An Assessment of the Quality of Child Abuse and Neglect Investigative Practices in the District of Columbia

Center for the Study of Social Policy
in collaboration with the
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AN ASSESSMENT OF THE QUALITY OF CHILD ABUSE AND NEGLECT INVESTIGATIVE PRACTICES IN THE DISTRICT OF COLUMBIA

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I. INTRODUCTION AND OVERVIEW

Under the LaShawn A v. Fenty (LaShawn) class action lawsuit concerning the District of Columbia's child welfare system, The Center for the Study of Social Policy (CSSP) serves as the independent court-appointed Monitor. In that capacity, in the spring and summer of 2007 CSSP collaborated with the District of Columbia's Child and Family Services Agency (CFSA) to assess the quality of the District's Intake and Investigation functions. Federal law, District law, and the LaShawn A. v. Fenty Amended Implementation Plan (AIP) require the Agency to initiate and complete investigations of child abuse and neglect in a timely manner, to interview the alleged child victims, their caretakers and other collateral contacts and to ensure the safety of children who may have been or are at-risk of being harmed. Federal law and the LaShawn AIP also require investigations to be of quality and that services and supports be put in place quickly to increase the likelihood that children can remain at home whenever safely possible and to reduce children's risk of being harmed in the future.

There have been many improvements in meeting the investigation outcomes in the AIP related to timeliness and procedural compliance. The findings of this review confirm the progress in these areas but identify significant concerns related to both the quality of investigations and the lack of supports put in place for families during investigations.

The timeliness and procedural compliance improvements in Intake and Investigations include the continuing reduction in the number of investigations not completed within the requisite 30 days. The backlog of investigations not complete within 30 days has remained under 50 for several months and investigations are being initiated within 48 hours as required by the AIP far more often[1]. Social workers are seeing children during investigations and are conducting safety assessments. Much of this improvement can be credited to an increase in staffing and consistently applied management strategies related to assignment of investigations. Workers and managers report that the overwhelming feeling of constant crisis has abated.

Additionally, supports have been put in place for the Intake and Investigations units that make the job more manageable. These include laptops, cell phones and the availability of cars. Clinical supports are also consistently available to investigators; nurses and specialists in substance abuse, domestic violence and mental health provide consultation and direct support to include conducting assessments and gathering and reviewing records or other documentation. Family Team Meetings are expected to be held with families when there is a consideration of removal and after children have been removed to address immediate safety and risk factors that

[1] District law requires that investigations be initiated within 24 hours.

necessitated removal.[2] When held prior to removal, these meetings can be used to prevent the removal or to assess potential placements within the extended family and also to begin addressing the safety and risk factors that necessitated removal.

This review shows that the most critical area for needed improvements is in the area of investigation quality. There are several areas of particular concern related to investigation quality:

- *Management attention in Intake and Investigations is heavily focused on timeliness of case processing without similar attention to conducting comprehensive assessments, ensuring the high quality of decision-making, addressing families' immediate needs, and initiating plans to reduce risk of harm to children.*
  The reforms in Intake and Investigations and across the Agency have been focused predominately on complying with the timeliness requirements of *LaShawn*. Parallel attention has not been given to enhancing the quality of the interactions with families and the decisions that are made. An effort must be made to both comply with timeliness and ensure that investigations comprehensively and systematically assess families' circumstances. A responsive approach to a family's strengths and needs is needed and decisions about safety and risk must flow from a logical assessment process.

- *Risk assessment implementation is incomplete and confusing.*
  CFSA has begun implementation of a Structured Decision Making™ (SDM) tool in the Investigations unit as a method to assess and document risk factors. These efforts are not yielding the desired result of adequate risk assessment information on each family that is clear and easily accessible. Multiple problems exist including: duplicative risk assessment tools are in use; the current risk assessment tool is not yet uploaded for use in CFSA's electronic case record (FACES); the hard copy risk assessment tool is not consistently available in case records; and a questionable policy and practice to destroy risk assessment documents in investigations where there has not been a substantiation of neglect or abuse but there has been a referral for the provision of services. Additionally, when the risk assessment tool was available in the case record for this review, the reviewers did not agree with the assessment of risk by Investigations social workers in some investigations.

- *Adequate services and supports are not put in place for families during an investigation.*
  Families reported to child protection are often in crisis and need immediate support. Determining the strengths and needs of the family and connecting them with appropriate service providers to ensure safety and reduce risk is a separate and distinctive task from determining whether the alleged abuse and/or neglect actually occurred. Both job functions are important and critical for the families and children with whom CFSA intervenes.

[2] Current policy does not include a "removal" Family Team Meeting for abuse investigations when a criminal investigation is under consideration. In practice, pre-removal Family Team Meetings are infrequently held.

- *The lack of specialized training, standardized procedures, and high quality practice expectations create inconsistencies in investigation practice.*
  Investigations staff do not receive training specifically geared toward their job descriptions nor is there a procedural manual or best practice guide to support workers. Additionally, CFSA's practice model is not being fully implemented across the Agency, including in Intake and Investigations work. The lack of these integral practice supports means that decision-making and action-planning are uneven and highly variable from worker to worker and supervisory unit to supervisory unit.

Several important quality improvement efforts have been emerging within Intake and Investigations including Grand Rounds, an internal case review process for Investigations supervisors developed collaboratively by CFSA's Quality Improvement and Intake and Investigations Administrations; using a screening panel to review all Hotline calls accepted for investigation; and a critical decision-making training for front-line supervisors and program managers entitled Critical Thinking and Safety Decision Making. Augmenting these improvements with additional specialized training for Investigators, standardized practice expectations and procedural guidelines would further aid in promoting consistency and enhancing quality.

The District continues to invest considerable resources in strengthening all aspects of its child welfare agency. The expectations for the results are high, commensurate with the level of investment. This includes the expectation that daily practices with children and families are aligned with the Agency's mission and practice model and that mechanisms are in place to continually understand whether both quantitative and qualitative outcomes are being consistently achieved.

II. METHODOLOGY AND STRUCTURE OF THE REPORT

This paper presents findings from a case record review of 40 CFSA investigations completed in March 2007. The review was based on information in CFSA's case record (FACES), as well as a review of hard copy risk assessments. These findings are highlighted throughout the report as Practice and Management Findings. Updated administrative data from March 2007 (the month of the case record review) or July 2007 (mid-year) are also presented regarding specific AIP requirements when these data illuminate progress towards the *LaShawn* compliance benchmarks.

It is important to note that the 40 investigations reviewed are not a statistically representative sample of all of the investigations completed during March 2007 and, therefore, the findings cannot be extrapolated to the entire universe of investigations. CFSA and the CSSP agreed that taking a snapshot of practice would be useful if it was combined with qualitative data collected from other sources. To gather this qualitative information, the Monitor conducted focus groups composed of staff of the District of Columbia's Metropolitan Police Department's Youth Division, Child Advocacy Center (CAC), the Children's National Medical Center Freddie Mac Foundation Child and Adolescent Protection Center (CNMC/CAPC), as well as Family Court Judges and Referees, CFSA Family Team Meeting facilitators, and CFSA Intake and Investigations managers, supervisors and social workers respectively. Information from the focus groups is interspersed throughout the "Practice Findings." Information based on regular attendance by the Monitor at CFSA's child fatality review meetings and Intake and Investigations Grand Rounds adds to the review of the quality of practice and decision-making with families reported to the Hotline for suspected maltreatment and is reflected in this report.

Each section of the report begins with best practice expectations related to how a quality child protective services system agency should function. This information is generic in nature and would apply to any public child protection system. The Monitor has taken this approach in the report in an effort to promote management and supervisory practices that enhance the quality of investigations. In other words, the Monitor hopes that information contained in this report provides the Agency with the opportunity to review its current investigations practices as compared to best practice information. Using the findings of this report, as well conducting its own assessment efforts, will allow the CFSA to determine what additional actions should be taken to improve the quality of its work and ensure better outcomes for children and families.

III. FINDINGS FROM THE CASE RECORD REVIEW

CFSA and its child and family serving agency partners have three primary roles related to child protection:

1. Responding to reports of suspected child abuse and/or neglect,
2. Protecting children from harm, and
3. Supporting families to reduce the risk of future harm to children.

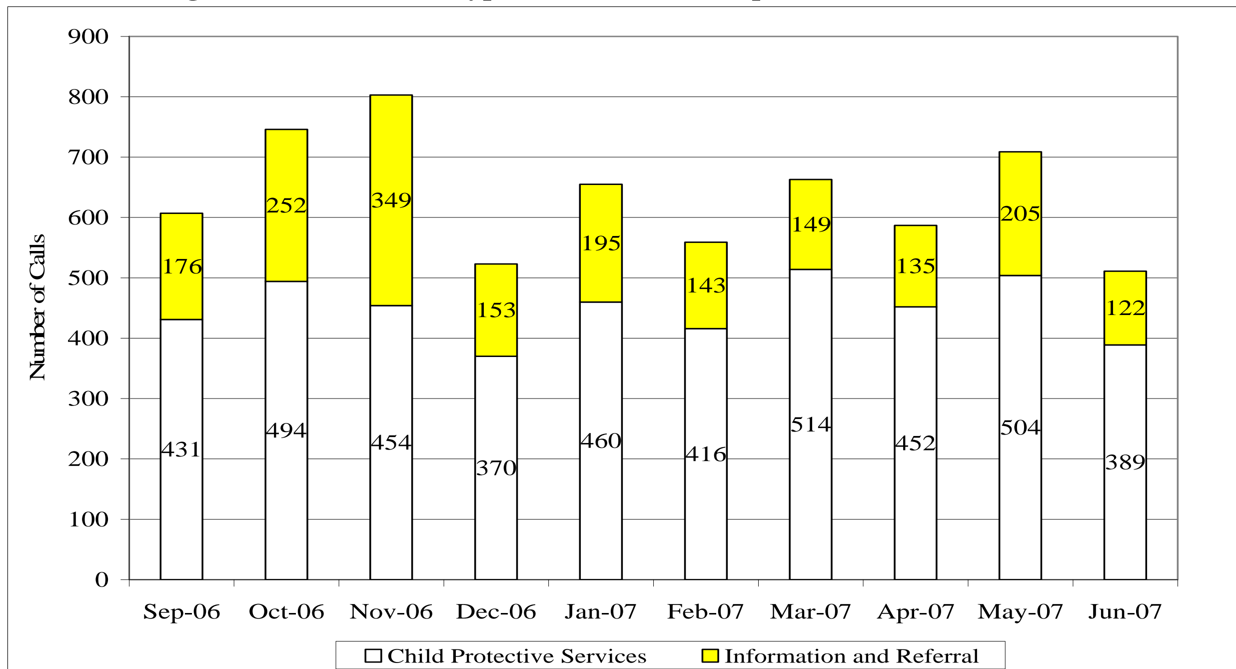
Intake and Investigations is the "front door" to a jurisdiction's public child welfare agency. Investigation staff act as gatekeepers to a child and family's involvement with the agency by determining: when children are in unsafe situations; when children are in situations that place them at various levels of risk of harm; what is needed and by whom to maintain children safely with their parents or caretakers; and whether a child, (or an adult who lives with them), needs to leave their home to ensure the child's safety and well-being.

A. Responding to Reports of Suspected Child Abuse and/or Neglect

1. Functions of the Hotline

A well-publicized and accessible mechanism for receiving reports of suspected child maltreatment 24 hours a day, seven days a week acts as the figurative and literal front door of the public child welfare agency. CFSA operates a 24-hour telephone Hotline for 'Intake' and 'Screening.' See Figure 1 below for data on the calls received at the CFSA Hotline between September 2006 and June 2007.

Figure 1: Number and Type of Hotline Calls September 2006 to June 2007



Source: CFSA Administrative Data, June 30, 2007.

Hotline staff need specific skills and tools in order to perform the crucial decision-making responsibilities their job entails. As the point of initial contact, the person who answers the telephone at the Hotline is expected to do so in a professional manner. This person must possess good listening skills, be patient, empathetic and a good decision-maker. Hotline staff are to gather information from the caller regarding the whereabouts of children and caretakers, the nature of suspected maltreatment and information to assess the strengths and needs of the family and possible safety and risk concerns.

Additionally, Hotline staff must have the necessary tools to elicit the information required to decide whether a report(er) requires diversion to a community-based or other agency or whether there is suspected child maltreatment that warrants investigation. The staff person must have access to the child protection system's records which provide the Hotline worker with immediate information about whether a family has had any prior contact with the child protection system, household composition, and other information which may be relevant to the current report of suspected child maltreatment.

Below are the practice findings related to functioning of the CFSA Child Protection Hotline.

Practice Finding 1:
Key mandated reporters participating in focus groups cite improvements to the CFSA Hotline.

Members of the *Children's National Medical Center Freddie Mac Foundation Child and Adolescent Protection Center (CNMC/CAPC) Focus Group* indicated improvements in Hotline functioning, including:

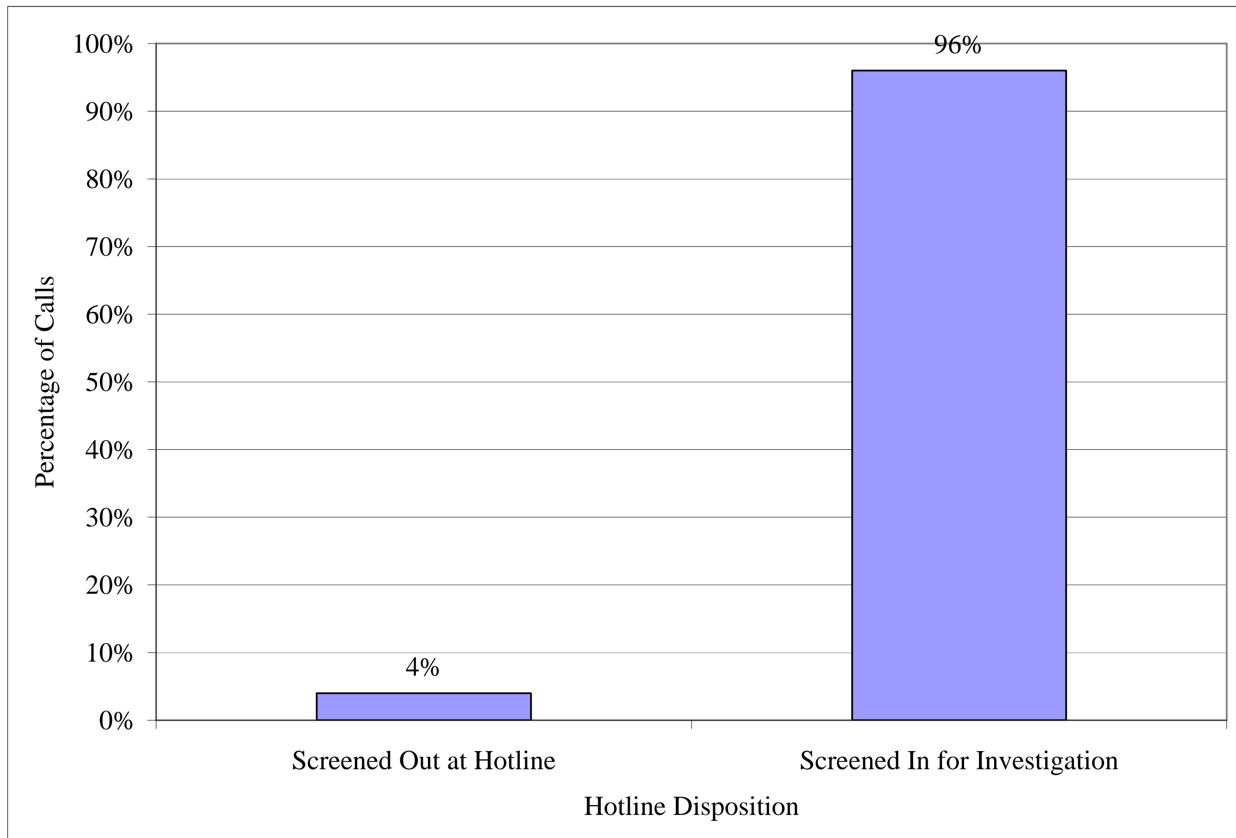
- Reduction of wait time for answering calls;
- Hotline staff more quickly reference whether the family has been previously involved with CFSA;
- Hotline staff seem more knowledgeable, ask more astute questions and are less adversarial; and
- Hotline staff collect a sufficient amount of assessment information during the call.

The Hotline staff must use the policies, laws, and practices guiding the operation of the Intake system to make a decision about whether to accept a report for an investigation. Sufficient information must be gathered to determine if the allegation meets the jurisdiction's legal definition of child abuse or neglect. When situations do not warrant an investigation, the staff person may refer the caller to other community services or law enforcement for additional help.

Practice Finding 2:
CFSA accepts for investigation nearly all allegations of abuse and neglect called into the Hotline.

Figure 2 below shows the calls to the CFSA Hotline in March 2007 that were related to allegations of abuse and neglect and the decision at the Hotline to accept the call for investigation or screen it out. Nearly 100% of the calls related to allegations of abuse and neglect were accepted for investigation, a trend that has continued since at least April 2006. There are several possible explanations for the nearly 100% acceptance of allegations for investigation to include efforts by CFSA to work with mandated reporters to more accurately identify suspected abuse and neglect, a more appropriate coding of the types of calls coming into the Hotline (i.e. information and referral vs. allegations of child abuse and neglect) and/or better screening by the Hotline staff to ensure that all potential abuse and neglect receives a response by the Agency. Conversely, these data may represent a lack of adequate assessment to screen out reports inappropriate for investigation. Additional analysis of Hotline practice is needed to make a full determination about this finding.

Figure 2: Disposition of Calls to the Hotline March 2007
(N=663)



Source: CFSA Administrative Data, March 31, 2007.

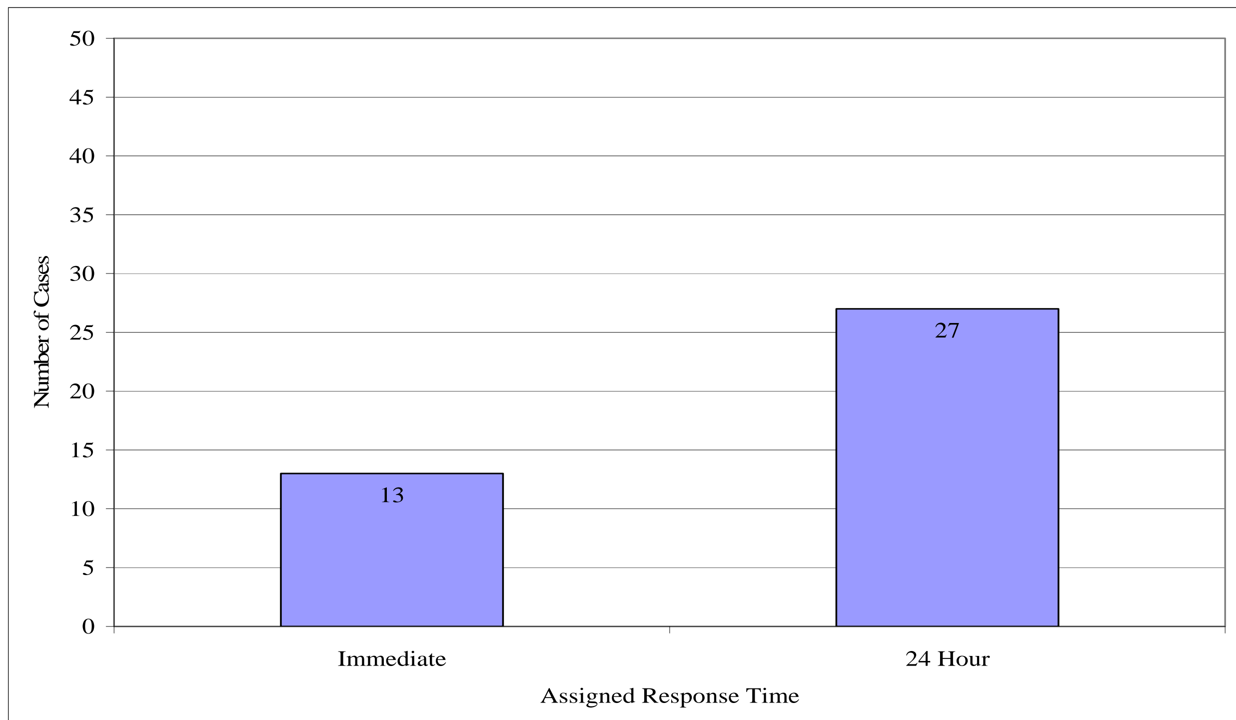
When the information provided to the Hotline worker is deemed sufficient enough to meet the jurisdiction's definition of child abuse or neglect, the report is screened in and the Hotline social worker determines a response time for initiating the investigation. In the District of Columbia, the response time is either "immediate" or "within 24 hours" based on the type and severity of the allegation. Hotline workers are assisted in determining the response time by completing a standardized checklist based on information gathered from the reporter. See Figure 3 below for information on the assignment of response times by CFSA's Hotline for the 40 investigations reviewed.

Practice Finding 3:
Hotline social workers are generally assigning appropriate response times for investigations.

Reviewers agreed with the response time assigned by the Hotline staff in 33 of 40 investigations. In 13 of the 40 investigations reviewed, the response time was determined to be immediate. In the remaining 27 investigations, the response time was determined to be within 24 hours.

Of the seven reports in which the reviewers did not agree with the assigned response time, four were assigned a 24 hour response time, yet, were for allegations of sexual abuse, which by policy should be responded to immediately if the alleged perpetrator has access to the child. For the remaining three investigations, reviewers judged that the response time did not require the "immediate" designation assigned. For example, a report of alleged physical abuse contained no allegations of serious physical abuse yet received an immediate response time designation.

Figure 3: Type of Response Time Assigned
(N=40)



Source: CSSP-CFSA Case Record Review, April 2007.

Practice Finding 4:
CFSA has created a Hotline Screening Panel of supervisory and managerial staff to help standardize decision-making, but as implemented this process may contribute to unnecessary delays in quickly responding to allegations of child abuse and neglect.

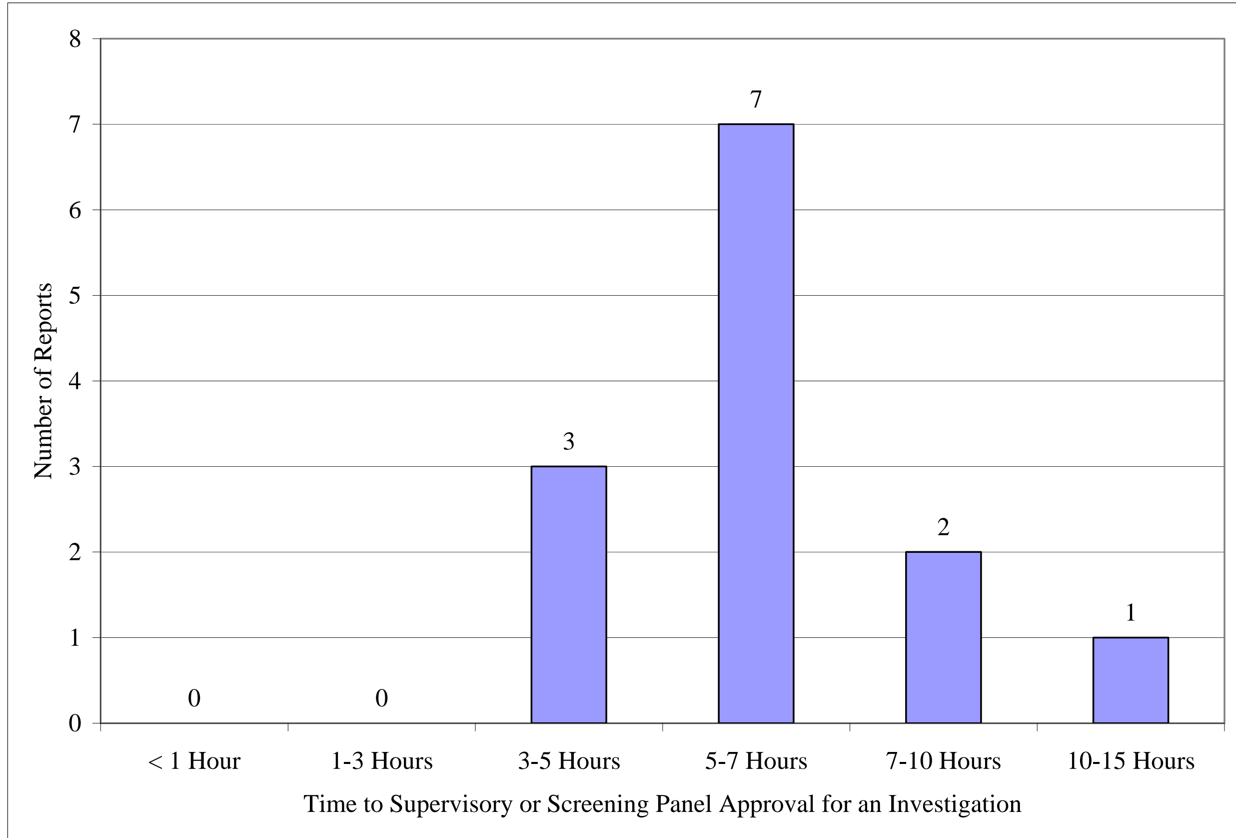
The purpose of the implementation of a twice daily staffing/screening process for supervisory review of reports to the Hotline is to ensure appropriate screening of reports and provide oversight of and accountability for the decision of whether or not to investigate. Focus group participants voiced concerns that an unintended consequence of this screening panel is that a lag time seems to have resulted by adding a supervisory review seemingly once per day to the Intake process.

The District's Metropolitan Police Department's Youth Division Detectives stated they often receive "bunched referrals" in the late afternoon, seemingly after the completion of the supervisory screening. They are concerned that receiving referrals in this manner negatively affects their response time to children and families.

The data in Figure 4 show that supervisory approval to move a report from the Hotline to an investigation unit is often delayed for many hours. This is particularly critical when the safety concerns are so great that an "immediate response" designation has been assigned. Of the 40 investigations reviewed, 13 investigations required an immediate response from CFSA as determined by the Hotline worker. Ten of the 13 calls requiring "immediate response" did not receive supervisory approval until 3 to 10 hours after the report was received.

Despite the time lag documented in the investigation records and indicated in Figure 4, CFSA Investigations managers have stated that social workers are nevertheless immediately assigned to begin working on 'higher' priority response investigations and are not delayed by awaiting the screening panel's result. Given the concerns raised by YD coupled with the below data, more review is necessary to determine the exact timeline between when a call is received and when a social worker makes contact with the alleged victim child.

Figure 4: Time to Supervisory Approval of Hotline Reports Designated "Immediate" for Investigation (N=13)



Source: CSSP-CFSA Case Record Review, April 2007.

2. Collaborating with Police and Partner Agencies

Depending on the severity of the allegations, particularly when actions by a parent or caretaker may rise to the level of a criminal act, the Hotline worker decides if, in addition to a child protection worker, dedicated law enforcement personnel should be notified for a 'joint investigation.' District law requires a joint investigation with the Youth Division of the MPD for serious abuse investigations and investigations where criminal prosecution may be warranted. Collaboration between the Investigations and law enforcement staff is intended to provide for timely sharing of information during the investigation and a reduction of the number of times children and family members are interviewed by professionals.

Practice Finding 5:
CFSA social workers partner with Metropolitan Police Department's Youth Division and the Child Advocacy Center to investigate child abuse reports.

There were seven investigations in the 40-investigation sample where a joint investigation was warranted. Of these seven investigations, six joint investigations occurred.

In one of those six investigations, an interview at the Child Advocacy Center was warranted and occurred.[3]

Practice Finding 6:
Law enforcement and social work professionals see the benefit and want expansion of collaborative work. More needs to be done to coordinate joint investigations.

Youth Division Detectives and staff of CFSA and the Child Advocacy Center (CAC) spoke positively of working together on investigating reports of child abuse. They experience the benefits of this multidisciplinary approach to investigation and would like to see a more strategic implementation of the legislative requirement for joint investigation.

A unit of CFSA social workers is currently housed off-site with Youth Division. However, those social workers are not dedicated to working solely on joint investigations. They are currently assigned to investigate a range of serious maltreatment reports including child fatalities, sexual abuse and severe physical abuse. Other social workers located at CFSA are also assigned to work on joint investigations

B. <u>Protecting Children from Harm</u>

1. Investigation Initiation

A person who contacts the child welfare agency in good faith to report suspected child maltreatment expects that someone with expertise in evaluating the status and functioning of children and their families will directly respond and assist in improving the child and/or family's

[3] Children are taken to the Child Advocacy Center for a multi-disciplinary forensic interview in investigations of sexual and serious physical abuse.

situation. The Investigation process of a child protection system should be designed to accomplish this expectation utilizing a range of resources within the agency, family, and community. Child protection workers, sometimes in partnership with law enforcement personnel, but more often alone conduct the investigation with information gathered at the Hotline, from the agency's records, from other accessible public system databases, from the family, and other sources.

Practice Finding 7:
The majority of investigations are initiated in a timely manner.

District law requires CFSA to initiate investigations within 24 hours and *LaShawn* requires investigations to be initiated within 48 hours. The initiation of an investigation includes interviews with all alleged victim children outside the presence of their caretakers.

CFSA has made significant improvement in the timely initiation of investigations. The review of 40 investigation records shows that 34 of the 40 investigations met either the District or *LaShawn* standard for investigation initiation; six investigations did not. Additionally, this is the first time the Monitor has been able to use an agreed upon definition of "good faith efforts"[4] and to determine with confidence the extent to which CFSA is making good faith efforts to locate and interview all children.

Table 1: Investigation Initiation (N=40)

Timeframe for Initiation	Number of Cases
All Victim Children Seen w/in 24 hours	27
All Victim Children Seen w/in 48 hours	4
Good Faith Efforts	3
Did Not Meet Standard	6
Total	*40*

Source: CSSP-CFSA Case Record Review, April 2007.

2. The Safety Assessment

The foremost task of workers who investigate allegations of suspected child maltreatment is to ensure that children are safe from harm. This vital determination is made during the first contact with children, that is, upon initiating the investigation. Safety is also a primary concern throughout the investigation. Within a short time period and while still gathering information, the worker must make an initial decision about whether the child(ren) is safe with his or her parent or caretaker or if there are actions which should be taken to ensure the child(ren)'s safety while the investigation continues.

[4] Good faith efforts include visiting the child's home, school and day care in an attempt to locate the child as well as contacting the reporter, if known, to gather additional information about the child's location. Additionally, contacts with the police shall be made within the first 48 hours for all Priority I and Priority II Abuse allegations when the family or child cannot be located.

Practice Finding 8:
CFSA social workers are gathering sufficient information upon initiating an investigation to make a safety decision for most, but not all children.

The record review found that appropriate initial safety decisions were being made in a majority of investigations. Reviewers concluded that the social worker gathered sufficient information to make a safety decision in 32 of the 40 investigations. Reviewers agreed with the investigator's safety decision in 29 of those 32 investigations. For those instances where the reviewer determined that sufficient information was not gathered, generally the worker had not met all of the children before completing the safety assessment.

3. Investigating the Reported Allegations

Investigating reported allegations of neglect and/or abuse requires gathering information from a range of relevant sources that are familiar with the functioning of the specific child and family in question. These individuals usually have relevant information both about the challenges a family may be facing which place a child at risk of harm and they may also provide facts about strengths of and resources available to the child and family.

Practice Finding 9:
CFSA social workers are more consistently making contacts with collaterals during investigations, but more remains to be done to ensure high quality investigations.

Reviewers noted that social workers made contact with collateral sources and gathered sufficient information in 30 of the 40 investigations. All five required collateral contacts were made in 20 of the 40 investigations.[5] In the investigations where there were collateral contacts, those contacts were with a range of parties including law enforcement and mental health professionals and relatives.

CFSA should continue to make improvements in this area as well as in gathering comprehensive information from professionals involved with children and families to inform assessment of risk and needs, as described below.

CFSA social workers are required, by policy and the AIP, to gather medical and educational information about children during an investigation to inform their assessment. Medical and educational personnel usually have the most contact with children aside from their families and are a good source of information about a child and family's well-being. Therefore, contact with these persons is critical in both the investigation of maltreatment allegations and the assessment of risk.

[5] The standards for the five core contacts are: 1) initial 24-hour face-to-face contact is held with alleged victim; 2) face-to-face interview is conducted with alleged maltreator; 3) contact with the reporting source; 4) contact with the medical and educational providers; and 5) all household members must be interviewed)

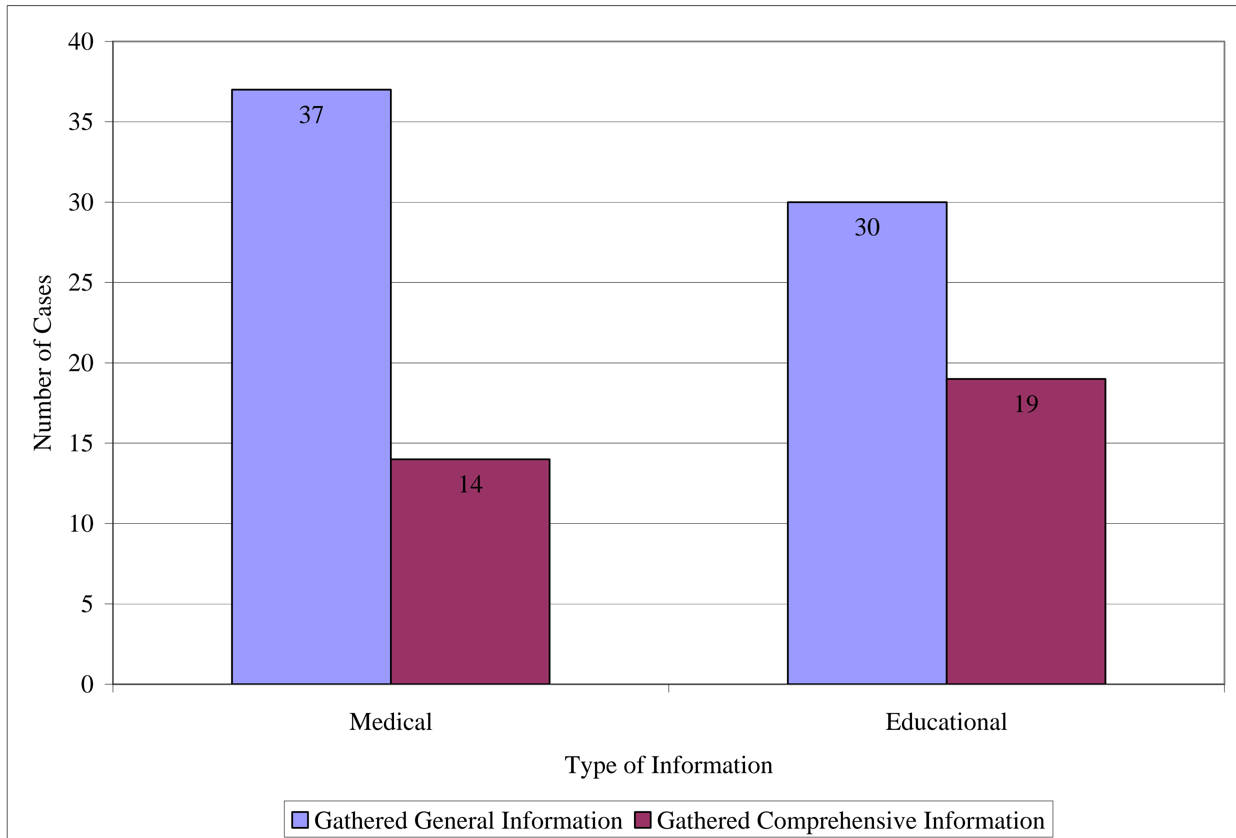
Practice Finding 10:
CFSA social workers are gathering basic information about children's medical and educational status but are not routinely collecting comprehensive information to more fully inform their assessments.

Reviewers noted whether social workers collected medical and educational information about children and assessed the type information gathered. That information ranged from basic to comprehensive as illustrated in Figure 5 below.

In 37 of 40 investigations, basic health status and immunization information was gathered. In 30 of the 34 investigations where children were of school age, basic educational information such as a child's attendance record was gathered.

In some investigations reviewers found that social workers gathered more extensive information about a child, such as behavioral and academic performance in school during face-to-face contact, telephone conversations or a review of documentation from educational professionals

Figure 5:
Medical and Educational Information Gathered During Investigations
(N=40, medical; N=34, educational)



Source: CSSP-CFSA Case Record Review, April 2007.

At times during an investigation, social workers may need to contact another professional to gather evidence or information about the child or family to make a determination regarding the allegations of maltreatment. For those families who do not consent to such evaluations or who otherwise refuse, court intervention may be required to ensure the evaluations needed to complete an investigation are obtained.[6]

Practice Finding 11:
Children are receiving medical and mental health evaluations to assist CFSA social workers in making determinations about allegations of abuse or neglect.

In 12 of the 40 investigations, reviewers determined that a child needed a medical evaluation in order to assist the social worker in making a determination about the allegation. In 10 of 12 of those investigations, the child(ren) received a medical evaluation. In one investigation a child needed and received a mental health evaluation to inform the investigation.

4. Assessing Risk of Harm

In addition to the mandate to investigate reported allegations of maltreatment suspected or identified during an investigation, workers assess risk of future harm to children. This is an essential part of the overall assessment as it serves as a fundamental planning process for providing preventive and supportive interventions for families.

The Children's Research Center's Structured Decision Making™ assessment tools are currently used in child protection systems across the country including the District of Columbia. These tools include a risk assessment form to be completed during an investigation of child maltreatment. The Children's Research Center's protocol for use of the risk assessment tool states that regardless of the determination made about the reported allegations, families with a low and moderate risk rating should be referred to a community-based provider for follow-up as needed. Additionally, families with a high or intensive risk rating, regardless of the determination about the investigated allegations, should be referred to the public agency's service system.

A quality assurance process is important in many different aspects of the Intake and Investigations. A structured periodic record review focused on particular questions can inform a system about practice and system strengths and needs. The Children's Research Center encourages review of a system's use of their assessment tools, suggesting an analysis of both the decisions practitioners make over time and the needs of the families that come to the Agency's attention. The child welfare agency itself and the larger child and family serving system may also be able to use this data to ensure they are developing strategies and adjusting to the demands of a population of children and families.

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[6] Some jurisdictions allow pre-petition subpoena requests. D.C. does not, but has proposed controversial legislation to give Investigators access to medical, mental health and educational records of all children who reside in a household where there is an abuse and neglect investigation.

Practice Finding 12:
CFSA does not have a consistent, reliable mechanism for assessing and tracking the assessment of risk of harm to children during investigations.

CFSA, like many other child welfare agencies, has policy requiring and has begun utilizing an updated Structured Decision Making™ (SDM) risk assessment tool during the investigative process to aid in decision-making[7]. This enhancement is intended to standardize the information gathering and review of risk factors affecting the lives of children and families.

However, the Agency has not yet integrated the updated SDM risk assessment tool into FACES. CFSA plans to use funds from a 20007 Congressional allocation to revise FACES to include the SDM risk assessment tool. As a result of the current lack of technological support, the updated SDM tool is completed in hard copy by social workers during the investigation. The "outdated" risk assessment tool, remains activated in FACES and it is functionally impossible for a social worker to close an investigation in FACES without first completing the outdated risk assessment tool. There is currently considerable inconsistency in both procedure and practice regarding risk assessment.

Practice Finding 13:
Neither CFSA's Structured Decision Making™ risk assessment tool or references to the results of the completed risk assessment tool is consistently maintained in the investigation records. Therefore, investigation records are incomplete with insufficient data about assessments of family strengths and challenges.

CFSA has implemented a questionable practice of maintaining the hard copy of the updated SDM risk assessment tool for substantiated investigations only. The Monitor is unclear about the rationale of that practice given that CFSA policy requires that in investigations where there has been an assessment of low or moderate risk of harm there should be consideration of a referral to the Healthy Families Thriving Communities Collaboratives (Collaboratives) for services. It is also not clear whether CFSA has opted not to follow all of the standards set forth by the Children's Research Center for use of their tool.

In the majority of investigations in which there was a substantiation of a report of abuse and/or neglect, no hard copy risk assessment tool could be located in the ongoing CFSA investigation record for the record review.[8] Additionally, for those investigations there was no documentation in FACES of the result of the hard copy risk assessment.

[7] The updated SDM risk assessment tool replaces a previously developed and implemented risk assessment tool.
[8] CFSA indicates its practice is to maintain hard copies of the assessment tool in substantiated cases and these are to be shared during the transition to CFSA or Collaborative workers who will be working with the family.

Practice Finding 14:
Reviewers did not agree with the CFSA social workers' assessment of risk.

Only four of the 18 hard copy risk assessments (which should have been accessible per CFSA policy as stated above) were available at the time of the review. In three of those four assessments, reviewers did not fully agree with the social workers' assessment of risk. Table 2 below shows the findings from the investigation record review related to risk assessment.

Table 2: Risk Assessment
(N=40)

Status of Risk Assessment Tool	Number of Cases	Investigation Finding	Reviewers' Assessment of the Quality of Risk Assessment
Hard Copy Risk Assessment Available	4	Substantiated – 4	Fully Agreed with Risk Assessment – 1 Partially Agreed with Risk Assessment – 3
Hard Copy Risk Assessment Required by Current CFSA Policy but Not Available in the Record	14	Substantiated – 14	Unable to Determine
No Risk Assessment Required to be Maintained per Current CFSA Policy and Assessment Not Available	22	Unfounded – 20 Inconclusive – 2	Unable to Determine
Total	40	40	

Source: CSSP-CFSA Case Record Review, April 2007.

C. Supporting Families to Reduce Risk to Children

1. Responding to the Needs of Children and Families

The child protection agency in any community is expected to respond to children and families who come to its attention through allegations of abuse or neglect and provide supports directly or by linking them to other agencies or providers. CFSA relies on the Healthy Families Thriving Communities Collaboratives, along with other community-based agencies, to provide a range of neighborhood-based supports. CFSA has an agreement with the Collaboratives to serve families where there has been an investigation of neglect or abuse allegations and the family's circumstances have been assessed to be of low or moderate risk. The goal of these interventions with families is to ensure that children can remain with their families with reduced risk of harm and to prevent families from entering or re-entering the child welfare system.

Practice Finding 15:
Families whose situation is assessed to be of low or moderate risk were not referred to the Collaboratives or community based organizations for supportive preventive interventions.

Practice Finding 16:
Families whose situation is assessed to be of high or intensive risk are being referred to CFSA services.

The outcome of the SDM™ risk assessment guides decision-making as to which type of service is to be provided to a family. SDM™ best practice guidelines suggest referrals for services be made for all investigated families at high or intensive risk regardless of whether the investigation is substantiated. CFSA current practice is to provide high or intensive unsubstantiated cases with information and referral to services based on the specific needs of the family. When children are not removed from home but the result of the risk assessment is that there is high or intensive risk of harm to the child(ren), the family is to be referred to a CFSA In-home social worker for services. Families with low or moderate risk are to be referred to the Collaboratives for services as needed.

Given the restrictions on maintaining risk assessment protocols in the case record for families that are not substantiated, reviewers only looked for the referrals for families with a substantiated investigation. There were 18 substantiated investigations; reviewers could find information on referrals for 15. In four of the 15 instances, the family's situation was assessed as low to moderate risk and there was no documentation in FACES that a referral had been made to a Collaborative, that a referral was not needed and/or that a referral was refused by the family.

For the remaining 11 investigations, the family situation was assessed at high or intensive risk and the families were referred to CFSA's ongoing services or connected to an existing open case. In eight of these 11 investigations, a child was removed from home during the investigation due to safety concerns.

2. Addressing Underlying Needs and Service Provision During Investigations

In order to make a decision on an allegation of child maltreatment, child protective services investigators are expected to gather all necessary information through interviews with children, family members, collateral contacts, other diagnostic activities such as formal evaluations and/or medical exams and the review of records which may be available from a variety of sources. Jurisdictions have different timeframes for completion of investigations, typically ranging from 30 days, (as in the District of Columbia) to 60 days. Completing these activities and synthesizing the data collected helps to ensure that the Agency has made the best determination about the allegations and has taken appropriate immediate action to ensure the safety of the children and to reduce the risk of further harm.

These activities are also completed to determine how best to support the family and meet their underlying needs so that the children can remain safely at home or return to their homes as quickly and as safely as possible. Effective human services practice demands that all child welfare system representatives provide children and families in need with the appropriate level of intervention at the time the need is identified. Families should not have to wait until the investigation is completed or until their case is referred to another social worker for action to be taken to address pressing needs.

Practice Finding 17:

Families' immediate needs are not being adequately addressed during the investigation.

This review found that while social workers document or make recommendations to families about useful follow-up services to be implemented once an investigation is closed and a referral is made to a Collaboratives, CFSA in-home or on-going services, services or service referrals are not typically initiated in the 30 day period of the investigation.

In some instances, this means a family in immediate need of services waits at least 30 days for the investigation to close and for transfer to another social worker before receiving any intervention to meet their needs.

Staff in the Investigations unit report that emergency services through the Collaboratives were previously immediately available to families during an investigation, but those services are no longer available due to the structure of CFSA's current contracts with the Collaboratives. With the absence of these services and a culture in the Investigations units focused on "making a determination about the allegations," service delivery to families in crisis is often delayed.

One important exception observed through the investigation record review is related to parents with substance abuse concerns; eight of nine parents needing substance abuse treatment were referred for those services during the investigative process. Three families were also aided with furniture during the investigation. Table 3 below shows the pattern of referrals for the 40 investigations in the record review.

Table 3: Service Referrals for Children and Families During an Investigation

Reviewer's Assessment of Type of Service Needed	Number of Children or Family Members Needing Service	Referral Made	Referral Not Made
Mental Health Treatment – Child	6	1	5
Substance Abuse Treatment – Child	1	0	1
Mental Health Treatment – Parent	5	1	4
Substance Abuse Treatment – Parent	9	8	1
Medical – Parent	1	0	1
Parenting Skills Class	7	4	3
Domestic Violence Services	1	1	0
Other[9]	22	14	8

Source: CSSP CFSA Case Record Review, April 2007.

Practice Finding 18:

There is evidence of supervisory review of and input in investigation records and many of those were deemed to be of good quality.

Supervisory input and directives to social workers were evident in half (20 of 40) of the records reviewed. 15 of those 20 investigations in which there was documented supervisory review were also deemed to be of quality by the reviewer.

[9] Other services included referrals for grief counseling, medical exams, family counseling, individual counseling, early intervention services, anger management and multi-systemic therapy.

IV. Managerial Functions within CFSA's Intake and Investigations Administration

A. Staffing

Along with a range of other resources, managerial functions must support the work of social workers with children and families. Managers oversee and adjust staffing levels based on a range of relevant data, including workload demands.

Management Finding 1:
Increased staffing during the daytime shifts is an improvement noted by CPS staff and external stakeholders. CPS staff turnover has diminished.

Staff and external partners acknowledged that increased staffing in the Intake unit has lead to better quality of investigations. Additionally, the specialized unit established to handle investigations of sexual abuse was noted as a positive step toward high quality investigations of sexual abuse.[10]

Further CNMC/CAPC staff pointed out that social workers, rather than social service associates, are more often accompanying children to the hospital for health screenings prior to placements and that this is helpful because the workers are knowledgeable about the child and family.

Management Finding 2:
Staffing levels for after hours and weekends remain insufficient.

There are three units covering the after hours and weekend shifts – one unit for the evening shift, one for the overnight shift and one for the weekend shift. Each of these units is staffed by a supervisor, three investigative social workers, one or two social services assistants and a Hotline worker. By all accounts, this staffing level is not adequate to meet the needs of children and families in crisis after normal business hours. Daytime staff frequently work overtime to provide additional coverage on these shifts, which results in worker burnout and increased overtime payments. Additionally, callers to the Hotline are sometimes placed on hold for extended periods of time in the evening due to inadequate staffing.

The CPS Program Analyst position also remains vacant and has currently been frozen by the Director. Program Analysts are responsible for reviewing and analyzing data and helping the leadership use analyses to manage each administration. The lack of an Analyst in Intake and Investigations means that these job responsibilities fall to the direct management staff who do not have the same level of data expertise nor the dedicated time to complete these functions. Having an Analyst assigned to child protective services could assist managers in determining where to focus their efforts and how to best allocate resources.

[10] Findings are from focus groups with CPS staff and Child Advocacy Center staff.

B. <u>Training and Standardized Procedures</u>

Management Finding 3:
There remain significant gaps in training and support for CPS workers.

Management Finding 4:
Joint training with the Metropolitan Police Department Youth Division staff and other partners is needed.

Several focus groups indicated gaps in training and suggested there should be increased attention to this area. Specific concerns include the scheduling of training, lack of availability of social work Continuing Education Units (CEUs) for the training provided by CFSA, limited training on the application and adherence to the Agency's Practice Model in investigations and the lack of joint training between CPS, MPD and other agencies to improve coordination and role clarification.

While the MPD Youth Division Detectives noted that they participated in some prior joint training with CFSA investigators, the Guardians Ad Litem and Child Advocacy Center staff both agreed that CFSA and YD were often not operating from a consistent understanding of policy or practice. These groups added that CFSA workers are often individually inconsistent and demonstrated limited competency around use of protocols or specialized knowledge in areas such as sexual abuse and cultural competency.

CPS workers and supervisors reported the core training they have received is generic and should be targeted to a wider range of topics necessary and useful in their roles. Newly hired workers slated to become investigators receive the standard pre-service training offered to all CFSA staff, but are not offered training specific to their jobs. In addition, there are very few in-service training opportunities focused on specific topics relevant to child protective services for previously hired investigations staff.

CFSA staff also saw a need for more opportunities for professional review and debriefing of investigations that occur in a supportive environment in order to foster their learning. Focus group members stated they think CFSA should do more to address the needs of staff with regard to the emotional impact of staff's work and they would like to see additional external supportive services for workers.

V. OVERARCHING CONCERNS RELATED TO QUALITY PRACTICE: CRITICAL DISCERNMENT AND COMPLIANCE EMPHASES

CFSA has made significant gains in meeting many of the investigation standards of *LaShawn*.

- The backlog of investigations is down to 57 investigations as of October 12, 2007
- In July 2007, 34% of investigations were initiated within 24 hours, 69% of investigations were initiated within 48 hours and good faith efforts to initiate within 48 hours were made in 25% of the investigations.
- 46% of investigations were completed within 30 days in July 2007.

Additionally, improvements in the assignment of investigations and management of the workload have allowed workers to attend more quickly to the safety and risk concerns of children and families. Plans to have In-Home social workers stationed in the community to provide services and supports to families with high or intensive risk factors is another important area of progress.

The Monitor remains concerned about the overall quality of investigative frontline practice. The intensive focus on timeliness of investigations has not been accompanied by an equal emphasis on the quality of decision-making and service linkage during the investigative process. The investigation record reviewers judged that only 20 of 40 investigations included the five core contacts required by policy and that 26 of the 40 investigations reviewed were of quality. In 32 of the investigations reviewed, reviewers determined that the information documented in the investigation record fully supported the investigation decision.

Table 4: Overall Quality of the Investigation (N=40)

	Yes	No	For Some Allegations
Was the investigation thorough, comprehensive, and of good quality?	26	14	N/A
Were the five Core Contacts made?	20	20	N/A
Does the information documented support the determination(s) for all allegations made in this investigation?	32	6	2

Source: CSSP CFSA Case Record Review, April 2007.

The Monitor also gathered data regarding the quality of investigations through attendance at CFSA and city-wide child fatality reviews and observation of "Investigations Grand Rounds" (a new continuous quality improvement activity in which Investigations are chosen randomly for review). These forums provide the Monitor with an additional in-depth look at the extent to which social workers and supervisors address safety and risk concerns as well as make efforts to meet child and family needs. A clear picture emerges from these reviews that too often the focus is on making a timely decision about whether or not abuse occurred in order to close the investigation and transfer the case. Some attention is focused on creating a list of recommended next steps for the subsequent worker to take, but the role of the Investigator in relaying the

information they have gathered and/or initiating services is minimal. The focus on timely initiation and timely closure of the investigation without the supports of specialized training and standardized procedures creates a compliance-based approach to this work rather than a focus on determining how best to help families in a time of crisis to keep their children safe.

All needed information is not gathered in every investigation (19 of 40 investigations included comprehensive educational information and 14 of 40 investigations included comprehensive medical information) and providing services to families during an investigation is not the typical course of action even when immediate service needs are easily identified. Additionally, there are minimal efforts to implement the CFSA practice model and begin building a family team during the investigation process. Family Team Meetings and a teaming approach are used predominately *after* children are removed from their homes rather than as a mechanism to determine if a removal can be avoided with the use of effective safety plans and services.

There is also a significant and immediate need for CFSA to create a continuous learning environment in Intake and Investigations and across the Agency with better collection of, analysis of, and managerial decision-making based on all forms of data. Staff at all levels should be encouraged to regularly assess their work, celebrate good work and modify practice to achieve results. For example, supervisors and managers should continually monitor the functioning of the Hotline in collaboration with staff to determine staffing patterns for the Hotline during particular shifts and certain times of the year, as call volume fluctuates. Also, the recordings of interactions between the caller and CPS Intake staff should be reviewed for quality assurance and oversight. The Hotline call recording system could be better utilized on a regular basis for training, supervision, and general oversight purposes. Management should use the recordings to highlight expected practices, review how a call could have been better handled, and compare the information given by the caller to the information documented by the recipient. Supervisors should also listen to calls in 'real-time' so that immediate feedback can be provided to staff.

VI. RECOMMENDATIONS FOR IMPROVEMENT

Hotline

1. CFSA should fully implement the Hotline telephone recording system and use the gathered information for practice and systemic improvement.

The Hotline telephone recording system helps monitor the quality of interactions between Hotline workers and community members making reports of suspected child abuse and neglect. Consistent monitoring of the calls by supervisors and managers in Intake is the first step toward producing changes and recognizing good practice.

CFSA has developed, but not fully implemented, a plan for supervisors, managers and administrators to review a minimum number of the backup tapes of Hotline calls for each worker every month, review subsequent case documentation and use the information gathered for coaching and supervision. Feedback to Hotline workers from their supervisors needs to happen in a timely manner and be perceived as relevant, unbiased, practical and objective. CFSA completed 117 of these reviews in June, July and August, which identified needed skill-building and practice improvements. CFSA needs to develop a comprehensive set of strategies to address these issues in order to improve the Hotline's quality of practice.

Data related to caller wait times and dropped calls should be continuously reviewed, analyzed and translated into call system improvements. This is a critical quality improvement function and needs to be fully implemented immediately.

2. Review the functioning of Hotline Screening Panel to ensure that it is not unnecessarily causing delays in responding to allegations of child abuse and neglect.

The Hotline Screening Panel's role in ensuring the quality of Hotline staff's decision-making is important; yet supervisory approval needs to happen in a timely manner so as not to delay the commencement of investigations. The case record review revealed significant time delays between the receipt of a call at the Hotline and the supervisory approval to accept the investigation. In some instances, this causes a time delay in notifying the MPD Youth Division of pending investigations that require their participation. It is unclear from the record review if the screening panel is also causing a delay related to when workers initially go out on each investigation. More assessment is needed to determine if the screening panel is slowing down the Agency's ability to timely initiate an investigation in accordance with policy, beginning as soon as a call is received at the Hotline.

Information Gathering

3. More effort must be made to interview the required "five core contacts" in every investigation.

Collateral contacts provide much of the necessary information used to determine the outcome of an investigation. An informed decision about each allegation of child abuse or neglect requires

interviewing all persons with information that might be of use. CFSA policy requires contact with:

- the alleged victim;
- the alleged maltreator;
- the reporting source;
- the medical and educational providers; and
- all household members.

CFSA must ensure that no investigation is closed without good faith efforts to interview and obtain information from each of these contacts. The results of these interviews need to be documented in the investigation record.

4. Investigators must gather comprehensive medical and educational information to adequately assess the family situation and make the necessary referrals.

The only way to fully assess a child and family's situation is to gather comprehensive information. Decision making and planning should be based on an assessment of the family's situation. Immunization information and documentation of a child's most recent medical exam are significant information but social workers must also speak to educational and medical personnel involved with each family to gather relevant information.

This information is not only useful in determining if there are concerns related to each child's health and educational status, but also in assessing whether any services are required to meet families' underlying needs and prevent further and future involvement with CFSA. Medical professionals and teachers may have information about families that is critical input to an investigator's assessment. Additionally, if a child is taken into custody and placed in foster care, medical and educational information is necessary so that pre-established doctors' appointments, medication and educational supports, for example, are provided and not missed during the transition to ongoing services.

Risk Assessment

5. Immediate and intensive action is needed to correct the inconsistent and inappropriate implementation of risk assessment and lack of consistent decision-making related to risk.

Structured Decision Making™ tools use clearly defined and demand consistently applied decision-making criteria for screening reports for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect.

The SDM risk assessment tool was designed to increase clarity with regard to risk assessment policy. However, the lack of integration of the SDM tool into FACES has resulted in confusion, duplication of risk assessment protocols, uneven application of risk assessment with families and conflicting risk levels. Additionally, there is a lack of documentation of the risk assessment and risk level for families whose investigations are unfounded or inconclusive which indicates a lack of adequate decision-making by the Intake and Investigations Administration related to risk

assessment. CFSA must take immediate steps to clarify and ensure implementation of its risk assessment process and policies by social workers and supervisors. The Monitor is also highly concerned about the lack of risk assessment data on families. CFSA needs to determine how to maintain risk information and make that information available when families are referred more than once to the Hotline. This aggregate data may also be useful in determining resource allocation.

Service Referral and Delivery

6. **Service implementation during the investigation is a critical need. CFSA must take additional steps to ensure that each family's underlying needs are both assessed and addressed as soon as the Agency becomes involved with the family in order for children to be safe, risk to be reduced and families to be strengthened.**

CFSA must identify emergency and crisis service providers and use flexible funds to link families to the supports necessary to address their needs as soon as possible during an investigation. Workers must simultaneously be able to assess whether abuse or neglect occurred and the needs of the family. Acting on family needs is a fundamental function of any social worker in a crisis situation; it is inappropriate to close an investigation without ensuring that there are mechanisms in place to begin to provide for the ongoing safety of children, reduce risk of harm to children, stabilize families, and increase the likelihood of successful reunification if the children have been removed.

7. **CFSA must refer and link all families, whose circumstances are deemed to be of low or moderate risk, to the Collaboratives or other community-based organizations to ensure that these families' identified needs are met. Additionally, CFSA must obtain follow-up information to ensure the families are being served by the Collaboratives or other community-based organizations.**

Successful implementation of Structured Decision Making™ requires that families whose circumstances are deemed to be of low or moderate risk be referred to community-based organizations for the provision of necessary supports. This case review revealed that CFSA is not adequately referring families to the Collaboratives, even the subset of families with a substantiated report of abuse or neglect and whose circumstances are deemed to be of low to moderate risk. As the first contact with these families, CFSA's Intake and Investigations units must engage all families with low or moderate risk and provide them with referrals to the Collaboratives or other similarly situated organizations, as needed.

In addition to providing families with referrals to community-based supports, CFSA must follow-up with the families and the Collaboratives or other agencies, to ensure the necessary services have been received and the risk of any future harm to children is being reduced.

Collaboration with Other Stakeholders

8. CFSA and MPD should assign workers as a co-located team to more effectively collaborate on joint investigations.

According to CFSA's Hotline policy, information about all accepted reports of severe physical abuse and sexual abuse are to be faxed to the Metropolitan Police Department (MPD) Youth Division. CFSA and Youth Division are to conduct a joint investigation for all severe physical abuse and sexual abuse investigations. Regular meetings between CFSA and MPD administrators and the placement of CFSA social workers at MPD have improved the relationship between the two agencies.

Even with the improved relationship and the CFSA social workers stationed at MPD, issues such scheduling differences and clarity of social worker assignment to joint investigations make true collaboration difficult. These issues could be resolved with the dedication of CFSA investigative workers and MPD staff who are trained to work as a team solely on duties related to joint investigations. This would allow for congruent scheduling, in which social workers would investigate concurrently with YD detectives rather than in a parallel manner.

Systemic Issues

9. Additional investigative staff is needed for overnight and weekend shifts.

Investigating alleged child abuse and neglect is a twenty-four hour a day, seven days a week job. It is crucial to child safety that the Hotline and Investigative units are adequately staffed in order to respond appropriately to reports. A number of sources reported under-staffing in the Intake and Investigations units during overnight and weekend hours causing delays in reports assigned for investigations. The agency must hire additional staff to ensure timely responses to allegations of child abuse and neglect.

10. Individualized training and skill development targeted for the investigations unit are needed to ensure that quality practices are implemented similarly across units. A policy and procedure guideline manual would also help to standardize practice.

The Agency has made great strides in providing training for all staff, however the work done by the Intake and Investigations unit requires specialized knowledge and support. Specialized training is a necessity for this job function. Pre-service and in-service training do not currently include a focus on intake and investigations for staff who will be joining these units.

A recent decision to have on-the-job training units assigned to investigations should give new workers the opportunity to carry investigation cases with training support prior to taking on a full caseload. However, these supervisory training units report to the training administrator rather than the child protective services administrator or manager. A joint accountability structure might be more useful and would ensure that the on-the-job training for workers in investigation training units covers both the expectations of the training administration as well as the policies,

practices and procedures of child protective services. This lack of specific training for child protective services workers may contribute to inconsistent practices and incomplete understanding of the policies and procedures of their jobs.

In addition to specialized training, a procedural guide would benefit the investigations staff's ability to increase the standardization and quality of practice. Current implementation of investigation policies is highly influenced by the managerial chain of individual units. Lacking clear procedures and protocols for practice, supervisors and managers have over time developed their own approach to handling different situations and these approaches are inconsistent from one supervisor to the next.

11. Overall quality of investigations could benefit from creating an open learning environment in CPS that values continuous quality improvement, focus on critical decision making and consistent application of best practices.

It is crucial that CFSA develop strategies to enhance their focus on the quality of investigations and adherence to the CFSA practice model during an investigation. CFSA has recently hired a new Associate Deputy for Programs who will focus in part on the functioning of Intake and Investigations. Other steps are necessary and the Monitor recommends a full internal assessment of quality and the development of a plan to address the issues that both CFSA and CSSP have identified in this report.