

Senate Finance Committee Subcommittee on Health and Human Resources

Recent Reviews of the
Richmond City Department of Social Services
Child Welfare Services

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Overview

- Virginia Children's Services System Transformation
- Allegations Surface
- Key Findings and Summaries of Reviews
 - Richmond Office of the City Auditor, Office of the Inspector General (OIG) – May 9th, 2013
 - Virginia Department of Social Services Quality Management Review (QMR) – June 2013
 - Child Welfare League of America (CWLA) - August 15th, 2013

Background – OIG Review

- Richmond City Council Members contact OIG
- Richmond City Employees contact OIG
- OIG initiates and completes investigation regarding the following allegations:
 - Employees alleged management decisions compromised children’s safety
 - Employee allegations of hostile work environment and unfair hiring practices

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Summary of Allegations - OIG

Employee Allegations	
Intimidation, Unrealistic Expectations and Lack of Guidance	<p>Behavior</p> <ul style="list-style-type: none"> •Supervisors exhibited rude behavior toward subordinates •Employees publicly humiliated and reprimanded •Employees who challenged upper management were removed and/or transferred to other service areas <p>Lack of proper guidance</p> <ul style="list-style-type: none"> •After initial employee training, there was lack of on-going training regarding records management •RDSS lacked policies and procedures to provide guidance for CPS workers to execute their job duties •Supervisors were not available for team development meetings <p>Unrealistic Expectations</p> <ul style="list-style-type: none"> •Employees negatively evaluated for minor performance issues without consideration of excessive workload •CPS had 599 active cases that transpired to 46 cases per employee. CWLA standards recommend 10 to 12 active cases per month •RDSS did not meet VDSS deadlines for certain tasks.

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Summary of Allegations - OIG

Employee Allegations	
<p>Employee Morale and Unsound Management Practices</p>	<p>Employee Turnover •During 2012 employee turnover increased to 35%, it was 15% in 2011.</p> <p>Lack of Confidence in Management •Employees expressed lack of confidence in Administration and RDSS Management to address concerns to resolve workplace issues. •Workers communicated concerns in memo to RDSS Director, who did not take any actions or offer to meet with employees. •During OIG interview, the RDSS Director indicated lack of knowledge regarding intimidation and change of direction in the CPS Unit. Accordingly, the Director did not take action to resolve the issues. In this case, this lack of knowledge about changes in RDSS and the potential impact of such changes. In this case the consequences were significant and impacted the health and safety of children in abusive homes.</p> <p>Unsound Management Practices •Caseworkers left children in unsafe environments. After May 2011, supervisors needed approval from Program Manager and Deputy Director before child removal from unsafe conditions. •Caseworkers were directed not to prepare Preliminary Protective Orders (PPO) and Emergency Removal Orders (ERO)</p>

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Summary of Allegations - OIG

Employee Allegations	
<p>Unsound Management Practices</p>	<p>Unsound Management Practices continued •Management edited prepared PPOs and EROs to minimize the impact so the Juvenile Court Judges would not fully understand facts reported •Management's instructions prevented caseworkers from discharging the duties of emergency removals •Limited caseworker contacts with City Attorneys •Management ignored professional medical recommendations</p> <p>Review of Case File Records •OIG investigators learned 35% (37 of 107) case files requested by VDSS Review team were missing. •OIG requested an additional 250 files, 24 case files had been purged appropriately, of the remaining 226 files 34% or 77 files were missing. The files were recreated, but did not contain original documentation (e.g. medical reports, assessments, etc.) •Several files were missing key documentation. •More than 50% of the files removed from the records room had "out-cards" indicating they were removed by caseworkers and supervisors.</p>

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Key Findings - OIG

- Poor Record Management
- Missing official case files
 - Case files lacked official documents
- Actions to reduce CPS removals went too far
 - Agency and worker practice left children in unsafe environments

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Background – VDSS QMR Review

- Review of RDSS internal child welfare practices and protocols
- Review of RDSS child welfare units
- Interview of external stakeholders

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Summary of Findings- QMR

Child Welfare Units	
Findings	<ul style="list-style-type: none"> • RDSS needs records management system as required by Virginia Code. Thirty-seven of the 131 CPS files requested to be reviewed could not be located by RCDSS staff at the time of the onsite review and have not been located to date (at time of report). • There has been a significant drop in the number of Emergency Removal Orders (EROs) and Preliminary Protective Orders (PPOs) filed with the Richmond court. There were 330 petitions filed in 2008 compared to only 84 petitions filed in 2012, a 75% decrease. • Many Family Assessments and Investigations that were determined to be "high risk" or "very high risk" were not opened to ongoing CPS services, as required by policy. • CPS staff have not received all mandatory CPS training. • The RCDSS professional working relationships with community partners/stakeholders, GALs, city attorneys, medical professionals, Multi-Disciplinary Team and others need immediate corrective action and significant improvement. • RCDSS must stop the practice of placing children with a goal of permanent foster care in group homes or residential treatment facilities. VA Code 63.2-908 states a child with the goal of Permanent Foster Care is to be placed in the residence of a person(s) who is determined to be appropriate in meeting the child's needs on a long-term basis. Residential treatment facilities and group homes are not personal residences.

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Summary of Findings- QMR

Child Welfare Units	
Findings	<ul style="list-style-type: none"> • The CPS Second Responder unit needs to be eliminated in its present form. Management should contact other large LDSS in the state for ideas. • Complete relative searches must be performed for all children when they enter foster care. • The RCDSS needs to develop a plan to address referrals for children in need of child-specific placements. • Training requirements for CPS staff have not been met. An examination of the staff training transcripts revealed that none of the CPS staff have completed state mandated training. • Workers complained that they were treated poorly, disregarded, and told they were "stupid". They reported that founded cases of abuse and neglect were changed to unfounded by upper management. These issues require immediate attention and correction by upper management. • The RCDSS Director must stay informed and become more involved in the work of the Executive Team, Program Managers, supervisors and staff in the child welfare division.

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Summary - QMR

- Corrective Action Plan (CAP)
 - VDSS Central Regional Office request
 - RDSS CAP conditionally accepted

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Background– Child Welfare League of America (CWLA)

- Broad review
 - Policies and practice
 - Training
 - Systems Integration
 - Relationships with Community Stakeholders

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Summary of Findings- QMR

CWLA Findings and Categories	
Findings	<p>Children's Rights</p> <ul style="list-style-type: none"> •The rights of child/ren to have their basic needs met were superseded by the perceived rights of the parents to keep their children at home. •Children with serious medical conditions who were living with their parents were not given consistent care on an ongoing basis. •Evidence in case records that City Attorneys' and social workers' voices were not heard regarding placement decisions. •Cases revealed protracted decision-making which left children in undesirable settings and impeded progress toward permanency. <p>Shared Responsibility and Leadership</p> <ul style="list-style-type: none"> •Direct correlation between the lack of responsible, transparent, and competent senior leadership and the challenges currently facing RDSS. •Lack of team cohesiveness. •Lack of leadership ability to understand the Virginia Children's Services Practice Model and the purpose of Virginia's Children's Service System Transformation.

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Summary of Findings- QMR

CWLA Findings and Categories	
Findings	<p>Engagement and Participation</p> <ul style="list-style-type: none"> •RDSS has not fully implemented the Virginia Children's Services Practice Model •Interviews with community partners indicated that efforts to build and sustain community collaborations for programs and services were sporadic until August, 2012. •Interviews and records indicated that parents and other family members were not engaged. <p>Supports and Services</p> <ul style="list-style-type: none"> •Interviews with community partners and staff indicated that community supports such as housing for families and preventive supports to families were in short supply, as were foster family resources. Once the recent challenges for RDSS became public, the available number of foster and adoptive family resources decreased. <p>Workforce</p> <ul style="list-style-type: none"> •Training was listed as a top priority by staff; however, staff stated when training was available, they could not attend due to lack of coverage. • Supervisors expressed concern that they were not provided with appropriate learning and professional development opportunities from within RDSS. • Interviews with staff and supervisors confirmed that not all current CPS social workers were certified in CPS, as required by VDSS guidance.

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Summary of Findings- QMR

	CWLA Findings and Categories
Findings	<p>Quality Improvement</p> <ul style="list-style-type: none"> •Although a Quality Improvement (QI) unit was created and was producing data relative to all facets of the child welfare programs, interviews with managers and staff revealed minimal understanding and use of the data produced. Senior staff did not know how to use information from the data systems (OASIS, SAFE Measures) and the unit was never fully integrated within the RDSS infrastructure. •Little, if any, attention was paid to data documenting the rise in caseloads and the CPS supervisory overload issues. <p>Race, Ethnicity and Culture</p> <ul style="list-style-type: none"> •Former leadership failed to use known best practices concerning racial disparity and disproportionality to guide decisions about child safety, permanency and well-being. • Interviews with staff and community partners revealed an environment that had been negatively impacted by a mistrust of the previous administration, adding to existing concerns about religious and church affiliations of both staff and agency leadership, as well as a distorted view of staff and client entitlement to various supports and services. • Interviews revealed instances where case assignments were made based upon the race/ethnicity of RDSS social workers rather than according to the skills of the social worker and the needs of the child and family.

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Actions to Date

- Leadership Transition in the late Winter early Spring
- Acting Deputy Chief Administrative Officer Steve Harms appointed
- Acting Social Services Director Tonya Vincent appointed
- Leadership change in key units
- Veteran Child Welfare Expert hired via contract
- Active recruitment for key leadership positions
- RDSS instituted initiatives to address backlog of referrals, on call, case openings and transfers, and file management procedures.
- Second Responder Unit disbanded and new “CPS On Call Protocol” implemented.
- Reallocated current staff and provided temporary resources to address the overdue referrals
- Training provided regarding on call protocol, court procedures, CPS assessment and investigations procedures

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Summary Recommendations

- VDSS CRO monitoring and assistance on CAP implementation
- Communications with and support for RDSS