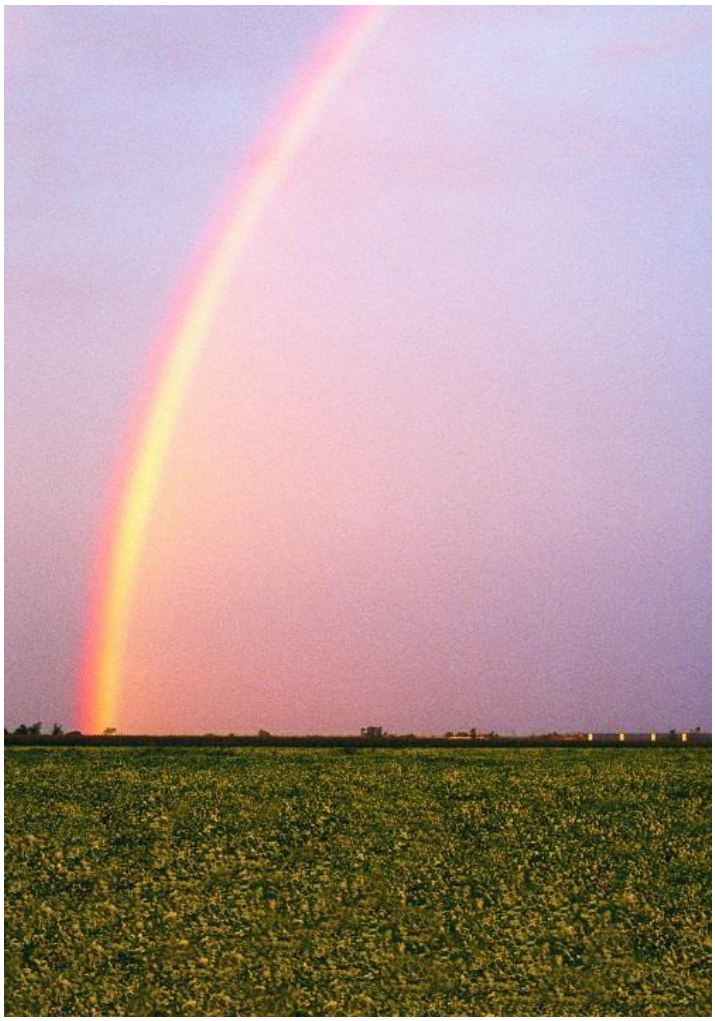
Wyoming Citizen Review Panel

2013-2014 Annual Report



2013-2014 Annual Report

Table of Contents

June 24, 2014

Another year has quickly passed and as I reflect, there have been many meaningful opportunities seized through coordination efforts in the state related to child and family wellbeing. Wyoming Citizen Review Panel has had opportunities to work with remarkable individuals and groups who are committed to improving the lives of Wyoming families.

It has been a productive year for the organization. We were able to hire all of the home visiting staff in August and direct services were initiated in October. We have been able to enroll 43 families in the program to support child development and family self-sufficiency. It has been a lot of hard work for the staff but the rewards are endless. It is our hope that we will be serving an additional 27 families by September. With the addition of home visitation and expanded efforts around the state by Prevent Child Abuse Wyoming, we were able to transition into a more supportive roll for the State of Wyoming Department of Family Services while retaining our outside perspective based citizen input. The reviews that we conducted with the Department of Family Services allowed the organization an opportunity to collaborate with communities to improve the safety and wellbeing of children and families.

As we move forward into the new year there is no better place to focus our attention than supporting healthy families and communities in Wyoming. We have an opportunity to be change makers and support families in their quest for greatness. We hope you will join us in welcoming the new year with open hearts and minds and embrace our opportunities for change.

Sincerely,

Jennifer Davis

Jennifer Davis

Executive Director of Wyoming Citizen Review Panel

Introduction

The Wyoming Citizen Review Panel (WYCRP) has the unique opportunity to offer a variety of programs that offer services focused on primary prevention of child abuse and neglect as well as promoting family self-sufficiency. We are able to participate with the State of Wyoming Department of Family Services (DFS) in performing local system reviews of services to children, youth and older adults. In efforts to support the work of Department of Family Services we focus on primary prevention efforts around the state through Prevent Child Abuse Wyoming and through home visitation services in four Wyoming counties. These programs allow us an opportunity to work with community partners to improve early care systems with the ultimate goal of preventing child abuse and neglect.

This year we had the opportunity to perform three local Department of Family Service's reviews and a partnered with the DFS state office to review the Northern Arapahoe Tribe on the Wind River Reservation. As an adjunct to these reviews, we also had the opportunity to review 14 Court Supervised Treatment Programs around the state. In our efforts to address systemic supports for families we are able to identify resources and system gaps among programs that address the same and/or similar populations. It provides an opportunity to link a variety of state agencies into a systems overview of programs that address a variety of needs in our communities, such as abuse and neglect, substance abuse and mental health issues. As we move forward in our efforts to promote self-sufficient families, we realize the importance of working in collaboration with a variety of agencies and programs to ensure the highest quality services.

This year's annual report reflects on three Wyoming communities that participated in the DFS review process with WYCRP. Recommendations of the Wyoming Child Death Review and Prevention Team are included in the annual report based on DFS case file reviews of major injury and deaths as a result of maltreatment and/or children in the custody of DFS. Director Steve Corsi of the Wyoming Department of Family Services determined that sexual abuse cases should be classified as major injuries because of the psychological impacts of this type of abuse that manifests in children. Based on Director Corsi recommendation, WCDRPT now reviews these cases to provide recommendations to increase awareness and promote prevention efforts.

WYCRP is committed to foster youth and alumni in our state by providing them an opportunity to voice their perspective of the system and motivate them to advocate for change. While our efforts to construct a strong alumni network in the state have not come to fruition, we were able to initiate efforts to bring a state chapter of Foster Care Alumni of American to Wyoming. Our efforts to support youth will come from recommendations based on the Foster Parent Survey and the Foster Youth Survey which was created in a combined effort of DFS and WYCRP.

WYCRP is excited about the progress of the last year and look forward to the coming year of building better programming and supporting child welfare issues in the state. We are fortunate

to have the opportunity to work with individuals and groups who want to create a positive change for Wyoming families.

2013 Wyoming Citizen Review Annual Report Information

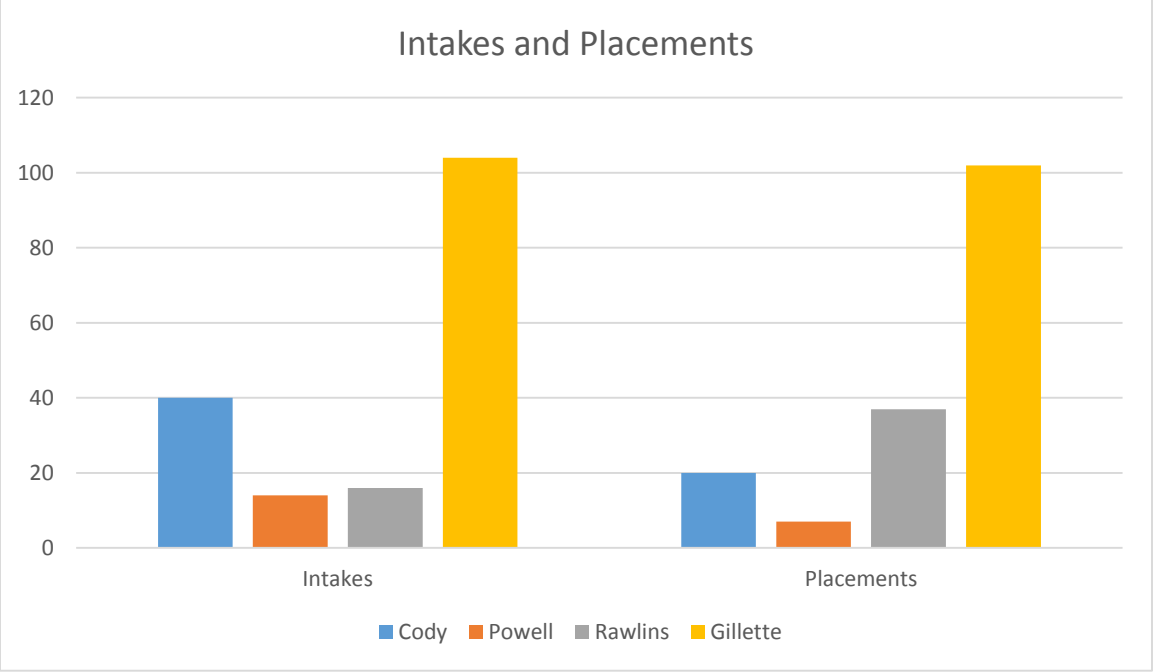
Child Protection/Juvenile Probation Reviews

Adult Protection Services SYNC Reviews

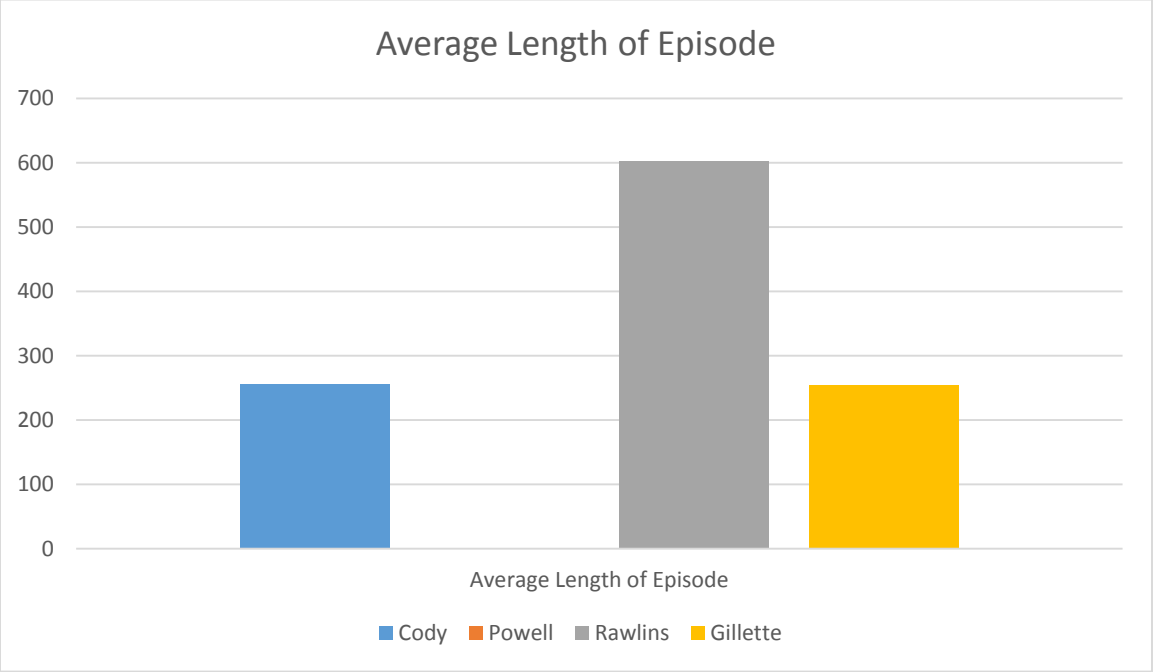
In each location there were a total of 10 files reviewed, split between child protection cases and juvenile probation cases as well as 3 adult protection cases. Each consisted of a file review utilizing the adapted CSFR form, interviews with clients/caregivers, interviews with staff and stakeholders, a mandated reporting presentation from Prevent Child Abuse Wyoming (PCAWY) in conjunction with the local office to medical personnel, and a community meeting of partners for child and adult welfare. The reviews were focused in three local DFS offices including Cody/Powell, Rawlins, and Gillette.

As we focused on the reviews there was specific information we were interested in collecting. The following graphs represent that information in a comparison to each reviewed county (this data was retrieved from the DFS Statpac for May 2014).

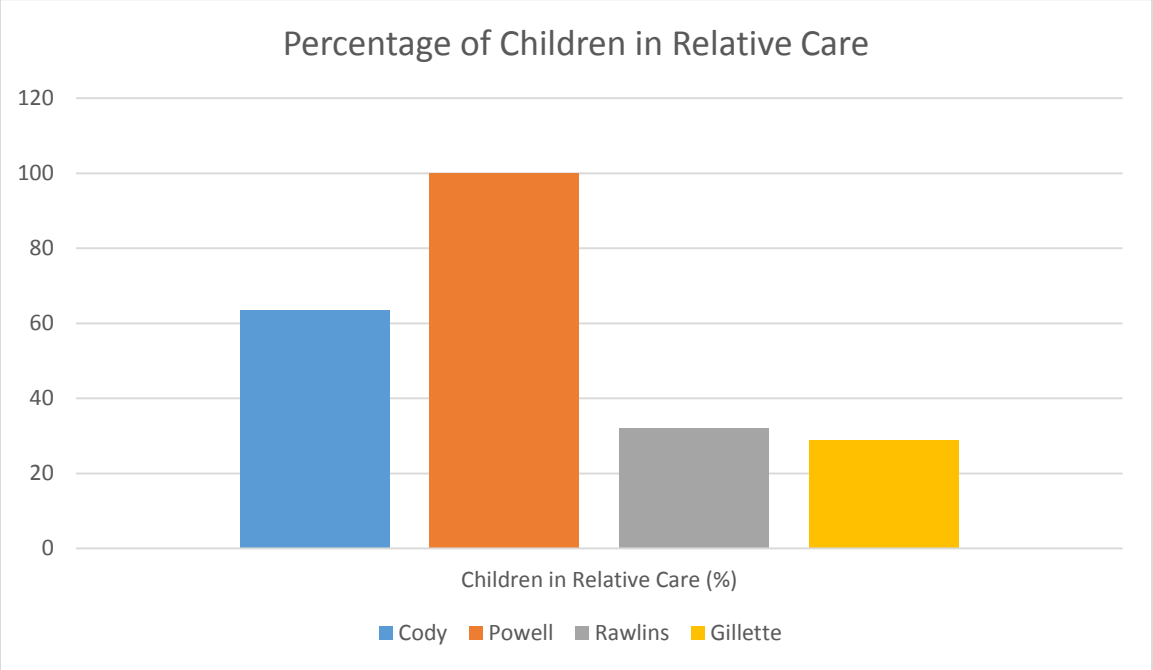
One of the areas of interest is determining how many children are in an out of home placement compared to the total number of intakes for each location.



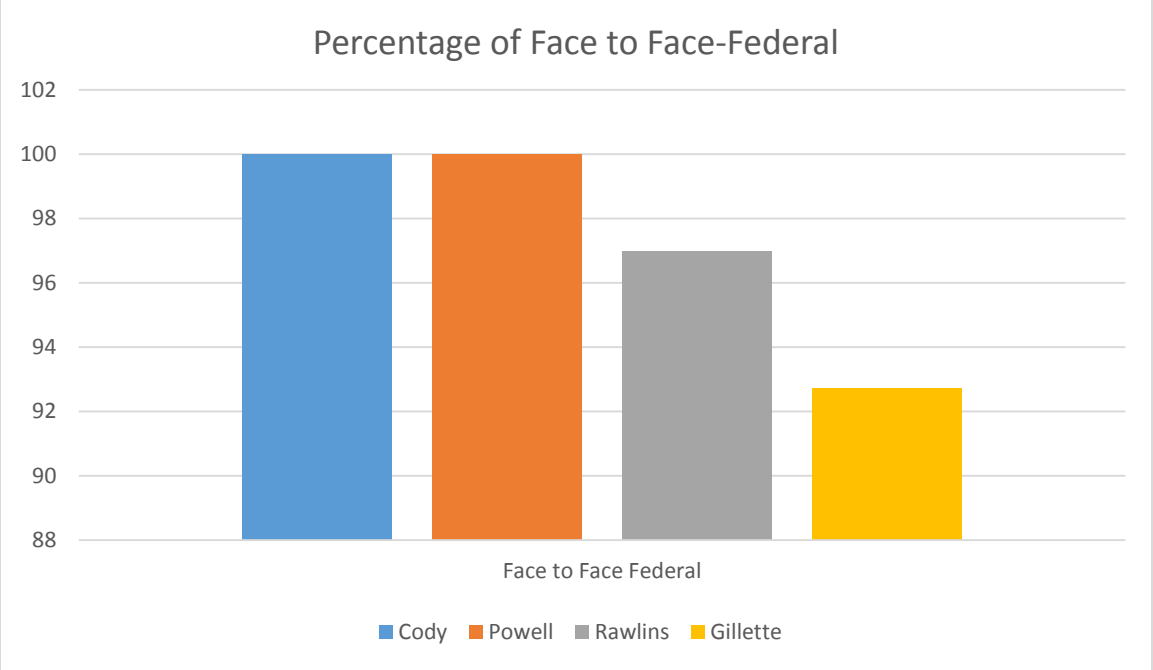
We were also interested in knowing the average length of time a case is open to assist with earlier establishment of permanency. (There was no data reported for Powell in this area)



It is a goal of DFS to place children in kinship care therefore it was important to determine the percentage of children in placement were actually placed with relatives.



As we completed the reviews, the local offices expressed how difficult it can be to achieve the required face to face contact each month especially with those children who are out of state, either with or without an Interstate Compact for the Placement of Children (ICPC). This chart reveals the percentage of time the case workers are making the federally mandated monthly face-to-face visits.



Cody and Powell

The review in Park County included the communities of Cody and Powell. Staff from both offices participated in the review process.

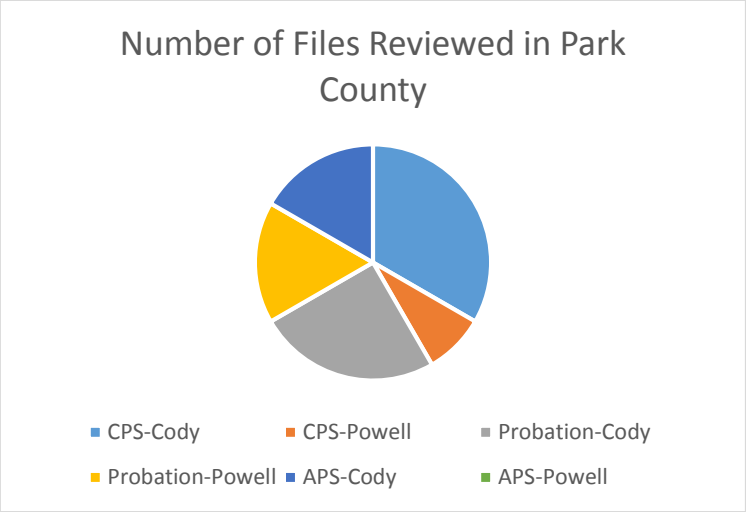
The review process included case file reviews and interviews with staff and community partners including the county attorney's office, the GAL office, and DFS staff from both offices including supervisors, case workers, and management. Also part of the review process included a community meeting with representation from DFS, Cody High School, Cody Police Department, CASA, Crisis Shelter, Guardian Ad Litem (GAL), Independent Living Coordinator, First Bank of Wyoming, County Attorney's Office from Cody and Powell, therapist from Positive Progressions and two foster parents.

The community meeting was supportive and positive of Department of Family Services operations in Cody and Powell. There were 25 attendees to the community meeting. There was discussion about the advantages of working together as a community to meet the welfare needs of the community. All the feedback from the community was positive. The community has a good understanding of DFS capacity which is evident by the high percentage of voluntary cases in this area.

Case files were reviewed from both facilities as follows:

Powell: APS-1, CPS-1, Probation-2

Cody: APS-2, CPS-4, Probation-3



Strengths:

- Community collaborations are strong
- Interoffice communication is effectively utilized among all staff
- County Attorney's Office is supportive and actively involved
- DFS has direct access to Cody PD data base
- County probation and DFS probation coordinate services
- Probation has direct access to high school for monitoring students
- Attendance court in Cody-DFS participates (District Court offers Attendance Court under Judge Cranfill)
- MDT meetings are monthly
- MDT team is coordinated well and structured for maximum participation by all players (ex. dates are adjusted so that all service providers can participate when possible)
  GAL is actively involved with DFS
- CASA recently reestablished in Cody
- Case files are organized well and accessible
- Several case workers are trained in forensic interviewing
- APS cases have good support in the community-especially with the judge
- APS exploitation cases are coordinated with a team member from the banking community
- Child Protection and Adult Protection Teams are actively functioning

Areas of growth specific to the local area:

- Improve communication with the medical community/hospital, particularly in the area of CPS. (This immediately improved after the coordinated training with Prevent Child Abuse Wyoming regarding mandatory reporting and signs and symptoms of child abuse and neglect.) It is noted that a representative from the hospital currently attends the APS meetings.
- Probation to offer additional after hour's contact/supervision with youth. DFS Probation to continue its weekly after hours ride alongs with law enforcement.

Recommendations specific to the communities of Cody and Powell:

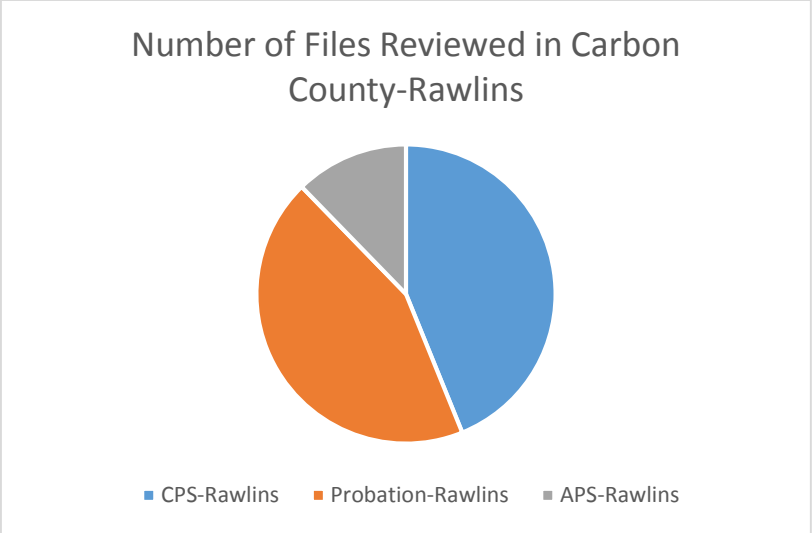
- Focus on better and open communication with medical personnel by ensuring that a representative from the hospital and/or medical community is part of the local Adult Protection and Child Protection Teams.
- Engage the community to recruit foster homes that care for teens and children with special needs. Current foster parents who attended the community meeting recommended asking current foster parents, youth in care, and alumni to assist in recruiting new foster parents because these groups know what the ideal placement involves.

Rawlins

The Carbon County review primarily focused on the community of Rawlins but also included the towns of Saratoga and Hannah. Staff from the Rawlins office covers all of these areas of Carbon County plus other small communities in the county.

The following case files were reviewed:

APS-3, CPS-5, Probation-5



The review process included case file reviews and interviews with staff and community partners including a current client (APS), the county attorney's office, the GAL office, and DFS staff including supervisors, case workers, and management. Also part of the review process included a community meeting with representation from DFS, Rawlins High School, Rawlins Middle School, Rawlins Elementary School, County Attorney's Office, Life Net, and local foster parents.

The community meeting was hosted at the local DFS office with nine community partners. There was representation from Life Net, Rawlins Elementary, Middle and High Schools, the County Attorney's Office, and two foster parents. The community meeting was reflective of a collaborative effort for child welfare in Carbon County. The partners felt like there was good communication among the agency and that there is always an opportunity to be heard. At times it is difficult for partners to really understand the limitations of the DFS agency. Carbon County has limited resources but it was apparent during the community meeting that this community rallies together to make the most of the available services to assist families.

Strengths:

- The staff has awareness of the available resources in the community for children and families, as well as outside resources around the state.
- The local schools and other community partners are engaged with the operations of the local DFS office.
- There is open communication in the community; which allows for program improvement on an ongoing basis.
- Foster parents report feeling supported and well educated to take children into their homes.
- The crisis shelter is set to open soon in Rawlins which will provide a needed resource for the community.

- DFS works well with the County Attorney's Office
- The cross training model has supported staff to be able to assist each other in the office especially during turn over.
- The juvenile services division is integrated into the community and has weekly staffing.
- Life Net was credited for coordinating the local MDTs which include the relevant partners.
- Community partners felt that the DFS reputation has "significantly improved" in the community.
- The Judge is supportive of DFS efforts in the community and makes an effort to know the community partners. The Judge has review hearings every three months instead of the required six months to facilitate involvement with the team.
- The County Attorney's office reports that the local DFS office is prepared for admission hearings.
- Life Net's ability to "remain neutral" in situations is an asset for case planning.
- GAL is involved in cases
- The local office gets a significant amount of voluntary cases
- APS client felt the local office was knowledgeable about resources in the community to help. The client felt supported in her move to the area.

Areas of growth/concerns specific to the local office:

- Case files were missing some documentation; primarily noted in the APS files.
- There are a lack of foster homes in the area which forces children back into "unstable homes" per some of the case workers.
- There has been a high turn-over with the mental health providers in the community which creates lack of consistency for families and difficulty to build trusting relationships. There is also a lack of psychiatrists to administer psychological medications which requires referrals out of the area.
- Case workers are required to perform face to face visits with placements in neighboring states which makes travel extensive and time consuming. This at times limits the case workers ability to provide adequate services to their local families due to increased travel commitments.
- There are a lack of community resources especially related to juvenile services and developmental disabilities in the adult population.
- There is a lack of affordable housing options in the area.
- There is a lack of local trainings which makes it difficult for staff to travel to distant areas due to time and finances.
- Due to the recent legislative change for CHINS cases there are now fewer resources for juveniles.
- DFS probation has difficulty finding a local agency to partner with to perform male UAs.
- There is no one trained in forensic interviewing in the local community so children have to be sent to another community which is time consuming and stressful for the child.
- Policy seems to change frequently which makes it difficult for case workers to keep current.

- The local office no longer has a foster care coordinator.
- GAL is not always included in the placement planning process.
- There is a lack of home visiting services in the area for families especially those in the prevention track.

Recommendations specific to Carbon County:

- Investigate with local partners the possibility of having a local team member as a forensic interviewer if that best meets the needs of the community.
- Recommend periodic case reviews to be sure that information is getting into the files and into WYCAPS
- Investigate working with the Department of Health on medical professional recruitment for the local area related to mental health services, primarily psychiatric services.
- Establish an MOU with local law enforcement or another agency to consistently provide male UAs for juvenile probation.

Gillette

The Campbell County review focused on the community of Gillette. The review focused on the systemic issues of the child and adult welfare system. The review process consists of interviews with staff, community stakeholders, clients, and file reviews. (Unfortunately all of the families that were contacted during the review did not respond to the invitation to speak with the review team).

Interviews included the Campbell County Attorney's Office, the GAL office, staff from all service areas, and Campbell County DFS management team. The APS case worker for Campbell County also covers Crook and Westin Counties.

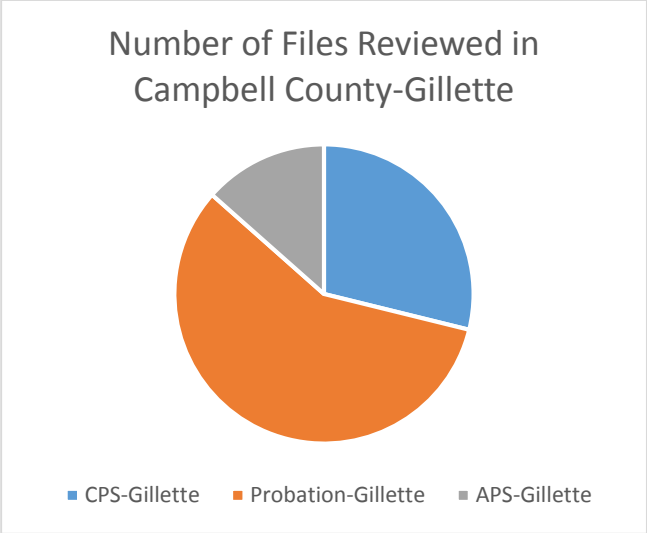
As part of the review process a community meeting is held with stakeholders. The meeting had representation from the local DFS office, Campbell County Public Health Office, Gillette Elementary and High Schools, the hospital, the Y.E.S. House, GAL, County Attorney's office, and the Child Support Authority. There was a total of 17 in attendance.

In Campbell County the following files were reviewed:

APS-3

CPS-3

Probation-6



The Campbell County DFS office has approximately 80 intakes a month and rejects approximately 30% of the cases.

Strengths:

- The Campbell County DFS office operates under a structure of an investigation team and an ongoing caseworker team which improves the balance of caseloads and internal communication.
- This office is utilizing the Signs of Safety program when implementing services to families. This program has led to a better understanding of the purpose of intervening with a family. It also helps the staff streamline their efforts with families which has helped attain permanency faster for children.
- Case files were labeled which allowed for easy access to information.
- Narratives are comprehensive.
- MDT meetings occur every three months with collaborative partners. If an MDT is necessary before the required three months, a special meeting is called to discuss any concerns.
- Campbell County has a comprehensive resource network which the local DFS office utilizes on a regular basis including a homeless shelter, the YES House, a Juvenile Detention Center, a crisis shelter, a dayhab facility, transitional housing facility for mentally ill individuals, private mental health providers who are willing to work on a sliding fee schedule, and public transportation.
- The local DFS office utilizes the Seattle Children's assessment program to assist with determination of appropriate placement.
- County probation and DFS probation work well together.

- There are several certified forensic interviewers available to the local office. DFS has two individuals who are able to conduct interviews if necessary. The County Attorney's Office prefers to utilize outside agencies to perform the interviews instead of DFS staff.
- Cross-training has helped to support team work in the office. This allows staff to feel comfortable assisting other workers when necessary.
- Weekly staff meeting are conducted to facilitate discussions about child and family wellbeing and promote timely permanency decisions.
- The local office promotes employee safety as first priority by working as a team during investigations of families where there is the possibility of violence, substance abuse, and/or mental illness. All staff are encouraged to have an additional staff member or law enforcement officer present if there is the potential of an unsafe environment.

Areas of growth/concerns specific to the local area:

- There is a lack of affordable, transitional and low income housing in Campbell County.
- Court system process creates a delay in relinquishing of parental rights. This impacts long term placements of children and youth in foster care delaying permanency.
- There is a lack of parenting classes that are accessible at all times. Often classes are only offered at certain times which makes it difficult to meet the needs of the families who have an immediate need.
- The agency struggles with the local diversion program
- Permanency hearings are often delayed and rescheduled which leads to prolonged placement
- Lack of mental health providers for sexual abuse victims
- No play therapists available in the area
- Lack of child psychiatrists.
- Lack of pediatricians
- Filing decisions are delayed at the County Attorney's office. On occasion cases are closed at the local DFS office and dependent on the ruling in the CA's office, cases have to be reopened. This causes confusion and distrust with families as they may have already completed their case plan.
- MDT meetings often lack an agenda which leads to poor utilization of team member's time.
- Lack of transportation for high risk youth (suicidal) from the hospital to WBI for treatment
- Lack of youth foster homes
- There is a delay in determining paternity at the Child Support Authority which delays permanency.
- At times case files are lacking certain documentation (specific forms related to case planning and permanency) however it is usually reflected in the narrative.
- There is a need for mental health support during the investigation process for APS cases.

Recommendations specific to Campbell County (Gillette):

- Work with Life Net to set agendas for MDTs prior to the meeting to maximize team member's time.
- Continue efforts to educate the community about the limitations of DFS, especially related to APS. May be helpful to have the state develop a PSA for communities to assist with education.

- Build a more collaborative relationship with mental health providers for assist with APS investigations.
- Coordinate with the state office, DOH, and WBI to find a solution for transportation of high risk youth so that the needs of the individual are met in a timely and safe manner.

Recommendations/Requests for the state DFS office:

- Provide additional WYCAPS training and field adjustment edits with input from the local offices.
- Reduce duplication of forms (both in WYCAPS and paper versions) by requesting input from the local offices on the redundancies of reporting.
- Purchase of iPads for all offices to use for on-call so they are able to easily access WYCAPS without returning to the office. This is a primary safety concern when it is necessary for staff to respond to a call in the middle of the night. Also implement the dictation pen in each local office as this promoted more efficiency with documentation as the case worker can upload case notes into the computer system
- Assess staffing ratios related to staff-aids. Staff aids are able to assist with office operations and paperwork allowing case workers time to focus on supporting the families with direct contact.
- State office workers perform more face-to-face contacts with the local offices to understand the direct field operations and directly support the work at that level. It provides an opportunity for both parties to understand the demands placed at all levels of the agency.
- Provide additional trainings for staff in the local areas related to worker wellbeing (secondary trauma) and offer supportive services as needed. This needs to be an ongoing training and an ongoing conversation with upper management.
- Implement Signs of Safety in all areas
- Provide a local forensic trainings around the state so that it is more readily available
- Provide a state wide messaging campaign to recruit foster parents. Consider utilizing alumni as a resource for messaging development
- Initiate a statewide messaging campaign and community training modules focused on explaining the roles and restrictions of DFS personnel
- Advocate at the federal level related to face-to-face contacts in neighboring states and the possibility of creating additional ICPCs
- Offer more trainings for foster parents related to RAD and FASD
- Reassess staffing needs, primarily APS due to the expanding elderly population and the increased incidence of financial exploitation
- Investigate options for CHINS cases as there a few individuals who are interested in seeing the age extended past 17
- Investigate the roll of the state office in possible legislative changes to Title 25 to determine the best course of action. It may be of benefit for the director and the judges of the state to have a discussion about the issues related to Title 25.

- Address permanency delays and establish local programming to assist with earlier determinations.

As part of the local case reviews, Prevent Child Abuse Wyoming partnered to offer a mandated reporting training in conjunction with the local DFS office for medical providers. These trainings consisted of definitions of abuse and neglect, signs and symptoms of abuse and neglect, mandated reporting requirements in the state of Wyoming, and prevention efforts. There was good participation from the community in each location. At two of the three hospitals (Park and Campbell County), the training was video recorded so that other staff could participate when their schedule allowed. Additional areas will be covered through Prevent Child Abuse Wyoming in an ongoing effort to train medical personnel on mandated reporting requirements in the state.

Foster Parent and Foster Youth State Surveys

Wyoming Citizen Review Panel in conjunction with the Wyoming Department of Family Services conducted two surveys focused on foster youth and foster parents in Wyoming. In an effort to obtain a better understanding of the needs of foster youth in Wyoming, it was determined that conducting a survey would be useful. As there was been difficulty obtaining foster homes in the state, this led to the decision to survey the current foster parents and determine their level of satisfaction with system and determine their needs to support their efforts in providing foster case for children in Wyoming.

The results of the Foster Parent and Foster Youth Surveys align with the information that was collected during the case file reviews. Based on the results of these two surveys further recommendations are provided for the State Department of Family Services.

Foster Parent Survey

The Wyoming Foster Parent Survey collected 178 responses with representation from each county with the exceptions of Park County – Powell area. Below is a demographic breakdown of the responses received:

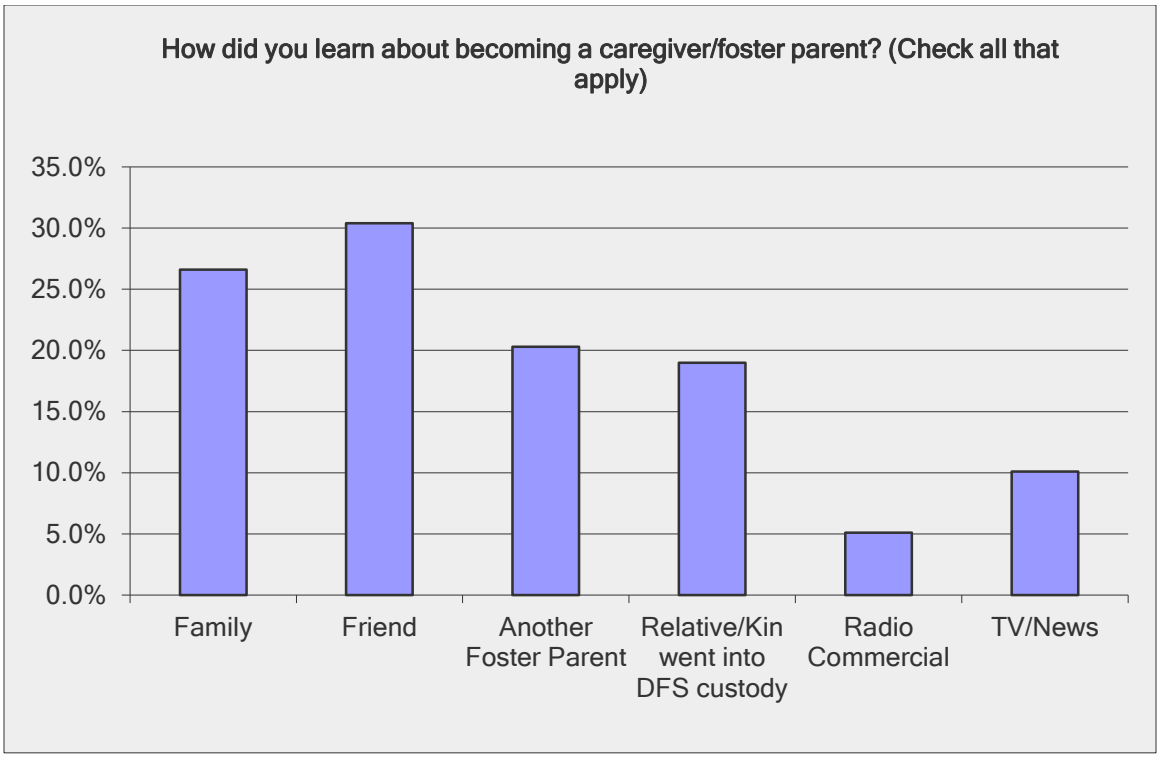
Residential County	Individual Response	Couple Responses
Albany	7	10
Big Horn (Greybull)	1	1
Big Horn (Lovell)	0	1
Campbell	5	4
Carbon	2	3
Converse	0	1
Crook	0	1
Fremont (Lander)	7	3
Fremont (Riverton)	3	6
Goshen	0	2
Hot Springs	1	1
Johnson	2	4
Laramie	12	17
Lincoln (Afton)	1	2
Lincoln (Kemmerer)	0	3
Natrona	12	19
Niobrara	2	0
Park (Cody)	2	3
Park (Powell)	0	0
Platte	2	1
Sheridan	7	5

Sublette	1	0
Sweetwater	4	3
Teton	1	0
Uinta	2	7
Washakie	0	1
Weston	0	1
Reservation (Eastern Shoshone)	0	1
Reservation (Northern Arapaho)	0	2
TOTAL:	74	102

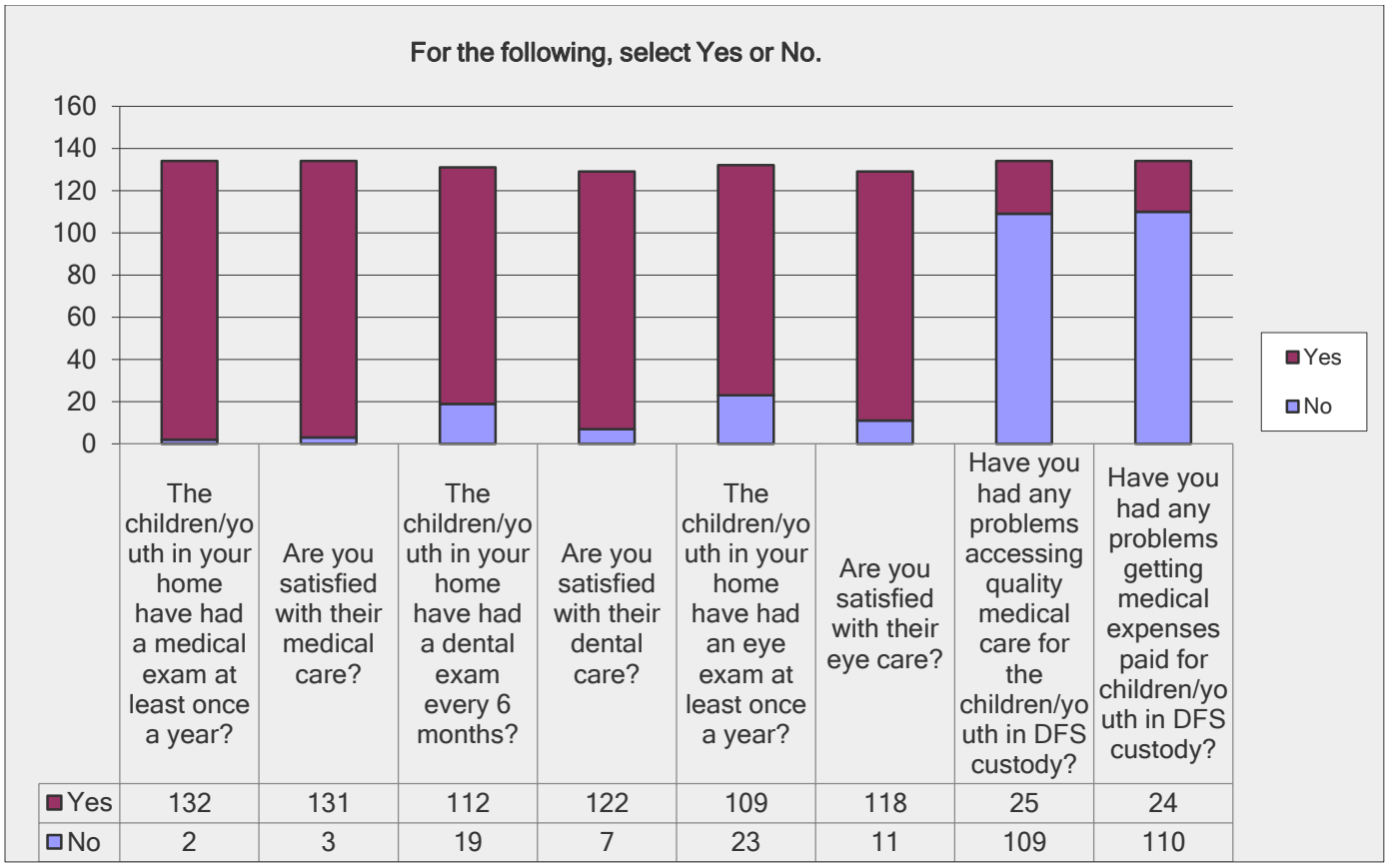
*2 – Skipped Responses

The review process included the following topics: Demographics, Supports & Training, Fostering Children/ Teens, Working with Caseworkers and Biological Parents and Supports for Children & Youth in Care. The following charts represent the responses to several of the questions from the survey.

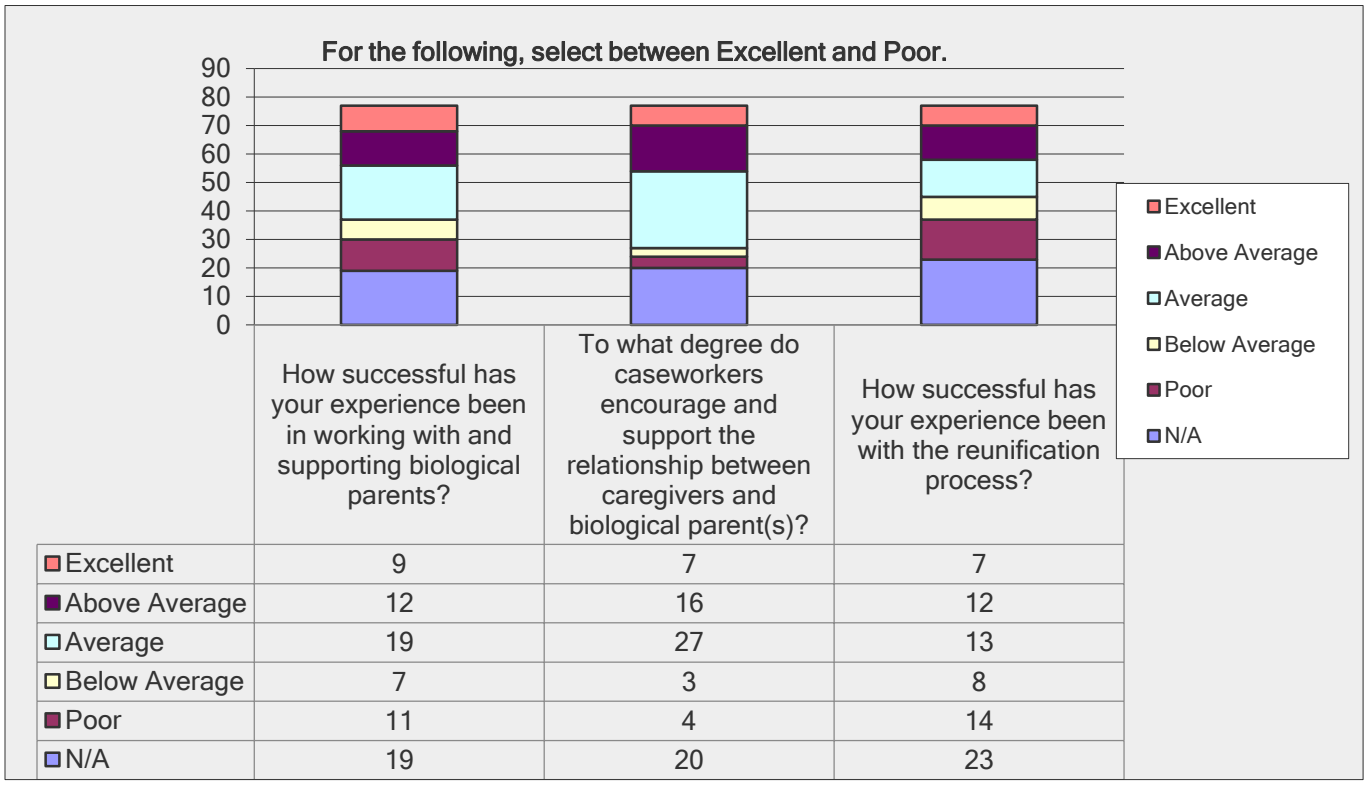
The chart below reveals how foster parents became enrolled in providing a home for the children in foster care in Wyoming. Of those who were initially recruited and offered a mentor, 100% felt that it was extremely helpful. This information will be useful in establishing a plan for messaging to recruit additional foster families in Wyoming.



This chart reveals that overall foster parents are satisfied with the medical care that is provided to the children in their care. Overall foster parents expressed that the medical care the children are receiving adequately meets their needs. Although many of the comments reflected that there is a shortage of medical/dental providers who accept Wyoming Medicaid. This is problematic as children may not be able to remain with their same provider or the foster parent may be forced to travel outside of the local area to locate a provider who will accept Medicaid.

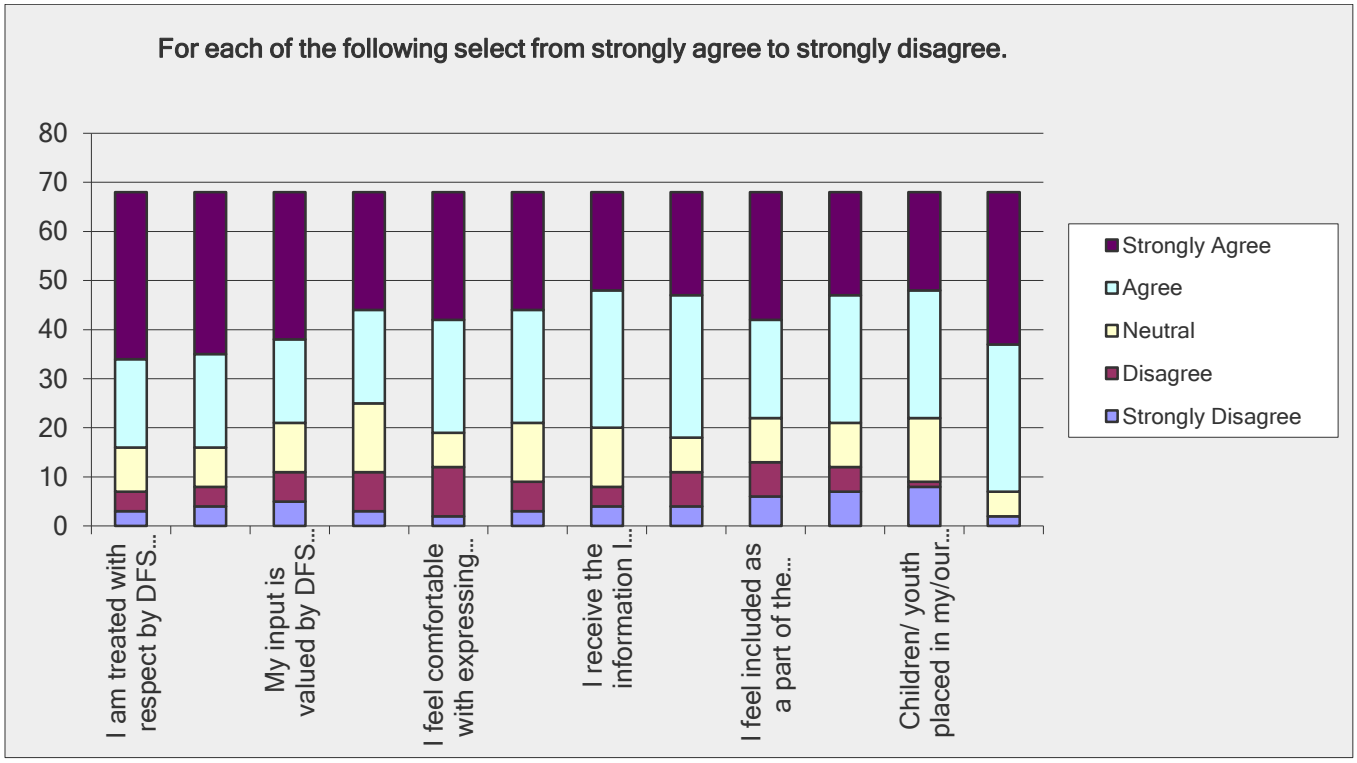


	The children/youth in your home have had a medical exam at least once a year?	Are you satisfied with their medical care?	The children/youth in your home have had a dental exam every 6 months?	Are you satisfied with their dental care?	The children/youth in your home have had an eye exam at least once a year?	Are you satisfied with their eye care?	Have you had any problems accessing quality medical care for the children/youth in DFS custody?	Have you had any problems getting medical expenses paid for children/youth in DFS custody?
Yes	132	131	112	122	109	118	25	24
No	2	3	19	7	23	11	109	110



	How successful has your experience been in working with and supporting biological parents?	To what degree do caseworkers encourage and support the relationship between caregivers and biological parent(s)?	How successful has your experience been with the reunification process?
Excellent	9	7	7
Above Average	12	16	12
Average	19	27	13
Below Average	7	3	8
Poor	11	4	14
N/A	19	20	23

The primary focus of children in out-of-home placement is reunification. The chart above reveals the relationship between the caseworkers, the foster families and the biological parents. One foster parents experience is revealed below, "We have not been encouraged to develop a relationship with the bio parents. Our caseworker has acted as a mediator between us most of the time. The bio parents have seemed diligent to work their action plan". Another foster parent expressed a different experience, "ALL of our placements have been returned to unhealthy environments despite our voicing concerns - and in some cases the children also voicing concerns. The GAL seems to ONLY follow DFS opinion". Obviously this is a difficult area for both biological and foster parents. This information will be helpful for DFS to establish a training program for foster parents about the importance of reunification as well as train the local staff on early permanency planning involving all parties as appropriate. This information serves as a direct link to information that was revealed in the DFS case reviews in the local areas.



The following questions correlate with the above chart.

1. "I am treated with respect by DFS staff"
2. "My input is valued by DFS staff"
3. "I feel comfortable with expressing my opinions to DFS"
4. "I receive the information I need on an ongoing basis"

5. “I feel included as a part of the team that supports the children/youth in my care”
6. “Children/youth placed in my/our home match the preferences identified during the home study”

As demonstrated in the chart above most foster parents agree that their relationship with DFS is adequate and allows them to meet the needs of the children placed in their care. One expression of this was when a family was uncomfortable with the child who had been placed in their home and DFS immediately resolved the situation as stated in this comment, “At one point I did not feel safe and the child was removed very quickly”. The above information will be able to assist DFS to determine if their current strategies of interacting with foster parents meets their needs.

The foster parent survey provided information that DFS will be able to utilize and incorporate into trainings for both staff and current/future foster parents. It is important that there is a cooperative relationship between foster parents and the child welfare system. The services go beyond the scope of DFS which reveals the importance of agencies and community resources working together to support children and youth in care. As DFS moves into the next five year planning process, it is imperative that the needs for foster children/youth to achieve “normalcy” through placement be addressed to meet federal mandates. It is important that there is community supports available to children/youth, foster parents, and local DFS offices. In the survey, foster parents identified that WIC, Medicaid, childcare assistance, counseling, Boys and Girls Clubs, school lunch programs, mental health services, recreational sports programs, and churches have been instrumental in providing supports to the children in their care. These are just a few examples of community connections that are required to support “normalcy” for children involved in the foster care system.

One area of concern for foster parents and children/youth in care was the inability to access documentation of personal information including birth certificates, social security cards, state identification cards, medical and school records. Without this documentation it is difficult to enroll children in activities or provide opportunities such as receiving a driver’s permit/license. It will be necessary to determine a procedure for this information to be readily available to foster parents and youth who are transitioning out of care.

RECOMMENDATIONS:

1. Coordinate with Medicaid to determine available providers in each area. Include a list of providers in all foster parent information packets. Due to lack of Medicaid providers in Wyoming related to medical, dental and mental health, the state of Wyoming Department of Family Services and the state of Wyoming Department of Health-Rural Health Division should coordinate efforts to recruit providers into the identified areas to support services for foster children in Wyoming.

2. “Normalcy” activities and opportunities need to be offered to all foster children. There needs to be an internal assessment of how to determine supports for foster parents in order to accomplish such tasks as providing an opportunity for driving with youth, providing recreational activities and employment to youth including transportation and costs for enrollment.
3. Provide access to required documentation for children in foster care so that foster parents have the ability to best meet the needs of these children while in their care. Transitional youth also need access to these documents and education on the importance of these documents as they transition into independent living.
4. Ensure that there is policies in place to provide foster parents an opportunity to be involved in MDT activities as well as an opportunity to express supports the child may need to be successful in placement.
5. Ensure all foster parents are educated about the importance of reunification and what their expectations will be in this process. Foster parents should be part of the initial permanency determination so that their expectations are clearly defined.
6. Provide additional training opportunities and topics relevant to foster parent’s needs. Some areas of interest expressed in the survey and during the local case reviews include RAD, FASD, trauma bonds, behavioral interventions and implementations, teen trainings, ADHD nutrition, car seat safety, adoption, drugs (signs of use), and mandated reporting and the process.
7. Further investigate a mentoring program for foster parents. This may be a useful recruiting tool. The importance of this effort was expressed in a comment from the survey. “Have each new foster family set up with a mentor of an experienced foster family. It's scary and hard and when you can go to someone who knows what you’re going through it helps a lot. Mentor System!!!! Also When I was trained I was never taught how to do the monthly paper work and invoices. It would have been helpful if I was shown that ahead of time.”

Overall the foster parent survey was a useful tool to acquire information from individuals who are directly impacted by interactions with the child welfare system. It is imperative that these families are supported through this process in order to retain the invaluable services they provide to Wyoming children.

Foster Youth Survey Review

The Wyoming Foster Care Youth Survey Review collected 178 responses from youth currently in care between the ages of 15 and 19 years old. Based on current residential placement, we have representation from each county and community with the exceptions of: Crook, Fremont (Riverton), Hot Springs, Niobrara, Sublette and the Eastern Shoshone and Northern Arapaho tribes on the Wind River Indian Reservation.

Below is a demographic breakdown of the responses based on home and currently residential county:

County	From	Currently Residing
Albany	3	2
Big Horn	4	4
Campbell	18	21
Carbon	6	1
Converse	4	2
Crook	3	0
Fremont (Lander)	2	1
Fremont (Riverton)	5	0
Goshen	0	3
Hot Springs	3	0
Johnson	3	1
Laramie	14	9
Lincoln (Afton)	1	1
Lincoln (Kemmerer)	1	1
Natrona	21	14
Niobrara	1	0
Park (Cody)	4	1
Park (Powell)	2	1
Platte	2	4
Sheridan	17	33
Sublette	3	0
Sweetwater	40	17
Teton	4	8
Uinta	0	3
Washakie	6	46
Weston	3	3
Eastern Shoshone	3	0
Northern Arapaho	5	0
Out-Of-State	5	2
TOTAL:	178	178

*0 – Skipped Responses

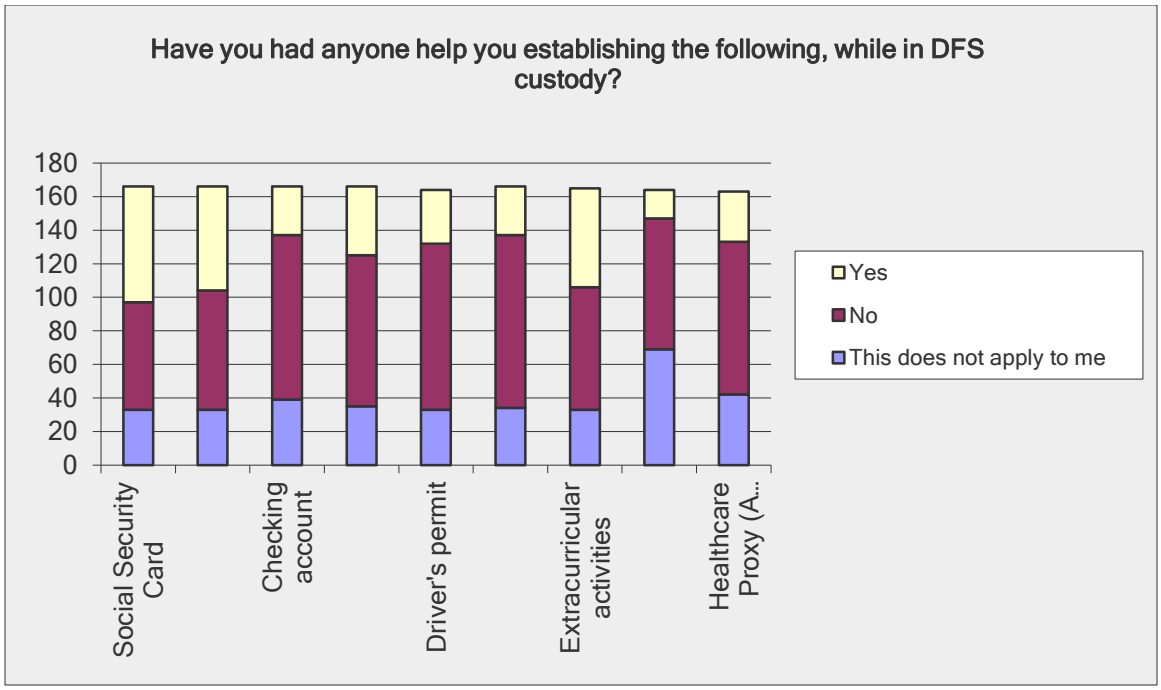
Below is a chart depicting current placements of youth survey respondents.

Adoptive Parent(s)	2
Biological Parent(s)	13
Relative Foster Home	7
Non-Relative Foster Home	6
Crisis Center/Group Home	36
Jail/Detention	3
Residential Treatment Center	25
Psychiatric Residential Treatment Center	5
Wyoming Girls School	25
Wyoming Boys School	50
Wyoming Cowboy Challenge Academy	2

*9 – Skipped Responses.

The review process included the following topics: Demographics, Placements, Foster Home Experience, Caseworker Experience, Health & Well-Being, Education, Case Plan and Independent and Transitional Living Plan.

The chart reveals responses from youth about assistance with establishment of documentation for "normalcy" activities for those currently in foster care. It is important to determine why there is a breakdown in establishment of these resources for youth as this impairs their ability to appropriately interact with their peer groups and set them up for successful transition out of care.



Another area of the survey focused on safety of placement from the youth's perspective. Overwhelming response reveals that youth agree that they are safe in their placements. Some of the specific questions included were:

"I feel safe in my placement"

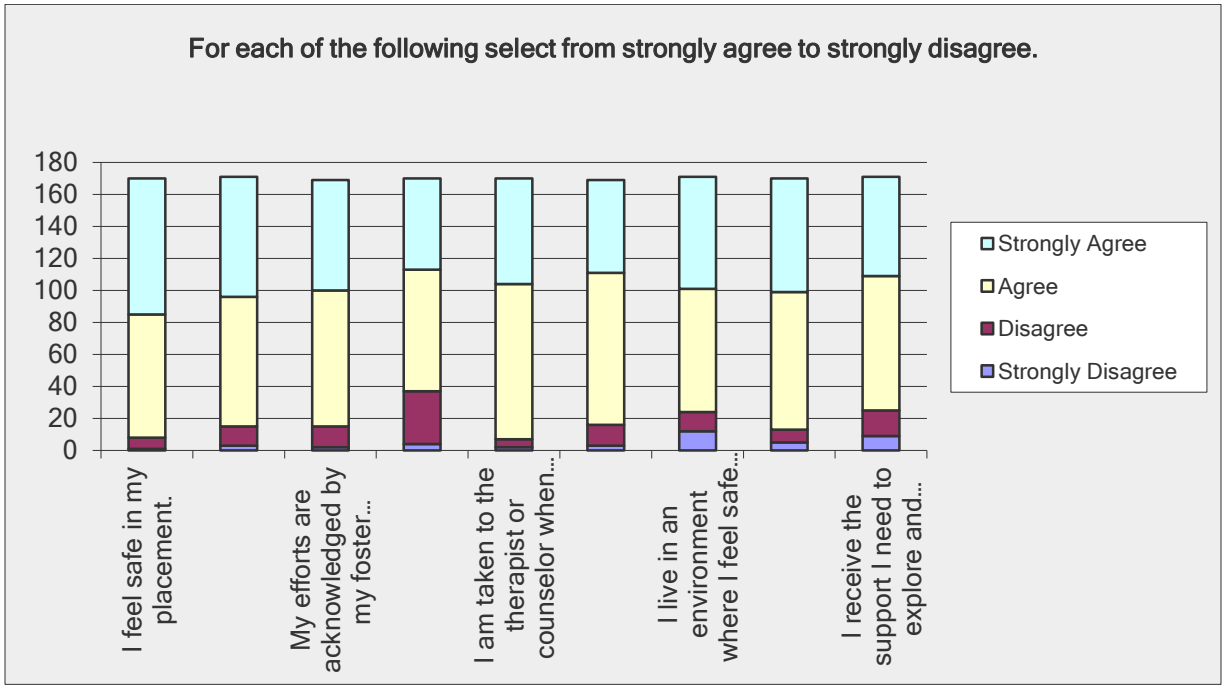
"My efforts are acknowledged by my foster parent/s, caregiver, guardian or staff."

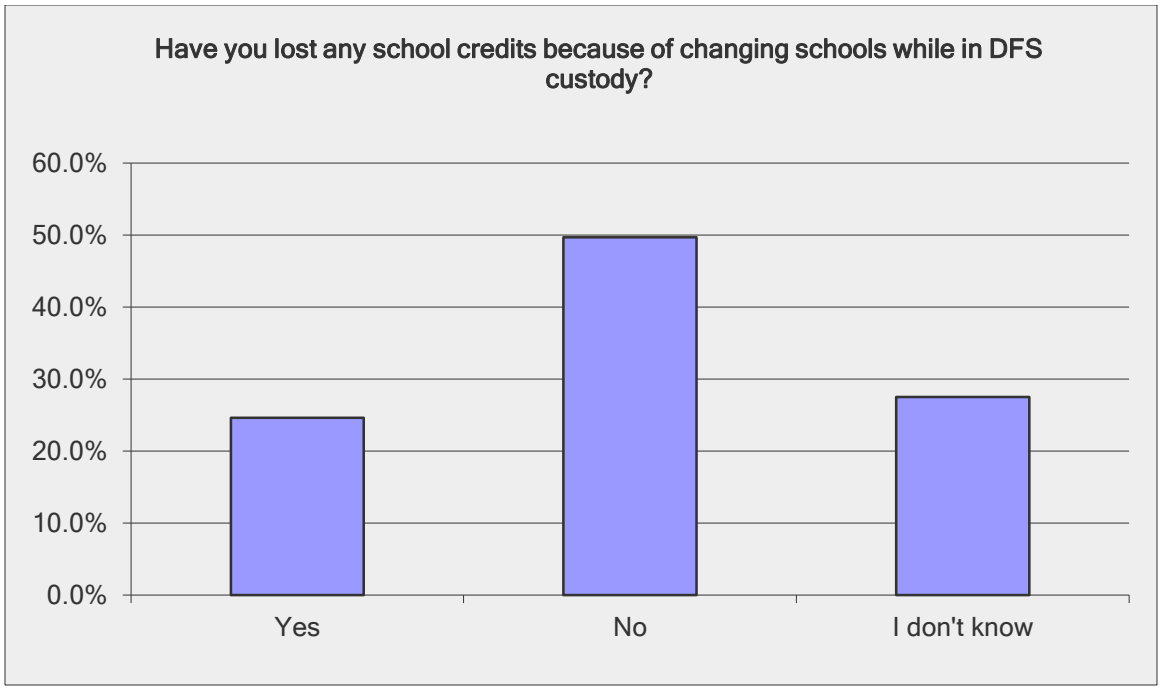
"I am taken to the therapist or counselor when necessary."

"I live in an environment where I feel safe to talk about my sexual orientation and gender identity."

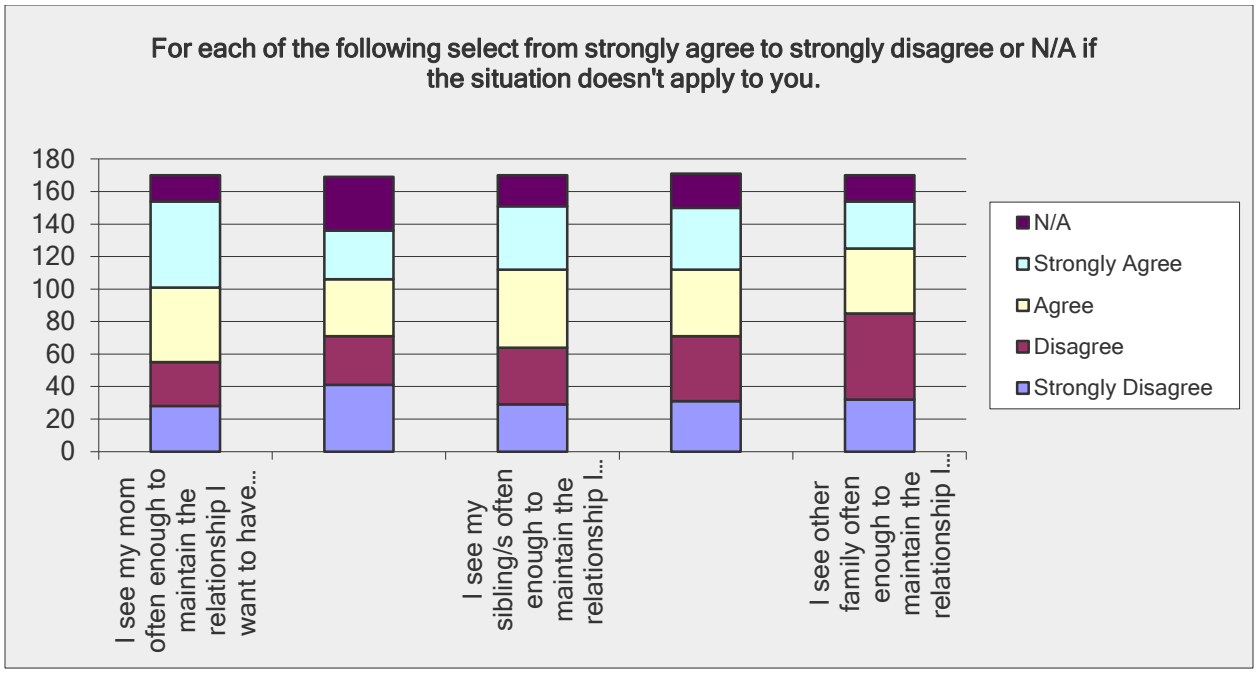
"I receive the support I need to explore and develop all aspects of my sexual orientation and gender identity."

Many of the youth commented that they were grateful that their foster families, whether it be relative care or non-relative care, allowed them to maintain a personal pet, engaged them in new experiences, allowed them the opportunity to experience a "family" which included a sense of belonging, food, clothing and shelter. One youth expressed how she was able to learn as well as be cared for; "They take care of me, help me with clothing, tech me to dress appropriately".





The above chart reveals that only a small percentage (24.55%) of youth have lost credits when transitioning schools during placement. At times youth are forced to change schools based on placement location (71.86%) and this information is important to know so that youth can remain on track for graduation regardless of their placement location. It is important to determine why there is a large percentage of youth who are unsure if they have lost credits. This would be an opportunity for the youth to advocate for his/herself in the school setting and determine their course for graduation. A majority of the youth surveyed, 81.59%, stated that they intended to attend college after graduation.



The above chart reveals the interactions of the youth with family during placement. There is a wide variety of responses. It would be useful to determine why youth are not having consistent interactions with certain family members. The questions are subjective about whether or not the youth has a desire to maintain the relationship. This information is important for DFS to determine why or why not the youth wants to maintain a relationship with different members of the youth's family so that they youth is respected in this process.

Some of the other information that was derived from the youth survey was that 64.78% of the youth reported communicating with their case worker either in-person, by phone, text, email or direct mail at least once a month. Only 65.54% of the youth stated that they meet with their caseworker in-person at least once a month. It will be imperative that DFS investigate why youth are not experiencing a higher contact rate with their assigned caseworker. Many of the youth did feel that when they were in contact with their caseworker, they were treated with respect and the caseworker had a vested interest in their achievements in school and valued their input about their transition plan. Although many youth felt that respected by their caseworker, the survey revealed that some of the youth were concerned that they were not listened to during MDT meeting. A youth stated a concern about "not being able to have a say in my MDT meetings" and another stated a concern about "not allowing me to do other options other than placement such as independent living because I will be seventeen in less than a month".

Youth also identified services that have been of benefit to them while in care including therapeutic services, case management services, family supports, independent living skills, a structured environment, drug treatment programs, anger management supports, and college

assistance (including funds). Youth requested more information related to ETV, transportation, and eligibility for Medicaid services until the age of 26.

RECOMMENDATIONS:

1. Ensure that case workers are educating youth on transitional resources especially those related to transportation, housing, medical eligibility (Medicaid), and ETV.
2. Coordinate with the Wyoming Department of Education to ensure that as foster youth transition between schools that credits are maintained for graduation. Empower youth to have conversations with the local schools to ensure their academics are in alignment for graduation.
3. Implement permanency round table discussions in all offices for youth at least by the age of 16 to ensure that a transition plan is in place. As part of the permanency round tables and MDTs, the youth would benefit from an alumni advocate to empower them to direct their transitional plan (especially for those that will age out of care).
4. Coordinate with Life Net to establish courses/trainings for youth that are meaningful for transition to independent living.
5. Investigate why youth do not have a higher percentage rate of contact with their case workers.

Overall the foster youth survey was a useful tool to acquire information from youth who are directly impacted in the child welfare system. The feedback that youth are able to provide to the state is invaluable as they have first-hand experience. There is a great deal to be learned from their perspective.

Wyoming Child Death Review and Prevention Team

The Wyoming Child Death Review and Prevention Team (WCDRPT) strives to minimize child major injuries and fatalities in Wyoming through comprehensive, multi-disciplinary case reviews. We actively advocate for child victims by making recommendations for change through prevention, intervention, training, education, legislation, and public policy. Between June 1, 2013 and June 30, 2014 the WCDRPT reviewed 10 case files, given to the team as a result of abuse or neglect from the Department of Family Services (DFS). In 2013, DFS established that they would be considering all substantiated cases of child sexual abuse as a "major injury" due to the long-term psychological impacts that this type of abuse can have. We have begun reviewing these cases in conjunction with the other case files received from DFS.

Below is an overall summary of the files reviewed, summary of each case, as well as the case and general recommendations formulated by the members of the WCDRPT.

Major Injury and Fatality Cases Reviewed (July 1, 2013 – June 30, 2014): 10

Number of Fatalities: 2

Number of Major Injuries: 8

All 10 cases were found to have at least one preventable component.

Case Summaries and Recommendations:

2013-006: Major Injury

9-month old male child was left in his car seat in the back of his father's pickup truck when his father failed to take him to day care. He was in the vehicle for over 8 hours in summer heat. When the mother arrived at the day care provider to pick up the child she was informed that he was not there. The mother contacted the father about the whereabouts of the child and the father discovered that the child had been left in the vehicle. The child was immediately taken the hospital and upon arrival had a temperature of 108 degrees, was cooled down and air lifted to a Colorado hospital. The child survived and has developmental disabilities related to the incident. The father was charged with child endangerment and his sentence was probationary and monetary, no jail time.

Case Recommendations:

- Day care/ child care facilities should institute policies to call parents/caretakers by a designated time if the child has not arrived at their location, unless otherwise notified by the parent.

- Employers could post signage or posters in their staff areas during warmer months around leaving children in unattended vehicles. OSHA, in particular, could utilize this idea as a prevention effort.
- Education around the dangers of leaving children in unattended vehicles should be promoted. Related prevention groups, agencies and organizations could link http://www.kidsandcars.org/ to their websites or social media for general prevention education tips.

2013-007: Major Injury

Police responded to a call of an 8-month old male who was unresponsive and not breathing. When officers arrived, they observed that the child was severely malnourished and had multiple bruises on various parts of his body. The child was brought to the local hospital and then air-lifted to a Denver hospital. A doctor at the Denver hospital stated this was the most severe case of abuse and chronic nutritional neglect he had seen. The child was below the cutoff for severe malnutrition and weighed less than his birth weight. The judge in the case stated that after seeing pictures of the child from the hospital, the incident looked more like torture than abuse. Numerous family members and roommates had knowledge of the abuse/neglect and failed to report. Both parents were substantiated on for abuse and neglect of all of the children in the home. The mother was convicted and was incarcerated for a period of time. The father was facing felony child abuse charges at the time the case was closed. Both parents had a history of abuse/neglect as a child.

Case Recommendations:

- A major concern in this case was that abuse and neglect to this child went unreported for a period of time by a family member, a roommate or a physician/nurse that may have seen the child between birth and the time of the incident. Stronger public education is needed about mandated reporting in Wyoming and what a citizen's responsibilities are. Medical professionals should also have a greater ability to track if a child has been seen by multiple providers. This could potentially alert providers that there is a history of possible abuse and/or neglect.
- Law Enforcement should receive increased training hours regarding how to address issues related to infants and children during investigations, whether they are the victim or just at a location where law enforcement is responding. Law enforcement should also be checking on the presence and welfare of any children at locations where domestic violence incidents have been reported.

2013-008: Fatality

A 3-year old female with special needs died as a result of respiratory distress and septic shock. She died within 24 hours of being taken into protective custody by law enforcement as a result of unsanitary living conditions and taken to the hospital, but her death was considered natural due to her special needs. This case was initially reported by a visitor to the home who reported the house as being dirty and the child was lying in her own feces and fluids. The child had been receiving home visitation services from an community program outside of DFS, but the records for this service stopped when the child was 18-months old. There was no record of involvement with Public Health after that point. There was no substantiation by DFS on the parents and no criminal charges were filed. This case was reviewed by the team as the child was in protective custody at the time of death.

Case Recommendations:

- In fatality cases, there should be a coroner's report, autopsy record, death certificate or other documentation to state the actual cause of death in every case file.
- There should be clear and concise narrative or documentation in fatality cases that do not have a substantiation attached as to specifically why there was no substantiation sought by DFS. The WCDRPT thought the lack of substantiation for neglect was a concerning factor in this case.

2013-009: Major Injury

The father of a 15-month old male received a call from the babysitter, reporting that the child was not breathing. The father instructed the babysitter to call 911 and rushed to the babysitter's house. The babysitter had also called her own mother and father and her mother performed CPR on the child until EMS arrived. The child was found to have severe head trauma and was air-lifted to a Denver hospital. During the interview with law enforcement, the babysitter admitted to shaking the child, flicking the child's ears, and hitting the child over a 2-3 day time span. The biological parents of the child had a joint custody agreement. The child suffered a traumatic brain injury and is predicted to have lifelong disabilities. The babysitter pleaded guilty to aggravated child abuse.

Case Recommendations:

- Continued education to parents and caretakers about the dangers of shaking an infant, as well as ensuring that anyone who may care for their child (babysitter, boyfriend/girlfriend, etc.) understands these dangers. It would also be of benefit to train on coping skills that can be used when an infant or child is crying for long periods of time or when the caregiver is feeling stressed by either internal or external factors.

2014-011: Major Injury

A resident of another state made contact with the local law enforcement agency about photographs they had received involving a Wyoming man sexually abusing his girlfriend's 3-year old daughter. The man had sent photos of himself engaging in sexual acts with a young female. The child's mother was allegedly unaware of the abuse. The man admitted to sexual misconduct with the child. The man was an illegal immigrant and only spoke Spanish. He was arrested for Sexual Assault in the third degree and Sexual Exploitation of children, and pled to two counts. Additional information about the outcome of this case is unknown (it likely became a case in Federal court).

Case Recommendations:

- Continue to be mindful of bi-lingual or multi-lingual services available in local areas. Language barriers can cause a multitude of issues during investigations and visitations. We understand there are translator shortages and cost factors to consider in this recommendation, but believe it is best practice to have a translator available to the DFS office whenever possible.
- Law enforcement efforts on the investigation of this case should be strongly commended.

2014-012: Fatality

Police responded to an incident involving a 4-week old male who was not breathing. The child's father had woken up to go to work and did not see him in the bassinet. He then saw the child's mother asleep on the couch and, shortly after, noticed the child was wedged between the cushions of the couch, with only his bottom and legs exposed. The child's mother reported that she fed the child approximately two hours prior and was unsure if she laid the child on the couch or if she had fallen asleep holding him. It was unclear if the mother was breastfeeding at the time of the incident. The father had attempted mouth-to-mouth and CPR on the child prior to paramedics arrival. The child was taken to the local hospital and was later air lifted to a Denver hospital where he died a few days later. Parents admitted to alcohol, marijuana and prescription medication usage. The mother reported using 24 hours prior to the incident. The parents were substantiated on for neglect. No criminal charges were filed in this case.

Case Recommendations:

- Continued prevention education to parents/caretakers and communities in general about the risks of abusing alcohol, illegal substances, and prescription medicines around children, and infants in particular.

- Continued prevention education surrounding the risks of bed-sharing, particularly on couches. This education should include the understanding that the parents/caretakers of infants can often be very tired, and falling asleep while feeding or soothing may occur, but it does not endorse risks of sleeping on the same surface as the infant at any time.
- Investigation practices should be consistent statewide regarding infant fatalities, particularly in cases involving bed-sharing, SIDS or SUID. Trainings around consistent and proper investigative practices should be offered to law enforcement, first responders, coroners and others who are involved in these investigations, until it becomes general knowledge and practice.

2014-013: Major Injury

5-month old female was taken to the hospital after her mother came home from work and her babysitter admitted to shaking the infant because she would not stop crying. He also admitted to the mother that he covered her face with a blanket after shaking her. The mother did not see any signs or symptoms of concern until later in the evening when the child became pale and was vomiting. The hospital did not see anything of immediate concern and told the mother to keep an eye on the child. The child continued to throw up everything she ate the next day, was lethargic and would not lay flat on her back. The child was then transferred to a hospital in Denver, where they found a possible fracture to her 5th rib, but no other injuries or signs of trauma. The male babysitter had a significant history of abuse as a child. He later pled guilty to child endangerment. This case follows a visible trend in Shaken Baby Syndrome incidents, where the perpetrator is often an unrelated, young male.

Case Recommendations:

- Continued education to parents and caretakers about the dangers of shaking an infant, as well as ensuring that anyone who may care for their child (babysitter, boyfriend/girlfriend, etc.) understands these dangers and what techniques can be used when an infant is crying for long periods of time.
- Continued education to parents/caretakers with financial constraints about affordable child care opportunities and systemic services that may be available to them within their community, or at a state level.
- Medical personnel should ensure that parents/caretakers fully understand any discharge paperwork and instructions when leaving a hospital or other facility. Delayed symptoms may be missed if the parent/caretaker does not understand what they need to watch for upon discharge.

2014-014: Major Injury

DFS received a report of a junior high school teacher having sexual contact with a 14 year old female and former student who he was currently working with as a tutor. The mother found nude photographs of her child on Facebook that the child had sent to the teacher. The child was interviewed at CAP, where she disclosed sexual contact. He pled guilty on two counts for 3rd Degree Sexual Abuse of a Minor.

Case Recommendations:

- Continued education to parents/caretakers and children about the benefits and dangers of social media and new technology in general.
- It would be useful for the case file narrative to provide thorough documentation about communication between DFS and local law enforcement in order to demonstrate cooperation between the agencies in the best interest of the victim.
- It is crucial that forensic interviews are handled by trained professionals to ensure proper documentation of the incident. If a community is not currently accessing a quality forensic interviewer for needed cases, these resources should be explored.
- Programs surrounding youth empowerment, positive development and healthy sexuality should be administered through schools to students and their parents. Programs that incorporate children, parents and educators are the most impactful and changing social norm messaging.

2014-017: Major Injury

2-year old female victim and her 10-year old brother were left at home alone while their mother went out to a bar with some friends. The mother had been in and out of the home a couple of times throughout the night with a couple of men. After her final return, she was extremely intoxicated, a man entered her home and took the 2-year old female from her crib and left with her in a stolen vehicle. He drove to a remote location and sexually assaulted the child. He left the child locked inside the vehicle out in a pasture. An individual passing by noticed the vehicle the following day, reported it to law enforcement, and the child was located. She was taken to the local hospital and then later transferred to a Denver hospital for additional examination and treatment. This case was ruled as a Stranger Abduction. The mother was substantiated on for neglect. The perpetrator was convicted of 1st degree Sexual Assault on a minor and Kidnapping.

Case Recommendations:

- Whenever possible, caseworkers should collect any follow up documentation surrounding investigations and sentencing, even if the perpetrator is 3rd party in an open case file. Having this documentation would create better-rounded case files and be beneficial in completing a thorough review.

2014-018: Major Injury

2-year old male was unable to bear weight on his left leg. The child was taken to the emergency room and no initial fractures were found. Two days later, the child was seen not using his arm very much. The child's mother was afraid that DFS would be called, so she asked the child's aunt and grandmother to take him back to the emergency room. X-rays revealed a spiral fracture to the child's arm, and an older, healing fracture in the child's other arm. No one observed the incident which would have caused the injury and no one admitted to harming the child. The mother's boyfriend had been alone with the child while the mother had gone for food. Mother received a substantiation for medical neglect and the boyfriend was not substantiated on or charged, due to lack of proof.

Case Recommendations:

- Cause and justification of substantiations should be clear within the case file. It was unclear in this case why the substantiation of medical neglect was made instead of a more general neglect substantiation. Otherwise, the case file was very complete.

RECOMMENDATIONS:

- There continues to be a trend in major injuries and fatalities involving an unrelated, young male as the perpetrator. This male is often times a close friend or significant other of the child's biological mother. Public awareness and education efforts surrounding Shaken Baby Syndrome and just general child abuse and neglect prevention should be continued and expanded as much as possible. Any person who cares for or comes in to contact with a child should be aware of basic child development, physical and emotional risks of child abuse and neglect, mandatory reporting standards and the ramifications if they do maltreat a child.

- A new SS-51 was created by the WCDRPT and DFS over a year ago, to be implemented with all new major injury and fatality cases. Only one of the ten files reviewed contained the new form. We would recommend that implantation is followed up on and ensured by DFS for their caseworkers to ensure an easier and more thorough review process.

- The WCDRPT should investigate what education or prevention training the Department of Corrections might be doing with sex offenders (particularly child sex offenders) while incarcerated. We would encourage this type of training and education continue to take place, and recommend that a program be developed if there is not currently a program.

- Continued public education about the true role of the Department of Family Services, what resources they have available and what restrictions they have relating to removing children from a home would be strongly supported.

- Increased training hours or a specific curriculum should be offered to law enforcement around investigations involving infants and children. This training should cover investigations where the infant/child is the victim as well as cases where the infant/child may just be at the location of a report (i.e. domestic violence incidents). Law enforcement should practice trauma-informed care with infants and children whenever possible, to reduce the likelihood of causing additional trauma in any way.

PREVENT CHILD ABUSE WYOMING

Prevent Child Abuse Wyoming has been focusing on expanding its outreach to the entire state. The target population for PCAWY is truly every Wyoming citizen, as we all have a part to play in our community and state in keeping children and families safe and healthy. Our library of free resource materials is available to anyone interested in them. Our Safe Sleep Campaign is targeted at new parents or parents with infants, most commonly in conjunction with the public health offices around the state. For the Child Abuse and Neglect and Mandatory Reporting in Wyoming training we have targeted medical personnel in Wyoming, from first responders to hospital staff to doctors and surgeons. We also have an adapted training for child care and home visitation professionals. We were very successful in recruiting for our target populations in this first quarter. We held three hospital trainings (West Park Hospital – Cody (and Powell), Memorial Hospital of Carbon County – Rawlins, Campbell County Memorial Hospital - Gillette) and two child-based services trainings (Wyoming Afterschool Alliance Annual Conference – Laramie, MIECHV home-visitation training – Casper). We had two other hospitals interested in scheduling a training, but are still working on dates at this time. We hope to serve/train 15-25 people at each training as a minimum. At two of the hospitals (Park County, Campbell County), the training was video recorded so that numerous additional staff could receive it when their schedule allowed. We had additional success at these trainings in terms of having requests to come back and train again, or train additional groups that are connected to those professionals in attendance.

We served 108 people at the trainings (not including those who utilized the video trainings). We also distributed 1256 newborn infant sleep sacks and Safe to Sleep brochures and information sheets to the 23 public health office for their distribution to families with infants that they work with in-office or through home visitation services. In addition, we collaborated with the Department of Health-Maternal and Child Health Division to distribute 3-6 month infant sleep sacks and Safe to Sleep brochures and information sheets to new mothers who participate in their Pregnancy Risk Assessment Monitoring System (PRAMS) surveys. In this quarter, the Division has picked up 132 sleep sacks and corresponding materials from our office for distribution. We will continue to contact hospitals around the state and work with child-based services whenever possible to provide trainings and materials. We will also continue to promote the free resources PCAWY has available to the public and work towards continued development of the Safe to Sleep and Shaken Baby Syndrome Campaigns.

The services that PCAWY are offering our communities includes 6 primary prevention trainings with child-based and/or home visitation services statewide, 4 primary prevention trainings at Wyoming hospitals, and access to free educational and informative materials by individuals, groups and organizations. These services were selected because of an identified need from medical personnel as well as from the Wyoming Child Death Review and Prevention Team for better training and knowledge of child abuse and neglect signs and symptoms and the mandatory reporting process for Wyoming. There have been a number of major injuries and/or fatalities involving repeat visits to hospitals and medical facilities with failures to report over the last few years. The trainings at the hospitals, in particular, have been a collaborative effort with the Department of Family Services office in the local area, as well as the local County Attorney's

office, GAL's and law enforcement when available. The child-based services trainings have also had success and we are looking to expand those opportunities over this next quarter. As mentioned in the "Population" section above, the educational materials we have distributed, particularly around our Safe Sleep Campaign, have been a success. We would like to see more distribution of the other educational resources we have available over the next two quarters, when events for distribution opportunities are more readily available.

We have had very positive results from surveys distributed at the end of each training. Some ideas that we are looking to implement include more multimedia (graphs, videos, visuals) in the presentation, and to give more concrete examples of different types of abuse throughout the presentation. This will help make the presentation even more effective for those receiving the trainings. We will consistently work to make sure the training is as up to date and effective as possible. Some other changes we will be looking at is creating a training more specifically focused on first responders, as there has been a request for such, as well as altering the child-based services version of the training to even better meet examples that child care workers, home visitation workers, and teachers can relate to. In terms of educational materials, we are in the process of evaluating the materials we have and what gaps in resources we may have, so we can fill those gaps and meet the needs and requests that have been made to PCAWY.

Pinwheel Garden planting by the Cheyenne Women's Civic League at the Children's Village.

More pinwheel pictures and documentation of PCAWY work can be seen on our website: www.pcawy.org.

PCAWY has diligently focused on fundraising efforts throughout the year focusing on both an indoor and outdoor volleyball tournament and the Pinwheel Garden Project. The Pinwheel Project is a state wide effort and our largest fundraiser. We also did a number of improvements to our website this year (www.pcawy.org). Prevent Child Abuse Wyoming is looking forward to new opportunities in the next year.

Wyoming Home Visitation Collaboration (Parents as Teachers Affiliate Program)

In April of 2013 Wyoming Citizen Review Panel was awarded a contract from Parents as Teachers National Center to implement home visitation services in the state of Wyoming under Maternal, Infant and Early Childhood Home Visitation Grant (MIECHV). WYCRP is the implementing agency for these funds in the state of Wyoming. In August of 2013 we hired nine staff members to deliver home visitation services and assist in the operations of this program. In October we initiated services under the affiliate program Parents as Teachers. Staff was trained in the curriculum and delivers the home based services in four high risk counties in Wyoming; Natrona, Fremont, Albany, and Sweetwater. We are currently serving 43 families in these areas by providing home based services focused on supporting parents about development and providing them resources related to early care in their local areas. Our goal is to have 70 families enrolled by September 1st, 2014.

This has been an exciting endeavor and we look forward to expanding our outreach into other communities as a primary prevention effort.

Conclusion

Wyoming Citizen Review Panel has had an exciting year filled with new opportunities. Our efforts continue to be focused on assisting the State of Wyoming Department of Family Services in their efforts to provide quality services related to the child welfare system as well as supporting primary prevention efforts through home visitation and Prevent Child Abuse Wyoming programming. It is our hope to be a leader in assisting the state and local communities by supporting self-sufficient families. The case reviews and surveys provide essential insight about the current state of the child welfare system in Wyoming. WYCRP has provided recommendations for the agency in order to improve the quality of services being delivered to our children and families. In the next year we will be focusing on our continued efforts with the State of Wyoming Department of Family Services to acquire information from Wyoming citizens about the quality of child and adult welfare. We are looking forward to our continued partnership with the agency to create a model of excellence.