PERFORMANCE AUDIT

FOLLOW-UP OF CHILD ABUSE AND NEGLECT REPORTING AND RESPONSE SYSTEM

From The Office Of State Auditor
Claire McCaskill

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State Auditor Of Missouri
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YELLOW SHEET

Child abuse hotline unit improved how it classifies calls, but more timely contact with child victims is needed along with increased monitoring of cases

This report addresses the Department of Social Services' progress on the seven recommendations most related to children's safety made in our first Child Abuse Hotline report (issued December 2000). Of these recommendations, the department has implemented three, partially implemented three and not implemented one. The audit concluded that while some improvements have been made since the previous report, further improvements are needed.

In fiscal year 2003, the hotline unit handled 108,685 hotline calls, and determined 79 percent needed investigation or follow-up by local offices. In this follow-up report, auditors focused on the case handling of children who had at least seven hotline calls made on their behalf over a two and a half-year period in Jackson and Greene counties and St. Louis. These 45 children and the 371 separate hotline calls included some children who died of abuse/neglect, despite more than two previous hotline calls. The following highlights the areas showing improvement and areas with continued weaknesses.

Weaknesses continue in case management at local offices

In responding to this report, department officials said insufficient staff and funding have limited their ability to address the case management deficiencies noted below.

Overdue reports resulted in some service delays to children

Overall, auditors found 39 percent of the abuse/neglect reports were overdue by 3 months (similar to 36 percent in the first audit), and 45 percent of the reports reviewed were not completed in 30 days as required. Auditors found at least two cases in which slow report completion led to the child and family not receiving services for months. In one case, a young girl with extensive medical problems possibly caused by her mother did not have a services case opened until six months after the first call. In addition, a services case involving an 11-year-old boy allegedly choked by his brother was not opened until six months after the initial call. (See page 9)

Initial contacts with children to ensure safety not timely

Auditors found caseworkers did not always follow policy in how quickly to contact a child who was the subject of a hotline call. Face-to-face visits are supposed to occur within 24 hours of a call considered an "investigation" and within 72 hours of a call deemed a

(over)

"family assessment." Auditors found that in 16 percent of the cases tested caseworkers did not see the child within the required time frame. In one case, it took 13 days before a caseworker contacted a young teenage boy who had been kicked out of his house and threatened with harm if he returned and harmed other household members. Auditors also found in 19 percent of the investigations reviewed caseworkers did not interview the children apart from the alleged perpetrator or other influential parties. (See page 11)

Abuse/neglect service cases not always closely monitored, one involved a fatality

Auditors found caseworkers did not adequately follow-up on family centered service cases—those cases where it was determined services were needed. In such cases, a caseworker is supposed to closely monitor the child and family through several face-to-face and collateral contacts to help prevent further abuse and keep the family together. Auditors found caseworkers did not make the appropriate number of contacts in 19 of 41 cases reviewed. In one possible high-risk sexual abuse case, the caseworker had not made contact for three months, despite a policy requiring multiple face-to-face contacts or contacts with collaterals during that period. In a fatality case, a caseworker responsible for monitoring a 5-year-old child with a degenerative medical condition only checked on the child's medical treatment with the mother, and did not confirm treatment with a physician. The child eventually died from lack of medical attention. (See page 12)

Improvements made

Call takers and caseworkers have more specific decision-making guidance in responding to calls

The prior report suggested Missouri follow 12 other states which use a Structured Decision Making process to help hotline call takers and local caseworkers to more accurately and consistently decide how to respond to a case. Division officials began implementing screening tools in the local offices in September 2002 to determine risk levels and whether to open a case for services. However, further guidance and training is needed. Auditors found in 10 percent of 70 calls tested the case facts did not support how the caseworkers decided a case should be handled. Division officials began implementing a new screening tool in the hotline unit in December 2003. A new protocol system is to be fully implemented after planned testing and necessary revisions are completed. (See page 6)

Percentage of incorrectly classified calls decreased

The prior report disclosed 3 percent of the calls deemed "unable to investigate" should have been investigated. In the current audit, auditors found 1 percent of "unable to investigate" calls to be incorrectly classified. In addition, hotline call takers are now required to check for prior hotline calls on a child and track the "unable to investigate" calls in a database for future reference, both of which did not occur before the first audit. (See page 7)

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ABBREVIATIONS

DSS	Department of Social Services
SAO	State Auditor's Office
SDM	Structured Decision Making
UTI	Unable to Investigate

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The state received over 108,000 hotline calls during fiscal year 2003 regarding child abuse and neglect, and case workers were asked to respond to most of these calls. The State Auditor's Office (SAO) issued a report titled Child Abuse and Neglect Reporting and Response System in December 2000 disclosing numerous deficiencies needing attention to improve the safety of Missouri's children. This follow-up report addresses (1) the status of seven prior recommendations directly relating to child safety, and (2) improvements needed in local office handling of child abuse and neglect cases involving children known to the system.

While some improvements have been made since the previous report, further improvements are needed. The department has implemented some features of structured decision making in its hotline unit and field operations, and continues to implement other improvements. We found weaknesses in the handling of child abuse and neglect report cases by caseworkers at local offices. Improvements needed include: timely completion of child abuse and neglect reports, the proper tracking of reports, timely and appropriate child victim and family contacts and interviews, increased service monitoring, and improved accuracy of report conclusions. These weaknesses can leave Missouri children at risk of abuse and neglect.

We continue to believe the recommendations in our December 2000 report should be fully implemented, and we have made some additional recommendations to address problems found in the handling of cases at local offices. In commenting on a draft of this report, the director stated he is committed to continuing to improve the department's efforts to protect these children while overcoming systemic obstacles such as staffing levels and compensation.

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We conducted our work in accordance with applicable standards contained in Government Auditing Standards, issued by the Comptroller General of the United States, and included such tests of the procedures and records as were considered appropriate under the circumstances.

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RESULTS AND RECOMMENDATIONS

Continued Improvements Are Needed to Decrease Risk to Children

The Department of Social Services (DSS) has taken steps to implement child safety-related recommendations made in our previous report.[1] While some improvements have been made since the previous report, further improvements are needed. We continued to find weaknesses in the department's handling of child abuse and neglect calls, both at the hotline unit and after they are referred to local offices for review and follow-up. Weaknesses in the local office caseworkers' handling of child abuse and neglect cases included untimely completion of child abuse and neglect reports and procedures not being followed to ensure child safety. These weaknesses exist, at least in part, because DSS has not taken necessary action to correct problems previously reported, has not adequately monitored the related activities, or not provided adequate guidance to the local caseworkers. As a result, Missouri children can continue to be left at risk of abuse and neglect.

Background

The Child Abuse and Neglect Hotline Unit received 108,685 hotline calls of suspected abuse and neglect during fiscal year 2003.[2] The unit is responsible for obtaining enough information from the caller to determine the seriousness of the situation and whether a caseworker needs to assist the child. Hotline workers screen each call and classify a call as either a child abuse and neglect report, a services-needed referral, or as unable to investigate (UTI). Any calls classified as either a child abuse and neglect report or a services-needed referral are forwarded to the appropriate local office, which were 85,688 during fiscal year 2003.[3] When a local office receives a child abuse and neglect report, a caseworker is to ensure the child is safe—through either an investigation if the caseworker believes the child is in imminent danger or a family assessment if the situation is deemed less serious. Once the child's initial safety is ensured, the caseworker is then required to monitor the child's situation and determine whether services should be provided to the family. While the family is receiving services, caseworkers are to monitor the family's progress and continue to ensure child safety. When a referral is received by a local office, a caseworker is required to contact the caller within 3 days to discuss the child's situation.

In December 2000, we issued a report on the Child Abuse and Neglect Reporting and Response System disclosing ineffective system management and some children being unnecessarily exposed to risk. The report recommended DSS implement a structured decision making (SDM) process in all aspects of the hotline response system—call receipt, screening, risk assessment, service, and placement decisions. The Children's Research Center, a division of the National Council on Crime and Delinquency, developed SDM to help guide decision making by providing useful, reliable and valid information on which to base decisions supported by actuarial research. SDM objectives are to:

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[1] Audit of Child Abuse and Neglect Reporting and Response System (SAO Report No. 2000-132, December 28, 2000).

[2] In August 2003, the Child Abuse and Neglect Hotline Reporting and Response System was moved to DSS' newly-created Children's Division. The system was previously under the Division of Family Services.

[3] DSS has 115 local offices, with at least one office in each county.

- introduce structure to critical decision points in the child welfare system,
- increase the consistency and validity of decision-making,
- target resources to families most at risk, and
- improve the effectiveness of child protective services.

Our 2000 report noted 12 states had implemented some elements of the SDM process, including Michigan, which had used the process longer than most of the other states. Michigan officials indicated SDM has been a better system than other systems they have experienced. If designed and implemented properly, it can help assist hotline personnel and caseworkers make difficult decisions related to child safety.

Scope and methodology

Our 2000 report included over 30 recommendations to improve the system. However, our current work followed up only on the seven prior recommendations we considered most directly related to child safety and evaluated certain case management practices in more detail.[4]

To evaluate calls made to the hotline unit which were classified as UTI, we selected a statistically random sample of 69[5] calls from a population of 3,786 UTI calls received from April to June 2003. We evaluated the UTI classification, supervisory review, completeness of documentation, and the review of prior calls by hotline personnel.

To assess division control systems over its call response log, we reviewed data on approximately 7,000 calls received during July 2003. We scanned the call response log and division reports to determine if division controls appropriately monitored the system and to ensure calls were being retrieved from the system and handled by the local offices in a timely manner.

To determine whether the local offices took appropriate actions on cases involving children known to the system (the subject of multiple prior calls), our current work involved an in-depth review of specific cases. To accomplish this, we selected 45 children's cases in three local offices—Greene County, Jackson County, and the city of St. Louis—based on the following criteria:

- child abuse or neglect hotline calls in June 2003 on a child having seven or more prior incidents reported since January 1, 2001 (the applicable children may have already been known to the system before that date),
- children who died due to child abuse and neglect in the previous three years having over 2 previous incidents reported (prior to the incident that resulted in their death), or
- calls about children made to the SAO hotline.

We reviewed the case files of these 45 children, involving 371 separate hotline calls classified as child abuse and neglect reports or referrals, and tested the incidents for various attributes relating to division policy and child safety. The number of incidents varied by attribute tested because

[4] See Appendix I for the remaining recommendations and their status, according to the division.
[5] See Appendix II.

certain attributes did not apply to all incidents. We interviewed responsible caseworkers and supervisors as necessary.

We reviewed applicable state and federal laws and regulations, division policies and procedures, and policies and procedures from various other states. During our work, we interviewed area and local employees, supervisors, and state level officials, and performed audit tests related to hotline unit decisions and case handling decisions. We also visited the Cole County office to assist in our planning efforts.

We obtained comments on a draft of this report during a meeting with the DSS director and division officials on March 11, 2004, and in a letter dated March 23, 2004. We incorporated their comments as appropriate. We conducted our work from July to December 2003.

Follow up of prior recommendations

Of the seven recommendations most related to child safety, DSS has fully implemented three, partially implemented three, and not implemented one. Table 1 presents the status of those recommendations as of December 2003.

Table 1: Status of Recommendations Most Related to Child Safety

Prior Recommendations	Status
1. Implement a SDM tool to increase consistency and accuracy in making intake, screening, risk assessment, service, and placement decisions.	Partially implemented
2. Improve the hotline unit quality control review process to ensure unable-to-investigate decisions are appropriate.	Partially implemented
3. Require hotline unit call takers check division records for prior reports of abuse on the child or family and document that check.	Implemented
4. Ensure unable-to-investigate worksheets document completely and appropriately the phone reports of abuse received by the hotline unit.	Implemented
5. Enter unable-to-investigate records into the automated Production System and retain them.	Implemented
6. Ensure reports are retrieved and acted on by field office workers by establishing a quality control system that requires the hotline unit to reconcile reports sent to local offices to reports printed and taken off the system for action.	Partially implemented
7. Ensure the child abuse and neglect investigations and/or family assessments are completed within the required time frame.	Not implemented

Source: Prepared by SAO.

Status of SDM implementation

DSS continues to implement SDM tools to help hotline unit personnel screen calls. While SDM tools have been implemented in the local offices, we found weaknesses in the caseworkers' use of these tools.

DSS continues to implement SDM features and other improvements

Division officials told us they have evaluated recommendations made to them through various reviews conducted by our office and other agencies. They prioritized those recommendations and focused initially on changes to the hotline unit. The hotline unit changes include technology upgrades and the creation of a new system for receiving and classifying calls. The division also plans to upgrade its phone system with a queuing system designed to prevent busy signals for callers.

Our 2000 report recommended SDM tools be developed and implemented to increase the consistency and accuracy of decisions (recommendation 1). During 2001 and 2002, the division developed SDM tools to help the hotline unit make investigation and family assessment tracking decisions. The division also developed and implemented local office SDM tools designed for use during the investigation and family assessment process. DSS trained caseworkers and implemented SDM tools in the local offices between September 2002 and May 2003.

Division officials told us they began implementing SDM screening tools in the hotline unit in December 2003. Division officials added they plan to continue implementing a protocol system in the hotline unit that incorporates SDM features while offering more specific guidance to call takers. Officials said this system is to give call takers guided direction to help ask pertinent questions and make appropriate decisions based on a call's facts and circumstances. According to division officials, they conducted new system training of selected call takers in December 2003 and testing in March 2004. The protocol system is to be fully implemented after planned testing and necessary revisions are completed.

More guidance is needed to ensure caseworkers properly use SDM tools

Caseworkers inconsistently used or documented SDM tools designed to determine risk levels or whether to open a case for services. DSS had not adequately monitored caseworkers' use of these tools or provided caseworkers any subsequent SDM follow-up training.

In the city of St. Louis and Cole County, we noted seven instances where caseworkers did not complete the second part of the SDM safety assessment form even though the children were determined to be safe. Division policy requires the entire form to be completed in all cases to initially determine and document whether the child is safe, conditionally safe, or unsafe in the home during the investigation or family assessment. Two caseworkers told us they did not complete the form because it was not required

when the child was determined to be safe. However, officials responsible for these offices told us the form is required to be fully completed in all cases.

The SDM risk assessment tool uses a risk-based approach to evaluate what further action should be taken in the case, including whether a case should be opened for services and the frequency of contacts needed with a family on an open case. The risk assessment weighs family characteristics to determine likelihood of further abuse. The facts of the case did not support the risk assessment for 10 percent (7 of 70) of applicable incidents reviewed. One caseworker stated he was unsure whether to use characteristics noted by caseworkers in prior calls or to treat each incident on its own merit.

Based on the conclusion of the report and the risk level determined, the SDM tools provide caseworkers a framework to determine what services should be provided. We found 16 percent (11 of 70) of the applicable case status decisions were not supported by case facts and risk levels assessed. Although we determined services had been provided, the exceptions noted included families with ongoing service cases, and families who were receiving services through other programs.

Improvements noted in hotline unit's handling of abuse and neglect calls

Our 2000 report noted hotline personnel (1) classified some calls as UTI when action could have been taken, (2) failed to always indicate if they checked for previous reports of abuse or neglect, and (3) failed to fully document calls on manual worksheets (recommendations 2, 3 and 4). In addition, hotline unit supervisors were not adequately monitoring taped calls and did not maintain a record of UTI calls for two months after a call had been taken (recommendations 2 and 5).

We found the following hotline unit improvements have been made:

- hotline unit guidelines require call takers to check previous calls as appropriate,
- quality control reviews have been implemented,[6]
- call information was found to be adequately documented for the items tested, and
- UTI information was being maintained in a database.

However, continued improvement is needed in the following area.

Calls incorrectly classified as UTI have declined

The percentage of misclassified UTI calls has decreased. Our 2000 report noted the hotline unit left some children at risk by classifying some calls as UTI when the calls actually met child abuse and neglect or referral criteria. The prior report concluded 3 percent of UTI calls tested were incorrectly classified and some action should have been taken, which means DSS personnel took no action related to these calls.

[6] Supervisors are required to review 10 percent of hotline calls. The 10 percent goal had not yet been met as of December 2003, but supervisors were performing more thorough reviews of UTI calls than during the previous audit, according to hotline unit management.

Based on our current work, we projected the hotline unit incorrectly classified an estimated 55 calls in our study population of 3,786 as UTI (representing an error rate of over 1 percent of the calls tested[7]). The one exception noted in our sample of 69 calls dealt with several young children living in a home with no utilities. It was reported the mother was using dirty water from outside for unknown purposes in the house. According to a hotline official, the call was not classified as a child abuse and neglect report because it was believed a lack of utilities alone did not meet the legal criteria of a report. The call taker documented the call would be classified as a UTI because the caller did not know how the dirty water was being used. That is, hotline staff stated outside water used to flush a toilet would not be considered a problem, but using it for drinking water would be considered neglect. However, a different hotline worker prepared an abuse and neglect report based on a subsequent call reporting the same concern involving the same family, and referred it to the field for action. The second hotline worker documented that even though the caller could not confirm how the outside water was used, it should be checked out.

Division policy defines a UTI as a call where there are no child neglect and abuse allegations or a case where insufficient identifying information is provided by the caller to conduct an investigation. In addition, division policy requires a call to be classified as a child abuse and neglect report if the report meets the definition of abuse/neglect described in the statutes. Section 210.110, RSMo 2000, defines neglect as the "failure to provide by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for the child's well-being." If a call does not meet this criteria, the hotline unit may prepare a preventive service referral when the facts and circumstances demonstrate the need for intervention or services to prevent child abuse and neglect from occurring. Based on the policy and criteria, the first call should not have been classified as a UTI. The inconsistent manner in which these two calls were handled also demonstrates the need for more guidance to be provided to call takers.

Controls need improvement to ensure timely action on referrals to the field

The 2000 report noted DSS had no assurance local offices acted on child abuse or neglect hotline calls (recommendation 6), and concluded some children were left at risk as some calls were not being retrieved from the automated referral system in a timely manner. As a result, the division issued corrective policy and established central office reviews to ensure personnel follow the policy.

We found improvements have been made, but additional referral system control safeguards are needed. We found four of the approximately 7,000 calls received in July 2003 had not been properly retrieved and removed from the automated referral system as of October 2003. In addition, we noted one call initially sent to a local office had been properly acknowledged as being received; however, that office subsequently transferred the call to another local office where it was not properly acknowledged as received for 24 days. Further review disclosed the children's situations involved in each of these calls had been acted upon by division caseworkers;

[7] See Appendix II.

however, some county and area offices were not performing the call acceptance procedures properly, causing the calls to remain on the log. Division officials stated a memo was re-sent to county and area offices outlining the correct procedures in February 2004.

Our review also disclosed that although the division had found no problems with the referral system since management reviews were initiated two years ago, it was not getting complete information covering all counties and areas of the state. Division officials told us this problem was due to a programming error and corrective action has been taken.

Weaknesses continue in case management at local offices

In our 2000 report, we highlighted problems with the untimely completion of child abuse and neglect reports along with recommended improvements. We also highlighted problems with local office personnel inconsistently classifying child abuse or neglect calls as family assessment or investigation for the same or similar types of cases. In our follow-up work relating to 45 children's cases, we found these problems continue. We also found weaknesses in caseworkers' handling of cases involving children subject to multiple child abuse or neglect calls. Caseworkers had not followed procedures in contacting and interviewing children and monitoring services provided to families. In addition, we found caseworkers' conclusions were not always accurate on cases. These weaknesses can be attributed to either a lack of guidance being provided to the local caseworkers or inadequate monitoring of the cases.

In responding to a draft of this report, the director said he does not have sufficient staff or funding to address most case management deficiencies. A division official indicated DSS budgeted 1,382 caseworker positions in the fiscal year 2004 budget, or 75 percent of the Council on Accreditation benchmark for staffing to workload ratios. Absent DSS data, we found the 20 caseworkers responsible for child abuse and neglect reports we reviewed averaged 25 cases; ranging from 10 to 40 cases per worker, based on our 45 selected cases.

Continued weaknesses completing timely reports

Untimely completion of reports continues to be a problem. Our 2000 report disclosed 4,482 overdue child abuse and neglect reports as of February 3, 2000, and 36 percent had been overdue more than 3 months. We recommended the division ensure the child abuse and neglect investigations/family assessments be completed within the required time frame (recommendation 7). As of February 21, 2004, DSS records showed 4,071 overdue child abuse and neglect reports, and 39 percent had been overdue more than 3 months. Our current work also found 45 percent (116 of 256) of the child abuse and neglect reports reviewed were not completed within 30 days. We also found 17 percent (43 of 256) of the reports reviewed had conclusions of probable cause, or services needed, indicating a risk of service delays. Division officials and two caseworkers told us high caseloads and understaffing was a primary reason for overdue reports and delayed services.

State law requires local offices to conduct an investigation or family assessment for each child abuse and neglect report. The resulting child abuse and neglect reports must be

completed within 30 days, unless good cause for the failure to complete the investigation is documented in the information system.[8] We found only 24 percent (28 of 116) of the overdue reports reviewed had a documented reason for the delayed conclusion. Reasons cited by two caseworkers for not documenting the cause for the delay in a case's conclusion included: a belief that local office management did not view it as important, and the time involved in preparing documentation justifying the delay and getting it approved.

Division officials stated the portion of the report process that is most often delayed is the paperwork, and the actual investigation or family assessment had likely been completed and a service case opened. However, we found at least two instances where a service case was not opened until after the report was concluded. A family centered services case for one family was not opened until the case was concluded six months after the incident, due to the report being combined with subsequent calls. This case involved a situation where a young girl was suffering from extensive medical problems which may have been caused or contributed to by the mother. In another instance, a report received in October 2002 involving an 11-year-old boy being choked by his older brother was not concluded until March 2003. The family centered services case was not opened until April 2003, six months after the report was received, even though the mother needed help controlling the brother who had severe behavioral problems.

Incidents not properly tracked as investigations or family assessments

Local office personnel continued to inconsistently classify child abuse or neglect calls for family assessment or investigation handling for the same or similar types of cases.[9] Our 2000 report attributed this inconsistency to caseworker confusion regarding when to perform family assessments and the level of judgment permitted in the decision-making process. Our current work found personnel did not track 7 percent (14 of 214) of the applicable incidents reviewed as required by division policy. Generally, the exceptions we found involved child abuse and neglect reports being handled as family assessments rather than as investigations. The tracking decision is important to a child's safety because it affects the timing of initial contact with the child, possible law enforcement involvement, and the manner of interviewing.

One of the exceptions involved young children being left in a car unattended. The responsible caseworker did not remember why she made the decision to perform a family assessment instead of an investigation. She looked at the file again and said, from reading the report, it may be that she compared this to other incidents she has been assigned involving children left in the car and thought this was not as serious. She said the children were unattended for only five minutes. In addition, the incident occurred outside a convenience store so the car was fairly close to where the parents were, rather

[8] Section 210.145(12), RSMo 2000.

[9] The two-track system (family assessment/investigation) provides the caseworker flexibility in determining the type of initial contact required. For cases of serious abuse, investigations are performed which require initial face-to-face contact within 24 hours and law enforcement notification. For less serious cases, a family assessment is performed which does not require law enforcement notification, and the time allowed for initial contact is longer.

than in a large retail store parking lot where the kids would be hundreds of feet from the parents. Overall, she could not explain her decision aside from not considering it a serious situation, and she said it did not occur on a hot day.

Effective December 2003, the division now requires the hotline unit to make the family assessment/investigation tracking decisions before the child abuse and neglects reports are sent to the local offices. Division officials told us bringing this decision function to the hotline unit should help ensure proper and consistent decisions.

Procedures not followed in contacting and interviewing children

We also found caseworkers did not always follow required policy in the initial contacts with children and their families or in conducting interviews. Once the decision to perform an investigation or family assessment is made, the caseworker is to initiate contact with the family to ensure the child's immediate safety, according to division policy. For investigations, initial contact must be a face-to-face visit with the child within 24 hours of the report being made. For family assessments, initial contact must be face-to-face within 72 hours as long as the child's safety has been ensured within 24 hours.

Our review of cases disclosed caseworkers did not initially see the child victims within the appropriate timeframe in 16 percent (30 of 184) of applicable incidents. The following examples illustrate weaknesses found:

- One caseworker did not visit a child until 13 days after the reported abuse. The incident involved a young teen-age boy whose custodial aunt reportedly kicked him out of her house and threatened to harm him if he harmed her or other members of her family again. The caseworker stated an initial attempt at contact was made, but the boy and family were not available. The caseworker said she subsequently went on vacation and did not attempt contact again for 13 days.

- Another caseworker failed to make timely initial contact with a young girl who was reportedly being abused and neglected by her step-mother, only verifying the child's immediate safety by contacting the child's father. The father and child both lived with the child's step-mother. This caseworker stated she believes she took the appropriate action given the division's previous contact with the family.

Two other caseworkers stated they did not see children within the required time-frame because either reported addresses were not current or the parents did not keep appointments.

For abuse or neglect reports deemed serious enough to warrant investigations, division policy requires caseworkers to interview each child victim separately from other victims and their parents or the alleged perpetrator. This policy has been established to help ensure the child is safe, does not feel inhibited to discuss the events that occurred, and is not coached by an influential party.

We found caseworkers responsible for 19 percent (10 of 52) of the investigations reviewed did not interview children apart from the alleged perpetrator or other influential parties. In one case, a caseworker interviewed a 12-year-old in the presence of his grandmother. The caseworker documented in the case narrative she could tell the child was reluctant to say anything negative about the mother, the alleged perpetrator, in front of the grandmother. This caseworker has since retired; therefore, we could not determine why the caseworker conducted the interview in this manner.

Three caseworkers we interviewed indicated they are aware of the division policy requiring children to be interviewed separately. However, one caseworker indicated he does not always insist on a separate interview unless the circumstances or nature of the allegations warrant such action. Another caseworker indicated that he generally interviews the child separately, but in the past did not always document this.

Inadequate service monitoring

We also found caseworkers did not adequately follow-up on a substantial number of family centered services cases reviewed. According to division policy, family centered services are typically provided when a child abuse or neglect incident is concluded to be probable cause (the abuse most likely occurred) or services needed. Family centered services are intended to offer the necessary help and prevent further abuse while maintaining the family in the home.

Of the applicable incidents we reviewed prior to the introduction of SDM tools where a case was opened for services, the number of contacts with the families required by policy were not made in 41 percent (7 of 17) of the instances. Prior to the introduction of the SDM tools, family centered services workers were required to make at least one face-to-face visit with the family per month, according to division policy. A family in one area was not seen by a family centered service worker until two months after their case was opened and a caseworker was assigned. The case involved a chronic neglect situation and the children were eventually taken into state custody.

Of the incidents reviewed after SDM tools were introduced where a case was opened for services, the appropriate number of contacts were not made in 50 percent (12 of 24) of the applicable incidents. For those cases opened using SDM tools, there is a matrix to determine the appropriate number of face-to-face contacts that must be made with the family by the family centered services caseworker and the number of contacts that must be made with other parties who are working with the family. The number of contacts is based on the risk level determined for the family, with an increased number of contacts required for higher risk families. We interviewed two family centered services workers and they cited a lack of time as the reason for not making the required contacts.

One report reviewed —for possible sexual abuse—represented the fourth child abuse and neglect report for a 4-year-old child (two prior family assessments and one investigation). The caseworker decided the child's risk of further abuse was high and a family centered services case should be opened. According to division policy, a service case with high

risk requires the following minimum monthly contacts with the family: two overall face-to-face contacts by the division or other collaterals, one face-to-face contact by division workers, and three collateral contacts. The family centered service worker made no face-to-face contacts or contacts with collaterals for three months, according to case documentation.

In a death case reviewed, a family centered services case had been opened to monitor whether a 5-year-old child with a serious degenerative medical condition was receiving proper medical attention. This was the child's third report for serious neglect issues. The family centered services worker only asked the mother whether the child had been taken to her physician and received medication, but did not verify this information with the physician, according to case file documentation and the physician's affidavit. The child eventually died due to complications from her medical condition as a result of receiving little or no medical attention or medication.

Report conclusions not always accurate

We found 7 percent (15 of 207) of caseworkers' conclusions were not supported by the case facts and documentation. Under SDM, conclusions reached in child abuse and neglect reports are very important in determining whether or not to open a family centered service case to help ensure child safety, or to close the case with no further division involvement, according to division policy.

According to division policy, if a caseworker decides to open a case, the risk level and conclusion also help determine the amount of follow-up contact with the family needed to ensure child safety and prevent further abuse. In one case reviewed, the conclusion stated services were needed by the family and the family declined; however, case documentation indicated the family was agreeable to receiving services. We also noted one case where the caseworker concluded the family could not be located; however, the reported information included possible locations of the family that were not investigated further. The caseworker did not remember why the other information was not used.

Conclusions

Protecting children who cannot protect themselves is an important responsibility of all stakeholders, including DSS. The state received over 100,000 calls during 2003 for children being abused or neglected, and caseworkers were asked to respond to most of these calls. Our 2000 report offered a number of recommendations designed to help improve the state's ability to protect these children. Our current work found some weaknesses continued and identified other areas DSS can improve to better ensure children are safe.

Some child safety-related recommendations made in our 2000 report have not been fully implemented, resulting in continued weaknesses. As such, some children may be left in harms way after someone concerned about their safety has notified DSS. While some progress has been made in implementing features of a SDM model, further improvements are needed. These

improvements include additional training on the usage of SDM tools in the local offices to improve consistency in case handling.

While improvements were noted in the hotline unit—the state's initial contact point for child safety, we found some calls are incorrectly classified as UTI and better controls are needed over the call referral system to ensure local offices take appropriate and timely action to ensure children are safe. These controls would include ensuring local and area offices properly accept calls.

During our current work, we reviewed DSS' actions involving 45 children, most of whom involved numerous abuse or neglect calls. We found local office handling of these child abuse and neglect reports needs improvement in regards to timely report completion, case tracking decisions, timely and appropriate child victim contacts and interviews, accurate report conclusions and increased service monitoring.

Case management is critical to ensuring children have continued safe environments. Furthermore, caseworkers can face many difficult decisions in high-risk situations, and may be assigned to a child's situation initially handled by another worker. As such, it is critical that children involved in abuse or neglect reports are seen and interviewed as required and the report conclusions are accurately and clearly documented.

If a caseworker decides family centered services would help improve a child's situation, then contacts made by the caseworkers with these families are critical in monitoring the families' progress toward their goals and reducing risk to the children. However, DSS cannot ensure children in these potentially high-risk homes are not susceptible to further abuse and neglect unless caseworkers perform adequate follow-up with the families.

Recommendations

We continue to believe the recommendations in our 2000 report should be implemented. Based on our current work, the DSS director should also take action to improve local offices' handling of child abuse and neglect cases to help address child safety issues. We recommend the DSS director ensure local offices:

1. Follow division policy regarding timely initial contacts with child victims, interviewing children separately during investigations, and adequately documenting contacts and interviews;

2. Conduct appropriate follow-up visits and collateral checks for family centered service cases; and

3. Accurately document case facts and circumstances in report conclusions.

Agency Comments

1. *We believe that our staff are doing a good job in assuring safety of children during a child abuse/neglect investigation and/or Family Assessment. Additional training is now being planned to further institutionalize the use of Structured Decision Making and our new documentation form (CPS-1). Like other state child welfare agencies, the Division is currently in the process of developing a Program Improvement Plan in response to the recently completed Federal Child and Family Services Review. This will lay out a plan to address a variety of issues relating to improved practice, within the context of our given resources.*

2. *We shall address this issue within the self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.*

3. *We shall address this issue within the self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.*

APPENDIX I

STATUS OF OTHER PRIOR RECOMMENDATIONS

This appendix presents the status of other recommendations made in the previous report on the Child Abuse and Neglect Reporting and Response System dated December 28, 2000. The status of these recommendations is based on a written communication provided by department officials since the previous report was issued and/or the department's response to the prior recommendation. Based on the information provided, 11 of these recommendations have been implemented, 2 have been partially implemented, 9 have not been implemented, and 3 cannot be implemented at this time. A formal follow-up of these recommendations was not performed during the current audit. The recommendations are presented in the order they were presented in the prior report.

Recommendation	Status	Comments
Retain tape recordings of hotline calls for possible use in future criminal prosecutions or for review board hearings.	Implemented.	
Establish a peer review quality control system to ensure policies and practices are consistently followed and applied throughout the DFS child abuse and neglect response system.	Implemented.	
Readdress the DFS study of overturns by the Child Abuse and Neglect Review Board on appeal of probable cause findings and take appropriate corrective action as suggested in the report.	Partially implemented.	The division indicated this is an ongoing process.
Establish quality controls that ensure the child abuse central registry and local case records are appropriately corrected to remove the probable cause finding when the alleged perpetrator wins an overturn on appeal.	Implemented.	
Develop a quality control system to ensure DFS is represented at Child Abuse and Neglect Review Board hearings as required by statute.	Implemented.	
Ensure children's services workers are provided adequate guidance and training on their responsibility to make appropriate decisions on whether to represent DFS custody children in probable cause finding appeal hearings.	Implemented.	

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Recommendation	Status	Comments
Send perpetrator notification letters by certified return receipt requested mail.	Not implemented.	The division disagreed with this recommendation.
Redefine hotline unit criteria definitions for preventive service referral classifications to better allow for the best interest of children to be served.	Not implemented.	The division disagreed with the finding indicating current policy met or exceeded statutory mandates.
Provide better policy and guidance to field staff on handling of preventive service referrals.	Implemented.	
Improve the understanding of the child abuse and neglect system by mandated reporters and the public by improving the quality and quantity of detailed information easily available. The DFS should increase efforts to explain what can be expected from the system.	Not implemented.	The division indicated at the time of the previous audit it had numerous initiatives in place to educate mandated reporters and disagreed with this recommendation.
Send responses to mandated reporters on the outcome of every call and the reasons for action or inaction.	Not implemented.	The division disagreed with this recommendation citing that policies were already in place to take action on every mandated report call and to notify them of the outcome.
Ensure hotline unit call takers make clear to mandated reporters what action can be expected based on the information provided.	Implemented.	
Develop methods to identify and disseminate best practices throughout the DFS system.	Implemented.	
Ensure DFS children's services goals are valid and measurable.	Not implemented.	The division indicated this was a single instance and was corrected prior to our review.

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Recommendation	Status	Comments
Ensure all accreditation council and other appropriate standards available as staffing planning tools are used to establish staffing allocations and future needs and goals.	See comment.	The director agrees with this recommendation; however, he does not have the budgetary means to implement it.
Perform time and workload studies to help determine needed staff allocations.	Not implemented.	The division indicated it uses caseload standards set by the Council on Accreditation.
Relocate open staff positions from areas unable to fill positions to areas where the positions can be filled, when necessary or beneficial.	Implemented.	
Develop a special team of investigators to assist "problem" areas and help ease the local offices' caseloads. This team could be sent to help counties who are having problems completing child abuse and neglect cases and making initial contacts on cases within the required time frames.	Not implemented.	The division felt this would not be necessary if fully staffed.
Increase salaries for both social worker and supervisor positions to make DFS jobs more competitive with surrounding states and private organizations who hire social workers.	See comment.	The director agrees with this recommendation; however, he does not have the budgetary means to implement it.
Provide increased financial compensation to workers who obtain advanced degrees or certifications.	See comment.	The director agrees with this recommendation; however, he does not have the budgetary means to implement it.

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Recommendation	Status	Comments
Ensure each full time children's services social worker is provided with a state-owned cellular phone.	Implemented.	At the time of the previous audit, the division indicated 629 cell phones had been made available to staff.
Provide children's services social workers with laptop computers and standard automated forms and letters, and/or dictation equipment and transcription services.	Implemented.	
Provide specialized training for: • Front line staff and supervisors on how to use the two track (investigation/family assessment) system to achieve the best possible results and to meet DFS management goals for the system. • Staff involved in child abuse and neglect investigations. This training should teach staff to adequately investigate, document and present investigation cases, increasing child safety and decreasing overturns on alleged perpetrator appeals. • Supervisors and county directors who supervise child abuse and neglect investigations and family assessments, but have no clinical experience in protective services.	Partially implemented.	The division indicated the implementation of this recommendation is ongoing.

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Recommendation	Status	Comments
Develop investigative teams for low population county groups to ensure specially trained workers and supervisors handle child abuse and neglect cases. These employees should not have other duties that interfere with their primary children's services functions.	Not implemented.	The division indicated this recommendation was cost prohibitive.
Make better use of the compensatory time monitoring system to more effectively manage its accumulation and use. Compensatory time should be: • Used before annual leave. • Used within a reasonable time frame. • Monitored for purposes of planning future staff allocations and identifying staffing problems or inequities.	Not implemented.	The division disagreed with this recommendation indicating it believed current policy was sufficient.

Source: Prepared by SAO based on DSS responses.

APPENDIX II

SAMPLE METHODOLOGY AND RESULTS

This appendix describes how we identified a study population and our sampling methodologies for one probability sample.

Audit Universe for Calls Classified as Unable to Investigate (UTI)

To measure the number of calls the hotline unit incorrectly classified as UTI, we reviewed a probability sample of 69 cases from a study population of 3,786 calls classified as UTI by the hotline unit during April, May, and June 2003. We based the sample size on a 95 percent confidence level with a 7 percent sampling precision and an expected error rate of 10 percent.

Based on the results of the sample, we estimate for 1.45 percent of the study population, or 55 calls classified as UTI, policy had not been followed when classifying the calls as a UTI.

Table II.1 displays the sample results.

Table II.1: Calls Incorrectly Classified as UTI

Category	Result
Sample Size	69
Calls Incorrectly Classified as UTI	1
Point Estimate Error Rate	1.45%
Point Estimate Quantity	55
Upper Limit Error Rate	7.77%
Upper Limit Estimate Quantity	294
Lower Limit Error Rate	.03%
Lower Limit Estimate Quantity	1

DEPARTMENT OF SOCIAL SERVICES COMMENTS

MISSOURI
DEPARTMENT OF SOCIAL SERVICES

BOB HOLDEN
GOVERNOR

Steve Roling
DIRECTOR

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March 23, 2004

The Honorable Claire McCaskill
Missouri State Auditor
Truman State Office Building, Room 880
P.O. Box 869
Jefferson City, Missouri 65101

Dear Ms. McCaskill:

The Children's Division's response to the audit report on the Child Abuse and Neglect Reporting and Response System is attached. We would first like to thank you for your time spent on this report and appreciate your acknowledgements relating to our efforts to improve the system. Additionally, we wish to thank you for making changes to the first draft of the report following our exit interview on March 11, 2004.

The Children's Division has many dedicated staff who are committed to assuring the safety of Missouri's children who come to our attention. We believe that Missouri has sound policy within its child welfare program, but we acknowledge that there may be gaps between our policy and practice in some instances, given our current staffing levels and resources. We have been addressing these matters on an internal and external basis, and will continue with our efforts to improve the entire continuum of child welfare services. In addition to our ongoing efforts, the Governor has recommended funding for the first year of a five year plan which will assist the Children's Division in meeting the standards put forth by the Council on Accreditation, a nationally recognized accreditation body. We believe this commitment will augment what we are already doing and result in better outcomes for Missouri's children and their families.

The observations of this report will be considered as we move forward in our efforts to improve our child welfare service system in a meaningful manner for the children and families we serve.

Sincerely,

Steve Roling
Director

BW/JCH/SR

cc: Frederic M. Simmens

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION

RESPONSE TO THE FOLLOW-UP AUDIT OF THE
CHILD ABUSE AND NEGLECT REPORTING AND RESPONSE SYSTEM

The Department of Social Services, Children's Division has reviewed the draft audit report (follow-up of the Child Abuse and Neglect Reporting and Response System) and appreciate the acknowledgements relating to our efforts to improve the system. Much effort has been undertaken within the past eighteen months to improve the entire continuum of child welfare service delivery. Other improvements are forthcoming as we strive to become the best system possible.

This audit began in June 2003, at a time when the Children's Division had just implemented Structured Decision Making (SDM) in the field. This was to better enable our staff in local offices to assess safety and risk during investigations and family assessments and to make key casework decisions based upon the assessed safety and risk. At the same time, the Division was in the process of implementing SDM principles at the Child Abuse and Neglect Hotline Unit (CANHU). The Division requested a postponement of the audit, believing additional time might provide a better picture on how these changes are impacting practice and policy and resulting in better outcomes for children and their families.

To strive for yet greater consistency among CANHU staff and to address any emergent calls more quickly, the Division developed protocol at the Hotline modeled after what is used by emergency medical system dispatchers. The SDM principles which were designed with the assistance of the Children's Research Center are embedded within this protocol. We sought the assistance of mandated reporters in establishing these key questions that staff must ask in each call. Testing and training continue on the use of the protocol.

Furthermore, the Division is upgrading the hardware used at the CANHU. This includes a queue system to get to emergent calls more quickly and to reduce the number of busy signals and better accommodate our call volume. We will be able to monitor the incoming calls, and real-time call center statistics when other hardware improvements are soon made.

We also believe the Audit Report generally indicates our field staff within the local offices are seeing children in a timely manner to assure safety during child abuse/neglect investigations and family assessments. We acknowledge that information obtained during these contacts is not always entered into the automated information system in a timely manner. We believe that much of

this is due to staffing shortages of the social service workers (75% of need) who complete the investigations/assessments and document the case activities, the lack of supervisors (68% of need) who review and sign off on the cases, and the lack of clerical support staff (43.5% of need) who enter the information into the system. We are optimistic that additional staff and resources may be forthcoming as the Division moves toward becoming nationally accredited, per Council of Accreditation standards.

We believe that Missouri has sound child welfare policy that reflects the best practice standards within the field. We are now conducting a comprehensive review and analysis of our practice as we prepare our Program Improvement Plan in response to the recently completed federal Child and Family Service Review. Additionally, we will be initiating a self-assessment process within each judicial circuit that will carefully look at the child welfare practice and outcomes of our staff within their local systems. This two-fold review and analysis of our practice will better enable our Division to respond to our high expectations and those of the general public.

There are several areas within the Audit Report to which the Division takes exception to, or believes the public needs further information.

- Of the seven prior recommendations (CA/N Audit 2000) most related to child safety, the Auditor notes that three have been fully implemented. We believe those listed as partially implemented have been addressed, are being tested, or are viewed as an ongoing process. The one recommendation listed as not implemented concerns investigations or family assessments not being completed within the required timeframe. As noted above, staffing shortages impact our ability to sufficiently address this concern.

- We appreciate the noted improvements concerning Unable to Investigate (UTI) calls found on page 7 of the Audit Report. Suggestions made within the previous audit have been helpful to us in reducing the percentage of total calls classified as UTI (16.7% in 2003, compared to 25% in 1999). The Division takes exception to the example listed on page 8 of the Audit Report concerning the dirty water and living conditions. We note that the audit team found concern with only one of the 69 cases which were reviewed. Our review determined that the first call qualified as a UTI as it lacked information relating to an adverse effect on the children. The second call provided <u>additional</u> information relating to the living conditions and the adverse impact on the children, and the call was then classified as a CA/N report.

- Page 7 referenced that more guidance is needed to ensure Division staff properly use SDM tools. It is the Division's policy that a safety assess-

ment be completed on each investigation and family assessment including those times when the child is found to be safe prior to the completion of the tool. It is also the Division's policy that caseworkers consider prior reports when completing the risk assessment to determine further action and needed services. We will review, clarify, and provide additional training covering the use of the SDM tools, including the use of prior reports.

- Page 9 referenced the continued weaknesses in completing timely reports. We believe our staff do a good job is assuring the safety of children when responding to a CA/N report, but our documentation and data entry is often not completed within thirty days. Our policy manual is clear on the statutory time frames for concluding a report, having that information entered with the automated information system, and what procedures are to be used in a delayed conclusion. Our agency expects the time frames to be followed by staff but recognizes that with existing staffing levels, all timeframes may not be met. We are concerned that service delivery may have been delayed in some cases referenced within the report and will address this issue within the self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.

- Page 10 reported that incidents are not properly tracked as investigations or family assessments. On December 22, 2003, all of the CANHU staff began implementing the SDM Track Assignment. The Track Assignment Guidelines are designed to determine if the screened-in report is an Investigation or Family Assessment. The local office will review the report to assess whether the appropriate track has been assigned or whether additional information received warrants a track change. The degree these changes occur at the local level will be monitored throughout the state.

- Page 11 reported that procedures are not followed in contacting and interviewing children. The Division again has specific policy and procedure outlined regarding timeframes for contact with victims. These concerns will be brought forth within the self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.

- Page 12 reports inadequate service monitoring. We are concerned that service delivery may be compromised by inconsistent monitoring and will address this issue within a self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development. The case contact guidelines specified within the SDM model, which are based on assessed risk, will be further trained.

- Page 13 addresses report conclusions which are not always accurate. The audit report referenced one instance in which the case record information seemed contradictory and that the family may have been willing to accept services, even though another part of the file indicated otherwise. Another case example indicated that the whereabouts of the family was unknown when this may not have been the case. We shall address this issue within a self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.

In summary, we believe the Division has good policy and we recognize that there is a need for improvement in our practice when implementing the policy. Barriers to implementation are dependent on a variety of factors such as limited resources, sufficient and ongoing training, and effective supervision. We will address these practice issues within the next six months as we complete and submit our Program Improvement Plan to the federal government and begin our circuit self-assessments. Additional resources will be needed for Missouri to realize lasting system change in child welfare. The Children's Division will need a long-term commitment from the state and the necessary investments in order to reduce caseloads, increase training for front-line staff and supervisors, increase our prevention efforts, and to realize the positive outcomes which are expected.

Recommendations:

Concerning the 25 other recommendations from the previous audit (December 2000), the Division has implemented 11 and partially implemented 2 as these are ongoing efforts. Another nine were not implemented because the Division disagreed with the Auditors conclusion or lacked the necessary financial resources for implementation. Lastly, another three were not implemented as they were outside of the Division's scope of authority.

Our specific responses to the three recommendations within the current Audit Report are as follows:

1. Follow division policy regarding timely initial contacts with child victims, interviewing children separately during investigations, and adequately documenting contacts and interviews;

   Division Response: We believe that our staff are doing a good job in assuring safety of children during a child abuse/neglect investigation and/or Family Assessment. Additional training is now being planned to further institutionalize the use of Structured Decision Making and our new documentation form (CPS-1). Like other state child welfare agen-

cies, the Division is currently in the process of developing a Program Improvement Plan in response to the recently completed Federal Child and Family Services Review. This will lay out a plan to address a variety of issues relating to improved practice, within the context of our given resources.

2. Conduct appropriate follow-up visits and collateral checks for family centered service cases;

   Division Response: We shall address this issue within the self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.

3. Accurately document case facts and circumstances in report conclusions.

   Division Response: We shall address this issue within the self-assessment process to be implemented within each judicial circuit and the Program Improvement Plan now under development.

JCH/BW
03/23/04

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