Wyoming Child Protective Services

September 2008

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EXECUTIVE SUMMARY
Wyoming Child Protective Services

Program Evaluation Section **September 2008**

Purpose

The Department of Family Services (DFS), Wyoming's child protective services (CPS) agency, responds to reports of child abuse or neglect (CA/N) that come to 28 field offices around the state. In 2007, there were nearly 8,000 such reports; DFS accepted and responded to about 5,000 of them. In August 2007, the Management Audit Committee requested an evaluation of the CPS multiple response system, CA/N investigations, DFS monitoring of child victims living at home, central registry management, and quality assurance efforts.

Background

A significant body of federal and state law directs how DFS conducts child welfare work in the state. The federal Adoption and Safe Families Act (1997) and 2005 revisions to Title 14 of Wyoming Statutes set a focus on attaining permanency for children, avoiding out-of-home placements, and implementing a multiple response or track system in which only the most severe CA/N incidents warrant DFS investigations and findings.

At present, DFS investigates only about one-fifth of accepted CPS reports, handling the rest through other interventions or service responses. Our full report (page 6) includes a process flow chart that highlights important CPS decision points and casework activities. From report intake through incident closure, caseworkers and supervisors must balance child safety, legal considerations, parental rights, and community expectations. The entire CPS process is complex and often ambiguous, guided by hundreds of pages of DFS policies and rules. With an average 2½-year experience level among caseworkers, experienced CPS supervisors are critical to child welfare practice in the state.

Results in Brief

CPS practice warrants improvement in each of the specific areas we reviewed. We have concerns with when and how supervisors assign accepted CA/N reports to tracks, as well as with the effectiveness of the track system itself. Caseworkers need to more thoroughly document investigation actions and better monitor those children receiving in-home services. DFS also needs to strengthen management of the central registry and enhance its quality assurance component.

Principal Findings

A CPS incident begins when a DFS supervisor accepts a CA/N report. By policy, within 24 hours of acceptance, incidents move into one of three tracks for casework: investigation, assessment, or prevention. The assessment and prevention tracks are intended to keep families' CPS issues from escalating to investigations. This hierarchy implies graduated degrees of DFS involvement – from offering assistance or service referrals, to investigating serious CA/N allegations (likely with law enforcement assistance).

Seven years after its implementation, we found two significant issues with the track system: CPS supervisors are assigning incidents inconsistently or not at all, and the track system is not effective in reducing families' severity of contacts. First, more than a third of CPS incidents lack a track assignment, and the wide variation we found among field offices in tracked incidents raises concerns about how supervisors are assigning similarly-situated incidents. To help establish greater purpose and consistency, DFS should seek statutory change to give supervisors more than 24 hours to assign tracks.

Second, the track system does not appear to help families avoid subsequent or more intense DFS contacts. In our review of randomly selected DFS client families' files, we saw that many families have multiple incidents spread among the tracks; despite repeated DFS contacts, there was little indication that their CPS issues improved. In assessment and prevention track incidents, where cooperation is optional, families rarely accepted services and their problems often worsened. We recommend that DFS heighten its scrutiny of families with chronic CPS issues, and that DFS evaluate how to make the track system effective or seek its repeal.

We also found that caseworkers are not consistently documenting evidence and findings in CPS investigations, as required in statute, policy, and training. Field offices use locally-developed documentation practices, thus undermining statewide consistency. For these most serious reports, we recommend that DFS adopt a statewide format for documenting CPS investigation decision points. Further, for each completed investigation, DFS should require thorough summary reports of evidence and findings.

DFS maintains a central registry of substantiated offenders and those "under investigation." It serves as an employment screen for entities dealing with vulnerable populations. We found that checks for individuals who are under investigation are complicated by the track system, requiring careful verification to avoid over-reporting. Under-reporting may occur if caseworkers did not follow proper notification procedures. We recommend continuing vigilance in "under investigation" registry checks, and in substantiated incidents, redoubled efforts to ensure proper notification of perpetrators.

Our review of files and electronic data indicates that DFS does not consistently monitor the safety of children who remain in the care of persons who have maltreated them. Data indicate caseworkers are not completing safety and risk assessments to the extent policy calls for, nor are they following up consistently on substantiated incidents. DFS should clarify policies in key areas and install electronic alerts to prompt visitations with children who remain in their homes.

Finally, by compiling data and establishing state CFSR outcome reviews, DFS has made considerable progress in quality assurance since our 1999 CPS report. Nevertheless, DFS should complement the state CFSR with more effective use of its vast data resources for internal administrative and casework process reviews.

Agency Comments

DFS agrees with five of the report's eight recommendations and partially agrees with the other three. For most, the agency outlines specific actions it intends to take to implement changes, and proposes dates within the next 12 months by which it will accomplish these changes.

Copies of the full report are available from the Wyoming Legislative Service Office. If you would like to receive the full report, please fill out the enclosed response card or phone 307-777-7881. The report is also available on the Wyoming Legislature's website at legisweb.state.wy.us

Recommendation Locator

Rec. Number	Page Number	Recommendation Summary	Party Addressed	Agency Response
1	19	DFS should seek statutory change to allow supervisors more time before assigning tracks.	DFS	Partially Agree
2	30	DFS should evaluate its track system to determine how to make it work as envisioned, or request its repeal.	DFS	Partially Agree
3	40	DFS should require caseworkers to prepare investigative plans or use a standardized investigation checklist.	DFS	Agree
4	40	DFS should require caseworkers to prepare evidence summaries after each CPS investigation.	DFS	Agree
5	46	DFS staff should be vigilant in “under investigation” central registry checks.	DFS	Agree
6	46	DFS should ensure notification of substantiated persons takes place and is properly documented.	DFS	Agree
7	55	DFS should balance family-centered practice with ensuring child safety by clarifying policies in key areas, and setting electronic alerts to prompt caseworkers to make visits to children in in-home services incidents.	DFS	Partially Agree
8	62	DFS should continue to expand quality assurance efforts with CPS casework and administrative process reviews.	DFS	Agree

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INTRODUCTION

Scope and Acknowledgements

Scope

W.S. 28-8-107(b) authorizes the Legislative Service Office to conduct program evaluations, performance audits, and analyses of policy alternatives. Generally, the purpose of such research is to provide a base of knowledge from which policymakers can make informed decisions.

In August 2007 the Management Audit Committee directed staff to undertake a review of Child Protective Services (CPS) within the Department of Family Services (DFS). This report addresses the following questions:

- How well is the system of graduated tracks (investigation, assessment, and prevention) working?
- How does DFS carry out CPS investigations and how thorough is the documentation? Why do caseworkers investigate only some reports?
- What is DFS' electronic tracking system for CPS incidents and how effective is it as a social services management tool?
- Why do some abused and neglected children remain at home in the care of persons substantiated for maltreating them? How does DFS monitor the children's safety?
- What information goes into the central registry of CPS substantiated offenders? How does DFS manage the registry?
- How has the quality assurance system changed since our 1999 review of CPS?

Acknowledgements

The Legislative Service Office expresses appreciation to DFS personnel at the state office and throughout the state for assisting

in this research. We also thank the Office of Administrative Hearings, the Citizens Review Panel, the DFS Advisory Council, and the many other government and nonprofit sector individuals who contributed their expertise.

CHAPTER 1

Background

The Department of Family Services (DFS), Wyoming's child protective services (CPS) agency, responds to reports of child abuse or neglect (CA/N) that come to field offices around the state. CA/N includes basic, educational and medical neglect; physical abuse; sexual abuse; and child major injuries or fatalities. DFS screens reports, accepts them when they meet statutory criteria for CA/N or rejects them, and responds as guided by rules and policies.

CPS in Wyoming is a complex process laden with ambiguity

From statute and rules to DFS policy and terminology to family situations, CPS is inherently ambiguous.

Even though the social goal – protecting children's health, safety, and welfare – is straightforward, the statutes, rules, policies, and practices guiding child protective services are both complex and imprecise. Statute calls for a range of discretion, starting when a supervisor screens a report to determine whether it fits statutory CA/N definitions, and continuing throughout the process to when agency personnel, either acting alone or with the court, determine that DFS involvement with a family should end.

Understanding this context also means accepting a certain level of ambiguity. This is because, within Wyoming CPS, there are terms used in multiple and overlapping ways, three different tracks of CPS intervention that are often difficult to distinguish, a complicated electronic data system that figures prominently in most processes, local protocols that affect how supervisors manage casework in their offices, and of course, the diverse circumstances that make no family's situation the same as any other's.

CPS caseworkers operate in a dynamic, pressured, and collaborative environment

Further, as described in our 1999 report, an effective child protection system does not rely solely on the efforts of DFS. An incident may involve many parties: other state agencies,

professional and non-professional reporters, law enforcement personnel, public and mental health agencies, prosecuting and defense attorneys, judges, guardians ad litem and court appointed special advocates, schools, and service providers.

Caseworkers must balance family, agency, and community values and expectations.

Caseworkers juggle these often competing interests in an atmosphere of contention, collaboration, and sometimes crisis. They need to make critical decisions quickly, often based on limited information and sometimes after only brief encounters with the children and their families. They need to assess individual family strengths while organizing appropriate services to help rehabilitate family actions that prompted a report of child maltreatment. From the moment a CPS report comes to DFS, caseworkers are balancing child safety, parental rights, and community expectations.

Federal and state laws guide child welfare agencies

A significant body of federal law governs child welfare practice in the states. Examples include the Child Abuse Prevention and Treatment Act (1974), the Indian Child Welfare Act (1978), and Adoption and Safe Families Act (1997). Each act sets practice and policy requirements for states that receive the related federal funding.

Reports of CA/N can involve not only DFS but also the courts.

In Wyoming, two Chapters of Title 14, Children, contain most of the laws concerning CPS. W.S 14-3-201 through 216 (see Appendix A), Child Protective Services, defines abuse and neglect, establishes general principles and processes DFS must follow, and requires DFS to establish and maintain a central registry of CA/N offenders. W.S. 14-3-401 through 440, the Child Protection Act, establishes the processes and requirements by which DFS can refer CA/N cases for adjudication through the Juvenile Court.

Wyoming's CPS workload and costs have increased since 2000

In 2007, DFS received nearly 8,000 CA/N reports, accepting about 5,000 to which a CPS caseworker then responded. This was

Since 2000, CPS reports have increased by more than one-third.

a 36 percent increase over 2000 (see Appendix B for intake and incident statistics). Other reports, those concerning children in need of supervision (CHINS) and delinquents, decreased by almost the same proportion. In that same time, legislative appropriations for CPS more than doubled, to almost $59 million for FY '09 –'10 (see Appendix C for contract service types and expenditures).

According to DFS, CPS incidents tend to be more complicated and difficult to manage than other child welfare incidents. Caseworkers must respond immediately when there is reason to believe children may be at imminent risk. CPS rules require immediate response to reports of many allegations, including those involving major injury and children under six, and in incidents that indicate a need to take protective custody.

DFS must respond immediately or within 24 hours, depending on a report's severity.

For all other accepted reports, caseworkers must initiate a response within 24 hours. Safety assessment, assignment to a service track, case planning, and management of services can follow, all designed to protect the children at risk and preserve their families. Services can be wide-ranging, from nutrition and parenting classes to mental health counseling and substance abuse treatment programs. Services are court-ordered in some situations, but if not, families can accept or decline DFS offers to provide them.

WYCAPS is the electronic incident tracking and data gathering system for CPS

DFS counts each accepted report as an "incident" in its WYCAPS information system.

WYCAPS, the Wyoming Children's Assistance and Protection System, is the DFS electronic system for aggregating data required for federal reports. To improve efforts in child welfare quality assurance, DFS has added reporting modules to this system that track each child welfare report. DFS acceptance of a report opens an "incident" in WYCAPS; from there, caseworkers create a narrative in which they record many of the actions taken. A family may have multiple incidents associated with multiple programs (CPS, delinquency, and CHINS actions) open in WYCAPS at the same time. Also, DFS uses WYCAPS to identify substantiated CA/N offenders for the central registry.

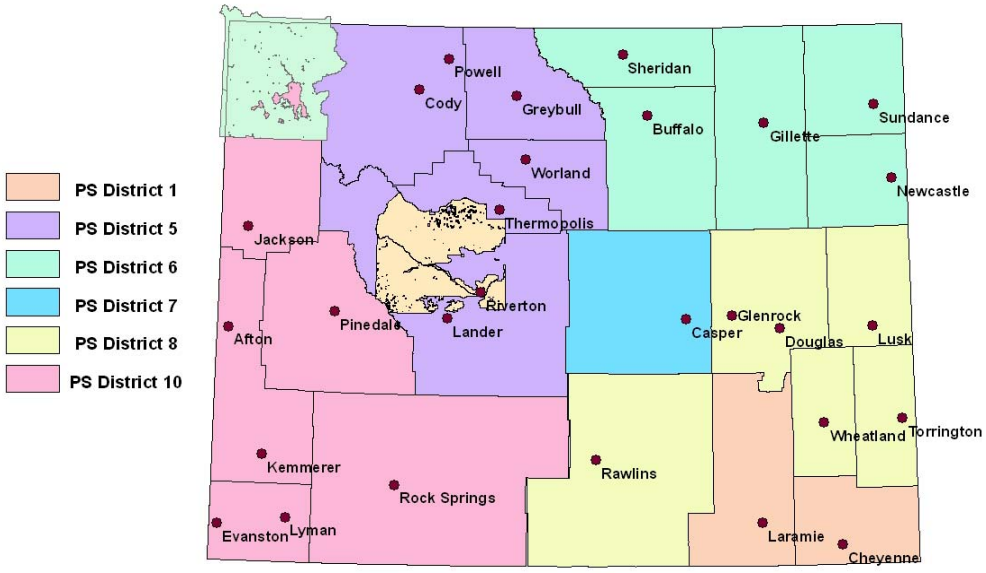
Most CPS staff work in local offices

Generally, CPS caseworkers staff only CPS incidents.

At the state level of DFS, the Protective Services Division has eight staff to administer CPS, most of them consultants working with CPS policy and practice. Locally, DFS has 28 offices in six districts (see Figure 1.1), with a total of 197 CPS positions; as of May 2008, 193 were filled. CPS workers include district managers, casework supervisors, caseworkers, and social service aides. In all but one small local office, CPS caseworkers work only CPS incidents. In some larger offices, they further specialize by conducting CPS investigations or managing and providing ongoing services.

Figure 1.1

DFS Offices and Districts



Source: LSO summary of DFS information.

Since our CPS report in 1999, DFS has divided child welfare functions at the state office into two divisions, Protective Services and Juvenile Services. The position of field operations administrator has been eliminated, with districts now reporting to the director's office.

CPS staff have varied social work experience and education levels

Almost all caseworkers, supervisors, and managers have post-secondary degrees.

Statewide, caseworkers have a median experience level of just over 2½ years; by contrast, the median for supervisor and manager experience is over 15 years. Almost all caseworkers, supervisors, and district managers have post-secondary degrees, while aides generally do not, due to the recruiting requirements for those positions. As we found in our 1999 report, turnover among CPS caseworkers is an ongoing problem both nationally and for DFS. Since 2000, annual caseworker turnover in DFS has fluctuated between 10 and 23 percent; in 2007 it was 21 percent.

Accepting reports, assigning tracks, planning and delivering services, are just some parts of the CPS process

Guidance through written policies and procedures is critical to the CPS process, according to the Governmental Accountability Office (GAO). In a study of CPS, GAO stated that "policies and procedures provide structure in the stressful environment in which caseworkers function, and reduce the probability of making mistakes."

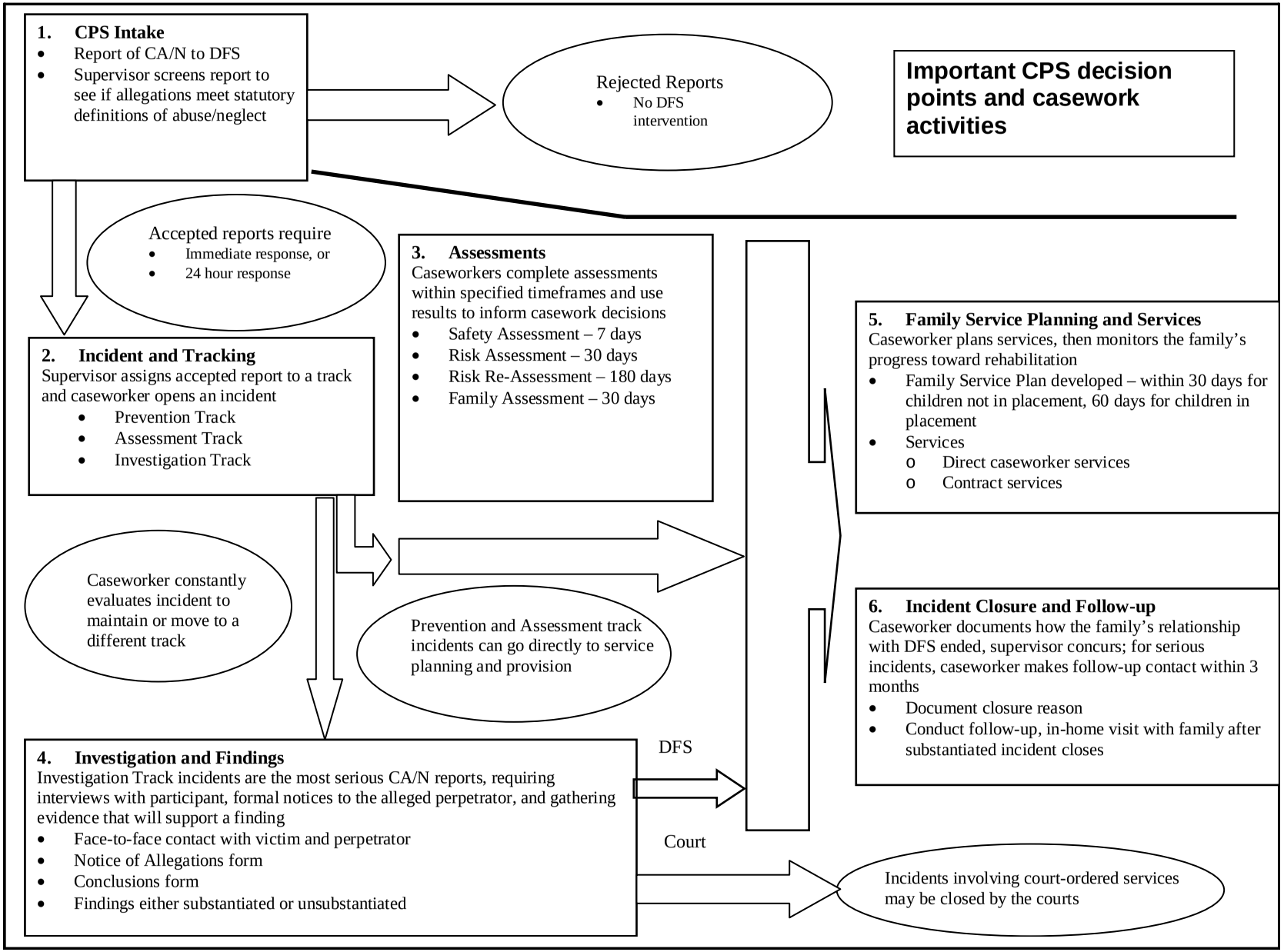
In the complex and stressful environment of CPS, policies and procedures are important.

DFS has more than 300 pages of policy that apply to the management of child protective services and child placement cases. In the last few years, the agency has been working to comprehensively evaluate its policies and procedures, with the intent to make them more accessible and clearer to caseworkers in the field. Since October of 2007, the Family Services Manual has been accessible online, through the "Publications" link on the DFS website, http://dfsweb.state.wy.us.

Because the CPS process can be intricate and hard to understand, we developed the following flow chart and summary of decision points (Figure 1.2 with accompanying narrative).

Figure 1.2

CPS process flow chart



Source: LSO summary of DFS statute, rules and policy.

Important CPS decision points and casework activities

From beginning (when CA/N reports come into DFS) to end (when DFS closes an incident), the CPS process can be complex and wide-ranging. Federal law, Wyoming statues, rules and regulations, and DFS policies set the standards. Generally, six broad categories of actions occur, with DFS making key decisions at these points: 1) intake, 2) tracking of accepted reports (incidents), 3) assessments, 4) investigations and findings, 5) family service (or "case") plan and service provision, 6) incident closure and follow-up. Not all of these take place in each CPS incident and may not occur in exactly this sequential order; for example, only some incidents are fully investigated, assessments may be done throughout the incident, and many do not involve family service planning or services.

1) Intake and Reporters Statute authorizes a central toll-free CA/N reporting system, but almost all reports go to local DFS offices. A DFS intake worker gathers as much identifying and situational information as possible from the reporter, and a supervisor screens the intake to determine if the report meets statutory definitions of CA/N. This must be done within 24 hours, although certain reports require immediate response. Supervisors reject reports not meeting CA/N definitions and no DFS response is necessary. Important intake information includes the basics of who, what, when, where, and how. Statute designates everyone as a mandated reporter; professional reporters include law enforcement, healthcare, education, and social services personnel.

2) Incident and Tracking Once accepted, a report becomes an open incident, often called a case; DFS organizes casework and recordkeeping around the incident. Since 2001, DFS has assigned intakes to one of three response categories, called tracks: *prevention, assessment,* and *investigation.*

- Prevention track: For reports with no specific allegations, but families may need services to alleviate identified CA/N risks.
- Assessment track: For reports with specific allegations against a family, the allegations present no apparent immediate safety concerns, and a collaborative approach can bring resolution to the presenting CA/N issues.
- Investigation track: The most serious track, assigned for reports meeting critical safety criteria where children may be in imminent danger, sexual abuse may be occurring, protective custody may result, or criminal charges may be pursued.

The first two tracks attempt to keep family situations from escalating to the investigation track, where findings of CA/N on the family must be substantiated or unsubstantiated.

3) Assessments To help make decisions on actions, caseworkers complete a series of assessments on accepted reports. Assessments take place at the beginning of an incident and throughout its duration.

Caseworkers constantly evaluate families to ensure that track assignment and assessments remain accurate; incidents that move up or down in track assignment may need to be reassessed. Each type of assessment helps evaluate a family's progress toward keeping the children safe and rehabilitating the family.

A *safety assessment* and safety plan must be completed within 7 calendar days of the report. In addition, where risks have been identified, caseworkers complete a *risk assessment* within 30 days. A *risk re-assessment* is required on incidents open for at least 6 months where risks were previously identified, or when new circumstances impact family risks. A *family assessment* is done within 30 days of the initial report, to identify family strengths and problem areas on which to base interventions and services.

4) Investigations and Findings Certain types of allegations require immediate DFS response and face-to-face contact with the victim and perpetrator. In the investigation process, alleged perpetrators of CA/N receive a Notice of Allegations about the alleged child maltreatment, as well as a formal Conclusion documenting the investigation findings.

If DFS finds a *preponderance of credible evidence* to support the conclusion that CA/N did occur, an investigation yields a substantiated finding. A substantiated perpetrator may make a voluntary statement of explanation which accompanies the finding onto the central registry of CA/N offenders. DFS allows up to six months to conduct investigations, with extensions allowed under special circumstances. Substantiated perpetrators may appeal findings within DFS, then to the Office of Administrative Hearings, and ultimately to District Court.

5) Family Service Planning and Services Some incidents develop to the point that families and caseworkers together devise a Family Services Plan. Previously called a case plan, it may change as a family's service needs or the children's permanency goals alter. DFS can offer *direct services* such as parenting classes, in-home visits, or transportation, through local staff. DFS may also offer *contract services* delivered by third-party providers; examples of such services include mental health and substance abuse evaluations and therapy, out-of-home placements for children, and medical and dental services paid for by Medicaid.

6) Incident Closure and Follow-up Case closure defines how CPS incidents eventually close – after successful completion of the case plan, a family's refusal of services, or court termination of an incident. Once an incident is closed, CPS interventions and contact with DFS staff effectively cease for most cases, unless another report on the family comes in. However, for incidents with substantiated allegations, DFS policy requires caseworkers to make a follow-up visit with the family within three months after closure.

Most accepted incidents do not require DFS investigation

Most CPS reports never reach formal investigation status.

Most CPS reports that come into DFS do not progress from intake to incident closure by meeting family service plan goals. Many do not require formal investigation, assessment, and casework to resolve, and only about one-fifth of CPS accepted reports reach formal investigation status. The remaining incidents, according to policy, become either assessment or prevention track incidents, as determined at intake. From 2004 to 2007, only about five percent of accepted incidents (three percent of all CPS reports) went through the entire CPS process by meeting family service plan goals.

"Goal achieved" and other closure reasons are not definitive

Caseworkers enter reasons into WYCAPS to close incidents and describe how DFS involvement ended. They sometimes note the reason as "goal achieved," although this label fails to reflect the varied casework activities that often take place prior to closure. Other examples of closure reasons include "unfounded" and "unable to locate," as well as the less clear "services not needed" and "family request."

DFS' child welfare system has received multiple federal and state reviews

States must undergo U.S. Dept. of Health and Human Services CFSR review to retain federal CPS funding.

The federal government, through the U.S. Department of Health and Human Services, began to perform Child and Family Services Reviews (CFSRs) in each state in 2001; Wyoming had its first CFSR the following year. Since federal funds account for about 18 percent of the CPS budget, Wyoming must comply with the CFSR to retain this funding. The CFSR targeted three outcomes of child safety, permanency and wellbeing, through examination of case files and aggregate data. As a result of the state not being "in substantial conformity" with several measures, Wyoming, like all states, submitted a Program Improvement Plan (PIP). DFS is currently drafting a PIP in response to the recent June 2008 federal review, its second.

After the 2002 CFSR, DFS implemented a "family-centered" casework practice model.

The main thrust of the 2002 PIP was shifting CPS in Wyoming from a focus on child safety to a family-centered concept. The cornerstone of PIP efforts was to implement family-centered practices designed to give families more input into the intervention, case planning, and services provided. This change meshed well with the assessment and prevention approaches (described on page 7) aimed at lessening the legalistic and often adversarial atmosphere in which caseworkers operate. DFS also undertook a broad review and revision of rules and policies, and now incorporates citizen feedback into its ongoing quality assurance efforts. The agency believes these changes have contributed to significant improvements, such as a clearer framework of rules and policies, more comprehensive casework practices, and better outcomes for children.

DFS receives many recommendations on how to improve child welfare system

Several oversight boards are reviewing the department's CPS practices.

DFS has a well-established, multi-faceted framework for child welfare oversight. Most prominent in this category are the federal Children and Family Services Review (CFSR) and the ongoing state version of the same review done by the Wyoming Citizen Review Panel. In addition, there are the DFS Advisory Board, the Interagency Children's Collaborative, and the Major Injury and Fatality Review, all in place and making recommendations. We sense that all of these recommendations may be overwhelming DFS' ability to analyze, synthesize, and translate them into consistently-applied CPS practice changes.

Recent LSO program evaluations identified problems with placements and financial accountability

DFS has addressed issues from our previous reports.

Wyoming is noted as having a high placement rate for children, a fact acknowledged by DFS in its most recent Statewide Assessment for the CFSR. However, since we completed evaluations in 2004 and 2005 covering placements at residential treatment centers and foster care, this report does not cover out-of-home placements. In response to the shortcomings we identified in those reports, DFS has instituted performance-based contracting, third-party reviews on continuing placement appropriateness, and tiered rates for different-aged children in family foster care.

DFS can do more to ensure consistent and effective CPS processes

Many entities continue to review CPS, but we did not see that any of them, or DFS itself, had looked at the specific aspects of CPS in which the Management Audit Committee expressed interest: the implementation and effectiveness of the track system, and investigation, in-home services, and central registry processes in and of themselves. Thus, we focused on these areas, and amid its many recommendations, encourage DFS to give ours particular consideration since they represent the Legislature's concerns.

DFS needs to adjust CPS processes to better fit with statutory and agency intentions.

When we reviewed CPS in these specific areas, we found that CPS processes can improve. To begin, we reviewed implementation of the track system and found concerns with both how accepted CA/N reports are assigned to tracks, as well as with how effective the multiple response system has been so far. Further, with respect to casework practices, we saw need for improvement in how caseworkers fulfill investigation responsibilities, and how they monitor children who remain in their homes with the caretakers who abused them. Finally, with respect to specific parts of the CPS program, we make suggestions for strengthening the central registry process, and for how DFS can enhance its own quality assurance program so it identifies the sorts of issues we found.

CHAPTER 2

CPS supervisors do not consistently assign incidents to tracks

Chapter Summary

Track assignment is a critical step in the CPS process because by definition, it determines the intensity and extent of DFS' involvement in families' lives. By following our file and incident review methodology (summarized in the box to the left), we found that despite clear statutory and DFS policy language, CPS supervisors are assigning incidents inconsistently or not at all to the three tracks. This has resulted in a lack of a true case management framework for caseworkers to follow when working cases through to closure. Further, since statute requires DFS to accept and track incidents within 24 hours of a report, many track decisions may be made hastily without needed information. We recommend that all accepted CA/N reports be assigned to a track, as envisioned by statute, and that track assignment decisions be more closely linked to casework practices.

File and Incident Review Methodology To review DFS' multiple response system effectiveness and track assignments, we selected a random sample of 137 files (referencing individual families) almost evenly divided between investigation files (68) and non-investigation files (69). We focused our review primarily on incidents opened between January 2004 and December 2007, although some files contained earlier and later incidents. This resulted in our analyzing hundreds of incidents from all CPS tracks. We examined both electronic records in WYCAPS and hard copy files stored at the local offices.

Statutes authorize a two-track, multiple response system

In 2005, the Legislature authorized in statute what had been DFS practice through rules since 2001: a multiple response approach, whereby caseworkers respond to reports of known or suspected CA/N by investigating or assessing them. Statutory criteria define the conditions for assigning a report as an investigation: when allegations indicate that criminal charges could be filed, children appear to be imminent danger and it is likely they will need to be removed from the home, or a child fatality, major injury, or sexual abuse has occurred. Statute requires local offices to assign reports that do not meet investigation criteria to the assessment track.

DFS developed a third level of response

Consistent with W.S. 14-3-203(a)(iii), DFS developed a third track, prevention services, through rules and policy. It is a means of encouraging prevention efforts such as making resource referrals for treatment. Rules define preventive services as appropriate for a report with no allegations of abuse or neglect, but with identified risk factors that might indicate the need for services. Designed also as a low-level service response for clients requesting assistance, the prevention track intends to decrease the likelihood of a family's subsequent DFS involvement through the higher-level tracks.

The investigation, assessment, and prevention tracks describe different response levels in CPS incidents.

This hierarchy of three tracks reflects the variety of CPS incidents caseworkers handle, and implies graduated degrees of caseworker labor and time involvement for them. Investigation track incidents often use more resources and involve many required activities, while assessment and prevention track incidents have fewer prescribed casework practices and documentation requirements.

We conducted a survey of DFS supervisors, who uniformly responded they believe the assessment and prevention tracks free caseworkers to do "actual social work." However, there was no consensus among them that these tracks were effective in either minimizing further CPS involvement, or satisfactorily addressing the problems presented in CA/N reports.

Supervisors are responsible for assigning incidents to tracks

Track assignment occurs early in the casework process: statute, rules and policy call for this decision within 24 hours of DFS receipt of a CA/N report. CPS supervisors make the track assignments based upon intake information; some reported they always consulted with caseworkers at this point, while others said they rarely did. By policy, supervisors can change tracks on opened incidents, either up to investigation or down to assessment, depending upon what caseworkers find with respect to investigation track criteria. From reviewing incident narratives and intakes, we saw that some supervisors specifically explain their track assignment reasoning, but many do not.

Track assignment occurs early in the CPS intervention.

Some supervisors consider a family's CPS history; others do not.

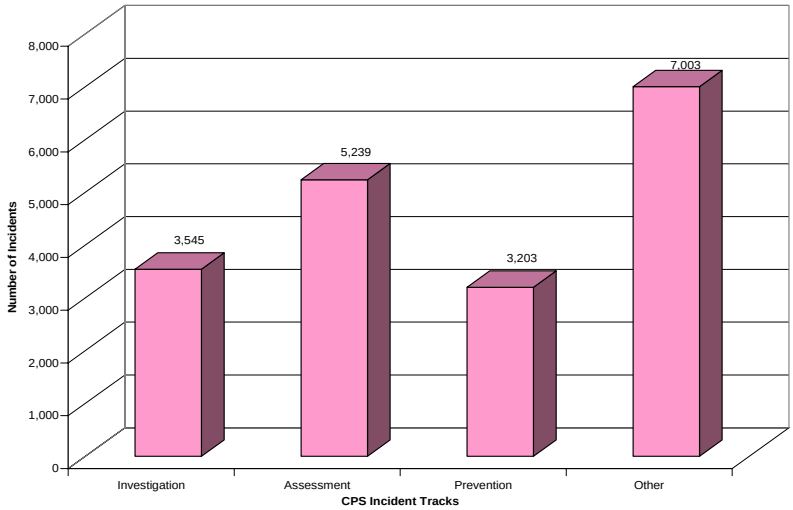
In survey responses, supervisors were unanimous in agreeing they rely upon policy and rules when making track assignments. They were less uniform in their responses as to whether a family's history with DFS, or its inclination to be cooperative, also affected the assignment. Some considered family history integral, while others based decisions strictly on whether the current allegations met the policy and rule criteria for the different tracks.

Supervisors do not assign tracks in more than one-third of CPS incidents

In the period we reviewed, CY 2004 – 2007, DFS processed approximately 19,000 incidents, mostly accepted reports of CA/N (see Figure 2.1, track assignments for accepted CPS incidents). Of that total, we found that 7,003 incidents (37 percent) listed no track assignment in WYCAPS. This report refers to these undefined incidents as "other," a category usually reserved for outliers rather than a proportion as large as this (see Appendix D for more track data).

Figure 2.1

Track assignments for accepted incidents
CY '04 – '07



Source: LSO analysis of DFS-WYCAPS data

It did not appear that "other" incidents were default investigations.

CPS policy instructs supervisors to assign CA/N reports as investigations when they are in doubt about which track to assign. However, we could not assume that in practice, supervisors had assigned these "other" incidents, by default, as investigations. In our review of hard copy files, we saw evidence that supervisors intended some of these "other" incidents to be worked as assessments, and some as "verifications" (not an alternative response defined in policy or rules).

Missing track assignments interfere with DFS' case management framework

CPS supervisors and caseworkers regularly handle these "other" incidents in the course of their work, and close them without identifying them by tracks. While this practice impedes evaluation of the track system, the more serious implication is that it interferes with the framework for consistent casework that policies for the various tracks provide.

A lack of clarity in track assignment can lead to inappropriate approaches to clients.

Regardless of track, statutes envision that DFS will respond appropriately to all CA/N reports, and ideally WYCAPS documentation of track assignments can support DFS managers in their duty to oversee caseworkers' responses. "Other" incidents, those not in a track, may not get an appropriate response. Without an investigation assignment, a caseworker may not approach a severe incident with law enforcement, as policy directs. On the other hand, if the benefit of the lower tracks is the flexibility to engage families in voluntarily accepting assistance, unclear direction from a missing track assignment may result in a caseworker applying a legalistic response that is not warranted.

Assessment and prevention tracks are not clearly differentiated as alternate responses

In general, we did not see a separate, graduated response system at work with these two tracks, as is envisioned in statute and DFS policy. DFS policy distinguishes prevention from assessment track incidents in that prevention track incidents do not have allegations associated with them. However, in our sample review, none of the incidents in the two tracks (0/32 assessment, and 0/19

prevention) showed formal allegations in the pertinent WYCAPS screens. According to policy, allegations are necessary in assessment incidents since they guide service provision.

Track designations are poorly documented…

Also, we saw intake reports which assigned incidents to the prevention track even though they contained formal allegation terms such as medical neglect or physical abuse. According to policy, these incidents should have been at least assessments, if not investigations. We saw little documentation of the decision-making process that went into assigning an incident to the prevention rather than the assessment track, or vice versa. From the information we had, we were also unable to identify similarities among incidents that made them more likely to be assigned to one track than the other.

…and used for multiple purposes.

Further, DFS uses the prevention track for the administrative purpose of managing subsidized adoption and guardianship payments. Here, the child has reached permanency, but the incident is held open in WYCAPS as prevention to allow for monthly payments to the adoptive parent or guardian receiving the subsidy until the child reaches 18 years of age. Mixing these incidents with active social service incidents diffuses the purpose of the prevention track and hampers analysis of its effectiveness.

Track assignment decisions occur quickly, sometimes before relevant data is gathered

Supervisors have only intake reports upon which to base track assignments.

Statute sets a 24-hour deadline for CPS supervisors to accept a report and assign a track. An intake report is often the only evidence available to the supervisor in that period; unless it is a report requiring immediate response, the caseworker has more time (one week) to establish contact with clients, complete a safety assessment, make an initial home visit, and compile client information and other evidence that preliminarily confirms or refutes the allegations. Supervisors often assign incidents to tracks in the absence of this information.

Track assignments should be made after

Other circumstances can complicate the supervisor's decision as well. For example, the intake may come from a report biased by ongoing custody disagreements between former spouses or other relatives. Because we saw so many varieties of this in our sample

gathering relevant information.

review, we concluded that an intake report may be sufficient to trigger DFS intervention, but it often does not give supervisors enough information on which to base track determinations.

Aggregate data show the closure reason for nearly 26 percent of the "other" incidents as "unfounded," and we saw supervisors delay making the track assignment until the family either cooperated or refused services. This suggests supervisors often do not know how to track an incident until caseworkers gather more information.

Wide variations in track assignment statistics indicate inconsistency among field offices

Aggregate track assignment statistics show that offices assign incidents in significantly different ways. We found that from office to office, the rates at which incidents are assigned to tracks varied widely (see Appendix D). For instance, in the Rawlins office only 3 percent of the incidents from 2002-2007 were assigned to the prevention track; in Kemmerer it was 27 percent. In the Torrington and Cody offices, assessment incidents amounted to over 40 percent of the workload, whereas the Cheyenne and Riverton supervisors assigned less than 10 percent of incidents to the assessment track.

Inconsistency in application may lead to inequity of treatment.

While the child welfare issues presented by populations in the different communities might vary, it is difficult to understand how they could be so different as to result in these wide-ranging track assignment rates. Community differences such as population size or economic conditions do not equate to observable trends in this data. From this analysis and our examination of track assignment decisions through the file review, we infer that there is inconsistency in decision-making, even though surveyed supervisors said policy guided them in track assignments.

Recommendation: DFS should seek statutory change to allow supervisors more time before assigning tracks.

For the track system to accomplish its potential, it needs to be used consistently.

Track assignment decisions properly reflect the state's graduated response to presenting CA/N problems. The multiple response track system can support effective casework practice, but to accomplish its potential, it needs to be used consistently and purposefully. We know state-level DFS officials often hear from the field that the paperwork involved in CPS is overwhelming, and that it detracts from the time available for casework with families. Nevertheless, track assignment and allegation recording are integral to the state's recently-implemented efforts to improve child welfare services through the track system.

For many incidents, to assign a track a supervisor needs more information than is in the initial report.

DFS needs to ensure that CPS supervisors are documenting all track assignment decisions. Then, track assignments will better link to case management if supervisors can delay the decision until after an initial information-gathering period. Undoubtedly some incidents are clear enough at intake that there is no question about track assignment; this is particularly true for investigation incidents where imminent danger to a child appears to exist, or when law enforcement already has taken protective custody.

However, for those incidents that do not present such clearly-drawn lines, supervisors need a broader knowledge base for making tracking decisions than the intake report may contain. Within a week, the supervisor should have results of the safety assessment, initial interviews, collateral contacts, and caseworker observations in hand.

CHAPTER 3

The track system has not had its anticipated effect

Chapter Summary

DFS hoped to engage families in services that would help them better care for their children.

Each time a family has an accepted CA/N report, DFS opens an incident and assigns it to one of three tracks for casework. DFS officials told us they adopted the track system so workers could engage some families in a less accusatory manner, through the assessment and prevention tracks, without reaching formal conclusions (substantiated, unsubstantiated or unfounded). Caseworkers could then offer families services to help them better care for their children.

The track system's purpose is to prevent problems from escalating.

To determine how well the track system is working, we looked at whether providing families with services (or the opportunity to get them) through the multiple response system, would lessen the need for further and more intensive DFS involvement. Policy supports that expectation, stating that the purpose of the prevention and assessment tracks is to "prevent problems from escalating to a level" where the more rigorous DFS approach(es) would be warranted. We found, however, that the track system does not reliably accomplish that purpose.

Although it is difficult to determine cause and effect in CPS because of the many circumstances surrounding each incident, we see two impediments to track system effectiveness. First, families do not have to cooperate with DFS recommendations unless ordered by courts, and only some substantiated investigation track incidents get to that level. Second, we believe that DFS limits the effectiveness of the multiple response system by treating each incident in relative isolation from the others that families often generate.

DFS should determine how to make the track system meet its potential, or seek its repeal.

DFS has an obligation to evaluate the track system to determine what changes are needed to meet its potential, or the agency should request its repeal. We believe a first step would be implementing higher level reviews of track assignments for families with multiple incidents to ensure decision-making is the most beneficial for the welfare of the children involved.

Multiple response is an accepted practice

The model advances family-centered practice.

The DFS multiple response or track system, and the rationale behind it, are typical of the multiple response approaches many states have adopted in their child welfare systems, dating back to the mid-1990's. Applying these models gives CPS agencies a method for allocating limited resources, but the primary benefit is advancing family-centered practice to provide interventions that match up with families' strengths and needs.

New tracks have not positively affected the level of families' later interactions with DFS

We divided our sample of CPS files into two groups, one focusing on investigation track incidents and one on non-investigation incidents (prevention and assessment track incidents, and "other"). Together, these samples involved 137 family groups which included at least one parent and child, and usually other persons who lived together as families.

In our file review, we saw that families have multiple CPS incidents spread among the tracks with little indication that their child welfare problems subside.

In our investigation sample, there were 220 CPS incidents spread among 68 families. A majority of them had a series of at least three incidents opened during the period we reviewed. Some families had as many as six to nine incidents, although most had five or fewer. As shown in Figure 3.1, families' levels of interaction with CPS move back and forth among the tracks, with little indication that their child welfare issues tend toward resolution.

In the sample we drew to examine incidents tracked as prevention, assessment, or "other," families were much less likely to have multiple incidents, and very few had investigation incidents during the period reviewed. However, since the closure reasons for nearly all these incidents indicate either that families did not accept the services offered, or caseworkers did not see that services were necessary, it does not appear that DFS involvement had much to do with resolving their child welfare problems.

Figure 3.1

Illustration of the sequence of incidents DFS opened for families LSO investigation track sample (34 of 68 families shown)

Family	Incidents opened during the period 2004-2007 (Note: illustration does not portray incident length, or intervals between incidents)								
	1	2	3	4	5	6	7	8	9
1	Inv-sub	Other							
2	Inv-sub								
3	Inv-sub								
4	Inv-sub	Other							
5	Inv-sub	Other	Inv-sub	Assess	Assess				
6	Inv-unsub								
7	Inv-unsub								
8	Other	Inv-sub							
9	Assess	Inv-sub	Assess	Assess					
10	Assess	Inv-unsub	Inv - sub						
11	Inv -sub								
12	Inv-sub	Inv-unsub	Inv – sub	Asses	Inv -unsub	Inv -sub			
13	Inv-sub	Inv-unsub							
14	Assess	Inv –sub.	Other	Other	Other	Inv –sub.	Prev.		
15	Inv –sub	Assess	Inv –sub						
16	Inv-unsub								
17	Inv-unsub	Other	Prev	Inv-unsub					
18	Other	Other	Assess	Assess	Assess	Inv-unsub	In-unsub	Inv-sub	
19	YF	Inv-unsub	Inv-unsub						
20	Assess	Inv-unsub	Inv-unsub	Assess	Inv-sub	Inv-sub			
21	Inv-sub	Prev							
22	Prev	Prev	Other	Prev	Prev	Inv-sub			
23	Other	Inv-unsub							
24	Other	Prev	Inv-sub	Inv-unsub					
25	Other	Prev	Inv-sub	Inv-unsub					
26	Inv-unsub	Inv-unsub							
27	Inv-sub	Inv-unsub							
28	Prev	Inv-sub							
29	Prev	Other	Other	Inv-sub					
30	Inv-sub	Inv-sub							
31	Inv-unsub								
32	Assess	Other	Assess	Inv-unsub	Inv-unsub	Inv-unsub			
33	Other	Other	Other	Inv-sub					
34	Inv-sub								

Key				
	Inv-sub	Investigation track - Substantiated	Assess	Assessment track
	Inv-unsub	Investigation track - Unsubstantiated	Prev	Prevention track
	Other	Incident without track assignment	YF	Non-CPS, Youth and Family incident

Source: LSO analysis of DFS WYCAPS data. See Appendix E for full sample.

Judging from track assignments, families' incidents often increased in seriousness

In our sample of investigation incidents, families with prevention and assessment track incidents tended to develop more serious child welfare problems, rather than improving or avoiding a

higher-level DFS response. We saw 17 drops in severity, according to track assignment of subsequent incidents, but 26 increases in track levels from one incident to the next.

Lower track incidents tended to be followed by investigation incidents.

Among the families that developed more serious problems were 15 instances where assessment incidents were followed by investigation incidents; 9 of these were substantiated. In 9 instances, an investigation track incident followed prevention track incidents, and a majority of those also ended as substantiated. By contrast, the most prevalent positive results we saw were assessment and prevention incidents that ended DFS' involvement with families; again, we saw 9 of these instances.

It was difficult to see the rationale for stepping down track assignments for families' subsequent incidents.

In reviewing the files, it was often difficult to see the rationale behind stepping down a family's subsequent incidents. Moving a later incident from investigation to assessment, for example, was puzzling since it was fairly typical for a family's child welfare issues to remain the same across incidents. Sometimes supervisors opened incidents as assessments when the families already had open investigation incidents in progress. One family struggled with the same neglect issues through four successive incidents: three of them were assessment track incidents, and one was an investigation substantiated for neglect. The determining factor for the increased DFS response, an investigation that led to substantiation, was the caseworker's request that the county attorney authorize temporary foster care for the children.

DFS assigned subsequent incidents to the investigation track when protective custody was taken.

It was more evident why DFS supervisors moved families' incidents up from prevention or assessment to investigation. As described above, the incident became an investigation if protective custody occurred; then, the involvement of law enforcement almost always prompted an investigative response from DFS. Or, if DFS first engaged parents through assessment for not attending to their children's medical needs but the parents refused to cooperate, DFS would often assign a subsequent report on the same issue to the investigation track.

Investigation track incidents may be most effective

In the aggregate, we found the most positive outcome is likely to occur after a family has experienced a CPS investigation that

results in a substantiation for child maltreatment. Often, however, a series of incidents in different tracks leads up to the investigation incident. In our sample, 31 families in the investigation track ended their involvement in CPS during the 2004 - 2007 period. This information suggests that the most intensive DFS response, a substantiated investigation and the casework and services that follow, is most effective in removing families from the CPS caseload, and by implication, in improving children's welfare. However, we did see 7 instances where families had substantiated incidents followed by other substantiations.

Courts may order parents to accept services when substantiations lead to neglect petitions.

From examining files, we know that in substantiated incidents, parents can benefit from typical court-ordered services; such services can prepare them to give their children better care. However, we also know that families with substantiated CA/N incidents exit from the Wyoming CPS arena for reasons other than having been rehabilitated. For example, they move from the state or lose permanent custody of their children, or the offending parent is incarcerated.

Even having an unsubstantiated incident seemed to end families' CPS involvement.

Yet, we found that having an unsubstantiated investigation incident was almost as effective in ending DFS involvement with families in our sample. In our sample of investigation incidents, 20 families had unsubstantiated investigation track incidents that were not followed by incidents of any kind during our review period. Incidents of this type rarely result in families obtaining services that might help them address the issues that prompted DFS to respond at its highest level of intervention, investigation.

The high number of incidents without a track assignment limits determinations of effectiveness

But we believe our review revealed valid indicators of track system effectiveness.

As shown in Chapter 2 and illustrated in Figure 3.1, incidents often are not identified in WYCAPS as being assigned to a track. Having so many "other" incidents hampered our attempt to analyze the effectiveness of the track system and limited our ability to draw conclusions. Nevertheless, we believe our sample is accurate in revealing indicators of investigation track effectiveness, and questioning that of the other two tracks.

Families' child welfare problems persist, as does DFS involvement in their lives

Assessment incidents result from reports that contain allegations of child abuse or neglect, when the allegations are not severe enough to warrant an investigation. Often families are reported again and DFS opens additional incidents, indicating that some level of child maltreatment has likely reoccurred or persisted. In our file review, we read descriptions of repeated and continuous, usually neglectful, treatment of children that prompted reports to DFS. Since many of these reports come from professional reporters, we believe that at least some level of maltreatment was often present and may have persisted during the interim between incident openings.

We read descriptions of repeated and continuous, usually neglectful, treatment of children that prompted reports to DFS.

According to DFS, in the most recent federal reporting period, 96 percent of children in the CPS system did not experience repeat maltreatment. However, for federal reporting requirements, DFS follows the federal standard, which considers maltreatment to have occurred under narrow circumstances: only if children are victims of repeated substantiated maltreatment in the six-month period following the initial substantiation.

DFS repeatedly, intermittently, contacts some families

With the multiple response capacity, DFS caseworkers potentially come in contact with families more than they would have previously. In the past, statute authorized DFS to either investigate or reject reports, although CPS supervisors indicate there has always been a prevention response for those families seeking DFS assistance. Now, through the assessment track, caseworkers can approach families with a service response; this can take place when reports contain allegations but DFS supervisors perceive there is no actionable abuse or neglect under the law **(**either the Child Protection Act or criminal statutes).

With the tracks, there are more CPS incidents, but fewer investigations.

Data show a higher number of CPS incidents now, under the track system, but DFS carries out fewer investigations. This suggests that caseworkers are contacting more families, or the same families more often. Looking again at Figure 3.1, the prevalence of non-investigation incidents shows that DFS now

DFS is making CPS contacts it would not have before the tracks.

quite often makes contacts with families that likely would not have occurred before the track system. Of the 220 CPS incidents covered in our investigation incident sample, 101 of them were non-investigation (prevention, assessment, or other). Figure 3.2, showing another excerpt from the full sample table, depicts how the intervals between incidents and their durations vary.

Figure 3.2

Example showing the intermittent nature and duration of families' CPS incidents

Family 20						
Incident	Assess	Inv-unsub	Inv-unsub	Assess	Inv-sub	Inv-sub/open
Dates open	10/21/05-12/1/05	3/30/06-12/6/06	12/1/06-2/20/07	10/8/07-11/16/07	11/14/07-1/3/08	12/4/07-open
Family 21						
Incident	Inv-sub	Prev				
Dates open	1/3/05-1/18/05	12/11/06-12/12/06				
Family 22						
Incident	Prev	Prev	Other	Prev	Prev	Inv-sub
Dates open	12/17/03-2/12/04	4/15/04-6/4/04	5/10/04-5/11/04	5/13/05-9/7/05	11/7/05-12/15/05	11/7/06-11/28/07
Family 23						
Incident	Other	Inv-unsub				
Dates open	3/18/05-3/25/05	5/14/06-6/14/06				
Family 24						
Incident	Other	Prev	Inv-sub	Inv-unsub		
Dates open	2/2/04-2/10/04	9/13/04-6/22/05	1/19/06-3/7/06	9/29/06-10/26/06		

Accepting DFS services is voluntary, unless court-ordered

District or county attorneys determine whether courts will be involved in CPS.

Often, when DFS investigates and substantiates allegations of neglect or abuse, the local office contacts the district or county attorney, requesting that a petition be filed in Juvenile Court under the Child Protection Act (W.S. 14-3-411). DFS provides assistance but district or county attorneys determine whether the "best interest of the child requires that judicial action be taken." Statute also allows – and this generally occurred in the incidents we reviewed – the court to hold adjudication of the petition in abeyance and instead, to issue a consent decree (see Figure 3.3 for typical consent decree requirements). Prosecutors and children's parents and guardians ad litem must agree to these decrees, and

courts implement them in both placement incidents and those where children remain in their homes.

Figure 3.3

Provisions typical of consent decrees

With parents substantiated for neglect, and children who either remained in the home or are now being reunified with parents

- Children remain in DFS custody with placement with parents.
- Parents will cooperate with DFS.
- Parents will allow DFS regular unannounced home visits.
- Parents will keep house clean, provide ample food.
- Parents will keep children clean and bathed.
- Children and parents will participate in counseling as requested.
- Children will have no unexcused absences from school.

Source: LSO review of DFS CPS files.

Consent decree requirements mostly mirror DFS family service plans.

MDTs are involved when families get into the courts.

For the court to dismiss the petition, parents must more or less meet the terms of the consent decree, which is much the same as the DFS family service plan. DFS caseworkers, along with MDTs, assist and monitor the parents as they work through their plans and consent decree requirements.

When services are optional, families most often do not accept them

Prosecutors tend not to file petitions for low-level CA/N, so families have had this option all along.

Our 1999 report on CPS criticized DFS for not providing more contracted services to the CPS population. Implementing the prevention and assessment level tracks has given DFS a way to attempt to engage families, provide caseworker counseling, and make referrals for services provided by other agencies or organizations. However, supervisors indicate that since acceptance of services is voluntary, DFS is not always successful in this. As supervisors explain:

- "On the flip side, families can refuse services and there is always the possibility more reports, sometimes more severe, will be filed with the Department."

- "(The track system) has allowed families to refuse services, but these are in cases where we don't have enough to refer to the District Attorney's Office and wouldn't be able to 'force' them to comply with a case plan regardless of how we assigned the case."

In our sample, nearly 80 percent of families in lower track incidents did not accept services.

We reviewed closure reasons for our sample of assessment and prevention incidents, and found that in nearly 80 percent of them the families did not accept the services offered by DFS. Where caseworkers were able to engage families, they most often provided casework counseling, such as discussing concerns and consequences for children living with continued parental drug use, domestic violence, or unsanitary living conditions. They also frequently provided case management, offering parents referrals for substance abuse evaluation, medical care for the children, food stamps, and day care.

Sometimes, DFS threatens higher track assignment to bring about a family's cooperation.

In lower track incidents that lack the support of a court order, some caseworkers try to use the multiple response system itself to bring about family cooperation. Although not sanctioned by policy, we occasionally saw that caseworkers told parents unless there was cooperation through an assessment track incident, the next incident would be tracked as investigation. In other cases, we saw supervisors hold off making track assignments until they could gauge families' inclination to cooperate in accepting and acting upon casework counseling and services.

Incident-based system does not lend itself to a sustained effort to address families' problems

DFS responses narrowly focus on the specific conditions that prompt CA/N reports.

DFS operates in an incident mode wherein each CPS intervention is triggered by an event, usually a report of some level of child maltreatment. The DFS actions and interventions that follow focus on the problems that prompted the report, and are contained within an "incident" that extends over a period of time, between the date the report was accepted and the date the caseworker and supervisor formally close DFS involvement. A family's case could be considered the collection of incidents that DFS has opened in response to accepted reports on the various individuals in the group.

DFS handles most incidents in isolation, not in the context of a family's case.

In effect, DFS handles most CPS incidents in isolation rather than in the context of a family's case. For example, we saw numerous assessment incidents closed after the parents cleaned their homes so they no longer posed the reported welfare threats to their children that prompted DFS attention. Caseworkers would typically make (or attempt to make) at least one return visit, and then close the incidents, often noting "goal achieved" as the closure reason. These same families often had subsequent incidents opened, usually for repeated reports of unsanitary living conditions. Verification of one clean-up did not address the underlying problems, which typically were poverty, substance abuse issues, and lack of parenting skills.

In the family-centered model, all circumstances, strengths and weaknesses are important.

The assessment and prevention tracks are meant to create a climate in which families comfortably seek assistance and use services available in their communities to prevent their problems from escalating to the investigation level. However, casework within the narrow confines of each incident seems counter-intuitive to the family-centered practice model, which DFS has focused on in the wake of the first federal review in 2002. In this model, all of a family's circumstances, strengths, and weaknesses are taken into consideration. Working an incident by addressing only the problem at hand, as illustrated in a single report, does not accomplish this.

Recommendation: DFS should evaluate its track system to determine how to make it work as envisioned, or request its repeal.

Children end up in chronic low-level CA/N situations until they worsen to the investigation level.

By taking the steps necessary to implement the track system in its rules in 2001, DFS indicated its belief in the model's potential. Seven years later, however, it has not evaluated its results, as other states have done, to determine if this model is meeting expectations. Our evaluation shows that the track system is not improving families' lots, and worse, that it may very well leave children in chronic low-level maltreatment situations until their predicaments worsen to the investigation level. Thus, we believe DFS has an obligation to determine what changes may be necessary to make the track system work, or seek its repeal.

DFS should better use information from repeated interactions with families.

From our perspective, CPS supervisors and caseworkers are not making full use of one of the track system's advantages: the family histories that result from their cycling through multiple incidents. While a uniform initial step in opening new incidents is for supervisors and caseworkers to review the histories in WYCAPS, we did not always see how this background knowledge informed subsequent track assignments or casework.

A higher level of review for families with multiple incidents seems necessary.

We believe DFS should consider creating a level of review beyond the supervisors and caseworkers immediately involved. Rather than continuing the cycle of opening and closing lower track incidents without managing to get the family connected with services to address its issues, at a certain threshold, DFS should initiate a higher level of review. DFS should determine what this review would look like, but it might include district managers, state office consultants, supervisors from other offices, or community child protection teams where they are active. The purpose would be to ensure that all available casework and service resources are brought to bear, including presenting affidavits to the courts for intervention.

If statute thwarts DFS' ability to use family histories in track assignment, it should seek necessary changes.

The statutory authorization for the track system itself limits families from becoming involved with DFS at its highest level, the investigation track. Only certain incidents qualify for the investigation response, but without investigation, there is not the substantiation that can lead to court action, and which in turn requires parental participation in a rehabilitation plan. If DFS believes it is unable to consider families' histories in assigning subsequent incidents to investigation, then it should request the Legislature to authorize such authority.

CHAPTER 4

Evidence gathered during CPS investigations is not well documented

Chapter Summary

The most severe CA/N reports should be formally investigated by DFS.

A key part of CPS casework is investigating CA/N reports in which there is potential that a child is in "imminent danger." Because the stakes are high, investigations need to take place promptly, and the findings that result need to be based on well-informed judgments of the facts. The consequences of findings can be drastic, both for the child victim and for the alleged perpetrator: if little credible evidence exists or the caseworker misses evidence, children may remain in a dangerous home or alleged perpetrators may be unfairly listed on the central registry.

Requirements to document the CPS investigation process and findings go largely unmet.

In reviewing DFS child protection investigations, we did not find a systemic problem with DFS caseworkers making arbitrary or unsupported findings to substantiate. Rather, findings generally had support from others, often professionals in the legal system such as police and county attorneys. However, we noted the general absence in narratives and case files of clearly written summaries of the steps caseworkers took and the evidence they gathered. Because of spotty documentation, we concluded that CPS caseworkers are not consistently putting into practice DFS' structured decision-making methodology as laid out in the policy manual, taught in CORE training, and mandated in statute.

CPS investigations need better documentation for both substantiated and unsubstantiated findings. Ultimately, DFS as an agency and caseworkers individually need to be prepared to defend their findings. We recommend that DFS require caseworkers to improve documentation of their investigation steps, and summarize in writing their findings and the evidence supporting them.

Substantiated findings require a preponderance of credible evidence

Investigated CA/N allegations must be either substantiated or unsubstantiated.

A CPS investigation is a caseworker's gathering of information such as interviews and other evidence, on which to base a finding about whether CA/N took place as reported. A *substantiated* or *unsubstantiated* finding represents a DFS decision that there is, or is not, enough evidence that an alleged perpetrator committed CA/N. In incidents where caseworkers find no evidence is available or that the allegations had no basis in fact, investigations may be closed as *unfounded*.

For each finding, CPS caseworkers must weigh both quantity and quality of evidence.

The statutory requirement for reaching a finding has two linked requirements: the evidence must be credible, and all the evidence together must meet preponderance of evidence legal standards. Preponderance of evidence generally means that a reasonable person can conclude CA/N occurred as alleged, that there is more than a 50 percent probability CA/N occurred. If the evidence meets this standard, allegations are substantiated; if not, they are unsubstantiated.

Criminal and Juvenile Court actions may impact some investigations and findings

County attorneys may file criminal charges or child protection petitions against some of the families in the DFS investigation track. Title 6 of Wyoming Statutes, Crimes and Offenses, outlines offenses against the family including child endangerment and abandonment. Child protection petitions, filed in Juvenile Courts, involve multi-disciplinary team consultation and give the state a way to order that families accept services and comply with family service plans.

Neglect is the focus of most CPS investigations

Most high-profile child protection incidents featured in the media tend to involve overt physical or sexual abuse or child endangerment (dangerous acts). The vast majority of incidents DFS investigates, however, involve basic neglect or one of its variants, such as educational neglect or negligent treatment of

Physical and sexual abuse account for only 15% of reported allegations.

children. During the four-year time frame we reviewed, from 2004 to 2007, basic neglect accounted for about half of the 6,877 allegations investigated (see Figure 4.1). Physical abuse, sexual abuse, and dangerous acts represented 6, 9, and 3 percent, respectively (see Appendix F for other allegation/finding statistics).

Figure 4.1

Allegations by type and finding
CY '04 – '07

Allegation Types	All Allegations	Percent of All Allegations	Substantiated	Unsubstantiated
Neglect	3,559	51.75%	1,669	1,890
Abuse	971	14.12%	307	664
Sexual Abuse	646	9.39%	256	390
Physical Abuse	412	5.99%	137	275
Lack of Supervision	269	3.91%	111	158
Dangerous Act	213	3.10%	151	62
Physical Injury	189	2.75%	64	125
Educational Neglect	170	2.47%	71	99
Medical Neglect	148	2.15%	44	104
Negligent Treatment	120	1.74%	66	54
Other	68	0.99%	40	28
Abandonment	44	0.64%	22	22
Emotional Abuse	38	0.55%	11	27
Mental Injury	14	0.20%	2	12
Psychological Abuse	5	0.07%	1	4
Unknown	5	0.07%	1	4
Deprivation	3	0.04%		3
Malnutrition	3	0.04%	2	1
Total	**6,877**	**100.00%**	**2,955**	**3,922**

Source: LSO analysis of DFS-WYCAPS data.

An important aspect of CPS investigation is multiplicity: each child in a family may be the subject of one or several allegations in a single report, and an alleged perpetrator may have multiple allegations, each involving multiple children. Thus, one report does not necessarily equate to only one allegation or one

One report does not equal one allegation, one perpetrator, or one child.

perpetrator. For example, there were 4,571 different victims and 3,713 separate perpetrators in the almost 6,900 allegations from the period we reviewed. More than one child was involved in the average investigation, with an average of two allegations against each alleged perpetrator.

Statute, DFS policy, and training require written confirmation of facts for CPS investigations

Statute, the DFS policy manual, and DFS' training for new caseworkers, CORE, call for thorough CPS investigations. Key points in policy and training instructions are that caseworkers should plan their investigations and then summarize their evidence and interviews in a comprehensive written report. Thus, a thorough investigation should document that a finding is reasonable, given the quantity and credibility of the evidence.

Statute requires written confirmation of CA/N allegations for all accepted CPS reports.

As part of changes to CPS statutes in 2005, the Legislature required that allegations of child abuse or neglect be followed by a written report confirming or not confirming what was alleged. To the extent such information is available, written reports are to include basic demographic information on the child(ren), parents, caretakers and alleged perpetrator, and the reporter's concerns. The written report may also include evidence of previous injuries to the child along with photographs, videos and x-rays, and any other relevant information. Some of this information may have been recorded during intake and the preliminary track assignment but typically, much of it is gathered during the CPS investigation.

DFS policy requires a structured, documented decision-making methodology for investigations

DFS policy requires a summary of facts and evidence for each finding.

Longstanding policy at DFS requires a specific, outlined "structured decision making process" for CPS investigations. Summarized in Figure 4.2, the process includes ten basic steps, from the initial response priority (i.e. immediate response or within 24 hours) to caseworker follow-up after incident closure. Included in this stepped process is the investigative report, a comprehensive report that pulls together the facts and evidence of the investigation.

Figure 4.2

DFS Family Services Manual investigation methodology

1. Response Priority – Cases are divided into immediate and twenty four (24) hour response.
2. Safety Assessment – Identify immediate threat of harm within seven (7) calendar days.
3. Safety Planning – Identify potential protection intervention within seven (7) calendar days.
4. Interviewing – Individual private interviews with the alleged perpetrator and victim(s), completed within seven (7) calendar days.
5. **Investigative Report – A comprehensive report documenting the facts and evidence.**
6. Risk Assessment – Evaluates future risk and is used to help make decisions related to service delivery.
7. Findings – the allegations are substantiated or unsubstantiated.
8. Case Assessment – Guides the development of the Family Service Plan.
9. Family Service Plan – Guides service delivery and interventions.
10. Follow-up – In substantiated cases, follow-up should occur within three (3) months of case closure to determine how the children and family are doing and evaluate the need to re-open the case.

Source: DFS Family Services manual

DFS CORE training emphasizes investigative planning and a "defensible" investigation

DFS CORE training for new caseworkers includes several days on how to carry out a thorough investigation. According to trainers, the central principle of any investigation is to anticipate the "defense." This reference to potential legal proceedings and a perpetrator's defense against substantiated findings underscores the need for thoroughness in every investigation.

DFS trains caseworkers to plan and document CPS investigations.

CORE trainers stress the use of an investigation plan document to guide caseworkers through the evidence-gathering process. The document has space to record the allegations reported, review previous DFS and law enforcement contacts, list the people who need to be interviewed, note other possible evidence and its sources, and special circumstances that may affect the investigation. New caseworkers receive training on how to complete these plans; they also role-play how to conduct investigative interviews.

CPS investigation process and evidence summaries are largely undocumented

In reviewing case files from the investigation track, we looked for plans that outlined the steps to be taken and for summaries of evidence gathered. We found varied documentation, but generally, the evidence supporting findings was more implied than explicitly stated or summarized. We often had to scour many pages of narrative log to find references to interviews and other types of evidence. Such information was usually scattered within other casework management and correspondence notes.

Local office protocols tend to prevail.

In the process, we learned that much of the documentation of CPS investigations is guided by local protocols or preferences, and that some local offices have developed their own practice aids. For example, a few offices use procedural checklists to help organize incident and investigative decision points. Some require summary or evidence reports in specific circumstances, such as when a case goes to juvenile or criminal court.

From our review, facts and evidence generally were not summarized in case files or WYCAPS.

However, after combining WYCAPS information with hardcopy files, we found that case files generally do not contain investigation plans or comprehensive investigation reports. Caseworkers rarely summarized findings in a case narrative, and when they did, the summary was usually short, with little detail to support how the preponderance of evidence standard for substantiated findings was met. We concluded that for any one incident, complete documentation was unlikely to be present, and that evidentiary support of findings was scattered, at best.

Burden of proof for substantiated findings is on the Department

Unreasonable or unsupported findings may impact children or adults.

The impact of both unsubstantiated and substantiated findings can be crucial. If a caseworker misses evidence and unsubstantiates allegations, an alleged perpetrator may continue to abuse or neglect children, with possible dire consequences. In that case, DFS will have to answer questions about its decision not to substantiate. If allegations are substantiated, the perpetrator is listed on the central registry, which can inhibit that person's ability to obtain employment in certain sectors. If a perpetrator appeals a

substantiation, DFS needs to be prepared to defend its finding internally and to outside authorities.

Substantiated findings appear to be supported by other professionals

Caseworkers may use non-DFS professionals' documents to support findings.

Many findings in our sample appeared to be supported by evidence from non-DFS professionals; few had only DFS caseworker and supervisor judgments. On most reports, even for those in prevention and assessment tracks, there was documentation of law enforcement involvement, generally when a caseworker attempted the first face-to-face contact with a family. Police reports were either referenced in the narrative or sometimes attached to the hard-copy file; these reports tended to be well-written and specific to the circumstances and conditions that elicited the CPS report. Similar documentation came from medical and educational professionals, although most files did not tie these pieces together.

In all steps of the investigation process, the burden of proof is on DFS to show that a preponderance of evidence exists to warrant substantiation. Without summaries, we remain concerned that other evidence which supports DFS findings may be overlooked or not fully examined. Also, when perpetrators appeal substantiated findings, the scattered nature of the evidence in files may hamper the state in defending caseworkers' actions.

Some DFS investigation practices do not match with statute, manual, and training

Trainers emphasize adhering to local protocols.

Statute and DFS policy require written confirmation of the facts of each report of CA/N; CORE training reinforces this point. DFS appears to want to guide new caseworkers to do their jobs consistently and effectively. However, we believe caseworker practices in this regard are not meeting the expectations set in statute, policy, and CORE training. Also, we found it unsettling that trainers emphasized supervisor discretion to set local protocols; this seems to undermine policy and training that stress using consistent and documented processes.

The CORE training we attended stressed the importance of using investigation plans, yet in our sample of investigation incidents, we did not see these plans being used. As a result, we are unable

Supervisors noted training for new caseworkers does not cover important investigation techniques.

to conclude that investigations are well-planned. We also did not see consistent use of comprehensive investigation reports. The supervisors we surveyed noted similar concerns, and two-thirds of those responding stated it would be helpful to have standardized, statewide checklists for monitoring investigations. Also, supervisors noted that current CORE training on investigations is general in nature and does not train workers in important areas such as proper child interviewing and other advanced techniques.

Recommendations:

- **DFS should require caseworkers to prepare investigative plans or use a standardized investigation checklist.**
- **DFS should require caseworkers to prepare evidence summaries after each CPS investigation.**

Investigations cover the most severe CPS reports DFS receives. They need to be detailed, accurate, and comprehensive because they set the stage for so much of what follows. The facts are important in unsubstantiated and substantiated findings alike, and when findings are challenged, caseworkers need to be able to clearly support what they did.

DFS needs to support caseworkers to do a better job of documenting CPS investigations.

We recommend that DFS require caseworkers to handle investigations in a more uniform and well-documented manner. This can be done by expanding policy to adopt the investigative plan or by approving a standard checklist that follows the investigation methodology already in policy. Also, after investigations, caseworkers need to prepare evidence summaries that are consistent with the comprehensive investigation report required in policy. In all, DFS can support caseworkers to do a better job of fulfilling statutory and policy requirements on investigations.

CHAPTER 5

Central registry heavily relies upon personal verification

Chapter Summary

Businesses involved with vulnerable populations use the central registry for potential employee background checks.

W.S. 14-3-213 requires DFS to maintain a central registry of child protection reports that are either substantiated or under investigation. Intended as a safeguard for vulnerable child and adult populations, the central registry is an employment screening tool for businesses and agencies working with such populations.

A registry check is in fact a records search of the DFS electronic data management system.

In effect, the registry is part of the DFS electronic data management system, WYCAPS, which enables DFS to search for individual names. Once a person is substantiated, meaning a DFS supervisor has determined there is a preponderance of evidence indicating that person committed CA/N, a caseworker enters the finding into the system. Thereafter, if that individual is the subject of a central registry check, DFS reports the substantiated status.

The process also relies heavily upon verbal verification with field office staff.

However, we found that the identification of individuals who are under investigation is not as straightforward as it could be, and that DFS relies upon a personal verification process to ensure that this category is accurately reported. Given the seriousness of central registry listing, we recommend that DFS continue its vigilance in this process and look for ways to strengthen it. Further, we learned that sometimes, DFS cannot report individuals who should be on the registry; these are persons for whom required notifications were not made, or persons whose notification could not be verified at the time of the check. Thus, we recommend DFS redouble its efforts to ensure caseworkers follow notification policies.

Statute sets central registry requirements

The Legislature made changes to registry statutes in 2005.

Statute requires that names and incidents listed on the registry be classified in one of two ways, as "under investigation" or "substantiated." DFS must reach a substantiation finding in an incident under investigation within six months, or remove the report from the registry. The Legislature made significant amendments to central registry statutes (W.S. 14-3-213 through 214) in 2005. Educational and mental health professionals received access to central registry information, and a provision was repealed that had limited registry reports to only those substantiated offenders who had exhausted all avenues for appeal under the Wyoming Administrative Procedure Act.

Statute limits access to the registry; DFS releases central registry information appropriately.

By statute, central registry information is available only to employers whose businesses are involved in serving the vulnerable populations envisioned in statute. Statute does not allow for casual inquiries or public release of central registry information. Our review of the organizations requesting registry checks showed that DFS releases information appropriately.

To check on a prospective employee, an employer submits a written and identifiable request with a waiver signed by the applicant, allowing DFS to release information to the employer. DFS charges $8.00 for performing the search. The DFS response must also be in writing; it goes to the employer by certified mail if reporting a central registry listing, or by regular mail if not.

The central registry continues to grow

Most individuals came on to the central registry prior to 2000.

According to WYCAPS data, the central registry lists about 11,000 names, counting only those individuals with at least one substantiated finding for at least one allegation. Figure 5.1 shows the annual count of individuals added to the registry based on their first substantiated findings. Most of the offenders were listed prior to 2000. There is not a way to use WYCAPS data to count the number of individuals who may be on the registry while "under investigation."

There is not a way to count those on the registry while in the "under investigation" status.

Figure 5.1

Number of persons with substantiated allegations

Year	Number of New Offenders	Total Offenders
2000	825	7,551
2001	610	8,161
2002	410	8,571
2003	461	9,032
2004	474	9,506
2005	511	10,017
2006	482	10,499
2007	488	10,987
Before 2000	**6,726**	**6,726**
Since 2000	**4,261**	**10,987**

Source: LSO analysis of DFS-WYCAPS data.

Wyoming employers request thousands of checks annually, but very few checks reveal a substantiated perpetrator.

Employer requests for central registry checks have remained level since 2001 (see Appendix G for other central registry statistics). In fiscal year 2007, state office staff processed nearly 18,000 screening requests from potential employers, an average of about 1,500 per month. DFS tracks the number of requests submitted and the businesses or state agencies that submit requests for billing purposes. The agency also records the number of positive "hits," that is, searches that identify individuals who have substantiated findings of CA/N. The total number of "hits" in FY 2007 was minimal, only 186, or approximately one percent of all requests.

In addition to checking WYCAPS and case files, state office staff access Division of Criminal Investigation records on the individuals in question. In the same time period, DCI hits numbered 371, or 2 percent of requests. DFS provided no information showing that it similarly tracks "under investigation" or "no record" results returned to employers.

Systematic monitoring and purges of the registry do not occur

Statute requires DFS to continuously monitor and analyze central registry data. However, staff have no mechanism to review whether names are appropriately on the registry, except through an individual request to expunge, remove, or amend a listing. DFS will modify the records for persons if supervisors or caseworkers

discover that DFS failed to properly notify them of allegations or findings. There is not a regularly scheduled or systematic review of incidents and files to verify adherence to notification procedures, so it is possible the registry contains names in error.

DFS performed two major purges to remove persons of low risk.

However, DFS made two concerted efforts in the 1990's to remove the names of those who had been substantiated for "low risk" complaints. Before introduction of the current track system, rules designated those types of complaints and field personnel evaluated records for possible removal of low risk substantiations. According to DFS officials, the purges took place after the adoption of rules in 1992, and again with conversion of records to WYCAPS in 1998.

People who request to be removed from the central registry are usually successful

The central registry is intended to contain the names of only the most serious offenders.

Statute authorizes DFS to amend, remove or expunge persons' records from the central registry upon a showing of good cause, and agency rules set forth the process and considerations for doing so. High-level DFS administrators consult with local managers to determine whether to remove individuals from the central registry. This occurs when listed individuals request removal, usually because they believe they can demonstrate rehabilitation.

These requests are infrequent, about 60 per year, but they often result in removal. According to agency data, of the 69 requests for review received in 2007, DFS denied 11, leaving these individuals' listings on the registry intact. DFS officials favorably responded to most of the requests (58, or 84 percent) by amending their findings to unsubstantiated, effectively removing them from the central registry.

State staff conduct registry checks

The process is not as simple as checking a list.

Two Juvenile Services Division staff at the state office, one full-time and another part-time, perform central registry checks. Although statutory language implies that the central registry is a separate databank or list, in practice it is not separate; instead it is the product of a records search.

There are three possible responses to an employer's inquiry: that an individual is a substantiated CA/N offender, is under investigation in an open CPS incident, or that the state has no record of either for the individual. The first and last categories are relatively straightforward; the second, where WYCAPS matches a name in an open incident and DFS reports that individual as being under investigation, is problematic.

Identifying substantiated individuals involves both the data system and confirmation with CPS field personnel

If evidence of notification is lacking in files, substantiated persons are not reported as "hits."

When WYCAPS links an individual's name to a substantiated finding, staff review other WYCAPS data and request that the appropriate field office pull hard copy case files to confirm the individual's status. If this process reveals discrepancies or if hard copy files do not show that proper notification procedures were followed, state office staff do not report the name as a substantiated perpetrator. In 2007, there were 60 such incidents, 5 due to lack of proper notification and 55 for lack of supporting documentation.

Confirmation is critical in "under-investigation" reports

With the track system, there are many open incidents, but few are open investigations.

When WYCAPS does not show an individual as a substantiated perpetrator, yet shows involvement in a currently open incident, the central registry staff preliminarily assume the individual is "under investigation." They then contact the appropriate field office to verify that individual's status.

Since the implementation of the track system, there are many open incidents that are not in fact, "under investigation." These include the assessment and prevention track incidents, and possibly many of the "other" incidents that supervisors have not assigned to tracks. Some of these, especially in the latter category, could have allegations attached to them through the WYCAPS system.

DFS does personal checks with field offices to confirm "under investigation" listings.

Consequently, there is the potential for central registry "under investigation" reports to include individuals who are involved in lower track or untracked incidents. However, this occurrence is avoided by state office staff contacting field office supervisors, requesting confirmatory documentation.

Recommendations:

- **DFS staff should be vigilant in "under investigation" central registry checks.**
- **DFS should ensure notification of substantiated persons takes place and is properly documented.**

Even though the personal contact component of the central registry check likely averts possible over-reporting in the "under-investigation" category, we again see problems relating to the large percentage of incidents that are not being tracked. If nothing else, the tendency not to track incidents creates the need for manual and personal verification in open incidents where individuals would never rise to central registry listing. Until this tracking issue is addressed, as recommended in Chapter 2, central registry staff must be particularly vigilant in their checks.

Complete and accurate records are necessary to ensure individuals are appropriately listed on the central registry.

We recognize that DFS is trying to use its WYCAPS system for many processes, some of which were not in place when it was built. However, since central registry checks stand to affect people in such a profound way, it is incumbent upon DFS to ensure that the system can unequivocally report what the central registry requires: individuals who have been substantiated and those who are under investigation. This could be accomplished by including a field to plainly designate those incidents that are in the investigation track.

We are also concerned that in FY 2007, nearly one-third more names would have been reported to those seeking central registry checks had DFS records been in order. Because local CPS staff did not properly document notices sent to persons substantiated for CA/N, or did not make the notification at all, DFS could not provide employers the assurances they need in making hiring decisions for positions working with vulnerable populations. Although DFS has policies requiring this documentation be done, caseworkers have not been reliably following them. The agency must take steps to ensure this documentation is done.

CHAPTER 6

Assurances that children remain safe in the home need to improve

Chapter Summary

The national news media frequently feature stories about incidents where children known by social services agencies to be at risk have been seriously harmed or even killed while in the care of their parents or other caretakers. Ensuring that children in its legal custody are safe, whether they are in foster care or living with their parents, is arguably one of DFS' most critical obligations. Further, by interacting with families through the assessment and prevention tracks, DFS caseworkers know about even more at-risk children, those who are not (yet) victims of substantiated abuse or neglect.

DFS needs to strengthen efforts to meet its basic obligation of protecting those children living in inherently risky situations.

Our review of CPS files and electronic data indicates that DFS does not consistently put forth efforts to ensure the safety of children who are in the care of parents or caregivers known to have compromised their children's welfare in the past. This is a population prone to relapsing into behaviors that are harmful to children. With the DFS change to the family-centered practice model and its focus on family preservation, CPS services for these families concentrate on the parents, attempting to improve their parenting skills and basic functioning. However, we believe DFS also needs to strengthen efforts to better meet its basic obligation, protecting children's health, safety, and welfare.

CPS children in the home are vulnerable

Law enforcement, not DFS, has authority to remove children from their homes.

A common perception is that child protection agencies often remove abused and neglected children from their family homes, then place them in foster care. However, in Wyoming, law enforcement officers have removal authority, not DFS; also, in our investigation incident sample from 2004-2007, just 22 percent of the incidents involved the removal of one or more children (see Appendix H for statistics on CPS placements).

Many children in foster care reunify with parents in trial home placements while still in the state's legal custody.

Thus, many children who are victims of substantiated abuse and neglect remain in their homes while the families receive services, meaning they are often in the care of the persons who earlier maltreated them. In addition, many children in foster care go on to reunify with their families through trial placements at home; some reunify successfully and remain at home after the state relinquishes custody. The children are vulnerable at all these stages because, according to a national study and our review of files, families who become involved in child protective services tend to repeatedly generate reports of child maltreatment.

Re-reporting and re-victimization are likely for CPS client population

In our review sample of families with substantiated incidents, most re-entered the CPS system within two years of closing those incidents.

Many families who become involved in child protective systems re-enter, sometimes voluntarily, but most likely due to multiple later reports on them. According to a 2005 U.S. Department of Health and Human Services study, after an initial accepted maltreatment incident, children will be involved in an average of two future reports and more than one future accepted incident. The study also concluded that some children require more intense services and continuous monitoring to insure safety and prevent long-term harm.

DFS client families in our sample had multiple incidents

Our sample of investigated and substantiated DFS incidents also showed that the families coming into contact with DFS did so repeatedly. Of the 51 cases with at least one substantiated incident, more than half had a subsequent report and accepted incident with DFS, including both tracked and untracked incidents. More than one-third had subsequent reports leading to a full CPS investigation, and 61 percent had either previous or subsequent investigations. Also similar to the national study, most families re-entered the CPS system relatively quickly – within two years after closure of a substantiated incident. In this sample of 220 incidents, DFS opened 123 of them either concurrently with other opened incidents or within six months of previous ones being closed.

Caseworkers are not always following policies for ensuring children's safety in their homes

In order for children to live safely in their homes after DFS receives allegations of CA/N, caseworkers engage, evaluate, serve, and monitor the family through the CPS process. Our review of DFS files and electronic data indicates that caseworkers are not consistent in their efforts to ensure the safety of the children in these uncertain circumstances.

LSO and federal reviews have stated this before

In 1999, DFS lacked a policy on how often caseworkers should visit CA/N victims living at home.

In our 1999 CPS report, we noted that DFS lacked a policy on how often caseworkers should see and evaluate the safety of children who are victims of abuse or neglect and living at home with the caretakers who maltreated them. We also noted concerns that DFS lacked the capability to electronically monitor whether caseworkers were regularly seeing these children. In 2002, the state's first federal review (CFSR) made a similar finding; caseworker visits with children were "not always of sufficient frequency and quality to ensure safety, permanency, and well-being."

Although policy and procedural changes have occurred, there is still room for improvement.

DFS has since implemented policy and procedural changes, but we believe still more improvement is needed in this critical area. To assess DFS safeguards for ensuring safety of children in these vulnerable circumstances, we focused on three policy areas and the procedures that apply to them: use of safety and risk assessments, face-to-face visits with children in their homes, and follow-up on substantiated incidents once they are closed. In our sample of cases, caseworkers were not consistently following DFS policy in these areas.

Formal safety and risk assessments are not completed as policy envisions

Since 2005, there have been CPS policies for safety and risk assessments to guide DFS casework. The policies are specific about when these assessments, including a risk re-assessment, are to be done; they apply to "all open cases where risks are identified."

In our file review, we did not see much evidence that safety and risk assessments were done.

We reviewed evidence of caseworkers' use of safety and risk assessments and risk reassessments by looking at both hard copy files and WYCAPS. In review of the hard copies, we saw that at most, half of the files included safety assessments for at least one of the incidents in the file. As to risk assessments and risk reassessments, the same was true for less than one-third of the files we reviewed. Further, we saw little indication in incident narratives that the results of these assessments were being applied to incident management.

WYCPAS aggregate data showed more, but not the expected level of completed assessments.

Because safety and risk assessments are so critical to ensuring children's safety, and because we saw so few of them documented in hard copy files, we turned to WYCAPS. We looked at aggregate data for all CPS incidents, as well as for the targeted incidents in our sample. Aggregate WYCAPS data show that caseworkers are completing safety and risk assessments in WYCAPS to a greater degree than we saw in the files, but still not to the extent required by policy. For example, as Figure 6.1 shows:

- Safety assessments are completed in most incidents.
- Risk assessments are completed in a majority of incidents, but less often in non-investigation cases.

The lack of risk re-assessments poses a concern.

- Risk re-assessments are completed in only one-third of investigation incidents, and rarely for non-investigation incidents.

We also found problems with caseworker timeliness in completing assessments. From the date a report is received, requirements are: completion within 7 days for safety, 30 days for risk, and 6 months for risk re-assessments. Our aggregate analysis showed that roughly one-third of the assessments in any category are not completed within policy timeframe requirements.

Figure 6.1

Incidents with completed safety, risk, and risk re-assessments
October 2005 – December 2007

Assessment	LSO Case File Review					
	Incidents		Investigations		Non-Investigations	
	Number	Percent	Number	Percent	Number	Percent
Safety	121	92.37%	67	98.53%	54	85.71%
Risk	76	58.02%	46	67.65%	30	47.62%
Risk Re-Assess	32	24.43%	25	36.76%	7	11.11%
Applicable Incidents	**131**		**68**		**63**	
Assessment	**All Incidents**					
	Incidents		**Investigations**		**Non-Investigations**	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Safety	8,520	85.49%	1,827	99.67%	6,693	82.29%
Risk	4,347	43.62%	1,313	71.63%	3,034	37.30%
Risk Re-Assess	1,418	14.23%	524	28.59%	894	10.99%
Applicable Incidents	**9,966**		**1,833**		**8,133**	

Source: LSO analysis of DFS-WYCAPS data. Since our study review period began before the assessment policies were developed, we considered only those incidents opened after October 1, 2005 when policy took effect instructing caseworkers to complete assessments electronically in WYCAPS.

Completed assessments are meant to inform case management decisions.

According to DFS, caseworkers are constantly and informally assessing families while managing cases. Some informality appears reasonable since documenting an assessment after each contact may be burdensome and inefficient. However, CPS policy states that certain decision points during management of an incident require documented safety and risk assessments. This, too, is reasonable: in addition to informing case management, completing these assessments can assist others such as judges, attorneys, and quality assurance reviewers in understanding the bases for caseworker decisions.

Policy is confusing about the use of risk assessments in prevention and assessment track incidents

Risk is a factor in all incidents, but policy does not require risk assessments in lower tracks.

When working an accepted DFS incident, policy directs caseworkers to complete safety assessments on *all* accepted reports (therefore any recorded incident), and to complete risk assessment and reassessments on all incidents with identified risks. Yet policy for the DFS prevention track says that risk assessments are not necessary, even though prevention incidents are opened due to "identified risk factors." A similar conflict

appears between the safety assessment and prevention track policies. Further, the assessment track policy does not mention the need for risk assessments, although by definition, risks must be present for DFS to open those incidents as well.

Caseworkers make fewer than required in-home visits to children who remain at home

Visits are to be at least monthly, but weekly is recommended.

DFS has enhanced policy since our 1999 LSO evaluation, adding guidance on visits with children who have not been placed out of their homes. "Face-to-Face Contact" policy states that the minimum frequency for such visits with non-placed children is monthly, but "weekly is recommended." The full policy is somewhat confusing, but it appears DFS expects these visits to occur in the family home if family preservation is the goal; the policy applies to incidents where placement has never occurred.

By policy, all children should be visited in their homes.

If the goal is family reunification, visits can be "in treatment plan meetings or family partnership conferences" as well as in the home. However, this policy does not meet the requirement in its own preamble: "per federal regulations, a caseworker shall visit all child(ren)/youth who have an open case with the Department of Family Services monthly, in the residence of the child."

We saw regular contact with families, but not necessarily face-to-face visits in children's homes.

In our review of a sample of investigation incidents, we saw that caseworkers generally attempt regular contact with families; much of that contact is not at families' homes, but via telephone calls or office visits, as policy seems to allow. However, since many families get involved with DFS for the very reason of conditions in their homes, it is a concern to us that more visits are not done in that locale. Further, based on our review of sample incidents, we saw the visits occur barely at the minimum level of monthly, and certainly not weekly.

Caseworkers are not complying with policy to follow-up on substantiated incidents

Since at least 2004, if not before, DFS has had a policy requiring a follow-up visit in substantiated incidents "within three months of case closure to determine how the children and family are doing and to evaluate the need to reopen the case." We did not see this occurring in our sample of investigation incidents. This was concerning because for a majority of the families in our sample who had closed, substantiated incidents, DFS opened new incidents within six months.

Supervisors said follow-up visits do not occur because families prefer it that way: but a majority in our sample had new incidents within 6 months.

In replies to our survey, CPS supervisors generally agreed that follow-ups do not happen with families in which substantiated abuse or neglect has occurred. One supervisor noted that caseworkers tell families to contact DFS if they need services, but families are usually relieved to have DFS out of their lives and do not want further contact. Others indicated that staff resources are not adequate to do follow-ups, and that DFS does not contact these families unless a new referral comes in.

Reunification and family preservation provide permanency for children

Since enactment of the federal Adoption and Safe Families Act (ASFA) in 1997, the national CPS focus on achieving permanency for children has heightened. Federal laws and corresponding state statutes emphasize family preservation and reunification, in recognition that children should have permanency in their lives, and that foster care does not necessarily provide that. Wyoming statutes also emphasize permanency in children's lives, whether through adoption or reunification with their own immediate or extended families:

Federal and state laws share the focus on permanency.

- **1997 creation of the Child Protection Act** When a child is adjudged to be neglected, the court shall ensure that reasonable efforts were made by DFS to prevent or eliminate the need for removal of the child from the home or to make it possible for the child to return to the home. (W.S. 14-3-429 (a)(iv))

- **2005 change to Wyoming Statute** State agency shall ensure that all CPS workers are trained in the principles of family-centered practice that focus on providing services to the entire family to achieve the goals of safety and permanency, including balancing the best interests of children with the rights of parents. (W.S. 14-3-203 (c)(i))

Family partnership conferences are voluntary. They involve people who know and care about a family coming together to develop a family service plan that protects the family's welfare. They aim to identify strengths, needs, and supports as well as **all** circumstances affecting the family.

LSO summary of DFS Family Partnership Policy

These changes in law were accompanied by DFS making conscious changes in approach to CPS. The July 2002 federal review (CFSR) by the U.S. Department of Health and Human Services emphasized outcomes of the state's child welfare system. This review noted deficiencies in DFS' family-centered practices, finding that DFS had focused the majority of its activities on the target child and had not provided adequate services to the child's family. In response, DFS developed and began implementing a family-centered service model as its overarching strategy. Major components of this strategy were the creation of a family-centered assessment process, the family-partnership conference planning model, and the quality assurance process examined in the following chapter.

Nearly all the services for in-home service incidents go to the parents.

From our review of family files for this study, the implications of this family-centered model are that some caseworkers expend great effort helping parents rehabilitate themselves so they can provide safe homes for their children. Indeed, we found that nearly all of the services provided for in-home service incidents focused upon the parents: substance abuse and mental health evaluations and tests, counseling, parenting classes, and assistance with applying for other benefits are examples.

But caseworkers must continually evaluate children's safety and risk.

Still, at the core of every DFS report is a concern about children's safety and current and future risk of maltreatment. This is why it is so important for caseworkers to continually evaluate safety and risk to children at critical points and document the conclusions they reach. It is especially critical when the DFS decision is to let them remain at home with parents who have been abusive or neglectful, and after placement, when reunifying children with these families.

Recommendation: DFS should balance family-centered practice with ensuring child safety by clarifying policies in key areas, and setting electronic alerts to prompt caseworkers to make visits to children in in-home services incidents.

DFS is consciously shifting its casework focus to encompassing all family members and avoiding placement.

When we evaluated CPS in 1999, agency philosophy centered around "safety first" and resulted in many out-of-home placements of child victims. Although DFS reports that its CPS rate of removal is still higher than the national average, its policy emphasizes the importance of maintaining children in their homes when possible. The agency is consciously shifting its casework focus to encompassing all family members in an incident and avoiding placements of alleged victims. This shift is congruent with best practices and national trends, but DFS has not attended as well as it might to a critical element of this change, providing overall assurances for child safety.

We recommend reviewing policies in key areas to ensure children are safe in their homes.

DFS must balance its family-centered practice approach with taking adequate measures to ensure children's safety in their homes. As steps in this direction, we recommend that DFS review its visitation policies to clarify that visits, at least monthly, should occur in children's homes, regardless of whether the service plan goal is family preservation or family reunification. Further, DFS should clarify how the safety and risk assessment policies apply to incidents in the different tracks, and determine a workable policy for follow-ups in substantiated incidents. Based upon the tendency for families to have recurring incidents, disregarding this policy does not seem prudent.

DFS might also adjust WYCAPS to monitor in-home services visits.

Although WYCAPS includes "alerts," or electronic prompts to remind caseworkers to complete certain tasks, it does not include one for in-home services visits to children. Nor does the system provide a means for supervisors to monitor whether those visits are made, as it does for out-of-home placement visits. It can be risky for children to remain at home in a neglectful or abusive environment, so we recommend that DFS add these components to WYCAPS.

CHAPTER 7

Despite positive trends in DFS quality assurance, some critical CPS processes are not reviewed

Chapter Summary

Our 1999 CPS evaluation recommended that DFS develop an institutional research function to evaluate both program and administrative effectiveness. Since that report, DFS has made good strides to provide more information, accountability, and measurement on CPS, including setting up a Quality Assurance Unit. However, almost all of the emphasis is on one evaluation method, a state Child and Family Services Review (called the state CFSR), which is modeled after the federal review.

Several important DFS processes, such as track assignments and the central registry, are not part of quality assurance monitoring. The public and the agency need to understand not only the outcomes staff and processes are achieving, but also how consistent, clear and fair those processes are. Both state-level and local staff now have access to CPS reports from WYCAPS data, and the state CFSR is a solid foundation for quality assurance. DFS needs to enhance this foundation with additional reviews of CPS casework and administrative processes.

Ensuring fair and consistent processes is as important as program outcomes.

DFS works with multiple boards to oversee CPS activities

For child welfare matters, DFS has oversight from several boards, including the DFS Advisory Board, the Interagency Children's Collaborative, and the federally-mandated Citizen Review Panel (CRP). Each has a distinct but somewhat overlapping duty to review aspects of the child welfare system and make recommendations for improvement. The most active of these boards, the CRP, is a stand-alone, nonprofit agency with federal funding; it administers the state CFSR process (explained later in this chapter) and has recently incorporated the functions of the Child Major Injury and Fatality Review.

Citizen Review Panel (CRP) is DFS' most active oversight board.

DFS has expanded reporting and use of data from WYCAPS

DFS data use and analysis capabilities have greatly improved since 1999.

A central theme in our 1999 CPS evaluation was the lack of useable data at the state level by which managers could gauge program effectiveness. This made it difficult for state-level consultants and program managers to identify specific CPS processes that needed improvement, or where needs might not be met. Implemented at about that time, WYCAPS has provided considerably more data analysis capacity. For example:

- **Alerts** WYCAPS notifies caseworkers to enter data and complete necessary fields. The system has alerts for both required data and discretionary or informational data.
- **Statpack** This reporting module gives statewide, district, county, and office-level aggregate statistics on all child welfare incidents for certain activities.
- **CARD** This confidential report provides DFS staff with information on an individual child and family.

DFS reviews CPS through the state CFSR

Since late 2004, DFS has worked closely with the CRP to conduct state CFSRs. These annual reviews are a replica of, and supplement to, the federal CFSR, entailing a series of highly-structured case file reviews. State CFSRs focus on a target child and family, with each case consisting of one or more incidents reported to DFS during a specified period of time.

State CFSR reviews are complex, time consuming, and expensive.

To date, the CRP and DFS have completed four cycles of the state CFSR and have reviewed over 400 child welfare cases, about half of which have been CPS cases. DFS quality assurance and field office staff assist with these reviews by drawing case samples from each office, performing or monitoring the reviews, and analyzing the data. Due to the size and complexity of these reviews, working with the state CFSRs is the focal point of almost all DFS quality assurance activities.

The state CFSR process covers 7 outcomes with 23 different casework items that focus on child safety, permanency, and wellbeing. Outcomes use multiple data points to gauge DFS compliance and performance with child welfare casework requirements, each scored individually. Figure 7.1 lists the outcomes and items scored for the reviews.

Figure 7.1

State CFSR evaluation instrument
Outcomes and items measured

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect
Item 1 – Timelines of initiating investigations of reports of child maltreatment
Item 2 – Repeat maltreatment
Safety Outcome 2: Children are safely maintained in their home whenever possible and appropriate
Item 3 – Services to family to protect child(ren) in home and prevent removal
Item 4 – Risk of harm to child(ren)

Permanency Outcome 1: Children have permanency and stability in their living situations
Item 5 – Foster care re-entries
Item 6 – Stability of foster care placement
Item 7 – Permanency goal for child
Item 8 – Reunification, guardianship, or permanent placement with relatives
Item 9 – Adoption
Item 10 – Permanency goal of other planned permanent living arrangement
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children
Item 11 – Proximity of foster care placement
Item 12 – Placement with siblings
Item 13 – Visiting with parents and siblings in foster care
Item 14 – Preserving connections
Item 15 – Relative placement
Item 16 – Relationship of child in care with parents

Wellbeing Outcome 1: Families have enhanced capacity to provide for their children's needs
Item 17 – Needs and services of child, parents, foster parents
Item 18 – Child and family involvement in case planning
Item 19 – Worker visits with child
Item 20 – Worker visits with parent(s)
Wellbeing Outcome 2: Children receive appropriate services to meet their educational needs
Item 21 – Educational needs of the child
Wellbeing Outcome 3: Children receive adequate services to meet their physical and mental health needs
Item 22 – Physical health of the child
Item 23 – Mental health of the child

Source: LSO summary from DFS-CRP documents.

Individual items receive ratings of "an area of strength" or "an area needing improvement." An additional step incorporates interviews with system stakeholders and family members, which help to enhance understanding of a case. DFS uses this review process to help gauge expected compliance (termed "substantial conformity" at the federal level) with the federal CFSR performance benchmarks. Caseworkers travel to other offices to participate in these reviews each review, giving them opportunity to share ideas and improve practices.

State CFSR focus does not complete DFS quality assurance responsibilities

Assurances that CPS procedures are fair and efficient remain important.

Daily, caseworkers make important decisions about whether and how government should intervene in families' lives for the purpose of child protection. The agency and the public need assurances that CPS procedures at all stages are effective, efficient, and fair. According to DFS officials, the CRP annual report acts as the agency's own quality assurance annual report.

DFS has already acknowledged CPS process studies are needed.

However, the CRP reports do not address DFS problems alone, or concern only CPS issues; they focus on systemic issues such as challenges with the legal system, and only some recommendations directly affect CPS processes and practices. On an intermittent basis, DFS staff examine some CPS-related processes. Examples include a limited analysis of the prevention track when it was relatively new, and brief studies of methamphetamine use among child welfare families, children of incarcerated parents, and placement episodes.

State CFSR shortcomings point to need for other review methods

In order to assess how fully state CFSRs fulfill the DFS quality assurance responsibility, we participated in the state CFSR process. We concluded that although the state CFSR is a good foundation from which DFS can provide some assurance of program quality, it is not by itself sufficient. Despite the strengths of the state CFSR, it will take additional components to fulfill the institutional research recommendation of our 1999 report.

CFSR is a complicated, limited review method

We were trained in how to score the state CFSR instrument, but despite the training and having reasonable background knowledge, we have three-concerns about how complicated, cumbersome, and incomplete this process is. Unless a citizen reviewer is very well-versed in CPS terms and concepts, it is a challenge to grasp CPS policy and casework requirements. Also, each office's organization of hard copy case files is different, and the review timeframe of a few hours is too short to gain full understanding of larger cases with multiple incidents. We think this may cause third-party citizen reviewers to rely too heavily on the DFS personnel on each team.

State CFSR citizen reviewers may rely too heavily on DFS personnel.

The state CFSR period under review is short, covering approximately the most recent year of a family's DFS involvement, while many case files reviewed include all reports and contacts with DFS over time. Families tend to come in and out of the system frequently, and the one incident or one year of it covered by a state CFSR review may not give a full picture. This is borne out by results of our sample review: the median investigation case (from first through final incident) lasted about 2.5 years and involved four distinct incidents. Finally, since the review focuses on outcomes for all types of child welfare cases, it does not review CPS-specific processes such as track assignments and their effectiveness.

Many families cycle in and out of the system beyond the state CFSR's "period under review" criterion.

System professionals debate possible flaws in the federal CFSR process

The CFSR does not appear to be a temporary review process at either the federal or state level. However, professionals in the child protection field have concerns about its methodology: small sample size and cases taken from only a few offices; samples are really not as "random" as stated since families must agree to be reviewed and interviewed; and many reviewers are professionals working in the system, so may be inherently subjective and sympathetic toward the agency. Wyoming's state CFSR overcomes some of these concerns by sampling cases from every office and performing reviews annually. Nevertheless, such concerns suggest that DFS needs to complement the state CFSR with other reviews and measurements.

CFSR shortcomings suggest other program review methods are needed.

DFS can build additional review capacity

Greater data analysis can help DFS oversight boards refine their purposes.

State managers currently have little information on what local protocols either enhance or detract from policy and practice requirements. To date, the state's own process studies have been irregular, performed when state-level staff have the time or expertise. Moreover, both the DFS Advisory Board and the Interagency Children's Collaborative appear to be at cross-roads. From interviews we found that these boards intend to re-define their work with respect to CPS; both wish to complement instead of duplicate the state CFSR process. DFS is in a position to help these boards refine their missions by recommending more targeted study areas identified through data analysis.

Recommendation: DFS should continue to expand quality assurance efforts with CPS casework and administrative process reviews.

DFS should incorporate CPS process evaluations into their program improvement plan for the federal CFSR.

We acknowledge the significant contribution the state CFSR process has made to DFS quality assurance since our report in 1999, and it is a positive move to include citizen participation through the CRP. Yet these efforts do not fully meet our 1999 recommendation to include consistent and rigorous analyses of CPS casework and administrative processes, as distinct from delinquency or CHINS casework. To complement the state CFSR, DFS needs to integrate ongoing evaluations of CPS processes into its quality assurance program.

CHAPTER 8

Conclusion

CPS remains a controversial and "noisy" business despite DFS progress.

In our 1999 evaluation of *Child Protective Services,* we noted that child protection is one of the most controversial functions of state government. Daily, caseworkers confront the dilemma of needing to protect children from abuse and neglect, while often trying to reunite them with neglectful or abusive families. As one DFS administrator said, "Some of the cases we deal with really do require the wisdom of Solomon. The families don't know what to do. The judges don't know what to do." Another stakeholder told us, "Everyone feels competent to offer an opinion on [CPS] work … Even if the system was perfect, it would still be noisy; this will never be a quiet business."

CPS is more transparent, data driven, and family focused than in 1999.

These circumstances have not changed since our 1999 evaluation and likely never will, but DFS has made considerable progress in the intervening nine years. CPS is moving toward greater transparency with changes such as the multiple response system, the family-centered practice model, analysis of WYCAPS data, and the quality assurance tool of the state CFSR. DFS maintains these are the fundamental pieces of a strong foundation for a CPS system, one that has yet to fully mature.

Setting aside systemic issues that are beyond one agency's control, DFS can do more to continue improving its own processes. We expect DFS to remain dedicated to the track system for screening and accepting CA/N reports, but we are concerned that as currently used, it is not a truly differentiated response system. DFS needs to ensure that workers are tracking all accepted reports, and that supervisors are consistently adhering to policy when assigning tracks. We also recommend that DFS give heightened scrutiny to cases in which families have had multiple incidents.

For the most serious CA/N reports, workers need to do a better job of documenting and summarizing their investigations. DFS should also put more emphasis on ensuring the safety of children who remain in their homes after substantiated reports, by

Serious CA/N reports need greater safety assurances for children remaining at home.

clarifying policies regarding safety and risk assessments, by conducting in-home visits with these families, and with follow-up contact after incidents are closed. It needs to diligently scrutinize central registry reports that individuals are "under investigation." Finally, we believe DFS still has work to do to meet our 1999 recommendation that it systematically evaluate CPS casework and administrative processes for its own management purposes.

AGENCY RESPONSE

Wyoming Child Protective Services

STATE OF WYOMING
DEPARTMENT OF FAMILY SERVICES
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Tony Lewis, Director

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Memorandum

To: The Honorable John Schiffer, Chairman
Management Audit Committee

From: Tony Lewis, Director

Date: September 2, 2008

Re: Agency Response to Child Protective Services Audit

Ref: TL – 08- 155

INTRODUCTION

The Department of Family Services (DFS) would like to acknowledge the time, effort and thoughtful analysis dedicated by the LSO staff to child protective services in its August 2008 Evaluation. We appreciate the careful review of CPS data, practice and finances, and we believe the recommendations are well focused and well-considered.

As the report notes, even though the goal of protecting children's health, safety and welfare is straightforward, the laws, rules and policy guiding child protective services are complex and imprecise. Moreover, the complexity of practice for social workers is compounded by the overlapping authorities of law officers, prosecuting attorneys, judges and health professionals. DFS caseworkers investigate reports of abuse with or without law enforcement and substantiate abuse or neglect. Police officers and physicians can also make inquiry and take physical custody of a child (DFS cannot). Locally-elected prosecutors decide whether to prosecute abuse or neglect and often set expectations for how local DFS and law enforcement should interact or respond to reports. Local multi-disciplinary teams make formal recommendations to the court, and the district or juvenile court judge makes the final decision whether to remove a child from the home and where the child is to be placed.

Given this landscape of sometimes competing interests and responsibilities, it is perhaps surprising that Wyoming is consistently one of the States that removes the most children from

families. Although comparisons can be misleading, Wyoming typically ranks high nationally in rates of removal both for child abuse and neglect (CA/N) and juvenile justice.

DFS data does not lend itself to any convenient statewide explanation. Explanations on a county level, however, are more revealing. Wyoming's highest rates of CPS placement occur in Platte, Natrona, Carbon, Sweetwater and Campbell counties, which are all well over twice the national placement average. Generally, close to two-thirds of Wyoming counties are at or below the national average, with Teton, Park and Uinta Counties placing children at about one-third the national rate. At the same time, safety measures are high and child mortality rates are not unusual in these counties.

What seems apparent looking at different child welfare data in different counties is that service structures have evolved to meet different demands. Counties that have experienced the biggest growth due to the mineral industry seem to rely more on crisis care and secure placement. Counties that have experienced slower growth, tend to place fewer children in out-of-home care and rely on community-based services. Counties that are beginning to struggle with growth, such as Converse, Carbon and Sublette, are experiencing demand for group home, family foster care and residential treatment services.

With these regional factors in mind, Wyoming's challenge in child protection seems straight forward. Unquestionably, child protective service practice and quality assurance need to get ahead of the game, and better non-secure services need to be developed in hard hit communities. In particular, CA/N cases need earlier and more intensive evaluation, as the audit suggests. Similar to the state's challenge in juvenile justice, DFS also needs to help struggling communities plan for and cultivate better local services and interventions.

RESPONSES:

RECOMMENDATION 1:
DFS should seek statutory change to allow supervisors more time before assigning tracks.

RESPONSE:
Partially Agree

DFS strongly agrees that supervisors need more time to evaluate and assign cases to proper tracks, though the agency does not agree it is necessary to revise statutes to accomplish this task. DFS, under the authority of existing statutes, can develop policies and guidance that will be more specific and provide better training and oversight. DFS intends to develop new policy in this regard and complete training by June 30, 2009.

The agency will also cooperate in statutory revision, should the Management Audit Committee so direct.

RECOMMENDATION 2:
DFS should evaluate its track system to determine how to make it work as envisioned, or request it repeal.

RESPONSE:
Partially Agree

DFS recognizes the need to evaluate the track system and make needed changes, though it does not believe that repeal of the track system is in the best interests of Wyoming children and families.

The multiple track response system is currently the nation's best practice model, given increasingly large volumes of child abuse and neglect reports, growing caseloads involving complex problems, and limited resources (Child Welfare Information Gateway, Children's Bureau/ACYF February 2008). The multiple track response system allows more flexibility in responding to child abuse and neglect reports, recognizing an adversarial focus is neither needed nor helpful for all cases. Understanding the family issues that lie beneath maltreatment reports and engaging families more effectively to use services to address their specific needs, can often be more productive in the long run than simply removing a child form the home. As the LSO's preliminary audit recommendation suggests, matching services to the needs of individual families -- while ensuring child safety – depends on a thorough evaluation and/or investigation of a family's relevant circumstances.

DFS will provide training to supervisors and caseworkers in regards to changes in policy and practice. After DFS provides training to supervisors and caseworkers, DFS will re-evaluate the track system and projects to have that evaluation complete by December, 2009.

RECOMMENDATION 3:
DFS should require caseworkers to prepare investigative plans or use a standardized investigation checklist.

RESPONSE:
Agree

DFS agrees caseworkers must prepare and execute CA/N investigations more effectively, and that pre-planning outlines, checklists and other tools will help standardize performance and lead to better management evaluation. A provision currently exists in DFS Policy 3.6 "Investigative Track", which provides guidance regarding the steps that need to be taken during an investigation and explains the rationale for conducting investigation by policy. However, DFS has not developed a standardized check list or methods for monitoring more uniform performance from county to county.

The Protective Services Division will take the following action steps to comply with this recommendation:

1. DFS will work with the field supervisors and managers to evaluate and implement tools, such as checklists, that will lead to more uniform planning, performance and evaluation of investigations.
2. The Protective Services Division will evaluate its current training and provide opportunities for case workers to attend trainings offered by various training agencies statewide to enhance their skills and increase specialization.

RECOMMENDATION 4:
DFS should require caseworkers to prepare evidence summaries after each investigation.

RESPONSE:
Agree

DFS agrees a detailed professional investigative report is essential to generate evidence summaries after each investigation which documents the findings. Investigative reports are often needed in court hearings, and are equally essential in the development of the case plan for the family. DFS proposes to take the following action to address this finding:

1. Regular trainings are scheduled to enhance the supervisors' skills to provide better supervision throughout the investigative process.
2. The Protective Services Division will provide on-site training regarding quality evidence summaries, to every CPS District.
3. DFS will evaluate the quality of evidence summaries over the next 12 months.

RECOMMENDATION 5:
DFS should be vigilant in "under investigation" central registry checks.

RESPONSE:
Agree

DFS agrees that it must continue to be vigilant in conducting Central Registry checks to ensure that names are appropriately released.

DFS recognizes the need to create a better data management process for the Central Registry. In order to develop this process, DFS will determine if changes to the current WYCAPS system are feasible or if the changes will need to be integrated into the next generation data system. DFS anticipates completing this up-front analysis of WYCAPS within the next 12 months. DFS will continue to evaluate and improve its standardized procedure to verify information prior to release.

RECOMMENDATION 6:
DFS should ensure notification of substantiated persons takes place and is properly documented.

RESPONSE:
Agree

The LSO audit noted that 5 people, who were not notified their names would be placed on the central registry, were not reported to employers due to lack of proper notification. DFS agrees notification must be done in all instances of investigated cases of abuse and neglect. This is required by law as a due process issue and is essential where refusal of employment is a possible result of an affirmative report.

DFS will assure notice is emphasized in the CORE training presented to all new case workers. It will moreover assure that supervisors are provided refresher training on the fundamental right to notice.

The LSO audit noted that 55 cases on the Central Registry were not reported to employers because there was not sufficient supporting documentation (see page 44). DFS has information documenting the majority of these names were entered on the Central Registry in the 1990's and 1980's, prior to WYCAPS and when policy allowed for the file to be destroyed after five years of inactivity.

We recognize the conversion of data from the old system to WYCAPS is insufficient and must routinely be validated by the field office. In addition, the retention schedule for CPS cases was revised near 1999 and now requires that CPS files be retained for a period of 99 years. To help ensure files are appropriately retained, supervisors will be provided follow-up training on file retention schedules.

RECOMMENDATION 7:
DFS must balance family-centered practice with ensuring child safety by clarifying policies in key areas, and setting electronic alerts to prompt caseworkers to make visits to children in in-home services incidents.

RESPONSE:
Partially Agree

DFS strongly agrees that child safety is a critical component of family-centered practice. While family centered practice may favor family preservation, it does not ignore serious safety needs. DFS has recently completed the design of its family-centered service model and is in the process of refining, retraining, and evaluating its implementation. Policy was modified to incorporate family-centered practice principles, with emphasis on all of the family members, and include emphasis on safety of all children. The current policy will be reviewed and updated to emphasize child safety is a priority.

Technical assistance is available to all Districts which can be provided on-site or through use of video conferencing as efforts are made to reduce out-of-home placements by working with the family, community service providers, schools, law enforcement and others who can assist with the case.

DFS agrees it must create a standardized methodology for tracking and monitoring contact between DFS caseworkers and children and families served within the in-home services population. Although DFS recognizes the importance of creating and implementing a process for monitoring contact for in-home services incidents, the agency believes developing a report that identifies incidents within the in-home services population that have not received contact in the current month and making the report available through the CARD reporting system would be a better strategy than creating additional WYCAPS alerts. Creating a report on the CARD database adds additional flexibility in reporting that is not available through WYCAPS and can be accomplished with considerably fewer resources. DFS anticipates completing the development of the report by spring of 2009.

RECOMMENDATION 8:
DFS should continue to expand quality assurance efforts with CPS casework and administrative process reviews.

RESPONSE:
Agree

DFS agrees there has been significant progress in the area of quality assurance, and it also agrees quality assurance activities should include areas beyond those measured in the state administered Mini-Child and Family Services Review (CFSR). DFS is currently in the process of evaluating and revising its quality assurance system and specifically the Mini-CFSR process it conducts throughout the state.

DFS believes the state level Mini-CFSR is a valuable process that produces much needed information on the performance of each DFS office; however DFS believes it can make better use of the information gathered from this process to create the necessary changes in practice to improve outcomes. As part of the aforementioned revisions to the state administered Mini-CFSR review process, DFS intends to require the development of more formal program improvement plans from each of the DFS offices reviewed. DFS believes through this more formal local planning process, the specific process and policy issues can be assessed, evaluated, and resolved.

As noted in the report, DFS has expanded its ability to analyze and interpret internal and external data and has greatly increased its reporting capacity since the 1999 LSO CPS audit. Although there has been considerable improvement in this area, DFS believes it can make better use of the data it currently collects for the purpose of monitoring compliance with CPS policy and procedure. DFS believes it can expand its current reporting capabilities to include reports to measure activities such as timeliness of investigation, completion of required safety and risk assessments, and frequency of contact between DFS caseworkers and children and families. DFS believes better utilization of existing data will be a valuable component in addressing the issues outlined within this recommendation.

Beyond the need to expand reporting capacity and monitoring, DFS agrees it needs to engage in more frequent and thorough analysis of specific practice, resource, and policy issues that impact services or the attainment of agency goals. DFS envisions using the findings from the state Mini-CFSR review process, the federal CFSR findings, and findings from related reports and audits to establish and prioritize a research agenda. By conducting specific analysis on the underlying issues that determine outcomes, DFS believes it will be able to make better informed decisions regarding resource allocation and develop more targeted strategies designed to improve outcomes for the families we serve.

The Honorable John Schiffer
September 2, 2008

APPENDICES

Wyoming Child Protective Services

APPENDIX A

Selected statutes

TITLE 14 – CHILDREN
CHAPTER 3 – PROTECTION
ARTICLE 2 - CHILD PROTECTIVE SERVICES

14-3-201. Purpose.

The purpose of W.S. 14-3-201 through 14-3-216 is to delineate the responsibilities of the state agency, other governmental agencies or officials, professionals and citizens to intervene on behalf of a child suspected of being abused or neglected, to protect the best interest of the child, to further offer protective services when necessary in order to prevent any harm to the child or any other children living in the home, to protect children from abuse or neglect which jeopardize their health or welfare, to stabilize the home environment, to preserve family life whenever possible and to provide permanency for the child in appropriate circumstances. The child's health, safety and welfare shall be of paramount concern in implementing and enforcing this article.

14-3-202. Definitions.

(a) As used in W.S. 14-3-201 through 14-3-216:

(i) "A person responsible for a child's welfare" includes the child's parent, noncustodial parent, guardian, custodian, stepparent, foster parent or other person, institution or agency having the physical custody or control of the child;

(ii) "Abuse" means inflicting or causing physical or mental injury, harm or imminent danger to the physical or mental health or welfare of a child other than by accidental means, including abandonment, unless the abandonment is a relinquishment substantially in accordance with W.S. 14-11-101 through 14-11-109, excessive or unreasonable corporal punishment, malnutrition or substantial risk thereof by reason of intentional or unintentional neglect, and the commission or allowing the commission of a sexual offense against a child as defined by law:

(A) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in his ability to function within a normal range of performance and behavior with due regard to his culture;

(B) "Physical injury" means any harm to a child including but not limited to disfigurement, impairment of any bodily organ, skin bruising if greater in magnitude than minor bruising associated with reasonable corporal punishment, bleeding, burns, fracture of any bone, subdural hematoma or substantial malnutrition;

(C) "Substantial risk" means a strong possibility as contrasted with a remote or insignificant possibility;

(D) "Imminent danger" includes threatened harm and means a statement, overt act, condition or status which represents an immediate and substantial risk of sexual abuse or physical or mental injury. "Imminent danger" includes violation of W.S. 31-5-233(m).

(iii) "Child" means any person under the age of eighteen (18);

(iv) "Child protective agency" means the field or regional offices of the department of family services;

(v) "Court proceedings" means child protective proceedings which have as their purpose the protection of a child through an adjudication of whether the child is abused or neglected, and the making of an appropriate order of disposition;

(vi) "Institutional child abuse and neglect" means situations of child abuse or neglect where a foster home or other public or private residential home, institution or agency is responsible for the child's welfare;

(vii) "Neglect" means a failure or refusal by those responsible for the child's welfare to provide adequate care, maintenance, supervision, education or medical, surgical or any other care necessary for the child's well being. Treatment given in good faith by spiritual means alone, through prayer, by a duly accredited practitioner in

accordance with the tenets and practices of a recognized church or religious denomination is not child neglect for that reason alone;

(viii) "State agency" means the state department of family services;

(ix) "Subject of the report" means any child reported under W.S. 14-3-201 through 14-3-216 or the child's parent, guardian or other person responsible for the child's welfare;

(x) "Unsubstantiated report" means any report made pursuant to W.S. 14-3-201 through 14-3-216 that, upon investigation, is not supported by a preponderance of the evidence;

(xi) "Substantiated report" means any report of child abuse or neglect made pursuant to W.S. 14-3-201 through 14-3-216 that, upon investigation, is supported by a preponderance of the evidence;

(xv) "Collaborative" means the interagency children's collaborative created by W.S. 14-3-215;

(xvi) "Department" means the state department of family services and its local offices;

(xvii) "Transportation" means the provision of a means to convey the child from one place to another by the custodian or someone acting on his behalf in the performance of required duties, but does not require the state to provide incidental travel or to purchase a motor vehicle for the child's own use to travel.

14-3-203. Duties of state agency; on-call services.

(a) The state agency shall:

(i) Administer W.S. 14-3-201 through 14-3-215;

(ii) Be responsible for strengthening and improving state and community efforts toward the prevention, identification and treatment of child abuse and neglect in the state; and

(iii) Refer any person or family seeking assistance in meeting child care responsibilities, whether or not the problem presented by the person or family is child abuse or neglect, to appropriate community resources, agencies, services or facilities.

(iv) Repealed By Laws 2005, ch. 236, § 4.

(b) The state agency may contract for assistance in providing on-call services. The assistance may include screening protection calls, making appropriate referrals to law enforcement and the agency, and maintaining a record of calls and referrals. Contractors shall have training in child protection services.

(c) The state agency shall ensure that all child protective service workers are trained:

(i) In the principles of family centered practice that focus on providing services to the entire family to achieve the goals of safety and permanency for children, including balancing the best interests of children with the rights of parents;

(ii) In the duty of the workers to inform the individual subject to a child abuse or neglect allegation, at the earliest opportunity during the initial contact, of the specific complaints or allegations made against the individual;

(iii) Concerning constitutional and statutory rights of children and families from and after the initial time of contact and the worker's legal duty not to violate the constitutional and statutory rights of children and families from and after the initial time of contact;

(iv) To know the state's legal definitions of physical abuse, sexual abuse, neglect, dependency and endangerment;

(v) To know the provisions of federal and state laws governing child welfare practice, including but not limited to the Adoption and Safe Families Act, Indian Child Welfare Act, Multi-Ethnic Placement Act and the Child Abuse Prevention and Treatment Act, as amended.

14-3-204. Duties of local child protective agency.

(a) The local child protective agency shall:

(i) Prepare a plan for child protective services under guidelines prepared by the state agency, and provide services under the plan to prevent further child abuse or neglect. The plan shall be reviewed annually by both agencies;

(ii) Receive, assess, investigate or arrange for investigation and coordinate investigation or assessment of all reports of known or suspected child abuse or neglect;

(iii) Within twenty-four (24) hours after notification of a suspected case of child abuse or neglect, initiate an investigation or assessment and verification of every report. The representative of the child protective agency shall, at the initial time of contact with the individual subject to a child abuse and neglect investigation or assessment, advise the individual of the specific complaints or allegations made against the individual. A thorough investigation or assessment and report of child abuse or neglect shall be made in the manner and time prescribed by the state agency pursuant to rules and regulations adopted in accordance with the Wyoming Administrative Procedure Act. If the child protective agency is denied reasonable access to a child by a parent or other persons and the agency deems that the best interest of the child so requires, it shall seek an appropriate court order by ex parte proceedings or other appropriate proceedings to see the child. The child protective agency shall assign a report:

(A) For investigation when allegations contained in the report indicate:

(I) That criminal charges could be filed, the child appears to be in imminent danger and it is likely the child will need to be removed from the home; or

(II) A child fatality, major injury or sexual abuse has occurred.

(B) For assessment when the report does not meet the criteria of subparagraph (A) of this paragraph.

(iv) If the investigation or assessment discloses that abuse or neglect is present, initiate services with the family of the abused or neglected child to assist in resolving problems that lead to or caused the child abuse or neglect;

(v) If the child protective agency is able through investigation to substantiate a case of abuse or neglect, it shall notify the person suspected of causing the abuse or neglect of his right to request a hearing pursuant to the Wyoming Administrative Procedure Act;

(vi) Make reasonable efforts to contact the noncustodial parent of the child and inform the parent of substantiated abuse or neglect in high risk or moderate risk cases as determined pursuant to rules and regulations of the state agency and inform the parent of any proposed action to be taken;

(vii) Cooperate, coordinate and assist with the prosecution and law enforcement agencies;

(viii) When the best interest of the child requires court action, contact the county and prosecuting attorney to initiate legal proceedings and assist the county and prosecuting attorney during the proceedings. If the county attorney elects not to bring court action the local child protective agency may petition the court for appointment of a guardian ad litem who shall act in the best interest of the child and who may petition the court to direct the county attorney to show cause why an action should not be commenced under W.S. 14-3-401 through 14-3-439; and

(ix) Refer a child receiving department services who is under the age of six (6) years to the department of health, division of developmental disabilities preschool program for educational and developmental screening and assessment.

14-3-205. Child abuse or neglect; persons required to report.

(a) Any person who knows or has reasonable cause to believe or suspect that a child has been abused or neglected or who observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, shall immediately report it to the child protective agency or local law enforcement agency or cause a report to be made.

(b) If a person reporting child abuse or neglect is a member of the staff of a medical or other public or private institution, school, facility or agency, he shall notify the person in charge or his designated agent as soon as possible, who is thereupon also responsible to make the report or cause the report to be made. Nothing in this subsection is intended to relieve individuals of their obligation to report on their own behalf unless a report has already been made or will be made.

(c) Any employer, public or private, who discharges, suspends, disciplines or penalizes an employee solely for making a report of neglect or abuse under W.S. 14-3-201 through 14-3-216 is guilty of a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars ($750.00), or both.

(d) Any person who knowingly and intentionally makes a false report of child abuse or neglect, or who encourages or coerces another person to make a false report of child abuse or neglect, is guilty of a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars ($750.00), or both.

14-3-206. Child abuse or neglect; written report; statewide reporting center; documentation; costs and admissibility thereof.

(a) Reports of child abuse or neglect or of suspected child abuse or neglect made to the local child protective agency or local law enforcement agency shall be:

(i) Conveyed immediately by the agency receiving the report to the appropriate local child protective agency or local law enforcement agency. The agencies shall continue cooperating and coordinating with each other during the investigation; and

(ii) Followed by a written report by the receiving agency confirming or not confirming the facts reported. The report shall provide to law enforcement or the local child protective agency the following, to the extent available:

(A) The name, age and address of the child;

(B) The name and address of any person responsible for the child's care;

(C) The nature and extent of the child's condition;

(D) The basis of the reporter's knowledge;

(E) The names and conditions of any other children relevant to the report;

(F) Any evidence of previous injuries to the child;

(G) Photographs, videos and x-rays with the identification of the person who created the evidence and the date the evidence was created; and

(H) Any other relevant information.

(b) The state agency may establish and maintain a statewide reporting center to receive reports of child abuse or neglect on a twenty-four (24) hour, seven (7) day week, toll free telephone number. Upon establishment of the service, all reports of child abuse or neglect may be made to the center which shall transfer the reports to the appropriate local child protective agency.

(c) Any person investigating, examining or treating suspected child abuse or neglect may document evidence of child abuse or neglect to the extent allowed by law by having photographs taken or causing x-rays to be made of the areas of trauma visible on a child who is the subject of the report or who is subject to a report. The reasonable cost of the photographs or x-rays shall be reimbursed by the appropriate local child protective agency. All photographs, x-rays or copies thereof shall be sent to the local child protective agency, admissible as evidence in any civil proceeding relating to child abuse or neglect, and shall state:

(i) The name of the subject;

(ii) The name, address and telephone number of the person taking the photographs or x-rays; and

(iii) The date and place they were taken.

14-3-208. Temporary protective custody; order; time limitation; remedial health care.

(a) When a child is taken into temporary protective custody pursuant to W.S. 14-3-405(a) and (b), the person taking custody shall immediately notify the local department of family services office and place or transfer temporary protective custody to the local department of family services office as soon as practicable. The local department of family services office shall:

(i) Accept physical custody of the child;

(ii) Make reasonable efforts to inform the parent, noncustodial parent or other person responsible for the child's welfare that the child has been taken into temporary protective custody, unless otherwise ordered by a court of competent jurisdiction;

(iii) Arrange for care and supervision of the child in the most appropriate and least restrictive setting necessary to meet the child's needs, including foster homes or other child care facilities certified by the department or approved by the court. When it is in the best interest of the child, the department shall place the child with the child's noncustodial birth parent or with the child's extended family, including adult siblings, grandparents, great-grandparents, aunts or uncles. Prior to approving placement with the child's noncustodial birth parent or extended family, the department shall determine whether anyone living in the home has been convicted of a crime involving

serious harm to children or has a substantiated case listed on the central registry established pursuant to W.S. 14-3-213. The department may leave the child in the care of a physician or hospital when necessary to ensure the child receives proper care. A neglected child shall not be placed in a jail or detention facility other than for a delinquent act;

(iv) Initiate an investigation of the allegations; and

(v) Assess the child's mental and physical needs, provide for the child's ordinary and emergency medical care and seek emergency court authorization for any extraordinary medical care that is needed prior to the shelter care hearing.

(b) The law enforcement or medical provider shall promptly notify the court and the district attorney of any child taken into temporary protective custody and placed in its care pursuant to W.S. 14-3-405 without a court order.

(c) Temporary protective custody shall not exceed forty-eight (48) hours, excluding weekends and legal holidays.

(d) When the court orders the child into the legal custody of the department pursuant to W.S. 14-3-409(d) or 14-3-429, the department shall:

(i) Accept legal custody of the child;

(ii) Continue or arrange for, care, transportation and supervision of the child as provided in paragraph (a)(iii) of this section;

(iii) Assess the child's mental and physical health needs and provide for the child's ordinary and emergency medical care;

(iv) Arrange for the provision of the education of the child, including participation in individualized education or developmental services;

(v) Participate in multidisciplinary team meetings to develop treatment recommendations for the child;

Perform any other duties ordered by the court relating to the care or custody of the child.

(vi) Perform any other duties ordered by the court relating to the care or custody of the child.

14-3-211. Appointment of counsel for child and other parties.

(a) The court shall appoint counsel to represent any child in a court proceeding in which the child is alleged to be abused or neglected. Any attorney representing a child under this section shall also serve as the child's guardian ad litem unless a guardian ad litem has been appointed by the court. The attorney or guardian ad litem shall be charged with representation of the child's best interest.

(b) The court may appoint counsel for any party when necessary in the interest of justice.

14-3-212. Child protection teams; creation; composition; duties; records confidential. (excerpted)

(a) The state agency and the local child protective agency shall encourage and assist in the creation of child protection teams within the communities in the state. The purposes of the child protection teams shall be to identify or develop community resources to serve abused and neglected children within the community, to advocate for improved services or procedures for such children and to provide information and assistance to the state agency, local child protection agency and multidisciplinary teams, if a multidisciplinary team has been appointed. The department may promulgate reasonable rules and regulations in accordance with the Wyoming Administrative Procedure Act to define the roles and procedures of child protection teams.

14-3-213. Central registry of child protection cases; establishment; operation; amendment, expungement or removal of records; classification and expungement of reports; statement of person accused.

(a) The state agency shall establish and maintain a record of all child protection reports and a central registry of "under investigation" or "substantiated" child protection reports in accordance with W.S. 42-2-111.

(b) Through the recording of reports, the state agency's recordkeeping system shall be operated to enable the state agency to:

(i) Immediately identify and locate prior reports of cases of child abuse or neglect to assist in the diagnosis of suspicious circumstances and the assessment of the needs of the child and his family;

(ii) Continuously monitor the current status of all pending child protection cases;

(iii) Regularly evaluate the effectiveness of existing laws and programs through the development and analysis of statistical and other information; and

(iv) Maintain a central registry of "under investigation" reports and "substantiated" reports of child abuse or neglect for provision of information to qualifying applicants pursuant to W.S. 14-3-214(f).

(c) Upon good cause shown and upon notice to the subject of an "under investigation" or "substantiated" report, the state agency may list, amend, expunge or remove any record from the central registry in accordance with rules and regulations adopted by the state agency.

(d) All reports of child abuse or neglect contained within the central registry shall be classified in one (1) of the following categories:

(i) "Under investigation"; or

(ii) "Substantiated".

(e) Within six (6) months all reports classified as "under investigation" shall be reclassified as "substantiated" or expunged from the central registry, unless the state agency is notified of an open criminal investigation or criminal prosecution. Unsubstantiated reports shall not be contained within the central registry.

(f) Any person named as a perpetrator of child abuse or neglect in any report maintained in the central registry which is classified as a substantiated report as defined in W.S. 14-3-202(a)(xi) shall have the right to have included in the report his statement concerning the incident giving rise to the report. Any person seeking to include a statement pursuant to this subsection shall provide the state agency with the statement. The state agency shall provide notice to any person identified as a perpetrator of his right to submit his statement in any report maintained in the central registry.

14-3-214. Confidentiality of records; penalties; access to information; attendance of school officials at interviews; access to central registry records pertaining to child protection cases.

(a) All records concerning reports and investigations of child abuse or neglect are confidential except as provided by W.S. 14-3-201 through 14-3-215. Any person who willfully violates this subsection is guilty of a misdemeanor and upon conviction shall be fined not more than five hundred dollars ($500.00) or imprisoned in the county jail not more than six (6) months, or both.

(b) Applications for access to records concerning child abuse or neglect contained in the state agency or local child protective agency shall be made in the manner and form prescribed by the state agency. Upon appropriate application, the state agency shall give access to any of the following persons or agencies for purposes directly related with the administration of W.S. 14-3-201 through 14-3-216:

(i) A local child protective agency;

(ii) A law enforcement agency, guardian ad litem, child protection team or the attorney representing the subject of the report;

(iii) A physician or surgeon who is treating an abused or neglected child, the child's family or a child he reasonably suspects may have been abused or neglected;

(iv) A person legally authorized to place a child in protective temporary custody when information in the report or record is required to determine whether to place the child in temporary protective custody;

(v) A person responsible for the welfare of the child;

(vi) A court or grand jury upon a showing that access to the records is necessary for the determination of an issue, in which case access shall be limited to in camera inspection unless the court finds public disclosure is necessary;

(vii) Court personnel who are investigating reported incidents of child abuse or neglect;

(viii) An education or mental health professional serving the child, if the state agency determines the information is necessary to provide appropriate educational or therapeutic interventions.

(c) A physician or person in charge of an institution, school, facility or agency making the report shall receive, upon written application to the state agency, a summary of the records concerning the subject of the report.

(d) Any person, agency or institution given access to information concerning the subject of the report shall not divulge or make public any information except as required for court proceedings.

(e) Nothing in W.S. 14-3-201 through 14-3-215 prohibits the attendance of any one (1) of the following at an interview conducted on school property by law enforcement or child protective agency personnel of a child suspected to be abused or neglected provided the person is not a subject of the allegation:

(i) The principal of the child's school or his designee; or

(ii) A child's teacher or, counselor, or specialist employed by the school or school district and assigned the duties of monitoring, reviewing or assisting in the child's welfare in cases of suspected child abuse or neglect.

(f) Upon appropriate application, the state agency shall provide to any chapter of a nationally recognized youth organization, child caring facility certified under W.S. 14-4-101 et seq., public or private school or state institution for employee or volunteer screening purposes a summary of central registry records maintained under state agency rules since December 31, 1986, for purposes of screening employees or volunteers. The state agency shall provide the results of the records check to the applicant by certified mail if the records check confirms the existence of a report "under investigation" or a "substantiated" finding of abuse or neglect. Otherwise, the state agency shall provide the results of the records check to the applicant by United States mail. The written results shall confirm that there is a report "under investigation", a "substantiated" finding of abuse or neglect on the central registry naming the individual or confirm that no record exists. When the individual is identified on the registry as a "substantiated" perpetrator of abuse or neglect, the report to the applicant shall contain information with respect to the date of the finding, specific type of abuse or neglect, a copy of the perpetrator's voluntary statement and whether an appeal is pending. The applicant shall submit a fee of ten dollars ($10.00) and proof satisfactory to the state agency that the prospective or current employee or volunteer whose records are being checked consents to the release of the information to the applicant. The applicant shall use the information received only for purposes of screening prospective employees and volunteers who may, through their employment or volunteer services, have unsupervised access to minors. Applicants, their employees or other agents shall not otherwise divulge or make public any information received under this section. The state agency shall notify any applicant receiving information under this subsection of any subsequent reclassification of the information pursuant to W.S. 14-3-213(e). The state agency shall screen all prospective agency employees in conformity with the procedure provided under this subsection.

(g) There is created a program administration account to be known as the "child and vulnerable adult abuse registry account". All fees collected under subsection (f) of this section shall be credited to this account.

14-3-215. Interagency children's collaborative.

(a) There is created an interagency children's collaborative. The collaborative shall be composed of:

(i) The director of the department of family services, or his designee;

(ii) The director of the department of health, or his designee;

(iii) The superintendent of public instruction, or his designee;

(iv) The director of the department of workforce services, or his designee; and

(v) The governor's appointee who shall represent families receiving services from the state agencies represented in paragraphs (i) through (iv) of this subsection.

(b) The department of family services shall adopt rules by July 1, 2005, to establish guidelines for review of case files of children in state custody as a result of any action commenced under this title. The rules shall be adopted by the department of family services with the advice of the departments of education, health and workforce services. In addition to providing for the review of cases and the progress made towards returning children in state custody to their homes, communities or other permanent placements, the guidelines shall provide specific processes for:

(i) Local multidisciplinary teams to voluntarily present case files to the collaborative for review;

(ii) The review of cases in which more than one (1) state agency provides services to the child and his family; and

(iii) The review of statewide availability and utilization of resources for children in state custody.

14-3-216. Other laws not superseded.

No laws of this state are superseded by the provisions of W.S. 14-3-201 through 14-3-216.

ARTICLE 4 - CHILD PROTECTION ACT

14-3-401. Short title.

This act shall be known and may be cited as the "Child Protection Act."

14-3-402. Definitions.

(a) As used in this act:

(i) "Adjudication" means a finding by the court or the jury, incorporated in a decree, as to the truth of the facts alleged in the petition;

(ii) "Adult" means an individual who has attained the age of majority;

(iii) "Child" means an individual who is under the age of majority;

(iv) "Clerk" means the clerk of a district court acting as the clerk of a juvenile court;

(v) "Commissioner" means a district court commissioner;

(vi) "Court" means the juvenile court established by W.S. 5-8-101;

(vii) "Custodian" means a person, institution or agency responsible for the child's welfare and having legal custody of a child by court order or having actual physical custody and control of a child and acting in loco parentis;

(viii) "Deprivation of custody" means transfer of legal custody by the court from a parent or previous legal custodian to another person, agency, organization or institution;

(ix) "Judge" means the judge of the juvenile court;

(x) "Legal custody" means a legal status created by court order which vests in a custodian the right to have physical custody of a minor, the right and duty to protect, train and discipline a minor, the duty to provide him with food, shelter, clothing, transportation, ordinary medical care, education and in an emergency, the right and duty to authorize surgery or other extraordinary medical care. The rights and duties of legal custody are subject to the rights and duties of the guardian of the person of the minor, and to residual parental rights and duties;

(xi) "Minor" means an individual who is under the age of majority;

(xii) "Neglected child" means a child:

(A) Who has been subjected to neglect as defined in W.S. 14-3-202(a)(vii);

(B) Who has been subjected to abuse as defined in W.S. 14-3-202(a)(ii).

(I)- (IV) Repealed By Laws 2005, ch. 236, § 4.

(xiii) "Parent" means either a natural or adoptive parent of the child, a person adjudged the parent of the child in judicial proceedings or a man presumed to be the father under W.S. 14-2-504;

(xiv) "Parties" include the child, his parents, guardian or custodian, the state of Wyoming and any other person made a party by an order to appear, or named by the juvenile court;

(xv) "Protective supervision" means a legal status created by court order following an adjudication of neglect, whereby the child is permitted to remain in his home subject to supervision by the department of family services, a county or state probation officer or other qualified agency or individual the court may designate;

(xvi) "Residual parental rights and duties" means those rights and duties remaining with the parents after legal custody, guardianship of the person or both have been vested in another person, agency or institution. Residual parental rights and duties include but are not limited to:

(A) The duty to support and provide necessities of life;

(B) The right to consent to adoption;

(C) The right to reasonable visitation unless restricted or prohibited by court order;

(D) The right to determine the minor's religious affiliation; and

(E) The right to petition on behalf of the minor.

(xvii) "Shelter care" means the temporary care of a child in physically unrestricting facilities pending court disposition or execution of a court order for placement or commitment;

(xviii) "Ordinary medical care" means medical, dental and vision examinations, routine medical, dental and vision treatment and emergency surgical procedures, but does not include nonemergency surgical procedures;

(xix) "Temporary protective custody" means a legal status created prior to a shelter care hearing when a court, law enforcement officer, physician, physician's assistant or nurse practitioner takes a child into protective custody pursuant to W.S. 14-3-405. Temporary protective custody vests in a custodian the duty to protect the child and arrange for the provision of food, shelter, clothing, transportation, ordinary medical care and education. Temporary protective custody shall be transferred from the law enforcement officer, physician, physician's assistant or nurse practitioner to the local child protection agency as soon as practicable to facilitate such care. Temporary protective custody divests the parent or custodian of his right to the custody and control of the child;

(xx) "Transportation" means as defined in W.S. 14-3-202(a)(xvii);

(xxi) "This act" means W.S. 14-3-401 through 14-3-440.

14-3-405. Taking of child into custody; when permitted.

(a) A child may be taken into custody by a law enforcement officer without a warrant or court order and without the consent of the parents, guardians or others exercising temporary or permanent control over the child when:

(i) There are reasonable grounds to believe a child is abandoned, lost, suffering from illness or injury or seriously endangered by his surroundings and immediate custody appears to be necessary for his protection; or

(ii) The child's conduct or behavior seriously endangers himself and immediate custody appears necessary.

(b) A child may be taken into temporary protective custody by a physician, physician's assistant or nurse practitioner without a warrant or court order and without the consent of the parents, guardians or others exercising temporary or permanent control over the child when the physician, physician's assistant or nurse practitioner treating the child, or a hospital in which the child is being treated, finds that there is reasonable cause to believe an imminent danger to the child's life, health or safety exists unless the child is taken into protective custody, whether or not additional medical treatment is required, and there is not time to apply for a court order.

(c) A district attorney may file an emergency petition, or the department of family services, a local law enforcement officer, an administrator of a hospital in which a child reasonably believed to have been abused or neglected is being treated, or any physician, physician's assistant or nurse practitioner who treated the child may request the court for a protective order. After considering the emergency petition or request, the judge or commissioner, upon finding that there is reasonable cause to believe that a child has been abused or neglected and that the child, by continuing in his place of residence or in the care and custody of the person responsible for his health, safety and welfare, would be in imminent danger of his life, health or safety, may:

(i) Issue an ex parte order or search warrant. The order shall place the child in the temporary protective custody of the local child protection agency;

(ii) Issue an emergency order or search warrant upon application and hearing, authorizing ordinary or emergency care of the child or authorizing a forensic examination to collect evidence.

(d) Temporary protective custody shall not exceed forty-eight (48) hours, excluding weekends and legal holidays.

(e) When necessary for the best interest or welfare of the child in temporary protective custody, a court may order medical or other necessary health care, including mental health and substance abuse care, notwithstanding the absence of a prior finding of child abuse or neglect.

14-3-411. Complaints alleging neglect; investigation and determination by district attorney.

Complaints alleging a child is neglected shall be referred to the office of the district attorney. The district attorney shall determine whether the best interest of the child requires that judicial action be taken. The department of family services and the county sheriff shall provide the district attorney with any assistance he may require in making an investigation. The district attorney shall prepare and file a petition with the court if he believes action is necessary to protect the interest of the child.

14-3-412. Commencement of proceedings; contents of petition.

(a) Proceedings in juvenile court are commenced by filing a petition with the clerk of the court. The petition and all subsequent pleadings, motions, orders and decrees shall be entitled "State of Wyoming, In the Interest of ...., minor." A petition shall be signed by the district attorney on information and belief of the alleged facts. All petitions must be verified.

(b) The petition shall set forth all jurisdictional facts, including but not limited to:

(i) The child's name, date of birth and address;

(ii) The names and addresses of the child's parents, guardian or custodian and the child's spouse, if any;

(iii) Whether the child is being held in shelter care and if so, the name and address of the facility and the time shelter care commenced;

(iv) A statement setting forth with particularity the facts which bring the child within the provisions of this act; and

(v) Whether the child is an Indian child as defined in the federal Indian Child Welfare Act and, if so, a statement setting forth with particularity the notice provided to the appropriate tribal court.

(c) The petition shall state if any of the facts enumerated in subsection (b) of this section are unknown.

14-3-425. Burden of proof required; verdict of jury; effect thereof.

(a) Allegations of conduct showing a child to be neglected must be proved by a preponderance of the evidence.

(b) If trial by jury is demanded, the jury shall decide issues of fact raised by the petition and return its verdict as to the truth of the allegations contained in the petition. A finding by the jury that the allegations are true is a determination that judicial intervention is necessary for the best interest and welfare of the child.

14-3-428. Abeyance of proceedings by consent decree; term of decree; reinstatement of proceedings; effect of discharge or completing term.

(a) At any time after the filing of a petition alleging a child to be neglected and before adjudication, the court may issue a consent decree ordering further proceedings held in abeyance. The placement of the child is subject to the terms, conditions and stipulations agreed to by the parties affected in accordance with W.S. 14-3-429. The consent decree shall not be entered without the consent of the district attorney, the child's guardian ad litem and the parents. Modifications to an existing consent decree may be allowed.

(b) The consent decree shall be in writing and copies given to all parties. The decree shall include the case plan for the family.

(c) A consent decree, if the child remains within the home, shall be in force for the period agreed upon by the parties unless sooner terminated by the court.

(d) If the child is placed outside the home, a consent decree shall be in force for the period agreed upon by the parties but not longer than six (6) months unless sooner terminated by the court. For good cause the court may grant one (1) extension of the consent decree for no longer than six (6) months.

(e) If a consent decree is in effect and the child is in placement, the court shall hold review hearings as provided by W.S. 14-3-431.

(f) If prior to discharge by the court or expiration of the consent decree, the parents or guardian of a child alleged to be neglected fail to fulfill the terms and conditions of the decree or a new petition is filed alleging the child to be neglected, the original petition and proceeding may be reinstated upon order of the court after hearing, and the court may proceed as though the consent decree had never been entered. If, as part of the consent decree, the parents or guardian made an admission to any of the allegations contained in the original petition, that admission shall be entered only if the court orders that the original petition and proceeding be reinstated and the admissions, if any, be entered. If the admission is entered, the court may proceed to disposition pursuant to W.S. 14-3-426.

(g) Parties discharged by the court under a consent decree without reinstatement of the original petition and proceeding shall not thereafter be proceeded against in any court for the same misconduct alleged in the original petition except concurrent criminal allegations or charges against a person accused to have abused or neglected a child shall not be affected by a consent decree.

14-3-429. Decree where child adjudged neglected; dispositions; terms and conditions; legal custody. (Excerpted)

(a) In determining the disposition to be made under this act in regard to any child:

(i) The court shall review the predisposition report, the recommendations, if any, of the multidisciplinary team, the case plan and other reports or evaluations ordered by the court and indicate on the record what materials were considered in reaching the disposition;

(ii) If the court does not place the child in accordance with the recommendations of the predisposition report or multidisciplinary team, the court shall enter on the record specific findings of fact relied upon to support its decision to deviate from the recommended disposition;

(iii) When a child is adjudged by the court to be neglected the court shall enter its decree to that effect and make a disposition as provided in this section that places the child in the least restrictive environment consistent with what is best suited to the public interest of preserving families and the physical, mental and moral welfare of the child;

(iv) When a child is adjudged to be neglected the court shall ensure that reasonable efforts were made by the department of family services to prevent or eliminate the need for removal of the child from the child's home or to make it possible for the child to return to the child's home. Before placing a child outside of the home, the court shall find by clear and convincing evidence that to return the child to the child's home would not be in the best interest of the child despite efforts that have been made;

(b) If the child is found to be neglected the court may:

(i) Permit the child to remain in the legal custody of his parents, guardian or custodian without protective supervision, subject to terms and conditions prescribed by the court;

(ii) Place the child under protective supervision;

(iii) Transfer temporary legal custody to a relative or other suitable adult the court finds qualified to receive and care for the child, with or without supervision, subject to terms and conditions prescribed by the court;

(iv) Transfer temporary legal custody to the department of family services or a state or local public agency responsible for the care and placement of neglected children, provided the child shall not be committed to the Wyoming boys' school, the Wyoming girls' school or the Wyoming state hospital.

14-3-440. Reasonable efforts for family reunification; exceptions.

(a) Except as provided in W.S. 14-2-309(b) or (c), reasonable efforts shall be made to preserve and reunify the family:

(i) Prior to placement of the child outside the home, to prevent or eliminate the need for removing the child from the child's home; and

(ii) To make it possible for the child to safely return to the child's home.

(b) In determining what reasonable efforts shall be made with respect to a child and in making those reasonable efforts, the child's health and safety shall be the paramount concern.

(c) Reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with the reasonable efforts described in subsection (a) of this section.

(d) If continuation of reasonable efforts described in subsection (a) of this section is determined to be inconsistent with the permanency plan for the child, reasonable efforts shall be made for placement of the child in a timely manner in accordance with the permanency plan, and to complete the steps necessary to finalize the permanent placement of the child.

(e) Reasonable efforts determinations shall include whether or not services to the family have been accessible, available and appropriate.

(f) The court shall make the reasonable efforts determinations required under this section at every court hearing. The reasonable efforts determinations shall be documented in the court's orders.

(g) Reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan, and to complete whatever steps are necessary to finalize the permanent placement of the child.

(h) Repealed by Laws 2005, ch. 201, § 2.

APPENDIX B

CPS intakes and incidents

Figure B.1

Report acceptance rate by DFS office, CY '01 – '07 [1]

Office	2000	2001	2002	2003	2004	2005	2006	2007
Cheyenne	52.2%	50.6%	53.3%	57.6%	66.0%	66.7%	64.7%	62.4%
Laramie	82.4%	89.8%	93.0%	87.5%	79.4%	72.4%	79.5%	79.1%
Cody	66.7%	49.3%	44.8%	42.1%	42.0%	62.9%	48.9%	35.3%
Powell	63.7%	47.0%	64.0%	63.3%	69.1%	80.5%	74.2%	64.2%
Lander	65.7%	53.1%	48.3%	66.3%	67.9%	52.4%	40.5%	53.5%
Riverton	72.1%	72.5%	76.3%	43.1%	42.6%	49.7%	38.8%	49.8%
Greybull	72.7%	74.3%	65.4%	63.9%	69.8%	52.3%	83.9%	62.9%
Thermopolis	80.6%	67.7%	60.9%	74.0%	63.5%	74.5%	66.3%	68.6%
Worland	63.7%	57.6%	59.6%	79.9%	65.6%	90.7%	80.3%	75.7%
Sheridan	63.5%	74.5%	78.2%	80.7%	80.1%	80.7%	67.9%	59.8%
Gillette	62.3%	67.2%	67.7%	63.9%	65.8%	59.1%	60.1%	59.0%
Sundance	76.5%	145.8%	59.4%	81.2%	85.3%	69.0%	121.9%	90.0%
Newcastle	68.1%	72.3%	69.1%	81.3%	89.5%	93.5%	66.7%	75.2%
Buffalo	84.8%	74.1%	54.5%	59.4%	101.5%	80.0%	78.0%	75.0%
Casper	64.7%	55.0%	56.8%	60.4%	57.7%	54.4%	59.2%	58.5%
Douglas	65.9%	72.0%	70.0%	80.5%	58.2%	50.0%	58.5%	62.4%
Lusk	76.2%	50.0%	66.7%	127.8%	65.6%	78.6%	90.0%	125.0%
Torrington	80.5%	84.5%	82.6%	84.3%	80.3%	73.5%	73.3%	72.6%
Wheatland	74.7%	71.5%	67.5%	72.9%	74.1%	76.2%	81.6%	70.4%
Rawlins	71.2%	71.4%	65.8%	70.7%	78.3%	65.6%	77.5%	81.3%
Afton	34.2%	41.9%	48.4%	60.9%	78.7%	95.6%	75.4%	60.3%
Kemmerer	83.6%	83.8%	178.6%	138.1%	93.8%	72.6%	55.8%	78.0%
Evanston	74.4%	64.9%	68.7%	77.8%	74.8%	65.9%	73.2%	54.2%
Lyman	121.9%	115.2%	100.0%	111.8%	79.6%	59.7%	46.2%	61.1%
Pinedale	100.0%	44.7%	59.2%	100.0%	68.6%	95.7%	126.3%	155.0%
Jackson	41.4%	41.2%	51.5%	55.6%	52.6%	51.5%	62.6%	53.8%
Rock Springs	63.6%	70.9%	70.7%	74.9%	75.8%	84.4%	80.1%	70.3%
Other (State Office)	0.0%			400.0%	0.0%	200.0%	0.0%	100.0%
Total	**65.0%**	**62.7%**	**63.4%**	**67.3%**	**67.3%**	**66.0%**	**65.4%**	**63.0%**

Source: LSO analysis of DFS-WYCAPS data. [1] The Glenrock office did not have any coded intakes, but did have assigned incidents. Also, some small offices may get incidents from supervisors in larger offices; these small offices have more incidents than intakes (greater than 100 percent acceptance rates).

Figure B.2

Total CPS reports (intakes) submitted to DFS by office, CY '00 – '07

Office	2000	2001	2002	2003	2004	2005	2006	2007	Total Intakes
Cheyenne	871	1,060	1,235	1,237	1,175	1,172	1,143	1,054	**8,947**
Laramie	102	88	100	104	126	116	156	158	**950**
Cody	123	136	203	195	169	116	88	116	**1,146**
Powell	91	100	100	98	97	82	120	120	**808**
Lander	67	64	87	80	81	84	148	170	**781**
Riverton	140	160	232	197	289	334	363	299	**2,014**
Greybull	110	113	127	97	106	109	93	124	**879**
Thermopolis	98	99	87	104	104	106	104	118	**820**
Worland	102	118	136	159	183	97	76	103	**974**
Sheridan	310	314	321	336	307	362	368	470	**2,788**
Gillette	427	516	622	817	944	938	963	1,057	**6,284**
Sundance	34	24	64	69	68	29	32	60	**380**
Newcastle	47	94	94	112	95	92	102	117	**753**
Buffalo	33	81	77	69	65	120	100	88	**633**
Casper	1,305	1,344	1,395	1,380	1,561	1,606	1,471	1,413	**11,475**
Douglas	173	143	160	226	213	228	193	213	**1,549**
Lusk	21	46	36	18	32	14	10	12	**189**
Torrington	174	148	161	198	229	234	187	175	**1,506**
Wheatland	87	130	117	166	135	105	125	98	**963**
Rawlins	139	126	199	198	198	247	204	192	**1,503**
Afton	79	93	64	115	61	45	61	68	**586**
Kemmerer	55	37	14	21	32	73	95	41	**368**
Evanston	207	202	259	316	389	343	269	203	**2,188**
Lyman	32	33	47	34	49	72	65	108	**440**
Pinedale	18	47	49	62	102	70	38	20	**406**
Jackson	99	68	99	126	76	97	107	91	**763**
Rock Springs	596	608	735	870	778	687	594	696	**5,564**
Other (State Office)	10	0	0	1	2	1	2	1	**17**
Total	**5,550**	**5,992**	**6,820**	**7,405**	**7,666**	**7,579**	**7,277**	**7,385**	**55,674**

Source: LSO analysis of DFS-WYCAPS data.

Figure B.3

Total accepted incidents by DFS office, CY '00 – '07

Office	2000	2001	2002	2003	2004	2005	2006	2007	Total Incidents
Cheyenne	455	536	658	713	775	782	739	658	**5,316**
Laramie	84	79	93	91	100	84	124	125	**780**
Cody	82	67	91	82	71	73	43	41	**550**
Powell	58	47	64	62	67	66	89	77	**530**
Lander	44	34	42	53	55	44	60	91	**423**
Riverton	101	116	177	85	123	166	141	149	**1,058**
Greybull	80	84	83	62	74	57	78	78	**596**
Thermopolis	79	67	53	77	66	79	69	81	**571**
Worland	65	68	81	127	120	88	61	78	**688**
Sheridan	197	234	251	271	246	292	250	281	**2,022**
Gillette	266	347	421	522	621	554	579	624	**3,934**
Sundance	26	35	38	56	58	20	39	54	**326**
Newcastle	32	68	65	91	85	86	68	88	**583**
Buffalo	28	60	42	41	66	96	78	66	**477**
Casper	844	739	792	834	900	873	871	826	**6,679**
Douglas	114	103	112	182	124	114	113	133	**995**
Glenrock	22	21	10	14	39	41	30	15	**192**
Lusk	16	23	24	23	21	11	9	15	**142**
Torrington	140	125	133	167	184	172	137	127	**1,185**
Wheatland	65	93	79	121	100	80	102	69	**709**
Rawlins	99	90	131	140	155	162	158	156	**1,091**
Afton	27	39	31	70	48	43	46	41	**345**
Kemmerer	46	31	25	29	30	53	53	32	**299**
Evanston	154	131	178	246	291	226	197	110	**1,533**
Lyman	39	38	47	38	39	43	30	66	**340**
Pinedale	18	21	29	62	70	67	48	31	**346**
Jackson	41	28	51	70	40	50	67	49	**396**
Rock Springs	379	431	520	652	590	580	476	489	**4,117**
Other (State Office)	0	0	0	4	0	2	0	1	**7**
Total	**3,601**	**3,755**	**4,321**	**4,985**	**5,158**	**5,004**	**4,755**	**4,651**	**36,230**

Source: LSO analysis of DFS-WYCAPS data.

Figure B.4

Report acceptance rate by CPS district, CY '01 – '07

District	2000	2001	2002	2003	2004	2005	2006	2007
District 1	55.4%	53.6%	56.3%	60.0%	67.3%	67.2%	66.4%	64.6%
District 5	69.6%	61.1%	60.8%	58.9%	56.0%	61.7%	54.5%	56.7%
District 6	64.5%	72.3%	69.4%	69.9%	72.8%	68.0%	64.8%	62.1%
District 7	64.7%	55.0%	56.8%	60.4%	57.7%	54.4%	59.2%	58.5%
District 8	76.8%	76.7%	72.7%	80.3%	77.2%	70.0%	76.4%	74.6%
District 10	64.8%	66.1%	69.5%	75.6%	74.5%	76.6%	74.6%	66.7%
Other (State Office)	0.0%			400.0%	0.0%	200.0%	0.0%	100.0%
Total	65.0%	62.7%	63.4%	67.3%	67.3%	66.0%	65.4%	63.0%

Source: LSO analysis of DFS-WYCAPS data.

Figure B.5

Total CPS reports (intakes) submitted to DFS by CPS district, CY '00 – '07

District	2000	2001	2002	2003	2004	2005	2006	2007	Total Intakes
District 1	973	1,148	1,335	1,341	1,301	1,288	1,299	1,212	**9,897**
District 5	731	790	972	930	1,029	928	992	1,050	**7,422**
District 6	851	1,029	1,178	1,403	1,479	1,541	1,565	1,792	**10,838**
District 7	1,305	1,344	1,395	1,380	1,561	1,606	1,471	1,413	**11,475**
District 8	594	593	673	806	807	828	719	690	**5,710**
District 10	1,086	1,088	1,267	1,544	1,487	1,387	1,229	1,227	**10,315**
Other (State Office)	10	0	0	1	2	1	2	1	17
Total	**5,550**	**5,992**	**6,820**	**7,405**	**7,666**	**7,579**	**7,277**	**7,385**	**55,674**

Source: LSO analysis of DFS-WYCAPS data.

Figure B.6

Total accepted incidents by CPS district, CY '00 – '07

District	2000	2001	2002	2003	2004	2005	2006	2007	Total Incidents
District 1	539	615	751	804	875	866	863	783	**6,096**
District 5	509	483	591	548	576	573	541	595	**4,416**
District 6	549	744	817	981	1,076	1,048	1,014	1,113	**7,342**
District 7	844	739	792	834	900	873	871	826	**6,679**
District 8	456	455	489	647	623	580	549	515	**4,314**
District 10	704	719	881	1,167	1,108	1,062	917	818	**7,376**
Other (State Office)	0	0	0	4	0	2	0	1	**7**
Total	**3,601**	**3,755**	**4,321**	**4,985**	**5,158**	**5,004**	**4,755**	**4,651**	**36,230**

Source: LSO analysis of DFS-WYCAPS data.


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APPENDIX C

CPS service types and costs

Figure C.1

Contract service expenditures by person (children and adults) and incident, CY '00 – '07

Cost per Person/Incident	Number of Persons	Number of Incidents	% of Persons	% of Incidents
$0.01 to $100.00	1,521	870	0.92%	2.31%
$100.01 to $500.00	2,368	1,294	1.44%	3.44%
$500.01 to $1,000.00	1,147	651	0.70%	1.73%
$1,000.01 to $10,000.00	2,673	1,646	1.62%	4.38%
$10,000.01 to $50,000.00	1,383	1,130	0.84%	3.01%
$50,000.01+	250	318	0.15%	0.85%
Subtotal (with costs)	**9,342**	**5,909**	**5.67%**	**15.72%**
subtotal (no costs)	**155,528**	**31,673**	**94.33%**	**84.28%**
Total	**164,870**	**37,582**	**100.00%**	**100.00%**

Source: LSO analysis of DFS-WYCAPS data.

Figure C.2

Total contract service cost and per person cost by service type, CY '00 – '07

Service Type	Total	Number of People	Median	Average
All Services	**$67,037,622.82**	**9,342**	**$775.65**	**$7,175.94**
Placement Services	**$54,679,292.08**	**-----**	**$0.00**	**$5,853.06**
Non-Placement Services	**$12,358,330.74**	**-----**	**$306.33**	**$1,322.88**
Subsidized Adoption	$6,900,273.90	364	$18,034.58	$18,956.80
Child Placing Agencies/Placement Fees	$1,755,399.17	314	$2,828.15	$5,590.44
Clothes Allowance	$301,526.14	1,937	$130.00	$155.67
Placement Reviews	$729.60	6	$64.28	$121.60
Counseling	$2,192,809.86	1,882	$550.00	$1,165.15
Day Care	$901,267.14	1,363	$197.75	$661.72
Day Treatment	$31,560.60	14	$1,533.00	$2,254.33
Detention	$89,740.09	33	$1,764.00	$2,719.40
Electronic Monitoring	$4,380.00	2	$2,190.00	$2,190.00
Evaluation	$1,075,703.88	1,724	$450.00	$624.32
Foster Care Non-Relative	$10,925,900.44	3,309	$1,173.33	$3,301.87
Foster Care Relative	$1,768,224.00	381	$3,474.68	$4,641.01
Family Preservation	$3,944,554.29	2,840	$197.10	$1,388.93
Group Home	$5,989,043.42	659	$4,505.00	$9,088.08
Subsidized Guardianship	$1,869,827.27	231	$6,120.00	$8,094.49
Independent Living	$150,887.18	35	$2,845.15	$4,311.06
Legal Services	$1,143,072.53	774	$660.94	$1,476.84
Long Term Foster Care Non-Relative	$20,432.98	11	$1,200.00	$1,857.54
MDT Coordinator	$772,811.12	1,471	$250.00	$525.36
Mentoring	$939,642.12	708	$200.00	$1,327.18
Out of Home Placement - Health	$856,775.79	49	$12,257.01	$17,485.22
Parenting	$14,020.56	36	$55.00	$389.46
Residential Treatment Center	$17,382,297.28	318	$36,697.50	$54,661.31
Respite	$330,182.96	1,292	$147.50	$255.56
Specialized Foster Care	$5,013,708.69	551	$4,550.00	$9,099.29
Substance Abuse Treatment	$30,301.65	29	$620.00	$1,044.88
Therapeutic Foster Care Non-Relative	$1,979,046.50	324	$3,603.25	$6,108.17
Therapeutic Foster Care Relative	$986.00	1	$986.00	$986.00
Tobacco Free Placement Homes	$126,906.95	258	$400.00	$491.89
Transportation	$525,610.71	947	$222.32	$555.03

Source: LSO analysis of DFS-WYCAPS data.

Figure C.3

Total contract service cost and per incident cost by service type, CY '00 – '07

Service Type	Total	Number of Incidents	Average	Median
All Services	**$67,037,622.82**	**5,909**	**$11,345.00**	**$1,220.00**
Placement	**$54,679,292.08**	**-----**	**$9,253.56**	**$80.00**
Non-Placement	**$12,358,330.74**	**-----**	**$2,091.44**	**$401.13**
Subsidized Adoption	$6,900,273.90	315	$21,905.63	$17,711.42
Child Placing Agencies/Placement Fees	$1,755,399.17	197	$8,910.66	$4,800.00
Clothes Allowance	$301,526.14	1,288	$234.10	$162.88
Placement Reviews	$729.60	6	$121.60	$64.28
Counseling	$2,192,809.86	1,483	$1,478.63	$580.00
Day Care	$901,267.14	858	$1,050.43	$322.92
Day Treatment	$31,560.60	13	$2,427.74	$1,800.00
Detention	$89,740.09	31	$2,894.84	$1,796.83
Electronic Monitoring	$4,380.00	2	$2,190.00	$2,190.00
Evaluation	$1,075,703.88	1,279	$841.05	$520.00
Foster Care Non-Relative	$10,925,900.44	2,166	$5,044.28	$1,279.57
Foster Care Relative	$1,768,224.00	221	$8,001.01	$5,085.75
Family Preservation	$3,944,554.29	2,061	$1,913.90	$256.28
Group Home	$5,989,043.42	561	$10,675.66	$5,175.00
Subsidized Guardianship	$1,869,827.27	139	$13,451.99	$9,520.00
Independent Living	$150,887.18	35	$4,311.06	$2,845.15
Legal Services	$1,143,072.53	558	$2,048.52	$827.00
Long Term Foster Care Non-Relative	$20,432.98	8	$2,554.12	$2,431.83
MDT Coordinator	$772,811.12	1,270	$608.51	$390.00
Mentoring	$939,642.12	563	$1,668.99	$270.00
Out of Home Placement - Health	$856,775.79	48	$17,849.50	$12,077.14
Parenting	$14,020.56	29	$483.47	$60.00
Residential Treatment Center	$17,382,297.28	300	$57,940.99	$39,136.76
Respite	$330,182.96	785	$420.62	$217.50
Specialized Foster Care	$5,013,708.69	401	$12,503.01	$6,311.30
Substance Abuse Treatment	$30,301.65	30	$1,010.06	$610.00
Therapeutic Foster Care Non-Relative	$1,979,046.50	256	$7,730.65	$4,176.00
Therapeutic Foster Care Relative	$986.00	1	$986.00	$986.00
Tobacco Free Placement Homes	$126,906.95	234	$542.34	$450.64
Transportation	$525,610.71	736	$714.14	$270.47

Source: LSO analysis of DFS-WYCAPS data.

Figure C.4

Total contract service cost by placement and non-placement services by DFS office, CY '00 – '07

Service Type	All Services	Placement Services	Non-Placement Services	Placement Services	Non-Placement Services
Laramie	$1,937,958.40	$1,628,047.80	$309,910.60	84.01%	15.99%
Greybull	$705,394.18	$546,163.22	$159,230.96	77.43%	22.57%
Gillette	$4,267,493.04	$2,856,555.44	$1,410,937.60	66.94%	33.06%
Rawlins	$2,711,597.60	$1,963,422.17	$748,175.43	72.41%	27.59%
Douglas	$1,602,463.21	$1,403,046.14	$199,417.07	87.56%	12.44%
Glenrock	$424,575.72	$371,393.35	$53,182.37	87.47%	12.53%
Sundance	$672,881.60	$594,226.65	$78,654.95	88.31%	11.69%
Lander	$753,259.66	$630,572.29	$122,687.37	83.71%	16.29%
Riverton	$2,731,059.75	$2,120,566.43	$610,493.32	77.65%	22.35%
Torrington	$2,966,333.58	$2,433,059.94	$533,273.64	82.02%	17.98%
Thermopolis	$765,312.26	$566,495.39	$198,816.87	74.02%	25.98%
Buffalo	$1,187,158.99	$926,435.48	$260,723.51	78.04%	21.96%
Cheyenne	$9,302,173.83	$7,150,438.82	$2,151,735.01	76.87%	23.13%
Kemmerer	$403,867.30	$370,824.74	$33,042.56	91.82%	8.18%
Afton	$387,632.35	$358,707.19	$28,925.16	92.54%	7.46%
Casper	$12,418,315.29	$10,463,413.37	$1,954,901.92	84.26%	15.74%
Lusk	$102,988.63	$75,442.96	$27,545.67	73.25%	26.75%
Cody	$2,516,642.74	$2,085,816.25	$430,826.49	82.88%	17.12%
Powell	$1,102,168.24	$857,128.66	$245,039.58	77.77%	22.23%
Wheatland	$2,422,692.35	$2,101,448.24	$321,244.11	86.74%	13.26%
Sheridan	$5,430,719.25	$4,205,642.24	$1,225,077.01	77.44%	22.56%
Pinedale	$288,694.04	$271,125.92	$17,568.12	93.91%	6.09%
Rock Springs	$3,785,096.79	$3,368,805.96	$416,290.83	89.00%	11.00%
Jackson	$525,781.20	$391,368.56	$134,412.64	74.44%	25.56%
Evanston	$924,685.41	$808,616.96	$116,068.45	87.45%	12.55%
Lyman	$234,621.52	$216,006.36	$18,615.16	92.07%	7.93%
Worland	$512,202.30	$374,102.65	$138,099.65	73.04%	26.96%
Newcastle	$743,509.77	$668,574.06	$74,935.71	89.92%	10.08%
Reservation	$5,210,343.82	$4,871,844.84	$338,498.98	93.50%	6.50%
Total Paid	**$67,037,622.82**	**$54,679,292.08**	**$12,358,330.74**	**81.57%**	**18.43%**

Source: LSO analysis of DFS-WYCAPS data.

Figure C.5

Total contract service cost by placement and non-placement services by CPS district, CY '00 – '07

District	All Services	Placement Services	Non-Placement Services	Placement Services	Non-Placement Services
District 1	$11,240,132.23	$8,778,486.62	$2,461,645.61	78.10%	21.90%
District 5	$9,086,039.13	$7,180,844.89	$1,905,194.24	79.03%	20.97%
District 6	$12,301,762.65	$9,251,433.87	$3,050,328.78	75.20%	24.80%
District 7	$12,418,315.29	$10,463,413.37	$1,954,901.92	84.26%	15.74%
District 8	$10,230,651.09	$8,347,812.80	$1,882,838.29	81.60%	18.40%
District 10	$6,550,378.61	$5,785,455.69	$764,922.92	88.32%	11.68%
Reservation	$5,210,343.82	$4,871,844.84	$338,498.98	93.50%	6.50%
Total Paid	**$67,037,622.82**	**$54,679,292.08**	**$12,358,330.74**	**81.57%**	**18.43%**

Source: LSO analysis of DFS-WYCAPS data.


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APPENDIX D

CPS track assignments for incidents

Figure D.1

Number and percent of incidents categorized into CPS response tracks and "other" by DFS district, CY '00 – '07 [1, 2]

Office	Prevention		Assessment		Investigation		Other (untracked)		All Incidents
	No.	%	No.	%	No.	%	No.	%	
District 1	1,590	26.08%	744	12.20%	1,913	31.38%	1,849	30.33%	**6,096**
District 5	612	13.86%	973	22.03%	1,565	35.43%	1,260	28.53%	**4,417**
District 6	934	12.72%	2,282	31.09%	1,700	23.16%	2,386	32.50%	**7,341**
District 7	1,123	16.81%	1,028	15.39%	2,436	36.47%	2,092	31.32%	**6,680**
District 8	332	7.70%	1,258	29.16%	1,494	34.63%	1,180	27.35%	**4,314**
District 10	1,309	17.75%	1,957	26.54%	2,270	30.78%	1,830	24.81%	**7,375**
State Office	1	14.29%	1	14.29%	2	28.57%	3	42.86%	**7**
Statewide Total	**5,901**	**16.29%**	**8,243**	**22.75%**	**11,380**	**31.41%**	**10,600**	**29.26%**	**36,230**

Source: LSO analysis of DFS-WYCAPS data.

[1] For some offices, the percentages for the prevention, assessment, investigation, and other (untracked) incidents do not add up to 100 percent since subsidized adoptions and guardianships are not included in this figure.

[2] Prevention and assessment track incidents numbers include incidents marked since August 2001, when the track system was implemented.

Figure D.2

Number and percent of incidents categorized into CPS response tracks and "other" by DFS office, CY '00 – '07 [1, 2]

Office	Prevention		Assessment		Investigation		Other (untracked)		All Incidents
	No.	%	No.	%	No.	%	No.	%	
Laramie	141	18.08%	280	35.90%	266	34.10%	93	11.92%	**780**
Greybull	60	10.07%	195	32.72%	194	32.55%	146	24.50%	**596**
Gillette	475	12.10%	1,355	34.52%	690	17.58%	1,389	35.39%	**3,925**
Rawlins	43	3.94%	171	15.67%	289	26.49%	588	53.90%	**1,091**
Douglas	85	8.54%	326	32.76%	387	38.89%	189	18.99%	**995**
Glenrock	15	7.81%	49	25.52%	70	36.46%	52	27.08%	**192**
Sundance	46	13.77%	57	17.07%	49	14.67%	177	52.99%	**334**
Lander	57	13.48%	78	18.44%	141	33.33%	145	34.28%	**423**
Riverton	142	13.42%	90	8.51%	363	34.31%	462	43.67%	**1,058**
Torrington	131	11.05%	504	42.53%	343	28.95%	190	16.03%	**1,185**
Thermopolis	125	21.89%	56	9.81%	248	43.43%	142	24.87%	**571**
Buffalo	63	13.26%	118	24.84%	132	27.79%	151	31.79%	**475**
Cheyenne	1,449	27.26%	464	8.73%	1,647	30.98%	1,756	33.03%	**5,316**
Kemmerer	81	27.00%	43	14.33%	94	31.33%	82	27.33%	**300**
Afton	20	5.80%	87	25.22%	153	44.35%	85	24.64%	**345**
Casper	1,123	16.81%	1,028	15.39%	2,436	36.47%	2,092	31.32%	**6,680**
Lusk	18	12.68%	56	39.44%	45	31.69%	23	16.20%	**142**
Cody	23	4.17%	240	43.48%	216	39.13%	71	12.86%	**552**
Powell	35	6.63%	166	31.44%	180	34.09%	147	27.84%	**528**
Wheatland	40	5.64%	152	21.44%	360	50.78%	138	19.46%	**709**
Sheridan	230	11.37%	631	31.19%	731	36.13%	425	21.01%	**2,023**
Pinedale	48	13.87%	106	30.64%	72	20.81%	119	34.39%	**346**
Rock Springs	682	16.57%	1,346	32.70%	1,261	30.64%	826	20.07%	**4,116**
Jackson	39	9.85%	99	25.00%	150	37.88%	102	25.76%	**396**
Evanston	352	22.98%	221	14.43%	438	28.59%	520	33.94%	**1,532**
Lyman	87	25.59%	55	16.18%	102	30.00%	96	28.24%	**340**
Worland	170	24.67%	148	21.48%	223	32.37%	147	21.34%	**689**
Newcastle	120	20.55%	121	20.72%	98	16.78%	244	41.78%	**584**
State Office	1	14.29%	1	14.29%	2	28.57%	3	42.86%	**7**
Statewide Total	**5,901**	**16.29%**	**8,243**	**22.75%**	**11,380**	**31.41%**	**10,600**	**29.26%**	**36,230**

Source: LSO analysis of DFS-WYCAPS data.

[1] For some offices, the percentages for the prevention, assessment, investigation, and other (untracked) incidents do not add up to 100 percent since subsidized adoptions and guardianships are not included in this figure.

[2] Prevention and assessment track incidents numbers include incidents marked since August 2001, when the track system was implemented.

Figure D.3

Annual CPS incident assigned to prevention track by DFS office, CY '00 – '07

Office	All Prevention Incidents	2001	2002	2003	2004	2005	2006	2007
Laramie	141	4	23	14	24	15	30	31
Greybull	60	1	14	17	10	7	4	7
Gillette	475	37	96	123	83	27	64	45
Rawlins	43	3	7	8	17	2	4	2
Douglas	85	9	17	18	18	6	11	6
Glenrock	15	2	2	1	4	2	3	1
Sundance	46	2	11	9	8	2	8	6
Lander	57		6	11	14	11	11	4
Riverton	142		5	8	22	53	42	12
Torrington	131		4	23	45	23	15	21
Thermopolis	125	5	7	25	15	22	22	29
Buffalo	63		4	2	5	21	17	14
Cheyenne	1,449	57	258	264	158	168	251	293
Kemmerer	81	2	3	6	6	25	25	14
Afton	20	3	1	9	3	3	1	
Casper	1,123	93	345	328	339	7	8	3
Lusk	18	2	4	6	2		1	3
Cody	23	2	1	4	7	7	2	
Powell	35	3	13	9	1	2	2	5
Wheatland	40	2	3	9	11	6	5	4
Sheridan	230	2	19	23	32	44	36	74
Pinedale	48	2	5	14	12	13	2	
Rock Springs	682	56	122	133	135	101	67	68
Jackson	39	3	10	13	7	3	3	
Evanston	352	5	56	60	63	68	58	42
Lyman	87	3	17	8	6	14	8	31
Worland	170	13	35	51	38	14	5	14
Newcastle	120	11	22	24	22	6	13	22
State Office	1			1				
Total	**5,901**	**322**	**1,110**	**1,221**	**1,107**	**672**	**718**	**751**

Source: LSO analysis of DFS-WYCAPS data.

Figure D.4

Annual CPS incident assigned to assessment track by DFS office, CY '00 – '07

Office	All Assessment Incidents	2001	2002	2003	2004	2005	2006	2007
Laramie	280	15	32	35	39	33	66	60
Greybull	195	21	36	24	25	27	33	29
Gillette	1,355	43	184	182	51	232	272	391
Rawlins	171	20	43	40	12	4	2	50
Douglas	326	14	24	60	48	49	60	71
Glenrock	49	1		7	14	11	13	3
Sundance	57	1	10	12	6	1	11	16
Lander	78	1	3	7	5	5	20	37
Riverton	90	8	24	9	7	11	9	22
Torrington	504	41	77	67	81	96	78	64
Thermopolis	56	10	3	10	7	14	8	4
Buffalo	118	5	8	15	10	11	35	34
Cheyenne	464	64	134	85	76	40	49	16
Kemmerer	43	4	8	2	7	12	9	1
Afton	87	10	9	18	4	13	16	17
Casper	1,028	37	82	108	93	176	249	283
Lusk	56	11	11	11	8	4	5	6
Cody	240	16	46	41	45	47	23	22
Powell	166	10	25	34	24	17	20	36
Wheatland	152	8	9	22	31	24	34	24
Sheridan	631	34	86	105	74	105	123	104
Pinedale	106	5	21	20	21	20	14	5
Rock Springs	1,346	68	184	223	178	175	234	284
Jackson	99	5	15	14	7	12	23	23
Evanston	221	30	20	24	65	41	27	14
Lyman	55	7	14	5	12	5	6	6
Worland	148	13	21	27	22	25	20	20
Newcastle	121	6	14	14	7	16	33	31
State Office	1							1
Total	**8,243**	**508**	**1,143**	**1,221**	**979**	**1,226**	**1,492**	**1,674**

Source: LSO analysis of DFS-WYCAPS data.

Figure D.5

Annual CPS incident assigned to investigation track by DFS office, CY '00 – '07

Office	All Investigations	2000	2001	2002	2003	2004	2005	2006	2007
Laramie	266	73	45	34	33	23	25	17	16
Greybull	194	58	29	23	7	15	15	25	22
Gillette	690	195	160	39	27	40	87	81	61
Rawlins	289	66	45	50	23	23	35	26	21
Douglas	387	41	58	59	92	31	40	24	42
Glenrock	70	9	9	4	6	14	17	5	6
Sundance	49	13	18	1	1	2	4	3	7
Lander	141	29	22	19	20	13	11	14	13
Riverton	363	89	68	50	18	34	36	48	20
Torrington	343	116	66	29	44	21	15	27	25
Thermopolis	248	64	38	34	27	26	25	15	19
Buffalo	132	16	38	19	13	13	18	10	5
Cheyenne	1,647	404	353	180	176	102	117	167	148
Kemmerer	94	31	18	6	7	8	6	13	5
Afton	153	23	19	12	18	23	18	23	17
Casper	2,436	543	418	247	222	234	225	253	294
Lusk	45	13	8	7	4	3	5	2	3
Cody	216	78	39	34	24	11	11	9	10
Powell	180	38	24	19	12	29	16	21	21
Wheatland	360	57	70	60	54	34	29	31	25
Sheridan	731	149	163	93	78	58	64	65	61
Pinedale	72	14	13	1	2	9	11	13	9
Rock Springs	1,261	323	283	172	126	105	105	74	73
Jackson	150	30	13	16	18	15	21	26	11
Evanston	438	101	47	63	60	67	37	45	18
Lyman	102	30	22	10	8	10	8	4	10
Worland	223	54	26	20	28	33	30	15	17
Newcastle	98	24	29	6	3	3	9	5	19
State Office	2				1		1		
Total	**11,380**	**2,681**	**2,141**	**1,307**	**1,152**	**999**	**1,041**	**1,061**	**998**

Source: LSO analysis of DFS-WYCAPS data.

Figure D.6

Annual CPS incidents not assigned to any response track by DFS office, CY '00 – '07

Office	All Other Incidents	2000	2001	2002	2003	2004	2005	2006	2007
Laramie	93	11	15	4	9	14	11	11	18
Greybull	146	22	33	10	14	23	8	16	20
Gillette	1,389	71	106	99	183	444	203	160	123
Rawlins	588	33	22	31	69	103	121	126	83
Douglas	189	73	20	12	11	25	18	18	12
Glenrock	52	13	9	3		7	10	7	3
Sundance	177	13	14	16	33	39	15	19	28
Lander	145	15	11	14	14	23	17	14	37
Riverton	462	12	40	98	50	60	65	42	95
Torrington	190	24	18	21	31	34	33	14	15
Thermopolis	142	15	14	9	15	18	18	24	29
Buffalo	151	12	17	9	11	32	42	16	12
Cheyenne	1,756	51	62	86	188	439	457	272	201
Kemmerer	82	15	7	8	14	9	10	6	13
Afton	85	4	7	9	25	18	9	6	7
Casper	2,092	301	191	118	175	234	466	361	246
Lusk	23	3	2	2	2	8	2	1	3
Cody	71	4	10	10	13	8	8	9	9
Powell	147	20	10	5	7	13	31	46	15
Wheatland	138	8	12	6	35	16	20	28	13
Sheridan	425	48	35	52	64	79	78	26	43
Pinedale	119	4	1	2	26	28	23	18	17
Rock Springs	826	56	24	42	170	172	199	100	63
Jackson	102	11	7	10	25	9	12	15	13
Evanston	520	53	49	39	102	96	79	67	35
Lyman	96	9	6	6	17	11	16	12	19
Worland	147	11	15	5	21	27	19	21	28
Newcastle	244	8	22	23	49	53	55	17	17
State Office	3				2		1		
Total	**10,600**	**920**	**779**	**749**	**1,375**	**2,042**	**2,046**	**1,472**	**1,217**

Source: LSO analysis of DFS-WYCAPS data.

APPENDIX E

Illustration of the sequence of incidents DFS opened for families in the LSO investigation track sample

Family	Incidents opened during the period 2004-2007 (Note: illustration does not portray incident length, or intervals between incidents)								
	Number of Incidents								
	1	2	3	4	5	6	7	8	9
1	Inv-sub	Other							
2	Inv-sub								
3	Inv-sub								
4	Inv-sub	Other							
5	Inv-sub →	Other→	Inv-sub	Assess	Assess				
6	Inv-unsub								
7	Inv-unsub								
8	Other	Inv-sub							
9	Assess	Inv-sub	Assess	Assess					
10	Assess	Inv-unsub	Inv - sub						
11	Inv -sub								
12	Inv-sub	Inv-unsub	Inv – sub	Asses	Inv-unsub	Inv-sub			
13	Inv-sub	Inv-unsub							
14	Assess	Inv –sub.	Other	Other	Other	Inv–sub	Prev.		
15	Inv –sub	Assess	Inv –sub						
16	Inv-unsub								
17	Inv-unsub	Other	Prev - →	Inv-unsub					
18	Other	Other	Assess	Assess	Assess	Inv-unsub	In-unsub	Inv-sub	
19	YF	Inv-unsub	Inv-unsub						
20	Assess	Inv-unsub	Inv-unsub	Assess	Inv-sub	Inv-sub			
21	Inv-sub	Prev							
22	Prev	Prev	Other	Prev	Prev	Inv-sub			
23	Other	Inv-unsub							
24	Other	Prev	Inv-sub	Inv-unsub					
25	Other	Prev	Inv-sub →	Inv-unsub					
26	Inv-unsub	Inv-unsub							
27	Inv-sub	Inv-unsub							
28	Prev	Inv-sub							
29	Prev	Other	Other	Inv-sub					
30	Inv-sub	Inv-sub							
31	Inv-unsub								
32	Assess	Other	Assess	Inv-unsub	Inv-unsub	Inv-unsub			
33	Other	Other	Other	Inv-sub					
34	Inv-sub								
35	Prev	Prev	Prev	Prev	Inv-unsub	Other	Inv-unsub	Other	Other
36	Inv-unsub	Other	Assess						
37	Assess	Inv-unsub	Other	Inv-sub	Inv-unsub	Inv-unsub	Other		
38	Prev	Inv-sub	Assess	Inv-unsub					
39	Prev	Inv-unsub	Assess	Inv-sub	Inv-sub				
40	Other	Other	Other	Inv-sub	Inv-unsub				
41	Inv-unsub	Other	Inv-unsub	Inv-unsub					
42	Other	Inv-sub →	←Assess	Other	Inv-unsub	Inv-sub			
43	Inv-unsub	Assess	Inv-unsub	Other	Other				
44	Inv-sub								
45	Inv-unsub	Other							
46	Inv-sub								
47	Assess	Assess	Assess	Other	Assess	Inv-no find	Inv-sub		

48	Inv-sub	Prev	Assess						
49	Inv-unsub								
50	Inv-sub	Inv-unsub	Assess						
51	Other	Other	Inv-sub						
52	Other	Inv-unsub							
53	Assess	Inv-sub	Other	Other	Other	Other	Inv-unsub		
54	Assess	Inv-sub							
55	Assess	Assess	Inv-sub						
56	Inv-sub	Inv-sub	Inv-sub	Inv-sub					
57	Inv-sub	Inv-unsub	PB						
58	Other	Inv-sub							
59	Inv-unsub	Assess	Inv-unsub	Inv-sub	Assess	Assess			
60	Assess	Inv-sub							
61	Inv-sub								
62	Inv-sub								
63	Inv-sub								
64	Inv-sub →	Other	Inv-sub ←	Inv-sub←	Prev-				
65	Prev	Inv-unsub	Inv-unsub	Inv-unsub					
66	Inv-unsub	Inv-sub							
67	Inv-sub	Other							
68	Inv-sub								

Key

Inv-sub	Investigation track - Substantiated	Assess	Assessment track
Inv-unsub	Investigation track - Unsubstantiated	Prev	Prevention track
Other	Incident without track assignment	YF	Non-CPS, Youth and Family incident

APPENDIX F

CPS allegation types and findings

Figure F.1

Number of allegations and percent substantiated and unsubstantiated by allegation type, CY '00 – '07

Allegation Type	Total Allegations	% of All Allegations	% Substantiated	% Unsubstantiated
Abandonment	195	0.89%	63.08%	36.92%
Abuse	1,817	8.25%	33.46%	66.54%
Dangerous Act	617	2.80%	57.70%	42.30%
Deprivation	17	0.08%	17.65%	82.35%
Educational Neglect	482	2.19%	48.55%	51.45%
Emotional Abuse	182	0.83%	26.92%	73.08%
Lack of Supervision	1,809	8.21%	44.56%	55.44%
Malnutrition	11	0.05%	36.36%	63.64%
Medical Neglect	480	2.18%	28.96%	71.04%
Mental Injury	22	0.10%	9.09%	90.91%
Nelgect	7,662	34.79%	49.75%	50.25%
Negligent Treatment	3,006	13.65%	35.66%	64.34%
Other	157	0.71%	43.95%	56.05%
Physical Abuse	2,861	12.99%	28.24%	71.76%
Physical Injury	658	2.99%	32.37%	67.63%
Psychological Abuse	63	0.29%	46.03%	53.97%
Sexual Abuse	1,973	8.96%	38.82%	61.18%
Unknown	13	0.06%	7.69%	92.31%
Total	**22,025**	**100.00%**	**41.29%**	**58.71%**

Source: LSO analysis of DFS-WYCAPS data.

Figure F.2

Number and percent of allegations by length in days from initial report to finding, CY '00 – '07

Date to Finding	All Allegation	Substantiated	Unsubstantiated	% All Allegation	% Substantiated	% Unsubstantiated
1-7 days	3,622	1,538	2,084	16.44%	16.91%	16.12%
8-30 days	5,531	2,118	3,413	25.11%	23.29%	26.39%
31-60 days	5,757	2,303	3,454	26.14%	25.32%	26.71%
61-90 days	3,832	1,594	2,238	17.40%	17.53%	17.31%
91-120 days	1,280	622	658	5.81%	6.84%	5.09%
121-150 days	678	316	362	3.08%	3.47%	2.80%
151-180 days	393	177	216	1.78%	1.95%	1.67%
181-365 days	738	321	417	3.35%	3.53%	3.22%
1+ year	172	96	76	0.78%	1.06%	0.59%
Unknown	22	9	13	0.10%	0.10%	0.10%
Total	**22,025**	**9,094**	**12,931**	**100.00%**	**100.00%**	**100.00%**
Average	**55 days**	**58 days**	**53 days**			
Median	**42 days**	**43 days**	**41 days**			

Source: LSO analysis of DFS-WYCAPS data.

Figure F.3

Number and percent of perpetrators and victims linked with number of allegations recorded for investigation track incidents, CY '00 – '07

Number of Allegations	Number of Perpetrators	Number of Victims	% of Perpetrators	% of Victims
1	4,417	7,647	61.43%	59.83%
2	1,463	3,190	20.35%	24.96%
3	645	902	8.97%	7.06%
4	324	515	4.51%	4.03%
5	115	258	1.60%	2.02%
6	86	130	1.20%	1.02%
7	48	68	0.67%	0.53%
8	29	28	0.40%	0.22%
9	22	16	0.31%	0.13%
10	13	13	0.18%	0.10%
11+	28	15	0.39%	0.12%
Total	**7,190**	**12,782**	**100.00%**	**100.00%**

Source: LSO analysis of DFS-WYCAPS data.

APPENDIX G

Central registry statistics

Figure G.1

Central registry background check applications with central registry and DCI pre-screen "hits," CY '00 – '07

Year	CR Applications	CR "Hits"	% with "Hits"	DCI Pre-Screens	% with DCI Hits
2000	9,938	109	1.10%	152	1.53%
2001	17,913	139	0.78%	242	1.35%
2002	16,460	126	0.77%	261	1.59%
2003	15,321	86	0.56%	208	1.36%
2004	16,199	116	0.72%	347	2.14%
2005	17,359	126	0.73%	395	2.28%
2006	17,010	165	0.97%	363	2.13%
2007	18,507	172	0.93%	410	2.22%
Average	**16,088**	**130**		**297**	
Increase '00-'07	**8,569**	**63**		**258**	
% Increase	**86%**	**58%**		**170%**	

Source: LSO analysis of DFS documents and data.

Figure G.2

Number of central registry applications submitted for background checks by organization type, CY '07

Business/Agent Category	Number of Applications	Average Applications per Business/Agent	% of Total Applications
Wyoming DFS	3,222	69	17.41%
Hospital/Health Care	3,171	34	17.13%
Early Child Care	2,979	6	16.10%
Child and DD Providers	1,862	27	10.06%
Other/Individuals	1,292	6	6.98%
Wyoming Department of Health	1,182	99	6.39%
Schools	872	218	4.71%
Natural Resource/Agriculture	790	132	4.27%
Religious Institutions	715	25	3.86%
Retirement/Senior Homes	675	12	3.65%
Youth Sports/Athletics	499	15	2.70%
Independent Living Orgs	393	33	2.12%
MH/SA Counseling	351	10	1.90%
Colleges/Higher Education	298	25	1.61%
Other States	171	2	0.92%
Legal Services	35	6	0.19%
Total	**18,507**	**15**	**100.00%**

Source: LSO analysis of DFS documents and data.

APPENDIX H

CPS placement statistics

Figure H.1

Number of placements per child and per incident with descriptive statistics, CY '00 - '07

Number of Placements	Persons	Incidents	% Persons	% Incidents
1	2,501	1,328	46.47%	35.23%
2	1,212	916	22.52%	24.30%
3	672	450	12.49%	11.94%
4	379	334	7.04%	8.86%
5	247	129	4.59%	3.42%
6	140	166	2.60%	4.40%
7	87	61	1.62%	1.62%
8	56	100	1.04%	2.65%
9	35	68	0.65%	1.80%
10	15	55	0.28%	1.46%
11+	38	162	0.71%	4.30%
Total	**5,382**	**3,769**	**100.00%**	**100.00%**
Average Placements	2.34	3.34		
Median Placements	2	2		
Minimum Placements	1	1		
Maximum Placements	22	50		

Source: LSO analysis of DFS-WYCAPS data.

Figure H.2

Total placements for CPS Districts by placement type, CY '00 – '07

		CPS District						
Placement Type	**Total Placements**	**1**	**5**	**6**	**7**	**8**	**10**	**Reservation**
Adoption	313	20	23	42	91	74	62	1
Boys School	18	4	5	0	1	3	3	2
Crisis Center	559	111	15	59	247	53	51	23
Detention	76	11	5	7	22	21	2	8
Foster Care Non-Relative	5,720	909	542	904	1,209	727	884	545
Foster Care Relative	2,267	196	123	201	396	331	338	682
Girls' School	16	0	2	0	0	0	2	12
Group Home	938	7	165	190	71	73	177	255
Hospital	54	8	10	11	18	3	4	0
Independent Living	25	7	4	1	2	2	7	2
Jail	44	7	4	2	4	7	13	7
Long Term Foster Care Non-Relative	26	1	2	4	4	7	3	5
Long Term Foster Care Relative	33	1	4	5	6	2	1	14
Pre-Adoptive Home	100	7	7	18	18	25	13	12
Psychiatric RTC	125	24	9	16	39	25	6	6
Residential Treatment Center	489	66	56	76	95	101	41	54
Runaway	42	15	0	1	14	3	2	7
Specialized Foster Care Non-Relative	433	99	95	126	64	29	3	17
Specialized Foster Care Relative	8	2	2	1	0	0	1	2
State Hospital	15	1	2	3	3	1	4	1
Therapeutic Foster Care Non-Relative	339	54	20	50	115	39	46	15
Therapeutic Foster Care Relative	7	2	0	0	0	0	3	2
Trial Home Placement	927	38	47	78	337	181	172	74
Total	**12,574**	**1,590**	**1,142**	**1,795**	**2,756**	**1,707**	**1,838**	**1,746**

Source: LSO analysis of DFS-WYCAPS data.

Figure H.3

Total and annual placements utilized by DFS office, CY '00 – '07

Office	Total Placements	2000	2001	2002	2003	2004	2005	2006	2007
Casper	2,756	275	284	291	307	280	419	476	424
Cheyenne	1,260	136	121	126	163	145	173	226	170
Rock Springs	1,183	91	68	61	135	150	184	267	227
Sheridan	746	88	81	120	123	75	98	88	73
Gillette	707	50	39	83	49	95	184	114	93
Rawlins	536	78	48	32	35	73	128	70	72
Wheatland	388	25	58	45	58	67	33	43	59
Douglas	384	14	18	28	55	71	88	44	66
Laramie	330	48	37	49	35	54	38	23	46
Riverton	316	21	33	36	40	50	50	50	36
Evanston	307	27	41	39	43	37	41	59	20
Torrington	254	20	43	40	36	42	30	22	21
Cody	252	31	51	64	32	23	20	16	15
Buffalo	160	9	43	19	13	22	31	14	9
Powell	143	14	32	11	11	26	24	15	10
Lander	117	20	10	28	23	14	4	5	13
Greybull	114	16	13	17	15	13	11	12	17
Worland	97	7		5	2	23	17	18	25
Glenrock	106	1	3	3	4	15	35	17	28
Newcastle	106	15	4	15	12	6	32	12	10
Thermopolis	103	10	4	17	20	17	18	9	8
Kemmerer	100	19	9	6	17	14	13	10	12
Sundance	76	2	11	8	7	6	8	17	17
Lyman	74	6	10	1	1	3	29	18	6
Jackson	72	22	5	5	14	3	6	6	11
Afton	55	6	19	11	1		6	6	6
Pinedale	47	5			1	7	10	2	22
Lusk	39	2	3	8	5	4	6	11	
Reservation	1,746	240	220	240	161	172	228	246	239
Total	**12,574**	**1,298**	**1,308**	**1,408**	**1,418**	**1,507**	**1,964**	**1,916**	**1,755**

Source: LSO analysis of DFS-WYCAPS data.


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APPENDIX I

Research Methodology

Summary of Methodologies

This evaluation was conducted according to statutory requirements and professional standards and methods for governmental audits. The research was conducted from August 2007 to July 2008.

General Methodology

To compile basic information about Child Protective Services (Child Protective Services W.S. 14-3-201 through 14-3-216, and related statutes), we reviewed relevant statutes, rules, professional literature, legislative history, agency literature, agency budget requests, previous studies and reports, and other information. To gain further understanding, we interviewed state-level DFS officials and Protective Services Division staff and surveyed local casework supervisors. We interviewed staff who administer the central registry as well as hearing officers from the Office of Administrative Hearings. We also observed meetings including the November 2007 state CFSR review in Laramie; a Child Major Injury and Fatality Review meeting; two DFS Advisory Board meetings; a central registry expungement hearing; and portions of the DFS new caseworker training, CORE. We concentrated on information and events from 1999 to the present.

Department of Family Services: documents

We requested and obtained agency documents to gather cost, staff turnover, casework experience and educational levels. We received reports including the DFS-prepared Self-Assessments for the two federal CFSR reviews, strategic plans, annual reports from DFS and other relevant agencies, the Program Improvement Plan from the first federal CFSR, the Family Services Manual, and CORE training handouts. We also reviewed material from the DFS website.

Department of Family Services: data

The data analyzed for this report should be considered current as of January 1, 2008. We requested and obtained records from WYCAPS on all current and closed CPS incidents since 2000, and we were also granted limited access to WYCAPS screens to gather incident-specific data that complemented our hard-copy file review. WYCAPS data is almost always entered by field staff around the state and WYCAPS allows caseworkers to over-write some data, but we analyzed only what was displayed at the time of our study. For example, we could not verify

whether incidents had been assigned previously to different tracks; we could only tell how incidents were assigned at the time of our query.

LSO case file review

A significant portion of our research consisted of a thorough review of electronic and hard-copy files on individual families. Akin to the state CFSR process, we designated a timeframe for our review to include families with incidents opened January 1, 2004 through December 31, 2007. Some reasons for this timeframe included, but are not limited to the following:

- Four years would be long enough to see most families' full history of DFS contact, and would be a considerably longer (and therefore a more comprehensive) period of review than the state CFSR calls for.
- The longer timeframe would show multiple incidents in multiple tracks for families, when this occurred.
- At the beginning of this timeframe, DFS implemented the family-centered practice casework paradigm, so our sample would show how that practice was implemented throughout the state.

To designate our sample, we took several random samples from the universe of incident identification numbers and related person identification numbers for children subject to allegations of CA/N. We submitted a list of 150 files to DFS: 75 cases with either substantiated or unsubstantiated investigation findings, 35 assessment track cases, 20 prevention track, and 20 untracked cases. In each case, families may have other incidents and other tracks in their history of DFS contacts, but we reviewed the cases primarily for the track type noted at the time of our query. DFS had hard-copy files delivered to Cheyenne; we reviewed these files at the DFS office after reviewing the related electronic records in WYCAPS.

Recent Program Evaluations

Child Protective Services	November 1999
Wyoming State Archives	May 2000
Turnover and Retention in Four Occupations	May 2000
Placement of Deferred Compensation	October 2000
Employees' Group Health Insurance	December 2000
State Park Fees	May 2001
Childcare Licensing	July 2001
Wyoming Public Television	January 2002
Wyoming Aeronautics Commission	May 2002
Attorney General's Office: Assignment of Attorneys and and Contracting for Legal Representation	November 2002
Game & Fish Department: Private Lands Public Wildlife Access Program	December 2002
Workers' Compensation Claims Processing	June 2003
Developmental Disabilities Division Adult Waiver Program	January 2004
Court-Ordered Placements at Residential Treatment Centers	November 2004
Wyoming Business Council	June 2005
Foster Care	September 2005
State-Level Education Governance	December 2005
HB 59: Substance Abuse Planning and Accountability	January 2006
Market Pay for State Employees	July 2006
Wyoming Drug Courts	July 2006
A&I HRD Role in State Hiring	December 2006
Kid Care CHIP: Wyoming's State Children's Health Insurance Program	June 2007
Wyoming Retirement System: Public Employee Plan	August 2007
WYDOT and General Fund Appropriations for Highways	May 2008

Evaluation reports can be obtained from:

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