title IV-E funding conditional on this certification. In recent years this funding has represented approximately \$10 million in federal funds for Alaska. All of the provisions cited above are included in current proposed legislation.

In our view, many of the provisions contained in bills currently being considered by the legislature (HB 375 and SB 272) will serve to address concerns we have about shortening stays in out-of-home placement and compliance with federal legislation. These proposed bills ensure continued federal support for child placement, training, and a workable management information system. We recommend the legislature evaluate the issues involved and consider appropriate revisions to the State's CINA statutes as set out in proposed legislation.

Recommendation No. 4

The DHSS director of administrative services should ensure expenditures for the retirement incentive program (RIP) are made in accordance with legislative appropriations.

The legislature passed a retirement incentive program during the 1996 legislative session. The bill requires departments pay for three years of employer contributions for each RIP participant. This effectively purchases three years of retirement benefits for each employee electing early retirement. The RIP legislation (Chapter 4, FSSLA 96, Section 22) requires the employer to file a proposed retirement incentive plan with the commissioner of administration. This plan must include a reimbursement agreement that:

Requires the employer, for each employee who retires under this plan to reimburse the appropriate retirement system, within three years after the end of the fiscal year in which the employee is appointed to retirement

In anticipation of state employees taking advantage of the RIP program, DHSS encumbered unexpended balances from various FY 97 appropriations for those employees that had applied for RIP. The majority of the employees who had applied for RIP in FY 97 were not scheduled to retire until after July 1, 1997 (FY 98) at the earliest. Additionally, for those employees who retired, DHSS paid the full three-year obligation using unexpended FY 97 funds, an amount totaling \$2,165,305.

The Alaska Constitution Article IX, Section 13 requires expenditures be made in accordance with legislative appropriations. We believe the initial obligation for RIP costs should not be recognized until an employee actually retires. Therefore payment of those costs should not be made from operating appropriations relating to years preceding an employee's retirement.

DFYS encumbered their FY 97 Family and Youth Services appropriation in the amount of \$880,000 at the end of the year to pay for RIP costs. This encumbrance was liquidated in FY 98 with a transfer to the Division of Retirement and Benefits totaling \$785,317. Out of 21 retirees who were employed through the Family and Youth Services appropriation, 3 retired during FY 97 and 18 retired during FY 98. The three-year employer costs for the 3 FY 97 participants totals \$107,954. Of this amount, \$6,412 represents the FY 97 portion of these costs based upon a 36 month, or 3 year, payment period. The remaining funds were spent for employees outside the Family and Youth Services appropriation and for RIP costs reflecting obligations of FY 98 through FY 01.

While the bill did not prohibit departments from paying the full employer cost in any one year, we believe this is inappropriate. The RIP program is designed to create cost savings within the positions involved by filling those positions with lower cost employees. Those savings, by design, should be realized incrementally as time passes. Payments for employer contributions of RIP retirees should reflect these annual savings and therefore payments should be made on an annual basis.

In addition, we believe paying the employer costs for RIP employees in one-lump sum violates the basic premise of the legislative budget process where annual operating

appropriations are made for operating costs of state agencies for a one-year time period. We believe using an operating appropriation for a three-year obligation is inappropriate.

The RIP legislation did not provide authority and specific allowance on how the funding is provided. Therefore, we believe the appropriation from which a retiring employee is funded should pay the relevant RIP costs.

We recommend the DHSS director of administrative services initiate corrective action by either: (1) reversing the expenditures made to the FY 97 appropriation and charge the correct fiscal years' appropriation; or, (2) with the concurrence of the Office of Management and Budget, request ratification from the legislature for these payments.

Recommendation No. 5

The director of DFYS should develop and implement a clear and consistent policy regarding when ROHs can be left uninvestigated.

As discussed in Background Information section, some ten years ago DFYS developed systematic guidelines to be followed in staff shortage or work overload situations. DFYS referred to this practice as "workload adjust." The guidelines, which were tied in part to the agency's workload measurement model, provided some central direction as to how work was to be prioritized in situations where workload demands precluded meeting all the agency's operating responsibilities. If the workload adjust situation continued, agency personnel were to use the workload measurement model to demonstrate the extent of the shortage in staff and as support in seeking additional resources.

Our evaluation of the escalating volume of ROHs to which the agency was unable to respond, along with various internal case reviews, concluded various offices in the State were applying the "workload adjust" guidelines in a very different manner from what was originally intended.

The guidelines intended for ROHs to be workload adjusted on a temporary basis when high caseload prevented timely investigation and review. However, rather than being a short term approach to responding to a period of high service demand, workload adjusting has become institutionalized as a standard, everyday response to increasing numbers of ROHs.

Though we recognize that Alaska Statute requires the agency to investigate all reports of harm, we are aware that there will likely be situations when the agency will find this mandate impossible to meet. In our view, it is important to have clear consistent guidelines for all child protection offices to follow. We also recommend that any such guideline be tied to a revised workload measurement model (see Recommendation No. 8) to clearly document the workload demands on staff and establish the need to prioritize between the various cases and ROHs. Additionally, a new, clear and consistent policy should be accompanied by uniform guidelines for assigning consistent priority ratings for all ROHs received. Such an integrated approach to workload adjusting and consistent priority ratings would promote better overall child safety in circumstances where demand for services exceed available staff.

Recommendation No. 6

The director of DFYS should continue efforts to develop an integrated professional development and training program in conjunction with the University of Alaska and pursue Title IV-E funding.

DFYS and UAA have signed a memorandum of agreement to develop a training program for current and potential social workers. This training will be at least two-fold in that it will provide the following:

1. A training academy designed to address core training and specialized training needs of DFYS workers.
2. A stipend program offered to DFYS employees who wish to enroll in the social worker program to obtain either their Bachelor of Social Work (BSW) or Master of Social Work (MSW). This program will require the student to commit to work for DFYS for a period of time after they obtain their BSW or MSW.

DFYS is currently pursuing dedicated federal training funds available to support the partnership. DHSS policies and procedures outline the department's commitment to ensuring staff have the knowledge and skills necessary to carry out responsibilities on a daily basis, in order to provide effective services.

An adequately funded, consistent training program is critical to child protection by providing more motivated, better-educated, and trained staff necessary to deal with the changing complexities of child protection. A well-trained and stable workforce is essential for effective functioning of child welfare programs. Undermining this infrastructure is the high rate of turnover of child welfare staff nationwide. The average duration of employment has been estimated to be less than two years.¹¹ The on-going drain of staff results in uncovered caseloads, discontinuity of service to families, and increased administrative costs.

We encourage DFYS in its efforts to seek the funding necessary to adequately train staff. We recommend DHSS continue to develop an integrated professional development and training program and pursue federal funding.

¹¹ *Partnership for Child Welfare*, February 1998, Vol. 5, No. 5

Recommendation No. 7

The director of the Division of Family and Youth Services should ensure accurate and timely entry of child protection case information into its management information system.

Child protection data detail is accumulated on DFYS' management information system database known as Prober. Prober is a relational database which stores information about each DFYS client. The information should provide management with useful, accurate information about the families served by DFYS, and virtually eliminate the practice of labor-intensive hand tallies. Due to time constraints on the social workers, lack of adequate training, unclear definitions for various Prober fields, and purported system anomalies, some case information was found to be inaccurate or incomplete.

Areas of concern include:

1. Lack of clear definition for cases not assigned. — DFYS staff incorrectly classified screening outcomes for child protective cases that were not assigned for investigation. Incorrect classification appears to be caused by lack of clear definitions for (1) non-CPS cases; (2) cases with insufficient information; and (3) cases that are not worked due to workload adjustment. Although staff advised us of recent meetings to clarify definitions, we were unable to obtain formal clarification.
2. Inconsistent classification of siblings on reports of arm screen. — DFYS district offices inconsistently account for siblings included on reports of harm received for physical or sexual abuse. One district office enters case information into the Prober ROH screen only for the victim(s) while another district office enters information on the ROH screen for all siblings as well as for the victim(s).
3. Limited fields on Prober. — Although Prober allows for reporting both a primary and secondary type of harm, often DFYS cannot discern which harm category poses more danger to a child (in cases where two or more are present). This is further complicated when the finding on the primary and secondary categories differ. For example, the finding for the primary harm category may be substantiated, while the secondary category is unconfirmed or invalid.
4. Untimely investigation closure on Prober. — At the time of our review, Prober reported 4,500 investigations open longer than 90 days. Our analysis of these open investigations showed that:
 - Investigations were actually closed but due to untimely paperwork, cases were not closed on Prober.

- The district office thought the investigation was closed in Prober and case file documentation was stamped as being entered into Prober. This problem could be the result of inaccurate data entry problem or a problem with the update of the database.
- The case was moved into on-going services however, the investigation paperwork was never completed.

Accurate management information is critical when used to justify additional funding, to assess the need to assign a report for investigation instead of workload adjusting a report, or to provide prior history of a family moving between Alaskan regions.

DFYS management should encourage timely and accurate input and provide clear and consistent definitions to the district offices. We also recommend DFYS continue to pursue development of a Statewide Automated Child Welfare Information System (SACWIS). The SACWIS should be developed in compliance with Title IV-E of the Social Security Act and should implement recommendations set forth by the U.S. DHHS Office of Information System Management.

Recommendation No. 8

The director of DFYS should develop an updated, accurate, and relevant workload measurement model.

Since the mid-1980s DFYS has had in place a workload measurement model which was integrated into the agency's management information system (MIS). The model took the form of a report which summarized the caseload work for each social worker, district office, region, and for the entire agency. Cases assigned to each worker were weighted based on the number of estimated work hours necessary to provide services. Service levels were established for each assigned case based on factors that ostensibly indicated how much social work a given case required. For example, a caseworker handling a case with custody issues will likely require more resources than a case without those circumstances.

Over recent years the workload measurement reports have become progressively irrelevant to agency managers. All managers we interviewed indicated these reports provide limited value in helping manage the caseloads they supervise. The primary complaint both managers and line social workers have about the workload measurement report was that it substantially understates the number of hours involved to carry out various tasks related to a case. For example, a worker is allocated only 5.7 hours for an investigation that does not result in emergency custody and 9.2 hours when emergency custody occurs.

A second problem managers point out is the report excludes cases that were not investigated. These cases, if investigated as required by statute, would substantially increase the investigation workload and increase the on-going workload to some degree. The workload report also fails to accurately measure cases that are prematurely closed in response to workload demands.

From our observations, developed through on-site fieldwork, including four days of "job shadowing" social workers, it appears these criticisms have merit. We noted, especially in rural district offices, the commute time alone may involve more time than allotted for the entire investigation. For the tasks observed, it consistently took workers longer to accomplish the work than what was assigned for that task by the model.

Despite these recognized shortcomings, we still believe the concept and value of such a workload measurement device is important. It does provide management, particularly at the statewide level, a comprehensive way to identify and gauge the distribution of the agency's workload. When developing the budget request for new positions discussed in Recommendation Nos. 1 and 2, we were told agency management relied in large part on the information in the workload measurement reports. Further, the original concept of workload adjusting cases, as discussed in Recommendation No. 4, involved reliance on the information generated by the workload measurement model.

We encourage DFYS management to retain the workload measurement model and take measures to reevaluate and revamp how it measures caseloads. The agency should, as funding permits, conduct new time studies that would serve as a basis for assigning updated, accurate time allotments to various casework tasks. The agency should seek input from both line social workers and supervisory line management in order to assure a revised model is useful and relevant to their needs.

AUDITOR COMMENTS

The child protection responsibilities of the Division of Family and Youth Services (DFYS) are extensive in both scope and impact. Statutorily DFYS is charged with investigating each report of harm it receives that is subject to its jurisdiction. Similar to most public protection statutes the mission of DFYS is stated in very absolutist terms. Due primarily to overall financial constraints, very few public protection agencies, including DFYS have been provided the funding necessary to meet the strict statutory standards.

DFYS, again like many other public protection agencies has to prioritize the use of its resources among the competing demands for its services. From our fieldwork and analysis of the agency's workload compared to current staffing, we have concluded more resources are needed. Particularly, additional social workers and the staff providing direct support to those positions are warranted. It is important to note, our support for 30 - 40 additional positions is not intended to fund the division to meet the absolute standard established in the statutes.

These extra positions may also prove to be needed for only the next three to five years. Clearly some past management decisions - such as carrying an excess of funded but unfilled social worker positions have contributed to the agency's backlog of work. Further, as reflected in our findings and recommendations, we believe the agency must improve its management tools. These would include an updated and relevant workload measurement model, and an improved management information system. Once these tools are available DFYS should conduct an evaluation of overall staff level, as well as the balance between line, management, and administrative staff.

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DEPT. OF HEALTH AND SOCIAL SERVICES

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April 1, 1998

Honorable Randy Phillips
Chairman
Legislative Budget and Audit Committee
State Capitol, Room 103
Juneau, Alaska 99801

RECEIVED
APR 01 1998
LEGISLATIVE AUDIT

Dear Senator Phillips:

Although I received only this morning the preliminary report of the just completed special audit of the Division of Family and Youth Services (DFYS) I agreed to record a brief response to the recommendations in order to expedite release of the final report tomorrow morning. Obviously, no detailed analysis and response can be prepared in that time. However, recognizing the urgency Committee members feel I agreed to this abbreviated response time.

The audit confirms two key conclusions reached last fall by the Governor's Child Protection Review Team and in other reviews of our child protection system: 1) that additional staff are needed in DFYS to meet the agency's statutory mandate to investigate reports of child abuse and neglect and intervene to protect children; and 2) changes are needed in Alaska's laws to enable child protection to occur earlier and to speed the process of placing children in safe, permanent homes.

I understand that the decision to depart from normal audit procedures and speed the audit of DFYS was prompted by a desire to gain information that will help ensure well-informed legislative decisions on budget requests and child protection legislation currently being considered. I hope the results of this audit will prompt speedy and favorable action on these matters this session.

As you consider these issues, please keep in mind that DFYS does not work in isolation – Alaska's child protection system involves many different agencies. Improving that system – be it through additional resources or statute changes – will require focusing on more than just DFYS.

My brief response to the substance of the draft recommendations is as follows.

Recommendation No. 1

The legislature should consider authorizing and funding additional social worker positions in order for the Division of Family and Youth Services (DFYS) within the Department of Health and Social Services (DHSS) to better meet the agency's statutory mandates.

I agree with auditors that additional staff is required to meet the Department's statutory responsibilities. Last year, DFYS was unable to investigate more than 3,700 reports of harm. That inability left many children at risk. Understaffing also contributed to early case closures, an inability to meet agency casework standards, and delays in taking action required to place children in safe, permanent homes.

As auditors pointed out, the inability to investigate and intervene results in problems becoming chronic and more severe and increases the difficulty and costs of later interventions. Auditors also noted that staff increases requested in the Governor's FY 99 budget represent a conservative estimate of staffing needs and were developed based on methodology known to underestimate actual time required to perform work. I would also point out that the staffing request is far below the additional 75 social workers needed to meet best practice standards as illustrated in the attached briefing paper prepared by the Child Welfare League of America.

Recommendation No. 2

If the Legislature appropriates additional funding for child protection services for FY 99, the commissioner of DHSS should report the effects of those increases to the Legislature.

I believe it is appropriate for the Department to track, analyze, and report on the impact of any additional resources made available to address critical problems identified in Alaska's child protection system. It is important to understand, however, that any new positions authorized in FY 99 will have limited impact by the February 1, 1999 date proposed for such a report. Positions will be phased in over the year and we will not be able to implement a zero tolerance policy – responding to all reports of harm until all positions are filled. Measures of the impact of new staff in achieving desired outcomes for children will truly be meaningful only in the longer term. Similarly, the impact of prevention efforts can only truly be measured in the long term. However, with recognition of these limits, I agree a status report is appropriate.

Recommendation No. 3

The legislature should consider amending relevant child protection statutes in order to provide a basis for better and more consistent casework.

The need for substantial revision of Alaska's child protection laws is clear. I agree with auditors that our laws should be strengthened to allow earlier intervention, shorten delays in placing children in permanent homes, and comply with key elements of new federal law.

Legislation proposed by Governor Knowles is designed specifically to accomplish these needed changes. HB 375 and SB 272 address the weaknesses in our current law, focus our efforts squarely on the best interests of children, and force earlier action by both agencies and parents to resolve conditions that place children at risk or to provide them with safe, permanent alternative homes. These bills would also ensure compliance with the landmark federal Adoption and Safe Families Act of 1997. Under that law, in Alaska, approximately \$10 million in Title IV-E funding hinges upon these statutory changes aimed at improving and speeding child protection.

Recommendation No. 4

The DHSS director of administrative services should ensure Retirement Incentive Program expenditures are paid in accordance with legislative appropriations.

I believe the Department followed both the law and established precedent in liquidating our obligation to employees under the Retirement Incentive Program. It is clear that when eligible employees elect to retire under this program an obligation for the Department is established. The law does not prohibit departments from paying all RIP obligations in a single year and our actions in doing so followed established precedent. The issue of when an obligation begins is open to interpretation and the RIP program is a unique circumstance, leaving room for reasonable disagreement.

By paying full RIP costs in FY 97, we were able increase our ability to fund positions in FY 98 and 99 – avoiding forced vacancies in up to six positions in those years. We felt it would be prudent to meet our obligation early if possible and assure our ability to use future appropriations to fill positions in the following years – rather than maintaining vacancies to fund RIP costs.

Recommendation No. 5

The director of DFYS should develop and implement a consistent policy regarding when ROHs can be left uninvestigated.

I agree with auditors that there should be clear management direction establishing priorities for assigning staff resources to respond to reports of harm when there are short-term conditions that require triage measures on a limited basis. I also agree that this direction should be consistently communicated and followed statewide.

At the same time, I believe it is critical to make a distinction between establishing priorities for short-term delays in response and a systematic policy that leaves some credible reports without the needed response. A delayed response will certainly be necessary in some limited circumstances. However, a policy that systematically leaves reports without a response is unacceptable. I believe auditors agree and acknowledge this in recommending additional staff. I agree, however, that clear direction and consistency is necessary to guide staff in the inevitable circumstances when staff illness or turnover make it impossible to respond to all reports as

quickly as they should be. I also believe that revised criteria to provide guidance in establishing priorities should be developed.

Recommendation No. 6

The director of DFYS should continue efforts to develop an integrated professional development and training program in conjunction with the University of Alaska and pursuance of Title IV-E funding.

I agree entirely that establishing a comprehensive training program is essential to achieving the outcomes we desire in our child protection system. I also agree that doing so in partnership with the University of Alaska provides an opportunity to institutionalize the program, maximize the use of federal funds to support the effort, and to develop an integrated program for professional development.

Recommendation No. 7

The director of the Division of Family and Youth Services (DFYS) should ensure accurate and timely entry of child protection case information into their management information system.

Auditors emphasized the importance of accurate and timely management information and the need to address time constraints, training and definition issues which affect the information used by DFYS to manage, evaluate and plan its programs and services. I agree. We have identified these same issues and are taking actions to address them and continue to pursue development of improved technology to make the agency's management information system a more valuable tool for caseworkers, supervisors, managers, and policy makers.

Recommendation No. 8

The director of DFYS should develop a more updated, accurate, and relevant workload measurement model.

Auditors, like agency staff, noted shortcomings in DFYS workload measurement model that systematically under-report the actual workload of the agency. I agree with auditors that the system must be revised or replaced so that it provides an accurate and reliable method of measuring the agency's workload so that resources can be deployed effectively and resource needs assessed accurately.

Honorable Randy Phillips
April 1, 1998
Page 5

Despite the tight time constraints under which this audit was handled, we appreciated the flexibility and cooperation shown by the staff of the Legislative Audit Division. Likewise, we have worked hard to make ourselves – and any pertinent information – available to the auditors. Nevertheless, as I have expressed, I am concerned about the departure from normal audit processes and the fact that an audit report was planned for release essentially without time for agency analysis and response. I hope the process employed in this instance does not set a precedent for future departures from long established standard practice.

Sincerely,

A handwritten signature in cursive script, appearing to read "Karen Perdue".

Karen Perdue
Commissioner

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Alaska DHSS Division of Family and Youth Services Briefing Paper

Introduction

The Department requested that the Child Welfare League of America's Center for Consultation and Professional Development complete an independent analysis of Alaska child welfare workload, staff levels, and related issues.

Federal and state statutes require the assessment and investigation of all reports of harm involving children, and appropriate action and services to protect them. This includes necessary family intervention and services, treatment for the children, and temporary or permanent care outside the family if required.

I. The Responsibilities of a Child Welfare Worker

Child Welfare staff are required to work toward achievement of the following Child Welfare Client Outcomes. The worker activities listed are examples of some of the actions and services required in support of each outcome, but are not intended to be complete.

A. CHILD SAFETY

The worker must determine:

- Whether there is sufficient evidence of risk to warrant investigation.
- Whether the child is in imminent risk requiring protective custody.
- Whether the child can be safely cared for in the family home.
- What services or actions would be required to protect the child.
- Whether the authority and intervention of the court is required.

The worker must initiate actions and services based upon the assessment.

B. PERMANENT FAMILY FOR THE CHILD

The worker must:

- Determine whether the parent(s) are able to make adequate progress to ensure the child's safety in the home.
- Make needed services available to the parents.
- Find a family who will meet the child's needs.
- Determine the long-term best interest for the child.
- Regularly reassess the case plan for adequacy and progress toward goals.

C. CULTURAL CONTINUITY FOR THE CHILD

The social worker must:

- Determine Tribal affiliation if a Native child.
- Ensure the child can remain within his own community.
- Locate relatives or alternate families who can continue important religious and cultural traditions for the child.
- Otherwise ensure that the child's cultural needs are addressed.

D. CHILD AND FAMILY WELL-BEING

The worker must:

- Complete a comprehensive social history and assessment to determine child and family needs.
- Ensure that appropriate services are provided, including managed referrals.
- If child is in out-of-home care, ensure the placement is in proximity to the parental home to allow for regular visitation and family involvement.
- Maintain regular contact with the child and family to ensure progress on meeting child's developmental needs.

II. The Impact of Workload Size on Child Welfare Service Delivery and Client Outcomes

CWLA National Standards for Abused and Neglected Children state that "caseloads should be maintained at reasonable levels. Any significant increase in caseload size raises the risks to children, may result in poor social work, and can lead to social worker burnout." In general, higher caseloads result in poorer quality casework which results in higher levels of risk and a lesser likelihood of permanence for children.

A 1998 study of New York State child welfare services concluded that high workload (above CWLA standards) resulted in incomplete and delayed completion of child abuse investigations, inability to regularly monitor clients, inability to provide legally-required field visits, and failure to ensure that required case plans were completed in a timely manner. In addition, the study concluded that caseworkers under these conditions are at risk of burn-out and of engaging in sub-standard child welfare practices. But most importantly, children's safety and well-being are subsequently at risk as a result of caseworker's high caseloads.

A child welfare case record review in Indiana (1991) showed serious endangerment of children resulting in their re-entry into foster care, due to high worker and supervisor caseloads and frequent staff turnover.

The Katz Study (1990), completed in Washington and Idaho, showed that timely case resolution and permanency for children occurred when caseloads were reduced to no more than 10 children per worker.

The Institute for Family Self-Sufficiency (1994) published a review of studies related to caseload standards in human services. Conclusions from those studies are:

- That there is a direct relationship between the amount of caseworker contact with clients, and the degree of success the clients had in reaching expected outcomes.
- That excessive caseloads adversely affect front-line workers' interactions with clients; that they tend to become more reactive and less proactive, and spend a higher proportion of their time documenting client activities at the expense of client contact.
- That with higher caseloads, staff tend to "cut corners, ignore problems, nominally comply with responsibilities, and in some cases, provide no services at all to clients."

There can be no question that workloads in excess of the CWLA standards create inefficiency in meeting the Department's legal mandates, result in unacceptable delays in addressing the needs of children and families, and place children at substantially greater risk of harm.

III. Child Welfare Workloads: A National Perspective

CWLA National Standards

The Child Welfare League of America's caseload standards, presented in its National Standards for Child Welfare (1993), consist of recommended ratios of clients to direct service staff based on the field consensus of what constitutes best practice. Development of these standards is based on an examination of current practices and their underlying assumptions, a survey of professional literature and standards developed by others, study of the most recent scientific findings of social work and related fields, and a review by a committee of experts in each service area.

CWLA caseload standards listed in the table below apply to three broad areas of child welfare services.

Child Welfare Service:	CWLA Caseload Standard:
Intake/Investigation	12 new investigations per month
In-Home Services	17 families
Children in Out-of-Home Care	12-15 children

When the standards are individualized to a particular office, county or state, they are adjusted by a number of factors that impact a caseworker's actual workload. These factors include variables such as the caseworker's actual assigned functions, the size of the geographic area covered and the availability of foster homes, parent aides and other resources.

A National Look at Child Welfare Caseloads

Direct comparisons of state caseloads may be misleading because job descriptions and other factors vary widely from state to state. As mentioned above, a more accurate comparison would be based on actual workloads, but such statistics are not available nationwide..

In comparing average 1995 caseload sizes in 15 states, CWLA found that the median state caseload size was 29% to 35% above the CWLA caseload standard. In some state and county child welfare systems studied by CWLA, the average caseload size was 50% to 75% higher than the CWLA caseload standard.

IV. Alaska Child Welfare Caseloads

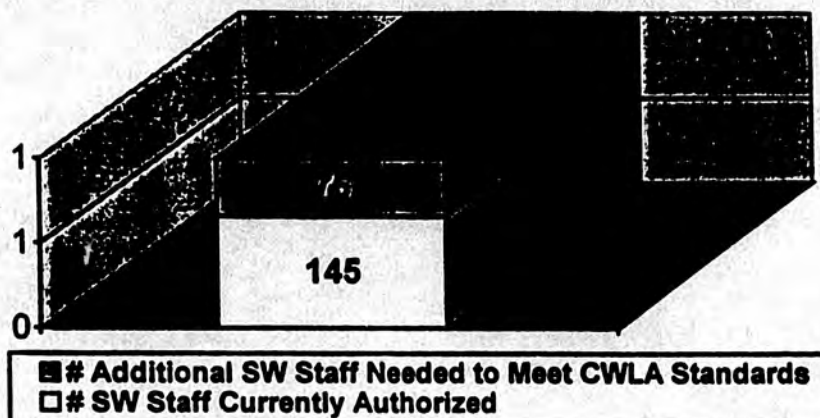
Current Caseload Data

Since many Alaska DFYS social workers provide two or three Child Welfare services, a statewide analysis of caseload can only be accomplished through examining aggregate statewide data. By applying CWLA caseload standards for each child welfare service to the total number of cases of that type statewide, we arrived at the number of social workers needed statewide to meet CWLA standards for each child welfare service. As shown in the table below, these numbers were added to determine that 210 social workers are needed statewide to meet CWLA standards for all child welfare services.

Application of CWLA Caseload Standards to Statewide Alaska DFYS Child Welfare Caseloads in January, 1998		
<i>Child Welfare Services:</i>	<i># of Cases Statewide in January, 1998</i>	<i>Estimated # of SW's Needed Statewide to Meet CWLA Standards</i>
Intake/Investigation: Currently Investigated	# New Investigations 711	Divided by 12 59.3
Intake/Investigation: Currently "Workload Adjusted"	# Reports of Harm 242	Divided by 12 20.2
In-Home Services	# Family Cases 510	Divided by 17 30
Out-of Home Care Services	# Child Cases 1507	Divided by 15 100.5
Estimated Total # of SW's Needed Statewide to Meet CWLA Standards for All Child Welfare Services		210

Since 145 social worker positions are currently authorized statewide, an estimated 52% increase for a total of 75 additional positions is needed to meet CWLA caseload standards, as shown in the following chart.

**Alaska DFYS Needs an Estimated Total of 210 Social
Work Staff Statewide to Meet CWLA Caseload Standards**



However, the workload standard must be adjusted by factors unique to the environment in which the work is being done. These factors include:

- The specific assigned functions and time requirements for each task.
- The individual competencies of each social worker, including both skills and experience.
- **The extent of the geographic area served and the availability of transportation.**
- The amount of time a social worker is expected to spend on community activities.
- **The availability of foster homes, in-home parent aides and other services.**
- The intensity of service an agency and the community consider appropriate.
- The number of other agencies or services involved in a family situation.
- The amount of time allocated to a social worker for agency activities such as staff meetings, staff and professional development, and administrative functions.

The need for 75 additional positions is actually a conservative estimate, since Alaska caseload standards should be smaller due to the large geographic areas covered by social workers in many rural areas, the transportation challenges, and the inadequate numbers of foster homes, parent aides and other resources.

That is, higher numbers of social work staff will be required to directly provide services which are not otherwise available in communities.

The problem is further exacerbated if a significant number of authorized positions are unfilled.

The Impact on Alaska Child Welfare Service Delivery and on Client Outcomes:

- "Workload adjust" resulted from dramatic increases in the numbers of Reports of Harm without the comparable increases in staff required to respond.
- High caseload size likely contributes to the fact that Alaska in 1995 had the highest rate in the country of removal of children from their family homes. (CWLA Stat Book, 1997).
- It is virtually certain that high workload is a significant factor in child deaths and other serious incidents involving children who are known to the department.
- It is virtually certain that the findings and concerns identified in recent studies of Alaska child welfare cases are at least partially the result of unreasonable staff workloads.

V. Recommendations

1. Fill all currently authorized child welfare positions.
2. Authorize a minimum of 75 more child welfare social work staff.
3. Or, as an alternative, authorize a combination of additional social work staff, together with contracts with community-based organizations for response to lower risk reports of harm, for an added total capacity equivalent to at least 75 additional staff.
4. Authorize the accompanying support staff required of at least 75 additional social workers: supervisors, clerical support, and social services assistants.
5. Complete an updated workload accounting study to determine the actual time required for social workers to perform key functions in the Alaska environment. It appears that the measures developed in the original Alaska workload accounting method some years ago under-represent

what these tasks require today. This would be consistent with generally accepted professional experience that current child welfare cases are more complicated, the investigative techniques and requirements more sophisticated, and the documentation requirements more stringent. A new study on time required to investigate reports of harm not involving placement, and involving placement, would verify whether these time allocations of workload accounting should be increased.

6. Examine the range of caseload sizes between offices, and put in place staff allocation methods that allow administrators to adjust staffing to result in workload equity.
7. Analyze staff recruitment, hiring and retention practices, including the importance of staff development and support.
8. Explore models for improved response:
 - Pilot a triple-tracking system for CPS intake and assessment. In a triple-track system, the child protection agency coordinates with law enforcement to investigate the most heinous child abuse reports, those that appear to involve criminal conduct that should be prosecuted. The child protection agency (without law enforcement) handles reports of serious, but non-criminal, child abuse and neglect. And community-based organizations respond to reports that do not involve clear abuse; these would be reports of general neglect or of concern regarding child nurturance.
 - Explore the use of paraprofessionals
9. Develop plan to end workload adjusting practice through the implementation of the above recommendations.
10. Re-examine and modify workload adjust criteria until which time the practice can be discontinued.
11. Examine the entire child welfare system to develop strategies to improve policies, casework decision-making, staff training, resource availability, quality assurance and other factors that also significantly impact client outcomes.

VI. References

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ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

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April 1, 1998

Members of the Legislative Budget
and Audit Committee:

We have reviewed the department's response addressed to Senator Phillips. In response to Recommendation No. 4, where we take exception with how the department utilized personal services authorizations to pay for retirement incentive program (RIP) for multiple years, the agency responded:

"...the Department followed both the law and established precedent in liquidating our obligation to employees under the Retirement Incentive Program. It is clear that when eligible employees elect to retire under this program an obligation for the Department is established. The law does not prohibit departments from paying all RIP obligations in a single year and our actions in doing so followed established precedent."

While we acknowledge the legislation which established the current RIP did not expressly prohibit the payment of participating employer costs out of a single year's appropriation, at the same time it specifically did not provide any allowance for participating agencies to do so. Absent such specific statutory provision, our view remains as it was stated in the report – an agency's operating appropriation, established based on a projected year's worth of activity, should only be used to fund the operations of the current operating cycle.

Sincerely,

A handwritten signature in cursive script that reads "Pat Davidson".

Pat Davidson, CPA
Legislative Auditor