☞ **07hr_JC-Au_Misc_pt04b**

☞ Details: Public Hearing: Follow-up: Audit Reports 06-1 and 06-2, Milwaukee County Child Welfare, Department of Health and Family Services (DHFS)

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2007-08
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

Kids Matter Inc.
Rebuilding Childhoods. Fostering Futures.

February 16, 2007

Honorable Jim Sullivan, Co-Chair
Joint Legislative Audit Committee
Room 15 South
State Capitol
P.O. Box 7882
Madison, WI 53707

Honorable Suzanne Jeskewitz, Co-Chair
Joint Legislative Audit Committee
Room 314 North
State Capitol
P.O. Box 8952
Madison, WI 53708

Dear Senator Sullivan and Representative Jeskewitz:

We are writing to express our concerns regarding the February 1, 2007 letter of Department of Health and Family Services Secretary Kevin Hayden and the Department's Final Report to the Joint Legislative Audit Committee. We are also writing to support the call for Legislative Audit Committee hearings on Safety Services, the recent child fatalities, and matters of accountability in the Bureau of Milwaukee Child Welfare.

Many in the Milwaukee community who pay attention to child welfare issues were surprised that Secretary Hayden's letter and the Department's report failed to mention the deaths of three children under the supervision of the Bureau of Milwaukee Child Welfare ("BMCW") during the period of the report. These deaths all took place in the period of May through November, 2006 -- a period of heightened BMCW oversight and development of corrective action plans in response to areas deemed in need of improvement by the Legislative Audit. One of these deaths included a child death by starvation – the second death by starvation of a child known to BMCW between 2004 and 2006. Starvation deaths are so rare that they are not included in national statistics relating to child fatalities, and yet we have had two starvation deaths in Milwaukee in recent years.

The failure of the Department to even mention these fatalities in its progress reports or to report the fatalities to the Partnership Council for nearly three months underscores the issues we face in Milwaukee. As the only county in the State of Wisconsin that is operated by the Department of Health and Family Services, we must appeal to the legislature to address matters such as child fatalities and independent reviews.

I am including copies of our letters to Secretary Hayden and the Bureau of Milwaukee Child Welfare Partnership Council. On behalf of the children, we are grateful that you will be holding hearings on these matters. The only way we can move forward for

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PHONE 414-344-1220 FAX 414-344-1230

children is to bring ongoing issues into the open, and find ways to work together so that children do not continue to fall through the cracks. We cannot let Wisconsin become the national leader in child fatalities due to starvation.

Sincerely,

Susan Conwell, J.D.
Executive Director

Kids Matter Inc.
Rebuilding Childhoods. Fostering Futures.

February 16, 2007

Secretary Hayden
Department of Health and Family Services
P.O. Box 7850
Madison, WI 53707-7850

Dear Secretary Hayden:

I am writing in response to your February 1, 2007 letter to the Co-Chairs of the Joint Legislative Audit Committee and attached Final Report to the Joint Legislative Audit Committee.

Many in the Milwaukee community who pay attention to child welfare issues were surprised that the letter and report failed to mention the deaths of three children under the supervision of the Bureau of Milwaukee Child Welfare ("BMCW") during the period of the report. These deaths all took place in the period of May through November, 2006 -- a period of heightened BMCW oversight and development of corrective action plans in response to the Legislative Audit. One of these deaths included a child death by starvation – the second death by starvation of a child known to BMCW between 2004 and 2006. Starvation deaths are so rare that they are not included in national statistics relating to child fatalities, and yet we have had two starvation deaths of children known to BMCW in Milwaukee in recent years.

While it is not unusual for a governmental body to highlight its accomplishments, we were quite disappointed that you completely failed to mention three child deaths, especially as those children were under BMCW supervision at the time of their deaths (one child committed suicide while in BMCW placement; one child died due to physical abuse by her parent while BMCW supervised the home placement; and one child starved to death while BMCW supervised her brother's placement in the home. The child who starved to death had her own safety services case. We believe a review of this case will show that the safety services case was closed prematurely.)

Rather than address the fatalities, you spend a great deal of time focusing on the Qualitative Service Review and several new initiatives that have yet to be implemented. While the process of review holds promise, so few cases were reviewed that the data is not statistically significant, and, as such, cannot be relied upon in assessing BMCW progress. You fail to acknowledge the deaths of three children – instead focusing on a sample of 15 cases out of more than 3000 children under BMCW supervision.

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We appreciate that you are new to your position, and may not be personally aware of the child fatalities. Here is an opportunity for you to become aware of issues of great importance to the community, and to deal with them in a forthright manner.

We request a meeting with you to discuss issues of accountability including but limited to: 1) failure of the Bureau of Milwaukee Child Welfare to provide complete information to the Partnership Council preventing that body from fulfilling the duties assigned to it by the Department of Health and Family Services (DCFS Memo Series 2000-07/Action, attached) including the review of child fatalities and near fatalities; 2) the need for an independent Children's Advocate with statutory authority to review cases, make recommendations to the Governor, Legislature and Department; 3) the serious decrease of placement options for abused and neglected children; and 4) six years worth of reports describing confusion of roles and duties relating to new allegations of abuse while a child abuse case is already open.

We look forward to discussing these matters as soon as practicable.

Sincerely,

Susan Conwell, J.D.
Executive Director

Kids Matter Inc.
Rebuilding Childhoods. Fostering Futures.

February 16, 2007

On Open Letter
To the Bureau of Milwaukee Child Welfare Partnership Council:

During November 2006, two children died while the Bureau of Milwaukee Child Welfare ("BMCW") supervised their homes or placements. Also in November, Children's Family and Community Partnerships announced layoffs. Yet, the regularly scheduled December 2006 meeting of the Partnership Council was cancelled. Further, neither of the deaths was addressed during the regularly scheduled meeting of the Partnership Council held in January 2007. This is a very serious omission.

Hopefully, as members of the Partnership Council, you are aware that you are assigned the duty of fatality and near-fatality review for the Bureau of Milwaukee Child Welfare (see attached DCFS Memo Series 2000-07/Action, especially page three). You cannot fulfill that role unless you insist on being informed of child fatalities and near fatalities.

I made presentations to the Partnership Council regarding this duty in 2002, 2003 and 2004. During 2004, the Child Abuse Review Team gave a presentation to the Partnership Council regarding its role in child fatality review, and made suggestions for how the Partnership Council could help improve the process of fatality review. Each of these presentations generated dialogue on the part of Council members, and BMCW Director Denise Revels Robinson gave a response to the CART team recommendations. Further recommendations regarding actions to be taken were referred to committees for further discussion and action. I personally reviewed the minutes for all Partnership Council meetings from 2004 through 2006 and can find no evidence that any of these referrals to committees actually resulted in discussions by committees. There is no evidence of a report back by a committee to the Partnership Council regarding child fatalities, or an annual report of the CART team to the Partnership Council. This duty is far too serious for this level of inaction.

There were three deaths of children under the supervision of BMCW during the period of May through November, 2006 -- a period of heightened BMCW oversight and development of corrective action plans in response to the Legislative Audit. One of these deaths included a child death by starvation – the second death by starvation of a child known to BMCW between 2004 and 2006. Starvation deaths are so rare that they are not included in national statistics relating to child fatalities, and yet we have had two starvation deaths of children known to BMCW in Milwaukee in a relatively short time.

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We recognize that you participate in the Partnership Council due to your dedication to helping children. You have particular skills and knowledge that you bring to the table to benefit children. We are requesting that you bring that knowledge and these skills to the issue of fatalities and near fatalities. It is extremely inappropriate for the Partnership Council to get its information from the newspaper.

We request that you take the following steps:

1) Support the creation of an independent Children's Advocate with statutory authority to secure records, review critical cases, and make recommendations to the Governor, the Legislature and the Partnership Council. The current system of PEM review and a contractual ombudsman that report to the Department with no ability to make specific recommendations or follow-up on those recommendations has not served Milwaukee children.
2) Direct BMCW to provide data regarding child fatalities and near fatalities at every Partnership Council meeting. Include a review of the Annual Report to the Governor and Legislature on Wisconsin Child Abuse and Neglect as a standard, annual agenda item. The most recently reviewed report on record is the 2001 Annual Report. This report shows, for instance, that Milwaukee continues to have a much lower rate of child abuse substantiation than most Wisconsin counties, even though we have a higher rate of reported abuse. This report should be of interest to the Partnership Council.
3) Specifically review the process for closing Safety Services cases, particularly when the parent refuses services or requests case closure prior to any engagement in services. Ask for data about multiple safety cases for the same family. Question how one family of five children can have one child on an ongoing court order, one child in Safety Services, and no interview or any services to the other children in the home, even after brutal physical assaults against one of the children. The Legislative Audit identified numerous challenges in Safety Services. Recent cases demonstrate considerable confusion regarding the transfer and closing on Safety Services cases and the handling of new calls to 220-SAFE while the family has an open Ongoing or Safety case.
4) Ask to see BMCW data reports in advance of the Partnership Council meetings so that Partnership Council members can ask informed questions. It is standard operating procedure for board members to receive information in advance of the meetings at which they will consider the information presented. Direct BMCW to include data regarding turnover of ongoing and safety staff to be included in the data provided to the Partnership Council. Notice that data for all child outcomes are not included in the data presented to the Partnership Council including: child fatalities, near fatalities, cases closed to juvenile justice, data on AWOL children, etc. This should be remedied.
5) Ask for a presentation regarding the training of safety staff, and inquire into the ability of staff to identify medical neglect and/or their support or lack of support for that function. Numerous parties, from the CART team to the

District Attorney's office, have identified the need for specifically trained staff to monitor or evaluate cases of medical neglect.

6) Ask for reports from the community and from agencies that work regularly with BMCW. For example, we have a very active Milwaukee CASA program (Court Appointed Special Advocates) in Milwaukee that could provide a presentation by volunteers. The District Attorney's and Public Defender's office have unique perspectives on the children seen by their offices. Invite foster parents to discuss their issues and concerns. Their input is critical but they have not had a place at the Partnership Council since 2003. Foster families have been departing BMCW service at a very rapid rate since that time. It is past time to get the foster family viewpoint in addition to the contractor viewpoint. Efforts have been made to appoint a youth to the Partnership Council. These efforts should be renewed.

Thank you for your consideration. It will take all of us working together to create a stronger child welfare system for our children.

Sincerely,

Susan Conwell, J.D.
Executive Director

STATE OF WISCONSIN
Department of Health and Family Services
Division of Children and Family Services

DCFS Memo Series 2000-07 /ACTION
March 13, 2000
Re: CITIZEN REVIEW PANELS

To: Area Administrators/Assistant Area Administrators
Bureau Directors
County Departments of Community Program Directors
County Departments of Developmental Disabilities Services Directors
County Departments of Human Services Directors
County Departments of Social Services Directors
Licensing Chiefs/Section Chiefs
Direct Services Supervisors
Tribal Chairpersons/Human Services Facilitators

From: Susan N. Dreyfus
Administrator

DOCUMENT SUMMARY

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires each state to establish Citizen Review Panels. These Panels will provide opportunities for citizens to play an integral role in assuring that States are meeting the goal of protecting children from abuse and neglect. Wisconsin will be establishing four or five panels throughout the state (including one to serve Milwaukee County). The requirements for the panels, as well as the application process for counties interested in establishing a panel, are described in this memo. Properly established, these review panels have the capacity to promote creative problem solving with the involvement of community members who represent a variety of disciplines. In addition, the annual reports of these boards have the potential for recommending needed changes and greater collaboration between the child welfare system and other service delivery systems.

General Background and Information

The federal Child Abuse Prevention and Treatment Act (CAPTA), as recently reauthorized, requires each state to establish Citizen Review Panels. The purpose of these panels is to provide new opportunities for citizens to play an integral role in assuring that States are meeting their goals of protecting children from abuse and neglect. The Governor's

certification that accompanied the State CAPTA plan included a required assurance that the citizen review panels required by CAPTA would be implemented.

Although the federal requirement of citizen review of a state's child protective services is new, citizen review panels have been around in differing formats for some time. Citizen review boards originated in the 1970's as a result of state-based initiatives to review the status of children in the foster care system. In the early 1980's, there was a dramatic increase in the creation of citizen review boards in response to federal P. L. 96-272, which required reviews of each child in foster care every six months.

Today, many states have established these review boards by statute or through judicial appointment. These foster care review boards have evolved as a major mechanism for case specific and system accountability and have served as effective lobbyists for foster children, as well as for state agencies. These boards have resulted in increased community awareness and ownership of child abuse and neglect issues and the strengths, weaknesses and challenges facing the child welfare services delivery system.

The Division of Children and Family Services believes that an active and creative partnership among the state, counties, tribes, private agencies and the community at large is the key to the future of public child welfare. There is a need to have the community involved if we are to be successful. We must make use of this opportunity to build a constituency for the public child welfare system and develop partnerships that share the goals of protection and permanence for children. The established panels are not intended to review policies and programs in all 72 counties, but are intended to provide a "snap shot" and give the general impact of policies and programs statewide. The Citizen Review Panels represent the community and consumer point of view. Their role is one portion of program and policy evaluation to assist the Department and counties in continually assessing the work we do and the services we provide to children and families in Wisconsin.

Mission Statement

The mission of the Citizen Review Panels is to assure that children and families in the community are provided the best possible services within the context of available resources and that children are protected from maltreatment. This mission will be achieved when the broader community has an understanding of and a voice in evaluating and assessing the child welfare system, advocating for the effective discharge of the responsibilities of the Child Protective Services system and those of the other community agencies that which support the child welfare system, promoting quality child protective services practice, advocating for the strengthening of and necessary resources for child protective services agencies, recommending and advocating for policies

and procedures that promote the highest quality child protective services practices and emphasizing cross-system problem-solving involving both formal and informal support agencies, groups and individuals and the development of mutual goals and the desire to enable effective changes.

What the Federal Law Requires

1. Each state must establish a minimum of three (3) citizen review panels.

2. Each panel must meet, at a minimum, quarterly.

3. Citizen review panels must evaluate the extent to which the State's child welfare system (both at the state and local levels) is effectively fulfilling its child protection responsibilities in accordance with the State CAPTA plan by:

    a. Examining the extent to which the State CPS system is coordinated with the foster care and adoption programs established under Title IV-E of the Social Security Act.

    b. Considering any reviews of child fatalities and near fatalities.

    c. Panels **may** review other criteria that they consider important to assure the protection of children, including the extent to which the State child protective services (CPS) system is coordinated with the foster care and adoption assistance programs.

4. Panels must prepare and submit an annual written report. These reports must be completed no later than October 31st of each year and should, at a minimum, contain a summary of each panel's activities and findings. Division staff will develop one report based on the panel reports for submission to the Administration for Children and Families.

The focus is on child welfare agencies in terms of monitoring (rather than the court systems, etc.), although those other systems must be considered in the context of the CPS system's ability to perform its functions.

Goals for Citizen Review Panels

- *To help build a constituency for child welfare*

- *To help educate the public and the community about critical CPS issues, practices, philosophy, etc.*

- *To evaluate policy vs. practice issues*
- *To evaluate resource issues/capabilities*
- *To evaluate and measure the impact of the relationships/philosophies/etc. of agencies external to the child welfare system in terms of their perspectives of themselves and of the child welfare system*
- *To measure success/effectiveness/outcomes*
- *To utilize learning and experience to affect/guide the development of the CAPTA plan*

Expectations of Citizen Review Panels

- To determine to what extent resources are provided to county agencies to help them meet requirements, standards, laws, etc.
- To determine to what extent requirements, policies, laws, etc., work to achieve the ends for which they were designed.
- To identify **systemic** issues that impact on the manner in which child welfare services are provided (e.g., corporation counsel has inadequate staff, policies and operations). Regional office will continue to respond to **individual** complaints.
- To review how the many agencies that provide services to children and families (e.g., mental health, alcohol and other drug abuse programs, schools, law enforcement, courts) are performing their functions relative to the child welfare system (e.g., funding, policies, operations).
- To explore the current nature of the relationships among various agencies (courts, law enforcement, schools, etc.) and how those relationships might be improved.
- To identify community expectations of the child welfare system, to compare those expectations with policies, practices and standards and to share with the community the parameters within which the child welfare system operates.
- To assist county and state policy-makers in assuring the quality of the services provided by the child welfare

system (e.g., policies, rules, laws and laws).

- To utilize state standards to provide consistent information to decision-makers at both the county and state levels of what is occurring in the child welfare system: what works and what doesn't.

Make-up of Panels (Recommended)

Size	10 to 15
Composition	CPS system representatives Customers Partners/stakeholders Judiciary and other legal system representatives (e.g., Guardians ad Litem, District Attorneys, Corporation Counsels) Local elected officials (mayor, county board supervisor, legislator, et. al.) Community leaders Professional organizations Service organizations (e.g., Lions, Rotary, Jaycees) Provider agency representatives (e.g., medical health, mental health, AODA, developmental disabilities, domestic violence, abuse and neglect prevention) Representatives of schools Tribal representatives in counties in which tribes are located

To the extent possible, panel members should reflect the programs, agencies and organizations indicated above and should also have mediation skills, listening skills, community organizing experience, knowledge of applying for grants and other funds. Panel members should also reflect the cultural make-up of the community.

The citizen review panel requirement need not create unnecessary duplication at the state and local level. The federal law allows states to utilize existing panels (e.g., child fatality panels, foster care review panels, multidisciplinary task forces), so long as the panels perform the functions required by the law. Therefore, while each of the panels must perform all of the functions required by the statute, the panels are not limited to only these functions and the depth and breadth of the review can be determined within the state. Accordingly, there is considerable

flexibility in designing these panels. It is the county agency's decision whether or not to utilize and expand an already existing panel. This is only one option available.

Meetings Each panel must meet at least quarterly. Each panel can decide how long it will meet (e.g., half-day, full day) and whether it will meet more frequently. Where the meetings will occur will be the decision of each panel

(Note: The Department is currently researching whether these meetings must be open under Ch. 19, Stats.)

Term of Office Each person would be asked to make a 3-year commitment but there would be no limit to the length of time an individual could serve. (Initially, 1/3 of the group would be appointed to a 1-year term, 1/3 to a 2-year term, and 1/3 to a 3-year term.)

Structure The panel chairperson would be selected from and by the group

Support* Records of meetings
Preparation and dissemination of materials to the panel prior to each meeting
Preparation of an annual report
Preparation of data (from both counties and statewide) for presentation to panels
Counties can consider utilizing contracted facilitators

(*some of this is pre-determined if these will be open meetings)

Conclusions

1. Wisconsin will create four citizen review panels. One of these will be the Partnership Council (or a subgroup or enhancement of that group) in Milwaukee County.

   The remaining three panels will operate on a pilot basis that will include a strong evaluation component to determine the efficacy of various models. To that end, the remaining three panels will be developed using three different models:

   a. Panel #1 will be comprised of all of the counties in one DHFS region.

b. Panel #2 will be comprised of all of the counties in one Judicial District.

c. Panel #3 will be one county.

These three panels will be comprised of distinct counties. That is, Panel #3 will not be in the same region as Panel #1 or the same district as Panel #2. Similarly, Panel #1 and Panel #2 will be comprised of counties that are not in the same geographic areas.

2. Panel #1 will consist of individuals recommended by each of the counties in the region subject to the make-up requirements indicated above. The county recommendations will be to the Administrator of the Division of Children and Family Services who shall, in consultation with the county agency directors and DHFS regional staff, appoint panel members from among the recommended individuals.

   Panel #2 will consist of individuals recommended by each of the counties in the Judicial District subject to the make-up requirements indicated above. The county recommendations will be to the Administrator of the Division of Children and Families and to the Chief Judge of the Judicial District who shall, in consultation with the county agency directors and DHFS regional staff, jointly appoint panel members from among the recommended individuals.

   Panel #3 will consist of individuals selected by the county agency director in a manner to be determined by that director. The director may wish to consider creating a new panel or utilizing an existing group, modified as necessary (such as the Family Preservation and Support Committee, fatality review panel or permanency planning review panel) to assure multidisciplinary involvement. The organization and composition of the panel shall be the county's decision subject to the make-up requirements indicated above.

3. The Department will provide funding to support the panels in an amount or amounts to be determined. Department regional and central office staff will provide technical assistance and consultation to each panel to the extent feasible. The applications to establish panels must include a proposed funding request from the Department.

4. The Department will develop and provide basic training for all panel members, consisting of a review of the statutes and Department policies, the CAPTA plan and other controlling documents.

5. Counties will provide additional information for panel members on local policies, procedures, practices, caseload standards and sizes, agency organization and other information necessary for the panel to achieve its goals and realize the mission described above.

6. Panels will review the policies and programs in the county in which it is organized (Panel #3) or the counties within the region or district in which they are located (Panels #1 and #2).

How to Apply

Those interested in volunteering to establish a panel should complete the attached Notice of Interest indicating that it will establish a panel to meet the requirements in this memo. The Notice of Interest should be submitted no later than April 7, 2000 to:

Amy Smith
Child Protective Services Specialist
DHFS/DCFS
P.O. Box 8916
Madison, WI 53708-8916
or FAXED to Ms. Smith at (608) 264-6750.

The Division will consult with Department regional staff and specific county agency directors for Panel #1 and regional staff, county agency directors and the Director of State Courts office for Panel #2.

We are willing to schedule an information meeting in the near future to discuss the specifics of the requirements and the panel operations if interest is expressed.

I encourage you to consider volunteering to become involved in this pilot program. I believe that this process will offer a great deal to all of us in improving the system of providing services to children and families.

REGIONAL OFFICE CONTACT:	Area Administrator
CENTRAL OFFICE CONTACT:	Amy Smith Child Protective Services Specialist Bureau of Programs and Policies 1 West Wilson St., P.O. Box 8916 Madison, WI 53708-8916 Phone: (608) 267-7732 FAX: (608) 264-6750 e-mail: smithae@dhfs.state.wi.us

c: Director of State Courts

Attachment
Notice of Interest in Forming a Citizen Review Panel

Last Revised: *January 23, 2003*


FORWARD

WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Jim Sullivan
State Representative Suzanne Jeskewitz

February 19, 2007

Mr. Kevin Hayden, Secretary
Department of Health and Family Services
1 West Wilson Street, Room 650
Madison, Wisconsin 53703

Dear Mr. Hayden:

Thank you for the written report you submitted on February 1, 2007, in which you describe the Department's progress in addressing the findings of the Legislative Audit Bureau's comprehensive evaluation of the Milwaukee County Child Welfare program (reports 06-1 and 06-2). Based on our review of your written report, and our concern about the recent tragic death of an infant in Milwaukee whose parents were receiving services from your Department, we believe it is both appropriate and timely for the Joint Legislative Audit Committee to conduct a follow-up hearing on the Milwaukee County Child Welfare program.

The Committee will hold a public hearing on Thursday, March 8, 2007, at approximately 11:00 a.m. in Room 411 South of the State Capitol. We ask you, and the appropriate members of your staff, to be present at the hearing to offer testimony in response to the audit findings, to update the Committee on your progress in implementing the Legislative Audit Bureau's recommendations, and to respond to questions from committee members. In addition, please be prepared to specifically discuss child safety services and the provision of these services to program participants in Milwaukee. As indicated on the enclosed hearing notice, the testimony received by the Committee during this portion of the public hearing will be by invitation only. Please plan to provide each committee member with a written copy of your testimony at the hearing.

Please contact Ms. Pamela Matthews in the office of Representative Suzanne Jeskewitz at 266-3796 to confirm your participation at the hearing. Thank you for your cooperation and we look forward to seeing you on March 8th.

Sincerely,

Senator Jim Sullivan, Co-chair
Joint Legislative Audit Committee

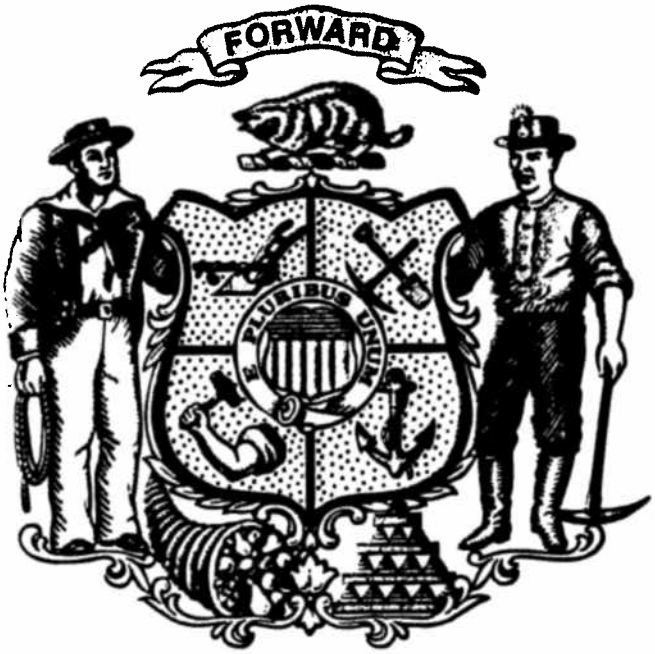
Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller
State Auditor

SENATOR SULLIVAN
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-2512 • Fax (608) 267-0367

REPRESENTATIVE JESKEWITZ
P.O. Box 8952 • Madison, WI 53708-8952
(608) 266-3796 • Fax (608) 282-3624


FORWARD
E PLURIBUS UNUM

DIVISION OF CHILDREN AND FAMILY SERVICES

1 WEST WILSON STREET
P O BOX 8916
MADISON WI 53708-8916

Telephone: 608-267-3905
FAX: 608-266-6836
dhfs.wisconsin.gov

Jim Doyle
Governor

Kevin R. Hayden
Secretary

State of Wisconsin
Department of Health and Family Services

February 26, 2008

Honorable Suzanne Jeskewitz
24th Assembly District
P.O. 8952
Madison, WI 53708

Dear Representative Jeskewitz:

I am responding to your January 15, 2008 letter regarding the staff turnover rate in the Bureau of Milwaukee Child Welfare (BMCW) and other issues brought to your attention by Kids Matter Inc.

I appreciate your concern for and commitment to the children and families we serve. I also want to acknowledge our appreciation of and ongoing relationship with Kids Matter Inc. in advocating for children and maintaining a safe and supportive community.

Within the context of the documents you forwarded, there are many different concepts and concerns identified by Kids Matter Inc. Without disregard to all of the work completed by Kids Matter Inc., I have prepared our response in three broad categories. Additionally, I am happy to discuss in more detail any of the other concerns raised.

Turnover measure used by BMCW

The challenge the BMCW must address regarding turnover is not in determining an adequate method to calculate the turnover rate, but rather how to effectively manage this issue that challenges child protective service agencies throughout the nation.

Several of the issues raised by Kids Matter Inc. are blended into the turnover concept within their documentation. For instance, there are references to vacancy rates not being included in the BMCW's definition, as well as what appears to be confusion between turnover rates and how caseloads are measured.

Since January 1, 2003 (the start of the Settlement Agreement), the BMCW has measured ongoing case manager turnover using the same method. The calculation of turnover used is the method which was prescribed in accordance with the Federal Settlement Agreement for the lawsuit against the State of Wisconsin, Jeanine B. v. Doyle. For reporting purposes related to the lawsuit, the BMCW was required to use the method described. The section of the settlement, including "turnover," is no longer enforceable. However, because the issue of staff turnover has a tremendous impact in the outcomes achieved for children and families in Milwaukee, we have begun to look at alternative ways of calculating turnover.

In the *Settlement Agreement First Semi-Annual Report, Process Indicators and Outcomes for the Period January 1 – June 30, 2007*, six of the seven pages dedicated to the issue of Ongoing Case Manager turnover provide additional information relevant to turnover. We believe it is very important for the BMCW, Milwaukee Child Welfare Partnership Council and other community stakeholders to be fully informed so they can make appropriate policy and programmatic decisions.

The additional information provided includes:

- The actual turnover numbers broken down by region and by month;
- Historical turnover performance from previous settlement periods;
- A summary and analysis of why individual OCMs left the workforce, including a breakout of how long they were employed;
- Length of employment of the active workforce at a point in time, compared to previous periods within the settlement;
- The reasons workers gave for leaving the workforce with a comparison to previous periods within the settlement;
- Supplemental information relative to recommendations provided in the report "Workforce Recruitment and Retention in the Bureau of Milwaukee Child Welfare: Results from Staff Surveys and Focus Groups (October 2005 authored by the Helen Bader School of Social Welfare – UWM, Child Welfare League of America, and Chapin Hall Center for Children – University of Chicago)" which includes the following recommended turnover calculations:
  - Staff stability by region, which includes historical information;
  - Turnover due to promotions and transfers; and
  - Non-preventable turnover.

We are committed to a transparent approach and thus we provide considerable information in volume and type relating to the turnover and staff retention among ongoing case managers. This information is intended to give the community deeper knowledge of the issues confronting the BMCW.

Turnover measures, vacancy rates, and caseload size

Several places within the documents provided by Kids Matter Inc. references that the definition/calculation of turnover used by the BMCW does not measure vacancies, case transfer, or the impact on children and families.

The turnover rate provided in the Settlement Report is not intended to directly measure the impact of turnover on families and children; it only measures the rate of turnover within the OCM positions. We agree with Kids Matter that there are other factors that significantly impact case progress and outcomes for children and families. The impact of case manager turnover on families cannot be easily represented by a simple calculation or formula. Achieving permanency is one of the primary goals for all children in the BMCW. Working to attain this goal, OCMs work as part of a multi-system team. As you know, no two cases are alike and what influences

one case to move forward to a positive outcome may be very different from what influences another case.

Caseload size: There is a distinct difference between the calculation of turnover and the calculation for average caseloads, as described in the Settlement Agreement. The Settlement Agreement also defines how the BMCW was required to measure the average caseload size for ongoing case managers. To calculate the caseload measure; "BMCW shall ensure that ongoing case managers have caseloads not to exceed an average . . . of 11 families per case-carrying manager. Compliance with this requirement at any given point in time shall be measured by averaging each Site's current monthly caseload average with the corresponding Site averages for the preceding two months."

On page 2 of the Kids Matter Inc. document "Illustration: In June 2007, 150 ongoing case managers were employed to manage 1757 family cases for a case management ratio of 11.71 cases for each case manager. The contractual limit is ..."

- The BMCW does not disagree that the overall average exceeded 11 cases per OCM in June 2007. In fact, in the public report for the period January 1 – June 30, 2007 the BMCW indicates a monthly average of 11.7. However, the BMCW also provides the three month rolling average of 11.4 as defined by the caseload measure of the Settlement Agreement.

Calculations

Ms. Conwell describes on page 2 in footnote #3 a variety of BMCW documents and various ongoing case manager numbers. The footnote correctly identifies different ongoing case manager numbers provided in the turnover calculation and the caseload calculation. The turnover calculation provides the number of ongoing case managers at the beginning of each month, those hired, and those who terminated their employment. This number is larger than the number of ongoing case managers used for the caseload calculation. The number of ongoing case managers identified for the caseload calculation excludes several of the ongoing case managers who are part of the turnover data. The turnover calculation identifies ongoing case managers in the system, entering the system, and exiting the system (or on an extended leave). This is an aggregate number. The number of ongoing case managers used for the caseload calculation is much more restrictive, because it shows the number of active ongoing case managers carrying at least one case. For example, as we stated earlier, mentors are not included in the caseload number (however their cases remain in the total), approximately 9 mentors overall; ongoing case managers in training who are not carrying an active case as the primary assignment are also excluded.

On page 6 of Ms. Conwell's letter, she states that "Significant math errors dilute reliability of turnover and other data reporting ... there is no doubt that the error rate for basic math calculations is unacceptably high . . ."

We acknowledge that the table layout/format in the most recent semi-annual public report may be confusing but in no way does it encourage an error rate that is unacceptably high, nor do we

believe it is incorrect. I have included the actual table from the semi-annual report in order to explain how we achieved our calculations.

Table 3.24: Ongoing case management turnover, January to June 2007

	Number of OCMs ending employment for any reason	Number of OCMs at beginning of month (and average)	Number of OCMs hired during period	Turnover rate for Period - per definition used in Settlement
January '07	6	180	7	3.2%
February '07	5	181	8	2.6%
March '07	4	184	2	2.2%
April '07	6	182	3	3.2%
May '07	9	179	1	5.0%
June '07	11	171	9	6.1%
2007 YTD	**41**	**180**	**30**	**19.5%**
CY 2006	63	202.8	30	25.5%
CY 2005	113	217.7	132	33.0%
CY 2004	131	219	100	38.6%
CY 2003	98	226.1	108	30.0%

The third column titled *Number of OCMs at the beginning of the month* ***(and average)*** is where we believe Ms. Conwell may have some confusion. The numbers reported in this column for CY 2003 through CY 2006 represent the average number of ongoing case managers per month for that year, as designated by **(and average)**. If these "**average"** numbers are used in a calculation to determine turnover for the year, it is understandable that a different percentage would be the result.

For example, Kids Matter Inc. calculated turnover for CY 2006 using the "average" from the above table: Turnover = 63/(202.8+30) or 27.06%.

The Settlement turnover calculation uses the number of OCMs at the beginning of the period, as described in the definition. For an annual measure that would be the number of active OCMs on January 1st, which was 217 in CY 2006 This number is not reflected in this table but was included in previous reports, all of which were shared with Kids Matter Inc. The Kids Matter Inc. calculations used the "average" numbers presented above which provides a different turnover percentage.

Using the correct data presented in the CY 2006 report (not the "average"), the resulting calculation is: Turnover = 63/ (217+30) or 25.5%. The 25.5% is the percentage reported in the CY 2006, which has been copied over into the above table.

It is understandable that Kids Matter Inc. did not recognize the difference between the monthly numbers and the "(and average)" yearly numbers, thereby erroneously calculating different annual percentages in their Kids Matter Math Check column. The narrative explanation for Table 3.24 in the report did not clearly differentiate between the two parts of the table. In order to avoid confusion in future reports, we will not provide the annual average, but will include the actual number of OCMs at the start of the period.

Moving forward

We aim to provide the most accurate information possible for all BMCW reporting purposes. If there are instances of errors in calculation/methodology, or other reporting issues, we welcome having the problems brought to our attention so that we can correct them.

We have been working closely with Ms. Conwell and Kids Matter on data items relating to staff turnover as well as other issues relevant to child welfare in Milwaukee and we will continue to do so in the future. We appreciate you sharing Ms. Conwell's concerns with us and we hope this adequately addresses those concerns.

Thank you for your commitment and dedication to children and families, especially those who are involved in the child welfare system. I look forward to working closely with you in the future on improving outcomes for children and families in Wisconsin.

Sincerely,

Reginald L. Bicha
Administrator


FORWARD
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Milwaukee County Child Welfare

Legislative Audit Bureau
March 2007

1

Audit Timeline

- LAB released two reports in February 2006:
  - program issues (report 06-1); and
  - finances and staffing (report 06-2).
- Joint Legislative Audit Committee held a public hearing in March 2006 in Milwaukee.
- The Department of Health and Family Services reported to the Joint Legislative Audit Committee on March 1, 2006, October 2, 2006, and February 1, 2007.

2

Key Facts and Findings

- From January 2001 through June 2005, program expenditures totaled $493.7 million.
- From January 2004 through June 2005, 30.9 percent of investigations of abuse and neglect exceeded the 60-day statutory time limit.
- Early in 2005, only 27.4 percent of court-ordered services for families were provided in a timely manner.
- In 25 of 48 cases in which children were removed from their homes, we identified problems in achieving permanent placements for children.

3

Key Facts and Findings

- 20 percent of children reunified with their parents reentered out-of-home care within 24 months.
- Coordination of service delivery between child welfare, Medical Assistance, and other support programs needed improvement.
- We found $677,694 in unallowable and questioned costs charged to the program by six contractors.

4

Audit Recommendations

- Improve the timeliness of investigations and the delivery of court-ordered services.
- Reduce the time children spend in out-of-home care.
- Ensure the adequacy of safety services.
- Improve service coordination with Medical Assistance, W-2, and other social services providers.

5

Audit Recommendations

- Monitor families who return for additional safety services within 12 months.
- Monitor families who have children placed in out-of-home care in the 12 months following receipt of safety services.
- Enforce contractual provisions if returning cases exceed prescribed rates.

6

Audit Recommendations

- Ensure that all children in out-of-home care receive annual medical and dental examinations.
- Continue to work to improve the retention of child welfare staff.
- Appropriately calculate compliance with performance standards specified in the settlement agreement.

7

Audit Recommendations

- Collect and analyze information on services that contractors provide to families.
- Monitor and assess La Causa's financial condition and debt.
- Require contractors to repay unallowable costs and either repay or provide additional documentation for questioned costs.

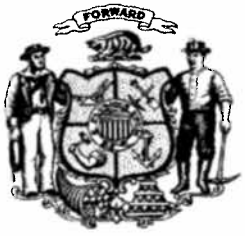
8

Audit Recommendations

- Ensure that new staff complete pre-service training before managing cases.
- Require Lutheran Social Services to reimburse state agencies for public funds spent on unallowable costs.

9

WISCONSIN STATE LEGISLATURE



Matthews, Pam

From: Susan Conwell [itbi.conwell@sbcglobal.net]
Sent: Wednesday, March 07, 2007 4:22 PM
To: Matthews, Pam; Matthews, Pam
Subject: something to watch for
Attachments: 4049045542-follow up questions March 8 2007.doc

Hi Pam,

I am still working out some specific questions. You will see a lot of repetition here. However, take a look at the bottom of the attachment. It looks like the department really lowered a standard. The Secretary's report p. 6 gives a performance standard for Safety Services as follows:
80% or more children who enter out-of-home care will not have had an open Safety Services case within the last 12 months." The old standard was no more than 4% could enter ongoing within a year. This new standards is effectively 20%. Look at the chart on page 51 of the Audit report. Even the worst performing contractor at the time was 17%.

I don't know if you can find out anything by tomorrow. But that seems a bit odd. Quite a change if I am reading this all correctly.

Sue

Susan Conwell, Director
Kids Matter, Inc.
2929 W. Highland Boulevard
Milwaukee, WI 53208
Phone: 414-344-1220 ext. 13
Fax: 414-344-1230

Background and questions regarding Safety Services:

The Federal Child and Family Services Review (conducted in 2003, reported in 2004), the Legislative Audit Bureau Audit (conducted in 2005 and reported in 2006), and the BMCW Quality Services Review (conducted in 2006 and reported in 2007) consistently raised issues relating to the quality of Safety Services, and/or the ability to keep children safely in their own homes while on child protection orders. Many of the issues raised related on unclear referral and investigation processes, inability to address specific risk factors (or take appropriate action if services are offered but refused). By contrast, BMCW has been able to react swiftly to allegations of abuse or neglect to children while in foster homes, and has largely investigated these allegations in a timely manner. The questions below are designed to seek clarity about what BMCW policies and procedures are relating to the investigation of new complaints in households that already have open child welfare or safety case, and how famiies can end up receiving both Safety and Ongoing Services.

When one child is removed from a home on an emergency basis due to substantiated abuse or neglect, what is the appropriate BMCW investigation procedure regarding additional children who remain in the care of the person against whom abuse or neglect was substantiated? Is it required that when one child is abused, other children in the home are at least interviewed or seen by the child abuse investigator to assure the safety of the other children in the home?

What is the proper procedure in a Safety Services case when physical abuse in the home has been substantiated, but the family refuses safety services? When and how are Safety Cases referred back to Initial Assessment and/or Ongoing services? Do Initial Assessment staff treat referrals from Safety Services as new cases, or do they look into recent family history such as refusal to cooperate with services, ongoing domestic violence or other risk factors in the household?

The audit found numerous examples of safety cases closing prematurely – in particular the cases on page 50 of Audit Report 1. What is the distinction between the Safety Program closing a case prematurely, and a family withdrawing from voluntary Safety Services? If a family has been found to have safety issues, but refuses safety services that address these issues and/or has new substantiated abuse or neglect allegations while the safety case is open, what steps are taken?

How does BMCW distinguish between multiple calls relating to a single incident of abuse and neglect, and new calls relating to new incidents of abuse and neglect that take place while a family is already receiving Safety Services or has their child placed with them on a court order in the home? What type of monitoring or evaluation has been done to make sure that new reports of abuse are communicated to ongoing staff and/or safety staff? BMCW provides data regarding reports of duplicate calls, and data regarding abuse allegations against children in foster homes, but does not provide data regarding new allegations regarding families receiving Safety Services, children on court ordered placements in their own homes, or children in placement with relatives. Are such data available? What does this data tell us about safety in the various types of placements, if anything. (The procedures for investigating claims of abuse while a child is in foster care are quite clear with significant deadlines for completing investigations and heightened

safety protections for the child in care. By comparison, the process of investigating new complaints regarding a family already receiving services seems quite muddled.)

The Final Report, page 10, states that "The [QSR} review did recommend that BMCW ensure a common understanding between Safety Services and Initial Assessment and what constitutes an appropriate response to ensure child safety. As part of the Qualitative Service Review quality improvement plan, BMCW and our private partner agencies are working together to train and provide technical assistance to their respective staff regarding the response to failed safety plans or new reports of maltreatment." What constitutes a failed safety plan? What are the appropriate responses to failed safety plans and new reports of maltreatment? Can you provide a copy of BMCW policy regarding failed safety plans and new reports of maltreatment? [This is an area in which BMCW is saying that it provides training and technical assistance, so they must be providing training and technical assistance regarding a specific policy. However, this particular area of new incidents of abuse while services are ongoing and families refusing services has been identified as problematic since the federal review. What is the policy?]

Under what circumstances would a family have an open child welfare case *and* an open case in Safety Services? Is this appropriate? How is communication between the programs insured? In the recent starvation death of an infant in Milwaukee, one problem seems to have been that the parent would not allow the safety services case manager to speak to the ongoing case manager. Do parents on child protection orders have the authority to prohibit the ongoing case manager in an open child welfare case from speaking to other BMCW contracted service providers? If this was an error, what steps are being taken to prevent this from happening again?

In Item 7 of the "Final Report to the Joint Legislative Audit Committee" (page 9), the Department describes several measures undertaken to improve the functioning of the Safety Services program. These changes include changing the reimbursement method to partner agencies and "establishing procedures and protocols regarding oversight and approval of cases in order to ensure that each family receives the services it needs while avoiding the risk of premature case closure." (p.10) What are these procedures and protocols? The Audit found that BMCW had established contract guidelines in the past, but had not asked for data or monitored contract compliance for three years. How will we ensure that these new protocols and procedures are used, and that performance is monitored?

The Final Report page 6 describes the performance expectation for Safety Services as follows:

Outcome I. Children will remain safely in their own homes. A. 80% or more children who enter out-of-home care will not have had an open Safety Services case within the last 12 months.

When the Legislative Audit was conducted in 2005, the performance standard was that no more than 4 % of families who receive Safety Services will have children who enter out-of-home care within the next 12 months? Why was the performance standard lessened to

allow 20% of children to enter foster care, when the original performance standard was 4%? [Note: the worst performing contractor identified by the auditors had a 17% rate of entry into foster care within 12 months. This performance standard is much lower than the performance of even the worst performing contractors. See "An Evaluation Milwaukee County Child Welfare: Program Issues," Legislative Audit Bureau, Report 06-1, Chart on page 51.] Has performance been measured against the new criteria? Are there any results?

What percentage of families receiving Safety Services have received Safety Services within the past 12 months? 24 months? What percentage of families receiving Safety Services have had a prior Ongoing child welfare case in the past 12 months? 24 months?


FORWARD
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Alberta Darling

Wisconsin State Senator

Member, Joint Committee on Finance

March 7, 2007

Senator Jim Sullivan, Co-chair
Joint Committee on Audit
Room 15 South—State Capitol
Madison, WI 53707
FAXED to 608.267.0367

Representative Sue Jeskewitz, Co-chair
Joint Committee on Audit
Room 314 North—State Capitol
Madison, WI 53707
FAXED to 608.282.3624

Dear Senator Sullivan and Representative Jeskewitz:

I am pleased you are holding a follow-up hearing on the audit of the Bureau of Milwaukee Child Welfare. It is clear there are still serious issues that need to be addressed by the Bureau and the Department of Health and Family Services (DHFS). I would appreciate it if you pursued the following questions where appropriate with the Department when they appear before you later this week.

This may seem like an obvious question but how can a child die while in the care of the Bureau? I read the story about the baby that starved to death last year in the Milwaukee Journal Sentinel with complete horror. For the record, I do not accept the excuse that the baby wasn't under the Bureau's care. If the brother is under the care of the Bureau because his stepmother was seen kicking him in the face, ALL of the children in that household were clearly at risk. To ignore the other children and deplorable surroundings is beyond my comprehension.

There is no room for error when you are talking about the lives of our most vulnerable citizens. Former DHFS Secretary Helene Nelson stated that funding was not an issue at an earlier hearing so if it's not about money, what is the problem? I feel comfortable saying it is likely a management issue and the buck stops at the top. The Secretary has to be accountable and must hold the private agencies to the same level of accountability. What kind of disciplinary action was taken against the caseworker(s) and agency involved in the death of the baby last November? How can we, as legislators and citizens, be sure the Department is taking the steps necessary to prevent future tragedies?

Thank you for your interest in my thoughts on this subject and for your leadership. Without your willingness to turn an attentive eye on the actions of the Bureau and DHFS, we would be unable to remedy the problems that exist. I look forward to working with the two of you to continue improving conditions for children touched by the child welfare system.

Sincerely,

Alberta

ALBERTA DARLING
State Senator – 8th District

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Kids Matter Inc.
Rebuilding Childhoods. Fostering Futures.

Susan Conwell
Conwell
Rebuild

March 8, 2007

Honorable Jim Sullivan, Co-Chair
Joint Legislative Audit Committee
Room 15 South
State Capitol
Madison, WI 53707

Honorable Suzanne Jeskewitz, Co-Chair
Joint Legislative Audit Committee
Room 314 North
State Capitol
Madison, WI 53708

Dear Senator Sullivan, Representative Jeskewitz and Honorable Committee Members:

Secretary Hayden's letter to the Legislative Audit Committee and the Final Report to the Joint Legislative Audit Committee ("Final Report") paint a positive and exciting picture of child welfare in Milwaukee. There have been recent gains – in particular there has been a reduction in caseloads, recent stabilization of child welfare staff and progress made toward reaching several lawsuit settlement performance outcomes.

However, the Secretary's letter and report veers into "truthiness" in critical areas such as recruitment and retention of foster parents, skirts some of the serious challenges facing Safety Services, and completely avoids the issue of child fatalities during the period under review. These issues are quite relevant to the health and well-being of children in Milwaukee, whether or not the Department addresses them in the Final Report.

While it is possible to address the Secretary's letter and the Final Report point by point, I am limiting our comments to concerns relating to child fatalities, foster parent recruitment, and Safety Services. I am including a list of question, in particular regarding Safety Services, that I hope members of the Legislative Audit Committee will consider addressing to the Department.

Finally, I ask that you keep two thoughts before you throughout the proceedings. First, the discussion of how children in Milwaukee are doing should not be limited to whether or not anything has gotten better since the Department took over the child welfare system in 1998. Of course there is progress. It would be a fiasco if an infusion of $55 million per year did not result in any improvements. Under Milwaukee County, social workers had caseloads of up to 50 families without any equivalent of Safety Services. Now, case managers have caseloads of no more than 11 families. Safety Services are able to keep children at home. Even so, three children under BMCW care died between May and November 2006. Additional GPR funds were needed to stabilize staff turnover rates that were among the highest in the nation. We face a severe shortage in suitable, safe

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placements for abused and neglected children. The question is not whether there are improvements, but whether or not children and families in Milwaukee are doing as well as they could be given the increase in resources.

Second, it is up to the legislature to ask for more accurate reporting from the Department. It is possible to present a report that accurately addresses strengths and challenges in a child welfare system. The Department presents a fair assessment of the struggles the Bureau of Milwaukee Child Welfare faces regarding the growing number of adolescents in foster care, and the difficulty of finding stable placements for them. Overall, however, the report is selective in its emphasis. One-quarter of the Final Report is dedicated to a $500,000 W-2 pilot project that earned mixed reviews, while the report fails to address the growing poverty of children in relative placements, a 23% net loss of foster parents in FY 2006 (despite extensive testimony last year regarding promised improvements), or child fatalities while Milwaukee may lead the nation in starvation deaths. The Department cannot develop productive responses to these problems if it does not acknowledge them.

Thank you for your kind attention to our concerns.

Sincerely,

Susan Conwell

Susan Conwell
Executive Director

Background and Questions Regarding Safety Services:

The Federal Child and Family Services Review (conducted in 2003, reported in 2004), the Legislative Audit Bureau Audit (conducted in 2005 and reported in 2006), and the BMCW Quality Services Review (conducted in 2006 and reported in 2007) consistently raised issues relating to the quality of Safety Services, and/or the ability to keep children safely in their own homes while on child protection orders. These issues include: unclear referral and investigation processes, inability to address specific risk factors or take appropriate action if services are offered to a family but refused. By contrast, BMCW has been able to react swiftly to allegations of abuse or neglect to children while in foster homes, and has largely investigated these allegations in a timely manner. The questions below are designed to seek clarity about what BMCW policies and procedures are relating to the investigation of new complaints in households that already have open child welfare or safety cases, and how families can end up receiving both Safety and Ongoing Services.

Premature case closure. The audit identified examples of safety cases closing prematurely, including a case that resulted in a child fatality (see page 50 of Audit Report 1). A recent fatality reflects similar problems. What is the distinction between the Safety Program closing a case prematurely, and a family withdrawing from voluntary Safety Services? If a family has been found to have safety issues, but refuses safety services that address these issues and/or has new substantiated abuse or neglect allegations while the safety case is open, what steps are taken?

Failed Safety Plans. The Final Report, page 10, states that "The [QSR} review did recommend that BMCW ensure a common understanding between Safety Services and Initial Assessment and what constitutes an appropriate response to ensure child safety. As part of the Qualitative Service Review quality improvement plan, BMCW and our private partner agencies are working together to train and provide technical assistance to their respective staff regarding the response to failed safety plans or new reports of maltreatment." Is a failed safety plan the same as a premature case closure? What are the appropriate responses to failed safety plans and new reports of maltreatment? Can you provide a copy of BMCW policy regarding failed safety plans and new reports of maltreatment?

Investigation Standards. When one child is removed from a home on an emergency basis and placed in out-of-home care, what is the appropriate BMCW investigation procedure regarding additional children who remain in the care of the person against whom abuse or neglect was substantiated? Is it required that when one child is abused, other children in the home are at least interviewed or seen by the child abuse investigator to assure the safety of the other children in the home?

Multiple reports/screenouts. How does BMCW distinguish between multiple calls relating to a single incident of abuse and neglect, and new calls relating to new incidents of abuse and neglect that take place while a family is already receiving Safety Services or has their child placed with them on a court order in the home? What type of monitoring or evaluation has been done to make sure that new reports of abuse are communicated to ongoing staff and/or safety staff? BMCW provides data regarding reports of duplicate

calls, and data regarding abuse allegations against children in foster homes, but does not provide data regarding new allegations regarding families receiving Safety Services, children on court ordered placements in their own homes, or children in placement with relatives. Are such data available? What does this data tell us about safety in the various types of placements, if anything?

Concurrent cases. Under what circumstances would a family have an open child welfare case *and* an open case in Safety Services? Is this appropriate? How is communication between the programs insured? In the recent starvation death of an infant in Milwaukee, one problem seems to have been that the parent would not allow the safety services case manager to speak to the ongoing case manager. Do parents on child protection orders have the authority to prohibit the ongoing case manager in an open child welfare case from speaking to other BMCW contracted service providers? If this was an error, what steps are being taken to prevent this from happening again?

Protocols. In Item 7 of the "Final Report to the Joint Legislative Audit Committee" (page 9), the Department describes several measures undertaken to improve the functioning of the Safety Services program. These changes include revising the reimbursement method to partner agencies and "establishing procedures and protocols regarding oversight and approval of cases in order to ensure that each family receives the services it needs while avoiding the risk of premature case closure." (p.10) What are these procedures and protocols? The Audit found that BMCW had established contract guidelines in the past, but had not asked for data or monitored contract compliance for three years. How will we ensure that these new protocols and procedures are used, and that performance is monitored?

Performance standards. The Final Report page 6 describes the performance expectation for Safety Services as follows:

> *Outcome I. Children will remain safely in their own homes. a. 80% or more children who enter out-of-home care will not have had an open Safety Services case within the last 12 months.*

Why was the measure changed from children to families? When the Legislative Audit was conducted in 2005, the performance standard was that "no more than 4 % of families who receive Safety Services will have children who enter out-of-home care within the next 12 months." [redacted] was the performance standard lessened to allow 20% of children to enter foster care, when the original performance standard was 4%? [Note: the worst performing contractor identified by the auditors had a 17% rate of entry into foster care within 12 months.]

What percentage of families receiving Safety Services have received Safety Services within the past 12 months? 24 months? What percentage of families receiving Safety Services have had a prior Ongoing child welfare case in the past 12 months? 24 months?

Additional Questions

Question Regarding Increased GPR to Contractors for Staff Salaries

How common is it to provide funding increases to contractors outside of the contracting process? Do other counties have staff turnover issues like those in Milwaukee? Were other counties allotted increased allocations for staff retention?

Questions regarding number of children "known" to BMCW vs. number of children on court orders

Over the last few weeks, BMCW contract agencies have been training staff in new policies and procedures relating to the attention to be given to children in households with children on child protection orders. Prior BMCW policy was that staff are only responsible for and are to limit themselves to children specifically named on the court order. As reported last week, staff are to be "responsible" for all children in the house, regardless of whether or not there is a court order. Without knowing the specifics of the policy change, we can only identify a few simple questions. How many children are in homes supervised by BMCW beyond the child/children named on the court order? How many additional children will be brought to the attention of the BMCW? Staff are raising concerns about how they will manage the new case load of children, though we do not yet know how many children or families are affected.


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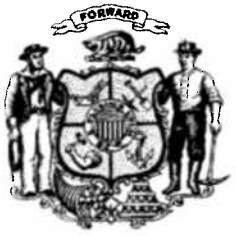
FORWARD

MILWAUKEE CHILD WELFARE PARTNERSHIP COUNCIL

1555 NORTH RIVERCENTER DRIVE, SUITE 220
MILWAUKEE WI 53212
Telephone: (414) 220-7000
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Testimony to the Joint Legislative Audit Committee by Pastor Archie Ivy, Chair Milwaukee Child Welfare Partnership Council March 8, 2007

Senator Sullivan, Representative Jeskewitz, Joint Legislative Audit Committee members, and others here today, as the chairperson of the Milwaukee Child Welfare Partnership Council, I am pleased to have been invited to address you regarding the views of the Partnership Council pertaining to child welfare services in Milwaukee County.

The tragic story of the death of an infant whose family was receiving services from the Bureau of Milwaukee Child Welfare as reported by the *Milwaukee Journal Sentinel* on February 6, 2007, focused attention on the important and difficult work of ensuring the safety of every child in Milwaukee. The death of any child is a tragedy and taken very seriously by all of us. It deeply affects the community and particularly those working with the family.

Without diminishing this tragedy, I, as the chair of the Milwaukee Child Welfare Partnership Council, would like to speak to the efforts and progress made by the bureau in the past ten years.

As you are aware, the Partnership Council represents a cross section of representatives from state, county, and local government as well as community representatives who are stakeholders in the welfare of our children. As such, we are charged with acting in an advisory capacity to assist the Department of Health and Family Services with:

- Developing policies and plans to improve child welfare services in Milwaukee County;
- Formulating measures for evaluating services;
- Suggesting funding priorities and opportunities, and
- Identifying ways to increase capacity for providing for the needs of families receiving Bureau of Milwaukee Child Welfare services.

The Executive Committee of the Partnership Council meets monthly and the full committee, including its associate members, meets quarterly. These quarterly meetings are well attended by other community stakeholders. Between meetings, we are kept abreast of issues that may arise through regular and open communication with the Bureau of Milwaukee Child Welfare director. In my work with the Partnership Council, I have found that the Bureau of Milwaukee Child Welfare is both transparent and accountable.

The Bureau's progress report to the Legislative Audit Bureau dated February 1, 2007 provides you with plenty of data on the progress the Bureau of Milwaukee Child Welfare has made, not only on the recommendations made by the this committee, but also on provisions of the Settlement Agreement. I do not need to reiterate any of that information. Rather, I would, as the chair of a community group of stakeholders, like to emphasize some of the information in the context of real families, living in a real community, experiencing very real challenges.

The cover letter attached to the report talks about the Qualitative Service Review baseline study undertaken in October 2006. Members of the Partnership Council and other stakeholders were involved in reviewing this assessment tool and had an opportunity to suggest changes. In January, the Executive Committee and later the full Partnership Council were briefed on the results of the Qualitative Service Review and provided the report. We were very impressed, as were the reviewers, with the high initial scores the Bureau of Milwaukee Child Welfare received.

The Qualitative Service Review was very "up close and personal." It involves interviewing families served to see how they felt about Bureau of Milwaukee Child Welfare's involvement in the most personal part of their lives. It also involved focus groups of staff, the courts, teachers, and other professionals who have worked with the Bureau.

Aside from the scores, I want to emphasize out two very important comments made in the final Qualitative Service Review report. One was the number of stakeholders who took the time to be part of the process. The reviewer commented that Milwaukee had more stakeholders participate than any of the previous reviews done in 14 states. This shows you that even though at times it appears we are failing as a community, Milwaukee cares about its children.

The second comment in the Qualitative Service Review that I would like you to focus on is the complexity of the families served by the Bureau of Milwaukee Child Welfare. The report states that of the families randomly selected for the intensive review, a large number of them faced what the report itself calls "multiple life-challenging conditions," such as drug and alcohol addiction, trauma, and mental illness.

The Legislative Audit Bureau report indicates preliminary findings show that at-risk families come into Safety Services because of issues of poverty: inadequate food, housing, clothing.

Thus, in the family receiving services - the *family* behind the data – you will see parents struggling with poverty as well as physical and mental health conditions that make it more difficult for them to care for their children independent of services.

The identification of such "co-occurring" conditions within a family indicates the need for services before the family reaches a point where children have to be removed to ensure their safety. As indicated in the Secretary's response to the Legislative Audit Bureau, this need is being addressed through better coordination of W-2 and child welfare services, including early identification of risk to child safety and well-being. The work of the pilot project at La Causa must be expanded.

Additionally, the report discusses the need to build the community capacity regarding the implementation of services to families, as well as the dental and medical care for children. We need to expand the capacity of Alcohol and Other Drug Additions services, mental health services for both

adults and children, and medical/dental care providers who accept Title 19 as insurance coverage and are located in Milwaukee's core.

Capacity building and integration of services goes beyond the ability of any one agency. It calls for a community response. Milwaukee has shown that it does care to respond. As an advisory group, the Partnership Council, commits itself to assisting the Department of Health and Family Services in guiding policy and planning around the issue of child welfare in Milwaukee County.

Thank you for your continued attention to this important issue and your support of the efforts of the Bureau of Milwaukee Child Welfare.


FORWARD
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Milwaukee County Child Welfare
Legislative Audit Bureau
Presentation to the Joint Legislative Audit Committee
Reports 06-1 and 06-2
March 8, 2007

Slide 1

Good morning.

Slide 2

In February 2006, the Audit Bureau released two reports that discussed the provision of child welfare services by DHFS' Bureau of Milwaukee Child Welfare.

In June 2005, the child welfare program in Milwaukee County served 3,188 children who had been removed from their homes to ensure their safety. An additional 266 families received safety services without having a child removed from the home.

Slide 3

I'd like to highlight several key facts and figures from our reports:

From January 2001 through June 2005, program expenditures totaled $493.7 million.

From January 2004 through June 2005, almost 31 percent of investigations of abuse and neglect exceeded the 60-day statutory time limit.

Early in 2005, only 27 percent of court-ordered services for families were provided in a timely manner.

In 25 of the 48 cases in which children were removed from their homes in January 2004, we identified problems in achieving permanent placements for the children.

Slide 4

20 percent of children reunified with their parents in the first half of 2003 subsequently re-entered out-of-home care within 24 months.

Coordination of service delivery between child welfare, Medical Assistance, and other support programs needed improvement.

We found almost $678,000 in unallowable and questioned costs charged to the program by six contractors.

Slide 5

Our reports contained a number of recommendations for DHFS to improve the program, including:

Improving the timeliness of investigations and the delivery of court-ordered services

Reducing the time children spend in out-of-home care

Ensuring the adequacy of safety services

Improving service coordination with Medical Assistance, W-2, and other social services providers

Slide 6

Monitoring families who return for additional safety services within 12 months

Monitoring families who have children placed in out-of-home care in the 12 months after having received safety services

Enforcing contractual provisions if returning cases exceed contractually prescribed rates

Slide 7

Ensuring that all children in out-of-home care receive annual medical and dental examinations

Continuing to work to improve the retention of child welfare staff

Appropriately calculating compliance with performance standards specified in a December 2002 settlement agreement

Slide 8

Collecting and analyzing information on services that contractors provide to families

Monitoring and assessing La Causa's financial condition and debt

Requiring contractors to repay unallowable costs and either repay or provide additional documentation for questioned costs

Slide 9

Ensuring that new staff complete pre-service training before managing cases

Requiring Lutheran Social Services to reimburse state agencies for public funds spent on unallowable costs

Slide 10

Thank you. Jan and I would be happy to answer your questions.

$100 million program