



A REPORT
TO THE
MONTANA
LEGISLATURE

PERFORMANCE AUDIT

Review of Child Abuse and Neglect Investigations

*Department of Public Health and
Human Services*

OCTOBER 2015

LEGISLATIVE AUDIT
DIVISION

14P-11

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Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Members of the performance audit staff hold degrees in disciplines appropriate to the audit process.

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October 2015

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the review of child abuse and neglect investigations. This report includes recommendations for improving processes relating to the receipt, assessment, and investigation of reports of alleged child maltreatment. Recommendations include strengthening various management procedures such as program documentation, supervisory oversight, and the use of management information to support program activities; improving compliance with investigative time frames; and resolving inconsistencies between state law and the safety-based protocol used by the department to investigate reports. A written response from the Department of Public Health and Human Services is included at the end of the report.

We wish to express our appreciation to department officials and staff for their cooperation and assistance throughout the audit.

Respectfully submitted,

/s/ Tori Hunthausen

Tori Hunthausen, CPA
Legislative Auditor

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MONTANA LEGISLATIVE AUDIT DIVISION

PERFORMANCE AUDIT

Review of Child Abuse and Neglect Investigations

Department of Public Health and Human Services

OCTOBER 2015

14P-11

REPORT SUMMARY

The Department of Public Health and Human Services needs to address inconsistent documentation, limited supervisory oversight, and a lack of management information related to child abuse and neglect reports. The department also needs to comply with state law regarding investigative time frames, and resolve inconsistencies between state law and its investigative protocol for making determinations of child abuse or neglect.

Context

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 emotional or physical neglect. In Montana, the Department of Public Health and Human Services (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 and continues with a field investigation of any allegation. According to department information, in fiscal year 2014, the department assessed 15,724 reports of alleged child abuse or neglect, with 7,812 of those reports categorized as requiring an investigation.

Audit work examined if the department consistently assesses reports of alleged child abuse via its intake function and if the investigations of reports meet statutory time frames and investigative protocols established by the department. As part of our review, we identified long-term and systemic management concerns in the areas of documentation, supervisory oversight, and the use of management information which the department should take steps to resolve.

For example, of 250 investigations included in our review sample, the department did not document notification to families of the outcome of the investigation 78 percent of the time. Audit work concluded that the department lacks basic access to some of the useful information it needs to effectively manage CPS work, due in part to an antiquated data system and the absence of a plan to actively use data to make informed management decisions. In addition to management concerns, we noted the department does not routinely meet statutorily-based investigative time frames or uniformly make final investigative determinations. Over 70 percent of investigations reviewed were not completed within 60 days as required by state law.

Results

Audit recommendations address the need for the department to strengthen various management controls, comply with statutory time frames, and address a lack of uniformity in making final investigative determinations. Recommendations include:

- ◆ Prioritizing documentation expectations for all intake and investigative activities.

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- ◆ Clarifying and implementing supervisory standards to review and verify intake and investigative activities.
- ◆ Developing a plan to actively use data to manage CPS activities, including using legislative funding for the implementation of an automated case management system.
- ◆ Complying with state law and department policy regarding priority and investigative time frames.
- ◆ Resolving inconsistencies between state law and department policy regarding making final investigative determinations.

Recommendation Concurrence	
Concur	4
Partially Concur	1
Do Not Concur	0
Source: Agency audit response included in final report.	

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Chapter I – Introduction and Background

Introduction

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 of Public Health and Human Services (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 fiscal year 2014, the department assessed 15,724 reports of alleged child abuse or neglect, with 7,812 of those reports categorized by the department's intake function as requiring an investigation. Other assessed reports were either considered informational only or were referred to other entities such as law enforcement or tribal authorities for further action. Based on legislative interest in CPS activities and the department's role in ensuring child welfare and safety, the Legislative Audit Committee prioritized a performance audit of CPS activities. This chapter discusses the scope of our audit work and provides background information on CPS activities in Montana, including areas within the department where we conducted audit work.

Audit Objectives

Based on assessment work, we developed the following two objectives for examining CPS activities:

1. Does the department's centralized intake function consistently process reports of child abuse and neglect to ensure the safety of children at risk of maltreatment?
2. Do department field investigations of reports of child abuse and neglect meet statutory timeline requirements and nationally-based safety investigative protocols adopted by the department?

Audit Scope

The continuum of CPS spans across many different activities within the department, including the receipt and assessment of a report of abuse or neglect, the investigation of that report if it rises to the statutory definition of abuse or neglect, in-home services where a child can safely remain in the home, and out-of-home care where a child cannot safely remain in the home. Examples of in-home services include parenting classes, child care, and home visits; out-of-home care includes removals with family, foster

care, and adoption placements to provide children with healthy family environments. Considering the breadth of these activities, we assessed these various functions within CPS to determine where to best focus our audit efforts. Based on our assessment work, we determined the intake and investigation of reports of abuse and neglect merited audit examination. The following paragraphs discuss scoping considerations regarding those areas of CPS activities in which we conducted audit work.

Centralized Intake

The department operates a Centralized Intake (CI) Bureau with a toll-free child abuse hotline 24 hours a day, 7 days a week, where department staff receives alleged reports of abuse or neglect, assess the level of risk to children, and prioritize reports according to the urgency with which field staff need to respond, if appropriate. Reports may also include requests for information or referrals to other agencies or functions within the department. Prior to January of 2002, reports were received by local field offices to determine the extent of investigation needed. A change to a CI process was implemented in 2002 in part to improve the consistency of the intake process, standardize information, and increase the amount of time field staff have to investigate reports. However, our assessment work indicated there were concerns regarding whether CI staff consistently assessed and forwarded reports to the field for investigation. Consequently, the centralized intake function was examined to determine if the department consistently processes reports of child abuse and neglect to ensure the safety of children at risk of abuse and neglect

Field Investigations

Once the department's CI function has determined an investigation is warranted and assigns a level of response, reports are forwarded to one of the department's 29 field offices where investigations occur. Field staff follow a safety-based investigative model which was implemented in 2012 to assess the threat to a child's safety as the basis for actions taken to protect that child. In contrast to the incident-based protocol formerly used by the department which focused on whether an alleged incident of abuse or neglect has occurred, the safety-based investigative model currently used by the department focuses on identifying safety threats to a child and working to mitigate those threats, which may include the removal of a child perceived to be in danger. This change in investigative model raised our concerns if the department was conducting investigations as defined in state law, administrative rules, and department policy. Our assessment work also identified a lack of meaningful management information available regarding investigative activities, due to an antiquated data system used by the department. Consequently, our audit examined the manner in which the department investigates alleged reports of child abuse or neglect, including if those

activities are conducted in compliance with applicable state laws, administrative rules, and department policies.

Audit Methodologies

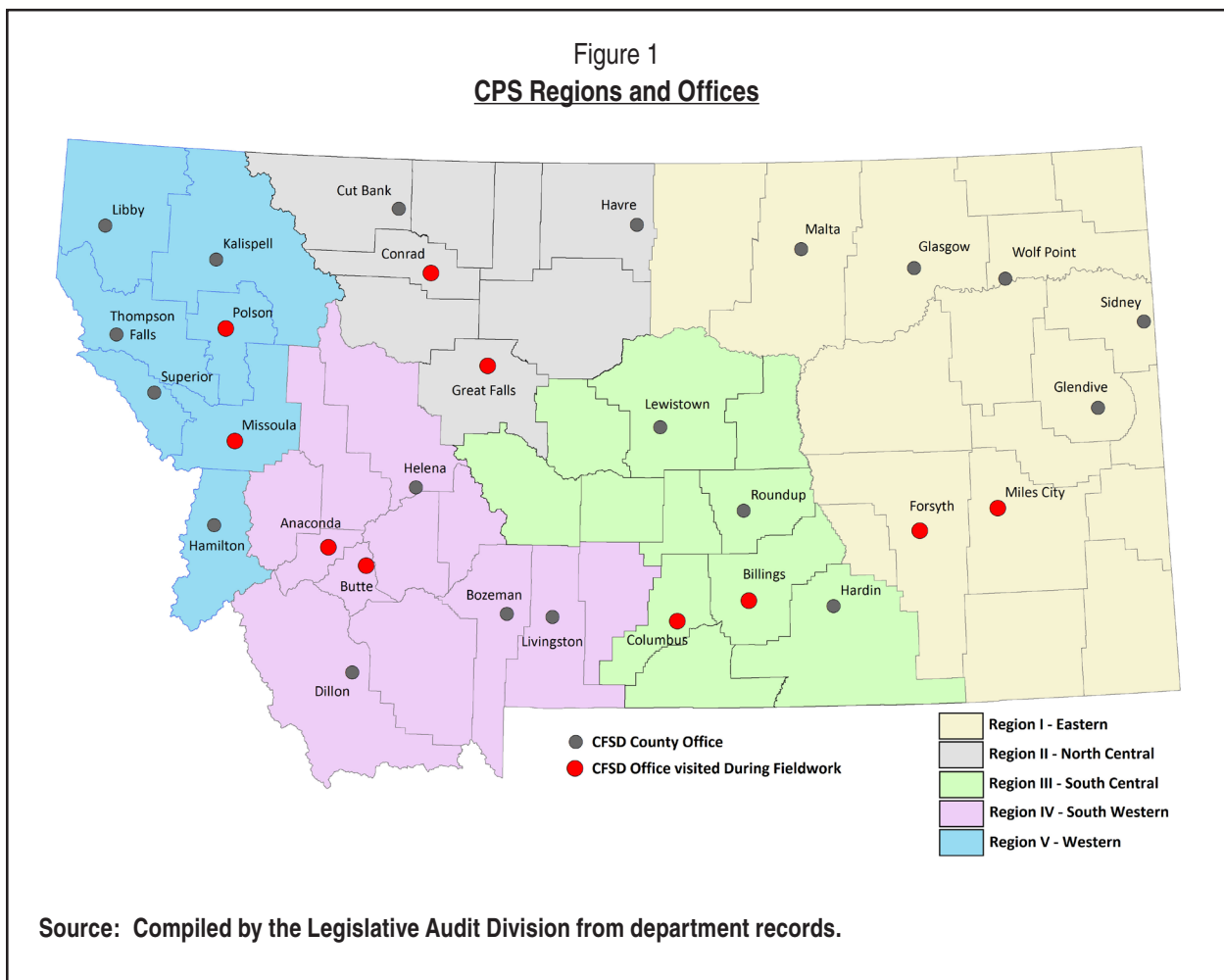
To accomplish our objectives, we completed the following methodologies:

- ◆ Obtained and reviewed applicable state laws, administrative rules, and department policies for assessing and investigating reports of child abuse or neglect,
- ◆ Obtained and reviewed applicable federal requirements for assessing and investigating reports of child abuse or neglect,
- ◆ Reviewed a sample of 351 hardcopy and electronic records of reports of child abuse or neglect assessed and referred by CI during fiscal year 2014 for ten counties in Montana—including Yellowstone, Cascade, Missoula, Silver Bow, Lake, Custer, Deer Lodge, Stillwater, Pondera, and Rosebud counties,
- ◆ Obtained and reviewed a sample of 15 phone call recordings of reports received by the department’s CI function to verify that information collected as part of the intake process is accurately documented,
- ◆ Obtained and reviewed report data from the department’s Child and Adult Protective System (CAPS) for all reports assessed from fiscal year 2010 through 2014 to evaluate data trends in reports received and the number of children receiving departmental services,
- ◆ Obtained access to CAPS to assess the capabilities of the system to document the receipt and investigation of reports of child abuse or neglect,
- ◆ Interviewed department staff in Helena and within each of the 10 county field offices in our sample of reports to discuss how reports of abuse or neglect are assessed and referred to the field for investigation,
- ◆ Interviewed a sample of mandatory reporters who frequently interact with the department to evaluate their perceptions of how the department receives and investigates reports of abuse or neglect, and
- ◆ Obtained and reviewed information for CPS activities in other states to assess how other jurisdictions administer similar activities.

The Receipt and Investigation of Reports of Alleged Child Abuse or Neglect

Reports of alleged child abuse or neglect are received, assessed, and investigated by the department’s Child and Family Services Division (CFSD), whose mission is to keep children safe and families strong. The division is responsible for ensuring the safety, permanency, and well-being of children under 18 years of age who have been the victims of—or are at substantial risk of being the victims of—child abuse and neglect. While the division receives and assesses reports of alleged abuse or neglect from a CI location in Helena, reports which are determined to require an investigation

are referred to field offices located in five geographic regions in 29 counties across the state to be investigated. In fiscal year 2015, CI was appropriated \$1,356,490 for personal services and operating expenses, with a full-time equivalent (FTE) of 22. For that same period, field services where investigations of alleged abuse or neglect occur was appropriated \$20,726,582 for personal services and operating expenses, with a FTE of 320.80. However, this figure does not solely represent staff who perform field investigations, but also includes field staff who perform other functions. Based on department information at the time of the audit, there were 175 field staff who performed investigations. Figure 1 illustrates the five geographic regions and field offices from which reports of alleged abuse are investigated. Offices we visited during audit work are denoted with the color red.



How Are Reports of Alleged Child Abuse or Neglect Received?

Reports of abuse or neglect are received by the department's CI function, which operates a toll-free child abuse hotline 24 hours a day, 7 days a week. CI staff assess reported information to determine if an investigation is warranted and, if so, makes a determination regarding the level of response needed. Through an interview process, CI staff determine if the alleged victim is a person under the age of 18 and if the suspected abuse or neglect crosses the thresholds of abuse or neglect defined in state law. CI staff receive extensive training on how to collect and analyze information from a reporter of suspected child abuse, including if the suspected abuse meets statutory thresholds and how quickly the report must be investigated. CI staff follow an intake decision-making tree to make a decision regarding if there is reasonable cause to suspect child abuse. Reasonable cause to suspect means cause that would lead a reasonable person to believe that abuse may have occurred or is occurring, based on all the facts and circumstances provided by the reporter. If CI staff have reasonable cause to suspect abuse, they will assign one of several possible statutory allegations the report of suspected abuse. Section 41-3-102, MCA, defines the various types of child abuse or neglect to which the department responds and assigns allegations. Types of allegations outlined in the law include abandonment, fatalities, educational neglect, drug exposure, medical neglect, physical neglect, physical abuse, psychological abuse or neglect, sexual abuse, or sexual exploitation. For example, §41-3-102 (19), MCA, defines physical abuse as an intentional act, an intentional omission, or gross negligence resulting in substantial skin bruising, internal bleeding, substantial injury to skin, subdural hematoma, burns, bone fractures, extreme pain, permanent or temporary disfigurement, impairment of any bodily organ or function, or death. CI staff follow an established protocol regarding making determinations of safety and urgency, including collecting and assessing household information, the extent and circumstances of the maltreatment, caregiver information, and safety hazards.

After CI has assigned an allegation to the report of abuse or neglect, they will assign a priority to the report which outlines the urgency in which the report must be investigated by field staff. For example, if the CI worker determines through the facts and circumstances provided by the report that the child is in immediate danger, the report will be assigned as a priority one, meaning that an immediate response is needed to ensure the safety of the child. All CPS reports—or those requiring an investigation—are investigated based on a priority established by CI. The following bullets represent the priorities assigned by CI and the associated investigative time frames for first contact based on the perceived risk to a child.

- ◆ CPS reports prioritized as Priority One (P1) require an immediate response within 24 hours,

- ◆ CPS reports prioritized as Priority Two (P2) require a response within 72 hours, and
- ◆ CPS reports prioritized as Priority Three (P3) require a response within 10 days.

CI staff have the ability to review any prior history of reports of alleged abuse or neglect within CAPS and may also conduct a search of the Criminal Justice Information Network maintained by the Montana Department of Justice if criminal activity is suspected. Non-CPS reports—or those which do not meet the criteria for an investigation—are screened out and may be considered informational only or may be referred by CI to other agencies or department functions, such as law enforcement, tribal authorities, or foster care licensing. Once CI has completed their assessment and determination, they forward all reports of suspected child abuse or neglect to field staff in one of 29 county offices via their information system called the Child and Adult Protective Services System (CAPS). However, reports prioritized as P1 are referred out immediately to on-call field staff. Reports prioritized as P2 may also be referred out to on-call field staff based on the day of receipt. For example, P2 reports received on a Friday will be referred out so field staff are able to meet the investigative time frame established by CI staff. Table 1 illustrates the number, category, and percentage of reports received and assessed by CI in fiscal year 2014.

Table 1
Reports as Categorized by Centralized Intake
 Fiscal Year 2014

Category	CI Initial Report Count	% of reported total
Child Protective Services Request (CFS)	1,191	7.6%
Child Protective Services Information (CPI)	5,399	34.3%
Child Protective Services (CPS)	7,812	49.7%
Licensing (LIC)	47	0.3%
Tribal (TRB)	1,275	8.1%
Totals	15,724	100.00%

Source: Compiled by the Legislative Audit Division from department records.

CFS reports mean when there is no need for an investigation but indicates a request for department services or an investigation by law enforcement; CPI reports represent when there is no need for an investigation, and any concerns which do not meet the criteria for risk to a child are documented; CPS reports meet the criteria for alleged abuse or neglect and will be investigated and assigned a priority; LIC are reports regarding alleged licensing violations for day cares, foster parents or other residential

facilities which will be referred to those oversight entities; and TRB represents reports which will be referred to tribal authorities. As illustrated by the table, in fiscal year 2014 approximately 50 percent of the reports received were categorized by CI as requiring an investigation by CPS investigative field staff, with the remaining 50 percent of reports not meeting the criteria for alleged abuse or neglect or not falling within the CFSD's jurisdiction to investigate.

How Are Reports of Alleged Child Abuse or Neglect Investigated?

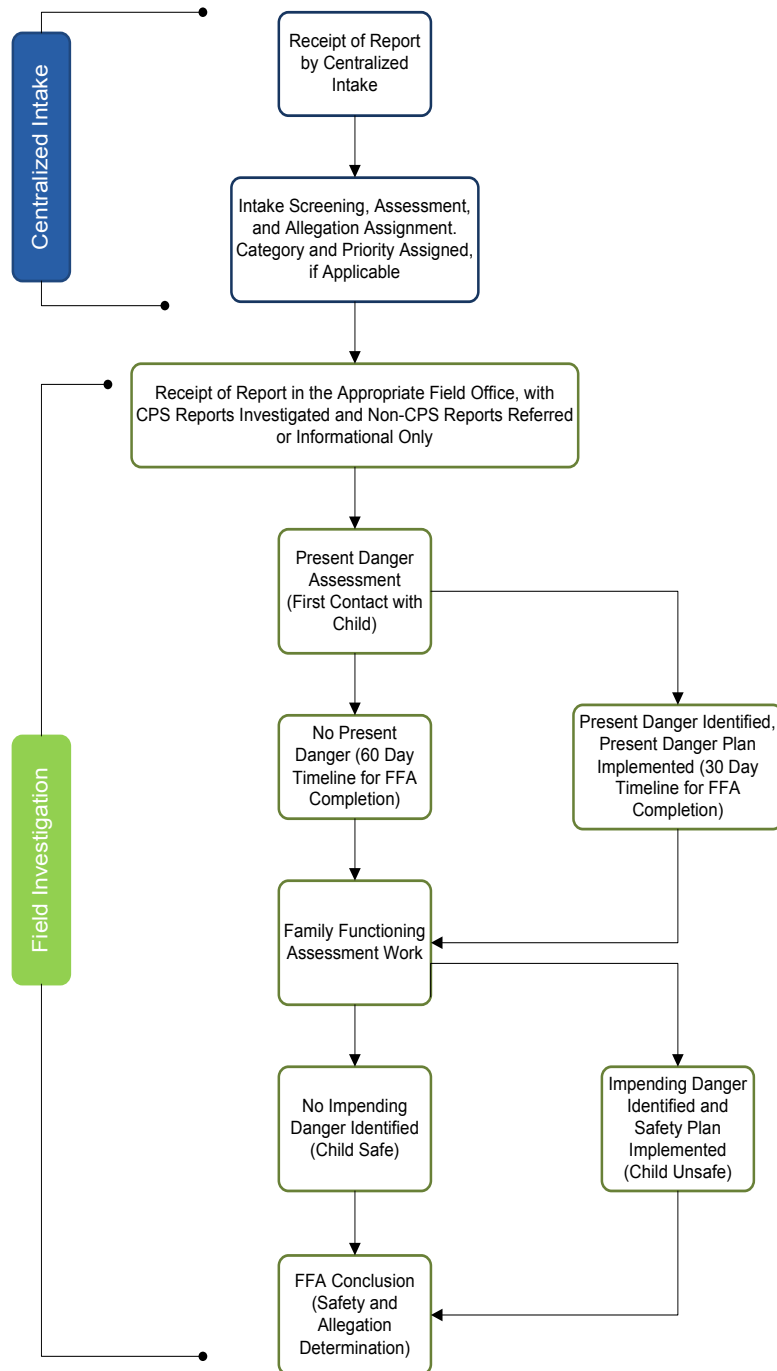
Based on the category and priority established by CI, investigative field staff will make contact with the target child and family to initiate an investigation, if applicable. Reports which are prioritized as P1 are essentially investigated immediately by on-call investigative field staff, including reports which are categorized as P2 and received on the weekend or a holiday. Reports categorized as P3 or non-CPS reports are available via CAPS for field supervisors to review and assign for investigation. Field supervisors review reports daily to determine if a report has been correctly categorized or prioritized by CI. Field supervisors and management may change the category or priority of a report received by CI, based on prior experience or additional field knowledge. P1 and P2 reports which are called out are generally not reviewed initially by field supervisors, but assigned directly to on-call staff, who will consult with supervisory staff upon receipt. Otherwise, P2 reports not received on a weekend or holiday and P3 reports are reviewed daily by field supervisors and assigned to investigative field staff based on experience and workload. Non-CPS reports which have been re-categorized as CPS reports by field supervisors will be assigned to investigative field staff.

Investigative field staff receive extensive training on how to collect and analyze information for an investigation of suspected child abuse or neglect, including protocols for interviewing family members and how to effectively assess the safety of any children who are the subject of an investigation. Once a CPS report has been assigned, whether by a supervisor or via an on-call assignment for a high priority report, investigative staff will review all available information for the report, including past reports. Investigative staff may call CI staff to clarify details. Investigative staff may also call the reporter to verify the facts of the report. At this point, investigative staff will attempt to make first contact with the target child within the prescribed time frame established by CI. This first contact may occur within a school setting or other out-of-home setting, if available and conducive to the investigation. The investigative protocol is to speak with the target child first, then any other children in the home, then the nonoffending parent, then the offending parent when possible. Through interview and observation during this initial family contact, the investigative worker will conduct a Present Danger Assessment to assess if there is any immediate danger in the home which requires protective action

to control the danger. If present danger is not identified, the investigative worker will summarize for the family their observations, collect contact information, and schedule a time to meet again to continue the investigative process. The investigation must be completed in 60 days from the date received by CI. If present danger is identified, the investigative worker will establish a Present Danger Plan (PDP) prior to departure to control for the danger. This plan may involve one parent leaving the home, a child staying with another family member, or another outside family member moving temporarily into the home. If the worker and the family cannot come to a voluntary agreement, it may be necessary to remove the child from the home and place with an outside family member or foster care. If a child leaves the home on a voluntary or involuntary basis, the worker conducts a name-based background check regarding the placement option. The investigation continues and must be completed in 30 days from the date received by CI, with the present danger plan in place for only 30 days.

The investigation—called the Family Functioning Assessment (FFA)—continues, with the investigative worker gathering relevant information within six areas of functioning to determine if the child is safe or unsafe. The purpose of the FFA is to develop an understanding of any impending safety threats to the child and whether those impending dangers can be controlled within the family or in another home situation. The outcome of a FFA is either an in-home or out-of-home safety plan. A safety plan replaces the PDP. The FFA also includes making a determination about the type of abuse or neglect which initiated the investigation. Since the circumstances of each investigation are unique, each investigation may also have unique factors, such as drug testing if there is alleged drug use or an assessment for alleged sexual abuse. Investigations generally all include additional interviews of family members and contacts. After the conclusion of the investigation, the investigative worker must notify the family of the determination and document the notification. Depending on the circumstances of the report and the placement of the child, the conclusion of the investigation may be the end of the department's involvement with the family or may be the beginning of continued services to the family. If the allegations are substantiated, the individual against whom the allegation is substantiated is entitled to due process and has the right to a fair hearing. Figure 2 (see page 9) illustrates the receipt, assessment, and investigation of alleged reports of child abuse and neglect received by the department.

Figure 2
The Intake and Investigation of Reports of Child Abuse or Neglect



Source: Compiled by the Legislative Audit Division from department records.

Current Audit Work Suggests Long-Term Management Issues

As part of current audit work, we reviewed a past performance audit of CPS conducted in 2002 in accordance with House Joint Resolution 32 enacted by the 2001 Legislature. Overall, past audit work identified a lack of uniformity in department practices, including recommendations for increasing consistency, improving documentation, and clarifying supervisory responsibilities. The audit also identified concerns with CAPS data reliability and usefulness. These concerns included the ability to generate reports and statistics, accuracy and completeness of data, and difficulties with using the system. Additional audit work of CAPS in 2004 also identified similar concerns, including the usefulness and accuracy of the data within the system. As part of our current work, we noted a similarity between past audit work and our current findings and recommendations. The department reports they have made changes to the program over the years, such as policy related to case file documentation and supervisor case load. Audit staff found documentation, supervisor oversight, and management information are areas that need continued improvement.

Report Contents

The remainder of this report includes chapters detailing our findings, conclusions, and recommendations in the following areas:

- ◆ Chapter II presents information on how the department should prioritize documentation and strengthen supervisory review of reports of alleged child abuse or neglect.
- ◆ Chapter III discusses how the department should implement a plan to actively use data collection measures within existing resources to manage CPS activities, and also fund a new data collection system for the department to manage reports of alleged child maltreatment.
- ◆ Chapter IV addresses how the department should establish a plan to investigate reports of alleged child abuse or neglect within statutory times and resolve inconsistencies between state law and the department's safety-based investigative model.

Chapter II – Documentation And Supervisory Oversight

Introduction

As part of both of our audit objectives, we assessed the consistency with which the Department of Public Health and Human Services (department) receives, assesses, and investigates reports of alleged child abuse or neglect in accordance with statutory and department requirements. For Child Protective Services (CPS) activities, reports of alleged abuse or neglect are centrally received and assessed by the department's Centralized Intake (CI) function in Helena, with reports referred to and investigated within one of the 29 field offices located in five geographic regions across the state. While both CI and investigative field staff have established intake and investigative protocols by which they assess and investigate reports of alleged abuse or neglect, during our audit work we identified a systemic lack of consistency and uniformity of intake and investigation activities attributable to:

- ◆ Limited intake and investigative documentation
- ◆ Inconsistent supervisory review and oversight

During our audit work, we determined that the department should take steps to clearly define documentation and supervisory expectations to improve the uniformity of intake and investigative activities. This chapter discusses our findings, conclusions, and recommendations related to prioritizing documentation expectations for CPS staff and clarifying guidelines for supervisory review and verification of CPS intake and investigative activities.

Review of Child Abuse and Neglect Reports

In fiscal year 2014, the department received and assessed 15,724 reports of alleged child abuse or neglect. As part of our audit work, we selected and reviewed a random sample of 351 of those reports of alleged child abuse or neglect from the total number of reports received by the department in fiscal year 2014. We selected reports referred to ten regional field offices in Yellowstone, Cascade, Missoula, Silver Bow, Lake, Custer, Deer Lodge, Stillwater, Pondera, and Rosebud counties. We selected these ten county offices from the five geographic regions managed by the department. Our selection of field offices included both urban and rural areas in order to obtain an adequate sample to determine if the department consistently assesses and investigates reports of alleged abuse or neglect. As the department documents all reports within its Child and Adult Protective System (CAPS), we were able to review the majority of report documentation in Helena. However, we also traveled to the ten counties in our sample to review any available documentation located in field offices and discuss

CPS activities with regional field staff. The following table represents the number of reports received from the department in each of the ten counties, the percentage of total reports received in fiscal year 2014, and the number of reports from our sample which we reviewed in each of those counties.

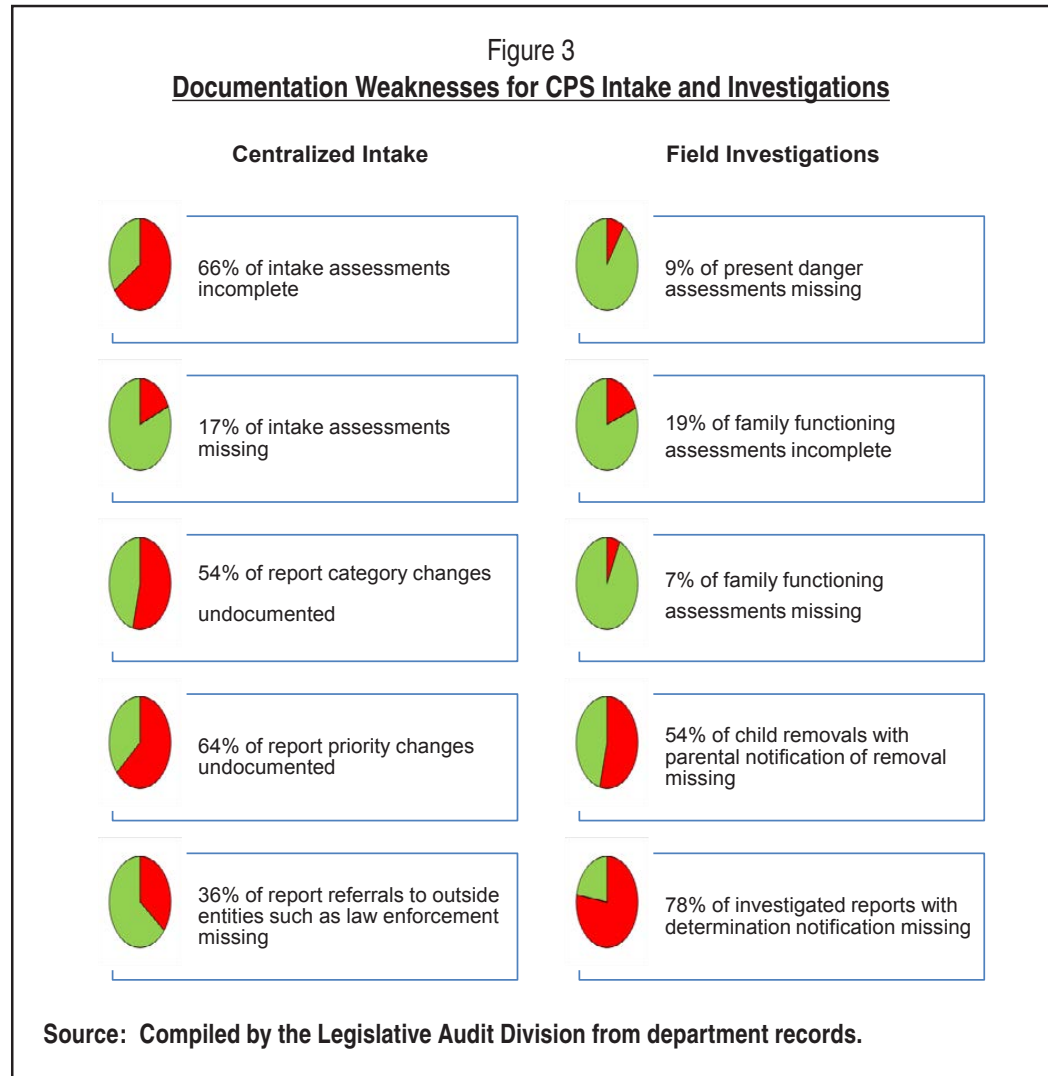
Table 2
**Ten Counties Sampled for Audit Review from Total Reports Received
in Fiscal Year 2014**

County	Number of Reports Received in 2014	Percentage of Total Reports Received Statewide in 2014	Number of Reports Reviewed During Audit
Yellowstone	2,533	16.11%	86
Cascade	1,744	11.09%	101
Missoula	1,496	9.51%	83
Silver Bow	730	4.64%	34
Lake	259	1.65%	12
Custer	183	1.16%	12
Deer Lodge	170	1.08%	10
Stillwater	87	0.55%	2
Pondera	71	0.45%	4
Rosebud	71	0.45%	7
Totals	7,344	46.69%	351

Source: Compiled by the Legislative Audit Division from department records.

Intake and Investigative Decisions Not Supported

We identified numerous instances of limited, inconsistent, or missing documentation, with department decisions for both intake and investigative activities not supported by available information. Overall, our work concluded that this lack of documentation was not isolated in nature, but rather represented a systemic concern within CPS whereby department staff does not consistently document how the department assesses and investigates reports of alleged abuse or neglect. For example, during the intake process, department staff will assess the extent and circumstance surrounding the alleged abuse or neglect in six assessment areas. However, in our review, we noted that due to limited or missing information it was unclear if department staff collected information in all six areas to assess the nature of the alleged abuse or neglect. Similarly, final investigative documents were frequently incomplete, with decisions regarding the abuse or neglect allegation determination missing. Figure 3 (see page 13) represents the kinds of documentation problems we identified for both intake and investigative activities over the course of our review.



As a result of the inconsistent documentation of intake and investigative activities, the department is frequently unable to support the decisions it makes when assessing or investigating reports of child abuse or neglect. The examples of limited and inconsistent documentation of program activities are widespread and represent a system-wide concern for the department to address and resolve. Over the course of audit work, we noted not only numerous incomplete and missing intake and investigative forms, but also limited information justifying intake assessment and investigative decisions. The rationale for investigating or not investigating a report was not always clearly documented, with several intake decisions unsupported. For example, in one report where a teen had established a plan for suicide, intake staff found no immediate danger to the child and categorized the report as a P2—respond within 72 hours, rather than as a P1—respond within 24 hours. When asked about this circumstance, department staff thought the report incorrectly prioritized, with no clear explanation as to why the report was prioritized as a P2 rather than a P1. In general, the standard by which

decisions were supported was not clearly documented, including how the intake decisions were based on the report narrative and information collected by intake staff.

Similarly, the rationale for final investigative determination outcomes was not clearly documented. Overall, documentation did not always support how decisions were based on evidence gathered during the investigative process. The limited and inconsistent documentation we observed over the course of the audit raises questions about the defensibility of intake and investigative activities, often with no clear rationale for department activities or outcomes. This weakens the integrity of the assessment and investigation of child abuse and neglect, and decreases its ability to defend program activities and decisions. Limited documentation also impacts the department's ability to consider any history when screening future reports, which can potentially affect the safety of the children who are the victims of alleged abuse or neglect.

The Department Has Not Prioritized Documenting CPS Decisions

Over the course of the audit, department staff routinely indicated they recognize CPS activities are not well documented. However, they stress their work keeps children safe and ultimately that is the focus of their activities, with documentation of those activities being secondary. Department management report that in the face of limited resources, when they are confronted with a choice of keeping children safe or documenting their activities, that they have chosen to keep children safe. Department management questioned the need to document certain activities. They do not think there are any specific legal requirements to document a number of their activities. For example, if a report of abuse or neglect does not meet the threshold for an investigation, it may be referred to a third party, such as law enforcement or tribal authorities. Audit work found that those referrals were frequently not documented, with department staff questioning the need to document those referrals. Regarding documentation, department staff also express concerns that CPS staff are already overwhelmed with work and requiring additional documentation expectations would be unproductive and unreasonable.

In addition to management not prioritizing documentation to support CPS activities and decisions, audit work noted that documentation expectations for various CPS activities are not clearly defined in department policies and procedures. For example, while department policy indicates that CAPS is the official case record of the services provided by the department, including intake information and investigative results, there are a number of steps in the process for which documentation expectations are not clearly defined. For example, field staff may change the category or priority of a report based on additional information, but while the change is documented

in CAPS, the rationale for the change is not routinely documented. Currently, department policy only indicates that a change may occur, not how these changes should be documented and supported. Similarly, the expectations for documenting referrals are unclear. Currently, department policy only indicates that referrals to law enforcement should happen immediately and should be documented in CAPS. However, the policy does not define what type of information should be documented or whose responsibility it is to document the referral. As for investigative activities, while there are opportunities for abbreviated investigations for low-risk reports, those circumstances are not clearly documented, with audit work noting 46 incomplete or partial investigations. However, the department could not support its decisions for conducting partial investigations or if these investigations met the criteria for partial investigations, due to limited documentation. Department staff also cite CAPS as a barrier to effectively documenting CPS activities; however, while the system is antiquated and has contributed to documentation weaknesses, the department still needs to consistently document CPS intake and investigative activities.

Other States Have More Stringent Documentation Expectations

We reviewed CPS activities in other states. In contrast to Montana, screening decisions in other states are required to be clearly documented. For example, in Oregon, when intake determines that an immediate response is not required, staff are required to document on the screening report form how the information indicates that a child's safety will not be compromised by a delayed response time. Other states have also defined how to refer different types of reports to other entities, including law enforcement. For example, in Oregon, administrative rules outline how timely those activities should happen, including a list of key information which must be documented on a cross-screening report. Similarly, other states also have developed specific guidance for documenting determinations. For example, South Dakota has established guidelines for making determinations, including specific instructions for documenting the information that supports the finding. CPS staff in Washington report they have experienced frequent legal action regarding CPS actions, making well documented activities and decisions an essential component of their work.

Documentation Represents a Basic Management Practice

While the department cites several reasons for inconsistent documentation of intake and investigative activities, the importance of accurate and thorough documentation of a CPS investigation is a crucial part of the investigative process and cannot be overstated. The department is a highly visible organization in the realm of child welfare in the state and the frequent subject of public interest. It is essential that the department clearly document the manner in which it investigates reports of alleged child abuse or

neglect. Not only does documentation represent a core management practice of any organization, but within the context of child welfare documentation represents the mechanism by which the department maintains the public's trust that they are acting appropriately to keep at-risk children out of harm's way. Over the course of audit work, we concluded inconsistent documentation represented an organizational culture which does not emphasize the importance of consistently documenting their activities.

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.*
-

CPS Intake and Investigative Activities Receive Limited Supervisory Oversight

In addition to the department not prioritizing documentation, our audit work noted evidence of limited supervisory oversight regarding intake and investigative activities. While supervisory oversight plays a pivotal role in the uniform and effective delivery of CPS activities, the department currently has limited expectations for supervisory oversight of CPS activities. Audit work identified not only limited evidence of supervisory review and approval of key documents but also unsupported intake and investigative decisions, which presumably were reviewed and approved by a supervisor. This included investigations which were delayed or dropped as a result of staff leave or attrition. The following bullets represent selected examples of limited supervisory oversight we identified as part of our audit work:

- ◆ Sixty-six percent of intake assessments were incomplete, with portions of household information, assessment areas, prior history, or screening decision missing.
- ◆ A report with an allegation of sexual assault was assessed as a Priority Three report—initiate investigation within ten days—but the investigation was initiated at 18 days, with the limited documentation indicating the assigned investigative worker was ill and the reason for the delayed investigation.
- ◆ Thirteen percent of initial present danger assessments lacked evidence of supervisory review and approval.

- ◆ Sixteen percent of final investigations lacked evidence of supervisory review and approval.
- ◆ A report of domestic violence was assessed as a Priority Two—initiate investigation with 72 hours—but was dropped and the investigation completed approximately six months after receipt of the report when a second report with the same allegation was received. Available documentation indicated that the assigned investigative worker had left the agency at some point after the first report. The child was removed from the home as a result of severe domestic violence alleged in the first and second report.

Department Policy Lacks Specificity Regarding Supervisory Responsibilities

Per department policy, intake supervisors review and approve screening decisions which include acceptance for assignment of an investigation, acceptance for services, or screened out at intake. The supervisor reviews and approves priority response decisions for reports accepted for investigation. It is the role of the supervisor to assure recommendations associated with screening and priority response decisions are supported by the information contained within the intake assessment and can be justified by the intake worker. The supervisor's decision to approve the intake worker's recommendation means the supervisor agrees with the recommendations, believes them to be supported by intake information, accepts the manner in which the intake information was analyzed, accepts the use of intake decision-making criteria, and is prepared to defend the recommendation as correct. As for the investigative process, department policy for the safety-based investigative process indicates that supervisors will review and approve each stage of the investigative process. In general, department policy for intake and investigative activities stresses the role of the supervisor in reviewing and approving various intake and investigative documents; however, existing policy is more conceptual in nature and does not provide prescriptive direction for the roles and responsibilities of supervisors. For example, current policy indicates supervisor approval is required for all types of determinations, but does not clearly outline what that approval looks like or how it is documented. As part of our audit work, supervisors frequently reported that they need more guidance, training, and support on how to effectively supervise investigative staff.

Intake and Investigations Lack Uniformity Which Could Endanger Children

As a result of limited supervisory oversight, not only are numerous stages of the report process not always documented, key assessment and investigative decisions are not reviewed and approved. Consequently, intake and investigative activities are not uniformly performed, which endangers the well-being of children who are at risk of or have been a victim of, child abuse or neglect. Department management indicates that

they have not clearly defined the roles and expectations of supervisors, including how supervisors review and verify that work is being conducted as expected, but are in the process of developing better guidance defining supervisory expectations. Department management indicate this may be contributing to lack of uniformity in intake and investigative activities. Department management indicate that audit observations regarding limited documentation and dropped reports are the responsibility of supervisors. But due to the increasing volume of reports and investigations, all staff are overwhelmed, including supervisors. Consequently, mistakes happen. However, audit work found that while FTE for field staff has remained fairly static from the fiscal year 2010 through 2014, the number of reports investigated by field staff has declined over that same period of time. Table 3 represents the FTE assigned as investigative field staff, number of reports investigated by field staff, and the ratio of FTE to investigations over that period of time.

As illustrated by the table, the ratio of investigations to FTE for investigative field staff has declined from fiscal years 2010 through 2014. According to department staff, while the number of investigations has declined, the number of children in the care of the department has risen steadily over the past five years. The number of children in care represents the number of children in the care or control of the department at any given time. From fiscal years 2010 through 2014, the number of children in care has risen from 1,369 to 1,972. While the number of children in care has risen, we noted the investigative workload of the department has remained fairly static over the period of our review.

Table 3
Ratio of FTE to Investigations
Fiscal Years 2010-2014

Fiscal Year	Reports Investigated	Field Staff FTE	Ratio of Investigations to FTE
2010	8,106	170.4	48:1
2011	8,526	169.5	50:1
2012	8,664	166.2	52:1
2013	7,639	162	47:1
2014	7,829	169.2	46:1

Source: Compiled by the Legislative Audit Division from department records.

Department staff also indicate they rely on reporters of alleged abuse and neglect who often only have incomplete information when reporting an alleged case of child abuse or neglect. Department management also cite an antiquated management information system as a barrier to effectively supervising intake and investigative activities. Nonetheless, the department should better define supervisory expectations, including how supervisors should review and verify that work is being conducted as expected.

Best Practices Stress the Role of CPS Supervisors

Information from the U.S. Department of Health and Human Service's Office of the Administration for Children and Families stress that child welfare supervisors play a pivotal role in fulfilling their agencies' missions and values. Effective supervision enhances staff performance and retention, and can lead to improved outcomes for children and families. These best practices provide various supervision resources, including a manual for effective supervisory practice in child protective services, which outlines the roles and responsibilities of the supervisor and provides practice-oriented advice on how to effectively carry out supervisory responsibilities, with a focus on best practices and critical issues in supervisory practice. Best practices also provide supervisory standards that promote uniformity and help to ensure that all social workers are equipped with the necessary skills to deliver competent and ethical services to their clients.

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.

CHAPTER III – Management Information Capabilities

Introduction

Over the course of our audit work, department management and staff frequently reported that the information management system used by the department—the Child and Adult Protective System (CAPS)—to record and administer Child Protective Services (CPS) activities was antiquated, not user-friendly, and presents a barrier for the department to effectively manage CPS intake and investigative work. Consequently, we assessed the functionality of CAPS, including its ability to record and provide meaningful management information to CPS staff to administer intake and investigative work. As part of our work, we obtained data extracts from CAPS to assess data trends for reports of alleged child abuse or neglect received by the department. We also developed and conducted a survey of investigative field staff to assess workload challenges and trends. Overall, our work found that CAPS is indeed antiquated, with the department lacking basic access to all the useful information it needs to effectively manage CPS work. We also found the department has recently taken steps to incorporate data analysis in managing intake and investigative work. We determined the department should establish a data analysis plan to actively use data to manage its work, including using funding provided by the 2015 Legislature to fund the implementation of an electronic records management system and an integrated, automated case management system. This chapter discusses management information further.

Lack of Data Impacts Management of CPS Activities

Due in part to the antiquated nature of CAPS, the department does not have access to all the useful information it needs to most effectively manage CPS intake and investigative work. Implemented by the department in approximately 1996, CAPS functions as a payment management system to track service provider and caregiver reimbursements, but is a poor tool to track programmatic-based information, such as the number of investigations and ongoing cases managed by individual CPS workers. Nor does CAPS allow for management to export management information in a user-friendly format. CAPS operates on an outdated technology platform which is not user-friendly, limiting the department's ability to effectively manage CPS intake and investigative activities. Overall, audit work concluded that CAPS is an antiquated legacy computer system with cursor-based noninteractive navigation limiting the department's ability to generate useful management information.

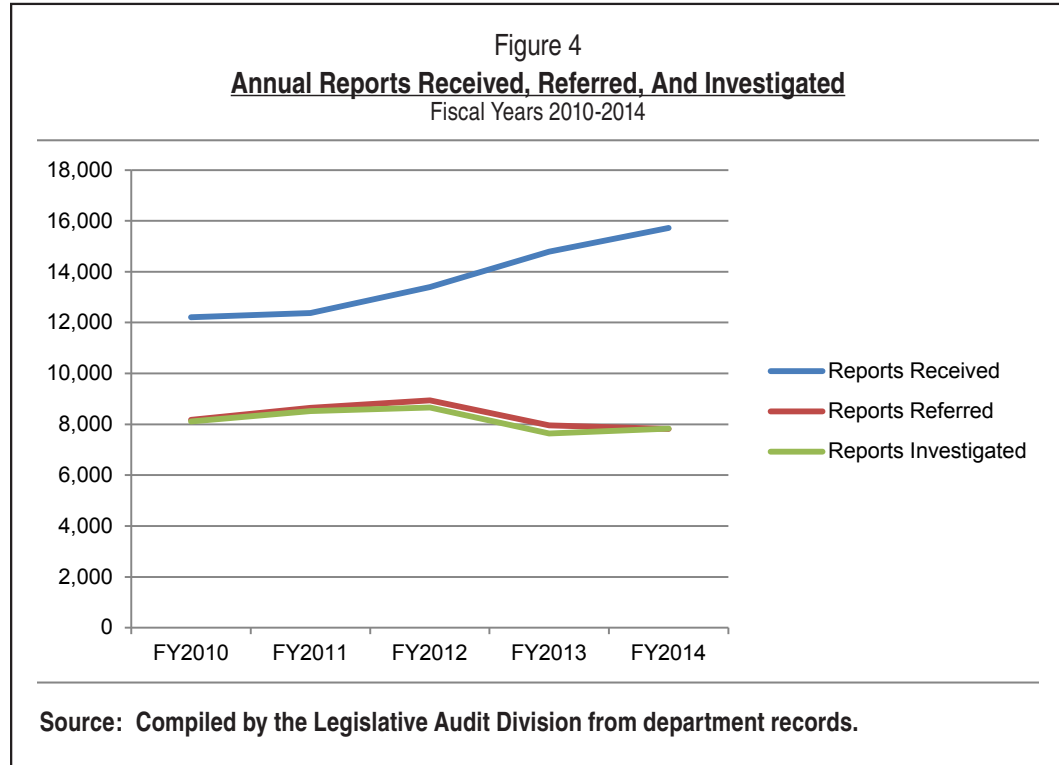
As a result of having limited available management data in CAPS, the department is not able to articulate the successes of CPS activities or meaningfully describe the challenges and struggles they face when assessing and investigating reports of child abuse and neglect. Consequently, their ability to most effectively manage program activities is questionable. For example, while department staff routinely report that they are overwhelmed by the number of reports received and investigated by the department, they are unable to clearly support that claim with caseload data. Over the course of audit work, we also noted circumstances where CAPS had inappropriately deleted reports of abuse or neglect due to a technical error and could not retrieve the data. Per department staff, they identified and corrected the error when we brought it to their attention. The department has begun to see the value in using data to manage program activities. While department staff have begun to look at current data in real time and see the value of using data to more actively manage the program, they do not frequently assess data trends over time. Data trend analysis is commonly used in the public sector to monitor program activities and forecast the impacts of policy changes. A study of trends regarding CPS activities could include evaluating report increases or decreases over time, comparing one period of time to another to evaluate the impact of policy shifts, comparing one geographic area to another, comparing one population of allegations to another, or making future projections to estimate the future number of reports to aid in resource planning. Limited management information impacts the department's ability to manage intake and investigation work load, and to defend program activities and decisions against potential litigation.

CONCLUSION

An antiquated data management system contributes to the department's inability to effectively manage CPS intake and investigative workload, exposing the department to legal risk and impacting the safety of at-risk children served by the department.

Examination of CPS Reporting Trends

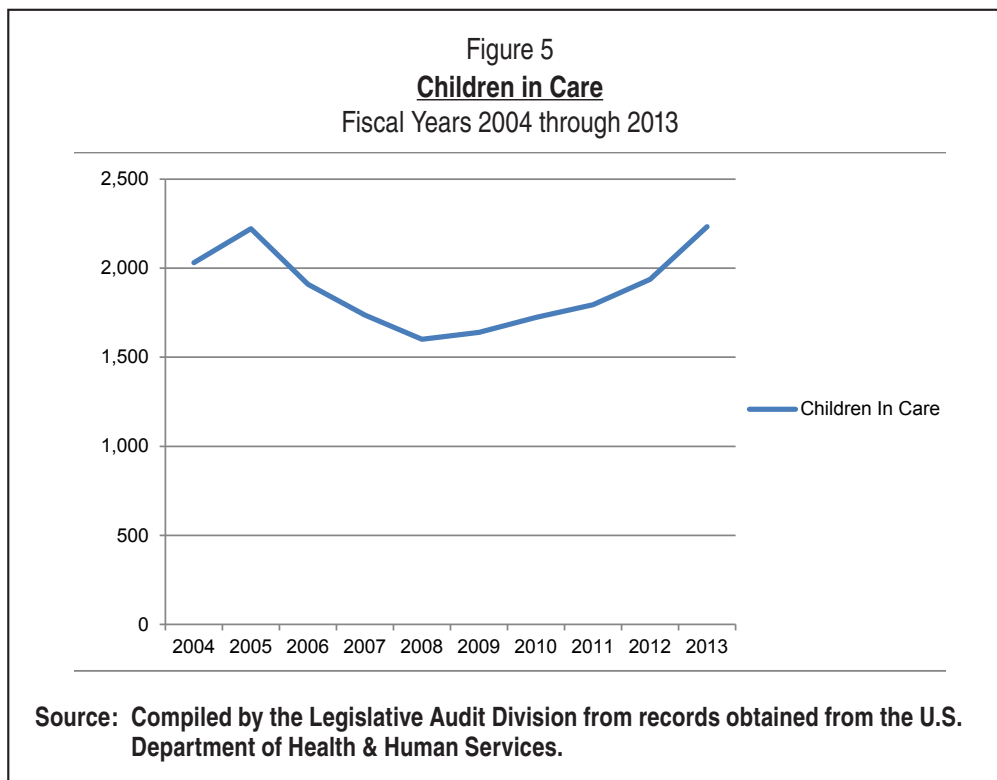
As a part of our work, we reviewed limited report data from CAPS for fiscal year 2010 through 2014 to assess any data trends related to the number of reports received, assessed, and investigated by the department. Figure 4 (see page 23) illustrates the total number of reports received by the department, and the number of reports referred by the department's Centralized Intake (CI) function to the field for investigation, and the number of reports investigated in the field.



As illustrated by the figure, the total number of reports received by the department was fairly steady in 2010 and 2011, but began to rise more dramatically beginning in 2012. According to the department, the rise in the number of reports received is out of their control, with the changes for the number reported unclear. While the number of reports received have risen over the past five years, the numbers of reports assessed and referred by the department's CI function to field staff for investigation has generally decreased over the same period of time. When field staff receive a report of alleged abuse or neglect from CI, they have the opportunity to change the category of the report based on additional information they may possess in the field. For example, investigative field staff may change a report which was categorized as not requiring an investigation to one that does require an investigation, based on personal experience or knowledge of a family who is the subject of a report of alleged abuse or neglect. Consequently, the number of reports referred and investigated may differ slightly. For example, in fiscal year 2014 CI referred 7,813 reports to the field for investigation, while the field investigated 7,829 reports of alleged child abuse or neglect. As illustrated by Figure 4, the number of reports assessed and referred to the field as requiring an investigation rose slowly through 2012, but declined significantly in 2013. Similarly, the number of reports actually investigated by field also rose gradually through 2012, but began to decline in 2013. Department management speculate that this may be attributable to the adoption of the more comprehensive safety-based response model in approximately 2012, with department staff overall conducting more accurate assessments of reports of alleged abuse within CI and in the field.

Children in Care Numbers Have Not Significantly Increased

Over the course of our work, department management routinely reported that children in care—or the number of children removed from parental control and in the care or control of the department—has significantly impacted their ability to complete work consistently or within required time frames. Consequently, as a part of our analysis of CPS data trends, we reviewed the most recently available children in care data reported by the department to the federal government for federal fiscal years 2004 through 2013. We also reviewed the number of FTE reported by the department for that same time period as responsible for conducting field investigations of abuse and neglect, including managing ongoing cases of child abuse and neglect when a child is removed from a family. The following figure illustrates the number of children in care in Montana during that period of time.

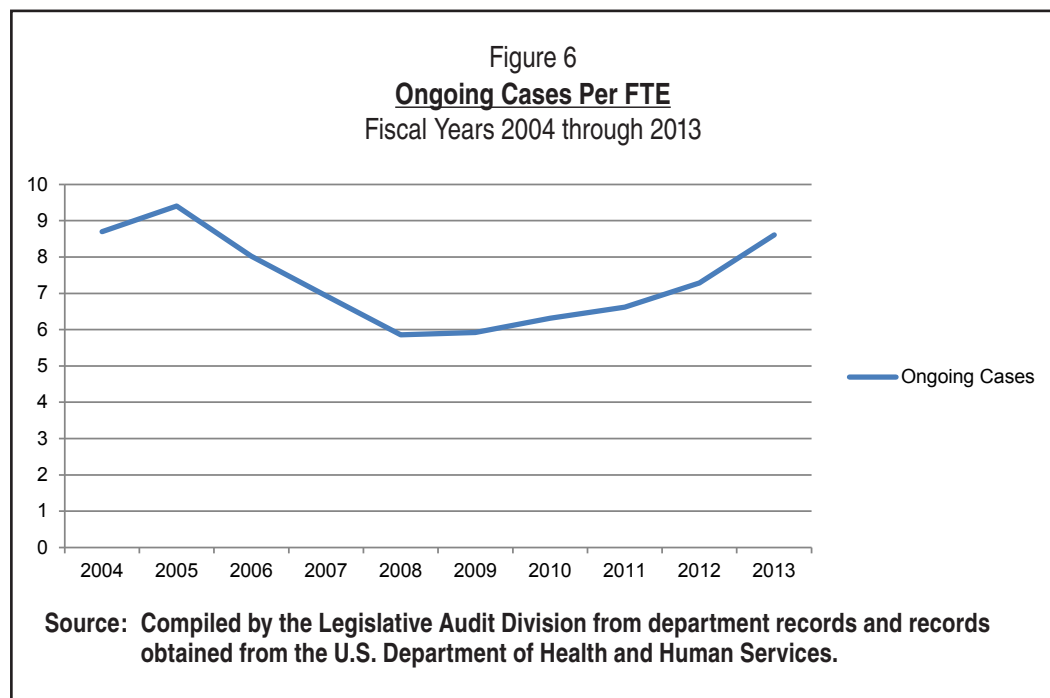


As illustrated by the figure, while the number of children in care of the department has certainly fluctuated over the ten-year period of our review, overall the number of children in care has remained fairly static, with the number of children in care increasing from 2,030 in federal fiscal year 2004 to 2,232 in 2013, for an increase of approximately 10 percent. Similarly, the number of FTE who perform field investigations and manage ongoing cases of child abuse or neglect has also remained fairly static over the ten-year period of our review, increasing approximately 10 percent from 145.90 FTE in state fiscal year 2004 to 162 FTE in state fiscal year 2013. Department management

attribute the increase in the number of children in care in Montana as attributable to an increase in methamphetamine usage and drug-related reports of alleged abuse or neglect. Audit work identified that the department also implemented a new more time-intensive and comprehensive safety-based response model in approximately 2012, which appears to align with the rise in the number of children whose families are receiving ongoing services from the department. Department management confirmed that when they implemented this new model in 2012, they were told to expect a rise in the number of children in care, but they also expected that after a brief period of adjustment to the new response model the number of children in care would decline.

Ongoing Case Assignment Has Declined

As noted, not only do field staff respond to and investigate reports of child abuse or neglect, they also are responsible for managing ongoing cases of child abuse and neglect when a child is removed from a family and placed in the care or control of the department. Over the course of the audit, department management indicated that while the number of investigations performed by field staff has generally declined over the past several years, the number of children in the care or control of the department has increased, which has resulted in an increase in workload and the number of ongoing cases managed by field staff. As a part of our work, we examined the number of ongoing cases assigned over time per FTE to assess the number of ongoing cases managed by field staff. We conducted this analysis by applying the current kids in care per ongoing case average for current field staff to prior years of the number of children in care from federal fiscal years 2004 through 2013.



As illustrated by the figure, the number of ongoing cases per FTE has generally remained fairly constant, with a decline of 8.7 ongoing cases per FTE in state fiscal year 2004 to 8.6 ongoing cases per FTE in state fiscal year 2013. Overall, this number is less than the current caseload standard of ten ongoing cases promulgated by the Child Welfare League of American for ongoing cases for CPS staff who perform both investigations and manage ongoing cases when a child is placed in the care or control of the department.

The Department Has Not Historically Evaluated Investigative Time Frames

As part of our review of CPS data trends, we also examined the timeliness of completed investigations. Per state law, the department is required to provide a report

Table 4 Average Days for Completion of CPS Investigations Fiscal Years 2010-2014	
Fiscal Year	Average Number of Days to Completion
2010	46
2011	47
2012	62
2013	74
2014	87

Source: Compiled by the Legislative Audit Division from department records.

of alleged child abuse or neglect within 60 days of the commencement of an investigation. Table 4 illustrates the average number of days for the completion of an investigation for the period of our review.

As illustrated by the table, the average number of days to the completion fell within statutory requirements until 2012 when the number began to gradually increase, leading to an approximately 89 percent increase in the average number of days to completion from 2010 through 2014. Department management indicate they simply have more children in care, with static resources, which has taxed their ability to complete investigations within statutory time frames. However, while the number of children in care has risen, our work indicates the workload of the department has remained fairly static over the period

of review. Our analysis does not support the department's contention that workloads have been increasing at a rate that exceeds available resources.

As noted earlier, the rise in the average number of days to complete an investigation appears to align with the department's implementation of a safety-based response model in 2012. While department management acknowledge this may be a factor, they have not examined this specifically, despite the fact that there appears to be a causal relationship between the implementation of their new safety-based response model and a number data trends impacting the intake and investigation of reports of alleged child abuse or neglect. According to department management, while they believe there may be value in assessing CPS data trends over time, they have focused

their efforts on developing tools to look at data in real time to more actively manage CPS intake and investigative activities. Based on our audit work, while the department has begun to more actively discuss the use of data to manage program activities, they do not routinely leverage data to conduct analysis of ongoing trends for receiving, assessing, and investigating reports of alleged child abuse or neglect.

CONCLUSION

While the department has begun to make plans to more actively use data to manage program activities, they have not historically looked at long-term data trends for reports of alleged abuse or neglect to manage CPS activities.

Audit Survey Supports Need to More Actively Manage Investigative Caseloads

Due to limited management information, we also conducted a survey of investigative field staff in order to get a more accurate picture of investigative caseloads. As part of our survey, we asked CPS field staff the size of their current caseload and to identify investigative bottlenecks or barriers. Currently the department has not established caseload standards for CPS field staff. As part of the survey, we also assessed staff longevity and process-oriented facts such as time spent on travel and documentation activities. Overall, the survey produced a response rate of 68 percent. As part of developing the survey, we determined that department staff consider several factors in defining caseloads, namely by the number of investigations, the number of ongoing cases, and the number of cases for which assistance is provided to another worker in another region or a child that recently moved to Montana. Department staff also consider the number of children in care in caseloads. The following bullets represent selected information we identified as part of our survey:

- ◆ Investigative workers reported the average number of investigations as 14, the average number of ongoing cases as 9, and the average number of children in care as 14.
- ◆ Investigative workers reported an average travel time of 7 hours weekly and an average of 15 hours weekly spent on paper work.
- ◆ Nearly 60 percent of respondents reported they had been on the job for two years or less.
- ◆ Frequent areas of improvement for the investigative process identified in the survey included shortening the investigative process and addressing electronic documentation issues.

When discussing the survey results, department management indicated the averages for ongoing cases appeared generally in line with what they might expect for staff workload, however, they emphasized that no two cases are alike. They also indicated that our information generally aligned with the information they have begun to recently gather as part of developing a spreadsheet tool to record and track ongoing case data for CPS field staff. They stressed that some of the answers provided by staff may be their perception and not reality, including paperwork and travel time. They questioned if staff may be inflating those numbers. However, department management has not conducted an analysis regarding the time staff spend on travel or paperwork. Our work indicated the ongoing caseload reported by staff as part of our survey appeared to generally align with caseload standards recommended by the Child Welfare League of America, a national child welfare organization. Investigative caseloads were over the recommended level of active investigations per worker. However, the department could benefit from a standardized caseload model to more effectively manage the work of their staff. Overall, department management agreed that caseloads was an area they recognize a need to more actively manage, which is why they have recently developed some tools to get a better handle on it. However, they have not yet established formal caseload standards by which they would measure or define caseload thresholds for staff. According to department management, they are reluctant to establish caseload standards until they receive additional resources from the Legislature. However, until the department establishes caseload standards, management is unable to clearly articulate to the legislature the resources needed to effectively manage CPS activities.

CONCLUSION

The department has not established caseload standards for CPS field staff; however, caseload standards could aid the department in more effectively managing their workload and clearly articulate its need for future resources.

The Department Has Not Developed a Plan to Use Data to Manage CPS Activities

Department staff frequently cite CAPS as a barrier to gathering meaningful data to manage program activities. They also report that documentation is not a high priority for staff and often is not stressed by management, which generates issues of unreliable or questionable data within CAPS. However, staff do recognize they need to more actively gather and use data to manage intake and investigative activities and have recently taken steps in that direction. For example, department management have recently created a spreadsheet tool to more accurately capture caseload data for investigative field staff, as CAPS does not have the ability to track investigations and

ongoing cases. While department staff recognize the need to more actively gather and analyze data, they have not developed a specific data analysis plan for moving forward. An analysis plan could help the department think through the data it collects, including considerations such as what will the data be used for and how will it be analyzed. Creating a data analysis plan could be an important way for the department to turn existing data into information which can be used to actively manage CPS activities.

While audit work indicates the department's current data system is antiquated and does not provide the department with access to all useful information, it is important for them to actively work within existing resources to manage program activities until such time as a new data system can be implemented. We noted the department has established high-level goals and objectives for CPS activities as a condition of federal funding related to foster care, adoptions, and various family reunification services. However, the department has not established any operational goals or objectives for assessing and investigating reports of alleged child abuse or neglect, including ongoing analysis to ensure those activities are occurring as expected. Overall, in our work, we noted that CAPS is a system which operates on an outdated technology platform and does not provide easy access to all management information; however, CAPS does track response time frames, the completion of investigations, and also provides the capability to document intake or investigative decisions. Currently, the department does not use all of the capabilities in CAPS to manage investigative staff caseloads.

Other States and Best Practices Emphasize the Importance of Data Management

We reviewed CPS activities in other states and best practices available from the U.S. Department of Health and Human Service's Office of the Administration for Children and Families. In contrast to Montana, other states commonly compile more comprehensive data which is used to track and manage CPS activities. Other states report these data systems are key to documenting CPS work, including investigative time frames, worker caseloads, and data trends over time. Staff in Washington report they have experienced frequent legal action regarding CPS activities, making strong data and documentation essential. In addition, best practices stress that data and information systems play a crucial role in child welfare. Developing and implementing case management systems and data collection tools that meet not only federal reporting requirements, but also the informational needs of an organization helps inform management decisions and support caseworkers' interactions with children, youth, and families. By actively analyzing and using available data, organizations can enhance program efficiency and improve outcomes for the families they serve.

The Montana Legislature Prioritized Funding to Develop a New CPS System

Department staff frequently cite how they have repeatedly and unsuccessfully asked the legislature for resources to obtain a new data system. However, in 2013, the Legislature provided the department with \$350,000 to develop a Request for Proposal (RFP) to develop a plan for a new data system for presentation to the 2015 Legislature. Consequently, the department released a Request for Information in 2014 to gauge interest in an RFP for building a new system for the department. Several potential vendors responded, with the cost of a new system ranging between \$25 and \$35 million. As part of our work, we reviewed the RFP developed by the department and noted that it outlined a number of elements which would address current shortcoming in CAPS, including documenting changes, providing for readily available data extracts, and supporting existing technology. However, citing limited vendor interest and the fact that none of the bids received met all of the RFP requirements, the department chose not to pursue funding for a comprehensive new system with the 2015 Legislature. The department decided instead to explore options to fund and implement a more specific data solution to track and use worker caseload information to manage CPS activities. Consequently, the department requested and the 2015 Legislature appropriated approximately \$4,000,000 within House Bill 2 (HB2) to the department. While HB2 does not specifically direct the department to use these resources to fund a new data system, we believe the department should use a portion of these resources to fund and implement a new electronic records and automated case management system.

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.*
-

CHAPTER IV – Investigative Time Frames and Determinations

Introduction

Once the Centralized Intake (CI) function within the Department of Public Health and Human Services (department) in Helena has determined that a report of alleged child abuse or neglect meets the statutory definitions of abuse or neglect and merits an investigation, CI will assign a priority based on the level of danger to the child and refer the report to one of the 29 field offices located in five geographic regions across the state. This is done to respond to the report in a timely manner based on the perceived risk to the child. After an investigation is initiated, the department has to provide a written report within 60 days of commencing an investigation. As part of our second objective, we evaluated if the department conducts investigations of reports of alleged abuse or neglect within required time frames and also within the requirements of the safety-based investigative protocol followed by the department. We found the department does not routinely meet investigative time frames. We also found the department does not uniformly make final investigative determinations regarding reports of alleged child abuse or neglect, due in part to investigative protocol, which de-emphasizes the initial allegation of alleged child abuse or neglect to which the department responds. Consequently, the department should strengthen compliance with investigative time frames and clarify the inconsistency between its investigative protocol and state law regarding making determinations of reports of child abuse or neglect. This chapter presents our findings, conclusions, and recommendations in this area.

State Law and Department Policy Outline

Investigative Time Frames

State law indicates it is the policy of the state of Montana to provide for the protection of children whose health and welfare may be adversely affected and further threatened by the conduct of those responsible for the children's care and protection. Section 41-3-202 (1), MCA, requires that upon receiving a report of abuse or neglect the department shall promptly assess the information contained in the report and make a determination regarding the level of response required and the time frame within which action must be initiated. And if the department makes a determination that an investigation is required, it shall promptly conduct a thorough investigation into the circumstances surrounding the allegations of abuse or neglect of the child. Section 41-2-202 (6), MCA, requires the department provide a written report, documenting determinations of any child abuse or neglect, within 60 days of commencing an investigation. In addition to the requirements in state law to investigate reports of child abuse or neglect in a timely manner, the department has also established policy which

further defines the timeliness of an investigation based on the perceived risk to a child. Per department policy, CPS reports prioritized as Priority One (P1) with a child in suspected immediate danger require an immediate response within 24 hours by field staff; reports prioritized as Priority Two (P2) require a response within 72 hours; and reports prioritized as Priority Three (P3) require a response within 10 days. These time frames outline the urgency with which investigative staff in the field must make initial face-to-face contact with the child in question. Investigations are to be completed within 60 days of receipt by CI.

Investigative Time Frames Are Not Being Met

As discussed in previous chapters, not all reports of alleged abuse or neglect received by the department require a field investigation. While the department's CI intake function will initially assess if an alleged report of abuse or neglect meets the standard for an investigation and assign a category and priority, investigative field staff may change the category or priority of a report based on prior experience or additional field knowledge. Reports may also be referred to other entities such as the department's licensing function or law enforcement for investigation. Subsequently, in our sample of reports of alleged abuse or neglect from fiscal year 2014, we reviewed 250 reports which were categorized as requiring an investigation by the field and subject to the department's various investigative time frames. As discussed, for reports requiring an investigation, the department will assign a priority which prescribes the urgency in which the department must make initial face-to-face contact with the target child. In our review, we noted that twenty percent of the reports we reviewed did not meet the priority times established by the department. Table 5 represents the 250 investigative reports we reviewed organized by the priority ultimately assigned by field staff, including the number of investigations for that priority, the number and percentage of reports which did not meet priority time frames, and median days to first contact.

As part of our audit work, we also reviewed the time to completion of an investigation for those 250 reports. We found that the department routinely

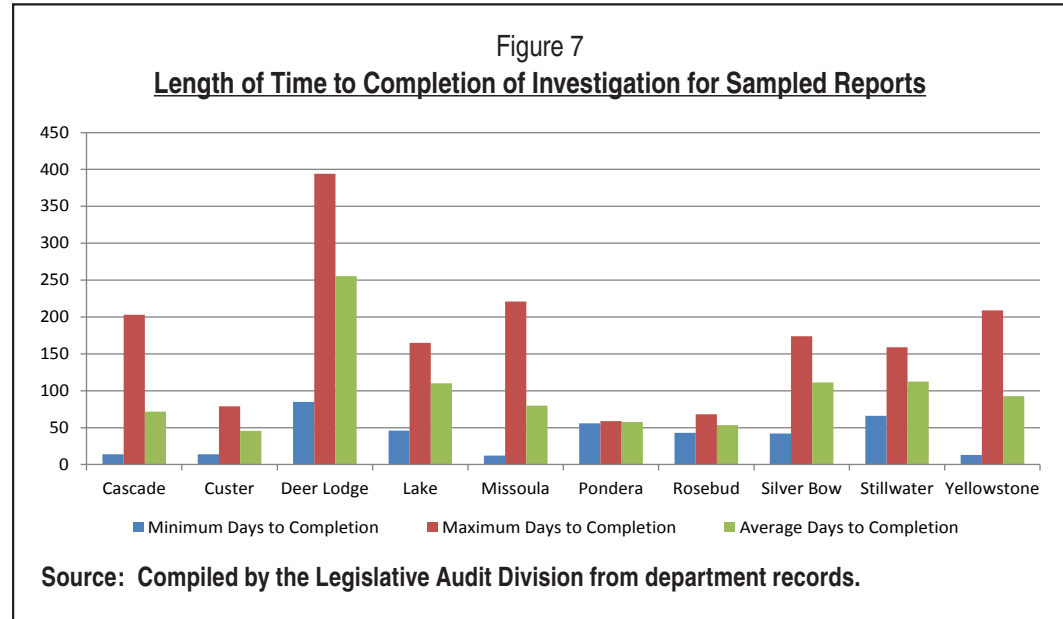
does not meet the statutory requirement to provide a written report within 60 days of commencing an investigation. In our review, we noted that over seventy percent of

Table 5
Priority Time Frames for Sampled Investigative Reports

Priority	Number of Reports	Number of Reports Not Meeting Time Frames	Percentage of Reports Not Meeting Time Frames	Median Days to First Contact
P1 (24 hours)	24	5	21%	0
P2 (72 hours)	144	31	22%	2
P3 (10 days)	82	14	17%	7

Source: Compiled by the Legislative Audit Division from department records.

reports were not completed within 60 days as required by state law. The completion of reports ranged from 12 days to 394 days and averaged 88 days to completion. The following figure illustrates the minimum, maximum, and average days to completion for the reports we reviewed in the ten counties in our sample.



We noted there may be some legitimate circumstances which are outside of the control of the department and may prevent field staff from meeting investigative time frames. For example, in regard to priority time frames, field staff may unsuccessfully be able to make face-to-face contact within prescribed time frames, due to uncooperative families or an inability to locate family members. Similarly, field staff may be unable to meet the statutory time frame for completing an investigation due to family members being unresponsive or unavailable. For example, in one circumstance, we noted that due to an injury, a child was transported to an out-of-state hospital which prevented the department from making contact with the family and meeting investigative time frames. However, in our review, we also observed examples where the priority time frame was not met due to assigned field staff being on personal leave. Overall, due to limited documentation the department was unable to generally provide support for why investigative time frames were not met. In our review, we also noted regional variations which generate questions about local staffing concerns which the department should actively analyze and address. While there may be legitimate circumstances outside of the control of the department, it would benefit the department to determine if there are factors such as staffing levels or process-oriented differences between regions impacting the completion of investigations in a timely manner.

Not Meeting Investigative Time Frames Increases Risks to Children

The purpose of investigative time frames is to respond to a report of alleged child abuse or neglect based on the perceived risk to the target child. Investigative time frames based on priority also provide the department with a tool to manage their investigative workload, based on how quickly they need to respond to a report of alleged child abuse. For example, reports which indicate that a child is not in immediate danger do not require an immediate response, while reports which indicate a present and significant danger to a child do require an immediate response. As a result of the department not meeting investigative time frames, not only is the department not in compliance with state laws and department policies, but more importantly, the department does not consistently respond to risk based on established protocols to assess the level of response required for a child perceived to be in harm's way. Without following the various time frame requirements outlined in the law and department policies, the department is unable to demonstrate that it responds to reports in the best interest of children and is providing for the protection of those children whose health and welfare may be adversely affected and further threatened by the conduct of those responsible for the children's care and protection.

The Department Believes Current Workload Inhibits Meeting Investigative Time Frames

Department staff routinely attribute their inability to consistently meet investigative time frames to an increase in the number of reports received by the department for investigations without adequate staffing resources. They indicate the number of children in the care of the department has been steadily increasing over the past several years, without the staffing resources to meet that need. They indicate current staff have overwhelming caseloads which prevent them from meeting time frames. Department management also reports that they frequently cannot meet investigative time frames because families are uncooperative or unresponsive to investigative workers. In these circumstances, department staff indicate the reason should be clearly documented why an investigation was completed outside of required time frames. Staff also report that they are unable to meet time frames as higher priority reports often take precedence over lower priority reports, which results in the response to lower priority reports delayed. Staff indicate the current data system used to track reports is outdated and does not allow for easy analysis of investigative trends. Recently, department staff have begun to develop additional methods to abbreviate investigative responsibilities for low-risk reports and also develop additional data tools to analyze program trends; however, department staff appear to be waiting for other entities such as the Legislature to act and provide additional resources for staff or data analysis, while they continue to struggle

to meet investigative time frames. Overall, department staff have not developed a plan on how to meet investigative time frames and appear to have accepted that they will never be able to meet those time frames within the boundaries of existing resources.

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.

Safety-Based Investigative Protocol
Not Consistent with State Law

When the department receives and assesses a report of alleged child abuse or neglect, CI staff will determine if there is reasonable cause to suspect that the child abuse or neglect may have occurred or is occurring based on the facts and circumstance provided by the reporter. If CI staff determine that abuse or neglect is present, they will assign an allegation according to a decision-making tree based on the various definitions of abuse or neglect as outlined in state law and department policy. Presently, the department assigns one or more of twelve possible allegations to reports of suspected child abuse or neglect as part of the intake process. The number of allegations assigned to a report can vary widely, with the number of children, adults, or types of alleged abuse. Section 41-3-102, MCA, defines the various types of child abuse or neglect to which the department responds and assigns allegations. Types of allegations outlined in the law include abandonment, educational neglect, drug exposure, medical neglect, physical neglect, physical abuse, psychological abuse or neglect, sexual abuse, or sexual exploitation. State law indicates that investigations of child abuse and neglect are investigated based on a reasonable cause to suspect an allegation of child abuse or neglect has occurred. Section 41-2-102 (25), MCA, indicates reasonable cause to suspect means cause that would lead a reasonable person to believe that child abuse or neglect may have occurred or is occurring, based on all the facts and circumstances known to the person. In our work, we identified examples of investigated reports where the child abuse or neglect may have occurred or was occurring, based on all the facts and circumstances gathered over the course of the investigation, but the initiating allegation was deemed to be not substantiated by the department. For example, we noted circumstances where CI had assigned a statutory allegation such as physical or psychological abuse to a report, with caregivers ultimately arrested for domestic

violence or drug use in the presence of children, yet the final investigative report was unsubstantiated, with that decision unsupported by available documentation.

While state law does not explicitly define what constitutes a substantiated determination, ARM 37.47.602 states that a substantiated report means that after an investigation, the investigating worker has determined by a preponderance of the evidence that 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. During the course of our audit work, we noted the department recently amended this definition of substantiation in administrative rules, adding the concept that the preparator of the alleged abuse may pose a danger to children. Department policy defines a substantiated report as where upon investigation the investigative worker has determined by a preponderance of the evidence that the facts showing that substantial risk of physical or psychological harm to the child exists or that the abuse, neglect, sexual abuse, or sexual exploitation occurred. Department policy further states that to substantiate abuse or neglect, the investigative worker must have evidence which, as a whole, shows that the facts indicate that it is more probable than not that the abuse or neglect actually occurred or that substantial risk of harm actually exists. However, in our audit work, we observed that while the department assigns allegations of abuse or neglect as part of its CI process based on statutory definitions of abuse or neglect, the safety-based investigative protocol followed by the department is much broader in scope than the incident-based focus on the current law or current definitions which guide the department when assigning an allegation to a report of alleged child abuse or neglect. Per department investigative guidance, the safety-based investigative protocol used by the department takes a comprehensive look into the functioning of a family who is the subject of an investigation of alleged abuse or neglect, with the scope of the investigation not defined by determining the presence or absence of incidents. Rather, the scope of the investigation is to identify the presence of safety threats and working with families to mitigate those threats.

Final Determinations of Alleged Abuse or Neglect Are Inconsistent

In our audit work, we noted that as a result of the department's use of a safety-based system, the initial allegation which generated the department's investigation is de-emphasized over the course of an investigation. The department inconsistently makes final allegation determinations regarding if a reasonable person believes that child abuse or neglect may have occurred or is occurring, based on all the facts and circumstances known to the person. Overall, of the 250 reports of child abuse and neglect we reviewed which required an investigation, we observed the department assigned a total of 625 allegations, in the areas of drug exposure, medical neglect,

physical abuse, physical neglect, psychological abuse or neglect, sexual abuse by a persons responsible for the welfare of a child, and sexual abuse by a unknown perpetrator. The following table illustrates the type of allegation, the number of allegations, the percentage of allegations, and the number of those allegations which were substantiated for the 250 reports of alleged child abuse or neglect from our review sample which were investigated in fiscal year 2014.

Table 6
**Allegation Type, Number, and Percentage from Investigated Reports
Reviewed in Audit Sample**

Allegation Type	Number of Allegations	Percentage of Allegations	Number of Substantiations
Drug Exposure (EMD)	12	1.92%	0
Medical Neglect (MDN)	3	0.48%	0
Physical Abuse (PHA)	29	4.64%	6
Physical Neglect (PHN)	547	87.52%	39
Psychological Abuse or Neglect (PSA)	20	3.20%	0
Sexual Abuse by a Person Responsible for Child Welfare (SAI)	12	1.92%	0
Sexual Abuse by an Unknown Perpetrator (SAS)	2	0.32%	0
Grand Total	625	100.00%	45

Source: Compiled by the Legislative Audit Division from department records.

As discussed in the prior finding section of this chapter, as part of an investigation of a report of alleged child abuse or neglect, per state law the department is required to complete a final investigation of that report, documenting their determinations of those child abuse or neglect cases. In our work, we noted that for those investigations we reviewed the department substantiated reports of abuse or neglect for approximately 7 percent of reports. And as discussed in the previous chapter, our work also indicated the department failed to notify families of investigative determinations 78 percent of the time for investigations we reviewed as part of audit work. Figure 8 (see page 38) illustrates the percentage of allegation determinations for those 250 reports we reviewed which required an investigation. Determinations categories used in this figure include substantiated where by a preponderance of the evidence the facts show abuse or neglect occurred; unsubstantiated where the department was unable to determine by a preponderance of the evidence abuse or neglect occurred; indicated where abuse or neglect occurred but the perpetrator is not legally responsible for the child; closed without findings where the department was unable to locate the family or due to a lack of evidence unable to complete the investigation; unfounded where the department

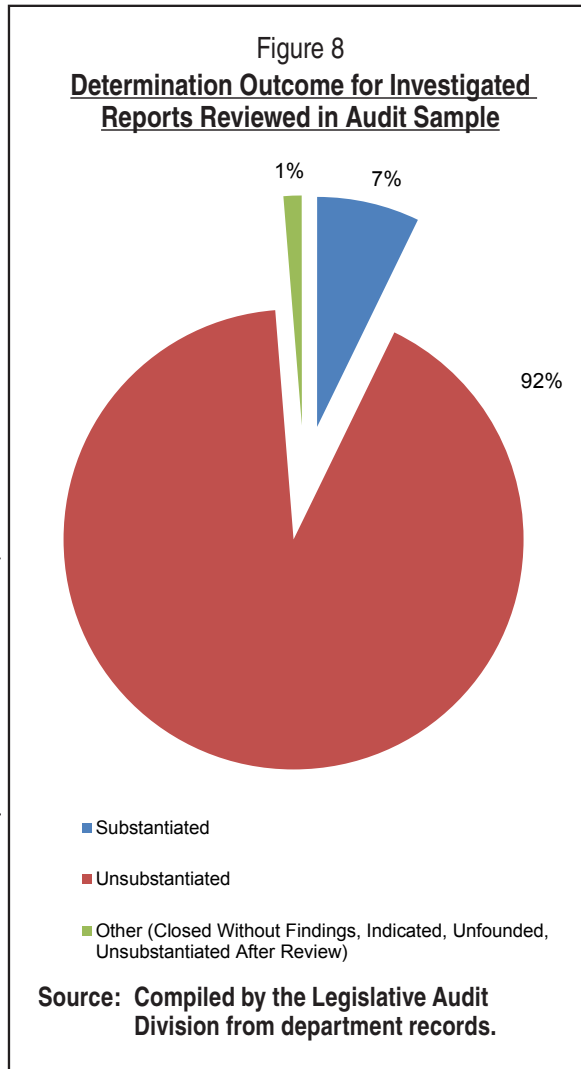
determined the abuse or neglect did not occur; and substantiation overturned where a substantiation was overturned during an internal or external review.

As illustrated by the figure, for those 250 reports we reviewed, the department substantiated abuse or neglect 45 times or approximately seven percent of the time. While it is not possible to speculate how frequently the department should have substantiated on reports of abuse and neglect, audit work identified several unsupported decisions where based on the evidence that the reported abuse, neglect, or exploitation appeared to have occurred. We identified examples of investigated reports where the child abuse or neglect may have occurred or was occurring, based on all the facts and circumstances gathered over the course of the investigation, but the initiating allegation was deemed

to be not substantiated by the department. Our work raises reasonable questions as to whether the department is consistently making determinations of alleged child abuse or neglect and if the number of reports which should be substantiated is currently underrepresented. Per state law, it is the policy of the state of Montana to provide for the protection of children whose health and welfare may be adversely affected and further threatened by the conduct of those responsible for the children's care and protection.

Department Believes Current State Law Is Outdated

Department staff indicates the current safety-based investigative protocol the department adopted in 2012 is a much more comprehensive look into how a family functions on a daily basis than the incident-based investigations of the past upon which current law is based. Staff report that the national trend for investigating reports of child abuse or neglect has moved to safety-based models, which Montana also did as the



result of past federal reviews of CPS activities. Regarding the outcome of investigations, staff report there is also a reluctance to substantiate on alleged perpetrators of abuse or neglect, as they believe their work should focus on providing services to families in need and not be punitive in nature. They express concerns that substantiating on an alleged perpetrator of abuse or neglect can have negative employment consequences for an individual, which can further damage a family and the ability of an adult to provide for the family. Department staff also report the decision to substantiate is frequently based on if the incident was isolated, and if the alleged perpetrator is cooperative and willing to work with the department or even likable.

Department staff also routinely report they are reluctant to substantiate due to a different standard of proof for investigative staff versus the legal standard used during the fair hearing process if a substantiation is challenged. The preponderance of the evidence standard followed by an investigative worker is a lower standard and does not require admissible evidence as is the standard in a legal proceeding such as the fair hearing process. During the course of audit work, as part of amending administrative rules, the department established more of a tiered-approach, where it will be possible to make a determination of founded rather than substantiated, which would have a lower burden of proof and would not have negative employment consequences. A determination of founded would mean that an investigation found probable cause that an incident occurred, rather than by a preponderance of the evidence the abuse or neglect did occur. However, this change in administrative rules does not resolve the inconsistencies between the department's safety-based investigative protocol and the incident-based focus of the law. Overall, department staff indicated that currently substantiations are not emphasized as part of the investigative process and not clearly defined in the context of the safety-based model. They indicated that state-law is much more incident-based in nature, outdated, and likely should be revisited at some point to address inconsistencies between the law and the safety-based investigative model. However, they report they have no plans to address these inconsistencies in the law at this point, indicating they would need to develop a wide consensus among many different stakeholders in the state to successfully make any changes. However, the department indicated as part of developing additional methods to abbreviate investigative responsibilities for low-risk reports, they also plan to more clearly define how investigative determinations fit within the scope of a safety-based investigative model.

Other States Have Addressed Statutory Inconsistencies

As part of our work, we reviewed similar activities in other states. We noted the investigation of reports of abuse and neglect in other states reviewed, including Washington, Idaho, Oregon, and South Dakota, share many similarities with Montana

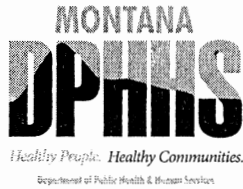
and are safety-based in nature, with investigations gauging the level of danger to a child and how to control for that danger. Staff in these other states said they also experienced an inconsistency between newly adopted safety-based investigative models and statutorily-driven definitions of child abuse and neglect which are more incident-based in nature. Other states report they have taken various approaches to resolving this conflict, including pursuing statutory changes or developing tools to more clearly align safety-based models with existing laws. For example, in Oregon, staff indicated they are developing training to educate judges and the legal community on the safety-based model in an effort to develop a common language for reports of child abuse or neglect which enter into legal or judicial proceedings.

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.

DEPARTMENT OF PUBLIC
HEALTH AND HUMAN
SERVICES

DEPARTMENT RESPONSE



A-1

Department of Public Health and Human Services

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Steve Bullock,
Governor

Richard H.
Opper, Director

October 9, 2015

Tori Hunthausen
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

RECEIVED
OCT 13 2015
LEGISLATIVE AUDIT DIV.

Re: Review of Child Abuse and Neglect Investigations audit

Dear Ms. Hunthausen:

The Department of Public Health and Human Services has reviewed the *Review of Child Abuse and Neglect Investigations Audit (14P-11)* completed by the Legislative Audit Division. Our responses and corrective action plans for each recommendation are provided below.

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.

Response: Concur

Corrective Action: The Department will clearly define intake and investigative activity documentation requirements in policies and procedures. The Department has revised its Centralized Intake Assessment and Family Functioning Assessment and the related policies and procedures to ensure that documentation requirements are more clearly defined. All necessary Department staff has been trained on the new policies and procedures and ongoing training and continuous quality improvement efforts are in place in an effort to better monitor documentation requirements.

Planned Completion Date: 11/30/2015

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.

Response: Concur

Corrective Action: The Department will revise its policies and procedures on investigation and intake activities to more clearly outline the role of the supervisor, the

standard for the review and oversight using the Continuous Quality Improvement (CQI) checklist and also include the requirement regarding the reassignment of investigations when turnover of staff occurs.

Planned Completion Date: 11/30/2015

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.
- 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 Services activities.

Response: Concur

Corrective Action: The Department has completed its data management plan and has put it into a program called Child and Family Stat that will allow Department management and staff to monitor performance in seven key results areas, including intake and investigation. The Department is meeting with vendors and other state agencies to review and identify potential solutions for an electronic case management system.

Planned Completion Date: 9/30/16

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.

Response: Partially concur

Corrective Action: The Department has revised its Family Functioning Assessment policy and procedure to require less documentation on reports that are low risk and do not rise to the level of needing to immediately remove a child and place the child in foster care. This revised process, policy and procedure has been trained to staff in August and September and has been in place for nearly a month. The Department does not concur that this can be done within existing resources indefinitely due to the fact that the number of children in foster care directly impacts the workload of child protection specialists. Child Protection Specialists are responsible for both investigations and ongoing case management, specifically in cases that lead to temporary removal and placement in foster care. The audit report fails to acknowledge the significant strain that increased foster care placements have had on caseworker time and the corresponding pressure on the investigative duties for which they are also responsible.

Planned Completion Date: Implemented

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.

Response: Concur

Corrective Action: The Department has taken steps to revise its Administrative Rule to align better with the SAMS model and has had its legal counsel train staff on the new tiered approach. The Department will continue to review to determine if other changes are necessary.

Planned Completion Date: Implemented

Sincerely,

A handwritten signature in black ink, appearing to read "Richard H. Opper", written in a cursive style. The signature is positioned above the typed name and title.

Richard H. Opper, Director
Department of Public Health and Human Services

cc: Bob Runkel, Economic Security Services Branch Manager
Sarah Corbally, Child and Family Services Division Administrator
Becky Schlauch, Business and Financial Services Division Administrator, Audit Liaison