LEGISLATIVE AUDIT DIVISION

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MEMORANDUM

TO:	Legislative Audit Committee Members
FROM:	William Soller, Performance Audit Manager
CC:	Sheila Hogan, Director, Department of Public Health and Human Services Maurita Johnson, Administrator, Child and Family Services Division
DATE:	October 2017
RE:	Performance Audit Follow-up (17SP-13): Review of Child Abuse and Neglect Investigations (orig. 14P-11)
ATTACHMENTS:	Original Performance Audit Summary

Introduction

In October 2015, we presented our performance audit of the *Review of Child Abuse and Neglect Investigations* (14P-11). The audit included five recommendations to the Department of Public Health and Human Services (department). We conducted follow-up work to assess the department's progress in implementing the audit's recommendations. This memorandum summarizes the results of our follow-up work in addition to presenting background information on how allegations of child abuse and neglect are investigated as part of Child Protective Services in Montana.

Overview

Audit work identified the need for the department to strengthen various management controls, comply with policy-based and statutory timeframes, and address a lack of uniformity in making final investigative determinations for child abuse and neglect investigations. While follow-up work indicated that the department has taken some positive steps to implement the audit's recommendations, there is still much work to be done. The overall status of the department's efforts can be best described as a work-in-progress, with several key actions still underway to strengthen investigative activities. Our performance audit contained five recommendations to the department. Based on our follow-up work, the department has partially implemented one recommendation, not implemented one recommendation, and is in the process of implementing three recommendations.

Background

Child Protective Services (CPS) generally refers to protection provided by a governmental agency for children under the age of 18 who are at risk of, or are experiencing physical, sexual, or emotional abuse or neglect. In Montana, the department administers CPS activities, providing a continuum of care that begins with an intake process to assess a reported situation of child abuse or neglect to determine the level of response needed, continues with a field investigation of any allegation, and ends with a child finding a permanent familial placement, if applicable. The final placement is often referred to as permanency and is the ultimate goal of all CPS activities. In calendar year 2016, the department assessed 18,724 reports of alleged child abuse or neglect, with 9,752 of those reports requiring an investigation. Other assessed reports either were considered informational only or were referred to other entities such as law enforcement or tribal authorities for further action. While the division receives and assesses reports of

alleged abuse or neglect from a centralized intake location in Helena, reports which are determined to require an investigation are referred to field offices located in five geographic regions across the state to be investigated. Since the original audit, there has been staff turnover in at the management level, including the administrator for CPS activities and the director of the department.

Audit Follow-Up Results

Our performance audit report contained five recommendations to the department. As part of follow-up work, we examined CPS program management materials and report data from calendar year 2016, reviewed legislation from the 2017 Legislative Session, reviewed a sample of 25 CPS reports and documentation from calendar year 2016, and interviewed CPS management and staff to obtain their perspective on progress the department has made to implement the audit recommendations. The following summarizes information relating to follow-up audit work and the implementation status of recommendations.

RECOMMENDATION #1:

We recommend the Department of Public Health and Human Services:

A. Prioritize documentation of Child Protective Services intake and investigative activities by clearly defining documentation requirements in policies and procedures.

B. Require documentation of all Child Protective Services intake and investigative activities.

Implementation Status – *Being Implemented*

The department more clearly defined several intake and investigative processes in policy and procedure, including documentation requirements for staff. For example, investigative field staff may change the category or priority of a report established by centralized intake based on additional information available in the field. During the initial audit, while investigative staff would change the category or priority of a report, there was limited documentation regarding the rationale for the change. Consequently, the department developed and implemented an internal/external change form to track and document the rationale for any changes made to the category or priority of a report by investigative field staff with those changes documented as part of the report's electronic file. In addition, the department has updated its centralized intake workbook and associated policies, including making several changes to centralized intake forms to provide more clarity regarding documentation requirements for recording family history and report referrals to other entities such as law enforcement or tribal authorities. During follow-up work, department management and staff characterized documentation as being much more emphasized as a result of the audit. However, they stressed that the lack of documentation audit work identified was frequently the result of staff focused on the work and not on documentation of the work.

Current department management also reported that many of the findings of the audit, including documentation, could be traced back to a lack of fidelity—or adherence—on the part of former management to the safety-based investigative model adopted by the department in 2012. For example, according to current department management, former management did not always stress the need to identify the conditions of return that a parent must meet in order for a child to safely return to their physical custody, which creates a delay in children returning home and consequently increases the number of children in foster care. Department management explained they are developing a continuous quality improvement (CQI) process based a federal review tool to ensure that CPS staff are complying with process requirements, including documentation. They expect this CQI process to be implemented as part of an ongoing strategic planning process. While department management reported that many of the audit findings related to a lack of fidelity to the safety-based investigative model, field staff interviewed as part of the follow-up thought that an unfair characterization, with the model currently implemented with fidelity in the field and their efforts always focused on the safety of children. Field staff also reported that they conduct periodic fidelity reviews to assess if activities are being conducted properly, including documentation. However, at the time of follow-up work, the department has not yet developed any policies or procedures to guide the fidelity review process, including how frequently the reviews should

occur. Centralized intake staff reported that supervisors will review intake forms and decisions about every six weeks to assess intake decisions and associated documentation.

As part of our follow-up work, we reviewed a sample of 25 reports received by the department in calendar year 2016 to assess if the department has placed additional emphasis on documentation of intake and investigative activities. Our review identified several instances of limited, missing, or inconsistent documentation. For example, while investigative documents provide for an opportunity to document why time frames may not have been met, our follow-up work identified 4 of 12 (33 percent) reports which required an investigation with no rationale why statutory time frames were not met. Overall, our follow-up work indicates that while the department has taken steps to prioritize and require documentation, inconsistent documentation is still a concern within CPS. This represents a risk to the department's ability to maintain the public's trust that they are acting appropriately to keep at-risk children out of harm's way.

RECOMMENDATION #2:

We recommend the Department of Public Health and Human Services clarify and implement existing policies and procedures regarding the role of supervisors, including standards for the review, oversight, and verification of intake and investigative activities and requirements for reassigning investigations when staff attrition occurs.

Implementation Status – *Being Implemented*

The department more clearly defined several intake and investigative processes in policy and procedure, including the role of supervisors for the review, oversight, and verification of intake and investigative activities. Department management and staff reported the audit highlighted the need for supervisory oversight and expectations to be more clearly outlined, including how supervisory oversight and review is documented on various intake and investigative forms. For example, the department implemented a CPS supervisor field guide to assist supervisors in accurately and comprehensively guiding their staff to gather sufficient information for an investigation, including how supervisory review and approval is documented. The department also clarified in policy the responsibility of a supervisor to reassign an investigation when a CPS worker leaves employment during an open investigation. Per the policy, the CPS supervisor is responsible for developing a plan for all open reports at the time of receiving notice of staff resignation. In addition, the investigation document used by the department provides a format for supervisors to record and document required supervisory reviews, consultations, and any justification for policy or procedures not being followed.

Department management similarly described how the limited supervisory oversight we observed as part of our audit work could be attributed in part to the fact the department never fully implemented the safety-based investigative model adopted by the department in 2012. They indicated they plan to fully implement the safety-based model. They are currently in the process of examining and rebuilding many of their core systems through process mapping efforts, which will be part of a strategic planning process that will be completed in 2019, including the development of a CQI process.

As part of our follow-up work, we reviewed a sample of 25 reports received by the department in calendar year 2016 to assess the roll of supervisors regarding the review, oversight, and verification of intake and investigative activities. Our review identified circumstances of inconsistent supervisory review and oversight. For example, while the final investigative document requires that a supervisor sign and date a report for review and closure, our follow-up work identified 3 of 12 (25 percent) final investigative reports that had been closed with no evidence of supervisory review and approval. As for centralized intake assessments, there are three possible locations where a supervisor may document their approval, making it difficult to ascertain if the assessment was reviewed by a supervisor. Consequently, 11 of the 25 (44 percent) intake assessments we reviewed did not provide clear evidence of supervisory review. According to department management, this is an area they recognize needs improvement and will be addressed by the future implementation of a new case management system, where supervisory approval

will be located in one rather than three possible locations. Overall, while the department has taken some steps to improve and clarify supervisory responsibilities, our follow-up work indicates that supervisory oversight also still represents an area that needs improving in the department's CPS activities.

RECOMMENDATION #3:

We recommend the Department of Public Health and Human Services:

A. Develop and implement a plan to actively use data collection measures, standards, and tools within existing resources to make informed management decisions and support intake and investigative activities for reports of child abuse and neglect, and

B. Prioritize a portion of funding provided by the 2015 Legislature for the implementation of an electronic records management system and an integrated, automated case management system to more comprehensively administer Child Protective Service activities.

Implementation Status – *Being Implemented*

As part of our follow-up work, department management and staff stressed they recognize the importance of data to manage CPS activities. Consequently, they have placed added emphasis on using data to actively track and administer intake and investigative work. Department management reported they are currently developing a web-based application called "Child and Family Stat" to monitor data in several key results areas, including centralized intake, investigations, and case management. They reported this application will allow them both to track and monitor CPS's strategic plan outcomes and daily work activities, such as meeting priority and investigative time frames. Department management reported they have not developed a formal plan to actively use data collection to manage CPS work. Rather, they describe the web-based application as the data management plan. They reported this application is still under development and expect it to be fully implemented in 2018.

While department management describe the application as a key solution to monitor CPS activities in the future, the field staff whom we interviewed indicated they had no knowledge of the application or its development. Until the application is developed, department management have implemented the use of monthly data extracts and reporting from their current information management system called the Child and Adult Protective System (CAPS). Our initial audit work determined that CAPS is an antiquated computer system with limited functionality to administer CPS activities. Nonetheless, department management have begun to put more effort in developing and reviewing available data extracts from CAPS to provide more meaningful data management tools. During the follow-up, we reviewed several examples of monthly management reports, which tracked numerous aspects of CPS work, including making changes in report priority or category, meeting initial face-to-face contact requirements, or completing investigations within statutory time frames. Based on interviews with both department management and staff, these monthly management reports are actively used to administer CPS activities, such as highlighting trends and staffing patterns.

According to department management, they have also prioritized funding for a new case management system to more comprehensively administer CPS activities. They reported they are currently developing a system by way of a "componentized" approach, where each component, or module, will have the flexibility to be independent of others, but integrate with other portions of the system. Based on the initial analysis, the department has determined that intake, investigations, and case management are the first priority of a componentized approach to system replacement. Per management, these major functions will have the biggest impact to users, and provide the greatest opportunity to streamline and automate tasks for CPS staff. During follow-up work, we reviewed planning documents for the development of this system and determined the system replacement is focused on improving the availability and accuracy of information for the effective delivery of timely and appropriate services for children at-risk of abuse or neglect. According to department management, the total project cost estimate for the system is unknown at this time. However, the department believes the first functional component (intake, investigations, and case management) will require a total of $1.5 million to fully develop and implement, of which $750,000 represents state funding and the remainder federal funding. Department management expect this initial

component will be implemented by October 2018, with full system development and implementation no sooner than the fall of 2022. Department management reported that suspending the development of the new system is currently on the list of potential solutions to get through the current state budget crisis.

RECOMMENDATION #4:

We recommend the Department of Public Health and Human Services comply with state law and department policies regarding priority and investigative time frames for reports of alleged child abuse or neglect by actively establishing and implementing a plan to meet investigative time frames with current resources.

Implementation Status – *Partially Implemented*

In response to the initial audit and follow-up work, department management indicated they are generally unable to meet existing time frames due a lack of resources and the rising number of children in foster care. They also reported that many of the CPS cases activities we reviewed as a part of our work were completed within required time frames, but simply not documented very well. Nonetheless, they reported having implemented a number of changes, which have enabled them to find additional efficiencies in how they conduct investigations, which has in turn improved their ability to meet investigative time frames. For example, the department has revised its final investigative document to require less documentation for reports that are determined to be low risk and do not rise to the level of the removal of a child. Department management and staff also reported the inability to meet time frames is sometimes attributable to the one worker-one family model, where a staff member is responsible for both the investigation and ongoing management of a case. Consequently, department management have generally transitioned staff duties in the field offices located in five geographic regions to an investigative/ongoing worker model, with some staff only responsible for investigations and other staff only responsible for ongoing case management.

Overall, department management and staff described these various efforts as short-term but positive changes that have been very successful tools to aid staff in meeting investigative time frames in the face of an ongoing increase of children removed from homes and placed in foster care. While department management has taken steps to identify and implement changes to increase investigative efficiencies, they believe that once fidelity to the investigative model has been established, adherence with associated time frames will improve. As part of our follow-up work, we reviewed report data from calendar year 2016 to evaluate the department's efforts on meeting investigative time frames. Of the 9,752 reports requiring an investigation, we found that over 60 percent of those reports were not completed within the 60-day time frame required by state law. The completion of those reports ranged from 0 days to 455 days and averaged 69 days to completion. As part of our follow-up work, we also reviewed a sample of 25 reports received by the department in calendar year 2016 to assess investigative time frames. This review identified 12 reports that required an investigation. Over 65 percent (8 of 12) of those reports were not investigated within required time frames, including either priorities for initial face-to-face contact or the completion of an investigative report within 60 days. Based on our follow-up work, while the department has taken steps to identify investigative efficiencies, meeting investigative time frames still represents a risk to children adversely affected by the conduct of those responsible for their care.

RECOMMENDATION #5:

We recommend the Department of Public Health and Human Services address and resolve the inconsistency between state law and the department's safety-based investigative protocol regarding making substantiations or other determinations for child abuse and neglect reports.

Implementation Status – *Not Implemented*

While the department's centralized intake function assigns allegations of potential child abuse or neglect according to incident-based definitions of abuse or neglect outlined in state law, the department's investigative model focuses on assessing the presence of safety threats to a child and working with

families to mitigate those threats. As a result of this difference, our audit work identified numerous inconsistencies in the way final investigative determinations are made for reports of alleged child abuse or neglect. In response to the audit, the department reported they amended administrative rules to establish more of a tiered approach to include a determination category of "founded" rather than "substantiated," which would have a lower burden of proof and would not have negative employment consequences for an alleged perpetrator. Per administrative rules, founded means that, after an investigation, the investigating worker has determined there is probable cause to believe that an act of child abuse or neglect occurred. Substantiated means that, after an investigation, the investigating worker has determined by a preponderance of evidence the reported act of child abuse, neglect, or exploitation occurred, and that the perpetrator of the abuse, neglect, or exploitation may pose a danger to children. Based on follow-up work, current department management and staff reported this tiered-approach does not make much sense from the perspective of addressing inconsistent final investigative determinations. They indicated the addition of a founded category provided opportunities for more accuracy when making a determination, but does not aid in making consistent investigative determinations. Rather, current management stressed this inconsistency could be traced also in part to a lack of fidelity to the safety-based investigative model adopted by the department in 2012. Once fidelity to the safety-based investigative model has been established and a CQI process implemented, the department will be able to monitor investigative activities for compliance and consistency, including making final determinations. Similarly, department field staff reported the fidelity reviews that they conduct are an important tool to assess all investigative activities to ensure they are being conducted correctly.

The discussion of incident-based versus a safety-based model continues to raise numerous questions regarding how the department investigates alleged reports of child abuse or neglect. Department management and staff acknowledge the two models represent fundamentally different approaches to investigating child abuse and neglect reports. While they are hopeful the incident-based nature of the law could be changed to mirror the safety-based focus of their investigative model in the future, they question if the two could be reconciled, as they represent such different approaches. As part of our follow-up work, we reviewed CPS-related legislation from the 2017 Legislature. HB 664 was introduced to create a task force to examine existing laws and processes for resolving child and abuse cases. While the bill was unsuccessful, department management and staff indicated this type of effort takes time but could open the door for changes in the future, including increasing consistency between state law and the department's safety-based investigative model. As part of our follow-up work, we also reviewed a sample of 25 reports received by the department in calendar year 2016 to assess final investigative determinations. Of 12 reports that required an investigation, we found that 11 of those reports were closed with a final determination of unsubstantiated and 1 report was closed with a final investigative determination of founded. Regarding the founded report, available documentation indicated while the perpetrator admitted to the allegation as part of the investigation, there was no rationale for why the allegation was founded and not substantiated, raising reasonable questions as to whether the department consistently makes determinations. Based on our follow-up work, there still appear to be inconsistencies present in the final determinations of alleged child abuse or neglect, as a result of the conflict between state law and the department's safety-based investigative model.

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