Report 06-1
February 2006

An Evaluation

Milwaukee County Child Welfare: Program Issues

Department of Health and Family Services

2005-2006 Joint Legislative Audit Committee Members

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From the Department of Health and Family Services

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State Auditor

February 8, 2006

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

We have completed an evaluation of the Milwaukee County child welfare program, as requested by the Joint Legislative Audit Committee. The program, which protects children from abuse and neglect, is administered by the Bureau of Milwaukee Child Welfare in the Department of Health and Family Services (DHFS), which contracts for most services. In June 2005, the program served 3,188 children who had been removed from their homes to ensure their safety. An additional 266 families received services without having a child removed from the home. From January 2001 through June 2005, program expenditures totaled $493.7 million. Our review of program expenditure and staffing issues is report 06-2.

DHFS has taken important steps in recent years to improve the welfare of children in Milwaukee County, including significantly reducing the number of children in out-of-home care. However, we identified concerns with the timeliness of investigations of child abuse and neglect, as well as the timeliness with which court-ordered services are provided. Collaboration and coordination among child welfare staff is limited, and problems related to establishing permanent placements were documented in 25 of 48 cases we reviewed. We make a number of recommendations for the Bureau to improve program management.

To assess whether the Bureau adequately ensured the safety of children, we reviewed 73 high-risk cases that were most likely to involve child abuse or neglect. The Bureau and its contractors took reasonable and appropriate action in 69 of these cases, but we believe more could have been done to protect children in the remaining 4 cases.

We appreciate the courtesy and cooperation extended to us by DHFS and the child welfare contractors. A response from DHFS follows the appendices.

Respectfully submitted,

Janice Mueller
State Auditor

JM/PS/ss

Report Highlights ■

Investigations of abuse and neglect have exceeded the 60-day statutory time limit.

Program improvements have reduced both the number of placements and the median stay in out-of-home care.

Improvements are needed to ensure the safety of children who remain with their families.

Sufficient action was taken to protect most, but not all, children from abuse and neglect.

Financial oversight should be improved.

Staff turnover remains a significant concern.

Counties have historically administered child welfare programs in Wisconsin. However, the Department of Health and Family Services (DHFS) began administering Milwaukee County's child welfare program in January 1998, following a 1993 class-action lawsuit filed in federal court. In June 2005, its Bureau of Milwaukee Child Welfare had 153 full-time equivalent employees (FTE), including 90 social workers who investigate allegations of abuse and neglect. Contractors employed approximately 500 staff to provide most other program services, such as case management for children who have been removed from their homes because of maltreatment. From January 2001 through June 2005, program expenditures totaled $493.7 million.

At the direction of the Joint Legislative Audit Committee, we conducted a comprehensive program evaluation. Report 06-1 addresses program management and performance, including:

- the timeliness of the Bureau's efforts to investigate allegations of abuse and neglect;
- the effectiveness of both out-of-home care and safety services that are provided when at-risk children remain at home, as well as the coordination of program services; and
- the Bureau's success in achieving 14 mandatory and 10 monitoring standards required by a settlement agreement arising from the lawsuit.

Report 06-2 addresses:

- program funding and expenditures, including the appropriateness of expenditures by program contractors; and

- staff turnover, qualifications, training, workloads, and salaries.

Investigations

From January 2004 through June 2005, the Bureau completed 14,224 investigations that involved 28,474 allegations of child abuse or neglect. A single investigation can include multiple allegations when, for example, more than one child is involved.

Statutes require investigations to be completed in 60 days. The Bureau exceeded the statutory time limit in 4,397 investigations, or 30.9 percent of those completed. It substantiated 15.2 percent of the allegations it investigated during the 18-month period we reviewed.

If the Bureau's investigation indicates that a child has been abused or neglected or that such treatment is imminent, the child is temporarily removed from the home. The Children's Court either determines that the child can safely be returned to the home or orders an out-of-home placement.

Out-of-Home Care

In June 2005, 3,188 Milwaukee County children were in foster care or other out-of-home placements. Nearly 40 percent of placements were in foster homes with non-relatives, although 771 children, or 24.2 percent, were placed with relatives participating in Kinship Care.

Significantly more children receive out-of-home care in Milwaukee County than elsewhere in Wisconsin, but the program's out-of-home placement rate declined 47.7 percent from January 2001 through June 2005. The Bureau's efforts to improve program operations contributed to this decline.

The median stay in out-of-home care also declined, from 39 months in June 2003 to 21 months in June 2005. However, in 25 of the 48 cases we reviewed, we identified problems such as insufficient coordination among child welfare staff. Children leave out-of-home care when their families are reunified, guardianship is transferred to a relative, they are adopted, or they reach adulthood.

Safety Services

Safety services—including parenting education, counseling, and drug and alcohol treatment—are made available to families by program contractors when children are not able to remain in the home without services. Participation is voluntary, although children may be removed from the home if family members do not agree to receive the safety services.

Safety services caseloads declined 63.4 percent from January 2001 through June 2005, from 727 to 266 families. The average period for which services were provided declined from 110 days in January 2003 to 81 days in January 2005. We found that some cases were closed prematurely.

For each family served, safety services contractors are paid $4,776, regardless of which services are provided or how long the case remains open. Through 2005, both case management and safety services contractors were contractually required to provide quarterly reports identifying the services provided to 10.0 percent of their cases. However, the Bureau has neither requested nor received any of these reports since early 2003.

Improving Performance

We analyzed 73 high-risk cases that were most likely to involve child abuse or neglect. In 69 of these cases, the Bureau and its contractors took reasonable and appropriate action. However, we found four cases in which efforts were insufficient to ensure children's safety. These included one case in which children were allowed to live in a condemned house for more than four months and another in which an infant died as a result of abuse.

We also found that 20.1 percent of children who were reunified with their parents from January through June 2003 reentered out-of-home care within 24 months. Further, 11.4 percent of families who ceased receiving safety services during the first 6 months of 2004 had children removed from the home within the next 12 months. This rate exceeded the 4.0 percent contractual limit. However, because the Bureau does not monitor compliance, no funds have ever been withheld from safety services contractors.

Through June 2005, the Bureau met 8 of 14 performance standards required under the court-approved settlement agreement between the State and plaintiffs in the 1993 class-action lawsuit. Each standard will remain in effect until there is agreement by the parties to the lawsuit or an arbitrator determines that it has been met.

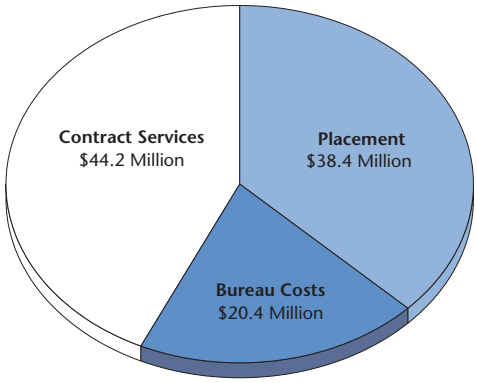
We found errors in the way the Bureau calculates its performance related to one permanency standard, which have overstated program success.

Program Finances

As shown in Figure 1, program expenditures fund the Bureau's costs, placement costs, and services provided by contractors. In 2004, they totaled $103.0 million.

Figure 1

2004 Milwaukee County Child Welfare Expenditures



We reviewed the appropriateness and reasonableness of costs that nine contractors charged the program in 2004. We found $677,694 in unallowable and questioned costs charged by six contractors, including payment of a $541,604 duplicate reimbursement request submitted by one contractor, Lutheran Social Services.

Another contractor, La Causa, has had difficulty controlling costs in the past. As of December 2005, La Causa's debt was $6.2 million. This debt will have to be monitored carefully because DHFS has awarded La Causa a $10.6 million contract to provide program services in 2006.

We also have concerns that 2006 case management contracts pay a fixed case rate regardless of the amount of service provided to families.

Staff Turnover

Turnover of child welfare staff is a significant concern in Milwaukee County and nationwide. Among the case managers employed by program contractors, turnover was 30.1 percent in 2003 and increased to 38.6 percent in 2004. In contrast, annual turnover among the Bureau's social workers has been approximately 10.0 percent.

Recommendations

Our report includes recommendations for DHFS to report to the Joint Legislative Audit Committee on its actions to:

- ☑ improve the timeliness of its investigations and the delivery of court-ordered services; reduce the time children spend in out-of-home care; ensure the adequacy of safety services; and improve service coordination with Medical Assistance, W-2, and other social services providers *(p. 82, report 06-1);*

- ☑ monitor families who return for additional safety services within 12 months, as well as those who have children placed in out-of home care in the 12 months following receipt of safety services, and enforce contractual provisions if returning cases exceed prescribed rates *(p. 52, report 06-1);*

- ☑ ensure that all children in out-of-home care receive annual medical and dental examinations *(p. 66, report 06-1);*

- ☑ continue to work to improve the retention of child welfare staff *(p. 36, report 06-2);*

- ☑ appropriately calculate the Bureau of Milwaukee Child Welfare's compliance with performance standards specified in the settlement agreement *(pp. 57, 59, and 66, report 06-1);*

- ☑ collect and analyze information on services that contractors provide to families *(p. 18, report 06-2);* and

- ☑ monitor and assess La Causa's financial condition *(p. 23, report 06-2).*

In addition, we recommend that DHFS:

- ☑ require contractors to repay $582,981 in unallowable costs and to either repay $94,713 in questioned costs or provide additional documentation *(p. 27, report 06-2)*; and

- ☑ ensure that new staff complete pre-service training before managing cases *(p. 33, report 06-2)*.

Finally, we include a recommendation for the departments of Justice, Public Instruction, and Workforce Development to require Lutheran Social Services to reimburse them for public funds spent on unallowable costs *(p. 25, report 06-2)*.

■ ■ ■ ■

Introduction ■

DHFS has administered the child welfare program in Milwaukee County since 1998.

DHFS assumed responsibility for Milwaukee County's child welfare program following a class-action lawsuit filed by the American Civil Liberties Union and Children's Rights, Inc., a nonprofit organization that advocates on behalf of abused and neglected children. In June 1993, the plaintiffs alleged that the State had failed to adequately oversee the program administered by the Milwaukee County Department of Human Services because:

- reports of suspected child abuse or neglect were not investigated properly;
- families were not provided with services to help them avoid unnecessary out-of-home placements, and children spent many years in government custody because of inadequate planning;
- children were often placed inappropriately and were unsupervised by child welfare staff;
- services to allow children to either return home or be adopted were inadequate; and
- child welfare staff had high caseloads and were inadequately trained and supervised.

In June 1999 and December 2000, the plaintiffs filed additional complaints alleging that children in the program continued to be harmed and that DHFS was violating federal law by not moving

children in government custody toward permanent legal placements.

DHFS administers the program under terms of a settlement agreement approved by a federal court.

DHFS began to administer the program on January 1, 1998, following enactment of 1995 Wisconsin Acts 27 and 303. In December 2002, the United States District Court for the Eastern District of Wisconsin approved a settlement agreement that noted improvements in the safety and well-being of children but established 14 mandatory performance standards and 10 monitoring standards. DHFS is expected to meet these standards over a three-year period that began in January 2003. Until DHFS demonstrates to the satisfaction of an arbitrator that all required standards have been met and the court upholds a petition for termination submitted by all parties, the settlement agreement will remain in effect.

There has been considerable legislative interest in evaluating the program, in part based on media reports of children who were harmed while in the State's custody. In addition, problems with child welfare contractors have been identified in recent years. To evaluate the effectiveness of service delivery, we examined electronic files for 171 cases, including:

- 73 cases selected from those most likely to involve children at risk of abuse or neglect;
- all of the out-of-home care cases that were opened in January 2004; and
- 50 of 64 safety services cases that were opened in January 2004.

In addition, we interviewed DHFS and contract staff; spoke with advocates and organizations interested in child welfare issues; contacted child welfare providers in five other Wisconsin counties and six other midwestern states; reviewed a number of studies completed by independent researchers; and reviewed meeting minutes of the Milwaukee Child Welfare Partnership Council, which was created by 1995 Wisconsin Act 303 to make recommendations for improving the county's child welfare program to DHFS and the Legislature.

Federal law requires states to record information about each child welfare case in a centralized case management system. Although DHFS maintains a statewide information and case management system that represents an official, legal record for each case, its information is sometimes inaccurate and incomplete, largely because of data-entry errors made by state or contract staff. We restricted most analyses to January 2003 or later, the period for which the most reliable information was available.

This report focuses on program management and performance. In conjunction with it, we have also released a report that addresses program expenditure and staffing issues (report 06-2).

Process Overview

The DHFS Bureau of Milwaukee Child Welfare receives allegations of child abuse and neglect.

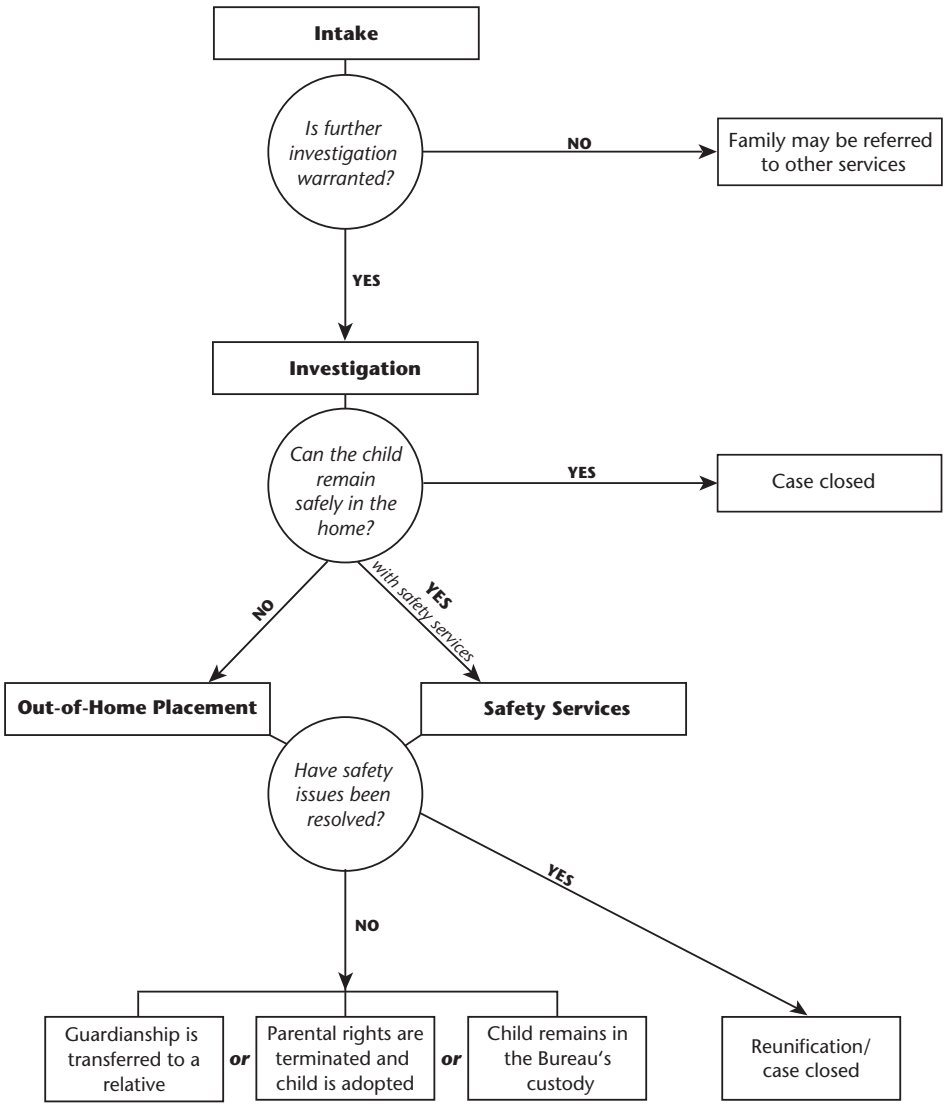
Figure 2 illustrates the process in place to resolve reported instances of abuse or neglect in Milwaukee County. Most allegations are reported by telephone to the Bureau's child welfare intake unit, which operates 24 hours each day, seven days per week. If an allegation involves abuse or neglect, the Bureau begins an investigation either the same day or within the next five days, depending on perceived seriousness. Statutes require the investigation to be completed within 60 days.

In practice, the investigation can take from a few days to a month or more to complete. It typically involves separate interviews with the child and other family members, as well as a review of information such as prior contact with the child welfare system. If the investigation determines that the child is safe, the case is closed. The family may, however, be referred to faith-based organizations, nonprofit organizations, and other community resources that provide counseling and other services.

If the Bureau determines that the child has been or is in danger of being abused or neglected but can safely remain in the home, the family is offered safety services that can include family counseling and parenting assistance, as well as regular home visits by child welfare staff. If the Bureau determines that the child is being abused or neglected or that such treatment is imminent, removal from the home is necessary and out-of-home placement begins immediately.

Figure 2

Resolution of Reported Child Abuse and Neglect



When a child is removed from the home, the Bureau first determines whether a fit and willing relative is able to provide care. If not, staff typically take the child to either an assessment home, which is a specialized foster home for children under 12 years of age, or an assessment center, which is a group home for children 12 or older. This initial, short-term placement allows the child's needs to be determined before an appropriate longer-term placement is found. Longer-term placements may be with a relative, in a foster home,

or—when the child has medical, physical, developmental, or emotional needs that cannot be met by such placements—in a treatment foster home, group home or residential care center. Treatment foster homes are similar to other foster homes except that the foster parents have received additional training in caring for children with special needs. Group homes serve from five to eight children, while residential care centers serve more than eight children.

The Children's Court determines whether removal of children from their homes is justified.

The children's division of the Milwaukee County circuit court, which is more commonly known as the Children's Court, is required to hold a detention hearing within 48 hours of a child's removal from the home to determine whether the child should remain temporarily in the custody of DHFS or be returned home. Bureau staff present evidence to demonstrate to a judge that remaining in the home would be detrimental to the child's welfare. If the court agrees, it appoints a guardian ad litem, who is an attorney assigned to ensure the child's best interests are represented. Typically, the district attorney's office also files a Child in Need of Protection or Services (CHIPS) petition requesting that the child remain in the custody of DHFS for a longer period in order to be placed in out-of-home care. A separate hearing on the CHIPS petition is scheduled.

Within 9 to 13 days of the detention hearing, Bureau staff meet with contracted case managers to identify parenting or environmental issues that adversely affected the child's safety and well-being and seek input in resolving these issues. Necessary child welfare services are identified, and the need for a long-term out-of-home placement is considered. Within 21 days of the detention hearing, a court commissioner holds a service implementation hearing to ensure that all parties are trying to resolve the case and to determine whether all necessary services are being provided for the child and the parents or guardian.

Within 30 days of the detention hearing, the Children's Court holds a hearing on the CHIPS petition. If the child's parents contest the petition, additional hearings may be held. If the petition is granted, DHFS is typically given custody of the child for a one-year period that can be extended by the court. The court specifies services the child and his or her family should receive so that the child can return to a safe home. These services may include substance abuse and mental health treatment, parenting education, and transportation assistance.

If an out-of-home placement is ordered by the Children's Court, state and federal law require the Bureau to identify the permanent placement goals for the child. This permanency plan must be completed within 60 days of the child's removal from the home and

approved by the court. If possible, the goal is reunification. If not, other goals are transferring guardianship to a relative, adoption, or keeping the child in government care until the age of 18. Every six months, the court reviews the permanency plan to ensure that it reflects the child's best interests and that adequate progress is being made in providing needed services.

If adoption is the preferable permanent placement, the district attorney's office files a termination of parental rights (TPR) petition with the court, which subsequently holds a hearing to consider evidence presented by the parents or their attorneys, the guardian ad litem, and the district attorney's office. If the petition is granted, the parents have no further legal rights or obligations regarding the child, who can be adopted. Until adoption is completed, the court continues to review permanency plans every six months.

If adoption is not the preferable permanent placement, a TPR petition typically is not filed. For example, if the child is in a stable placement with a relative, the court may transfer legal guardianship to that relative. Alternatively, particularly if the child is a teenager, he or she may remain in foster care until the age of 18 and receive services to prepare for independent living as an adult. A child typically leaves the child welfare program upon reaching the age of 18.

Trends in Program Participation

Out-of-home placements and use of safety services have declined.

Both the number of children in out-of-home placements and the number of families receiving safety services declined from January 2001 to June 2005. Out-of-home placements declined 47.7 percent, from 6,094 in January 2001 to 3,188 in June 2005. The number of families receiving safety services declined 63.4 percent, from 727 in January 2001 to 266 in June 2005.

The Bureau's efforts to improve program operations have contributed to the decline in out-of-home placements. In addition, changes in federal law in the late 1990s emphasized the importance of allowing children to remain in their homes whenever possible. The number of children in out-of-home care has declined steadily throughout the United States since 1999, and available information suggests that urban caseloads have declined more than those in suburban and rural areas.

Because we were unable to identify caseload information for urban areas comparable to Milwaukee County, we reviewed available state-level data. As shown in Table 1, for every 1,000 children in Milwaukee County, 15.6 were in out-of-home care in

September 2003. Among midwestern states, out-of-home care caseloads ranged from 5.5 per 1,000 children in Indiana to 8.4 per 1,000 children in Michigan.

Table 1

Out-of-Home Care Caseloads
As of September 30, 2003

	Number of Children in Out-of-Home Care	Number of Children in Out-of-Home Care per 1,000 Children
Indiana	8,899	5.5
Minnesota	7,338	5.9
Wisconsin	7,824	5.9
Illinois	21,608	6.7
Ohio	19,323	6.9
Iowa	5,011	7.2
Michigan	21,376	8.4
Milwaukee County	3,795	15.6

Significantly more children receive out-of-home care in Milwaukee County than elsewhere in Wisconsin.

More recent comparative data were available for Wisconsin counties. From December 2001 through June 2005, the number of children in out-of-home care declined 28.6 percent in Milwaukee County but increased 13.9 percent in the balance of the state. Among counties outside of Milwaukee with the largest caseloads, there were increases of 93.9 percent in Brown, 33.9 percent in Rock, and 4.7 percent in Racine counties, and decreases of 28.4 percent in Kenosha and 8.6 percent in Dane counties. Significantly more children receive out-of-home care in Milwaukee County than elsewhere in the state.

Service Providers

DHFS contracts for the provision of most child welfare services in Milwaukee County.

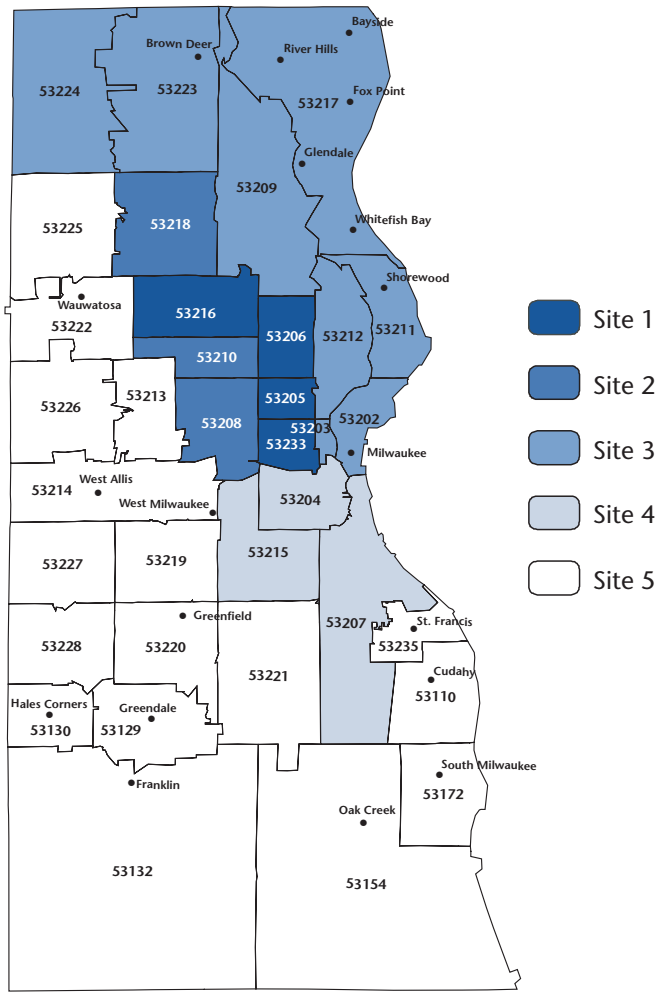
Bureau staff conduct intake activities and investigate most allegations of child abuse and neglect, but DHFS contracts for the provision of most child welfare services in Milwaukee County. In June 2005, the Bureau employed 153 FTE staff, while the four private contractors that provided case management, foster care, safety, and

adoption services had approximately 500 FTE employees. DHFS also contracts for other services, such as independent living services for teenagers who will soon turn 18 and leave the program. A more detailed analysis of staffing—including the problem of turnover—is included in report 06-2.

To distribute caseloads evenly among contractors, DHFS divided Milwaukee County into five sites based on zip code boundaries, as shown in Figure 3. The names of the primary child welfare contractors from 2001 through 2005 are listed in Appendix 1.

Figure 3

Child Welfare Site Boundaries in Milwaukee County
2005



For most of 2005, two contractors provided case management and safety services. A single contractor provided all foster home placement services in that year, and another contractor provided all adoption placement services. As shown in Table 2, Milwaukee County provided safety services for one site, but it ceased accepting new cases beginning in March 2005. Most contractors subcontracted for many of the services they provided.

Table 2

Primary Child Welfare Contractors in Milwaukee County, by Type of Service
2005

	Site 1	Site 2	Site 3	Site 4	Site 5
Case Management	Children's Family and Community Partnerships			La Causa	Children's Family and Community Partnerships
Safety Services	Children's Family and Community Partnerships			La Causa	Milwaukee County/ La Causa[1]
Foster Home Placement	Lutheran Social Services of Wisconsin and Upper Michigan, Inc.				
Adoption Placement	Children's Service Society of Wisconsin				

[1] Beginning in March 2005, La Causa was assigned all new safety services cases in Site 5.

Funding and Expenditures

As shown in Table 3, the Bureau's largest source of funding is general purpose revenue (GPR), which includes amounts that would have been distributed to Milwaukee County as shared revenue but were instead diverted by 1995 Wisconsin Act 27 to help fund child welfare. Federal funding comes from Title IV-E—a program that supports foster care and adoption services, administration, and staff training—as well as Temporary Assistance for Needy Families (TANF), which also funds programs such as Wisconsin Works (W-2) and the Wisconsin Shares Child Care Subsidy Program. Other funding includes child support and Social Security Insurance payments that Milwaukee County collected for children in out-of-home placements.

Table 3

Bureau of Milwaukee Child Welfare Budget, by Funding Source
(In Millions)

Funding Source	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05
GPR[1]	$ 70.2	$ 70.4	$ 72.6	$ 74.6
Federal Funds				
Title IV-E	25.0	25.0	22.4	22.5
TANF	11.7	11.7	13.2	13.5
Other[2]	2.1	3.2	2.2	2.1
Subtotal	**38.8**	**39.9**	**37.8**	**38.1**
Other[3]	3.0	3.0	2.7	2.7
Total	**$112.0**	**$113.3**	**$113.1**	**$115.4**

[1] Includes funds that would have been distributed to Milwaukee County as shared revenue and the basic county allocation, as well as other GPR.
[2] Includes funding for alcohol and other drug addiction services, adoption incentive funds, and independent living funds for teenagers in the program.
[3] Includes child support and Social Security Insurance payments that Milwaukee County collected for children in out-of-home placements.

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

From January 2001 through June 2005, program expenditures totaled $493.7 million. Expenditures are grouped in three broad categories, as shown in Table 4. Bureau costs include payments for the salaries and fringe benefits of Bureau staff, as well as for facilities, supplies, and overhead. Placement expenditures reflect monthly payments to out-of-home care providers, such as foster parents. Contract expenditures include payments to contractors for program services, including case management, safety, foster care, and adoption services.

Table 4

Milwaukee Child Welfare Program Expenditures, by Category
(In Millions)

Expenditure Category	2001	2002	2003	2004	January through June 2005
Bureau Costs	$ 16.4	$ 16.1	$ 17.4	$ 20.4	$ 9.0
Placement	50.2	52.3	42.8	38.4	20.3
Contract Services	47.6	44.5	50.0	44.2	24.1
Total	**$114.2**	**$112.9**	**$110.2**	**$103.0**	**$53.4**

Program expenditures declined 9.8 percent from 2001 to 2004.

Although the State budgets for the program on a fiscal year basis, we analyzed expenditures by calendar year, which is how child welfare contracts are executed. Expenditures declined 9.8 percent in the four full years shown, from $114.2 million in 2001 to $103.0 million in 2004.

Both placement and contract services expenditures declined in 2004 because the number of children in out-of-home care and the number of families who received safety services declined. However, Bureau costs increased 24.4 percent, from $16.4 million in 2001 to $20.4 million in 2004, largely because of increased costs associated with maintaining and operating the Wisconsin Statewide Automated Child Welfare Information System (WiSACWIS), which contains the electronic case files for families in the child welfare program in Milwaukee County and in the balance of the state. Program expenditures exclude costs of the children's division of the Milwaukee County circuit court. These costs, which totaled $9.6 million in 2005, are paid with a combination of GPR and county funds. A more detailed analysis of expenditures is included in report 06-2.

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Investigations of Child Abuse and Neglect ■

The Bureau is statutorily required to investigate allegations of child abuse and neglect.

One of the Bureau's main responsibilities is to investigate allegations of child abuse and neglect. It is required by statutes to initiate an investigation within 24 hours of receiving an allegation of child abuse or neglect and to complete its investigations within 60 days. When allegations involve foster parents, staff of licensed foster care facilities, or conflicts of interest—such as when a Bureau staff member is accused of maltreatment—statutes require an independent investigation. We examined data for all investigations completed by the Bureau and its independent contractor from January 2004 through June 2005 and found problems related to timeliness.

Initiating Investigations

An individual who believes that a child has been abused or neglected can report the incident by telephone at any time. A line is staffed by the Bureau weekdays from 8:00 a.m. until 12:30 a.m., and otherwise by an answering service that immediately contacts the Bureau if allegations appear to warrant it. If the Bureau determines there is reasonable cause to suspect that a child's safety is at risk, it initiates an investigation.

In the first six months of 2005, 74.6 percent of calls that alleged maltreatment were investigated.

As shown in Table 5, investigations were initiated for 74.6 percent of calls received during the first six months of 2005. Investigations are initiated and scheduled based on the seriousness of allegations.

Table 5

Responses to Calls Alleging Maltreatment

	2003	2004	January through June 2005	Total
Investigation Initiated	9,424	10,157	5,083	24,664
Investigation Not Initiated	4,688	4,150	1,734	10,572
Total Calls	**14,112**	**14,307**	**6,817**	**35,236**
Percentage of Calls for Which an Investigation Was Initiated	66.8%	71.0%	74.6%	70.0%

Section 48.981(3)(c)(1), Wis. Stats., requires a "diligent investigation" to begin within 24 hours after abuse or neglect is reported. In September 1994, DHFS established statewide policies for investigations. According to these policies, investigations are deemed to have begun when child welfare staff collect basic information during the telephone calls alleging maltreatment, and an immediate response by child welfare staff is required if this information indicates a child's safety is in danger.

From January 2003 through June 2005, the Bureau did not respond to most allegations within 24 hours.

As shown in Table 6, a small number of investigations began within two hours, because the allegations indicated there was an immediate threat to a child's safety. However, the Bureau assigned a response time of two to five days for 72.0 percent of the investigations it initiated from January 2003 through June 2005.

In assigning different response times, the Bureau appropriately placed a higher priority on acting quickly when the alleged maltreaters were caregivers. For example, it assigned a response time of 24 hours or less for:

- 52.2 percent of calls alleging maltreatment by foster parents or the staff of a licensed foster care facility;

- 25.2 percent of calls alleging maltreatment by parents, step parents, and other primary caregivers;

- 11.1 percent of calls alleging maltreatment by relatives who live outside the home, teachers, and other secondary caregivers; and

- 2.9 percent of calls alleging maltreatment by a child's peers, family friends, and other non-caregivers.

Table 6

Assigned Response Times for Investigations Initiated by the Bureau of Milwaukee Child Welfare
January 2003 through June 2005

Assigned Response Time	Number of Investigations	Percentage of Total
2 Hours	213	0.9%
Same Day	3,067	12.4
24 Hours	2,031	8.2
2 to 5 Days	17,742	72.0
Unknown[1]	1,611	6.5
Total	**24,664**	**100.0%**

[1] The Bureau did not indicate response times for these calls.

Although DHFS policies consider investigations to have begun during the initial telephone calls alleging maltreatment, we believe it is reasonable to expect all assigned response times to meet the statutory requirement because the Bureau has sufficient staff to do so. It has assigned 90 staff to investigate allegations. This number appears to be sufficient to handle the 27 calls, on average, that it decides to investigate each day.

Completing Investigations

Based on information collected during an investigation, the Bureau determines whether there is sufficient evidence to substantiate allegations of maltreatment. An investigation may involve more than one child. Furthermore, investigations often include multiple allegations, several alleged maltreaters, and multiple types of alleged maltreatment.

Nearly one-third of investigations were not completed within 60 days.

Although s. 48.981(3)(c)(4), Wis. Stats., requires investigations to be completed within 60 days, the Bureau requires them to be completed within 30 days. However, as shown in Table 7, 30.9 percent of the 14,224 investigations completed by the Bureau and its contractor from January 2004 through June 2005 took longer than the 60 days allowed by statutes, while 56.0 percent took longer than the 30 days allowed by the Bureau. The Bureau's data indicate that 322 of the 4,397 investigations required more than 12 months to complete. In the period shown, the median time to complete Bureau investigations increased from 34.9 days in 2004 to 38.8 days in 2005, while the median time to complete independent investigations declined from 34.5 to 32.6 days.

Table 7

Number of Days to Complete Investigations
January 2004 through June 2005

	Bureau-Conducted Investigations		Contractor-Conducted Investigations		Total	
Number of Days	Number	Percentage of Total	Number	Percentage of Total	Number	Percentage of Total
0 to 30	5,973	44.1%	282	42.3%	6,255	44.0%
31 to 60	3,256	24.0	316	47.4	3,572	25.1
More Than 60	4,328	31.9	69	10.3	4,397	30.9
Total	**13,557**	**100.0%**	**667**	**100.0%**	**14,224**	**100.0%**

Statutes allow the Bureau to remove a child who is unsafe from the home at any time or provide the family with services, even while an investigation is ongoing. Nevertheless, completing the investigation in a timely manner is important because the services needed to protect the child and help the family may not be identified until the investigation is completed.

The Bureau and its independent investigator substantiated 15.2 percent of 28,474 allegations.

The 14,224 investigations completed through June 2005 by the Bureau and its independent investigator included 28,474 allegations. As shown in Table 8, the Bureau substantiated 15.4 percent of the allegations it investigated, while the independent contractor substantiated 10.0 percent of those it investigated.

Table 8

Outcomes of Maltreatment Allegations
January 2004 through June 2005

Outcome of Abuse and Neglect Investigations	Bureau Investigations		Independent Investigations		Total	
	Number of Allegations	Percentage of Total	Number of Allegations	Percentage of Total	Number of Allegations	Percentage of Total
Unsubstantiated	21,336	78.5%	1,104	86.3%	22,440	78.8%
Substantiated	4,187	15.4	128	10.0	4,315	15.2
Other[1]	1,672	6.1	47	3.7	1,719	6.0
Total	**27,195**	**100.0%**	**1,279**	**100.0%**	**28,474**	**100.0%**

[1] Reflects pending investigations and those that were closed because individuals who had information about whether maltreatment occurred could not be located.

As shown in Table 9, neglect was the most common type of maltreatment alleged, but sexual abuse was the most likely to be substantiated. The higher substantiation rate for allegations of sexual abuse is due in part to consensual sexual contact between adolescents, which is often admitted. Under s. 948.02(2), Wis. Stats., it is a felony for anyone to have sexual contact with an individual younger than 16.

Table 9

Allegations of Maltreatment, by Type
January 2004 through June 2005

Type of Maltreatment	Number of Allegations	Number Substantiated	Percentage Substantiated
Neglect	12,865	1,755	13.6%
Physical Abuse	7,142	685	9.6
Sexual Contact and Abuse[1]	5,418	1,799	33.2
Other[2]	3,049	76	2.5
Total	**28,474**	**4,315**	15.2

[1] Includes consensual sexual contact between adolescents.
[2] Includes maltreatment likely to occur, emotional damage, unborn child abuse, and unspecified types of maltreatment.

Primary caregivers of children accounted for 56.3 percent of the 4,315 maltreaters.

As shown in Table 10, 56.3 percent of maltreaters were primary caregivers, including parents, step-parents, foster parents, and other individuals who lived in the home. Approximately one-quarter of maltreaters were secondary caregivers—such as childcare providers, relatives not living in the home, and teachers—or non-caregivers such as peers, family friends, neighbors, and strangers. The relationship between children and 18.8 percent of maltreaters was unknown.

Table 10

Relationship of the Maltreater to the Child
January 2004 through June 2005

Maltreater	Neglect	Physical Abuse	Sexual Contact and Abuse	Other[1]	Total	Percentage of Total
Primary Caregiver	1,630	519	212	72	2,433	56.3%
Secondary Caregiver	26	37	137	1	201	4.7
Non-Caregivers	26	48	797	0	871	20.2
Unknown	73	81	653	3	810	18.8
Total	**1,755**	**685**	**1,799**	**76**	**4,315**	**100.0%**

[1] Includes emotional damage, abuse of an unborn child, and incidents where abuse was likely to occur.

More than 200 children were the subject of four or more investigations from January 2004 through June 2005, including:

- 4 children who were each the subject of seven investigations;
- 12 children who were each the subject of six investigations;
- 46 children who were each the subject of five investigations; and
- 145 children who were each the subject of four investigations.

From January 2004 through June 2005, 225 children were maltreated multiple times.

Multiple instances of maltreatment were substantiated for 225 children, including:

- 201 children who were maltreated twice;
- 21 children who were maltreated three times; and
- 3 children who were maltreated four times.

When children were maltreated multiple times, the Bureau was more successful in meeting the 60-day statutory deadline for completing investigations: 55.5 percent of these investigations were completed in 30 days or less, 22.5 percent required 31 to 60 days, and 22.0 percent required more than 60 days. As noted, 30.9 percent of all investigations were completed in more than 60 days.

▪▪▪▪

Out-of-Home Care ■

To manage the cases of children placed in out-of-home care, the Bureau oversees case management contractors that arrange services for children and their parents, provide regular contact, and pursue appropriate permanency goals. The time children remain in out-of-home care has declined considerably. However, limited collaboration among child welfare staff has resulted in delays in services being provided in a timely manner.

Caseload Characteristics

The number of Milwaukee County children entering out-of-home care increased during each of the six-month periods shown in Table 11.

Approximately one-third of children in out-of-home care in Milwaukee County are between 10 and 14 years old.

As shown in Table 12, children of both sexes and all age ranges are placed in out-of-home care, but approximately one-third of all children in out-of-home care are between 10 and 14 years old, and approximately three-quarters are African-American. These characteristics remained relatively consistent from June 2003 through June 2005.

Table 11

Milwaukee County Children Entering Out-of-Home Care
January 2003 through June 2005

Six-Month Period	Number of Children	Percentage Change from Prior Six Months
January 2003 through June 2003	446	–
July 2003 through December 2003	502	12.6%
January 2004 through June 2004	556	10.8
July 2004 through December 2004	615	10.6
January 2005 through June 2005	659	7.2
Total	**2,778**	

Table 12

Profile of Milwaukee County Children in Out-of-Home Care

	June 2003		June 2004		June 2005	
	Number	Percentage	Number	Percentage	Number	Percentage
Gender						
Male	2,064	50.9%	1,748	51.5%	1,609	50.5%
Female	1,992	49.1	1,643	48.5	1,579	49.5
Total	**4,056**	**100.0%**	**3,391**	**100.0%**	**3,188**	**100.0%**
Age						
0 to 4	867	21.4%	737	21.7%	716	22.5%
5 to 9	1,058	26.1	835	24.6	683	21.4
10 to 14	1,356	33.4	1,094	32.3	966	30.3
15 and over	775	19.1	725	21.4	823	25.8
Total	**4,056**	**100.0%**	**3,391**	**100.0%**	**3,188**	**100.0%**
Race/Ethnicity						
African-American	3,115	76.9%	2,584	76.2%	2,396	75.2%
White	452	11.1	382	11.3	407	12.8
Hispanic/Latino	399	9.8	336	9.9	278	8.7
Native American	32	0.8	21	0.6	35	1.1
Asian	13	0.3	6	0.2	7	0.2
Native Hawaiian/ Pacific Islander	2	<0.1	1	<0.1	1	<0.1
Unknown	43	1.1	61	1.8	64	2.0
Total	**4,056**	**100.0%**	**3,391**	**100.0%**	**3,188**	**100.0%**

We were unable to obtain demographic information on parents or primary caregivers. However, the Chapin Hall Center for Children, a research institute affiliated with the University of Chicago, reviewed almost 500 out-of-home care cases in Milwaukee County open between November 2000 and May 2003 and found that most parents and caregivers were poor, unemployed, and African-American. Among the birth parents and primary caregivers, it found that:

- 57.2 percent were African-American and 24.8 percent were white;
- 9.7 percent were 20 years old or younger, 39.4 percent were 21 to 30, 35.4 percent were 31 to 40, and 15.5 percent were 41 and older;
- 49.3 percent had at least a high school diploma or equivalent, while 4.9 percent had completed no more than the eighth grade;
- 61.7 percent were unemployed or not in the workforce, while 25.3 percent worked full-time; and
- the median annual family income was $7,416, and 71.3 percent were below the federal poverty line.

Ensuring Appropriate Placements

Appropriate placements help ensure children are safe and achieve their permanency goals.

Appropriate placements help ensure that children are safe, their needs are met, and they are either reunified with their families or achieve other appropriate permanency goals. When possible, children are placed with relatives. Relatives either may be licensed as foster parents or may participate in the Kinship Care program, which provides $215 per month to help cover the costs of caring for a child. Children whose medical or behavioral needs cannot be met by relatives or in other regular foster homes may be assigned to placements providing a higher level of care, such as treatment foster homes, group homes, and residential care centers.

Children are most likely to be placed in foster homes of non-relatives.

As shown in Table 13, children are most likely to be placed in foster homes of non-relatives, although the percentage of placements in this category is decreasing. Both the number and the percentage of higher-level-of-care placements increased because more children with considerable medical, emotional, and behavioral needs have been placed in out-of-home care in recent years.

Table 13

Children in Out-of-Home Care, by Type of Placement

Placement Type	June 2003 Number	June 2003 Percentage	June 2004 Number	June 2004 Percentage	June 2005 Number	June 2005 Percentage
Foster Home of Non-Relatives	2,052	50.6%	1,608	47.5%	1,264	39.6%
Kinship Care	834	20.6	777	22.9	771	24.2
Foster Home of Relatives	813	20.0	595	17.5	481	15.1
Higher-Level-of-Care Placement[1]	134	3.3	289	8.5	471	14.8
Other[2]	223	5.5	122	3.6	201	6.3
Total	**4,056**	**100.0%**	**3,391**	**100.0%**	**3,188**	**100.0%**

[1] Includes children in treatment foster homes, group homes, and residential care centers.
[2] Includes children in detention centers, assessment homes and centers, and unknown placements.

Table 14 shows demographic and economic information for licensed foster parents. Most are either single women or married couples. Three-quarters are African-American, 70.4 percent are older than 40, and more than one-half have annual household incomes of less than $26,000.

Ensuring that children in out-of-home care have stable placements is important to their well-being, and repeatedly changing a child's placement may increase the amount of time spent in out-of-home care. Each year, the Bureau comprehensively reviews a random sample of more than 200 cases to determine whether families were served appropriately, and it uses these reviews to identify areas in which its own and contract staff need improvement. The 2003 and 2004 comprehensive case reviews noted concerns with placement stability, including a lack of collaboration between case managers and foster care staff. The 2004 review also found that case managers missed opportunities to make placements more stable by, for example, providing additional services and support to foster parents.

Table 14

Profile of Foster Parents
December 31, 2004

Description	Number	Percentage of Total
Age		
18 to 30	81	6.7%
31 to 40	276	22.9
41 to 50	334	27.7
51 to 60	284	23.5
61 to 70	187	15.5
71 and over	45	3.7
Total	**1,207**	**100.0%**
Race/Ethnicity		
African-American	908	75.1%
White	240	19.9
Hispanic/Latino	26	2.2
Native American	5	0.4
Asian	1	0.1
Native Hawaiian/Pacific Islander	1	0.1
Unknown	26	2.2
Total	**1,207**	**100.0%**
Marital Status		
Single Female	452	37.5%
Married Couple	417	34.6
Divorced	179	14.8
Separated	54	4.5
Unmarried Couple	33	2.7
Single Male	27	2.2
Unknown	45	3.7
Total	**1,207**	**100.0%**

Description	Number	Percentage of Total
Primary Language		
English	838	69.4%
Spanish	8	0.7
Other	4	0.3
Unknown	357	29.6
Total	**1,207**	**100.0%**
Annual Household Income		
Less than $11,000	142	11.8%
$11,000 to $25,999	519	42.9
$26,000 to $49,999	393	32.6
$50,000 to $74,999	104	8.6
$75,000 and over	49	4.1
Total	**1,207**	**100.0%**
Education Level		
Never Completed High School	297	24.6%
High School Graduate	374	31.1
Tech. School or Some College	325	26.9
College Degree	178	14.7
Unknown	33	2.7
Total	**1,207**	**100.0%**
Location		
Site 1	287	23.8%
Site 2	295	24.4
Site 3	321	26.6
Site 4	46	3.8
Site 5	165	13.7
Out of County	93	7.7
Total	**1,207**	**100.0%**

Placement stability improves with good matches between children and foster homes. However, case managers and foster care staff reported difficulties in finding foster homes, particularly those willing to accept teenagers, children with special needs, and sibling groups. Although the number of children in out-of-home care declined by 28.0 percent from January 2003 to June 2005, the number of licensed foster homes declined 35.3 percent. On average, 22.9 foster homes were newly licensed each month, but 43.0 closed. It should be noted, however, that 29.4 percent of the closures occurred because families adopted the children in their care.

Placement stability also requires coordination between case managers and foster care staff. Bureau policies require case managers to collaborate with foster care staff to ensure appropriate placements and the establishment of timely permanency goals, but they do not include specific time frames or specify how or when such collaboration should occur. Staff reported that program managers encourage them to conduct joint visits to foster homes, including within five days of placing a child, so that support plans—including any services the foster home may need to provide appropriate care—can be developed cooperatively. In a July 2004 report on its progress in implementing the settlement agreement, the Bureau stated that joint visits were being conducted.

To evaluate the extent of coordination between case managers and foster care staff, we reviewed electronic files for all children who entered out-of-home care in January 2004. We tracked 48 cases through June 2005. Among them were 27 cases involving a total of 40 foster home placements.

Coordination between case managers and foster care staff was minimal.

For those 27 cases, joint visits were infrequent and coordination was often minimal. For example, 16 cases, or 59.3 percent, had no record of any joint visits. For six cases, only one visit was recorded. Two or more visits were made in only five cases. When placement changes occurred, joint visits often were not conducted promptly. They occurred within five days of only 2 of the 40 placement changes. Case managers and foster care staff indicate that scheduling difficulties have limited joint visits.

Achieving Permanency for Children

For out-of-home care to result in permanency requires:

- effective case management to ensure that necessary services are implemented in a timely manner and that appropriate meetings are held with the children and all other parties involved in a case; and

- effective permanency planning, which involves setting and working toward appropriate goals for the children.

Case Management

Before the Children's Court will allow the return of a child who has been removed from the home, parents must have sufficiently addressed the issues that caused the removal, such as drug and alcohol dependency or inadequate parenting skills. A service implementation hearing, which the Children's Court typically holds within 21 days after a child is removed from the home, determines whether services are being implemented and whether the case is expeditiously moving toward resolution.

Only 27.4 percent of court-ordered services were in place shortly after children were removed from their homes.

Because the Children's Court was concerned that services were not being initiated in a timely manner, it began tracking the extent to which they were in place at the time of the service implementation hearing. It determined that from mid-February through late-June 2005, only 27.4 percent of 530 services it had ordered for 171 cases were in place at the time of the hearing. Another 45.4 percent of ordered services had been scheduled but not yet implemented, while 27.2 percent had not yet been referred to a service provider. No new services were ordered by the Children's Court in 12 of the 171 cases, typically because the parents or children were already receiving the services it deemed necessary.

Services cannot be implemented in a timely manner when service providers are unwilling or unable to accept additional cases, and child welfare staff and advocates indicate there is a shortage of providers offering mental health assessments and alcohol and other drug addiction services. Furthermore, parents may delay consent for their children to receive services, and the service-authorization process involves multiple steps that can result in delays. The Bureau's 2003 and 2004 comprehensive case reviews also identified concerns such as case managers who did not have regular contact with service providers or discuss the appropriateness and success of service-provision efforts.

Both the child welfare contracts and the Bureau's policies require case managers to have monthly face-to-face contact with each child in out-of-home care, and the contracts specify that case managers must visit a child without the caregiver present. When appropriate, monthly visits are to alternate between the child's placement and another setting. In addition, the contracts and policies require case managers to have face-to-face contact with a child within five days of receiving a case, and all contacts are to be documented in the case files.

Required monthly contact occurred in 95.0 percent of the 48 cases we reviewed.

In 95.0 percent of the out-of-home care cases we tracked from January 2004 through June 2005, all monthly contacts occurred as required. However, 25.0 percent of applicable cases did not have documented contact within five days of their receipt by case managers. In addition, case notes for 65.8 percent of the contacts did not indicate whether the case managers spoke with children outside their caregivers' presence. Visit length was recorded for approximately one-third of documented contacts and ranged from five minutes to seven hours. The median was 45 minutes.

One-third of the required meetings among child welfare staff did not occur in 48 cases we reviewed.

Since 2003, contracts have also required that all parties involved in a case, including the parents, the Bureau and its contractors, and service providers, meet every three months. In February 2003, the Bureau described these coordinated service team meetings as the most effective way to achieve positive outcomes for families. However, it did not develop a detailed policy related to them until May 2005, when it specified whom to invite and the topics to be discussed. Furthermore, we found that approximately one-third of the required meetings did not occur. Of the 48 out-of-home care cases we tracked from January 2004 through June 2005, 37 were open for six months or more and should have had at least two meetings. However:

- 11 cases had very few meetings, and 4 had none;
- 12 cases had meetings that did not begin until more than six months after the case opened, gaps of more than four months between meetings, or meetings with few of the relevant participants; and
- 10 cases had regular meetings, as required.

At 159 of the coordinated service team meetings documented in the case files, attendance was often limited. The case files did not list the participants for 13 of these meetings. For the remaining meetings:

- service providers were present at 65.8 percent of all meetings;
- birth parents were present at 54.8 percent of all meetings;
- foster care licensing staff were present at 31.5 percent of all meetings held for children in foster care placements;

- foster parents were present at 33.3 percent of all meetings held for children in foster care placements; and

- adoptions staff were present at only 7.6 percent of meetings held for children who had been in care for six months or more.

Similarly, the Bureau's 2004 comprehensive case review found that nearly one-fourth of cases had no coordinated service team meetings. Some birth parents and foster parents reported that they had not been invited, did not know the purpose of the meetings, or did not believe their views were heard at the meetings that did occur. The review recommended that child welfare staff ensure the meetings occur.

Permanency Planning

As noted, state and federal laws require the Children's Court to approve a permanency plan within 60 days of a child's removal from the home, and to approve a new plan after every six months the child remains in out-of-home care. State and federal law allow child welfare staff to simultaneously pursue multiple permanency goals in a process known as concurrent planning, which is intended to minimize delays and disruptions if the initial permanency goal subsequently becomes unfeasible and is changed.

State and federal law require a TPR petition to be filed in Children's Court when a child has been in care for 15 of the last 22 months, except for three reasons that must be documented before the child is in care for 15 months:

- when the child is being cared for by a relative;

- when there is a compelling reason why the petition is not in his or her best interests; or

- when the Bureau has not provided a family with the services necessary for the child's safe return home.

The Bureau's policies for permanency planning are limited.

The Bureau's policies for permanency planning are limited. They do not provide guidance on how or when permanency goals other than reunification should be established, when concurrent planning should occur, when adoptions staff should become involved with cases, or which case management activities are needed. Further, they do not specify when a TPR referral should be made to the district

attorney's office so that it can be filed by the time a child reaches 15 months in care. Similarly, guidance on how and when TPR exceptions should be used is limited.

Limited policies likely account for child welfare staff's contradictory explanations of when and how concurrent planning occurs and when TPR referrals are made to the district attorney's office. Staff also indicate there can be significant delays between when a referral is made, the petition is filed, and the proceedings are finalized. After the 2003 and 2004 comprehensive case reviews identified a lack of coordination between case managers and adoptions staff, the Bureau indicated that coordination would be improved, but its efforts appear to have had limited success. For example, adoptions staff told us they are not always informed about children whose permanency goal is adoption.

We identified problems related to permanency planning for 25 of the 48 cases we reviewed.

In 25 of the 48 cases we reviewed, we identified a number of problems related to permanency planning, including:

- 18 cases in which coordination with adoptions staff should have occurred or should have occurred earlier, but did not;
- 11 cases for which permanency plans or case progress evaluations contained insufficient or outdated information;
- 9 cases for which TPR exceptions may have been used inappropriately or were not properly documented;
- 6 cases with lengthy delays in the TPR process; and
- 9 cases with a lack of concurrent planning or a failure to seek adoptive resources.

For example, our review found:

- A five-year-old with a permanency goal of adoption was placed with his grandmother early in 2004. The grandmother did not agree to adopt the child until late in 2005. For almost two years, while the grandmother would not agree to adopt the child, child welfare staff did not attempt to seek an alternate placement that would have provided permanency.

- An infant with serious medical needs had a permanency goal of adoption. Although there were significant concerns about whether the birth mother would ever be able to care for the infant, who was placed with foster parents who wanted to adopt him, a TPR petition was not filed for 20 months. Within two months of the filing, the foster parents began the process of adopting the child.

- Although an infant had a permanency goal of adoption since being taken into custody at birth early in 2004, adoptions staff were not involved in the case until 13 months later. The file indicates that late in 2005, a foster family intended to adopt the infant.

- The Bureau requires case managers to explain why a given permanency goal is in a child's best interests, but four case files had no rationale statement, which indicates inadequate case management and permanency planning. Late in 2005, one child had been reunified with his mother, while the other three remained in out-of-home care.

Assessing Effectiveness

One way to evaluate a child welfare contractor's efforts to achieve timely permanency goals is to examine how long children are in out-of-home care. We also determined the reasons children leave out-of-home care and the extent to which they return.

In September 2003, the median time children stayed in out-of-home care in Wisconsin was 18.3 months. Among six other midwestern states, only Illinois had a higher median stay: 36.2 months. In Indiana, Iowa, Michigan, Minnesota, and Ohio, median stays ranged from 9.9 to 15.6 months.

The median stay in out-of-home care has declined.

More recent data for children in Milwaukee County are shown in Table 15. The median stay in out-of-home care declined from 39 months in June 2003 to 21 months in June 2005. Moreover, the percentage of children in out-of-home care for less than 12 months increased significantly. However, the percentage of children in out-of-home care for more than 60 months remained relatively consistent.

Table 15

Time Milwaukee County Children Stay in Out-of-Home Care

	June 2003		June 2004		June 2005	
Number of Months	Number	Percentage	Number	Percentage	Number	Percentage
<1 to 12	802	19.8%	1,007	29.6%	1,096	34.3%
13 to 24	617	15.2	467	13.8	612	19.2
25 to 36	473	11.7	315	9.3	238	7.5
37 to 48	576	14.2	278	8.2	187	5.9
49 to 60	414	10.2	314	9.3	155	4.9
More than 60	1,174	28.9	1,010	29.8	900	28.2
Total	**4,056**	**100.0%**	**3,391**	**100.0%**	**3,188**	**100.0%**
Median Stay	39 Months		32 Months		21 Months	

Children in Milwaukee County remain in out-of-home care longer than those in Brown, Dane, Kenosha, Racine, and Rock counties. DHFS summary data for June 2005 indicate that in these five counties, the median stay in out-of-home care ranged from 10.0 months in Kenosha County to 11.6 months in Racine County.

The most common reasons for leaving out-of-home care are family reunification and adoption.

As shown in Table 16, children in Milwaukee County most commonly left out-of-home care because of family reunification and adoption. If trends in the first half of 2005 continued for the entire year, fewer adoptions will have occurred in 2005 than in 2003 or 2004. Contractors report that approximately 80 percent of adoptions are by foster parents, but confirming data were not readily available.

Table 16

Reasons Milwaukee County Children Leave Out-of-Home Care

Reason for Leaving	2003	2004	January–June 2005	Total
Reunified with Parents	755	649	302	1,706
Adoption	565	566	213	1,344
Transfer of Guardianship	317	164	67	548
Reached Adulthood	113	103	59	275

As shown in Table 17, 30.9 percent of all Milwaukee County children who entered out-of-home care from January through June 2003 were reunified with their parents after 12 months, while 36.8 percent were reunified after 24 months; however, after 24 months, 37.5 percent remained in out-of-home care. The relatively low percentage of children who are reunified with their parents within two years of being removed from their homes suggests that earlier and more focused concurrent planning efforts may be needed.

Table 17

Status of Milwaukee County Children Who Entered Out-of Home Care from January through June 2003

	12 Months After Entry		24 Months After Entry	
Status	Number	Percentage	Number	Percentage
In Out-of-Home Care	247	55.5%	167	37.5%
Reunified with Parents	138	30.9	164	36.8
Adopted	13	2.9	47	10.5
Transfer of Guardianship	9	2.0	22	4.9
Placed with a Relative	12	2.7	14	3.1
Aged Out	5	1.1	8	1.8
Other[1]	22	4.9	24	5.4
Total	**446**	**100.0%**	**446**	**100.0%**

[1] Includes children who were runaways, who were in correctional facilities, who had died, or whose outcomes were unknown.

To ensure that children remain safe and the necessary services continue to be provided, cases typically remain under supervision of the Bureau and Children's Court for several months after family reunification. Our case file review found that this period of supervision ranged from 1.7 to 11.3 months and averaged 6.3 months.

Permanency goals are not achieved when children return to out-of-home care. The Chapin Hall Center for Children found that from the late 1990s through 2000, reentry rates in Milwaukee County declined from approximately 30 percent to 20 percent. Limits in available data prevented us from independently determining reentry rates over time, but we examined the extent to which children who left out-of-home care from January through June 2003 subsequently returned.

One-fifth of children who were reunified with their parents reentered out-of-home care within 24 months.

As shown in Table 18, 20.1 percent of children who had been reunified with their parents reentered out-of-home care within 24 months. Reentry rates for children involved with transfers of guardianship were substantially lower, and only one child who left out-of-home care because of adoption reentered care within 24 months.

Table 18

Milwaukee County Children Who Reentered Out-of-Home Care[1]

Reason for Leaving	Number Who Left	Reentry within 12 Months		Reentry within 24 Months	
		Number	Percentage	Number	Percentage
Reunification	403	56	13.9%	81	20.1%
Transfer of Guardianship	166	5	3.0	8	4.8
Adoption	265	0	0.0	1	0.4

[1] Among children who left out-of-home care from January through June 2003.

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Safety Services ■

Safety services are available to families of children who are in danger of abuse or maltreatment.

Safety services such as parenting education, counseling, and drug and alcohol treatment are available to entire families until the circumstances that endangered their children are ameliorated. Participation in safety services is voluntary, although children in danger of abuse or neglect may be removed from the home unless family members agree to receive them. We identified problems with the adequacy of available safety services, the extent to which child welfare cases are closed before families are prepared to function without safety services, and the frequency with which families return to the child welfare system after having received safety services.

Provision of Services

The Bureau refers families for safety services, which are managed by contractors that also manage safety services cases. The Bureau requires its contractors' safety services managers to meet with families within 24 hours of a referral for services. Bureau staff also attend the initial meeting, where the services that a family will receive are determined by the safety services manager. The Bureau requires the safety services manager to meet with each family member every seven days thereafter, to assess services effectiveness and the safety of all children in the home.

Unsafe conditions may result if a parent or other adult becomes unwilling to receive safety services or does not cooperate with the

safety services manager. If a safety services manager determines that a child's safety cannot be ensured, the case must immediately be referred to the Bureau, which will reassess the family and may place the child in out-of-home care. Cases are closed when the safety services manager determines that all children in the home are unlikely to be abused or neglected.

The number of families receiving safety services declined 39.6 percent since January 2003.

Because the number of families receiving safety services typically fluctuates from month to month, we calculated the average monthly caseloads for six-month periods, as shown in Table 19. The number of families receiving safety services declined 39.6 percent from January 2003 through June 2005. This decline may correspond to an increase in the provision of safety services only when there is a threat to the safety of the children. The Bureau indicates that in the past, some families received safety services based on their need for social or economic support services.

Table 19

Milwaukee County Families Receiving Safety Services
January 2003 through June 2005

Six-Month Period	Average Number of Families Receiving Safety Services per Month
January through June 2003	462
July through December 2003	376
January through June 2004	327
July through December 2004	328
January through June 2005	279

Because limited data are compiled on the families who receive safety services, we reviewed case files for 50 randomly selected families who began receiving services in January 2004. As shown in Table 20, most of these families were headed by single, African-American mothers. They had an average of three children each, but nine had only one child. Approximately three-quarters of the children were eight or younger.

Table 20

Profile of the Heads of Families Receiving Safety Services[1]
January 2004

Description	Number	Percentage of Total	Description	Number	Percentage of Total
Gender			**Age**		
Female	49	98.0%	Under 21	3	6.0%
Male	1	2.0	21 to 25	14	28.0
Total	**50**	**100.0%**	26 to 30	11	22.0
			31 to 35	11	22.0
Race/Ethnicity			36 to 40	9	18.0
African-American	33	66.0%	41 to 45	2	4.0
White	11	22.0	46 and Over	0	0.0
Hispanic/Latino	2	4.0	**Total**	**50**	**100.0%**
Native American	2	4.0			
Unknown	2	4.0	**Marital Status**		
Total	**50**	**100.0%**	Single	47	94.0%
			Married	3	6.0
			Total	**50**	**100.0%**

[1] Based on our review of 50 families who began to receive services in January 2004.

Milwaukee County is the only Wisconsin county to provide safety services.

According to DHFS, Milwaukee County is the only county in Wisconsin that provides safety services. Among six surrounding midwestern states, only Iowa and Michigan provide safety services that are similar to Milwaukee County's. Since March 2005, Iowa has offered services to families who have abused or neglected their children but are deemed unlikely to do so again, and to families who have not abused or neglected their children but are at substantial risk of doing so. Michigan offers short-term, intensive, in-home services to families in which abuse, neglect, or delinquency is likely to occur. Caseworkers are assigned only two families at a time, and cases remain open for one month, on average.

Case Management Responsibilities

Child welfare contracts and the Bureau's policies specify a number of case management responsibilities for safety services managers.

We focused on four primary requirements that are measurable:

- all service providers must meet with a family within 7 days after a family is enrolled for services;
- safety services managers must meet with all family members at least once every 7 days thereafter;
- every 7 days, safety services managers must complete a safety assessment for each family that determines whether the services are effective, the family is making progress in addressing the issues that resulted in their receiving safety services, and the children are at risk of maltreatment; and
- safety services managers are required to schedule a coordinated service team meeting 7 days after a family is enrolled for services, and then every 30 days thereafter. Like those held on behalf of children in out-of-home care, these meetings include child welfare staff and service providers and are held to discuss a family's progress and whether the services are working as intended.

As shown in Table 21, contractors' compliance with three of the four requirements has been poor.

Table 21

Safety Services Contractors' Compliance with Selected Requirements[1]

Requirement	Cases in Compliance		Cases Not in Compliance	
	Number	Percentage of Total	Number	Percentage of Total
All Service Providers Meet with the Family within 7 Days	15	30.0%	35	70.0%
Safety Services Manager Meets with the Family Every 7 Days	17	34.0	33	66.0
Safety Services Manager Completes Safety Assessments Every 7 Days	33	66.0	17	34.0
Coordinated Service Team Meetings are Held Monthly	0	0.0	50	100.0

[1] Based on our review of 50 families who began to receive services in January 2004.

In 35 of 50 case files we reviewed, service providers did not meet with the families as soon as required.

It is important for families to receive needed services quickly so that they can address the issues that led them to receive safety services. However, in 70.0 percent of the case files we reviewed, all service providers did not meet with families within the first seven days, as required. In addition, a total of 192 services were ordered for the 50 families, but only 127 services began within the required seven-day period. Appointments for the other 65 services were scheduled to begin after the seven-day period. These delays likely occurred because safety services managers misunderstood the requirements.

For example, many with whom we spoke thought it was sufficient to have scheduled initial appointments with service providers by the end of seven days, regardless of when meetings actually occurred. We found that safety services managers tried to meet with all family members every seven days and typically made multiple attempts to visit all children. However, at least one meeting was not held as required in 66.0 percent of the cases we reviewed, primarily because families rescheduled or missed meetings or teenage children unexpectedly failed to attend.

For 17 of the 50 cases we reviewed, at least one safety assessment was not completed every seven days. The assessments were one day late in eight of these cases, two or three days late in five cases, and more than three days late in four cases. In one case that was open for 11 weeks, four safety assessments ranged from 3 to 33 days late. In another case that was open for 21 weeks, three assessments were each two days late, and a fourth was two months late. The Bureau's 2004 comprehensive case review also noted concerns with the safety assessments, including that safety services managers often completed superficial assessments and did not always assess all family members.

No coordinated service team meetings were held for 35 of the 50 cases we reviewed.

None of the 50 cases we reviewed complied with monthly coordinated service team requirements. No meetings were ever held for 35 cases, or 70.0 percent of those we reviewed. Only one or two meetings were held for the remaining 15 cases. For example:

- One family had its first meeting 82 days after it began receiving services. This meeting included a parenting assistant responsible for providing information on appropriate disciplinary strategies, child development, and basic medical and physical care, and a counselor the case file indicated the mother had never before met.

- Another family had only one meeting during the 146 days it received services. Although the child's teachers attended the meeting, a parenting assistant and a family counselor did not.

- A third family had only one meeting during the 256 days it received services. The meeting occurred after the family had received services for 72 days.

Bureau policies indicate that coordinated service team meetings should include all relevant individuals involved with a case, such as all service providers, school officials, attorneys, family friends, and spiritual leaders identified by the family. However, Bureau officials consider such a meeting to have occurred even if only a few of these individuals were present. We did not consider a coordinated service team meeting to have occurred if only a limited number of individuals attended and there was no information in a file to indicate that others had been invited but declined to attend.

Length of Services

For each family served, safety services contractors are paid $4,776, regardless of which services are provided or how long the case remains open. That payment is calculated at a rate of $1,194 per month for four months. However, if families continue to need services after four months, contractors are supposed to continue to provide them without additional payment, and if families stop receiving services after less than four months, contractors are still paid the full $4,776.

Receipt of safety services declined from an average of 110 days in January 2003 to 81 days in January 2005.

As shown in Table 22, the average period for which families received safety services had declined to less than three months by January 2005, when it was 81 days. Just 20.6 percent of families received safety services for more than 120 days in January 2005, compared to 40.7 percent in January 2003.

Table 22

Receipt of Safety Services

Number of Days Receiving Services	Families Who Began Receiving Safety Services in: January 2003	June 2003	January 2004	June 2004	January 2005
0 to 30	6	4	3	6	7
31 to 60	18	18	20	13	18
61 to 90	15	15	8	28	15
91 to 120	25	30	14	18	14
121 to 150	26	19	12	10	9
151 to 180	7	9	5	4	5
181 or more	11	7	7	3	0
Total Families	**108**	**102**	**69**	**82**	**68**
Average Days	110 Days	108 Days	104 Days	90 Days	81 Days

Because it seems unlikely that the severity of problems faced by families has decreased over time, the decline in the average number of days families received safety services raises concerns. The average period for which services are provided could also be expected to be closer to 120 days, or the four-month period that is the basis of contractor payments.

The staff of safety services contractors indicated they were sometimes told by their supervisors to close cases because contract payments were ending. One individual stated that a case will not be closed if the children are unsafe, but the contractor will refer the children back to the Bureau after about four and one-half months so that placement in out-of-home care can be considered. Another stated that cases are sometimes closed even though the families still need services. The Bureau's 2004 comprehensive case review found that a "small number" of cases were closed before families were ready to function without services. We also found that some cases were closed prematurely.

Our file review included cases that were open from 11 to 322 days. During this time, the files indicate that most families made progress in addressing the issues for which they were referred to safety services. For example, one mother and her three children were visited by their safety services manager at least once every seven

days and regularly met with therapists and parenting assistants. The safety services manager helped the children to enroll in several school programs and the mother to enroll in Medical Assistance during the 105 days the case was open.

Some safety services cases were closed prematurely.

However, some cases were closed before families were ready to function without services. In one case, a mother, two daughters, and a newborn son began receiving safety services after a substantiated allegation of neglect and an unsubstantiated allegation of abuse of an unborn child. During the 130 days the case was open, the mother never attended the alcohol and drug assessment that had been ordered for her, and her daughters never attended the mentoring services that had been ordered for them. The final case entry indicated that although the children were currently safe, there were concerns because the mother continued to use illegal drugs and was not fulfilling her parental duties, the two daughters could not control their behavior, and the newborn could not protect himself.

In another case, a mother, her teenage daughter, and a younger son were living in a home where the daughter was sexually abused by another adult. The safety services manager helped the family obtain psychological evaluations, food, and clothing. However, during the 95 days the case was open, the mother never attended the drug abuse counseling that had been ordered for her, the daughter never attended the counseling appointments that had been ordered for her, and alternative housing to allow the daughter to live away from her abuser was not located for the family. The case was closed even though the safety services manager had not met with the family during the prior three weeks.

Assessing Effectiveness

The Bureau does not monitor how often families return to the child welfare program.

One way to assess the effectiveness of safety services is to determine the extent to which families subsequently return to the child welfare program. Contractors are required to ensure that no more than 4.0 percent of the families who receive safety services have children placed in out-of-home care within the next 12 months. To enforce this requirement, which was instituted to help ensure that contractors provide adequate services, DHFS may withhold up to 0.4 percent of a contract's value if the reentry rate exceeds 4.0 percent. However, because the Bureau does not monitor contractors' compliance, no funds have ever been withheld. Furthermore, we question whether the cost of the penalty, which would amount to $5,734 on the average $1.4 million contract for each site, is sufficient to compel compliance.

As shown in Table 23, we found that 11.4 percent of families who ceased receiving safety services during the first 6 months of 2004 had children who entered out-of-home care within 12 months. This rate is nearly three times the reentry limit specified in contracts. On average, these 55 families received safety services for 100 days, or slightly less than the 104-day average for all families who received safety services in early 2004.

Table 23

Families Whose Children Entered Out-of-Home Care within One Year of Safety Services

	Number of Families Who Ended Safety Services from January through June 2004	Number of Families Whose Children Entered Out-of-Home Care within One Year	Percentage of Families Whose Children Entered Out-of-Home Care
Site 1	92	16	17.4%
Site 2	63	4	6.3
Site 3	107	13	12.1
Site 4	61	5	8.2
Site 5	160	17	10.6
Total	**483**	**55**	11.4

Contracts also require DHFS to monitor the number of families returning for additional safety services. If that number exceeds an acceptable limit, DHFS may require the contractor to review its procedures and complete a corrective action plan.

Because the Bureau has not established this limit, it is not possible to fully assess the effectiveness of safety services or the extent to which contractors are meeting contractual requirements. However, we determined the extent to which the 402 families who began receiving safety services during the first half of 2005 had also received them in the recent past. As shown in Table 24, 3.5 percent of these 402 families had received services within the prior 6 months, and 7.5 percent had received them within the prior 12 months.

Table 24

Previous Receipt of Safety Services[1]

	Number of Families	Percentage of Total
Receipt of Safety Services within the Prior:		
6 Months	14	3.5%
12 Months	30	7.5

[1] Among 402 families who began receiving safety services from January through June 2005.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by February 1, 2007, on:

- *the steps it will take to monitor the number and characteristics of families who return for safety services within 12 months, and the number of children who enter out-of-home care within 12 months of having received safety services;*
- *how it will enforce contractual penalty provisions if returning cases exceed the prescribed rates; and*
- *whether it plans to increase monetary penalties to levels that are more likely to compel contractors to achieve the prescribed results.*

■ ■ ■ ■

Performance Standards ■

The Bureau has had mixed success in achieving the settlement agreement's performance standards.

Through June 2005, the Bureau has had mixed success in achieving the 14 mandatory and 10 monitoring standards required by the December 2002 settlement agreement. From January through June 2005, which was the most recent period for which data were available during our fieldwork, the Bureau met 8 of the 14 mandatory performance standards, but it did not meet the other 6.

Two of the mandatory performance standards required the Bureau to take specific actions, and both of these have been achieved:

- The Bureau was required to work with the Milwaukee County District Attorney's office to ensure adequate legal representation is available for court proceedings for TPR petitions, and in July 2003 it signed a memorandum of agreement agreeing to do so.

- The Bureau was required to seek legislative approval for an increase in foster care rates, and rates were increased by 5.0 percent beginning in January 2006.

The remaining mandatory standards focus on three broad areas of the Bureau's ongoing operations:

- helping children who have been removed from their homes to achieve permanency in a timely manner;

- helping to ensure they remain safe from abuse and neglect while in out-of-home care; and
- helping to ensure their well-being.

Mandatory Performance Standards

The settlement agreement requires the Bureau to produce semiannual reports on its progress in meeting performance standards, as well as annual comprehensive case reviews that identify programmatic areas in which both Bureau and contract staff can improve. In 2005, the Bureau employed 11 program evaluation managers to ensure data the contractors enter into the files are complete and accurate and make recommendations to Bureau managers for improving how families are served by the child welfare program. However, better and more complete information would help the Bureau make informed decisions about how to improve its efforts to ensure children in out-of-home care achieve permanency in a timely manner.

Permanency

The settlement agreement established five permanency standards that are intended to:

- increase the percentage of children who receive TPR petitions or exceptions after they have been in out-of-home care for 15 of the last 22 months;
- increase the percentage of children who receive TPR petitions or exceptions after they have been in out-of-home care for more than 15 of the last 22 months;
- reduce the percentage of children who remain in out-of-home care for more than 24 months;
- increase the number of children who return home within 12 months of entering out-of-home care; and
- increase the percentage of children who are adopted within 24 months of entering out-of-home care.

As shown in Table 25, the requirements for achieving each standard have increased in each year since the settlement agreement took effect. Standards the Bureau did not report meeting are highlighted.

Table 25

Reported Performance Related to Permanency Standards[1]

Performance Standard	2003	2004	January through June 2005
TPR Petition or Exception after Children Spend 15 of the Last 22 Months in Out-of-Home Care			
Requirement	At Least 65.0%	At Least 75.0%	At Least 90.0%
Bureau-Reported Performance	76.8	88.4	**89.9**
TPR Petition or Exception after Children Spend More Than 15 of the Last 22 Months in Out-of-Home Care			
Requirement	At Least 75.0	At Least 85.0	At Least 90.0
Bureau-Reported Performance	88.1	94.5	**58.7**
Children in Out-of-Home Care for More Than 24 Months			
Requirement	No More Than 40.0	No More Than 35.0	No More Than 25.0
Bureau-Reported Performance	**44.2**	30.2	**25.5**
Children Returned Home within 12 Months of Entering Out-of-Home Care[2]			
Requirement	n.a.	At Least 65.0	At Least 71.0
Bureau-Reported Performance	45.0	**63.0**	**69.3**
Children Adopted within 24 Months of Entering Out-of-Home Care			
Requirement	At Least 20.0	At Least 25.0	At Least 30.0
Bureau-Reported Performance	**14.2**	**15.5**	**20.6**

[1] Information reported by the Bureau.
[2] For 2003, the Bureau was required only to monitor, not to achieve, this measure.

Although the Bureau reported improvements in its performance each year in four of the five areas, it did not report meeting any permanency standards during the first six months of 2005, and it has never reported meeting the standard for adoption within 24 months. Three standards were reported as nearly met for January through June 2005.

We found errors with the Bureau's methodology for calculating one standard.

We found errors in the way the Bureau calculates its performance related to children who receive TPR petitions or exceptions after they have been in out-of-home care for 15 of the last 22 months. The Bureau:

- calculates the standard for children in out-of-home care for 16 months, rather than for the required 15 months;
- includes children who are no longer in out-of-home care; and
- counts children multiple times, even though federal law states that they should be counted only once.

We found the Bureau has never met the standard for children who receive a TPR petition or exception.

Doing so increases the likelihood that the Bureau will meet the performance standard, as it has reported. However, when calculated correctly, the standard has never been met. Furthermore, as shown in Table 26, the Bureau's actual performance declined from 44.2 percent of cases in 2003 to 30.5 percent in the first six months of 2005, and it has been significantly lower than the requirements specified in the settlement agreement.

The settlement agreement states that this standard is to be calculated for children in Bureau custody "reaching 15 of the last 22 months in out-of-home care." DHFS believes that the standard should also take into account children who receive TPR petitions or exceptions before 15 months, to recognize that the Bureau sometimes acts more quickly than the agreement requires. However, relevant documentation related to this standard does not make clear such an intent, and other standards the Bureau is required to meet already give it credit for acting quickly in achieving permanency for children. The Bureau does not take these children into account in its calculations of this standard, and neither did we.

Table 26

Bureau's Actual Performance on the Percentage of Children Who Receive a TPR Petition or Exception After Being in Out-of-Home Care for 15 of the Last 22 Months

	Number of Children in Out-of-Home Care for 15 of 22 Months	Number of Children Whose Cases Met the Performance Standard	Annual Performance Target	Percentage of Children Whose Cases Met the Performance Standard
2003	728	322	65.0%	44.2%
2004	576	217	75.0	37.7
2005[1]	357	109	90.0	30.5
Total	**1,661**	**648**		39.0

[1] January through June 2005.

From January 2003 though June 2005, we found that TPR petitions were filed for only 5.5 percent of the children who were in out-of-home care for 15 of the last 22 months. The remaining 94.5 percent of children remained in out-of-home care because of exceptions. The most common exception, which was provided for 56.3 percent of the children, was that filing a TPR petition would not be in the child's best interests. Typically, this means that efforts at reunification with the child's family continue. It should be noted, however, that the percentage of children for whom the Bureau filed TPR petitions increased from 2.6 percent in 2003 to 9.9 percent during the first six months of 2005.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1, 2006, on the steps it has taken to ensure the Bureau of Milwaukee Child Welfare appropriately calculates the percentage of children who receive a termination of parental rights petition or an exception when the children have been in out-of-home care for 15 of the last 22 months, such as counting children only once and including only those children who are actually in out-of-home care at the 15-month point.

We also noted that the methods used to calculate two permanency standards comply with the settlement agreement's provisions, but they may not provide the most complete or useful information for assessing the Bureau's performance. First, the settlement agreement does not specify how the Bureau should calculate the percentage of children who receive TPR petitions or exceptions after being in out-of-home care for more than 15 of the last 22 months. The Bureau's method for measuring performance is based on one point in time, January 1 of each year, and does not include all children in a given year who have been in out-of-home care for more than 15 of the last 22 months. There are other ways to calculate this measure so that it includes all children. For example, each month the Bureau could identify the number of children who had been in out-of-home care for more than 15 of the last 22 months and then determine how many of them subsequently received TPR petitions or exceptions by the end of the year.

Second, the settlement agreement requires the Bureau to calculate the percentage of children who remain in out-of-home care for more than 24 months as a percentage of 5,533 children, which is the number of children in out-of-home care when the agreement was approved in 2002. However, the number of children in out-of-home care declined to 3,188 in June 2005, so the standard in the settlement agreement does not accurately portray the percentage of all children actually in out-of-home care for more than 24 months. The Bureau and attorneys for the settlement agreement's plaintiffs recognize the limitations of the standard, so the Bureau also calculates its performance based on actual caseloads, but only for certain months within the year, and not on an annual basis.

The percentage of children in out-of-home care for more than 24 months is greater than the Bureau has reported.

As shown in Table 27, the actual percentage of children who were in out-of-home care for more than 24 months is substantially greater than what is indicated using the method prescribed in the settlement agreement. The standard the Bureau did not meet is highlighted. We could not calculate this percentage for 2003 because data were incomplete.

Table 27

Performance Related to Children in Out-of-Home Care for More than 24 Months

	2004	January through June 2005
Settlement Agreement Requirement	No More Than 35.0%	No More Than 25.0%
Performance		
Based on Settlement Agreement Methodology	30.2	**25.5**
Based on Actual Caseloads	50.3	45.0

As noted, the methods the Bureau uses to calculate these two permanency standards comply with the settlement agreement. However, alternative methods would provide more complete information on the Bureau's performance.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1, 2006, on the steps it has taken to ensure the Bureau of Milwaukee Child Welfare:

- *considers other ways to calculate the percentage of children who have been in out-of-home care for more than 15 of the last 22 months and subsequently receive a termination of parental rights petition or an exception; and*

- *uses the actual number of children in out-of-home care to calculate the percentage of children who remain in out-of-home care for more than 24 months, and reports these results along with the results from the methodology specified in the settlement agreement.*

Safety

Four of the settlement agreement's performance standards relate to safety and are intended to:

- reduce the percentage of children in out-of-home care who are maltreated by foster parents or the staff of licensed child care facilities, such as group homes;
- increase the percentage of referrals within three business days to the contractor that independently investigates alleged maltreatment;
- increase the percentage of independent investigations assigned to an investigator within three business days of receipt; and
- increase the percentage of independent investigations completed within 60 days.

The Bureau has consistently met three of the four safety standards.

Three of the four safety standards have been met. As shown in Table 28, the standard that related to maltreatment of children in out-of-home care was not met in 2004. However, performance in that year may have been an exception, given that performance in the first six months of 2005 showed improvement.

Table 28

Reported Performance Related to Safety Standards[1]

Performance Standard	2003	2004	January through June 2005
Maltreatment of Children in Out-of-Home Care			
Requirement	No More Than 0.70%	No More Than 0.65%	No More Than 0.60%
Bureau-Reported Performance	0.57	**0.85**	0.58
Referrals for Independent Investigations			
Requirement	At Least 80.0	At Least 85.0	At Least 90.0
Bureau-Reported Performance	99.8	99.4	98.7
Assignment of Referrals to Independent Investigators			
Requirement	At Least 80.0	At Least 85.0	At Least 90.0
Bureau-Reported Performance	99.6	99.8	100.0
Completion of Independent Investigations			
Requirement	At Least 80.0	At Least 85.0	At Least 90.0
Bureau-Reported Performance	97.6	98.1	100.0

[1] Information reported by the Bureau.

Well-Being of Children

Five of the settlement agreement's performance standards relate to well-being of children and are intended to:

- limit the three-month rolling average caseload at each of the Bureau's five sites to 11.0 cases per case manager;
- increase the percentage of children with three or fewer placements while in out-of-home care;
- ensure that placements in assessment centers do not exceed 30 days, or 60 days if two 15-day extensions are approved;

- ensure that placements in stabilization centers, which provide short-term placements for children whose out-of-home placements are disrupted, do not exceed 20 days; and

- ensure that case managers at each of the Bureau's five sites have monthly face-to-face visits with at least 90.0 percent of all children in out-of-home care.

The Bureau reported that the caseload limit specified in the settlement agreement has been achieved for the most part. At Site 5, where a new contractor began administering case management services in January 2005, the three-month rolling average caseload was slightly above the 11.0 caseload standard. It was 12.3 in December 2004, 12.7 in January 2005, and 12.3 in February 2005.

Four of the five well-being performance standards have been met.

As shown in Table 29, the Bureau has never met the standard for children having three or fewer placements while in out-of-home care, but it met the remaining standards. It should be noted that the settlement agreement does not include specific performance requirements for the two standards relating to assessment center placements and stabilization center placements. However, administrative code requires that children remain in assessment centers for no more than 60 days and statutes require that they remain in stabilization centers for no more than 20 days.

Table 29

Reported Performance Related to Well-Being Standards[1]

Performance Standard	2003	2004	January through June 2005
Children with Three or Fewer Placements while in Out-of-Home Care			
Requirement	At Least 80.0%	At Least 82.0%	At Least 90.0%
Bureau-Reported Performance	**75.9**	**72.1**	**71.2**
Assessment Center Placements Less than 60 Days[2]			
Requirement	n.a	n.a	n.a
Bureau-Reported Performance	n.a	95.4	91.4
Stabilization Center Placements Less than 20 Days[3]			
Requirement	n.a.	n.a	n.a
Bureau-Reported Performance	n.a.	72.2	74.8
Monthly Face-to-Face Visits			
Requirement	At Least 90.0	At Least 90.0	At Least 90.0
Bureau-Reported Performance	96.4[4]	97.0	97.0

[1] Information reported by the Bureau.
[2] The settlement agreement did not require the Bureau to measure its performance in 2003. Although the agreement does not include specific performance requirements, administrative code requires 100.0 percent compliance.
[3] The settlement agreement did not require the Bureau to measure its performance in 2003. Although the agreement does not include specific performance requirements, statutes require 100.0 percent compliance.
[4] Percentage represents the July through December 2003 average.

Each of the standards in the settlement agreement will remain in effect until there is agreement by the parties to the lawsuit or an arbitrator determines that it has been met during two consecutive six-month periods. If a standard is eventually met, the arbitrator may agree to remove it from the agreement's reporting requirements. However, if a standard is not met, the reporting requirements of the agreement will remain in effect for it. Some have suggested that management of Milwaukee child welfare should be returned to the county, but such a change does not appear to be a viable option at this time, given the Bureau's progress to date in meeting the standards.

Monitor-Only Performance Standards

The settlement agreement also includes ten monitor-only standards.

The settlement agreement also includes ten monitor-only standards without required performance targets:

- determining the average number of children per case manager at each of the Bureau's five sites;
- determining the rate of case manager turnover at each of the five sites;
- providing health screening to all children within five business days of their first out-of-home care placement, except for children discharged from a hospital to a placement;
- providing all children in out-of-home care with annual medical examinations;
- providing all children in out-of-home care with annual dental examinations;
- having initial permanency plan hearings for all children within 60 days of their first out-of-home care placement;
- completing semiannual permanency plan reviews for all children in out-of-home care;
- providing assessments to families within 90 days of their children's first out-of-home care placement;
- providing foster parents with complete information packets regarding their children's health and educational backgrounds; and
- determining the percentage of children who reenter out-of-home care within one year.

Fewer children received timely initial health screenings than the Bureau has reported.

As shown in Table 30, the Bureau's data indicate that performance related to these measures has also been mixed, with improvements in most areas from 2003 to 2004, but declines in the first half of 2005. However, we found inaccuracies in the Bureau's data related to initial health screening, which is to be provided to all children within five business days of their first out-of-home care placement, except for children discharged from a hospital to a placement. The Bureau's counts include children who were discharged from a

hospital to a placement; children who were returned home within five days of their first placement but did not receive initial health screenings; and children who received initial health screenings more than five business days after their first placement, including two children who received initial health screenings after having been in out-of-home care for 80 days. We recalculated, excluding these children, and found that 65.5 percent of children received initial health screenings in 2004 (compared to the Bureau's reported 76.4 percent), and 45.3 percent received them in the first six months of 2005 (compared to the Bureau's reported 59.3 percent).

Table 30

Performance Related to Monitor-Only Standards[1]

Standard	2003	2004	January through June 2005
Average Number of Children per Case Manager	19.5	18.5	18.1
Case Manager Turnover[2]	30.1%	38.6%	30.7%
Initial Health Screenings	58.2	76.4	59.3
Annual Medical Examinations	54.6	74.3	68.8
Annual Dental Examinations	42.7	64.8	63.3
Initial Permanency Plan Reviews	97.0	97.0	99.0
Semiannual Permanency Plan Reviews	64.1	77.1	91.3
Family Assessments	96.4	97.3	95.0
Placement Packets	91.0	85.0	96.0
Reentry into Out-of-Home Care Within One Year	7.1	6.6	5.7

[1] Information reported by the Bureau.
[2] Percentages represent annual Bureau-wide averages. The percentage for January through June 2005 is the estimated annual total, based on actual turnover during the first half of the year.

Children should receive initial health screenings in a timely manner so medical needs can be understood and addressed quickly. Similarly, annual medical and dental examinations reduce children's risks of developing potentially severe medical or dental problems, so 2005 performance declines in these areas are of concern.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by February 1, 2007, on the steps it has taken to ensure:

- *children in out-of-home care receive annual medical and dental examinations; and*

- *the Bureau of Milwaukee Child Welfare uses an appropriate methodology for calculating the percentage of children who receive initial health screenings within five business days of entering out-of-home care.*

■ ■ ■ ■

Ensuring the Safety of Children ■

Addressing allegations of abuse and neglect is often difficult. Investigations can be complex, and conclusive evidence may be lacking. In addition, many families involved with the child welfare program have significant problems that are not easily resolved, including alcohol and drug dependencies. To evaluate the Bureau's efforts to ensure the safety of children in Milwaukee County, we analyzed files for 73 high-risk cases to determine whether allegations were appropriately investigated and children were appropriately served. In most instances, the Bureau and its contractors took reasonable and appropriate action, but we found four cases in which efforts were insufficient to ensure children's safety.

Assessing Efforts to Protect Children

We reviewed 73 cases involving children most likely to be at risk from abuse or neglect, including 29 fatalities.

The 73 cases we reviewed included:

- all 10 fatalities of children in out-of-home care that occurred from 2002 through 2004;
- all 19 child fatalities from 2002 through 2004 that occurred because of maltreatment;
- 31 cases in which the Bureau substantiated allegations of maltreatment but did not remove children from their homes, and for which summary data indicate no services were provided in 2004; and

- 13 cases involving families against whom five or more allegations of maltreatment were made in 2004.

None of the ten fatalities of children in out-of-home care occurred because of abuse or neglect. Instead, eight fatalities occurred because of children's pre-existing medical conditions, and two occurred as a result of accidents. None of the 19 families of children who died from maltreatment were involved with the child welfare program at the time of the fatalities, although 13 families did have prior contact, typically at least several months before the fatalities occurred. Six families had no contact with the Bureau before the fatalities occurred.

In most cases we reviewed, the Bureau and its contractors took appropriate action.

In most of the 44 active cases we reviewed, the Bureau and its contractors took appropriate action. Although the summary data indicated no services had been provided in 31 of these cases, the files showed otherwise. In some instances, services were not ordered because they had already been put in place when previous allegations were substantiated. In others, the files indicated why the Bureau took no action. For example, a child must be in imminent danger to be removed from the home. If the Bureau cannot substantiate that sufficient danger exists, it can instead offer safety services to the family, but it may be unable to take further action if the family refuses these voluntary services. During our file review, we found:

- Late in 2004, the Bureau substantiated an allegation of neglect against a mother who had been arrested a third time and incarcerated for repeatedly allowing her children to be truant from school. The file indicated that the family environment was "chaotic" and that the children were living with a cousin while the mother was in jail. When the family refused safety services, the Bureau closed the case because it believed that the children were no longer in imminent danger and it had no legal grounds to remove them from the home. At the time our fieldwork in November 2005, the Bureau had no further contact with the family.

- Early in 2004, the Bureau substantiated an allegation that a teenage girl with learning disabilities in an immigrant family had been struck by her mother. The file stated that the strict discipline used by the family was likely acceptable in their country of origin. After the family refused safety services, the Bureau closed

the case because it had no legal grounds to remove the girl from the home, the family environment appeared to have improved, and the parents expressed remorse. At the time of our fieldwork in November 2005, the Bureau had no further contact with the family.

In four cases, insufficient action appears to have been taken to ensure the safety of the children.

However, in 4 of the 73 cases we reviewed, the Bureau and Wisconsin Community Services Network, which provided out-of-home care services for all cases, do not appear to have taken sufficient action to ensure the safety of the children. In the first case, four different case managers were assigned to the family from late 2003 through mid-2004, which likely contributed to the problems we identified.

The first case involved multiple allegations that six children were neglected.

This case involved multiple allegations of child neglect by a mother of ten who had repeated involvement with the child welfare system over the past 16 years. Her parental rights for two children had been terminated, and two other children had been placed in permanent foster care. The family had a case manager, but it is unclear whether the mother or the six children still living with her were receiving any child welfare services late in 2003, when the mother requested housing assistance for herself and these children because the City of Milwaukee had condemned her house.

According to Milwaukee municipal code, a building that is unfit for human habitation creates a hazard to the safety or welfare of the occupants. Therefore, many would argue that the case manager should have immediately moved the children to a safe environment. However, there is no record of any action taking place until two months later, when the case manager began helping the family find another house. The family continued to live in the condemned house for more than two additional months.

Early in 2004, the Bureau received two allegations of neglect because the family's living conditions were poor, there was little food in the house, the mother allegedly used illegal drugs, and the children did not attend school regularly. The Bureau referred these allegations to the family's case manager, as is its practice, although it was unclear from the file when the case manager had last visited the home.

The following month, the Bureau received another allegation that the mother was neglecting her children. Two Bureau staff visited the home and found that it was clean but heated only by a stove. The file notes that "the conditions of the home were not nearly as serious as reported" and that safety concerns were insufficient to warrant

the children's removal. However, two days later, a different Bureau staff member visited the home and noted:

- there was no crib for the eight-month-old infant;
- the family had limited food and personal hygiene products;
- the kitchen was infested with cockroaches;
- the window in the children's bedroom was broken, which resulted in "ice cold" temperatures in the room; and
- the mother possibly abused alcohol and drugs and had "marginal parenting practices which pose significant risk to her children."

It seems unlikely that the conditions in the home could have changed so drastically in the two days between the two visits by different Bureau staff.

After the Bureau substantiated the allegation of neglect, the family moved in with a relative. The Bureau therefore did not remove the children from the mother's care, but she was offered parenting skills training and help in obtaining housing and enrolling in the W-2 program. The case file does not indicate whether the mother accepted these services. In mid-2004, when the Bureau last had contact with the family, the mother stated her children were living with her brother.

The second case involved allegations of medical neglect.

The second case involved allegations of medical neglect. A teenage girl had learning disabilities and health problems. Since 1998, the Bureau had investigated 16 allegations of maltreatment involving the family and had substantiated 1. The girl's parents, who had nine other children, both had mild mental disabilities. The mother died of a terminal illness in mid-2004. The following month, the Bureau began investigating an allegation that the girl's father was medically neglecting her.

Statutes require that an investigation be completed within 60 days, but this investigation was not yet completed when the girl suffered a seizure late in 2004. Four days later—and 104 days after the investigation began—the Bureau substantiated the allegation. The file notes that the family "has been ravaged by violence, poverty, abuse, neglect & substance abuse" for years, and that "services that were put in place to try to assist this family did little to improve the lives of the 10 children." The Bureau took custody of the girl,

Children's Court granted a CHIPS petition, and the girl was placed in a foster home, where it is anticipated she will remain until she turns 18. The most recent entry in the file, made late in 2005, indicated the girl was doing well in the foster home.

The third case involved unsubstantiated and substantiated allegations against a foster parent.

The third case involved both unsubstantiated and substantiated allegations against a foster parent. Four siblings were first placed in a foster home in early 2003. In mid-2003, the Bureau received an allegation that a foster parent had hit one of the children with a belt. The foster parent admitted to a child welfare worker that she had hit the foster child with her hand but stated that the children's case manager had advised her to deny that she had done so when questioned by the Bureau's investigative staff. The file indicates the foster parent subsequently denied hitting the foster children, and the allegation was unsubstantiated. If the allegation had been substantiated, the foster parent could have lost her license because foster parents are not allowed to use physical discipline against foster children.

In addition, when the four children were initially placed in the foster home, the Bureau had informed the foster parent that their severe dental problems needed immediate care. Eleven months later, the case manager indicated in the file that all of the children's health needs had been addressed. However, during the 17 months they were in the foster home, only one of the four children received dental care. After they were moved to the home of a family who planned to adopt them, two of the children required several visits to a dentist to remove teeth and fill cavities. In mid-2004, the Bureau substantiated an allegation of medical neglect against the foster parent and subsequently revoked the foster home's license. The most recent entry in the file, made in mid-2005, indicated that a grandmother received guardianship of one of the four children, while the family was in the process of adopting the other three. All four children reported that they are doing well.

The fourth case involved the death of a child.

The fourth case involved the death of a one-year-old child. The Bureau placed two young children in foster care late in 1998 after their teenage mother—who was homeless, had mental health issues, and abused drugs and alcohol—threatened to drown one of them. In mid-2001, the children were returned to the mother, who had since given birth to a third child. Early in 2002, she gave birth to a fourth child. The following day, a hospital told the Bureau that she had tested positive for marijuana use.

There was no indication in the file that the Bureau took any action in response to the information on the mother's use of illegal drugs. In the following month, the Bureau received an allegation that the mother was homeless and living in drug houses with two of her

children, but it did not initiate an investigation because her whereabouts were unknown. The file did not include any information that indicated the police had attempted to locate the mother at this time. One year later, the mother left her one-year-old child in the care of a family friend. Over the course of a five-day period, the friend's two teenage children physically abused the child until he died. It was only after the death of the child that the file indicated the police were involved in attempting to locate the mother. The most recent entry in the file, made early in 2003, indicated that two of the other three children were living with a grandparent, while the third was living with an aunt.

Given that the Bureau received information on two occasions early in 2002 that the mother was engaging in activities that had previously resulted in children being removed from her custody, we question whether sufficient action was taken to ensure the safety of the children. Although the Bureau did not know the mother's whereabouts when it received the allegation of neglect early in 2002, it knew where the children's grandmother lived and could have initiated an investigation.

■ ■ ■ ■

Coordination of Services ■

Families and children in the child welfare program often need a variety of services, such as health care, work assistance, and child care. Many are also eligible for Medical Assistance, W-2, and other programs, and three of the settlement agreement's monitor-only performance standards are related to health care. Advocates have raised concerns about the extent to which families actually receive health care, work assistance, and other services, as well as the level of coordination among the programs. We found that service coordination is limited.

Participation Levels

Children who have been removed from their homes are automatically eligible to participate in the Medical Assistance program. More than 95.0 percent of eligible children likely receive Medical Assistance services annually, but the available data prevented us from determining a precise number. As shown in Table 31, recent Medical Assistance expenditures for children in out-of-home care in Milwaukee County have been approximately $20 million per fiscal year. In FY 2003-04, the last year for which detailed information was available at the time of our fieldwork, the largest Medical Assistance expenditures were for health maintenance organization capitation payments ($4.1 million), inpatient hospital services ($2.1 million), prescription drugs ($2.0 million), and mental health crisis intervention services ($1.8 million).

Table 31

Medical Assistance Expenditures for Children in Out-of-Home Care in Milwaukee County[1]
(In Millions)

Fiscal Year	Expenditures
2001-02	$20.5
2002-03	20.0
2003-04	18.4
2004-05	20.8

[1] Reflects the fiscal year in which payments for services were made; services could have been provided up to one year earlier.

Child welfare staff and advocates with whom we spoke said that providing health care services to children in out-of-home care is often challenging because not enough physicians and dentists are willing to accept Medical Assistance reimbursement rates. We found that approximately one-third of children in out-of-home care in the first half of 2005 did not receive annual medical or dental examinations. We also determined the extent to which mothers who received safety services and mothers who had at least one child removed from the home participated in Medical Assistance, Food Shares (previously known as Food Stamps), Wisconsin Shares Child Care Subsidy program, the W-2 program, and other work assistance programs. Our analysis focused on mothers because many of these support programs serve women primarily, and few families in the child welfare program are headed by single fathers.

Few mothers with children in out-of-home care participated in other support programs.

As shown in Table 32, few mothers with children in out-of-home care participated in support programs other than Medical Assistance and Food Shares during the three months we analyzed. Because most parents with children in out-of-home care are poor and unemployed, they are likely to qualify for a number of these programs. However, if all children have been removed from the home, a mother typically loses her eligibility for Medical Assistance and is ineligible to receive W-2 cash payments or subsidized child care, which may partially explain the low participation rates. As shown in Table 33, mothers receiving safety services were more likely to participate in other support programs, although relatively few received child care subsidies or participated in W-2 or other work programs.

Table 32

Support Program Participation by Mothers with Children in Out-of-Home Care

Program	January 2003	January 2004	January 2005
Medical Assistance	25.6%	34.6%	35.6%
Food Shares	41.1	39.2	40.8
Child Care Subsidy	3.9	4.7	3.2
W-2:			
Subsidized Placements	8.2	8.6	8.3
Unsubsidized Placements	1.3	0.8	1.0
Other Work Programs[1]	18.6	15.7	11.0

[1] Includes Food Stamp Employment and Training, Children First, Welfare to Work, and Workforce Attachment and Advancement.

Table 33

Support Program Participation by Mothers Receiving Safety Services

Program	January 2003	January 2004	January 2005
Medical Assistance	58.7%	67.0%	66.7%
Food Shares	60.8	68.6	68.3
Child Care Subsidy	12.2	19.9	18.8
W-2:			
Subsidized Placements	25.7	34.0	28.0
Unsubsidized Placements	5.9	3.7	4.8
Other Work Programs[1]	24.3	30.9	16.1

[1] Includes Food Stamp Employment and Training, Children First, Welfare to Work, and Workforce Attachment and Advancement.

Coordination of child welfare and W-2 program services is limited.

Coordination of service delivery may be limited even if an individual participates in both the child welfare and the W-2 programs. For example:

- In a review of 48 out-of-home care case files, we found that W-2 staff did not attend any of 146 coordinated service team meetings that were held while those cases were open.

- In a review of 50 safety services case files, we found instances of safety services managers never contacting a family's W-2 caseworker, including one case that was open for 146 days.

- In the same review, we also found instances of W-2 caseworkers not returning telephone calls from safety services managers and parents. In one case, both the safety services manager and the mother left unreturned messages, although the mother was uncertain about the name of her W-2 caseworker because of personnel changes.

- Some child welfare and W-2 staff did not fully understand eligibility requirements for each program. For example, one case file we reviewed indicated that the child welfare case manager gave incorrect information to a mother regarding her eligibility to receive W-2 benefits.

Efforts to Improve Coordination

Two service integration pilot projects operate in Milwaukee County.

In June 2004, the Governor's Wisconsin Service Integration Initiative was created to identify strategies for improving the coordination of service delivery. In October 2004, two service integration pilot projects began in Milwaukee County. Each involves a W-2 and a child welfare contractor.

First, United Migrant Opportunity Services (UMOS), a W-2 contractor, and La Causa, the primary child welfare contractor for Site 4, are working together to minimize duplication of services and reduce the confusion of families who seek services from both programs. A UMOS staff member at La Causa and a La Causa staff member at UMOS provide program information, train other staff, and provide services to families. In September 2005, DHFS provided $573,200 in unexpended GPR to help fund this project through June 2007.

In the past, if UMOS determined that a family needed services outside of those provided by the W-2 program, it referred the family to community resources such as nonprofit and faith-based organizations. With the funding available under the pilot project,

UMOS will instead refer the family to La Causa, which will provide the services. The participating families do not enter the child welfare program, and Bureau staff are not involved with them.

Second, Maximus, a W-2 contractor, is funding a liaison staff position to be located at Children's Family and Community Partnerships, a child welfare contractor that began providing services in 2005. The two organizations expect the position to facilitate communication, train staff, and participate in meetings with families who are receiving safety services. No state funding has been provided to support this project.

DHFS is developing a managed care pilot program in Milwaukee County.

Finally, efforts have been made to improve children's access to health care. For example, 1999 Wisconsin Act 9, the 1999-2001 Biennial Budget Act, required DHFS to develop a managed care pilot program to improve access, quality, and efficiency in health care for children in out-of-home care in Milwaukee County. Children in foster care and those placed in the Kinship Care program by a court order will be enrolled in this program automatically, but children whose families are receiving safety services are not eligible for enrollment.

DHFS estimates that once all eligible children are participating, the program's cost will be $15.0 to $17.0 million annually. These costs will be covered by Medical Assistance funds. In July 2005, DHFS selected Abri Health Plan, a private health maintenance organization, to manage the program, which is scheduled to begin in April 2006. The contract is not expected to be signed until March 2006, but the request for proposals requires:

- a coordinated system of health care to meet the children's physical, dental, behavioral, developmental, mental health, and substance abuse needs;
- initial and ongoing assessments of each child;
- development of a coordinated health care plan within six weeks of a child's enrollment in the program; and
- provision or arrangement for most health care services covered by Medical Assistance.

■ ■ ■ ■

Improving the Child Welfare Program ■

Additional efforts are needed to improve the child welfare program.

Because of improvements DHFS has put in place, both the number of children in out-of-home care and the median length of their stays have declined significantly. Nevertheless, additional efforts are needed to improve management and operation of the child welfare program.

Recent Program Modifications

One strategy already underway to help achieve permanency goals in a timely manner is to provide financial incentives to relatives of children in out-of-home care. Currently, if guardianship is transferred to a relative who is also a foster parent, foster care payments end and the case is closed. Some relatives may be discouraged from pursuing guardianship for this reason. In September 2004, the federal Department of Health and Human Services granted DHFS a waiver to provide subsidized guardianship payments that are equivalent to the monthly foster care payments in Milwaukee County. 2005 Wisconsin Act 25, the 2005-07 Biennial Budget Act, contained statutory changes to enable this project.

Second, the Bureau's dual licensure project seeks to improve placement decisions for young children. Through this project, foster care and adoptions contractors collaborate to license foster homes while also approving the homes as potential adoptive placements, and they jointly decide which children to place in the homes. As of June 2005, eight homes had been licensed under the project, and eight more were being studied.

Third, to reduce statutory barriers that affect the TPR and adoption processes, the Joint Legislative Council's Special Committee on Adoption and Termination of Parental Rights was established in 2004. In 2005, the committee recommended statutory changes to:

- clarify when a parent's rights can be involuntarily terminated by the Children's Court;
- clarify the procedures and time lines for appealing the Children's Court's decision to terminate a parent's rights; and
- require individuals who have not previously adopted a child to obtain training, for which DHFS pays, on issues that may confront adoptive parents.

In June 2005, the Legislative Council introduced 2005 Assembly Bill 521 to enact the committee's recommendations. The bill was passed by the Assembly in December 2005 and by the Senate in January 2006.

Fourth, the 2005-07 Biennial Budget Act provides an additional $1.2 million annually, beginning in January 2006, to make preventive safety services available to families with children who are not at immediate risk of maltreatment. It is hoped that if more preventive services are offered, fewer children will later need to be removed from their homes.

In June 2005, DHFS contracted for a child welfare ombudsman in Milwaukee County.

DHFS recently made two additional changes that are intended to improve the operations of the Milwaukee County child welfare program. In June 2005, it contracted with the Planning Council for Health and Human Services, Inc., an independent and nonprofit organization, to operate the Office of the Milwaukee Ombudsman for Child Welfare. The office has 2.5 FTE positions, including an ombudsman, that are expected to provide independent, impartial reviews pertaining to families' concerns involving the Bureau. The office can recommend specific corrective action, including changes to the Bureau's policies and procedures, but it has no authority to compel the Bureau to implement its recommendations. DHFS has used $403,400 in unspent child welfare funds that had been allocated to the Bureau for operational expenses—including $293,600 in GPR and $109,800 in federal funds—to cover the office's costs during the 2005-07 biennium. The ombudsman's office had not been in operation long enough at the time of our fieldwork for us to assess its effectiveness.

In 2006, DHFS plans to execute new child welfare contracts.

In addition, DHFS is executing new child welfare contracts that will reduce the number of child welfare service sites from five to three, in order to better balance workloads among the sites and more closely align sites with the boundaries of neighborhoods and W-2 regions. The new site boundaries are shown in Appendix 2. When finalized, the contracts are expected to run for one year—calendar year 2006—but be renewed annually for eight years if DHFS determines that a contractor's performance has been satisfactory.

Under the new contracts, safety services contractors will continue to be paid $4,776 for each family served, regardless of which services are provided or how long a case remains open. However, the contracts will change the way that case management contractors are paid. For example, case management contractors will be paid $1,036 per month for each case, regardless of the amount of services provided to families. Other contract provisions were not finalized at the time of our fieldwork, but the request for proposals anticipates additional changes:

- To limit contractors' risk of being underpaid under the flat case rate, DHFS may cover all their reasonable costs related to administration, as well as the case manager salaries and fringe benefits needed to keep the average caseload below 11.0 cases per manager.

- Case management contractors may be responsible for 50.0 percent of the first $250,000 in losses they incur to purchase services for families.

- Case management contractors that meet contractually specified permanence, safety, and well-being performance standards may earn up to 3.0 percent of the contract amount that is set aside as a reserve and use these funds to serve families.

Later in the renewal period, case management contractors may be required to assume more financial risks. For example, contractors may be responsible for a larger portion of any losses incurred to purchase services for families in 2007 and thereafter. However, it is possible that DHFS could modify these provisions if a contractor incurred large losses.

Addressing Future Challenges

Additional efforts are needed to address the problems we noted, so that children will be served more effectively. For example, when

investigations of child abuse and neglect are not completed within the 60-day limit set in statutes, instances of abuse or neglect can continue for longer periods.

In addition, we have concerns about how case management contractors are paid under the 2006 contracts. As noted, case management services were not always initiated in a timely manner in the first half of 2005: only 27.4 percent of court-ordered services were in place shortly after children were removed from their homes. Under the new contracts, case management contractors will receive a monthly rate of $1,036 per case even if they do not initiate services for families after their children have been placed in out-of-home care.

Similarly, under the new contracts, safety services contractors will continue to receive four monthly payments for each family served regardless of the actual time for which they provided services. If the average period for which families receive safety services continues to decline in 2006, contractors will benefit financially and families may not receive the services they need.

☑ Recommendation

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by February 1, 2007, on its progress at meeting key performance measures, including:

- *improving the timeliness of its investigations of child abuse and neglect;*
- *improving the timeliness of services ordered for each family when a child is removed from the home;*
- *continuing efforts to reduce the time children spend in out-of-home care;*
- *ensuring the adequacy of safety services provided by contractors; and*
- *improving coordination of services with Medical Assistance, W-2, and other social services providers.*

If the provisions in the 2006 child welfare contracts do not result in effective and efficient service delivery, it may be necessary for DHFS to modify the relevant contractual provisions before extending the contracts in 2007.

In the longer term, the Milwaukee child welfare program faces additional challenges that need to be addressed, such as:

- increasing the access of children in out-of-home care to health care, including providing them with initial health screenings and annual medical and dental examinations;

- increasing the number of physicians, dentists, and other service providers that are willing to accept Medical Assistance reimbursement rates; and

- addressing staff turnover issues, which are discussed in report 06-2.

■ ■ ■ ■

Appendix 1

Primary Child Welfare Contractors in Milwaukee County, by Type of Service Provided

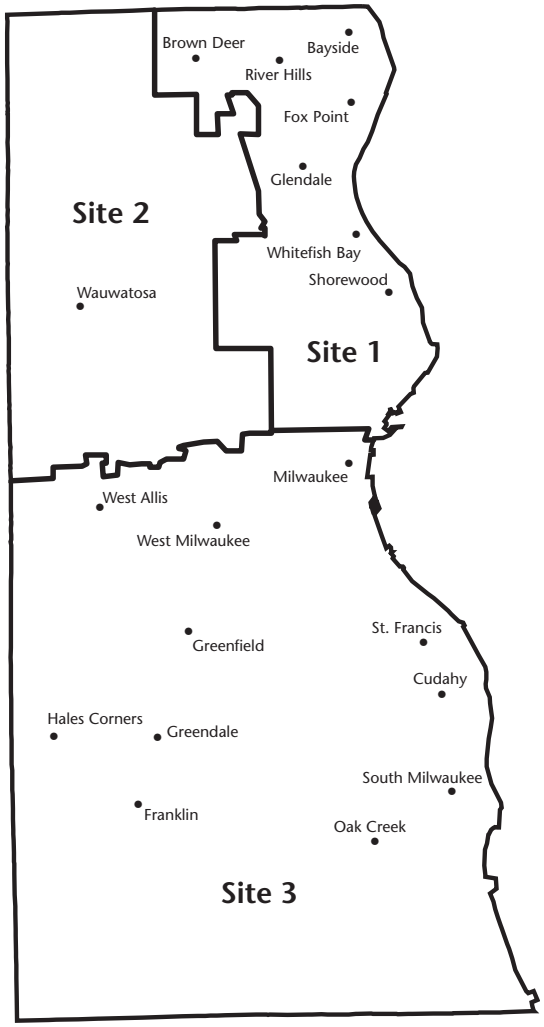
Service Provided	2001	2002	2003	2004	2005
Ongoing Case Management					
Site 1	Wisconsin Community Service Network				Children's Family and Community Partnerships
Site 2	Milwaukee County	Wisconsin Community Service Network			Children's Family and Community Partnerships
Site 3	Innovative Family Partnerships				Children's Family and Community Partnerships
Site 4	La Causa				
Site 5	Milwaukee County	Innovative Family Partnerships			Children's Family and Community Partnerships
Safety Services					
Site 1	Wisconsin Community Service Network				Children's Family and Community Partnerships
Site 2	Milwaukee County			Wisconsin Community Service Network	Children's Family and Community Partnerships
Site 3	Innovative Family Partnerships				Children's Family and Community Partnerships
Site 4	La Causa[1]				
Site 5	Milwaukee County				La Causa[2]
Foster Care Licensing	Milwaukee County	Lutheran Social Services			
Adoption	Milwaukee County	Children's Service Society of Wisconsin			
Independent Investigations	Milwaukee County	Community Impact Program			
Staff Training	UW-Milwaukee				
Determining Eligibility for Federal Funding	Milwaukee County	Maximus			
Independent Living	UW-Milwaukee		Lad Lake		

[1] As of October 2001.
[2] Milwaukee County was originally responsible for the site but ceased accepting new cases in February 2005.

Appendix 2

Child Welfare Site Boundaries in Milwaukee County

2006



State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

January 30, 2006

Janice Mueller
State Auditor
Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

The Department of Health and Family Services has no responsibility more important or challenging than that of the Bureau of Milwaukee Child Welfare (BMCW) -- to protect children at serious risk of abuse or neglect, and strengthen and support families. We concur with the State Auditor's letter stating that:

> *"DHFS has taken important steps in recent years to improve the welfare of children in Milwaukee County, including significantly reducing the number of children in out-of-home care."*

Equally, we concur with the State Auditor that there are:

> *"... concerns with the timeliness of investigations... (and) court-ordered services... collaboration and coordination ... and problems related to establishing permanent placements...(and) more could have been done to protect children (in 4 of 73 high-risk cases they reviewed)."*

We can, and we must, do more to improve the performance of BMCW, based both on the audit findings and our own assessments. We are committed to do this, first and foremost, to serve children and families better. We are also committed to being accountable for our performance and responsible stewards of resources.

This letter reports on significant actions already taken, and added actions we plan, to achieve needed improvements. The letter is divided into three parts.

1. *Past progress: Since the State took over administration of the child welfare program in Milwaukee in 1998, very significant progress has been made to protect children and provide them with safe homes.*

2. *Promising initiatives in progress: In the past year, the State has begun several major initiatives to address root causes and underlying problems in BMCW performance, included but not limited to, addressing case manager turnover, contractor accountability, and system collaboration.*

3. *Added actions to improve management performance: We will take action very shortly to strengthen BMCW's internal capacity for better supervision of contracts, personnel, data*

reporting, and other management functions. We will also develop and enforce policies to respond to high-risk cases, such as those reviewed by the auditors.

The actual recommendations of the auditors call for DHFS to report to the Joint Legislative Audit Committee on steps we are taking to improve performance in specified areas the auditors found deficient. We accept the recommendations and will report on each specified issue on the dates the auditors recommended. In addition, we will report by early March of this year on our actions to upgrade BMCW internal management capacity.

I appreciate the thoroughness of the auditors' work including their consideration of the history, past progress, and the complex nature of the child welfare system. This context is essential to considering added actions needed now. I reflect the same approach in this letter – reviewing past and current initiatives before describing further actions.

It is also important to remember the volume and complexity of the work that BMCW does, and the essentiality of supporting the individuals and the agencies that do this work.

BMCW receives more than 30,000 calls to its child abuse and neglect hotline each year, and each of those calls -- and the well-being of each child and family-- be treated in the best possible way. State social workers who respond to these calls often go out in the middle of the night and enter homes under the most traumatic of circumstances. Similarly, the ongoing case managers of our contract agency partners work with families with complex needs and stresses. As we focus on serving children and families better, we are and we must continue to be committed to supporting the state and partner agency staff who do this incredibly important and extremely difficult work.

Working together, we are absolutely committed to taking BMCW's performance to the next level of service – the level that the children and families of Milwaukee deserve.

Past Progress

BMCW has made significant progress since the State took over administration of the program in 1998. At that time, the child welfare system was truly in crisis. The hotline was inadequately staffed and callers routinely could not get through to make a report.

Case managers were assigned caseloads up to one hundred, an untenable situation. Some children were assigned to "vacant zones" and given no case manager to watch over them. For the children who were assigned a case manager, months or even years could go by before the worker visited the child.

There were no preventative services designed to keep the family intact, and therefore, removing a child from the home was the only option. There were approximately 7,000 children involved in the system, and children remained in out-of-home care for long periods of time.

Today, callers reporting abuse and neglect have their calls answered and responded to 24 hours a day, seven days a week. Caseloads have been reduced to a maximum of ten families per worker and every child is assigned a case manager.

Face-to-face contact between a worker and a child occurs at least monthly, and there is a countywide network of service providers. The number of children in out-of-home care has dropped to 2,800, and more children are achieving permanency than ever before. An innovative Safety Services program has been put in place which allows families to remain intact if possible — consistent with national laws and best practice guidelines —while providing assurances of safety for the children.

Overall, the State has made significant improvements in a majority of the outcomes specified in the *Jeanine B.* settlement agreement, the settlement of the lawsuit about child welfare performance in Milwaukee. For each year of the three year agreement, the performance standards have increased and the State has continued to meet a majority of them and is close to meeting others.

Underlying Challenges

At the same time we note real progress, we also acknowledge that over the years, BMCW, like the children and families it has served, has experienced significant struggles and challenges. We have not met all the standards established in the settlement, although we are absolutely committed to doing so. These performance shortfalls are related to some underlying system problems we are currently working hard to address.

First and foremost is case manager turnover. As noted by the auditors in their separate report on finances and staffing at BMCW, turnover is a serious problem nationally and at BMCW. The constant introduction of new and inexperienced case mangers results in confusion and lack of continuity in executing agency policy and procedures. This in turn negatively affects their ability to work effectively with their clients. In addition, workers who are unfamiliar with the history of a case are less effective in providing necessary information and making recommendations in court. As described briefly below, we have recently undertaken a series of initiatives to get at this underlying root cause of many of BMCW's performance problems.

A second underlying system problem is the availability of strong, stable and expert contractors. Before the State took over the county government-operated child welfare system, there were no private agencies in Milwaukee with the capacity and experience necessary to operate such a system. The State and the private sector, working together, literally created a new organizational infrastructure and "grew" the expertise. There has been a learning curve, as well as some fragility and turnover in the private agency contracts.

We believe the most recent RFP process for Safety and Ongoing Case Management Services has resulted in selection of agencies with expertise and capacity to do this work well. While the auditors point to the past and current financial condition of one contractor, La Causa, we want to express our support for that agency's action plan to improve their financial stability and affirm our commitment to work with them in that regard. La Causa has shown the capacity to serve children and families well, and we appreciate their continued service as a BMCW contractor, along with that of our other ongoing and safety services partner, Children's Family and Community Partnerships. Stability of agencies is important for continued quality improvement in system performance, and particularly, stability for children and families. As described in the next section, we are working with our partner agencies to define new contract terms that emphasize achievement of performance outcomes.

A third underlying issue is the complexity of the public-private system design created when the State undertook this responsibility in 1998. Although the basic infrastructure of a state-run system is now in place, serious challenges remain in making the system work as effectively as we would wish. Part of the challenge lies in the fact that State workers receive the reports of abuse and neglect and go out to homes to do initial assessments, but the handling of cases thereafter—whether the child is removed from the home or stays in the home while the family receives social services—is done by private agencies. Because each agency is a private not-for-profit business and has its own culture and business practices, coordination can be challenging. "Case handoffs" between workers in different agencies are not always smooth, and staff turnover compounds the problem. As noted below, in partnership with our contract agencies, we are tackling this head-on as an immediate priority as well.

A fourth basic challenge has been identifying a sufficient number of the most appropriate foster homes to care for children. We are missing the mark in the *Jeanine B.* settlement agreement for stability and quality of foster placements. This long-standing problem is aggravated now by the mix of children we are seeking to place. More than half of the children in out-of-home care are age 10 and older, and BMCW has experienced an increase in older children entering out-of-home care during the past year. We also have larger sibling groups and children with very special health care and behavioral needs. Finding good matches for these children is challenging.

Frustration persists among BMCW employees, the court and community advocates, all of whom want to improve the quality of services available to children and their families. This frustration exists in virtually every child welfare system in the country, but we are absolutely dedicated to finding ways that the Milwaukee system can grow and improve.

Recent Initiatives to Address System Challenges

About nine months ago, I appointed a new leader, the best administrator I could find, to take on the responsibility of the Division of Children and Family Services (which includes BMCW, statewide child welfare, and related functions). Since the appointment of Burnie Bridge in this role, we have undertaken several significant initiatives to address the four underlying systemic problems described above and also other important performance issues, such as the provision of health care to children.

Addressing these systemic problems is necessary to achieve the significant, tangible performance improvements we are seeking. We understand these are long-range strategies, but believe they are critical.

Administrator Bridge and the BMCW management are working collaboratively with the Milwaukee Child Welfare Partnership Council, our contract agency partners and others on these initiatives. We know that BMCW cannot achieve these improvements alone, and we value these essential partnerships. Administrator Bridge has reinvigorated the partnerships, including but not limited to, inviting the benefits of a more active Council. Recently undertaken initiatives are directed at the following:

1) Improving worker recruitment and retention. Several strategies, such as increasing workers' salaries and offering both full and part-time Masters Degree training in exchange for a work commitment, are already underway. Others, such as improving worker training and mentoring, are actively planned for

rollout this year. BMCW has also created workgroups composed of staff from all program areas to make recommendations addressing turnover. The Milwaukee Child Welfare Partnership Council has provided support and guidance throughout this process and has identified worker turnover as its principal area of focus.

2) Data-based quality improvement. Working with a nationally recognized authority on child welfare practice, we are beginning a long-term quality improvement approach that is designed around stronger analysis and understanding of how best to improve our practice and system performance. We have engaged outside assistance, a national leader, who has been receiving extensive praise for developing a tool that is reality-based and results in true, positive changes. Members of the Milwaukee community have been convened as a steering committee to actively guide this work. We believe this system approach will address the collaboration issues raised by the auditors, the "case handoff" problems described above, and other key issues by helping all parties work in a focused manner on common agendas for improvement.

3) Recruiting, training and supporting quality foster families. We have begun an exciting collaboration with faith-based groups to develop new, culturally competent strategies for outreach, recruitment, and support of successful foster parents. This will build on a number of measures BMCW has already taken to augment support for foster families and emphasize improved recruitment.

4) Health care for foster children. A new managed care organization for foster children—the first of its kind in the United States—is being implemented by my Department and is scheduled to open its doors shortly. Because foster children have a proportionally high need for mental, physical and dental health services, we hope this new privately operated enterprise will help improve the level of services they receive.

5) Contractor relations that emphasize performance. We have completed a RFP process and are developing new contracts with case management agency partners in 2006. The contracts will be structured to emphasize performance outcomes and performance improvement. There will be regular opportunities for taking stock and collaborative problem-solving, all within the context of well defined measurements that we believe will improve communication, coordination and accountability. We will also be instituting different and improved management monitoring methods of contractors' performance, noted in the last section.

The Need for Further Action in Response to the Audit

The Legislative Audit report both confirms areas of which we were aware and reveals new issues in need of immediate attention.

1. Reduction of risks of maltreatment in high-risk cases

Our first priority is doing our best to ensure that children are safe. The auditors reviewed 73 high-risk cases from 2002 through 2004. These involved cases where children died, cases where there were multiple allegations of maltreatment, and cases in which BMCW substantiated allegations of maltreatment but did not

remove children from their homes, or in which summary data did not show services were provided. As summarized in the State Auditor's cover letter, "*The Bureau and its contractors took reasonable and appropriate action in 69 of these cases, but we believe more could have been done to protect children in the remaining 4 cases.*"

We find each of these cases troubling. The audit identifies delayed attention to inadequate housing in one case, delayed medical or dental care in another, and delayed or inconsistent assessments of a seriously deficient home in a third. We agree that "more could have been done" to help the children. Of course, it is not possible for state and contract agency staff to foresee and prevent all abuse and neglect of children. However, we must aim to come as close as we can to that ideal goal – and in practical terms, we must do better than we have done. In each of these cases, earlier or more substantial efforts might have been beneficial.

Of the four cases, one case resulted in a child's death. We are saddened by this tragedy. Although it is very difficult to contemplate the death of any child, we are troubled by the fact that BMCW and others may have been able to do more to reduce the risk of such a tragic outcome for a child.

In this case, a health care institution called the hotline to inquire if a case was currently open for its patient. The caller noted concerns surrounding activities its patient, a pregnant women, was engaging in, but it did not make an official report of abuse or neglect. The woman had previously been involved with BMCW and her two older children removed to foster care, but the children had been returned to her and no BMCW case was "open" at the time. The BMCW worker who took the call made the decision that the call did not require intervention. Later, the Bureau received an allegation that the mother was homeless and living in unsafe conditions, but again did not initiate an investigation because her whereabouts were unknown.

A year later, the mother left one of her children in the care of a family friend and that friend's teenage daughters physically abused him until he died. The perpetrators of this crime have been convicted and were sentenced to prison.

Beginning immediately, we will establish and implement new standards for our response to cases in which health care providers report concerns of this nature to BMCW staff. We will also contact health care providers to remind them of their mandated responsibility to report any suspected child abuse and neglect, including infants who are drug positive at birth. We will establish new protocols for our collaboration with them so the Bureau can assess those situations to determine when services are warranted. In cases where individuals have a past open case with the Bureau, the improved process will require immediate, timely action to identify and assess any potential safety issues. It will also require greater collaboration with law enforcement to locate parents whose whereabouts are unknown to BMCW.

2. <u>Added attention to timely investigations and services</u>

In general, turnover of caseworkers and lack of timely investigations documented by the auditors contribute to heightened risks that children and families will not receive the best attention and children may not be protected. We will review the auditors' work files assessing the functioning and timeliness of the initial intake and investigation function so we can understand more fully the situation that currently exists and determine what other actions must be taken to assure the best standard of service.

We also recognize that the auditors' reports of premature termination of Safety Services and the management of this function may also need more focused attention. We will review this further with the auditors, contractors and staff. We will report on plans and actions for improvement, as recommended by the auditors.

We have previously recognized the slow start-up of some ongoing case management services. We are working with the Children's Court and our contractors to correct this situation.

All of the program performance improvements we are seeking will be supported by the previously discussed system change initiatives – such as improved workforce stability, contractor performance and a structured process for overall system and outcome improvement.

3. Significant upgrading of internal management capacity in BMCW

One strong message in the audit is the need to significantly improve the internal management of the Bureau. In particular, there are substantive concerns expressed about data reporting, contract monitoring and similar administrative controls. These will compel changes in management structure, internal controls, and capacity within BMCW to perform these key functions. We recognize also the need to strengthen contract management and related functions. For example, the auditors recommended we secure added information from contractors on services provided to families and other measures to improve contract monitoring and compliance.

We are in the midst of developing a plan that will significantly upgrade BMCW's capacity to assure data integrity and competence in core management functions. We will convene a small panel of top notch management experts to provide an independent review of our proposed operational improvement plans. We will also review our plans with legislative audit staff for their counsel on whether we are responding adequately to their concerns. We expect to finalize these plans and announce them yet this spring.

We are committed to accurate, transparent and meaningful data reporting to the Court, the Governor and Legislature, the Milwaukee community, and the general public. We have agreed with the plaintiffs in the court settlement agreement on methods for reporting, which we have diligently sought to follow. In one area, the auditors have identified a need to change our calculation to be consistent with the settlement agreement and in consultation with plaintiffs' counsel, we will do so. In other areas, the auditors have suggested other changes in methodology and added data to be reported. We have reviewed all these matters with plaintiffs' attorney and will comply with the expectations of the settlement agreement fully. We will also take other steps to improve the adequacy of data from BMCW to meet the needs of multiple stakeholders.

Closing

In summary, we are committed to move BMCW to a new level of performance. Much positive change is underway, and new efforts will result from our response to the audit. We will report to the Joint Legislative Audit committee as recommended on our progress in these areas.

I appreciate that Governors and Legislators of both parties, over a number of years, have committed to providing a strong state program of child welfare to protect children and help families in Milwaukee. I anticipate, with gratitude, that the welfare of these children will remain paramount in all our minds and will receive serious, realistic attention and continued investments. Improvement in Milwaukee Child Welfare is a long-term priority deserving our best, mutual efforts.

Sincerely,

Helene Nelson
Secretary