



# CITIZEN REVIEW PANEL

# ANNUAL REPORT

*for calendar year*

# 2002

*submitted by*

The Nevada Citizen Review Panel

*to*

The Division of Child and Family Services

# TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>2</b>
<b>OVERVIEW OF THE NEVADA CITIZEN REVIEW PANEL .....</b>	<b>4</b>
FEDERAL REQUIREMENTS.....	4
<i>Scope of Responsibilities</i> .....	4
STATE REQUIREMENTS.....	4
NEVADA CITIZEN REVIEW PANEL .....	5
MEETING DATES AND ACTIVITIES.....	6
<b>PANEL ACTIVITIES AND RECOMMENDATIONS .....</b>	<b>8</b>
INTRODUCTION.....	8
RECOMMENDATIONS: INSTITUTIONAL ABUSE INVESTIGATIONS.....	9
SUMMARY: CASE RECORD REVIEW DEVELOPMENT.....	13
SUMMARY: PANEL INVOLVEMENT IN CFS REVIEWS.....	14
SUMMARY: CAPTA STATE PLAN.....	15
MONITORING OF FY 2001 RECOMMENDATIONS.....	16
<i>Panel Role and Functioning</i> .....	16
<i>Yearly Update to CAPTA State Plan</i> .....	16
<i>Maltreatment in Foster Care Settings</i> .....	16
<i>Child Data</i> .....	19
<i>Institutional Abuse Investigation Training</i> .....	19
<b>APPENDIX A: OVERVIEW OF THE STATE CHILD WELFARE SYSTEM .....</b>	<b>21</b>
CHILD DEATH REVIEW TEAMS.....	22
SUBSTITUTE CARE – FOSTER CARE.....	24
<b>APPENDIX B: PANEL MEMBERS .....</b>	<b>27</b>

## EXECUTIVE SUMMARY

The State of Nevada Citizen Review Panel (CRP) was established in 1999 under Nevada Revised Statute (NRS) 432B.396 and has federally mandated responsibilities under Title I of the Child Abuse Prevention and Treatment Act (CAPTA). The Panel has the following primary mission:

*To ensure the protection and safety of children through an evaluation of the Child Abuse Prevention and Treatment Act State Plan by examining State and local agencies' policies and procedures and specific cases where appropriate.*

The Panel consists of 12 members appointed by the Administrator of the Division of Child and Family Services (DCFS), who also serves on the Panel. The group includes representation from a variety of State and County agencies, community organizations, and professional backgrounds.

The Panel works toward fulfilling the following three primary goals:

1. Review the CAPTA State Plan and updates on an annual basis.
2. Review at least one policy area from the Governor's assurances.
3. Follow up on previous recommendations.

In essence, the Panel's work consists of the review of internal policies and procedures within the child protective services (CPS) system. Each year, the Panel's findings are summarized in an Annual Report submitted to the federal government as part of the CAPTA requirements.

The areas of review set for 2002 included the following:

1. CPS policy review focused on investigations of abuse in institutional settings.
2. Development of a case record review process, initially focused on investigations of abuse in institutional settings.
3. Planning involvement in the federal Child and Family Services (CFS) Reviews.
4. Annual review of the CAPTA State Plan.
5. Monitoring of recommendations from the prior year's Annual Report.

During 2002, the Panel narrowed its focus considerably as it worked to follow up on the areas of review initiated in 2001. The primary area of focus for this year was the policy review focused on investigations of abuse in institutional settings. To facilitate this review, the Panel examined in detail the policies and procedures for institutional abuse cases that are in place for Washoe County, Clark County, and the rural areas of Nevada.

Additionally, the Panel began planning its case record review process in order to commence the case review requirements of CAPTA. The Panel began by developing a draft survey instrument to be used for case reviews. In keeping with the primary area of focus established for 2002, the survey instrument is designed to evaluate the intake and assessment of abuse cases in institutional settings.

The Panel members also worked in conjunction with staff to develop a workplan for 2003. The focus on institutional abuse cases will continue in 2003 with the implementation of the case record review process. Currently, the Panel plans to divide its members into regional teams and examine case records in the three primary regions of the state: north, south and rural. Once the survey instrument is complete, the Panel will initiate the case record review process in mid-2003.

The Panel also received a presentation on the federal Child and Family Services (CFS) Reviews and discussed taking an active role in the statewide assessment process to prepare for the review. Nevada is scheduled for its onsite review in February, 2004. Additionally, the Panel members reviewed the yearly update to the CAPTA State Plan. As part of the CAPTA focus, Panel members participated in a national teleconference, *Improving Agency Services: The Role of CAPTA Citizen Review Panels*, in order to improve members' understanding of the Panel's roles and responsibilities.

Also during 2002, the Panel followed up on the previous year's areas of review through monitoring of the following:

1. Panel role and functioning
2. Yearly update to CAPTA State Plan
3. Maltreatment in foster care settings
4. Child data
5. Institutional abuse investigation training

A report on the Panel's monitoring activities is included as part of this Annual Report.

# OVERVIEW OF THE NEVADA CITIZEN REVIEW PANEL

## Federal Requirements

As outlined in Public Law 104-235, Section 106 under Title I of the Child Abuse Prevention and Treatment Act (CAPTA) provides for a state grant program for the support and improvement of state CPS systems. This law sets forth a variety of eligibility requirements, including the establishment of citizen review panels. The purpose of the panels is “to provide new opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from abuse and neglect.”

The citizen review panel system within a given state must meet certain operational requirements and meet a scope of responsibilities within the function of the panel. These are outlined as follows.

### *Scope of Responsibilities*

Each citizen review panel is required to review the compliance of State and local CPS agencies in the fulfillment of their responsibilities with respect to the following:

- Work in accordance with the CAPTA State Plan.
- Examine State and local policies and procedures.
- Review specific cases, when appropriate.
- Review other criteria the panel determines important to the protection of children, including the following:
  1. Review of the extent to which the State CPS system is coordinated with the Title IV-E foster care and adoption assistance programs.
  2. Review of child fatalities and near fatalities.

## State Requirements

As part of the CAPTA requirements, states are required to codify citizen review panels as part of State law. In Nevada, this was completed with the passage of Assembly Bill (AB) 158 during the 1999 Legislative session. The relevant text of AB 158 was incorporated into the Nevada Revised Statutes (NRS) under Chapter 432B.396. This law reads as follows:

The Division of Child and Family Services shall:

1. Establish a panel comprised of volunteer members to evaluate the extent to which agencies which provide protective services are effectively discharging their responsibilities for the protection of children.
2. Adopt regulations to carry out the provisions of subsection 1 which must include, without limitation, the imposition of appropriate restrictions on the disclosure of information obtained by the panel and civil sanctions for the violation of those restrictions.

During 2001, NRS 432B.396 was amended as a result of AB 248 to establish civil sanctions for violation of confidentiality on the part of review panel members. This amendment includes additional language highlighted in subsection two as follows:

1. Establish a panel comprised of volunteer members to evaluate the extent to which agencies which provide protective services are effectively discharging their responsibilities for the protection of children.
2. Adopt regulations to carry out the provisions of subsection 1 which must include, without limitation, the imposition of appropriate restrictions on the disclosure of information obtained by the panel and civil sanctions for the violation of those restrictions. **The civil sanctions may provide for the imposition in appropriate cases of a civil penalty of not more than \$500. The Division may bring an action to recover any civil penalty imposed and shall deposit any money recovered with the State Treasurer for credit to the State General Fund.**

## Nevada Citizen Review Panel

The State of Nevada Citizen Review Panel (CRP) operates with the following mission:

*To ensure the protection and safety of children through an evaluation of the Child Abuse Prevention and Treatment Act State Plan by examining State and local agencies' policies and procedures and specific cases where appropriate.*

The Panel consists of 12 members appointed by the Administrator of the Division of Child and Family Services (DCFS), who also serves on the Panel. The group includes representation from a variety of State and County agencies, community organizations, and professional backgrounds. Membership categories for the Panel are not federally mandated. However, they are based on the membership categories mandated under CAPTA for the Children's Justice Act (CJA) Task Force. The CJA Task Force functions in a complementary manner with the CRP, and therefore the membership was mirrored accordingly.

The Panel works toward fulfilling the following three primary goals:

1. Review the CAPTA State Plan and updates on an annual basis.
2. Review at least one policy area from the Governor's assurances.

3. Follow up on previous recommendations.

In essence, the Panel's work consists of the review of internal policies and procedures within the CPS system. Each year, the Panel's findings are summarized in an Annual Report submitted to the federal government as part of the CAPTA requirements.

Appendix A of this report includes a detailed overview of the State child welfare system, which describes the key components of the system of care reviewed by the Panel. Appendix B of this report includes a list of the current members along with their respective affiliations and areas of representation.

## Meeting Dates and Activities

During 2002, the Panel met five times to focus on specific activities related to its primary areas of review for the year as follows:

<i>Meeting Date</i>	<i>Topics</i>
February 4, 2002	<ul style="list-style-type: none"><li>• Review workplan for 2002</li><li>• Monitoring of 2001 recommendations</li><li>• Review Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) specific to institutional abuse.</li><li>• Review of CAPTA requirements.</li><li>• Review of CAPTA State Plan update.</li><li>• Planning for institutional abuse policy review.</li></ul>
April 8, 2002	<ul style="list-style-type: none"><li>• Additional review Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) specific to institutional abuse.</li><li>• Staff presentations on institutional abuse policies and procedures for Washoe and Clark Counties.</li><li>• Monitoring of 2001 recommendations.</li><li>• Additional review CAPTA requirements.</li><li>• Review revised workplan for 2002 and proposed workplan for 2003.</li></ul>
June 28, 2002	<ul style="list-style-type: none"><li>• Staff presentations on institutional abuse policies and procedures for rural areas including Elko, Fallon, and Carson Counties.</li><li>• Begin review of case record review survey instrument.</li><li>• Begin planning for case record review process.</li><li>• Contractor update on multi-agency response to child abuse investigations in institutional settings.</li></ul>

<i>Meeting Date</i>	<i>Topics</i>
October 22, 2002	<ul style="list-style-type: none"> <li>• Continue review of case record review survey instrument and planning for process.</li> <li>• Overview of federal Child and Family Services (CFS) Reviews and discussion of Panel participation.</li> <li>• Participation in national teleconference: <i>Improving Agency Services: The Role of CAPTA Citizen Review Panels</i></li> </ul>
December 17, 2002	<ul style="list-style-type: none"> <li>• Review and finalize 2002 Annual Report.</li> <li>• Continued review of case record review survey instrument and planning for process.</li> </ul>

# PANEL ACTIVITIES AND RECOMMENDATIONS

## Introduction

During 2002, the Panel members collaborated with staff to develop a workplan for the year. Staff recommended that the Panel tighten its focus and work to build a stronger Annual Report that includes clear ideas about how policies and procedures can change to help improve service delivery within the State system.

Based on this, the Panel decided to narrow its focus considerably as it worked to follow up on the areas of review initiated in 2001. It was determined that the primary area of focus would be a policy review focused on investigations of abuse in institutional settings. This would be highlighted in the work of the Panel for the year, along with the other primary areas of review from the 2002 workplan as follows:

1. CPS policy review focused on investigations of abuse in institutional settings.
2. Development of a case record review process, initially focused on investigations of abuse in institutional settings.
3. Planning involvement in the federal Child and Family Services (CFS) Reviews.
4. Annual review of CAPTA State Plan.
5. Monitoring of recommendations from the prior year's Annual Report.

As part of the policy review focused on investigations of abuse in institutional settings, the Panel began working with a contractor, Candace Young-Richey, employed by DCFS to assess agency response to these types of cases. The contractor interfaces with both the CRP and the CJA Task Force to help tie the work of the two groups together. The goal of the project is to help create stronger recommendations on the part of the CRP and the CJA Task Force, as well as develop concrete information in the form of an assessment of the State's current capacity to address institutional abuse. Together, these efforts will enable DCFS, the Panel, and the Task Force to present a strong case for change to the State Legislature.

Based on this, the recommendations for 2002 were made in the Panel's primary area of review: CPS policy review focused on investigations of abuse in institutional settings. These are presented in detail below, along with summaries of the major activities undertaken for the other primary areas of review.

## Recommendations: Institutional Abuse Investigations

**Recommendation 1:** Agencies should adopt specific policies to require that institutional abuse investigations are assigned to appropriately trained staff.

**Discussion:** The Panel members recognize that institutional abuse investigations require a different set of skills and knowledge, and therefore should be assigned to staff who are more skilled and can effectively complete the investigations. Although the Panel recognizes the specialized skills needed by institutional abuse investigators, ideally all CPS workers should have basic skills and understanding relevant to these types of investigations. This will contribute to connectivity and coordination of institutional abuse investigations, as well as promote a team approach.

**Recommendation 2:** Agencies should adopt specific policies to provide specialized training to staff members designated to conduct institutional abuse investigations.

**Discussion:** The quality of training for individuals who complete institutional abuse investigations needs to be given priority. The Panel members recognize that caseworkers are often put in an environment where they have not been trained. Therefore, specialized training is critical in order to equip staff with the skills and abilities needed to effectively conduct institutional abuse investigations. Staff supervisors need to also understand the skills needed by staff, legal issues, and special requirements of the institutional abuse investigation process. Beyond this, training should be periodically updated and additional opportunities should be provided to staff across the long-term.

**Recommendation 3:** Multi-disciplinary teams (MDTs) should be formalized in agency policies and procedures, specific to the coordination of investigations between CPS and law enforcement. Policies and procedures should also ensure that MDT members recognize and understand their responsibilities clearly.

**Discussion:** The Panel members understand that currently, MDTs in place statewide vary between being formal and informal. Formalization is important not only because joint efforts between CPS and law enforcement are often difficult to implement, but also because it is provided for in State law through NRS 432B.350. Improvement is needed in the cooperation between CPS and law enforcement, and collaboration is critical in order to change the outcomes of institutional abuse cases and promote better care on the part of institutions.

Team work is important because the more there is outside involvement, the more objectivity is imposed on a given investigation. MDTs serve to create a check and balance system between agencies. The MDT approach used in the rural areas, particularly Elko, appears to be working effectively and should be used a model throughout Nevada.

**Recommendation 4:** The Panel recommends to the Children's Justice Act (CJA) Task Force that the uniform curriculum developed as part of the POST Project include a clear understanding

of what institutional abuse is and emphasize the importance of an MDT approach for CPS investigations specific to institutional abuse.

**Discussion:** The Panel understands that the CJA Task Force has established a Subcommittee on Peace Officers' Standards and Training (POST) that recently completed a set of recommendations to improve the way training is provided to law enforcement personnel on child abuse and neglect investigations. These recommendations were approved by the POST Commission in September, 2002, and will be followed by the actual rewrite of a statewide, uniform curriculum. The Panel believes it is important to include in this curriculum a focus on institutional abuse as part of this specific effort to improve MDT investigations of child abuse and neglect.

**Recommendation 5:** CPS and Licensing staff members need to establish protocols for sharing information about investigations. A coordinated tracking system between the two would make everyone involved in an investigation equally aware of the status of a case.

**Discussion:** The Panel recognizes that the involvement of Licensing staff in institutional abuse investigations is critical. In particular, Licensing staff is responsible for reviewing institutional policies to determine if they are abusive or not. Additionally, a succession of unsubstantiated reports should be tracked and support services should be provided as necessary to help prevent abuse.

**Recommendation 6:** Separate policies and procedures should be established for investigations of foster homes versus other institutional settings.

**Discussion:** Because of the fundamental differences in the way children are served in foster homes as compared with other institutional settings, establishing different policies, procedures, and methods for both types of investigations is necessary.

**Recommendation 7:** A uniform definition of institutional abuse should be established in NRS 432B and used statewide.

**Discussion:** The Panel members recognize that substantiation of abuse in institutions is different compared with foster homes. Additionally, they understand that it is sometimes not clear to investigators what constitutes institutional abuse and what does not. Staff have reported to the Panel that context is key in institutional abuse cases, and investigators have to look at the rules and procedures used within a program that dictate the dynamic of service provision at a given institution.

However, while the Panel members understand that institutional policies can substantially impact what is considered abuse and not abuse, it is problematic that there are different regional standards regarding what constitutes abuse. This variation in definitions is troubling. It is the way investigations are conducted that should reflect the differences in institutional policies, not the definition of abuse. Although it may be difficult to establish a uniform definition, a category within NRS 432B specific to institutional abuse should be created that includes a uniform definition.

**Recommendation 8:** Agencies should consider contracting out institutional abuse investigations if it is deemed appropriate for certain circumstances in order to avoid a conflict of interest.

**Discussion:** Some Panel members recognize that there is a possible conflict of interest in foster care settings where a single agency may license, place children, and investigate alleged abuse. In these cases, outside contracting may be a good way to reduce conflict of interest. Some Panel members also suggested that dedicated staff or a separate unit within an agency could conduct investigations if contracting is not determined to be feasible. If this approach is used, investigations would be seen as internal and possibly require additional training.

Conversely, some Panel members discussed the fact that institutional abuse investigations referred to outside contractors often create timeline problems, i.e., they tend to be longer than is feasible to promote follow-through on the part of staff involved in the process and their ability to take personnel action. Additionally, secondary consequences need to be considered as a matter of respect for the care providers. Institutional staff may be put on leave without pay during the course of an investigation and suffer as a result of an extended time frame.

**Recommendation 9:** Through policies and procedures, DCFS should clarify how the investigation by State staff of institutional abuse perpetrated by other State staff is conducted and how it is affected by disciplinary procedures outlined by State Personnel.

**Discussion:** Related to recommendation 8, the Panel is specifically concerned about the conflict of interest that arises when State workers investigate other State workers involved in alleged cases of abuse in institutional settings, i.e., investigating one's own. In particular, substantiation requires termination of employment and this may further increase the conflict of interest since all staff involved in such cases are employed by the State. Additionally, the Panel members would like to clarify how State Personnel becomes involved when a staff person is terminated based on substantiation of abuse.

**Recommendation 10:** Agencies should adopt specific policies and procedures to initiate a quality assurance review at institutions where substantiated cases of abuse have been overturned on appeal.

**Discussion:** The Panel members are concerned that once a substantiated case in an institutional setting has been overturned on appeal, CPS and Licensing staff may not follow up to ensure there is ongoing accountability on the part of the institution for appropriate service provision.

**Recommendation 11:** Gaps in data interface capability between the Counties and the State need to be addressed in order to establish an accurate statewide database of children in foster care.

**Discussion:** Given today's information technology, the lack of a statewide database of children in foster care is a serious concern. The data infrastructure required to establish this needs to be agreed upon, planned, fiscally supported, and implemented.

**Recommendation 12:** Policies and procedures should be established to formalize the interaction between State and County agencies and tribal entities involved in cases of institutional abuse.

**Discussion:** Regarding the issue of sovereign territory in tribal cases, the Panel recognizes that issues of jurisdiction can be confusing. However, this should not prevent formal collaboration with tribes to enforce appropriate procedures when jurisdiction overlaps.

**Recommendation 13:** Specific to foster care settings, State and County agencies need to develop a better response system for foster families including in-home training, support services, and monitoring.

**Discussion:** The Panel members are concerned that short of substantiating abuse, not enough is done in homes where there are problems. The quality of care that a child receives needs to be addressed in cases that may fall short of an abuse report. More supportive intervention is needed to preserve placements that includes appropriate pre-service training, in-home training, support services, foster parent mentoring, and monitoring in the form of ongoing contact with foster homes and group homes.

These types of intervention provide support prior to a crisis and help preserve the safety of children. The Panel recommends that current services be preserved and additional resources be allocated to appropriate support and preservation of foster families caring for children. The Panel views these support services as a necessary component of the DCFS initiative to maintain children in family foster homes with wraparound services.

## **Summary: Case Record Review Development**

During 2002, the Panel members were reminded that part of the CRP requirements includes conducting case reviews. In order to do this effectively, the Panel members agreed to start with the primary area of review for the year: CPS policy review focused on investigations of abuse in institutional settings. It was decided that the members would begin by looking at the intake and assessment of institutional abuse cases. Members plan to focus on case record reviews, which will include institutional site visits and interviewing case workers.

This work began with the development of a case record review survey instrument. The Panel relied on the State's CPS Case Compliance Record Review Sheet as a source format. This is a detailed document used to ensure compliance with Nevada Revised Statutes (NRS). This was narrowed and customized into a simplified format in order to fit the Panel's focus on intake and assessment procedures surrounding abuse in institutional settings.

The case record reviews will enable the Panel to look closely at how CPS staff decides to take a case and what steps are taken. Other key issues surrounding intake include looking at the experience level of staff that takes a referral, staff training, and how decisions are made about referrals. It was agreed that upon completion of the case record review survey instrument, the Panel members would schedule a mock review in order to understand what an 'ideal' case looks like. Because Panel members are being asked to make judgments about the quality of staff response, they need to understand what this involves. A mock case that demonstrates best practices will enable the members to more effectively conduct actual on site reviews.

The Panel plans to divide into regional teams and examine case records in the three primary regions of the state: north, south and rural. Once the survey instrument is complete, the Panel will initiate the case record review process in mid-2003. It was also agreed that the first scheduled case reviews would be considered a pilot project, after which the members would report their findings at the next regularly scheduled Panel meeting and work to further develop and refine the process.

The members agreed it is important to conduct on site reviews at field offices, versus just inviting staff to make presentations at meetings. This type of review structure will lend more authority to the Panel's Annual Report.

As part of the case record review development, the Panel also reviewed Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) specific to abuse investigations. It was agreed that a review of the applicable laws and codes is a critical starting point for examining intake and assessment surrounding institutional abuse. In particular, this underscores the importance of ensuring that consistent definitions are used by staff and uniform policies and procedures are in place for both State and County agencies. The Panel will continue to focus specifically on these issues during 2003.

## **Summary: Panel Involvement in CFS Reviews**

During its October 22 meeting, the Panel members learned that the primary purpose of the federal Child and Family Services (CFS) Reviews is to determine how well the State system is operating. The goal is then to capitalize on the federal momentum to advocate for positive change within the system. One of the key components of the review process is to identify areas of weakness in order to promote system change.

As part of the CFS Reviews, a statewide assessment is completed by State staff within the six months prior to the review date. It was recommended that the CRP become involved in the assessment portion of the review process. Specifically, this involves assessment of the seven systemic factors that are examined as part of the review:

1. Statewide information system
2. Service array
3. Case review system
4. Staff training
5. Quality assurance system
6. Agency responsiveness to the community
7. Foster and adoptive parent licensing, recruitment, and retention

The statewide assessment for Nevada is due by December, 2003. The onsite review starts in February, 2004. Las Vegas is the initial designated review site, and the reviewers will choose two other sites based on the information provided in the statewide assessment. Any case open as of October 1, 2002, which is the beginning of federal fiscal year 2003, can be examined as part of the review.

The Panel members also learned about the different criteria that may determine what systemic factors are in or out of compliance. These determinations are followed by a program improvement phase, which is supposed to begin 90 days after review results are issued. This includes the development of a program improvement plan.

The Panel members are scheduled to review a timeline of the assessment process with State staff in early 2003 and work to develop plans for CRP involvement.

## Summary: CAPTA State Plan

The yearly update to the CAPTA State Plan was reviewed briefly at the February 4 and April 8 meetings, along with discussion of CAPTA requirements. The Panel members reviewed an update to the Five-Year Comprehensive Child and Family Services Plan for 1999 – 2004. The members also received supplementary information to help them understand where their work fits into the CAPTA State Plan. The members also reviewed the primary goals outlined in the basic state grant application.

The Panel's work for 2002 centered on the following CAPTA assurances:

- (i) child abuse reporting;
- (ii) immediate screening, safety assessment, and prompt investigation of such reports;
- (iii) immediate steps to be taken to ensure and protect the safety of the abused or neglected child and of any other child under the same care who may also be in danger of abuse or neglect and ensuring their placement in a safe environment;
- (vii) the cooperation of State law enforcement officials, court of competent jurisdiction, and appropriate State agencies providing human services in the investigation, assessment, prosecution, and treatment of child abuse or neglect;

## **Monitoring of FY 2001 Recommendations**

Also during 2002, the Panel followed up on the previous year's areas of review through monitoring of the following:

1. Panel role and functioning
2. Yearly update to CAPTA State Plan
3. Maltreatment in foster care settings
4. Child data
5. Institutional abuse investigation training

### ***Panel Role and Functioning***

During the monitoring of the 2001 recommendations, the Panel received DCFS staff feedback on the 2001 Annual Report that was positive and indicated that the group has done good work. However, this feedback also included discussion that the Panel did not cite source material in some of its recommendations, i.e., Nevada Revised Statutes (NRS), policies and procedures, etc. Also, staff pointed out that some of the recommendations appeared to comment on things that have already been done or work that has been already started within DCFS.

This feedback underscored the importance of the Panel beginning its monitoring efforts and hearing staff reports so that the members remain updated on ongoing projects at DCFS. Furthermore, the monitoring process made clear the need to narrow the Panel's focus on a specific area of review. This resulted in the development of the 2002 and 2003 workplans, as well as determining the primary area of review on CPS policy review focused on investigations of abuse in institutional settings.

### ***Yearly Update to CAPTA State Plan***

As recommended in 2001, review of the yearly CAPTA update included an overview of changes presented by State staff to the Panel during a regularly scheduled meeting. This review was completed at February 4 and April 8 meetings as summarized above.

### ***Maltreatment in Foster Care Settings***

Staff responses to recommendations in this area of review were provided at the February 4 meeting. Additional information on the development of a new safety assessment instrument was provided at the June 28 meeting.

**Recommendation 1:** Prescreening of foster parents is critical to the welfare of children. Licensing staff members need to ensure that foster parents can adequately meet the needs of foster children prior to placement.

**Response:** Staff members conduct home visits with a variety of requirements that include seeing the child alone and viewing the child's room. Additionally, staff members are encouraged to communicate with one another regarding foster homes. Staff agreed that Licensing needs to communicate more with CPS line staff.

The daily rate for foster families was increased during the last Legislative session, although Nevada's rate is still below the national average and recommended amount. Staff noted that special needs and medically fragile children get extra reimbursements.

**Recommendation 2:** Personal strengths and attributes need to be examined by Licensing staff along with concrete indicators such as safety, living space, and annual income.

**Response:** DCFS has implemented a 24-page, universal application format that examines some of the indicators included in the recommendation. Prior to its expansion into the current format, the application was only 10 pages. The application can be used by any applicant for relative placement, interstate compact placement, foster home, or adoptive home. This universal format replaced separate applications that were being used for these different types of placements.

A national technical assistance project was started in 2002 that includes developing a study on foster home placement and permanency, with Las Vegas as one of the pilot project areas. This is being conducted by the National Resource Center for Permanency Planning of Hunter College in New York.

The Panel members also received a report on the development of a safety assessment instrument for foster care. Staff distributed a draft of the instrument, which was developed by a multi-agency committee that includes State and County representatives. The committee drew from assessments used in Colorado, Illinois, and Vermont. The initial assessment instrument is currently being field tested in Las Vegas and Fallon. After the field testing is complete, a finalized form for ongoing cases will be developed. Staff noted that development of the safety assessment instrument is partially in response to the CRP recommendation that safety be looked at more carefully.

**Recommendation 3:** The need for continued improvement of Licensing practices is still evident. Improvements have been made by DCFS Licensing staff, but more work needs to be done.

**Response:** Staff said the Panel members need to be more specific. The Panel noted that policies and procedures related to licensing have been communicated through staff presentations, and the Panel would like to see documentation of these for review.

**Recommendation 4:** Child welfare staff should develop a culture where there is more positive, supportive intervention in foster care settings.

**Response:** Staff noted that foster parents typically perceive that the highest level of intervention is made in each case. When parents are under scrutiny, they are likely to feel negative. Staff explained that for a social worker there is no advantage to investigating a complaint in a foster home because the likelihood of losing the home is high, and they believe staff does not want to treat the foster parents negatively. Staff suggested that foster parents might be informed during orientation and training sessions what may happen if they are investigated to help reduce negative perceptions of scrutiny.

**Recommendation 5:** Differential response should be implemented for problems that arise in foster care that are referred to CPS.

**Response:** Staff explained that the differential response model would be difficult to apply to foster care settings. Differential response is a process whereby a report of alleged abuse or neglect is not investigated based on the apparent level of seriousness, but instead the family is contacted and offered voluntary services. Specifically, differential response reports are not entered into the central registry and this model is not appropriate for foster care because every referral needs to be investigated. Staff noted that another recommendation in the 2001 report suggests conducting two different types or levels of investigations, which they believe is a better recommendation to build on.

**Recommendation 6:** Clinical response teams should be established that can be mobilized to provide services to foster families in need in order to maintain placements during times of crisis.

**Response:** Staff reported that this is a matter of obtaining funding and additional staff resources.

**Recommendation 7:** The cluster model should be implemented statewide to provide peer support and respite services for foster families.

**Response:** Staff suggested that the Panel seek feedback from southern staff involved in the cluster model development at the Neighborhood Care Centers to see how this approach is working prior to recommending that it be implemented statewide. The cluster model is a geographically based model of service provision that has been initially organized according to regional zip codes.

**Recommendation 8:** Outreach to foster parent associations should be a priority. The child welfare system should explore ways fund these associations and empower them to provide a variety of supports and activities to benefit foster families.

**Response:** Staff reported that DCFS has provided funding to foster parent associations, totaling \$55,000 for 2001.

**Recommendation 9:** Services to children should be made available that help prevent problems from escalating to CPS and Licensing referrals. Foster parents need access to timely assessment, intervention, and treatment for children under their care, which will significantly improve the quality of foster care.

**Response:** Staff reported that this is a matter of obtaining funding and additional staff resources.

**Recommendation 10:** In rural areas where there are not accessible services because of Medicaid limitations, DCFS and the Counties should develop a system by which services are paid for where needed. Lack of Medicaid coverage in a certain area or for a certain service should not be a reason to not provide services.

**Response:** Staff explained that sometimes lack of services is not a funding issue but rather a staff resource issue because personnel may not be available in rural areas. Staff underscored the statewide problem of obtaining and retaining rural personnel.

**Recommendation 11:** Protective measures need to include reducing multiple placements. It is important to recognize that every time a child is moved it is harmful.

**Response:** Staff agreed that the ideal approach is to find the best home for a child when first placed.

## ***Child Data***

At the February 4 meeting, the Panel reviewed a data report on foster care licensing including statistics for relative and non-relative placements in a variety of areas statewide. The Panel members and staff discussed the accuracy problem with vacancy rates, in which homes can be shown vacant for a variety of reasons. For example, homes available may not be licensed for certain types of children. Additionally, there are often issues about separating sibling groups and cases where foster parents simply do not feel a child is appropriate for their home.

At the June 28 meeting, the Panel members previewed a draft of the 2002 edition of the Division of Child and Family Services (DCFS) Child Abuse and Neglect Statistics. This included review of key statistics such as substantiated and unsubstantiated cases.

## ***Institutional Abuse Investigation Training***

At the February 4 meeting, the Panel members received a report from Candace Young-Richey, the contractor working with DCFS to complete an assessment of multi-agency response to child abuse investigations in institutional settings. This project was contracted out by the CJA Task Force to examine in detail the issue of institutional abuse. Key aspects of the project include the following:

- Interviewing staff involved in abuse cases at residential institutions, including CPS and Licensing staff.
- Exploring what is currently known about institutional abuse.
- Literature review and examination of other states' model programs and responses to institutional abuse.

- Examining the lack of standardized Licensing across the state.
- Exploring why reports of abuse at institutional settings are not entered into the central registry and why law enforcement does not interface with the State or Counties for data reporting.
- Exploring related issues including restraint techniques, handling of children with special needs, resource limitations, staff knowledge of institutional abuse issues, and standardized protocols and responses.
- Examining the definition of abuse relative to the level of care children are in.

At the June 28 meeting, the Panel members received a follow-up report on the project that included feedback from the initial staff interviews. CPS staff has concerns that include the following:

- |   |   |
|---|---|
| • Substantiation criteria                   | • Valid measurement of the incidence of abuse |
| • Training needs                            | • Standardization of protocols                |
| • Data                                      | • Agency roles                                |
| • Intake                                    | • Worker roles                                |
| • Referrals                                 | • Investigation processes                     |
| • Reports                                   | • Use of evidence                             |
| • Licensing standardization and Involvement |   |

The contractor reported that she will be examining these issues as she continues work on the project.

## **APPENDIX A: OVERVIEW OF THE STATE CHILD WELFARE SYSTEM**

Prior to 2001, the child welfare system in Nevada was bifurcated between State and County agencies as a result of State law. Under Nevada Revised Statute (NRS) 432B.352, the law required that counties in which the “population is 100,000 or more shall provide protective services for the children in that county and pay the cost of all those services.” In Nevada there are two counties that meet this criterion: Washoe County in northern Nevada and Clark County in southern Nevada. As a result, there are three separate agencies that provide child welfare and child protective services (CPS):

1. State of Nevada Division of Child and Family Services (DCFS)
2. Washoe County Department of Social Services (WCDSS)
3. Clark County Family and Youth Services (CCFYS)

These agencies work together through the CPS Statewide Managers Team, also known as the Nevada Child Protection and Permanency Planning Team. This team collaborates on pertinent law, regulation, and policy issues necessary to maintain statewide consistency for investigative and casework practices. The CPS Statewide Managers Team assists with the development and oversight of the Child Abuse Prevention and Treatment Act (CAPTA) Basic State Grant.

The child protection agencies conduct child abuse investigations and may take children into protective custody and place them in licensed foster homes. Bifurcation occurred when the County child protection agencies transferred long term or other foster care or potential adoption cases to the State via DCFS. Children were transferred from their initial CPS placement in the County to the State agency’s licensed foster care home. The transfer included changes in social workers, court process, and service delivery systems.

However, during 2001, the Nevada State Legislature passed Assembly Bill (AB) 1 of the 17<sup>th</sup> Special Session, which provides for the integration of State and local child welfare services. This bill is intended to end the practice of transferring cases from the Counties to the State, thereby reducing the number of changes in placement for a child in protective custody. Integration means that the two larger Counties will incorporate the previously separate child welfare functions of foster care and adoptions into one continuous system of child protection. The following are directives of AB 1:

- Transfers certain duties of the Division of Child and Family Services (DCFS), under the Department of Human Resources (DHR), to agencies of Washoe and Clark Counties.
- Establishes a Legislative Committee on Children, Youth, and Families to oversee the system transition.
- Makes appropriations to fund the transition between State and County agencies.

The implementation of this transition is projected to occur through 2005. WCDSS began implementation in April, 2002, and CCFYS implementation has been delayed. The integration of child welfare services is intended to accomplish the following:

- Begin to eliminate the inefficiencies of the current system by reducing the number of placements of children in foster homes.
- Decrease the length of time that children remain in out-of-home care and ensure that children are placed in permanent homes as soon as possible.
- Establish rates for foster care reimbursement at a level that enables a provider of foster care to care for a child adequately. Rates should be standardized within each county and structured in a manner that avoids any unnecessary interruptions in foster home placements because of changing levels of reimbursements.
- Establish as a priority the fairness to employees affected by the integration of the child welfare system.
- Establish that DCFS and counties whose population is 100,000 or more have a shared fiscal responsibility for the costs of providing child welfare services, must be committed to ensuring through negotiation in good faith future maintenance of their efforts in providing these services, and must equitably share future costs for providing these services.
- Establish that integration of the child welfare system in Nevada will allow the placement of children in a child welfare system that is adequately funded and structured to avoid unnecessary interruptions in placement and will ensure that permanency is achieved for children in accordance with federal and state laws.

## **Child Death Review Teams**

Child Death Review Teams, required by CAPTA, have been organized throughout Nevada since 1993. Technical assistance has been provided with CAPTA funds to assist with child fatality issues through presentation of a forum for discussion and through the establishment of a workplan to address these issues in Nevada. Some issues that were identified include varying definitions of child abuse and neglect and the use of various forms. Participants included representatives from the following entities:

- Coroner's office
- State of Nevada Health Division
- Law enforcement
- District attorneys
- Child protective services (CPS)
- Medical professionals including pathologists and representatives from laboratories, hospitals, and clinics
- Court Appointed Special Advocates (CASA)
- Family Resource Centers (FRCs)
- School districts

Child Death Review Teams are now organized and active throughout the State. There are five regional teams and a statewide team housed in social service agencies. Regional teams consist of the following:

1. Washoe County Department of Social Services (WCDSS)
2. Clark County Family and Youth Services (CCFYS)
3. Rural Northeastern Nevada (Elko area)
4. Fallon
5. Carson (Carson, Douglas, Storey, and Lyon Counties)

During 2000, the statewide team was successful in developing common terminology and definitions for statewide application. A standardized data collection instrument developed by the statewide team, with input from coroners and the Bureau of Health Planning and Statistics, has been implemented along with appropriate protocols.

The statewide team has also narrowed the field of categories relating to deaths down to six and developed a single review form for data entry. The statewide report captures global data in these six categories and the system has the capacity to search for detailed information. CCFYS maintains the database for the teams and generates the statewide report.

The system operates in the following manner:

- All autopsy reports sent for review from the coroner's office in the north are sent to WCDSS where they are disseminated to the appropriate Child Death Review Team. Likewise in the south, all autopsy reports sent for review from the coroner's office are sent to CCFYS where they are disseminated to the appropriate Child Death Review Team.
- Each Child Death Review Team meets to discuss these reports and each has a set of review forms that they keep for determinations by the team.
- At the end of the calendar year, the forms are sent to CCFYS for processing and generation of the annual report.

Although there are some variations, the death review process is similar within each county. The general model tends to follow a six-step process, outlined as follows:

1. The coroner identifies the modes of death prior to any analysis or involvement by a Child Death Review Team. The coroner lists one of four modes of death on the death certificate: 1) accidental, 2) homicidal, 3) natural, or 4) undetermined.
2. The health district or a county health office forwards all child death information to the coroner, who then forwards it to the Child Death Review Team Coordinator. This is done the first of every month in counties where a death has occurred. In other counties, it occurs only on an as-needed basis.

3. The Coordinator sends out notification to all Team members listing the children who will be reviewed at the next meeting.
4. Team members review each case from the perspective of their representative agencies or professional backgrounds to determine the necessity of further review.
5. The Team meets on a monthly basis, or as needed, to discuss the facts surrounding the death and the involvement of various agencies. It then draws conclusions from these facts to assist responsible parties to take necessary actions. Verbal exchange of information at team meetings is informal and confidential. No minutes are kept. Data on number, type of cases, and recommendations are logged. Notes on protocol and policy issues are also recorded.
6. The Team's review may be cursory or in-depth, depending upon the available information and the perceived need and basis of several risk factors including drug ingestion, undetermined cause of death, head trauma, malnutrition, bathtub drowning, suffocation, fractures, sudden infant death syndrome (SIDS), blunt force trauma, homicide, child abuse, neglect, burns, sexual abuse, gunshot wounds, stillborn or fetal death that may be drug related, and poisoning.

## **Substitute Care – Foster Care**

The authority for the substitute care program is delegated to the Division of Child and Family Services (DCFS) by Nevada Revised Statutes (NRS) 432.020, which establishes the Division's responsibility to support and maintain children placed in its custody, and NRS 432.032, which provides authority to adopt program regulations. NRS 432B.190 requires the Division to provide for the protection of the legal rights of parents and children, to evaluate the development and contents of plans submitted for approval regarding efforts to avoid removal of children from their homes, and to facilitate return where removal is necessary.

Substitute care is a family-focused service that provides for the temporary care of children in need of protection. Its services are aimed at changing behaviors in parents that have resulted in child maltreatment leading to out-of-home placement. The Division returns children who have been removed and may be safely restored to their families through the provision of services to the child and family. When reunification is not possible, the Division seeks alternative permanency options which best suit the child's needs. Specifically, the Division provides assessment and comprehensive case management services that support the child, the parents, and the caregivers.

The continuum of out-of-home care services includes emergency shelter care, foster family care (including placements with relatives), group home care, therapeutic foster care, respite care, residential treatment care both in and out of state, and independent living services. The Division emphasizes the safety and well being of children, recognizes the family as the fundamental foundation of child rearing, and acknowledges the importance of a comprehensive, community-based, child-centered, family-focused, and culturally competent teamwork approach.

The Division believes families offer children and young adults opportunities for permanency and family relationships that are intended to last a lifetime. Permanency affords the stability and security that children must have for building competency and self-reliance and for maximizing their cultural and spiritual growth. The Division supports collaborative efforts in every community to help assure permanence in the lives of all children.

DCFS began major child welfare reform in 1992 with the commitment to move from a protective authority to a family-centered approach in casework. The first phase was the adoption of a training series for social workers that incorporates the philosophy and principles of family-centered practice in the four major casework areas:

1. Child protective services (CPS)
2. Adoption
3. Foster care
4. Child welfare

In 1994, the second phase of this initiative included the creation of the Foster Care Statewide Steering Committee to address professionalization, training, and retention of foster caregivers. The goal was to improve the quality of foster care by means of a family-centered approach with foster caregivers. The yearlong efforts of this task force and its three subcommittees resulted in a number of improvements within foster care. These included the following:

- Implementation of a 36-hour pre-service foster parent training curriculum
- Involvement of foster care providers in case planning
- Promotion of the development of a Foster Parent Bill of Rights

To continue the efforts of this initiative and to address the quality of care standards required by the Adoption and Safe Families Act (ASFA), DCFS formed a Quality of Care Standards (QCS) Statewide Task Force. The Task Force reviewed current standards and suggested additional standards to improve services and practices. The QCS Task Force was composed of child welfare managers, supervisors, social workers, specialists, foster care providers, and representatives from County social services. The Task Force represented Nevada's three geographic regions: north, south, and rural. Five areas were addressed by the Task Force:

1. Foster care licensing
2. Training
3. Retention and support
4. Quality of care for foster children
5. Professionalization of foster caregivers

After an initial review and recommendation report was developed, the QCS Task Force membership was dissolved into other groups that continue to evaluate the five areas outlined above and to recommend ways to improve the delivery of services and quality of care for children in foster care.

Specific to the training implemented by the Task Force, Nevada adopted a 36-hour pre-service training curriculum in 1997, which is now required of all potential foster and adoptive families. The training is designed to provide families with knowledge and skills that can greatly contribute to their success. Some families will decide that foster care and/or adoption is not for them, while others will begin to gain an understanding of the role of their family and how additional children can enhance their family life.

The northern and southern regions have trainers on staff who provide the 36-hour pre-service training. The rural region contracts out to a local provider to recruit and train foster homes, using the same pre-service curriculum. This is an established curriculum developed by the Institute for Human Services in Columbus, Ohio, which is widely considered to be state-of-the-art training.

## APPENDIX B: PANEL MEMBERS

<i>Member</i>	<i>Affiliation</i>	<i>Representation</i>
Appell, Annette	University of Nevada, Las Vegas – School of Law	Children’s Attorney – southern region
Bredlau, Mary	Palm Mortuary	Faith Community – southern region
Capello, Michael or Durand, Jim	Washoe County Department of Social Services (WCDSS)	Child Protective Services – northern region
Coppa, Dan	Juvenile Justice Commission	Law Enforcement – northern region
Cotton, Ed	Division of Child and Family Services (DCFS)	Division Administrator – northern region
Herzik, Mary	Court Appointed Special Advocates (CASA) of Washoe County	CASA – northern region
Moorehead, Larry	Foster Parent	Foster Parent – northern region
Stillian, Carol	Clark County Department of Family & Youth Services (CCDFYS)	Child Protective Services – southern region
Swetnam, Laurel	DCFS – Southern Regional Early Childhood Services	Mental Health – southern region
Walker, Marcia Rose	Economic Opportunity Board (EOB)	Community Representative – southern region
Vacant		Child Welfare
Vacant		Public Defender