State of Washington
Joint Legislative Audit and Review Committee

Child Protective Services

Report 97-2

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CHILD PROTECTIVE SERVICES

Summary

In January 1996, the Joint Legislative Audit and Review Committee (JLARC) approved a proposal for a performance audit of the case management and investigatory practices of Child Protective Services (CPS).

A major finding of this report is that the CPS screening and assessment process is cautious and devotes a large amount of resources to investigating referrals which are eventually determined to be unfounded or inconclusive. While some degree of caution within CPS would be expected, the extent of the caution may result in unintended demands on state resources and disruption to the family and child being investigated. The report recommends further study to identify strategies that will shorten the time it takes to determine that a referral is unfounded or inconclusive. JLARC has developed a model that can assist CPS in evaluating its success in implementing these and other strategies for enhancing the agency's performance.

A large amount of resources are devoted to unfounded allegations

There are nine recommendations in this report for providing more efficient use of resources, achieving compliance with statutory training and case management requirements, and for developing a means to evaluate agency performance. CPS is also directed to report back to JLARC by January 1, 1998, on the progress of addressing the findings and implementing the recommendations of this audit.

MAJOR AREAS OF REVIEW

Limits in Identifying Best Practices

The states of Florida, Iowa, and Missouri have been nationally recognized for their recent program reforms in child protective services. This recognition is largely due to legislative changes that

are intended to increase the safety of children through improved services. We found that most of these services are similar to those that are currently provided in Washington State (see Chapter 4). Nevertheless, neither these states nor Washington have been shown to be states with best practices that other states should emulate. The changes that have been implemented in these states have been based on professional opinion rather than on documented evidence demonstrating that the adopted reforms will achieve their purpose.

Outcome data on the rate of re-abuse are not yet available

A limitation of the information from Washington and other states is that it offers ***output*** data on the number of referrals received and processed, but no ***outcome*** data as to the effects of how it manages these referrals. One important outcome measure, not yet available for any of the key states or for Washington, is the rate of re-abuse. Washington has recently included this rate as a performance measure, but will not be able to begin collecting data concerning it until July 1997.

Even when data on re-abuse becomes available, this information will not immediately show how successful CPS has been. This is because there is no standard for what is an acceptable, or unavoidable, rate of re-abuse. Nevertheless, once the state of Washington begins to collect information on this rate, it will have the opportunity to evaluate how its management of referrals can affect the rate of abuse (as well as other outcomes).

Although there is no industry standard for this rate, knowledge of what practices work and do not work is invaluable information, and can be used to inform decision makers about the strategies that have the most potential to reduce the rate of abuse. JLARC has developed a model that can be used for this purpose. The development of outcome measures, together with the ability to evaluate the practices that influence these outcomes should improve CPS' performance. This would also make Washington a lead state in measuring the effectiveness of CPS.

We recommend that CPS establish targets for outcome oriented performance measures, and analyze the characteristics of re-abuse.

Analysis of Referral Outcomes

Applying the JLARC model, we conducted an analysis of the Fiscal Year (FY) 1995 referrals that CPS accepted for assessment and

investigation. We found that the screening process used by CPS to assess the degree of imminent danger to children is cautious. Risk is assessed for each referral twice, once during initial assessment and again when the case is closed. Risk assigned in 77 percent of the completed investigations was higher when the referral was received than when it was closed. In cases where more time was spent on the initial risk assessment, there was less of a downgrade in the risk assessment when the case was closed. This suggests that the accuracy of the initial assessment increases in proportion to the amount of time spent researching the referral. We also found that 40 percent of the fully completed investigations were determined to be unfounded or inconclusive, with a median of 68 days per case to reach case closure.

One would expect that some degree of caution should be exercised within CPS so that any errors in risk assessment favor the mandated priority of children's safety. However, the extent of this caution has its impacts, such as:

- The risk to the child of continued abuse or neglect while the investigation is underway;
- Additional demands on limited state resources to investigate a referral whose allegations are eventually unfounded or inconclusive;
- A diversion of state resources from investigating allegations which may eventually be founded; and
- The disruption to the lives of the family and child being investigated.

Need for maintaining child safety while mitigating other impacts

In order to maintain practices that err on the side of child safety and mitigate impacts, we recommend that the characteristics of unfounded and inconclusive cases be analyzed so that these cases can be closed sooner. This will provide new information for CPS to determine whether more or re-allocated resources should be added to the initial risk assessment process, and how that process can be improved to increase its efficiency and effectiveness.

We also looked at national standards to determine an appropriate caseload size. The well publicized caseload standard of one worker to seventeen cases set by the Child Welfare League of America is not

in operation in any state, and no one can say with certainty the degree to which it would improve child safety. However, JLARC's model can be used to analyze the effects of caseload or workload levels on outcomes and program performance. This would provide decision makers with new information about how outcomes may be affected by changes in staff resources or case management practices.

Agency Compliance

We found that CPS generally complies with agency and statutory policies which require CPS to: notify parents of their rights during an investigation; notify law enforcement when it receives a referral of child abuse or neglect; and screen referrals within specified time frames.

CPS does not, however, adequately track and monitor caseworkers' training, and it appears that caseworkers are not receiving all the required training as mandated in agency policy. Furthermore, agency policy is not in compliance with the state statute requiring caseworkers to complete specific coursework prior to carrying cases without direct supervision.

We recommend that CPS modify its current policies to include the specific time frame for caseworkers to complete coursework. We also recommend that CPS utilize the resources of the Department of Personnel (DOP) to monitor and track completed coursework.

Finally, we found that CPS is complying with the agency's policy that requires CPS to complete an investigation within 90 days of receiving a referral only 52 percent of the time. CPS should be able to achieve a higher rate of compliance with this policy if it implements the recommendations listed under Chapter 2, *Analysis of Referral Outcomes*.

Progress Report Required

We recommend that CPS report back to JLARC by January 1, 1998, on the progress of addressing the findings and implementing the recommendations of this report.

AGENCY RESPONSE

The Department of Social and Health Services provided a response in which it concurs or partially concurs with the nine recommendations of this report. The full text of DSHS's response, as well as the audit team's comments, are provided in Appendix 2.

The Office of Financial Management also provided a response stating that the conclusions about response times that are reached in this study and the OFM/Management Improvement Project are similar.

ACKNOWLEDGEMENTS

We wish to thank Child Protective Services staff from around the state who generously contributed their time, information, and insights to our effort. Their patience and desire to assist us in our endeavors is greatly appreciated. We wish to especially thank the management of the Division of Children and Family Services who provided a considerable amount of data and support.

This study was conducted by JLARC staff members Kathy Gookin, Martin Chaw, and Gerry McLaughlin with technical assistance from the project consultant, Dr. Lowell Kuehn of Pacific Northwest Consulting Services. Kathy Gookin was the team leader and Bob Thomas was the project supervisor.

Cheryle A. Broom
Legislative Auditor

On January 10, 1997, this report was approved by the Joint Legislative Audit and Review Committee and its distribution authorized.

Senator Al Bauer
Chair

RECOMMENDATIONS

Summary

Recommendation 1

The Division of Children and Family Services should analyze the characteristics of unfounded and inconclusive referrals and identify strategies that will shorten the time it takes to reach case closure.

Legislation Required:	None
Fiscal Impact:	A potential for redistributing resources
Completion Date:	January 1998

Recommendation 2

The Division of Children and Family Services should evaluate the workload requirements of the various types of referrals and redistribute its workforce as appropriate.

Legislation Required:	None
Fiscal Impact:	A potential for even distribution of workload
Completion Date:	January 1998

Recommendation 3

The Division of Children and Family Services should evaluate best practices in its field offices to assess if opportunities exist to improve performance.

Legislation Required:	None
Fiscal Impact:	A potential for efficiencies
Completion Date:	January 1998

Recommendation 4

The Children's Administration should analyze the characteristics of re-occurrences of serious child abuse/neglect after a case is open and on recently closed cases.

Legislation Required:	None
Fiscal Impact:	None
Completion Date:	January 1998

Recommendation 5

The Children's Administration should import Case and Management Information System data into a relational data base (that contains information from additional sources) at regular intervals.

Legislation Required:	None
Fiscal Impact:	None
Completion Date:	January 1998

Recommendation 6

The Children's Administration should establish targets for outcome oriented performance measures.

Legislation Required:	None
Fiscal Impact:	None
Completion Date:	January 1998

Recommendation 7

The Children's Administration should modify current departmental policies governing employee training to include the specific time frame and prerequisite completion of coursework requirements for caseworkers.

Legislation Required:	None
Fiscal Impact:	None
Completion Date:	January 1998

Recommendation 8

The Children's Administration should utilize the Department of Personnel's Human Resource Development Information System (HRDIS) to monitor compliance with coursework requirements.

Legislation Required:	None
Fiscal Impact:	None
Completion Date:	January 1998

Recommendation 9

The Children's Administration should report back to the Joint Legislative Audit and Review Committee by January 1, 1998, on the progress of addressing the findings and implementing the recommendations of this report.

Legislation Required:	None
Fiscal Impact:	None
Completion Date:	January 1998

INTRODUCTION

Chapter One

In January 1996, JLARC approved a proposal for a performance audit of CPS. As part of the pre-audit survey process, JLARC staff was charged with determining the issues which could be addressed in a performance audit of CPS operations and its case management system. Stakeholders representing state elected officials, legislative staff, agency staff, and community-based agencies were contacted. Comments from these individuals were used to assist in narrowing the focus of the study to two common topics related to CPS—case management and investigatory practices. A more detailed statement of this study's scope and objectives can be found in Appendix 1.

Focus on case management and investigatory practices

It is important to note that this performance audit did not include an investigation of individual caseworkers or supervisory decisions, nor did this performance audit attempt to evaluate the appropriateness of the findings, assessments of risk, conclusions, or other information for any particular referral. Our audit focused on the general performance of the CPS case management and investigation system.

STUDY APPROACH

A model of analysis was developed for the study

An analytical model was developed for the purpose of examining several aspects of CPS caseload management and investigatory practices. Computerized data for FY 1995 were collected from the Case and Management Information System (CAMIS), the Children's Administration Budget Office, the Department of Social and Health Services (DSHS) Employee Services Division, and DOP's Human Resource Information Systems Division (HRDIS). The data were

downloaded into tables contained within a relational database[1] so that a single analysis of all of the data could be conducted. The tables from the relational database were then statistically analyzed through the use of a software package.

The CAMIS data was the largest source of information and considered to be key to our analysis.[2] Therefore, a field study was conducted to determine if the CAMIS data were reliable. We found an error rate of less than 1 percent within each region. A description of this validation process and its outcomes is provided in Appendix 2.[3]

We also conducted interviews with management and field staff, and reviewed CPS statutes, reports, and division operating policies and procedures. The areas of review include:

Management

The extent to which performance measures and quality control practices in managerial decision making are used were analyzed. We also analyzed the extent to which managerial practices are consistent among the six regional offices and 44 field offices. A review of the outcome differences between offices and regions was also conducted to determine if these differences could be a result of variations in management practices.

Some data could not be adequately matched

An attempt was made to assess quality control during caseworker turnover, but the data that was provided could not be adequately matched to the CAMIS data.

Case Management and Investigations

We reviewed the extent to which case management and investigatory practices were consistent between the regions. This review also included an assessment of the degree to which investigatory efforts were duplicative of other agencies.

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[1] A relational database is a group of tables of data that can be analyzed.
[2] The data set consisted of 64 selected variables that are also being used by the Office of Children's Administration Research to conduct a federally funded CPS decision-making study.
[3] We compared computer generated documents to information contained within the case files. Our data validation process did not examine the accuracy of the caseworker's transfer of information into the CAMIS system.

Statutory Compliance

We assessed the extent to which CPS is in compliance with statutory and administrative policies. Policies included in this review were: timelines for reviewing and closing investigations on a referral; requirements to notify parents of their constitutional rights; and mandatory reports to law enforcement agencies.

Training

Our review also included assessing the extent to which training courses were completed by CPS caseworkers since 1979 to determine compliance with statutory and agency policies. The analysis was conducted within the context of case management outcomes.

An attempt was made to assess the impacts of training on case management. However, the data that was provided to JLARC could not be adequately matched to the CAMIS data.

Best Practices

We contacted many national organizations to determine which states are known as Child Welfare Program reform states. We reviewed their programs to identify any services that have proven to be successful, and which may have applicability to the state of Washington.

CPS OVERVIEW

CPS is one of three major programs within the Division of Children and Family Services

CPS is one of three major program areas within the Division of Children and Family Services (DCFS), which is part of the Children's Administration of DSHS. DCFS operates on an annual operating budget of $89 million and 1,560 FTEs, or about 2 percent of the DSHS annual operating budget and about 9 percent of the DSHS FTEs.[4] Approximately 420 of the FTEs are caseworkers that are assigned cases within the CPS program.

[4] 1996 AFRS actual data per the Legislative Evaluation and Accountability Program (LEAP) Committee. This figure does not include expenditures for foster care payments and contracted direct services.

DCFS is responsible for investigating allegations of child abuse and neglect and for statewide child protection, family preservation, foster care and adoption services for children aged 0 - 18 years of age. Services administered by DCFS are provided through three major programs: CPS, Child Welfare Services (CWS), and Family Reconciliation Services (FRS).

Child Protective Services (CPS) provides 24 hour-a-day, seven days a week intake, screening, and investigatory services for allegations of child abuse and neglect. Within 90 days of receiving an allegation, CPS must determine whether a case is founded, unfounded, or inconclusive, and must close or transfer the case to another service. CPS services can continue if there is a voluntary service agreement with the family, or if a dependency action is filed in court.

Family Reconciliation Services (FRS) provides services which are devoted to maintaining the family unit and preventing out-of-home placement of adolescents. Participation in these services is voluntary, and is available 24 hours a day, seven days a week. Families requesting services are offered intake and assessment services and, if further intervention services are needed, are referred to in-home crisis counseling which can last up to 15 hours over a 30-day period.

Child Welfare Services (CWS) provides placement prevention and permanency planning services to children and families who may need services due to serious problems. CWS services are also available for cases transferring from CPS or from FRS when these services are not successful in resolving the family's problems.

ANALYSIS OF REFERRAL OUTCOMES

Chapter Two

Overview

This chapter overviews the management and flow of a typical referral, and analyzes the variables that affect the timeliness and quality of investigative practices. To assist in this analysis, we developed a model that analyzes the effect of the initial and overall risk assessments of a referral, the characteristics of offices, and the characteristics of the referral. This model was used to evaluate the management of referrals. This model also provides a framework from which policy makers can develop strategies for CPS. The findings, conclusions, and recommendations for this chapter are the results of an analysis of computerized case management data provided by CPS for FY 1995.

CASE MOVEMENT AND RISK ASSESSMENT

A typical CPS referral moves through three major phases during a standard investigatory review. These three phases are: case intake, case assessment/planning, and case summary assessment. These phases are described in greater detail below.

Case Intake

At this stage, a referral is received, and an assigned intake caseworker screens the referral to determine if sufficient grounds exist for acceptance and further investigation. CPS has 72 hours from the time of receiving a referral to determine whether to accept the referral for investigation or screen it out.[1] However, if the child's

[1] DCFS Practices and Procedures Guide, Section 2200.

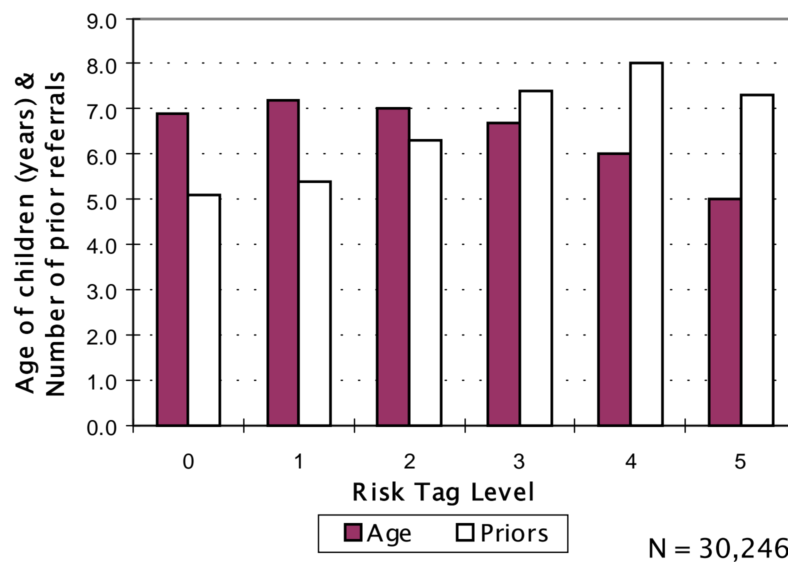
CPS has 24 hours to screen an emergent referral, and 72 hours to screen a non-emergent referral

safety is thought to be in imminent danger, an emergent response code is assigned and the referral must be screened and, if accepted, an investigation begun within 24 hours. A non-emergent response code allows 72 hours for screening and requires an investigation to begin within 10 days.[2] Once a referral is accepted for investigation, an initial risk tag is assigned.[3] We found that 96 percent of the emergent referrals and 99 percent of the non-emergent referrals were responded to within this policy.

Sources of referrals are parents, relatives, neighbors, friends, school personnel, law enforcement agencies, medical personnel, therapists and social service agencies. Approximately 65 percent of referrals are accepted for investigations and 30 percent are screened out. The remaining 5 percent are unacceptable referrals from third-parties and are referred to law enforcement for further investigation. For our study, 41,660 referrals were accepted for investigations during FY 95.

Exhibit 1 shows that younger children have a higher number of prior referrals and are assigned higher risk tags than older children. Within the risk tag range of 0 through 5, a 5 indicates a presumption of greatest risk to the child and a 0 suggests little or no risk.

Exhibit 1
Average Age of Children Versus Number of Prior Referrals by Risk Tag



[2] DCFS Practices and Procedures Guide, Section 2300.
[3] The risk tag is based upon eight different factors which assess the relative risk to the child based upon the child's characteristics, severity of abuse/neglect, chronicity, caretaker characteristics, child relationship with caretaker, social and economic factors and perpetrator access.

Exhibit 2, below, illustrates the distribution of initial risk tags that were assigned to the accepted referrals. It is interesting to note that almost 80 percent of the referrals accepted are assigned an initial risk tag of 3 or greater.

Exhibit 2
Distribution of Referrals by Initial Risk Tag

Initial Risk Tag	Number of Referrals	Percentage
0	545	Negligible
1	4,291	10
2	4,707	11
3	14,100	34
4	7,808	20
5	10,209	25
Total	**41,660**	**100%**

Exhibit 3, below, shows the distribution of referrals by abuse type, and the average number of days from receipt of the referral to case closure. This exhibit shows that the primary categories of abuse and neglect include physical neglect, physical abuse, and sexual abuse.

Exhibit 3
Number of Referrals and Average Number of Days to Reach Case Closure by Category of Abuse/Neglect

Title of Abuse/Neglect Category	Number of Referrals	Average Number of Days
Abandonment	174	116
Physical abuse	8,068	135
Sexual abuse and physical neglect	399	137
Sexual abuse	3,781	145
Physical neglect	9,413	149
Physical and medical neglect	218	149
Physical abuse, physical and emotional neglect	132	152
Medical neglect	860	152
Physical and emotional abuse	354	157
Emotional abuse	781	159
Physical neglect and emotional abuse	215	166

As indicated by these numbers, the most frequent categories of abuse and neglect include physical neglect, physical abuse, and sexual abuse. It is also interesting to note that higher risk tags are assigned to younger children with a larger number of prior referrals and that almost 80 percent of the referrals received are assigned an initial risk tag of 3 or greater.

Case Assessment and Planning

This is the investigative and intervention phase of services. Caseworker activities include home visits; contacting witnesses in person and on the telephone; face-to-face interviews with the family; referrals to services such as medical, dental, substance abuse, mental health, financial, parenting classes, coordination with law enforcement personnel, court actions; and computer data entry.

Court orders and law enforcement personnel authorize out-of-home placements

A caseworker may request a court order for temporary out-of-home placement if the risk of leaving the child at home is assessed to be great. Law enforcement personnel may also remove children from their homes and transfer custody to the care of CPS personnel. An additional court order is required to either return the child to his/her home, or continue out-of-home placement. In rare cases, a permanent out-of-home placement occurs in the form of foster care or adoption, but this is the work of the CWS Program, not CPS.[4] Caseworkers can only take children into their custody via a court order or at the request of law enforcement personnel.

CPS attempts to provide out-of-home placements with relatives, but every placement requires a home study conducted by CPS and a criminal history background check of all residents in the home. This is often not possible in cases where children are already in the custody of law enforcement agents, and when the incidents occur in the middle of the night.

52% compliance with the 90-day rule

According to agency policy, CPS has up to 90 days to either: 1) enter into a written voluntary service agreement with the family that will be signed by the family members; 2) file a dependency action with juvenile court; or 3) close the referral.[5] In FY 95, 52 percent of the referrals accepted for investigations were closed within 90 days.

[4] RCW 13.34.060.

[5] WAC 388-15-132(3).

Case Summary Assessment (Completion)

Once an investigation of a referral is concluded, a summary assessment is prepared whereby a final risk tag is assigned and an overall assessment of the grounds of the allegation(s) is made. Of the 41,660 referrals accepted for investigations, 11,414 referrals did not receive a summary assessment.[6] Another 40 percent of the referrals were eventually found to be either inconclusive or unfounded.

40% of the referrals were determined to be unfounded or inconclusive

During this stage, referrals are also assigned a final risk tag. This risk tag reflects additional information gained during the investigation and can be presumed to more accurately reflect the relative risk of harm to the child. For referrals with summary assessments in FY 95, the initial risk tag was downgraded for 77 percent of the cases, 9 percent of the referrals were upgraded, and 14 percent of the referrals retained their initial risk tag.

77% of initial risk tags are downgraded at summary assessment

Exhibit 4 provides a breakdown of the distribution of the referrals that were accepted for investigation. It is interesting to note that only 28 percent of these allegations were founded. The majority were found to be either inconclusive or unfounded.

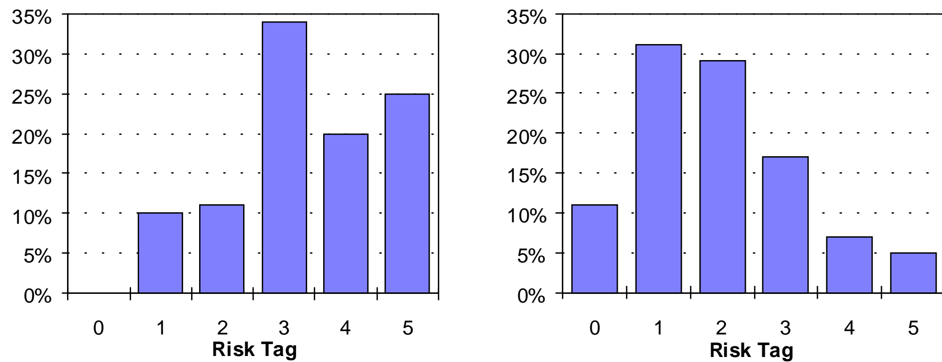
Exhibit 4
Distribution of CPS Referrals by Conclusionary Findings

Conclusionary Findings	**Percent of Total**
Allegations founded	28
Concluded without summary assessment	27
Allegations found to be inconclusive	22
Allegations found to be unfounded	18
Findings not available	5
Total (41,660 referrals)	**100%**

[6] A summary assessment is not required of referrals with risk tags of 0, 1 or 2 (5,614 referrals). However, there were some referrals with a risk tag greater than 2 which did not include a summary assessment (5,800 referrals). It is not clear why this was. There are several possibilities: 1) the allegation was investigated, but was eventually unfounded and the conclusionary data were never entered; 2) further investigation was deemed unnecessary and alternative intervention services were offered; or 3) the data for these allegations was incomplete. In the absence of further research into these specific referrals, we are unable to conclude why a summary assessment or conclusionary finding was not issued.

Exhibit 5 illustrates the cautious nature of the CPS screening process. As discussed above, the majority of these referrals received an initial risk tag of 3 or greater. At the conclusion of these referrals, the majority (71 percent) of referrals were assigned a final risk tag of 2 or less.

Exhibit 5
Percentage Distribution of Initial and Final Risk Tags



Risk tags were more likely to be sustained when more time was spent during in-take

It appears that the screening process used by CPS is cautious. In cases where more time was spent on the initial risk assessment, we found that there was less of a downgrade in the risk assessment when the case was closed.[7] This suggests that the accuracy of the initial assessment increases in proportion to the amount of time spent researching the referral.

Exhibit 6 shows the average and median number of days caseworkers took to reach case closure.

Exhibit 6

Findings	Average Days	Median Days
Founded	154	96
Inconclusive	139	78
Unfounded	120	57
Total= 30,246		

[7] According to discussions with CPS staff, the downgrade in the final risk tag level may be due to the caseworker determining that an intervention has successfully reduced the original level of risk to the child. However, our data did not include information on intervention services nor the effectiveness of these services. Thus we were not able to verify their assertion.

For unfounded and inconclusive cases combined, it took a median of 68 days to reach case closure.[8] One would expect that a degree of caution should be exercised within CPS so that any errors in risk assessment favor children's safety. However, the practice of taking a median of 68 days has its impacts, such as:

Unfounded and inconclusive referrals typically took 68 days to reach case closure

Demands on limited state resources. A large share of state and agency resources are directed toward the investigation of an allegation which, in most cases, turns out to be less severe than originally estimated. This may result in fewer resources available for those allegations which do warrant intensive state intervention. The strain on state resources is especially apparent when considering that the median time to close a referral that is deemed unfounded or inconclusive is 68 days.

Impacts of the 68 days

Diversion of state resources. The attention and resources directed to investigating allegations which are eventually unfounded could have been more effectively used to investigate other referrals whose allegations may eventually be founded. This imbalance speaks to the need for CPS to identify and determine the reasons why there is a large number of referrals whose allegations are eventually unfounded or inconclusive.

Disruption to the family. An intensive investigation of allegations of child abuse or neglect can be disruptive and cause tension within the family being investigated. The effects of the disruption are exacerbated if the allegation is unfounded. Given the time elapsed on a case, this may represent a serious imposition into the lives of the family and the child being investigated, especially if the child is temporarily removed from the home during the investigation.

Risk to the child. During an investigation, if a decision is made to leave the child at home with the alleged perpetrator, the risk of subsequent abuse or neglect continues until the investigation has been closed.

It is important to note that we do not know, and neither does the agency, how much time is spent actually working on the case from the time of referral to case closure. Also, neither we nor the agency

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[8] Given the distribution of the data used in this analysis, the median, rather than the arithmatic mean (average) is more representative of the typical case.

can determine from the data how much time elapses from when a case is opened to when families are notified that allegations have been determined to be unfounded or inconclusive. Therefore, we cannot quantify the extent of the impacts.

TIME TO COMPLETE INTAKE INVESTIGATION AND QUALITY CONTROL

Our analysis identified a key factor that heavily influences the initial assessment, and therefore influences the demands on state resources and the clients of CPS—the time expended during the intake screening process.

As discussed above, intake units are responsible for screening incoming referrals and assessing the allegations of imminent danger to the child. From the data above it appears that the screening process for the initial risk assessment is highly cautious. This is evidenced by the shift, or downgrade, of the initial risk tag and is also evidenced by the large number of referrals that were accepted for investigations, but whose allegations were eventually unfounded or inconclusive.

Our analysis of the case management data provided by CPS indicates that more time spent by the intake caseworker to identify the issues and allegations of a referral may result in less time spent by caseworkers to conduct further investigations of a referral,[9] and may reduce the chance that the initial risk tag is downgraded significantly.[10] The intake caseworker and the investigative caseworker may be different persons, depending upon the availability of staff and individual staffing assignments.

This suggests that the accuracy of the initial assessment increases in proportion to the amount of time spent researching the referral. We also found that the lower the caseload per caseworker, the less chance that the initial risk tag is downgraded.[11] This further suggests that the quality of the initial assessment is influenced by the thoroughness of the initial analysis.

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[9] Correlation coefficient of -0.23.
[10] Correlation coefficient of 0.42.
[11] Correlation coefficient of -0.39.

A thorough analysis of the intake process is required

In order to identify the best strategies for improving the quality of the initial assessment, a thorough analysis of the intake process is required. This analysis should be conducted with the purpose of identifying the reasons why a large number of referrals, whose allegations are accepted, take a median of 68 days to be determined as unfounded or inconclusive. Once these reasons are identified, strategies can then be developed and applied accordingly.

We also identified two additional factors that appear to influence the initial assessment: caseload to caseworker ratios and the differences between offices. These two factors are explained below.

THE EFFECTS OF CASELOAD SIZES

We examined the number of cases per worker in FY 95 and found that number to be highly variable. A total of 862 caseworkers investigated 30,246 cases, for a statewide ratio of 35:1. Without explanation, this ratio may be misleading because 80 caseworkers report investigating 100 or more cases in the fiscal year studied, with the highest number being 386. On the other hand, 394 (46 percent) report investigating 10 or less cases. Some of this disparity may be explained by the split in some workers' duties between CPS and other DCFS programs, and the fact that some workers left CPS at the beginning and end of the twelve month period. We cannot, however, determine why the number would be as high as 46 percent for 10 or less cases, nor how a worker would complete 386 cases when only 10 percent of the total number of workers completed more than 100 cases.

Caseload ratios impact the processing of cases

What impact does caseload size have on the processing of cases? We found that offices with caseworkers with high caseload ratios reach case closure in fewer days and are more likely to downgrade the initial risk tag. By studying the differences between offices, it would appear that caseload ratios impact the time given to investigation and the downgrading of the initial risk tag, and also influence the degree to which out-of-home placements occur.[12]

[12] However, our data does not specify when the out-of-home placement occurred. Furthermore, according to the 1995 Data Integrity Study performed by the DSHS Office of Operations Review, a 19.5 percent error rate was identified for this data field.

Evaluating Caseloads Versus Workloads

Assigning workload weights has the potential for more accurately distributing resources

The number of cases a worker processes is not always an accurate indicator of the amount of work accomplished. For instance, the tasks required for a worker assigned to ten low risk cases are very different than for the worker who has been assigned to ten high risk cases. An alternative approach to assess workload is to assign weights to various types of cases, so that each worker's caseload can be evaluated for the amount of effort required to fulfill his or her responsibilities. In June 1994, DCFS conducted a workload study to determine standards for how much time is spent on various activities versus how much time is desirable for each activity. However, this study did not weight cases by type. Establishing a system of assigning caseload points according to the types of cases that are assigned to each caseworker has the potential for more accurately distributing resources.

BEST PRACTICES WITHIN WASHINGTON

Desireable and undesireable performance qualities were identified by location

The Omak, Yakima, and Vancouver offices have been identified as having some performance qualities that could be considered desirable. They include a low number of downgraded risk tags from the initial assessment to case closure, the fewest number days from referral receipt to case closure, and the ability to handle the highest volume of cases.

The Central and Eastside offices within King County and the Centralia offices have been identified as having performance qualities that could be considered undesirable. These offices had the greatest amount of downgraded risk tags, took the most days to process referrals, and handled a low volume of cases.

Although we conducted management interviews in each of the regions, further information is needed prior to being able to pinpoint the causes of these performance differences.

FINDINGS AND CONCLUSIONS

We found there was a sharp downgrading of the initial risk tags in 77 percent of the referrals and a large proportion of accepted

referrals whose allegations were eventually determined to be unfounded or inconclusive. This has its impacts which may be mitigated through an analysis of the characteristics of unfounded and inconclusive cases. Such analysis might reduce the time it takes to make these determinations while still maintaining caution that errs on the side of child safety.

Improving the accuracy of the screening process may mitigate impacts

We therefore find that a more thorough analysis of the intake process is required. Such an analysis would serve to identify strategies to improve the quality and accuracy of the intake screening and assessment process.

RECOMMENDATIONS

Recommendation 1:

The Division of Children and Family Services should analyze the characteristics of unfounded and inconclusive referrals and identify strategies that will shorten the time it takes to reach case closure.

Recommendation 2:

The Division of Children and Family Services should evaluate the workload requirements of the various types of referrals and redistribute its workforce as appropriate.

Recommendation 3:

The Division of Children and Family Services should evaluate best practices in its field offices to assess if opportunities exist to improve performance.

MANAGEMENT PRACTICES

Chapter Three

Overview

This chapter provides an overview of the measures used by CPS to assess its performance and how these measures compare to those used by the state of Oregon. We also provide an overview of the practices established by CPS to ensure quality services and assess the extent to which CPS' efforts are duplicative of other state agencies.

PERFORMANCE MEASURES

The Children's Administration developed a set of performance measures in November 1995, prior to the recent requirement for agencies to include performance measures with their August 1996 budget submittals to the Office of Financial Management (OFM).[1] An internal data tracking system has been subsequently developed by the Children's Administration to assess the agency's success in meeting their performance measures, although not enough time has elapsed to generate the data for evaluation as part of this performance audit. The first statewide quarterly reporting on performance measures occurred in September 1996.

Program performance measures have been *outcome* vs *output* oriented

Measures of program performance in the past have been ***output*** versus ***outcome*** oriented. While CPS has done a good job of monitoring the number of referrals received, response times, and the number of cases per caseworker, it has not measured the effectiveness of the services delivered.

One measure of program effectiveness is the rate of re-occurrence of serious child abuse/neglect after a case is open, and on recently

[1] C317, L96 - Performance Assessment of State Government.

The re-occurrence of serious child abuse/ neglect needs to be tracked

WA has an opportunity to become a leader

Oregon is considered a leader

closed cases. This measure of performance appears in the agency's August 23, 1996 budget submittal, but measurement data will not become available until July 1, 1997. Even when the data are available, it will be difficult to judge an acceptable level of re-occurrence, as there is currently no industry standard. Data from other states are not comparable, as each state has its own definition for substantiating allegations of abuse or neglect.

Nevertheless, once the state of Washington begins to collect information on the re-occurrence of abuse/neglect, it will have the opportunity to evaluate how its management of referrals can affect this rate (as well as other outcomes). Even though there is no industry standard for an acceptable level of re-occurrence of abuse, a knowledge of what practices work and do not work is invaluable information, and can be used to inform decision makers about the strategies that have the most potential to reduce this rate. As discussed in Chapter 2, JLARC has developed a model (a relational database) that can be used for this purpose. The development of outcome measures, together with the ability to evaluate the practices that influence these outcomes, would make Washington a lead state in measuring the effectiveness of CPS.

COMPARISON TO OREGON

A review of the Children's Administration performance measures indicates that they include many of the same items as the state of Oregon. Although Oregon was not identified as a state with recent policy reform, many other states have looked towards Oregon as the leader in outcome based performance measure development.[2] It is the only state that has a comprehensive list of performance measures for child welfare services and longitudinal data to support them. Oregon uses averages of their outcomes for calendar year 1990 through 1992 as their baseline, and targets two standard deviations from the baseline as a benchmark. Budgetary baselines are adjusted for inflation.

The items Washington and Oregon have in common include increases or decreases in the re-occurrence of abuse/neglect, the number of children entering foster care, the length of stay in foster care, family

[2] Fourth Annual Roundtable on Outcome Measures, San Antonio, Texas, May 1996.

reunification, the length of time to achieve permanent placement, stability for children in foster care, out-of-home placement with consistency in race or ethnicity, the safety of children in foster care, and staff diversity, and staff training. It is not known whether child protective services in Oregon promotes child safety to a greater degree than Washington because the two states do not have comparable data. A complete list of Washington's Children's Administration performance measures are included in this report as Appendix 5.

QUALITY CONTROL

The Children's Administration has a new quality control unit

During the past fiscal year, the Children's Administration established a new Office of Quality Assurance and Training. The purpose of the unit is to develop systems for internal evaluation and develop quality control mechanisms to improve existing Children's Administration programs, and to promote and disseminate best social work practices within the Children's Administration.[3]

All accepted referrals receive supervisory review

In the past, the administration has relied on quarterly regional reports and local controls to ensure that referrals and investigations occur within policies that are predicated on statutes. Every accepted referral is required to be reviewed by a supervisor prior to being assigned for investigation. The supervisor can screen-out the referral, alter the initial risk tag that was assigned by the telephone screener, or make no changes. The number and types of referrals that are not accepted for investigation (screened-out) are also monitored at the regional and statewide level. In a recent example of local quality control by the Children's Administration management, it was observed that an office in Region 3 had a much higher screen-out rate than other offices within the region. Upon investigation, it was discovered that staff did not have adequate training to ask probing questions for the information they need to properly screen-in referrals.[4] To remedy this identified shortfall, subsequent training was provided by CPS.

The recent development of a consistent data tracking system that is related to performance measures should assist the administration in additional monitoring of quality control.

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[3] Draft mission statement for the Children's Administration - Office of Quality Assurance.

[4] Interview with Barb Myers, Region 3 Regional CPS Coordinator

Findings about quality control monitoring of required training appear in Chapter 4. This is an area that has not been properly monitored, and for which the agency is out of compliance with legislative requirements.

The impact of case-worker turnover could not be deter-mined

Our analysis attempted to assess the impact of caseworker turnover on the management of CPS referrals. However, the data that was provided to JLARC staff could not be adequately matched to CAMIS data, thus we were not able to perform this analysis.

DUPLICATION WITH OTHER AGENCIES

One of the issues identified in the study scope and objectives is whether CPS investigations duplicate the work of other agencies. The focus of our study was on potential duplication with law enforcement agencies.

In the case of CPS, investigations are performed for the purpose of determining the severity of future risk to a child. This may not produce a preponderance of physical evidence, as requirements for the burden of proof are much less than in a criminal court of law. Time frames for response range from 24 hours to ten days. The purpose of the CPS investigation is not so much to prove that a particular act occurred, but to evaluate and reduce the risk of a future act of abuse or neglect from occurring. This means that although the original referral may have been for something that cannot be proven (reasons include lack of credible witnesses and third-party evidence), the caseworker may still identify living conditions that warrant protection for the child, and often times siblings of the child. Court proceedings for CPS dependency cases occur in the civil court system.

In the case of law enforcement, the purpose of the investigation is to determine if a crime that can be prosecuted was committed. There has to be a preponderance of evidence that is admissible in criminal court. Physical evidence is gathered via search warrants and tape recorded interviews. The statute of limitations on felony crimes in the state of Washington is ten years.[5] Transferring responsibility

[5] RCW 9A.04.080.

for investigations of child abuse and neglect away from CPS to law enforcement would mean that law enforcement would need to operate two separate sets of investigation procedures in order to provide child safety. The Washington Association of Sheriffs and Police Chiefs believes the process would cost more and many CPS cases would be of low priority, given the life threatening nature of many of law enforcement's current requests for service.[6] Relying on law enforcement for investigations of child abuse and neglect without imposing similar time constraints as those required of CPS would obviously pose a risk to the immediate protection of children.

Law enforcement and CPS investigations differ tremendously, although one can work to support the other. Law enforcement agencies are automatically notified of all criminal allegations of child abuse/neglect by CPS, and often law enforcement personnel refer cases to CPS. Additionally, law enforcement officials are mandatory reporters of child abuse/neglect allegations, and children can be removed from their homes by law enforcement personnel when child safety is a serious concern.[7]

Law enforcement and CPS investigations are different, but can support each other

We therefore find that the purposes of CPS and law enforcement agencies are different, and are consistent with required policies and procedures. We find no evidence of duplicative efforts.

RECOMMENDATIONS

Based on the findings presented above, the following recommendations are made:

Recommendation 4

The Children's Administration should analyze the characteristics of re-occurrences of serious child abuse/neglect after a case is open and on recently closed cases.

[6] Per Executive Director of the Washington Association of Sheriffs and Police Chiefs.
[7] DCFS Case Services Policy Manual, Section #3240.

Recommendation 5

The Children's Administration should import Case and Management Information System data into a relational database (that contains information from additional sources) at regular intervals.

Recommendation 6

The Children's Administration should establish targets for outcome oriented performance measures.

BEST PRACTICES OF OTHER STATES

Chapter Four

Overview

This part of the report provides an overview of child welfare program reform efforts in three other states which were identified as leaders in this effort. These three states include Florida, Iowa, and Missouri. We also discuss the extent to which these efforts are applicable to Washington's child welfare program. The efforts of five additional states (Nevada, New Hampshire, South Carolina, South Dakota, and Utah) are summarized in Appendix 6.

IDENTIFYING STATES WITH PROGRAM REFORM

Numerous national organizations were contacted in an attempt to identify states that have demonstrated recent improvement in child protective practices that may be applicable to Washington. These organizations include the American Humane Association, the Child Welfare League of America (CWLA), the National Conference of State Legislatures (NCLS), the Center for Study of Social Policy, the American Bar Association, the National Association of Public Child Welfare Administrators, and the National Center on Child Abuse and Neglect. Additionally, a member of JLARC's study team attended the Fourth Annual Roundtable on Outcome Measures in Child Welfare Services that was held in San Antonio, Texas in May 1996.

From these contacts, eight states were identified as leaders in child welfare reform efforts. Three of the states (Florida, Iowa, and Missouri) were identified by many of the aforementioned organizations as progressive in their approach and have been the focus of our study. When we contacted each of the eight states, we

Changes in other states were based on opinions rather than outcome data

learned that the program changes that have been initiated are based on opinion, rather than demonstrated improvement in child safety. There is no outcome data from any of the states that demonstrates that these changes result in increasing children's safety. Therefore, we cannot conclude that any of the states that are considered leaders in reform have actually reformed their services. We do, however, provide further information about their programs.

AN OVERVIEW OF THE STATES

The following information provides a brief overview of the programs in the three key states. More detailed information about the three key states, as well as information about the five remaining states, can be found in Appendix 6.

Florida

Florida has a multiple response system

In 1993, the Florida Legislature approved legislation allowing communities and the department to develop "differential community systems" for child protection. Known as the Family Services Response System (FSRS), this alternative method is intended to offer a non-adversarial response to child abuse and neglect. It allows for an assessment of the risk, and then the delivery of services to remove that risk while providing support to the family. Law enforcement assumes responsibility for investigations. Through local initiatives such as public forums, open meetings, and other means of gathering input, the department has developed FSRF plans unique to each district. As of March 1995, 51 of the 67 counties had specific implementation dates for the FSRS. The remaining 16 counties will begin their planning process over the following year. (The state of Virginia recently passed similar legislation.)

Districts in Florida are developing specific evaluation measures which will reflect the effectiveness of the enabling legislation. Measures include the total number of children (families) served through FSRS, the number of children removed from the home, and the average cost of services. They will also include the effect of FSRS in reducing the number of children removed from the home and the reduction in child protective investigations. Plans are also underway to establish an evaluation by an independent provider.

In the town of Jacksonville, Florida, there has been a decentralization of services that involves local churches, United Way, scout troops, and other community-based organizations. The program was started with a grant from the Edna McConnell Clark Foundation. The city and county have pooled their resources which has actually increased their service level through a reduction in duplicated services. The premise of this program is that the closer the service is located to the family's home, the more likely it is to accurately assess and deliver needed services. The program has been implemented in half of Jacksonville. Outcome measures have been set by United Way, although there are no preliminary results available.

Services have been decentralized in Jacksonville, Florida

Iowa

A child protection task force was formed by the legislature in response to a need for a review of child protective investigations. Iowa was experiencing the same public outcry that most states have experienced, ranging from families who have been subject to investigations as well as professionals, including mandatory reporters, who often do not feel that investigative intervention results in satisfactory outcomes for maltreated children.

A key recommendation of the task force was the creation of pilot projects in which the department would respond to reports of child maltreatment with an assessment-based approach, accompanied by radical changes in the use of the child abuse registry. This proposal was put forth by the department because child protective services staff with experience in conducting "investigations" have long recognized the difficulty presented by their own program in adopting the same approach for each incident of child abuse reported. This "one size fits all" approach fails to distinguish between minor, isolated incidents of maltreatment and those forms which are significant, dangerous and repetitive.

Iowa has established pilot projects for a more flexible approach

The department was charged with selecting pilot areas of the state in which to initiate a new, more flexible approach in responding to maltreatment allegations. The pilot projects were to be initiated by January 15, 1996. No outcome on the success or failure of the reform has been produced.

Missouri

Missouri has also established demonstration projects for a flexible response system

During the 1993-94 Legislative Session, the state of Missouri passed a law which revised the Child Abuse and Neglect statutes. The most significant revision is the establishment of a demonstration initiative to assess the impact of utilizing two different methods of intervening when there is a report of child abuse or neglect. The law requires the Division of Family Services (DFS) to investigate some reports of abuse and neglect, but allows a family assessment on cases that do not require law enforcement involvement or removal of a child. The initiative established five demonstration sites which run for three years. They will test the philosophy of this two-track service delivery system and assess its effectiveness in improving the response of the division and the community to reports of child abuse and neglect. The division solicited proposals to work in collaboration with other local community stakeholders, such as juvenile courts, public schools, law enforcement, treatment agencies, etc.

The underlying principle of the Child Protection System is that the families coming to the attention of the division have different intervention needs and require flexible responses in order to protect children and meet the needs of the family.

The division has contracted for an independent evaluation of the demonstration projects. The evaluation will address the program outcomes and results that the site believes are important to be measured to determine the success or failure of the "two-track" system. The providers of these changed services are to include the outcomes or results expected in their proposals.

COMPARING THESE STATES TO WASHINGTON STATE

Output Versus Outcome Measures

No outcome data on the success of changes are available

Child welfare service data systems have historically been *output* versus *outcome* oriented. In other words, they track the number of referrals received, the type of abuse alleged, various characteristics of both the victims and the accused, and processing time frames. They do not analyze the effects of case management practices. Although many of the reform states have innovative projects

underway, none have outcome data available. This makes it impossible to determine the value they would add to Washington State's program. No states were able to provide an evaluation of the success or failure of their reforms, although many are underway. The state of Oregon has developed a set of outcome measures that is similar to Washington's and anticipates their first report in January 1997. Oregon is the first state to develop a measurement system with longitudinal data. Further discussion about Oregon's performance measures appears in Chapter 2.

When it was discovered that outcome data was not available on recently reformed programs, we reviewed national statistics that compare the states to each other.[1] Upon discussing these statistics with their authors, we discovered that the information is self-reported by the states, and operational definitions vary tremendously from state to state. Thus, there is no apples to apples comparison of important statistics, such as the rate of substantiated allegations and re-referrals. Furthermore, an indicator in one state may have entirely opposite implications in a neighboring state. For example, a high rate of substantiated allegations could mean a higher frequency of child abuse, or it could indicate better communication with law enforcement and more accountability for child abusers. In addition, states vary tremendously in the amount of evidence required to substantiate an allegation. A simpler example is the issue of re-referrals. One state may measure how many children are re-referred within one year, and another state might measure how many children are re-referred only if the prior referral was substantiated.

Each state defines their own measures, offering no apples-to-apples comparisons

Caseworker-to-Caseload Ratios

None of the states or nationally-based organizations that we contacted were able to provide outcome data on the effects of lower caseworker to caseload ratios. The CWLA's often quoted standard of one caseworker for every seventeen active cases is intended to be a goal for the continuing improvement of services for children. It was adopted in 1988 along with a set of standards for services, and according the Deputy Director of the CWLA, was not based on

The impact of smaller caseloads has not been measured

[1] Child Welfare League of America State Book, 1995 and Child Maltreatment 1994: Reports from the States to the National Center on Child Abuse and Neglect.

demonstrated and proven services. There are states with higher and lower caseload sizes than Washington State, but we do not have comparative data to determine if the difference in caseload size ultimately effects the safety of the child or promotes family preservation.

Commonalties With Reform States

WA State already has many services other states are just beginning to try

In Washington State, the CPS system already has many of the components the reform states are just beginning to try. This includes a multiple response system where, depending on assessed risk, an in-coming referral can receive an assessment and an investigation. Furthermore, the child may receive welfare services (in the form of day care or medical care) and the family may choose to be involved in reconciliation services. The only component of reform Washington is not using is the contracting of assessment services at the community level. None of the demonstration projects in other states have outcome data to indicate that this service delivery model makes children safer. It should be noted that Washington State's risk assessment process has served as a model for many other states.

AGENCY COMPLIANCE

Chapter Five

Overview

This chapter assesses the extent to which CPS is meeting legislative and policy established requirements for reviewing, accepting, investigating, and adjudicating an allegation of child abuse or neglect, and caseworker training. It also discusses the appropriateness of the statutes for the efficient and effective conduct of the agency mission.

REVIEW OF STATUTES

Current statutes are appropriate for CPS

Statutes governing the protection of the health and welfare of dependent children in the state are found in sub-sections of three chapters of the RCW. These chapters are also adopted in administrative policy (see WAC 388-15). Specifically, the laws governing child welfare in this state are included in:

- RCW 13.34: Juvenile Court Act - Dependency and termination of parent child relationships
- RCW 26.44: Abuse of children and dependent persons
- RCW 74.13: Child welfare services
- RCW 74.14A: Children and family services
- RCW 74.14B: Children's services
- RCW 74.14C: Family preservation services

A brief synopsis of each of the laws is provided in Appendix 7.

Through our interviews with regional management, we attempted to determine if current statutes are appropriate for the efficient and effective conduct of the agency mission, and the extent to which they

hinder the execution of CPS duties. We found that current statutes are appropriate for the agency and do not interfere with CPS's ability to carry out its daily functions and overall mandate.

STATUTORY COMPLIANCE

The following information provides our assessment of the Children's Administration's compliance with statutes that apply to the operations of the CPS program.

Law Enforcement Notification

The Children's Administration has a procedure which provides for law enforcement notification that is consistent with statutory requirements. The data we had available for our study did not indicate whether law enforcement was notified. However, we were able to check the files from our sample of 400 cases for documentation of law enforcement notification. The files in Tacoma and Everett most consistently contained a copy of the CAMIS print out that is automatically sent to law enforcement agencies in cases where it is believed the child is in immediate danger, and where the investigation reveals reasonable cause to believe that a crime against a child may have been committed.

Notification of Parental Rights

CPS complies with law enforcement and parental rights notifications

CPS is required to notify the parent, guardian, or legal custodian of a child alleged to be the victim of child abuse and neglect at the earliest possible date that will not jeopardize the safety or protection of the child in the course of the investigation. CPS is also required to provide notification of temporary custody and due process rights to parents or legal guardians of children who are removed from their homes. The data we had available did not indicate whether a notice of parental rights was issued.[1] However, in our review of sample files, we did find that case files contained a copy of the signed Temporary Custody Notification Form, which is used by DSHS to inform parents of their rights.[2] Furthermore, we were informed that

[1] DSHS has a duty to notify parents or legal guardians of their rights as specified under WAC 388-15-134.

[2] This form (DSHS 09-731) is included under a publication entitled *Parent's Guide to Child Protective Services*. This publication informs parents of their legal rights and the form is signed by the parent and the caseworker and filed as part of the case record.

judges routinely verify notification of parental rights during hearings, prior to ruling on actions that remove children from their homes.[3]

Caseworker Training

CPS policy does not comply with the statutory caseworker training requriements

RCW 74.14B.010 directs DCFS to establish minimum standards of training and competency for its caseworkers. This law directs that "comprehensive training for caseworkers shall be completed before such caseworkers are assigned to case-carrying responsibilities without direct supervision." However, the statute does not specify what comprehensive training should include. Contrary to this statutory directive, current DCFS policy does not require caseworkers to complete any required training prior to carrying caseloads without direct supervision. In practice, regional offices may assign caseworkers to work and train under the guidance of a senior caseworker, however this practice is not required.

COMPLIANCE WITH AGENCY POLICIES

Agency policy is established in the DCFS Practices and Procedures Guide, which is designed as a reference to assist caseworkers in the execution of their duties.[4] This guide establishes the practices and procedures which govern caseworkers in CPS, FRS, CWS, and Case Supports. Our report is limited to a compliance assessment of the CPS section of the guide. An overview of the policies governing case intake and investigation is provided in Chapter 3.

Ninety-Day Rule[5]

CPS does not fully comply with the 90 day rule

According to this rule, CPS is supposed to close all investigations of child abuse and neglect within 90 days of receiving a referral. Additionally, the social worker is supposed to achieve one of three outcomes for the investigation: 1) a written, voluntary service agreement with the family, which is signed by the family members; 2) a dependency action filed in juvenile court; or 3) closure of the referral.

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[3] Interview with Barb Meyers, Region 3.
[4] Agency policy is also established in WAC 388-15.
[5] DCFS Practices and Procedures Guide, section 2520 and 2530 and WAC 388-15-132 (3)(e).

Our review of CAMIS database records show that of 41,000 referrals accepted for investigations in FY 95, investigations were closed within 90 days for 52 percent of the referrals.

Caseworker Training

Children's Administration caseworkers are required by law and departmental administrative policy to complete training in several different areas. Course work is generally provided by the Training Center, which is operated by DSHS. Specialized training is occasionally contracted-out to other organizations with expertise in the specified topic.

CPS does not adequately track caseworker training

This performance audit evaluates the extent to which all CPS caseworkers have completed required training. Specialized training is required of supervisors and, in addition, training may also be developed and required by each regional administrator. We were unable to assess the degree to which CPS complies with its training policies in these latter two areas, due to the lack of centralized training records. Our focus has been on CPS caseworker training that is required by statute and policy.

Study Approach

Our study utilized a database provided by DOP for all Caseworker 1s, 2s, 3s, and 4s that were coded to the CPS program.[6] Information in this database includes the titles of the training courses, the date in which the course was taken, and the number of hours logged per course. The data represents the period beginning 1979 to present. It should be noted that CPS use of this database is inconsistent and is not mandated for the regional offices. Further, no alternative database or centralized tracking mechanism is used throughout all regional offices to maintain information on completed coursework. Thus, our discussion and findings are limited by the extent of the information available through the Human Resource Development Information System (HRDIS) database and it likely reflects an underreporting of the training that has occurred.

[6] This database, called the Human Resource Development Information System (HRDIS), is maintained by DOP and is available to DSHS and other agencies to track completed professional development coursework by employee.

We found that 15 percent (248) of the courses accounted for 75 percent (186,900) hours of training. From a review of the course titles, it appears that the subject areas for the courses were consistent with the professional development and duties of CPS caseworkers. Examples of these course topics include: child abuse investigative techniques, permanency planning, risk assessment training, child placement training, computer applications, interviewing techniques, and substance abuse training.

Our database included 27,768 classes spread over 3,849 course titles.[7] However, identifying and grouping selected course titles for specific subject areas was a task that surpassed our available resources. Thus, for purposes of this report, course titles which were identified through discussion with DCFS staff or closely matched the required topic were grouped and analyzed.

Exhibit 6 provides the compliance levels with required training for staff. A brief description of the training, and additional requirements is provided in Appendix 8.

Exhibit 7
Percentage of CPS Caseworkers in Compliance With Required Training

Training Requirement	Percentage in Compliance
Diversity	45%
Academy[8]	37%
CAMIS (computer)	27%
Social Service Payment	16%
HIV/AIDS Prevention	13%
Orientation	7%
Sexual Harassment	3%
Ethics	3%
Safety Orientation	3%
Non-discrimination	1%

[7] Since this database includes training for all DCFS employees, only the records for those employees who carried CPS cases for the period of our study were analyzed.

[8] Academy training is given in a series of three, week-long courses.

Based on the limited extent of the information provided above, it appears that DCFS caseworkers are not receiving all the required training as mandated in agency policy. Furthermore, DCFS policy is not in compliance with the state statute requiring caseworkers to complete specific coursework prior to carrying cases.

FINDINGS AND CONCLUSIONS

Management controls for meeting investigation and training time frames need strengthening

We find that CPS is generally in compliance with the time frames governing the initial screening and acceptance of a referral for investigation.

We also find that DCFS is not complying with the agency policy which requires investigations to be closed within 90 days. Further investigation is needed to determine why many referrals are out of compliance with this standard, and to identify strategies to either improve compliance and/or modify this standard. (Recommendation 1 in Chapter 2 addresses this finding.)

We further find that DCFS management and its caseworkers would benefit from formalized policies governing the timing of coursework requirements for caseworkers.

DCFS management would also benefit if they were to mandate all regions and regional offices to make use of the HRDIS database maintained by DOP.

RECOMMENDATIONS

Recommendation 7

The Children's Administration should modify current departmental policies governing employee training to include the specific time frame and prerequisite completion of coursework requirements for caseworkers.

Recommendation 8

The Children's Administration should utilize the Department of Personnel's Human Resource Development Information System (HRDIS) to monitor compliance with coursework requirements.

Recommendation 9

The Children's Administration should report back to the Joint Legislative Audit and Review Committee by January 1, 1998, on the progress of addressing the findings and implementing the recommendations of this report.

SCOPE AND OBJECTIVES

Appendix 1

SCOPE

The scope of this audit shall include the operations of the Child Protective Services (CPS) within the Division of Children and Family Services of the Department of Social and Health Services (DSHS). The audit shall be limited to the mandates, policies, management practices, and operations related to conducting investigations and processing caseload.

OBJECTIVES

Caseload Management

A. Statutory Compliance

- Evaluate if CPS is in compliance with statutory and other legislative mandates.
- Evaluate if current statutes are appropriate for the efficient and effective conduct of the agency mission.

B. Performance Measures, Quality Control, and Best Practices

- Evaluate the adequacy of performance measures that are used to assess caseload management practices.
- Determine how quality control for caseload management is maintained, especially during turnover of caseworkers.
- Review the best practices of caseload management strategies and policies in other states and determine if Washington can benefit from these strategies and/or policies.

C. Regional Management and Training

- Evaluate the consistency of caseload management practices between regions.
- Evaluate the extent to which adequate and timely training is provided to caseworkers and staff.

Investigatory Practices

A. Statutory Compliance

- Determine if investigative practices and protocols are implemented within the parameters established by statute.
- Determine if investigative practices and protocols comply with state and federal laws governing and protecting individual rights.

B. Performance Measures, Quality Control, and Best Practices

- Evaluate the adequacy of performance measures used to assess investigative practices.

C. Regional Management

- Evaluate the consistency of investigatory practices between regions.
- Evaluate the extent to which adequate and timely training is provided to investigatory staff.

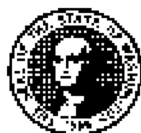
D. Duplication of Effort

- Determine if the investigative practices duplicate the services of other agencies.

AGENCY RESPONSE

Appendix 2

- Department of Social and Health Services
- Auditor's Comments to Agency Response
- Office of Financial Management



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia WA 98504-5000

December 30, 1996

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JLARC

Cheryle Broom, Legislative Auditor
Joint Legislative Audit and Review Committee
506 16th Avenue SE
Olympia WA 98501-2323

Dear Ms. Broom:

This letter is the Department of Social and Health Services (DSHS) formal response to the recommendations made in the Joint Legislative Audit and Review Committee (JLARC) Child Protective Services Preliminary Report.

The Children's Administration (CA) appreciates the hard work and analysis provided by your staff. We found the statistical work particularly useful in helping the CA begin to look at data in new and creative ways. Additionally, we thank the committee members for their continuing interest and support of children's issues and programs.

As you requested, we have responded in grid format which is attached to this letter as an appendix. We have included a narrative for certain points in each chapter which bear clarification.

Chapter 2

<u>Case Movement and Risk Assessment</u>

There is no investigation (face to face) on the majority of intakes that are given an initial risk tag of 1 or 2. Therefore, the comments in the JLARC Preliminary Report refer to cases assessed as moderate or high risk at intake, not all intakes accepted by the CA. Using 1995 statistics, there were 76,342 referrals to CPS and 51.3 percent or 39,180 of those were accepted for investigation. The remaining 48.7 percent were screened out.

In several places throughout the state, the Division of Children and Family Services (DCFS) refers low risk cases directly to an alternative response system (ARS) also called continuum of care projects. If the cases referred to ARS (3,042) are added into the total accepted cases (39,186), there were 42,223 cases in 1995 eligible for investigation.

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Of those, 9,063 or 21.5 percent, were classified level 1 or 2 at intake and received a low standard of investigation (no one saw caretaker or child and no finding was made). If the ARS cases and the low risk cases that were not investigated are deducted, the JLARC report is actually based upon 30,117 cases or 39 percent of the total intakes in the system in 1995.

Case Assessment and Planning

It is unclear how long a social worker spends on investigation. The JLARC report states that only 52 percent of referrals investigated were closed within 90 days. Many investigations are most likely completed the same day they are conducted, while others take longer. What is clear is that many social workers do not complete their paperwork in a timely fashion although their work with the family is complete within the 90-day period.

Case Summary Assessment (completion)

In its report, JLARC makes a finding that 40 percent of CPS intakes are unfounded or inconclusive and that these cases either should not have been investigated or would have been founded if more time had been spent on the investigation. This assumption is incorrect for several reasons. First, a case cannot be founded just because the social worker thinks abuse occurred, absent sufficient evidence.

Second, risk is assigned at intake based on several criteria, including age of the child, reported caretaker impairments, chronicity of abuse, etc. The risk assessment guidelines indicate that a baseline level of risk is established based on the highest level of risk for individual risk factors present in a given case. For example, a child under age 5 is automatically given a risk tag of 5 unless there are mitigating factors to lower the initial risk rating.

Several years ago, the CA looked at the issue of changes in the level of risk from intake to after investigation and found that children under age 5 who were reported for neglect concerns (lack of supervision, etc.) were being classified low risk and not investigated. This practice left some children in potentially dangerous situations. A policy, therefore, was instituted that all referrals about children under age 5 should be classified at least moderate risk and receive a high standard of investigation (face to face).

Even though some of these cases may not be founded after investigation, the CA felt it was important to be cautious because of the vulnerability of young children. This policy, in part, explains why there is a large number of intakes that receive initial risk tags of 3, 4, and 5 at intake, but are lowered to 1 or 2 after investigation.

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JLARC focused on the issue of substantiation in Chapter 2 of its report; however, the Washington risk assessment model was created was to focus on "risk" not findings of abuse. The 90-day rule allows social workers to keep "risk" cases open for services even if the case is not "founded."

The report also implies that a 60 percent substantiation rate is too low. The argument is made that the substantiation rate would be higher if social workers spent more time on investigations. Yet, the report also argues that the 40 percent of cases not founded indicates that social workers are unnecessarily involved in too many families' lives. It is not clear how these assumptions should be interpreted.

Time to Complete Intake Investigation and Quality Control

The data extract used by JLARC was predominantly based on a program designed by the Office of Children's Administration Research (OCAR) for a federally-funded study to evaluate decision-making in CPS. The data was "cleaned" to address inaccuracies of inconsistencies in the data. OCAR researchers identified three major problems with the estimate of 120 or 130 days for the mean "time to complete an investigation" reported by JLARC which indicated specific adjustments that were needed to use the data accurately:

- The numerical value is overstated due to inadequate cleaning of the data set before calculation. Many cases will show multiple referrals on a given family, often over an extended length of time, but only the last referral received actually is connected to the summary assessment. However, in extracting the data from CAMIS, the summary assessment is associated with the first referral, leading to a calculated length of service that is spuriously long. To avoid this problem, OCAR first unduplicated the data set to avoid making these false associations. The mean value after such cleaning is 77 days (median 49 days). To further insure against false associations, we deleted all cases that had a length of service greater than 240 days. A survey of a random sample of 100 of the deleted cases revealed that the summary assessment information showed that 32 percent of them was not all related to the referral information (totally unconnected cases and investigations). The mean of this truncated subset is 62 days (median 43 days).

- Whether the data set is cleaned up or not, the mean is a misleading measure of how long the vast majority of cases take to investigate, because the distribution of times is highly skewed (long "tailing" to extremely long times). The standard statistical measure of what is called "central tendency" or the value that accurately represents the majority of cases is not the mean but a mean adjusted for the tailing in the data. This adjustment provides a measure that most people find much more intuitively

accurate when they examine the full distribution of the data. The value of this adjusted mean for all referrals is 48 days and for our truncated data set is 44 days.

- Regardless of which measure of central tendency is used, the variable assumed by JLARC to represent time of investigation is not related to time of investigation. JLARC assumes that the length of service (the CAMIS variable used to calculate their and our estimates, the time between referral date and summary assessment completion date) is a suitable proxy of the time it takes to complete an investigation. In our experience, and our interviews with caseworkers, this is not correct: the length of service has little or nothing to do with the time it takes to investigate a case. Rather, it reflects the administrative and paperwork requirements placed on caseworkers, and the extremely high workload most caseworkers face. Caseworkers also frequently hold cases open waiting for information from other sources to come in, reports from monitoring of the client, etc. In other words, they more than likely complete their portions of case investigation relatively quickly and then put off the paperwork until the last minute. If the agency had a 120-day rule, the mean would likely increase by about 30 days, and if it had a 60-day rule, the mean would decrease by about 30 days, with little impact on the mean time of investigation. There is currently not a "time-to-investigate" variable in CAMIS and thus this question cannot yet be answered properly.

Effects of Caseload Size

The total number of social workers in DCFS is 862. Each month an average of only 292.2 FTEs were assigned to the CPS category statewide. These FTEs do the vast majority of the CPS investigations. Even if the FTEs doing CPS intake are added, the total CPS FTEs is 369.4 not 420 FTEs as the report states.

Evaluating Caseload Versus Workload

Case-weight assessment is currently being done informally by every DCFS supervisor and cases are being assigned accordingly.

General Comments

The JLARC investigators interviewed a number of CA staff. They were told several times about a number of projects the Children's Administration has undertaken in recent years yet there is no recognition in the report of these projects. Specifically, the National Council on Child Abuse and Neglect funded a 3-year CPS decision-making project. The primary purpose of the grant is to research the risk assessment process

and make recommendations on how to improve its efficiency and effectiveness. The database the CA developed for this project was used by JLARC to conduct its analysis.

In their discussion of caseworker training and workload, JLARC did not reference the CA's initiative in conducting the workload study. Specifically, the report did not acknowledge that the CA has already determined that for social workers to fully comply with law and policy, additional workers are needed.

Chapter 3

The JLARC Report fails to recognize that the CA established outcome measures for the 1997 - 99 budget proposal. The CA recently established a quarterly reporting requirement by the regions. In the past, there was no formalized, systematic method by which to collect performance or outcome measures.

Chapter 4

The JLARC Report does not recognize that Washington State is a national leader in risk assessment.

Chapter 5

90-Day Rule

As stated previously in this response, the CAMIS database shows only the number of summary assessments completed within 90 days. Investigations could have been completed and the summary assessment not yet entered onto CAMIS.

Caseworker Training

The JLARC finding on compliance with caseworker training was based on records, in the Human Resource Development Information System (HRDIS) for the Academy course. Currently, the JLARC findings initiated the CA review of previous Academy training. This training is either listed in HRDIS under other course titles or was not fully documented. The Division of Management Services is currently reconciling training records for caseworker academy training.

The Children's Administration is re-evaluating its current policy to clarify mandatory training. This revised policy will provide clearer direction to offices and regions on required training and timelines.

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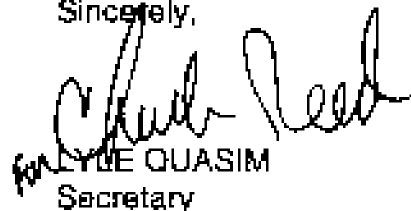
The CA policy is that social workers must be supervised if they are carrying cases before completing the Academy Training. A statutory change may be needed because it is difficult to implement the current statutory requirement given the high caseloads, large span of control for supervisors and the three month period it takes to complete Academy Training.

Thank you for the opportunity to comment on the Preliminary Report.

Sincerely,



for LYLE QUASIM
Secretary

Auditor's Comments on the Children's Administration's Response to the Preliminary Report of the Child Protective Services Performance Audit

The agency's partial or full concurrence with all of the recommendations demonstrates a commitment to further evaluating the quality and efficiency of Child Protective Services. Their comments are extensive and the JLARC auditors wanted to clarify some of the information they have presented. The first section, below, pertains to the agency's narrative remarks. The second section pertains to their appendix, which provides comment on each of the recommendations.

Auditor's Comments to Agency Response - General

1. On page 2, the agency states that it is unclear how long a social worker spends on investigations, and that the low rate of compliance with required time frames is due to a delay in completing paperwork. When we discussed this with the agency, we were informed that there was a policy decision to count the date the paperwork is completed as the case closure date. Our analysis was conducted accordingly. An important point is that no one, including the agency, knows how long it takes to complete investigations, other than the paperwork completion date.

2. On page 2, the agency states that JLARC makes a finding that the unfounded and inconclusive cases should not have been investigated. This is likely a misinterpretation. JLARC's finding is that it takes a median of 68 days, and an average of 130 days, to reach case closure on unfounded and inconclusive referrals, and that this practice has many impacts. The resulting recommendation is that the characteristics of these cases should be analyzed to identify strategies to shorten the number of days to case closure. The auditors want to be clear that all allegations should be taken seriously so that judgment continues to err on the side of child safety, as required by statute. We believe shortening the number of days to case closure, particularly for unfounded cases, will allow resources to be re-directed to the more serious cases of child abuse and neglect.

3. On page 3, the agency states that the audit report implies that a 60 percent substantiation rate is too low, and that social workers are unnecessarily involved in too many families' lives. The auditors do not make this implication. The auditors provide readers with the impacts of investigating allegations that are eventually determined to be unfounded or inconclusive. These cases represent 40 percent of the referrals that were accepted for investigation and which take a median of 68 days to close. Our corresponding recommendation proposes a method of mitigating impacts, while still erring on the side of child safety.

4. On page 3, the agency states that the numerical value for the time to complete an investigation is overstated due to inadequate "cleaning" of data. The agency shared their methodology of cleaning data for their federally funded CPS Decision-making Study. Our uses of the data differed, and it was our consultant's opinion that removing data from the data set would not provide an accurate accounting of the actual practices of the agency. Both the median and average number of days to reach case closure are provided in the report to demonstrate the full range of data. The agency's statement that only the last referral received is actually connected to the summary assessment is incorrect.

5. Pages 4 and 5 contain numerous statements about the preliminary report that are inaccurate. For instance, the agency response says the number of FTEs for CPS is 369.4, not 420 FTEs as the report states. However, the agency provided the original number of 420 FTEs when the study was being conducted. In Chapter 3, there is extensive discussion about the agency's inclusion of performance and outcome measures in its recent biennial budget request. The agency response says the JLARC report fails to recognize this fact. Additionally, page 23 of the preliminary report discusses that Washington State's risk assessment process is viewed as a model for many other states. The agency's reply says that the JLARC report fails to recognize this fact.

   The agency's response reflects information from an earlier working draft of the report, and it is possible that the staff responding for the agency were working from that draft rather than the preliminary report. The agency was involved in a technical review process at which time technical corrections were made which are reflected in the preliminary report.

Auditor's Comments to Agency Response - Recommendations

Recommendation 1: The Division of Children and Family Services should analyze the characteristics of unfounded and inconclusive referrals and identify strategies that will shorten the time it takes to reach case closure.

Agency Position and Comments: Partially concur. It is unclear from the report that this recommendation applies only to risk levels 3, 4, and 5. To accomplish this recommendation would require additional resources.

Auditor's Comments: This recommendation applies to all referrals which are eventually determined to be unfounded or inconclusive. The purpose of the recommendation is to enable the agency to direct resources toward the more serious cases and away from cases whose allegations are eventually determined to be unfounded or inconclusive.

Recommendation 2: The Division of Children and Family Services should evaluate the workload requirements of the various types of referrals and redistribute its workforce as appropriate.

Agency Position and Comments: Partially concur. DCFS has already evaluated the workload of its social workers; however, caseload size does not equate to workload for each social worker. The Children's Administration (CA) does not believe simple redistribution of workforce is the answer to increase consistency of findings. A reduction in workload is necessary.

Auditor's Comments: The performance audit supports the DCFS Workload Study, stating that "caseload size does not accurately reflect the amount of work required of caseworkers." The primary problem with only using the Workload Study is that it averages the amount of time spent on caseworker activities, and does not address the disparity in the workload between offices around the state. The goal of the recommendation is to provide a more even distribution of resources that is based on workload. The need for any additional resources is a separate issue that could not be evaluated prior to implementing this recommendation.

Recommendation 3: The Division of Children and Family Services should evaluate best practices in its field offices to assess if opportunities exist to improve performance.

Agency Position and Comments: Concur. CA just held a two-day "Best Practices" conference to share new and creative ideas. Additional resources for the Quality Assurance Unit would be necessary to accomplish this statewide.

Auditor's Comments: An analytical model was developed during the performance audit using data from four sources to determine offices with best practices. Subsequent use of this model by DCFS would assist the agency in identifying the characteristics of best practices to assess if opportunities exist to improve performance.

Recommendation 4: The Children's Administration should analyze the characteristics of re-occurrences of serious child abuse/neglect after a case is open and on recently closed cases.

Agency Position and Comments: Concur. The Office of CA Research began analyzing this data before the JLARC audit was commenced. This study is part of the CPS Decision-making Grant.

Auditor's Comments: When the grant expires, the rate of re-occurring child abuse will still be a critical outcome measure. The recommendation is intended to support this on-going effort by the agency.

Recommendation 5: The Children's Administration should import Case and Management Information System data into a relational database (that contains information from additional sources) at regular intervals.

Agency Position and Comments: Concur. The CA is beginning to implement a "data warehouse" which will be a relational database containing CAMIS data. It will support, over time, relevant data from additional systems. The database will provide query tools that will allow CA system users and managers to obtain and analyze summary level data for improved decision making.

Auditor's Comments: The recommendation is intended to support this on-going effort by the agency.

Recommendation 6: The Children's Administration should establish targets for outcome-oriented performance measures.

Agency Position and Comments: Concur. Meaningful targets can be set only after an initial baseline is established. The CA will soon have the capacity to establish this baseline.

Auditor's Comments: None.

Recommendation 7: The Children's Administration should modify current departmental policies governing employee training to include the specific time frame and prerequisite completion of coursework requirements for caseworkers.

Agency Position and Comments: Concur. This recommendation is already included in the draft CA Operations Manual.

Auditor's Comments: None.

Recommendation 8: The Children's Administration should utilize the Department of Personnel's Human Resource Development Information System (HRDIS) to monitor compliance with coursework requirements.

Agency Position and Comments: Partially concur. The CA Academy is now provided in-house. As a result, the CA is in a better position to ensure that the academy training is documented. The CA will reconcile social worker academy training attended by existing caseworkers. HRDIS still has limitations in tracking all CA training.

Auditor's Comments: The agency does not adequately track or monitor training that is required by statute. When we asked for the information, the agency directed us to the Department of Personnel's HRDIS program.

Recommendation 9: The Children's Administration should report back to the Joint Legislative Audit and Review Committee by January 1, 1998, on the progress of addressing the findings and implementing the recommendations of this report.

Agency Position and Comments: Partially concur. Reporting back to JLARC in a year is not problematic. However, unless new resources are in place by that time, not all recommendations with which the CA concurs will be in place.

Auditor's Comments: The recommendations are focused toward more efficient use of existing resources, rather than an assumption that additional resources are necessary. In the absence of adequate outcome data about the *quality* of services, we were unable to determine the need for additional *quantities* of services. We recognize this difference of opinion with the agency.

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December 31, 1996

Cheryle A. Broom, Legislative Auditor
Joint Legislative Audit and Review Committee
Post Office Box 40910
Olympia, Washington 98504-0910

Dear Ms. Broom:

Thank you for providing the Office of Financial Management (OFM) the opportunity to review the preliminary report on Child Protective Services.

OFM has been coordinating the Management Improvement Project of the Children and Family Services Division of the Department of Social and Health Services (DSHS). Work on the project is being conducted by Deloitte and Touche. A draft report on the initial phase of their work addresses some of the issues raised in the preliminary report.

Deloitte and Touche have indicated in the draft report that the response time for most Child Protective Services referrals were in compliance with DSHS policy. Based upon a review of the first 100, of a proposed 320 cases, 88 percent of the emergent referrals were within a 24 hour time frame and 88 percent of all non-emergent referrals, for which data were available, were within a 10 day period.

The preliminary report reaches a similar conclusion in that 96 percent of the emergent referrals and 99 percent of the non-emergent referrals received a response within prescribed time limits. The variance between the two conclusions of the two studies may be attributable in part to differences that Deloitte and Touche have identified in the information contained in CAMIS and case record files.

If you should have any questions on the Management Improvement Project, please contact Russ Lidman of OFM at (360) 902-0650.

Sincerely,

Gary S. Robinson

Gary S. Robinson
Acting Director

TECHNICAL APPROACH TO VALIDATION OF DATA

Appendix 3

In support of this performance audit, the Division of Children and Family Services was requested to provide a download of computerized records maintained for all accepted referrals for the period July 1, 1994, through June 30, 1995. This data set contained approximately 70,000 referrals and 64 variables of information for each referral.

This data set is also being used by the Office of Children's Administration Research (OCAR) to conduct a federally funded CPS decision-making study. For the purposes of this federal study, OCAR truncated the data set, excluding: 1) cases with a length of service beyond 240 days and all or most of the risk variables and/or overall risk labeled insufficient, not applicable, or missing; 2) cases with a review or transfer status; 3) multiple abuse cases and cases with type of abuse entirely missing; and 4) cases with any of the risk assessment matrix variables missing or labeled "insufficient information to assess." Since truncating the data in this manner would have excluded a large number of the cases that were appropriate to be included within our analysis, we used the entire data set.

In order to ensure that this data was accurate, our validation effort compared selected records in the data set with hard-copy printouts maintained in the individual case files. The purpose of this effort was to ensure that the computerized records downloaded to JLARC were correctly correlated to actual case file printouts. The validation effort did not attempt to assess whether information from handwritten documents was correctly transferred to the computer.

A stratified random sample of 400 referrals was selected for this validation effort. This sample size provides a confidence level of 95 percent and 5 percent margin of error. The sample was weighted for the relative distribution of referrals among the 44 offices within each of the 6 DCFS service regions. For each referral in the sample, 16 of the 64 variables provided were selected to validate the data. These 16 variables were considered fundamental to our analysis and any significant problems with these variables would compromise the integrity of the rest of the audit.

Our validation effort was conducted in two phases. Phase one included a pre-test within the Olympia and Tacoma DCFS offices to estimate the amount of time required to validate the entire sample and to refine our field validation forms.[1] During phase two, we requested

[1] During this process it was discovered that the data was corrupted when it was downloaded to our computer. A second data was received, and the validation process was successfully completed.

DCFS to centralize the selected sample of referrals to one or two offices within each region to expedite our validation effort. Reviews were conducted in the DCFS offices located in Spokane, Yakima, Everett, Seattle, Bellevue, Tacoma, Olympia, and Lacey. Staff from the House Appropriations Committee and the Senate Ways and Means Committee assisted in the field validation.

Our validation effort determined that the data set received was accurate, with an average error rate of less than one percent within each region. This error rate is well within the acceptable range of error for determining the statistical validity of this database.

SUMMARY OF CONSULTANT'S ANALYTIC MODEL AND METHODOLOGY

Appendix 4

Background

Several electronic databases were provided for this report. Analysis of the data were completed in Microsoft Access for Windows version 7.0 and SPSS Base 7.0 for Windows. These programs were used to analyze case management practices for the fiscal year ending June 30, 1995.

The databases analyzed included the following:

- Case and Management Information System (CAMIS) download for FY 95 for referrals with and without summary assessments.
- Human Resource Data Information System (HRDIS) for the years 1979-present, Department of Personnel.
- DSHS, Division of Personnel Services, Personnel appointment data for the period 7/1/94 to 6/30/95.
- DSHS, Division of Personnel Services, Personnel actions data for the period 7/1/94 to 6/30/95.
- DSHS, Division of Personnel Services, Personnel years of experience for current caseworkers.
- DSHS, Division of Personnel Services, Personnel demographics.
- DSHS, Division of Personnel Services, Organizational titles and codes.

Approach

The consultant performed bivariate and multivariate regression analysis using SPSS. Correlation coefficients (Pearson's r) were used to analyze the strengths of associations between two or more variables.

In addition, a theoretical model was developed based upon these correlation coefficients. This model was used to illustrate the flow of a referral and the influence key variables may have at various stages during an investigation of a referral.

Analysis of the data focused primarily upon the CAMIS database provided to JLARC. This database included 41,660 referrals for the fiscal year ending June 30, 1995. For each referral, 64 variables were provided. Our analysis did not use all 64 variables as not all were relevant to our study. Summarized below, are the 16 CAMIS key variables and 5 additional personnel variables which were selected and analyzed:

- Age of victim - age of the child victim identified in the referral.
- Child abuse and neglect codes - type of abuse or neglect.
- Lag in time from receipt to decision date - number of days elapsed from time of referral receipt to decision date.
- Lag in time from receipt to summary assessment date - number of days elapsed from time of referral receipt to summary assessment date.
- No. of prior referrals - number of prior referrals.
- Number of hours per completed training course - number of hours of credited for the training course.
- Office number - unique three digit numeric code identifying the location of the DCFS office.
- Overall findings - assessment of the allegation of abuse or neglect (founded, unfounded, or inconclusive).
- Overall risk tag - final risk tag of the referral.
- Placement code - placement outcome of the child.
- Referral decision date - date the referral was accepted for investigation.
- Referral received date - date the referral was received.
- Referral response code - 24 hours (emergent) or 10 days (non-emergent) response standard.
- Referral risk tag - initial risk tag of the referral.
- Referral standard of investigation - standard of investigation (high or low).
- Region number - unique single digit numeric code identifying the region of the state.
- Summary assessment date - date in which a summary assessment was completed.
- Title of training courses - title of training course completed by caseworker.
- Worker hire date - date in which worker was appointed as a caseworker.
- Worker ID number - unique six character alpha numeric code identifying caseworker on referral.
- Worker social security number - unique nine digit numeric code identifying caseworker (used to determine training courses completed).

About the Consultant

Dr. Lowell “Duke” Kuehn is a principal with the consulting firm of Pacific Northwest Consulting Services. In addition, Dr. Kuehn is a professor with The Evergreen State College, Master’s of Public Administration Program.

CHILDREN'S ADMINISTRATION PERFORMANCE MEASURES

Appendix 5

The following lists the performance measures developed by Children's Administration which were included in their 1997-99 proposed biennial budget to the Governor.[1]

Child Safety - Keeping children safe from serious maltreatment in their own homes, in child daycare, and in out-of-home care settings.

Number of abuse or neglect related child deaths on open cases and on recently closed cases - calendar year.

Re-occurrence of serious child abuse/neglect after a case is open on recently closed cases.

Child and Family Health and Well Being - Helping families and communities safeguard and improve the well being of children.

Percent of CPS families receiving in-home services paid through the Social Services Payment System.

Percent of children entering placement after Intensive Family Preservation Services, by ethnicity.

Available licensed child day care slots per 100 children aged 0-12 years.

Children reunited with family.

Percent of children in placement with less than two placement moves.

Permanency - Accomplishing timely resolutions to out-of-home placements for children who must be removed from the care of their parents.

[1] 1997-99 Biennial Budget request for the Department of Social and Health Services, Children's Administration, Form B-11 dated 8/23/96.

Average number of days from initial placement to end of placement episode, by ethnicity.

Rate of kinship care use for children in out-of-home placement (percentage).

Management Improvements - Maintaining strong administrative performance and budgetary accountability.

Percent of regional FTE expenditures within plus or minus 5 percent of allotments.

Percent of regional budgets within plus or minus 5 percent variance.

Percent of regions achieving at least 100 percent of projected revenue target.

Percent of regions achieving 90 percent of affirmative action goals for new hires.

OVERVIEW OF THE STATES

Appendix 6

Florida

The state of Florida has made recent changes at the state level and in the town of Jacksonville. At the state level, there has been a movement away from the Department of Health and Rehabilitative Services (HRS) conducting investigations of child abuse and neglect to that being a function of law enforcement. The HRS has developed a plan that moves towards a family-centered service that supports and preserves families while working in partnership with the community. The following were the basic tenants of these reforms:

- The system must be less adversarial and more family centered.
- Communities must work in partnership with the department in supporting and preserving families.
- Services must be provided in the least intrusive way possible.

The communities' key stakeholders in the child protective service arena and the department developed a core set of values to guide the reform of child protection in Florida. The values are:

- Every Florida child should have a permanent family to support and nurture his/her growth in an environment free of neglect and abuse.
- Families are competent caretakers and providers for their children, and they should have the opportunity to receive assistance on a voluntary basis in the least intrusive and most positive manner possible when needed.
- Children can be protected through early assessment and family-centered, supportive services to preserve the family and when appropriate, reunified with parents.
- Communities are responsible for providing safe and secure neighborhoods with supports and services available and accessible for families.
- Removal of a child is still necessary when families are not willing or able to become competent caretakers.

- Children who cannot continue to live with their birth families should be placed with relatives, with other families, or in an independent living arrangement within a time frame that meets the children's needs.

- The key function of HRS-funded services should and must be child and family assessments, and the oversight of the provision of needed services to protect the child and support the family.

In 1993, the Florida Legislature approved legislation allowing communities and the department to develop "differential community systems" for child protection. Known as the Family Services Response System (FSRS), this alternative method is intended to offer a non-adversarial response to child abuse and neglect. It allows for an assessment of the risk and then, the delivery of services to remove that risk while providing support to the family. Law enforcement assumes responsibility for investigations. Through local initiatives such as public forums, open meetings, and other means of gathering input, the department has developed FSRF plans unique to each district. As of March 1995, 51 of the 67 counties had specific implementation dates for the FSRS. The remaining 16 counties will begin their planning process over the following year.

The program description for Florida refers to the development of specific outcome evaluation measures which will reflect the effectiveness of the enabling legislation. Some of the measures listed are quantitative outputs, not outcomes. For example, outcome measures include the total number of children (families) served through FSRS, the number of children removed from the home, and the average cost of services. These are quantities of service, not the effects or outcomes as a result of the services. Additional measures are outcome oriented and include the effect of FSRS in reducing the number of children removed from the home and the reduction in child protective investigations. Plans are also underway to establish an evaluation by an independent provider.

In the town of Jacksonville, Florida, the city and county have pooled resources which has actually increased service levels through a reduction in duplicated services. Services are now provided by local churches, United Way, scout troops, and other community-based organizations. The premise of this program is that the closer the service is located to the family's home, the more likely it is to accurately assess and deliver needed services. The program has been implemented in half of Jacksonville. Outcome measures have been set by United Way, although there are no results available.

Iowa

A child protection task force was formed by the legislature in response to a need for a review of child protective investigations. Iowa was experiencing the same public outcry that most states have experienced, ranging from families who have been subject to investigations as

well as professionals, including mandatory reporters, who often do not feel that investigative intervention results in satisfactory outcomes for maltreated children. A key recommendation of the task force was the creation of pilot projects in which the department would respond to reports of child maltreatment with an assessment-based approach, accompanied by radical changes in the use of the child abuse registry. This proposal was put forth by the department because child protective services staff with experience in conducting "investigations" have long recognized the difficulty presented by their own program in adopting the same approach for each incident of child abuse reported. This "one-size-fits all" approach fails to distinguish between minor, isolated incidents of maltreatment and those incidents which are significant, dangerous, and repetitive.

The department was charged with selecting pilot areas of the state in which to initiate a new, more flexible approach in responding to maltreatment allegations. Key components of this legislation, and rules and policies which accompany it are:

- The department's response to a report of child abuse will be determined by *each unique situation* and will be driven by an assessment of the *child's safety* and the *family functioning.*

- *Only* maltreatment which is significant will result in placement in the child abuse registry.

- *All* case information will be maintained, either as open or closed, in assessment service files.

- Far greater emphasis is placed upon a *strength-based assessment* of the family where a full assessment is necessary; less emphasis will be placed on the isolated incident reported.

- There is greater reliance on identification of *non-traditional services of supports* for children and families.

Italics, above, were provided with the state of Iowa information packet.

The pilot projects were to be initiated by January 15, 1996. No outcome on the success or failure of the reform has been produced.

Missouri

During the 1993-94 Legislative Session, the state of Missouri passed a law which revised the Child Abuse and Neglect statutes. The most significant revision is the establishment of a demonstration initiative to assess the impact of utilizing two different methods of

intervening when there is a report of child abuse or neglect. The law requires the Division of Family Services (DFS) to investigate some reports of abuse and neglect, but allows a family assessment on cases that do not require law enforcement involvement or removal of a child. The initiative established five demonstration sites which run for three years. They will test the philosophy of the two-track service delivery system and assess its effectiveness in improving the response of the division and the community to reports of child abuse and neglect. The division solicited proposals to work in collaboration with other local community stakeholders, such as juvenile courts, public schools, law enforcement, treatment agencies, etc.

The division will be contracting for an independent evaluation of the demonstration projects. The evaluation will address the program outcomes and results that the site believes are important to be measured to determine the success or failure of the "two-track" system. The providers of these changed services are to include the outcomes or results expected in their proposals.

The underlying principle of the revised Child Protection System is that the families coming to the attention of the division have different intervention needs and require flexible responses in order to protect children and meet the needs of the family. The philosophical basis for the legislation includes:

- Parents have the primary responsibility for, and are the primary resource for their children.
- All child welfare intervention by state and community agencies has its first goal, the welfare and safety of the child.
- The Child Protection System must be designated to be child-centered, family-focused, community-based, and culturally sensitive.
- The division will collaborate with the community to identify, support, and treat families in a family-supportive, non-threatening manner, in both Investigative and Family Assessment situations.
- A Family Assessment approach, which stresses the strengths of the family, identifies and treats family needs, and assures the safety of the child, is the appropriate approach for cases not requiring law enforcement involvement of the removal of the child.
- Neighborhoods and communities are the primary source of opportunities and supports for families, and have a primary responsibility in assuring the safety and vitality of their members.

- Only a comparatively small percentage of current Child Abuse and Neglect reports are criminal in nature or will result in the removal of the child or alleged perpetrator.

- Division staff who co-investigate serious Child Abuse and Neglect reports with law enforcement must be competent in law enforcement procedures, fact finding, evidence gathering, etc., as well as effective social intervention and assessment.

- Service needs identified with all families should be addressed as quickly and effectively as possible by the Division of Family Services, the community, and the family making decisions.

- Services and supports for families are designed to build on the strengths and resources of families and communities.

- The Child Protection System will not unnecessarily label families or individuals as either perpetrators of abuse and/or neglect or victims of abuse and/or neglect.

New Hampshire

Although there has been no legislative change, this state has redefined its role to provide all child welfare services from a family-centered orientation. The mission of the Department of Human Services is to provide support and services to families, while investigative functions more appropriately belong to law enforcement agencies. As a result, New Hampshire's child welfare agency developed protocols with law enforcement so that a police officer and a social worker jointly contact a family in which severe injury or physical abuse to a child has been reported. In such cases, while the police officer performs the investigation, the social worker assesses the family and develops a service plan. In other circumstances where law enforcement protocols do not apply, the same comprehensive, family-centered assessment is performed. Each service plan is therefore based on a combined family systems, strengths, resources, and risk assessment which is done in concert with the family. The service plan is focused on solutions so that the family and the worker know what goals they are attempting to achieve as well as the array of resources required.

Additionally, families that have shown progress in addressing the problems that brought them to the attention of the child welfare system can enlist the help of division staff to jointly recommend that the family case be removed from the state central registry. Since this system provides families with the possibility of clearing their record, it further supports families in a non-judgmental way.

Community support for family-based child protective services in New Hampshire occurred through presentations on these services at a number of forums in all parts of the state. Interagency teams and task forces also convened to discuss changes in the provision of child welfare services.

South Carolina

Like Missouri, the South Carolina Department of Social Services built community support for dual-track services through community planning efforts around family preservation and family support services. Along with the University of South Carolina, with which the state contracted to develop its family preservation and support plan, the department is working with the state United Way agency to address child welfare issues. The department is careful not to oversell the reform because the complexity of cases requiring child welfare services cannot be addressed with one legislative change.

In order to maintain consistency of investigations across counties within South Carolina, the state wants to provide more program and resource flexibility to the counties so they can meet local needs. In order to target existing resources, the department sees the need to examine which cases make it into which tracks in order to determine if certain types of cases are over-represented. It is also undertaking an effort to determine how much of a worker's decision is predicated on resource availability and professional safety. Staff training is undergoing revision to emphasize family-centered practice and the need to intervene early by providing services to try to prevent a family from becoming abusive or neglectful.

South Dakota

There were a number of events that precipitated the state of South Dakota to develop a two-track response to providing child protective services. In late 1993, South Dakota established a working group of case workers, supervisors, and other concerned parties to identify how cases were assigned to receive either investigation or assessment services. The working group took a random sample from offices across the state and determined if the referrals involved criminal activity, whether there appeared to be risk to the child, and what might happen if an investigation had not been initiated. They found that the intake process needed to be more detailed and required collateral contacts in order to make a definite assignment in either track. Approximately 70 percent of the cases studied could have been assigned to assessment teams, and the remainder to investigators.

As a result of the study, the Department of Social Services initiated dual-track pilots in December 1994 that provide increased training on intake, changed staffing patterns, and additional criteria to guide assessments. All pilot sites have shown an increase in intake time–which averages 3 hours–due to more thorough assessments. Judith Hines, program administrator of Child Protection Services, believes that increased time at the front end allows cases to be assigned correctly, and also allows for cases requiring referrals to other services to be screened out. Ironically, there has been an increase in cases assigned to the investigative track (approximately 64 percent) and a subsequent decrease in those going to the assessment track (36 percent). Hines attributed this change to a lack of staff familiarity with new procedures, a situation that is being remedied with a revision in the competency-based training curriculum.

Important changes have resulted from the dual-track approach to serving families in South Dakota. The first is the opportunity to offer services to families who do not have substantiated cases of abuse or neglect. In addition, workers are no longer fact finders but instead provide services and support. Families assigned to the assessment track are voluntary and do not receive services unless they want them.

Utah

The Child Welfare Reform Act of Utah was developed in response to legislative concerns with the state's child welfare system. The legislation attempts to comprehensively reform all aspects of the child welfare system, including the Juvenile Court, the Division of Family Services, foster parents, and child advocates. Highlights of the bill include:

- Clarifies the primary goal and purpose of the Division of Family Services to provide child welfare services through preventive and family preservation services. However, when a child's welfare is endangered or reasonable efforts to reunify a child with his family have failed, the division shall, in keeping with its ultimate goal and purpose of protecting children, quickly provide the child with a permanent and stable environment.

- Mandates a comprehensive training program for new and existing division employees. Requires new employees to undergo a minimum level of training before being given independent case responsibilities.

- Requires the division to develop a state-of-the-art management information system. This system is to provide case workers with the information they need to effectively manage their caseloads.

- Directs the division to develop outcome measures and to annually report to the legislature on the division's performance in relation to these outcomes. Also requires the Department of Human Services to annually review a sample of child welfare and child protective services cases to ensure that state and federal law and division policies are followed.

- Institutes several new requirements governing actions that must be taken when a child is removed from his/her natural home. These include holding a shelter hearing within 48 hours from removal, requiring that notice be given to the parents, requiring that in order for the child to remain in the custody of the division that the court find clear and convincing evidence that a situation exists that endangers the child, and requiring that in most instances the court may only order reunification services for up to 12 months.

- Requires that a disposition hearing on the child's case be held within 18 months after the date of placement into the division's custody. Provides that if reunification were ordered by the court, that the court shall order the minor be returned to the physical custody of his parents unless it finds by a preponderance of evidence that return of the child would be detrimental to his/her physical or emotional well being.

- Establishes conditions when reunification services need not be provided. These include when the whereabouts of the parents are unknown; when the parent is suffering from a mental illness of such magnitude that it renders him/her incapable of utilizing those services; or, when the parent has been convicted of causing the death of another child through abuse or neglect.

Principles of the Utah Child Welfare Reform Act include:

- Children have the right and the state has a responsibility: protection and permanency.

- Both parents and children deserve careful assessment and due process.

- Evidence of abuse or neglect should be established early in the process, so that children don't languish in foster care.

- Children have the right to permanency.

- A parent's right to reunification services is limited by time and circumstances.

- The Division of Family Services should be accountable for its decisions and actions.

- Foster parents have a limited but recognized interest in children who have been placed in their homes.

- Extended family is the first choice for placement of a child.

- The Division of Family Services should take an active and responsible role in the training of caseworkers, and in the management of information regarding children who are in the welfare system.

OVERVIEW OF STATUTES

Appendix 7

RCW 13.34 - Juvenile Court Act

This act declares that the family unit is a fundamental resource of American life which should be nurtured, and further declares that the family unit should remain intact unless the child's right to conditions of basic nurture, health, or safety is jeopardized. Provisions for taking a child into temporary custody or placing a child into shelter care are established.

RCW 26.44: Abuse of Children and Dependent Persons

The bond between a child and his or her parent/guardian is declared of paramount importance, and that any intervention into the life of the child is also an intervention into the life of the parent/guardian. However, in cases of abuse or neglect, emergency intervention is justified.

RCW 26.44.030(4) & 74.13.031(3): Reporting to Local Law Enforcement

CPS is required to notify local law enforcement officials, within 24 hours, of all referrals whose response time is emergent. With the exception of a child fatality, which shall be reported to local law enforcement immediately, all other cases shall be reported within 72 hours of receipt.

If an oral report is made to local law enforcement, a written report must follow within five days of receipt of the referral.

RCW 26.44.030(10): Notification of Parental Rights

CPS caseworkers are to advise parents immediately, regardless of the time of day, that a child has been taken into custody, the reasons why the child was taken into custody, and the general information about the child's placement.

RCW 74.13: Child Welfare Services

Programs and services to safeguard, protect, and contribute to the welfare of the children are established. In addition, this chapter include crisis residential centers, child care, and sexually aggressive youth.

RCW 74.14A: Children and Family Services

Services for emotionally disturbed and mentally ill children, and nonresidential community-based treatment programs for juvenile offenders are established. This chapter reiterates the declaration of purpose in RCW 13.34.

RCW 74.14B: Children's Services

Provisions for the hiring and training of caseworkers are created. Caseworkers are required to complete comprehensive training prior to being assigned to case-carrying responsibilities without direct supervision. Training for foster parents, services to abused and neglected children, and treatment services for sexually abused children are also established.

RCW 74.14C: Family Preservation Services

This chapter states that the number of children entering foster care is increasing and that up-front services are required to decrease the number of children entering out-of-home care and to eventually lower foster care payments. This chapter establishes intensive, home or community-based, family preservation services. An annual report on the rates in which intensive family preservation services prevent out-of-home placements is due to the legislature beginning on September 1, 1997.

DESCRIPTION OF TRAINING REQUIREMENTS

Appendix 8

Academy Training (CA Operations Policy 8321)
New employees are required to receive training on the agency's mission, programs, client populations, and job-specific training to enable social workers to meet minimum standards established by the training. Enrollment in the Academy is required within 90 days of hire. Academy training is given as a series of three, week-long courses.

CAMIS Training
Employees are also provided training on the use of the Case and Management Information System, which is an automated case record system that can also produce management reports.

Diversity (DSHS Diversity Initiative)
Departmental policy requires that each region provide their employees with training on client and employee diversity, affirmative action, and non-discrimination. A course developed for DCFS employees to address this requirement was entitled "Common Ground."

Ethics (RCW 42.52.900)
Training is provided to all employees on understanding and establishing an ethical workplace. This course is required of all employees.

HIV/AIDS Prevention (RCW 7.70.065 & 70.24)
Training is provided to enhance employee awareness of HIV/AIDS, prevention of the spread of the disease, civil rights of clients, and the responsibilities of employees and service providers.

New Employee Orientation (WAC 356-39-030)
Each region is required to provide its new employees an orientation. This orientation includes an overview of required job-related training and assistance with career planning.

Non Discrimination (RCW 49.60)
Overview of the laws and agency policies against discrimination is provided. This includes employment, ethnic, religious, marital status, sexual orientation, national origin, age, disability, or veterans.

Safety Orientation (WAC 296-24-040)
Employers are required to provide a formal accident prevention program tailored to the needs of the particular sites in which the employees work.

Sexual Harassment (Executive Order 89-01)
Training is required for employees to provide and maintain a work environment free from sexual harassment for its employees.

Social Service Payment System (CA Operations Policy 8310)
Employees are required to receive training in the use of the Social Service Payment System (SSPS).