COMPILATION OF RECOMMENDATIONS FROM PREVIOUS REPORTS RELATING TO WASHINGTON'S CHILD WELFARE SYSTEM

Prepared By

Sonja Hallum Office of Program Research

For Use By

The Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services 2005

OVERSIGHT, REVIEW AND ACCOUNTABILITY

Policy and Procedure

- 1. Institute a standardized process for reviewing and documenting CPS investigations. OFCO at 8 (Robinson Review).
- 2. Establish baseline expectations for consistency, e.g., practice standards, protocols, checkpoints, etc. Make it the job of leadership (Regional Administrators through supervisors) to assure their consistent attainment. Community values/mores should enhance, not modify, these baseline standards. *Riveland* @15.
 - a. Regional Administrators have authority to structure delivery in their own regions. This autonomy creates issues of consistency of practice standards.
- 3. A separate unit should be established to monitor cases, which require on-going agency services. *Id.*
- 4. A separate unit should be established that only investigates child abuse and neglect allegations and does not perform service delivery. *Id.*

Supervisor Role

- 5. Clarify the management responsibilities and roles for supervisory staff. Create greater alignment between authority, accountability and responsibility for supervisors. Supervisors are the critical link in the chain of accountability that begins with the CPS worker and goes through the DSHS Secretary to the citizens. Increase the time available for supervisors to guide and grow staff. Decrease the time through automation or delegation needed for routine monitoring tasks. *Riveland at 18*.
- 6. The staff supervisor ratio must be reduced to allow adequate oversight of casework practice, and to allow supervisors to act as on-the-job mentors to caseworkers. In our investigation we found that caseworkers tend to work independently with supervisors unaware of case activities. To ensure accountability supervisory oversight must be strengthened. *Advisory at 20*.

Office of Program Research

- 7. Supervisors must take an active role in questioning the conclusions that social workers make about a given family, and in reviewing and challenging the social worker's case plan. *OFCO 8/3 at 1 (Nobles Review)*.
- 8. Strengthen supervisory review of CPS investigations. *OFCO 8/3 at 1 (Nobles Review)*

Accountability

- 9. DCFS must develop clear performance expectations for staff and must be given greater autonomy to fire staff who do not meet those standards. The agency is not effective in correcting unsatisfactory employee performance. Attempts at employee discipline are often thwarted by indifferent upper management support of unit supervisors, in combination with strong employee union backing. Management must set clear expectations of staff performance, conduct fair monitoring of performance, and strong corrective actions with employees who do not meet performance expectations. *Advisory at 21*.
- 10. Consequences should apply when social workers and supervisors fail to follow policy and protocols in practice manuals, policy, RCW and WAC. *OFCO 8/3 at 1 (Gomez Review)*.
- 11. CA should develop and implement corrective/ disciplinary action if supervisors or workers fail to comply with investigation standards. The yearly staff personnel evaluation process should be reformed to encourage peer and client review of caseworker performance. Supervisory performance should also be formally reviewed by front-line caseworkers. *OFCO at 8 (Robinson Review)*.

Performance, Outcome, and Quality Assurance Measures

- 12. Increase emphasis on outcomes measurement and performance management. *Implementation*.
- 13. The Children's Administration should establish targets for outcome oriented performance measures. *JLARC at* 22.
- 14. The Children's Administration should analyze the characteristics of re-occurrences of serious child abuse/neglect after a case is open and on recently closed cases. *JLARC at 21*.

Office of Program Research

- a. Measures of program performance in the past have been output versus outcome oriented. While CPS has done a good job of monitoring the number of referrals received, response times, and the number of cases per caseworker, it has not measured the effectiveness of the services delivered. One measure of program effectiveness is the rate of re-occurrence of serious child abuse/neglect after a case is open, and on recently closed cases. *JLARC at 17*.
- 15. Daily practice should reflect full implementation of intake quality assurance processes. *Fatality Review at 1 (Champagne-Loop Review)*.
- 16. The Children's Administration should utilize the Department of Personnel's Human Resource Development Information System (HRDIS) to monitor compliance with coursework requirements. *JLARC at* 34.
- 17. A Continuous Quality Insurance team (CQI) should be initiated to strengthen objective decision making by social workers and supervisors with regards to case management. *Fatality Review at 1 (Nobles Review)*.

Bibliography

- 1. "Adolescents in Need of Long Term Placement"
- 2. "Child Protective Services in Washington State Administrative Assessment" Riveland Associates (*Riveland*), July 2000.
- 3. "The Management Improvement Project," Deloitte & Touche Consulting Group(*Management*), January 1997.
- 4. "Implementation Plan and Recommended Approach to Lasting Change" Deloitte & Touche Consulting Group(*Implementation*), March 1997.
- 5. "Child Protective Services Report 97-2," Joint Legislative Audit and Review Committee (JLARC), 1997.
- 6. "A Community Perspective: The Report of The Child Welfare Citizen Advisory Board" (*Advisory*), February 1993.
- 7. "Recommendations of Respective CA Fatality Review Committees by Issue" Office of Family and Children's Ombudsman (*Fatality Reviews*), August 3, 2005.
- 8. "OFCO Issues and Recommendations" Office of Family and Children's Ombudsman (*OFCO*), September 12, 2005.