PERFORMANCE AUDIT

AUDIT OF CHILD ABUSE AND NEGLECT REPORTING AND RESPONSE SYSTEM

From The Office Of State Auditor
Claire McCaskill

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December 28, 2000

The child abuse and neglect hotline system could be more effectively managed. Children are at risk because quality control systems are not effective and in some instances are non-existent.

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Office Of The
State Auditor Of Missouri
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YELLOW SHEET

Concerned citizens seeking protection for at risk children through the child abuse and neglect hotline cannot always depend on the results.

Our office began auditing the hotline system run by the Division of Family Services after two boys died from abuse, despite at least 11 hotline calls about possible neglect - including an incorrectly categorized call just before their deaths. Our staff focused on determining how the system received, reviewed and resolved hotline calls. The audit tested decision making processes, tracked actions taken and studied the outcomes.

Our review showed that while many calls are properly handled, ineffective oversight by top managers leaves many children in danger of further mistreatment. Our findings fall into two major issues: overall quality control and investment in field staff. Without an adequate monitoring system, managers could not detect problems when they occurred and, in some cases, ignored detected problems. Managers also did not adequately support their field staff, which contributed to low morale and high turnover. The following highlights our findings:

Inconsistent decision making

Our tests showed that field staff did not make consistent decisions about hotline calls. We presented a series of calls to several workers and received varying responses. The workers were requested to decide if the calls met abuse or neglect criteria and if so to classify them for either investigation or family assessment. In our test, we included two calls made on behalf of three children who died and found 83 percent of those tested chose a different action than was chosen by the workers who originally handled those cases. In a call of a mother forcing an 8-year-old to breast feed which was not accepted by the original call taker, all those tested said it should have been accepted as a child abuse and neglect report or referral for services rather than an unable to investigate case, which it was. We proposed a decision making model that leaves less room for inconsistencies and worker judgment. (See page 4)

Calls incorrectly classified

Of the 95,000 calls received in 1999, call takers determined one quarter of them could not be investigated, which means no action occurred. But our audit showed many calls are incorrectly classified. In our small sample, we found 50 incorrectly categorized calls. We presented these cases to DFS officials in May 2000 to give the children another chance at protection, but officials only agreed with our reassessment on one case and took no action on the rest. One of our examples included an inadequately clothed boy locked outside his home on a cold day. The hotline manager defended the decision with: “Let’s face it, 38 degrees isn’t going to kill anyone.” (See page 6)

Our review of these uninvestigated calls showed hotline workers did not always indicate if they checked for previous reports of abuse and did not fully document the call on the manual worksheet. In addition, supervisors approving the categorization of these calls never listened to the taped calls to monitor a call taker's judgment. Finally, once a call is considered unable to investigate, usable records of the call are destroyed within two months. (See page 9)

Reports of abuse ignored

There is no assurance that the county offices will act on calls referred to them by the hotline unit. We found 33 calls in three months that received no action because the county staffs never pulled the call off the automated referral system. We could not determine the historical magnitude of this problem because the automated system only displays calls for a 3-month period. DFS officials have since tried to correct this issue. (See page 11)

Nearly half substantiated calls overturned

During 1999, the child abuse review board overturned on appeal 40 percent of all investigations substantiating probable abuse. The review board cited poor case management as the reason for 26 percent of the overturned cases. DFS has known of the high overturn rate for at least four years and hired an employee to create a better case-management plan, but then ignored the employee's suggestions. (See page 13)

More investment in staff needed

The DFS Central office has not fully supported the field staff which suffers from low morale and high staff turnover and as a result cannot complete tasks within deadlines or have confidence in their decision-making. We attribute these problems to low pay, inadequate equipment, and training.

Missouri ranks 45th in the nation on basic pay and offers only a 4 percent raise for promotion to supervisor, which is nearly one third less than what four surrounding states offer. There is also no pay differential for staff obtaining a Master's degree or professional licensing. (See page 26) Workers are inefficient due to inadequate equipment, such as some workers having to type or handwrite their reports due to a lack of computers. (See page 29) And all employee levels, from workers to supervisors, shared concerns about the adequacy of training and lack of guidance. In fact some directors, with background in Income Maintenance not Children Services, said they were uncomfortable supervising social workers. (See page 31)

We realize that the role of DFS staff in receiving and processing hotline calls and cases is very difficult. We also realize that no one in DFS wants a child at risk to remain at risk. For this realization to remain true, senior managers need to take a more proactive role in managing the organization and institute effective quality controls. Our recommendations offer some simple mechanical steps to meet this goal.

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Missouri State Auditor

Honorable Roger Wilson, Governor
and
Steve Renne, Acting Director Department of Social Services
and
Denise Cross, Director Division of Family Services

The State Auditor's Office audited the Department of Social Services Division of Family Services'(DFS) child abuse and neglect hotline reporting and response system. The impetus for this audit came from the public outcry over some high profile abuse/neglect cases. My office received numerous calls expressing great concern over the plight of abused or neglected children in many locations over the state.

The purpose of the audit was to determine if hotline calls that alleged child abuse and neglect were properly received, documented, and referred to the appropriate local DFS city or county office; whether those offices made certain the child or children were adequately protected and the calls were handled in accordance with the Missouri statutes, Code of State Regulations, and division policy. The audit included a review of operations of the central Child Abuse/Neglect Hotline unit and the subsequent follow-up handling of abuse and neglect cases in local DFS offices.

We concluded the child abuse and neglect hotline response system was not effectively managed and some children were unnecessarily left at risk. Quality control systems were not effective and in some instances were non-existent. Senior managers in the DFS need to take a more proactive role in managing the hotline and child abuse/neglect system.

We also determined the DFS Central Office has not been as supportive of field staff as they need to be. Field staffs are expected to carry unreasonable workloads while at the same time they have not received competitive salaries, modern tools, and training that could alleviate some of their burden. DFS officials generally agreed with most of the recommendations and provided acceptable implementation dates. Some responses were not clear and they will be followed up on during our followup process.

Claire McCaskill
State Auditor

August 30, 2000 (fieldwork completion)

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RESULTS AND RECOMMENDATIONS

1. Child Abuse and Neglect Cases Can Be Better Managed to Ensure Children Are Protected

The decentralized, reactive management style of the Division of Family Services (DFS) did not ensure that child abuse and neglect hotline calls would be processed properly and meet the need to adequately protect each at risk child. Audit tests disclosed:

- The decision to accept a child abuse and neglect report as an investigation or family assessment was not consistent among DFS social workers.
- Hotline staff decided not to accept child abuse and neglect reports when they should and could have referred allegations to local offices for investigation or other services.
- Hotline calls forwarded to field locations were not always reviewed or acted on.
- Substantiated hotline cases were overturned on appeal because they were not properly prepared or presented.
- Children's services were cut back or denied because field staff were told to reduce costs.

These conditions occurred because DFS management did not take a proactive approach to evaluating major elements of the hotline decision-making process. Quality control systems did not work properly or were nonexistent in some management processes. In some instances, no action was taken to correct problems that were disclosed. More guidance and supervision was needed to assist field level social workers in making consistent decisions and developing cases. As a result, some children did not receive the services or protection they were entitled to and there is no assurance that child abuse and neglect decisions are correct or will be appropriate.

The DFS is responsible for handling Child Abuse and Neglect Hotline calls

The DFS Children's Services personnel receive calls reporting child abuse and neglect and determine how to respond by evaluating the information received, performing an investigation if necessary, and documenting the circumstances found. If needed, appropriate services intended to prevent future incidents of abuse or neglect are initiated.

(*See Appendix III, page 45, for a more detailed description of the Child Abuse and Neglect System process.)*

The DFS receives a very high volume of calls. Calls are received from private citizens, mandated reporters,[1] family members, and non-caretakers. Call takers classify calls in various

[1] Mandated reporters are required by law to call the child abuse hotline if they see evidence of child abuse and neglect. Examples of mandated reporters are school officials, law enforcement, nurses, doctors, day care workers etc.

categories of which the large majority are classified as either child abuse and neglect reports, mandated reporter referrals, or unable-to-investigate calls and to a lesser extent, new born crisis, non caretaker, or preventive service referrals.

In order for a call to be classified as child abuse and neglect, it must meet the following criteria:

- The child is under age 18.
- The alleged perpetrator has care, custody, and control of the child.
- The alleged abusive or neglectful treatment is having an adverse effect on the child.
- The report meets the definition of abuse/neglect described in state statues.

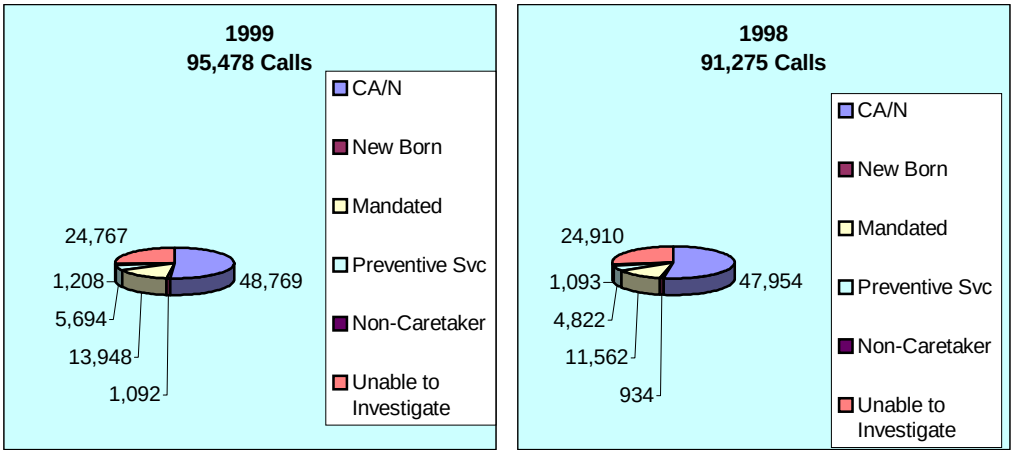
In instances when the call taken by the hotline unit does not meet either child abuse and neglect or referral criteria or if no identifying information can be obtained, the information is coded unable to investigate.

There are two types of newborn crisis referrals--drug-involved and non-drug-involved. For drug-involved referrals the new born must show signs and symptoms of drug/alcohol. For non-drug-involved referrals there must be allegations of potential serious risk of abuse/neglect upon release of the newborn from the hospital.

Non caretaker referrals result from calls from persons other than mandated reporters identifying possible abuse or neglect where the alleged perpetrator has no care, custody, or control of the child.

Preventive Service Referrals result from calls made by persons other than mandated reporters where actual abuse or neglect has not yet occurred, but where the actions of the child, caretaker, another juvenile or adult demonstrates the need for intervention and possible service delivery to prevent child abuse and neglect from occurring.

The number and classifications of hotline calls received during 1999 and 1998 are shown below:



DFS staff need help to make consistent decisions on case handling

Audit tests revealed that given the same case situations, local office personnel would choose varying responses. We asked 17 local social workers to read documentation of 5 actual hotline calls to determine, using available policy and resources, whether the allegations met child abuse and neglect criteria and if so to classify for either the Family Assessment[2] or Investigation track. The following table discloses test results that identify inconsistencies in the responses received from the workers in the test and workers who handled the actual calls.

	Number of social workers who categorized cases as				
Case No	Family Assessment	Investigation	Other	Total	Actual Result
1	3	11	0	14	Family Assessment[3]
2	2	15	0	17	Family Assessment
3	7	9	1	17	Unable to Investigate
4	17	0	0	17	Family Assessment
5	8	9	0	17	Family Assessment

- Case number three was actually classified as unable-to-investigate (no action taken to protect child), by the hotline unit while all the test workers believed it met child abuse and neglect or referral criteria and most thought it should have been classified as an Investigation. This call reported a mother who was forcing her 8-year old child to breast-feed nightly. We brought the lack of action on this case to the attention of the Child Abuse and Neglect Hotline Unit (hotline unit) and DFS Central Office on May 18, 2000, but they declined to take any action to protect the well being of this child. This denial is a reflection of problems with categorizing cases as unable to investigate when something could have been done. We discuss this problem on page 6 of this report.

- Three children in cases one and two died as a result of abuse and/or neglect within months of being incorrectly classified and handled by DFS as Family Assessment cases. While most workers participating in the test correctly classified and screened these two hotline reports as Investigations, the deaths lend a tragic emphasis to the problems of inconsistency in decision making on DFS cases.

Three children died

In order to gain an understanding of why decisions varied significantly, we reviewed training procedures and supervisory practices, queried social workers, participated in a walk-through of an actual call, and examined decision-making systems used in other states. We determined that the basic training was satisfactory but field workers were confused in some cases about when or when not to use the Family Assessment track. Additionally, differences in decision making from one case to another and from one social worker to another occurred because social workers could

[2] The two-track system (family assessment/investigation) provides the social worker the flexibility in determining whether to bring law enforcement in or to counsel the family. Investigations are ordered when the social worker feels there is a high likelihood that some abuse or neglect has occurred. These require law enforcement involvement. Family assessments allow the social worker to determine what type of services including counseling, parenting classes etc. might help the family overcome their problems in handling children.

[3] One case was not given to some workers because they were aware of the case.

exercise considerable judgment in their decision-making. Other states developed useful decision making tools that would help social workers make better and more consistent decisions.

Structured Decision Making Model

The National Council on Crime and Delinquency established The Children's Research Center to help federal, state and local child welfare agencies reduce child abuse and neglect by developing case management systems and conducting research that improves service delivery to children and families.

A structured decision model would help

According to the Children's Research Center published materials, the National Council was established in 1907 to perform a similar role for private and public agencies serving delinquent children. The National Council branched out to Children's Protective Services after successful completion of a risk assessment model for Alaska's delinquent population by devising a system to provide the same structure for Alaska's Children's Protective Service program.

Approximately 12 states have implemented some elements of the structured decision model approach. The model is a system of several basic components used to structure the decision-making process for Children's Protective Services. At the heart of the system is a series of tools used to assess families and structure the agency response to them. The following tools are used at multiple decision points, ranging from call intake to family reunification:

- Response Priority--A decision system to guide whether a call should be accepted or not and how quickly investigative staff should respond to a report alleging child abuse/neglect.

- Safety Assessment--To determine the threat of immediate harm and identify steps needed to protect children.

- Risk Assessment--A research-based system to estimate the likelihood of future abuse/neglect.

- Family and Child Strengths and Needs Assessments--Assessments to guide service planning.

- Reassessments--Safety, risk and needs are reassessed periodically to determine the need for changes in service levels and/or changes in permanency planning.

- Service Levels--The service levels and associated standards are designed to ensure that staff time and attention is concentrated on those families at the highest levels of risk and need.

- Workload Management--A workload measurement and accounting system for determining the number of child welfare staff needed to allocate the workload equitably among staff.

- Management Information--A process of using aggregate family assessment data, agency response/decision data and workload data to assist managers in planning, monitoring, budgeting and evaluation.

The objectives of the model are:

1. To introduce structure to critical decision points in the child welfare system.

2. To increase the consistency and validity of decision making.

3. To target resources to families most at risk.

4. To improve the effectiveness of Child Protective Services.

Our audit work included research into other states that have implemented elements of the model. This research led us to visit Michigan because that state has used the model longer than most other states. While in Michigan, we discussed the model with State officials, several local front line workers having varying levels of experience and length of service, front line supervisors, and County Administrators from two different counties. In those discussions, workers gave varying responses depending upon their level of experience as to the helpfulness of the model, but most agreed it was especially helpful as a learning tool for inexperienced workers serving to guide them in making difficult decisions. Everyone we interviewed stated that the model should be retained and thought it was a better system than other systems they had experienced.

Quality controls could be improved

The DFS should have more effective oversight systems to ensure child abuse allegations are reviewed and appropriate actions are taken. DFS relies more on supervisory reviews and signature systems rather than proactive review and oversight of program activities. As a result, central office staff is not aware of problems or do not take effective corrective action when problems are known.

Calls could have been referred for local action but were classified as unable to investigate by the hotline unit

The hotline unit tape records all calls received. Our audit found that the hotline unit categorized calls as "Unable-To-Investigate" when the calls actually met child abuse and neglect or referral criteria, leaving children at risk. The hotline unit classifies approximately 25 percent of all calls as unable-to-investigate. There were 1,757 and 1,880 calls classified unable-to-investigate in December 1999 and January 2000 respectively. To evaluate the hotline unit's handling of unable-to-investigate calls we tested 6 percent of the December 1999 calls and all of the January 2000 calls. We concluded that 50 of the unable-to-investigate calls tested (3%) were incorrectly classified as unable-to-investigate and some action should have been taken. *(See Appendix III, page 51, for a more detailed description of unable-to-investigate classification and Appendix VI page 61, for detailed test results).*

The following are examples of calls incorrectly classified:

- The caller alleged that the parents of a 9-year old girl beat her with a broken hockey stick. The call taker said the case would be considered a child abuse and neglect case if a prior call could be found with the address for the victim. No action was taken. We found the victim's address in a prior report in the hotline system. The child continued to be at risk.

Girl allegedly beaten with broken hockey stick

- The caller and his friends observed a 5-year old child screaming, "Mommy, Mommy, let me in, it's cold out here!" The caller said the temperature was 38 degrees and he was concerned because the child had been outside for up to 1 hour in only a short sleeve T-shirt, thin pants, and socks. The caller stated he and his friends, in spite of wearing coats and heavy clothing, were still cold. The caller reported that the child's mother told him she was punishing the child. The call taker told the caller the hotline could not do anything because the incident did not meet the 1-hour "lock out law." (Being locked out for over an hour.) A supervisor told us that this case did not meet the criteria for child abuse and neglect because the call taker could not be certain that the door was locked. Our audit disclosed that there is no "lock out law," the wind chill at that day and time was 16 degrees, and the hotline unit manager was not concerned with this case. He stated in response to our concern, "Let's face it, 38 degrees isn't going to kill anyone."

Inadequately clothed child left out in cold

- A mandated reporter (psychologist) stated that a 12-year old boy revealed in a therapy session that his friend's parents punished his friend by keeping him in a cage 5' high and 9' wide. The reporter could only give the victim's first name, age, and school. The call taker did not pursue the call because the caller did not identify the victim's last name or address. Our audit disclosed that this call could have been referred to the local county office, which could have contacted the school and obtained such information.

Boy alleged to be locked in cage by his parents

- The caller stated a mother and 3 children under the age of five were living in a filthy apartment. Human feces and rotten, molded laundry covered much of the floor the last time the caller went to the home a few months prior. At that time, the caller and others had to wear masks to enter the home due to the strong odors. Ten days before the reporter called in, fumigators refused to spray the apartment because of the odors. The call taker dismissed the call because the caller could not confirm if the condition existed within 1 or 2 days of the call. The hotline received a repeat call a few days later and a different call taker determined that the condition had existed within the last week before the call and referred the case to the local office for review.

Family is living in filthy conditions

All of the questions we posed on the 50 cases were presented to DFS executive and management officials in May 2000 when we discovered them in an attempt to make sure the children had another chance for protection. We presented them again 2 months later. At the first presentation, these officials assured us that they would look into each case because they were concerned that children were still at risk. At the second presentation, the officials acknowledged that they agreed with only 1 of the 50 cases and never took action on the rest. The above examples are typical of all 50 cases we questioned. These examples demonstrate that at least a referral for preventive services could have been made. For each case, children are still at risk.

DFS officials choose not to respond

Call takers and supervisors should be more diligent in documenting and reviewing calls before categorizing as unable-to-investigate

The hotline unit call takers did not document on the unable-to-investigate worksheet whether they had checked DFS records for prior child abuse and neglect calls or Referrals for the child's family on 288 of 882 (33%) calls tested. Prior child abuse and neglect calls and referrals are important because they could indicate a family history of abuse or neglect and that the current allegations should be checked out. Prior records could also provide addresses or other needed information the current caller cannot provide, raising the priority of the call from an unable-to-investigate to a child abuse and neglect or Referral. We located prior records for 140 of 333, or 43 percent of all calls tested (the 288 mentioned above and 45 others we questioned). In all 140 instances, the call takers either did not document that they checked for priors or documented fewer prior records than we found.

Not enough is done to ensure that cases are reviewed

From listening to the tape recordings of these unable-to-investigate calls, we noted that hotline unit call takers do not always fully document the call on the unable-to-investigate worksheet, often omitting pertinent information. One call taker did not put any narrative on the majority of her unable-to-investigate worksheets. This omission made it impossible for the supervisor to review the allegations of the call (which supervisors are required to do) to approve the decision. Even so, the supervisor signed off on all the worksheets.

We also noted in 18 of 331 unable-to-investigate calls tested, the reporter called again, gave the same information to a different call taker, and the second call taker classified the case as either a child abuse and neglect report or Referral. This further supports that the initial calls should not have been classified unable-to-investigate.

The causes for improperly categorizing calls as unable-to-investigate may be attributed to a policy in the hotline unit that too narrowly interprets what can be referred for review, the lack of attention by unit supervisors, the lack of thorough review of prior records by call takers, and the lack of a quality control system to detect problems.

Hotline unit personnel narrowly interpreted procedures unnecessarily

According to the hotline unit manager, calls are categorized as unable-to-investigate when they do not meet the criteria for child abuse and neglect, various special referral categories, or 11 specific criteria for preventive service referrals. Our review of this policy disclosed that it is not an effective management tool and it causes calls to be improperly dismissed. For example, a caller could allege that a child is going from door to door begging for food, or that there are drug activities in a child's home and the hotline unit would not consider making a referral for preventive services. The 11 criteria for referral to preventive services were not meant to be exclusive for any case. In fact, the DFS Investigative Manual and guidance provided by DFS Training and Policy personnel confirm that these 11 criteria are not the only criteria to consider when deciding if preventive service is needed.

DFS trainers and policy specialists stated the 11 situations listed in the manuals are only the more severe examples and are not the only situations that should be considered appropriate for preventive service. Preventive services are intended to prevent child abuse or neglect from occurring. According to the DFS training supervisor a preventive service referral is any call where no specific incident of abuse or neglect has occurred, but the caller has concerns for the family.

Unable-to-investigate calls are not included in the hotline unit quality control system and the limited quality control placed on these calls is not effective

Hotline unit senior officials advised that incoming calls received are subject to random supervisory check. This check includes reviewing documentation by the call taker and listening to the tape recordings of the calls to ensure that they are satisfied with the call taker's response. This quality control measure assures the officials that they can identify judgment errors or identify staff training needs.

However, once a call is categorized as an unable-to-investigate call, the only quality control measure used is the supervisor's signature, which signifies agreement that it is an unable-to-investigate call. Audit results disclosed that supervisors never listen to the tape recordings of the calls, and do not know that information recorded on the unable-to-investigate worksheets is incomplete. This is troubling because the unable-to-investigate call is the most vulnerable to judgmental error and the impact of the error is to do nothing for the endangered child. The implication of the terms "unable-to-investigate" is that the call cannot be investigated—there is some missing information that does not allow the call taker to take action. However, as discussed previously, this is not the case. Call takers are making judgments based on narrow interpretations of policies that could and have led to making inappropriate decisions.

Unable to investigate or won't investigate?

Review of the hotline unit monthly and yearly production reports for calendar year (CY) 1999 indicated that although the hotline's average unable-to-investigate calls are 25 percent of total calls received, some call takers had unable-to-investigate average percentages as low as 11 and as high as 50. Hotline unit management should have

discovered these inconsistencies when reviewing the monthly production reports. These reports could help identify workers who need more training or call takers who need more management monitoring.

Our 2-month review of unable-to-investigate calls, previously discussed, identified that workers who unjustifiably categorized multiple calls as unable-to-investigate often had above average unable-to-investigate percentages:

- A new call taker who was in her first month made multiple errors on unable-to-investigate calls and she classified 48 percent of her calls as unable-to-investigate. This high rate suggests there is reason for concern about the adequacy of the hotline unit training program and/or the adequacy of supervisory monitoring of the new workers.

- One experienced call taker has categorized 50 percent of the calls received as unable-to-investigate for the last 3 years. At one point in CY99, this call taker's percentage of unable-to-investigate calls was 60.

- The call taker who failed to document a narrative for most of her unable-to-investigate calls also had multiple errors on our 2-month unable-to-investigate review and classified an average of 35 percent of all her calls in CY99 as unable-to-investigate.

Quality control is not effective

The record keeping system for unable-to-investigate calls is not currently conducive to effective quality controls and needs to improve. There are no tape or manual records of unable-to-investigate calls after 6-months and all written records are destroyed after 60 days. Manual unable-to-investigate worksheets are not filed in an easily retrievable manner and are destroyed after 60 days, leaving no written record of the call. Although the tape recordings of these calls are retained for 6 months, they are not easily retrievable without the worksheet, so the tapes are only useful for 60 days. After 6 months, the tapes are erased and there are no records of the calls.

Better quality control would include (i) retaining all documentation of unable-to-investigate calls for the same period as other calls, (ii) ensuring documentation of the call on the worksheets is complete, (iii) reviewing production reports to identify problem areas, (iv) trending of calls to determine how many are received on the same victim (whether or not they were categorized as unable-to-investigate), and randomly listening to tape recordings of unable-to-investigate calls to ensure call takers and supervisors made the appropriate decisions. Additionally, we found that one state compiles unable-to-investigate calls and refers the victim to the county office for review after three unable-to-investigate calls with similar allegations from different sources are received. A similar system would be helpful and would serve as a final check on the quality of the unable-to-investigate decision.

Children were left at risk because local offices did not always act on child abuse and neglect reports and Referrals from the hotline unit

There is no assurance that the county offices will act on calls referred to them by the hotline unit. In February 2000 we visited a field office to review local abuse report handling. One referral we asked to review had not been retrieved from the automated referral system and no action had been taken even though the office received the referral nearly 3 months earlier. The office did not know about this call until our request. To determine the extent of the problem, we checked for similar delayed handling in other counties for the 3-month period of December through February.

Reports of abuse were ignored

We found 33 calls in the 3 months that received no action because the county staffs never retrieved the calls from an automated referral system. We also found 10 calls that remained on the automated referral system for up to 7 days or more before being retrieved for action. Such inaction left some of the children listed in these calls at risk. Many children may have been similarly ignored in the past, but because the automated referral system only displays calls for a 3-month period, there is no way to determine the historical magnitude of this problem. Our audit also found that DFS officials could have identified these unretrieved calls by reviewing monthly overdue listings and following up on cases more than 1 month old. Adequate review would have detected the child abuse and neglect reports not taken off the automated referral system for action.

In response to these problems, DFS management issued corrective policy to their staff during June 2000. However, managers did not monitor if the staff followed the new policy. To ensure the corrective action worked, we again reviewed the automated referral system in August and found another 27 referrals that were not retrieved in the 3 months from May 1st through July 31st.

Initial DFS corrective action not effective

During September 2000, the DFS responded to our second review

- indicating that 4 of the 27 incidents still on the automated referral system on our August review had not been acted on by the local office until we brought this to their attention, and

- outlining a new corrective action plan that included periodic Central Office monitoring that may address these problems.

Inconsistencies and errors in case handling at field offices could be improved by initiating quality control and peer review programs

The lack of adequate, systemwide quality controls or peer review programs prevented DFS management from identifying inconsistencies and errors noted during our field visits and case handling reviews.

During our audit we visited five field offices to review case processing activities for appropriateness and consistency with policy. We interviewed both Area and county front-line and administrative personnel to ensure we understood how each office applied the various DFS policies and procedures. We reviewed case files to evaluate policy compliance. Audit tests disclosed:

- Required supervisory review and approval was not done or was not documented on 30 percent of 181 cases reviewed.

- Child contact was not initiated within 24 hours as required on child abuse and neglect reports for 11 percent of 187 cases reviewed.

- Required notification to involved parties that investigations were going to take over 90 days to complete was not sent in 40 of 40 (100%) delayed cases reviewed.

- Required risk assessment forms were not completed for 20 percent of the 35 investigations reviewed.

- Case files contained no record of sending the required perpetrator notification of the right to appeal in 9 of 95 affected cases.

The DFS needs to implement adequate quality controls or peer review systems to ensure case handling errors or policy noncompliance by field offices are identified and corrected.

The Child Abuse and Neglect Review Board overturned substantiated findings

During state Fiscal Year (FY) 99, the review board overturned on appeal 40 percent of all investigations substantiating probable abuse. (*See Appendix III, page 48, for a more detailed description of the review board appeal process.)* The cases reviewed and overturned by the review board in FY 99 and FY00 are shown below:

Fiscal Year	*Number Reviewed*	*Number Overturned*	*Percent*
1999	301	119	40
2000 (9 Mo)	185	58	31

Audit tests disclosed that the review board cited poor case management as the reason for 26 percent of the overturns of cases in FY 1999. The review board defined poor case management as

- incomplete interviews with child abuse victims,

- incomplete interviews with collateral witnesses,

- failure to collect available documentation or evidence to support allegations,

- improper investigation procedures,
- incomplete reports,
- poor question formulation in interviews,
- poor writing skills, and
- poor case presentation skills.

The DFS has been aware of these investigation problems for at least 4 years. They hired a former review board member in 1996 as an employee to study cases brought to the review board to determine how the cases could have been better managed. The former board member reviewed 250 case appeals and attended review board hearings for 18 months. The employee provided four memos from August 1996 to January 1998 to the former DFS Director outlining her findings and suggestions for decreasing the number of overturns due to poor investigations. She suggested that workers receive specialized case investigation and presentation training. She recommended that DFS officials notify DFS workers when a finding is overturned and describe the deficiencies causing the overturn. She stressed the need for supervisory involvement to help ensure the deficiencies were corrected.

DFS executives ignored suggestions

On January 22, 1998, the former DFS Director responded that nothing could be done. As a result, 5 years have elapsed and the same problems are occurring—high overturn rates and no action to remedy the causes. The former review board member, out of frustration, accepted a different job opportunity with the Department of Social Services.

Our review of overturned cases and discussions with review board members and DFS employees revealed the following:

- **DFS did not correct 14 instances of overturned probable cause findings in the computer record system.** As a result, the name of the alleged perpetrator remained on the abuse registry, which can subject DFS to litigation, and it is unfair to the alleged perpetrator.

- **DFS was not represented at 22 of 465 (5%) hearings during 1999 and 2000.** In instances when DFS was not represented at the hearings, the review board overturned the finding decision on 10 cases or 33 percent in FY99 and in 71 percent of cases during the FY00 to date (July 1999-March 2000). The failure to appear at appeal hearings to explain probable cause findings could contribute to the review board overturning the findings. In addition, state regulations require that appropriate local and area division staff and/or legal counsel represent DFS in the appeal hearings.

DFS not represented in 22 appeal hearings

- **DFS only represented 1 of 33 children in state custody in appeals hearings during FY 1999 and FY 2000.** Social workers assigned to children in state custody

revealed they were confused as to their responsibility to represent the child in appeal hearings when an investigation has found probable cause of abuse by a foster parent or residential home worker. While the DFS is not required by law to represent the child in these hearings, it is the responsibility of the legal custodian to decide whether and by whom the child should be represented. The DFS or a Guardian ad Litum should usually represent these children in appeal hearings.

- **Notification letters to perpetrators are not sent by registered mail.** Some perpetrators requested and were granted appeal reviews from "probable cause" incidents as far back as 1995 even though under state law the alleged perpetrator only has 60 days after notification to request an appeal hearing. These late appeals occur because the DFS has no proof the perpetrator received the required notification letter sent after the original finding. If DFS sent the notification letters by registered mail as several other states do, they would have the necessary proof to prevent outdated appeal hearings.

Late appeals can be avoided

Cost reduction initiative cut Children's Treatment Services

Two high level supervisors told us the utilization review contributed to delays in providing services and may ultimately have been one contributor to one child's death from abuse. The worker was considering how to obtain needed services in view of DFS management's orders limiting children's treatment services expenditures and using only Medicaid covered services where possible. During the time the worker was trying to locate drug counseling services the child died. At the time of the death, the delay had been over 2 weeks and although the death might still have occurred absent the children's treatment services expenditure cutbacks, the concerns of the high level supervisors appear to be warranted.

Staff believes service cutbacks were detrimental

The children's treatment services program provides for many different services to children and families, including counseling, therapy, psychological evaluations, drug screenings, and paternity testing. DFS senior managers realized in early March 2000, that if spending for these services continued at the then current rates, expenditures would exceed available funding. These senior managers ordered staff to perform a utilization review. The Central Office mandate required that every authorization for children's treatment services be reviewed by staff above the supervisor I level, and any new service requests had to be thoroughly documented and forwarded to the Area Office for approval. All Medicaid eligible children would receive services from a Medicaid provider, thus avoiding use of children's treatment services funds.

According to DFS management, they intended the review to ensure that Medicaid covered services would be used in place of children's treatment services funds because of the funding limitation problem. They assured us that they did not cut essential services and have approved new authorizations if it was in the best interest of the child.

Front line staff and supervisors say children are going without needed services

Although Central Office officials stated they did not intend for services to be cut or for children to go without needed services, social workers insist the message they received was to cut services, which caused some children to go without needed services. This inconsistency may be attributed to DFS' decentralized communication and management style. For example, the following are the instructions received by social workers in one office regarding the utilization review process :

"If there are children receiving children's treatment services for therapy, they will be cut off as of March 31. Unless court has ordered you to provide a specific number or hours per week or month, cut whatever they have in half," and in closing, ". . . it is my recommendation that you do not suggest or imply to any court official that a service will be put in place if they order DFS to pay for it. If word were to get out that you had taken such action . . . well, you can fill in your own blank."

The concerns noted below were received from front line staff and supervisors in response to our questionnaires and discussions. These conflict with the Central Office stance that no children have been harmed by this review.

A supervisor stated:

- "DFS is no longer able to provide preventative services to children and their families. Only after the family is in serious trouble will DFS give them the services they need."

Social Workers stated:

- "If the services were not ordered by a court or if the child could not receive services through a Medicaid provider the child was actually going without needed services."

- "Some kids had seen a counselor for 4-5 months and then had to start seeing a new counselor who is Medicaid eligible, it was just like having the child start over."

- "In my county there is only one Medicaid provider, and those people don't have the needed background in child abuse and neglect like other children's treatment services counselors, so we have no choice but to send children to these unqualified providers."

Inadequate Preventive Service Referral policies leave children at risk

The hotline unit classifies calls concerning (i) parents who abuse alcohol and drugs, (ii) children with inadequate food and hygiene, and (iii) children with inadequate shelter (those who face

eminent eviction, homelessness or utility shutoff) as unable-to-investigate instead of considering a preventive service referral or a child abuse and neglect referral. We attribute this problem to the hotline unit's narrow interpretation of DFS policy. Preventive service referrals are calls made by permissive reporters (those not mandated) where no actual abuse or neglect has occurred, but where the actions of the child, caretaker, another juvenile or adult demonstrates the need for intervention and possible service delivery to prevent child abuse and neglect from occurring.

Hotline unit handling of preventive service referrals:

The DFS training and policy personnel gave us several examples of what would constitute a preventive service referral. This guidance confirmed our conclusions that DFS should not ignore calls alleging drug and alcohol use by parents, or calls claiming children begged for food. Examples include a concerned citizen who reported children in the neighborhood going around begging for food and reports of children at risk because the parent was in a drug induced stupor. Calls such as these and others should have been classified as preventive service referral and sent to county offices for review and action, instead they were classified as unable-to-investigate, which prevented any action to help the children.

Preventive services should be used

DFS staff stated their opinion, which is not stated anywhere in policy, that drug and alcohol abuse is simply a "lifestyle choice" for parents and does not constitute child abuse if the child is not using. Although the act of abusing drugs and alcohol around children itself does not constitute child abuse, studies have shown that without preventive measures in many such children's lives, they are at great risk of abuse and neglect. DFS staff chooses to ignore these children until an actual act of child abuse or neglect has occurred. Waiting for the effects of these and other problems to be obviously visible is unfortunate and often comes too late for the emotional and physical well being of children.

The only reports involving drugs and alcohol the hotline unit classifies as child abuse and neglect are those involving:

- Working Methamphetamine labs, because they pose a physical threat to the child.
- Providing drugs or alcohol for consumption to children, only if under 8 years old.
- Forcing children to sell drugs.
- Allowing children under 8 to use tobacco, drugs and alcohol because of the danger of fires or similar problems that could cause physical harm to the child.

DFS managers should expand the hotline unit criteria for accepting calls as preventive service referral and child abuse and neglect calls to include additional areas of concern such as drugs and alcohol abuse by parents, and inadequate food, hygiene or shelter. Even if the hotline unit call takers feel that calls do not meet the criteria for preventive service referrals or child abuse and neglect, they should ensure that appropriate authorities are informed in the case of drug use or sale by parents and inform callers of community services that could help children who are going without adequate food or shelter.

Better policy is needed to guide local office handling of preventive service referrals

Policy guidance is not clear

Local DFS county offices are not handling preventive service referrals consistently across the state. We attributed these inconsistencies to unclear policy guidance to local offices. Training personnel explained that local offices should see the family and use the suggested assessment techniques to get to know the family's strengths/needs and determine services that can best help the family and protect the children. Local DFS office handling of preventive service referrals varied from visiting with the family and filling out assessment forms to simply returning the reporter's call.

The DFS should issue clear policy guidance for the handling of preventive service referrals and use quality control and peer review programs to ensure the policy is implemented consistently across the state.

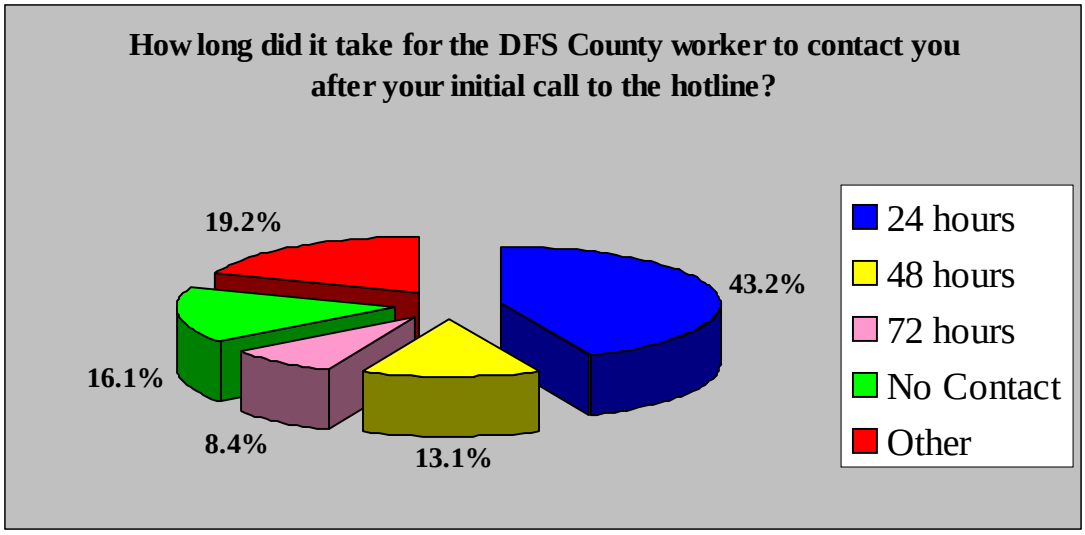
Mandated reporters often have a negative perception of the DFS

We received several calls from mandated reporters during our audit where the caller expressed concern with how DFS handled their calls. Based on these calls, we conducted a survey of 1,530 mandated reporters throughout the state and confirmed that there is a perception problem with mandated reporters. This result confirms the result of DFS' own study done in August and September 1999, however DFS managers had not taken any corrective action. The DFS has contributed to this perception by:

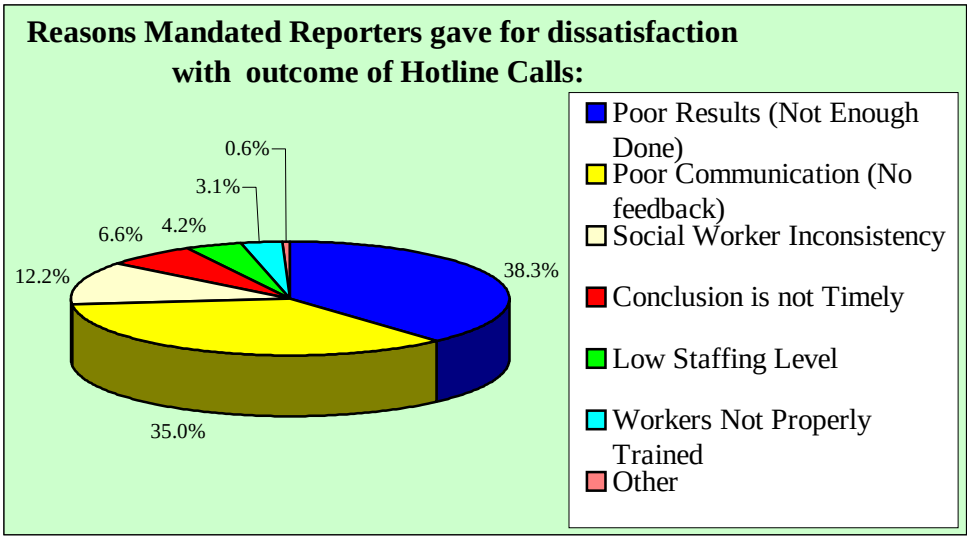
- Not contacting the mandated reporter within the required time frames for both child abuse and neglect reports and Mandated Reporter Referrals.
- Not informing mandated reporters of the outcome of their calls.
- Not providing adequate policy and guidelines for handling Mandated Reporter Referrals.
- Assuming mandated reporters are aware of the hotline system and how it works.
- Not taking steps to correct mandated reporter misunderstanding of the hotline system.

State law requires certain professionals such as physicians, nurses, teachers, and police officers having reasonable cause to suspect a child has been or may be subjected to abuse or neglect or observing a child being subjected to such conditions or circumstances to immediately report to the DFS. However, what should be reported is not always clear to these reporters. This creates a dilemma for the DFS on how to handle the numerous calls made by mandated reporters. Many abuse reports from mandated reporters do not meet DFS criteria for family intervention, family contact, or even further review by the DFS, while mandated callers expect something to be done. When nothing happens, the negative perception grows. (*See Appendix II, page 38, for more information on laws covering Mandated Reporter rules and Appendix III for additional detailed Mandated Reporter procedures.)*

DFS decided to deal with the mandate for professionals by creating a category for calls from mandated reporters that do not meet child abuse and neglect report criteria. When a mandated reporter calls the hotline unit, the call can either be classified as a child abuse and neglect report or a Mandated Reporter Referral (referral). If a call is classified as a child abuse and neglect report, it will be sent to the county office and the assigned social worker should contact the mandated reporter and initiate action within 24 hours. If not a child abuse and neglect report, the call is classified as a referral. All calls classified as mandated referrals are sent to the local offices where workers are to call the mandated reporter within 3 days (72 hours) so they can agree on community services that might help the family or agree that further action is or is not needed. Audit tests showed that in 31 percent of the referrals reviewed DFS did not contact the reporter in a timely manner. As shown in the chart below mandated reporters indicated in questionnaire responses they are not always contacted by DFS staff in a timely manner.



Until September of 2000, the call back within 72 hours was the only requirement for mandated referrals, but DFS has recently issued new policy and guidance on how workers should document their handling of referrals. In addition to not ensuring mandated reporter calls are returned in a timely manner, DFS officials also do not require letters to be sent to mandated reporters informing them of the outcome and actions taken on their calls.



As the chart confirms, the lack of collaboration and feedback on case outcomes by DFS leads to mandated reporter dissatisfaction.

DFS hotline unit staff could communicate better with mandated reporters

The hotline unit policies and procedures take for granted that mandated reporters understand the hotline system, when in fact many do not. For example, during September 2000, a mandated reporter who was very concerned about a child she reported as being sexually abused contacted us. When a DFS worker did not contact the caller and the child had not been seen or examined within 24 hours, the caller called the hotline again believing her previous call had been a child abuse and neglect report and questioned why no action had been taken.

DFS hotline staffs do not explain call procedures

Our review of the situation determined the hotline worker did not explain to the reporter that, based on responses to the call taker's questions, the call would be handled as a mandated referral and not a child abuse and neglect report. This misunderstanding caused the call to be downgraded to a referral requiring a call to the mandated reporter within 72 hours when it should have been a child abuse and neglect call requiring investigation the same day. The caller believed the call reported a child abuse and neglect situation and it would be acted on immediately. This misunderstanding caused a 2-year old child to be left at risk of continuing abuse.

DFS staff can improve mandated reporter and public understanding

The DFS is aware many mandated reporters have a negative perception and attribute the perception to a lack of understanding of the role and powers of the DFS. The hotline unit conducted a survey of mandated reporters during part of August and September 1999 that reconfirmed this image, but DFS management has taken no action to correct the problem. We planned to review the DFS survey results during our audit, but DFS staff destroyed the responses.

DFS didn't work to educate reporters

Our study determined that DFS managers had not taken any proactive action to correct the perception problems with mandated reporters. Possible corrective actions to improve mandated reporter perceptions would include:

- Expanding informational program efforts to inform mandated reporters (and the public) as to how the hotline system works and what they *can* and *cannot* expect to result from a call reporting abuse or neglect. During our research, we noted other states and the St. Louis City DFS office have prepared manuals explaining the entire hotline process to the mandated reporters and providing guidance on what information is needed to make a report. Some states also include this type of information on their Internet websites.

- Using quality control and peer review programs to ensure that mandated reporters be contacted within the required time for child abuse and neglect reports and referrals.

- Sending notification letters to mandated reporters informing them of the outcome of their calls to the hotline unit.

- Ensuring that hotline unit personnel explain expected call classification and handling to reporters so they agree calls are given the proper classification.

DFS Central Office managers need to disseminate preventive best practices to all offices

DFS managers have not developed a means to identify and disseminate across the system the best preventive practices used in various local offices or in other states. Some of these best practices originated at local DFS offices, but have not been established on a statewide basis by DFS management. The following are best practices that could be implemented to help DFS staff statewide serve the best interest of children's safety.

- A Substance Abuse Specialist is used by St. Louis City DFS (Area 6) to assist social workers in identifying and treating families with substance abuse problems during home visits and family conferences.

- St. Louis City has developed a way to identify and treat chronic neglect families. These families need intensified treatment services to make lasting improvements in their lives. This is one of the first programs of its kind in the nation. St. Louis City staff has frequently presented program details at the request of many other states, but DFS management has not disseminated the program across Missouri.

St. Louis City pioneers chronic neglect reviews

- St. Louis City has taken a preventive approach to educational neglect. The hotline unit does not take calls reporting education neglect unless the reporter shows exhaustive effort on the part of the school to correct the problem and the child has missed a great deal of school. In contrast, St. Louis City DFS arranged for schools to send a fax notice when a

child has missed 10 days of school. This allows the local office to initiate early preventive or intervention efforts before the problem becomes more serious.

- In at least some Michigan counties, unable-to-investigate calls are put into the computer system to allow for easy tracking and access and to allow for re-evaluation of the need for possible DFS intervention when a family has three unable-to-investigate calls of similar allegations of abuse from three different sources.

(*See Appendix IV, page 53, for a complete listing of best practices noted during our audit.)*

DFS performance goals and measures need improvement

At least one performance goal and measure used by DFS was not valid or measurable. The DFS goal was to "Increase the number of safe children from 90.7 percent to 91.5 percent." The measure used was the number of children returned to their home safely from DFS custody, which they defined as "a child who has been home for 1 year without another substantiated incident of child abuse and neglect." The outcome actually reported by DFS in the FY 2001 Budget Request for this goal was 98.2 percent, but audit analysis showed the measurement was not valid.

DFS managers used a partial year measurement instead of a complete calendar year for each child. As a result, a child who was returned home in the last month of the FY was counted as safe for the entire year instead of just safe for 1 month. In addition, the measure did not include the children removed from their homes during family assessments, children removed from their homes because of referrals, or children who received some type of services but were left in their homes. During FY00, DFS managers realized this error and began using a full-year measurement. In the future when measuring and reporting its performance, DFS managers should ensure the performance goals used are valid and measurable and should not exclude major segments of the population it seeks to protect and/or serve.

Conclusion

We realize that the role of DFS staff in receiving and processing hotline calls and cases is very difficult. DFS staffs are always under scrutiny for whatever decision they make on a call. We also realize no one in DFS wants a child at risk to remain at risk and DFS staff make many decisions that are right for the family and the child. The audit, however, disclosed that improvements in management are necessary and needed to ensure that children are not at risk when they do not have to be. The issues we have discussed in this section of the report and will discuss in the next section concern the role of top management in DFS. Senior officials will need to take a proactive role in ensuring their organization is functioning as they envisioned and in the best interest of the public. These officials need to take the responsibility and accountability for establishing effective quality controls to ensure decisions are properly made and to ensure staff receive the support they need to make and document decisions. Senior officials need to heed the concerns of staff and reviewers and proactively identify problems and resolve them. Our recommendations will assist in identifying some of the things that need to be done.

Recommendations

We recommend DFS officials:

1.1 Implement a structured decision making tool to increase consistency and accuracy in making intake, screening, risk assessment, service and placement decisions.

1.2 Require that hotline unit call takers check DFS records for prior reports of abuse on the child or family and document that check.

1.3 Ensure unable-to-investigate worksheets document completely and appropriately the phone reports of abuse received by the hotline unit.

1.4 Improve the hotline unit quality control review process to ensure unable-to-investigate decisions are appropriate.

1.5 Enter unable-to-investigate records into the automated Production System and retain them.

1.6 Retain tape recordings of hotline calls for possible use in future criminal prosecutions or for review board hearings.

1.7 Ensure reports are retrieved and acted on by field office staff by establishing a quality control system that requires the hotline unit to reconcile reports sent to field offices to reports printed and taken off the system for action.

1.8 Establish a peer review quality control system to ensure policies and practices are consistently followed and applied throughout the DFS child abuse and neglect response system.

1.9 Readdress the DFS study of overturns by the Child Abuse and Neglect Review Board on appeal of probable cause findings and take appropriate corrective action as suggested in the report.

1.10 Establish quality controls that ensure the child abuse central registry and local case records are appropriately corrected to remove the probable cause finding when the alleged perpetrator wins an overturn on appeal.

1.11 Develop a quality control system to ensure DFS is represented at Child Abuse and Neglect Review Board hearings as required by statute.

1.12 Ensure Children's Services workers are provided adequate guidance and training on their responsibility to make appropriate decisions on whether to represent DFS custody children in probable cause finding appeal hearings.

1.13 Send perpetrator notification letters by certified return receipt requested mail.

1.14 Redefine hotline unit criteria definitions for preventive service referral classifications to better allow for the best interest of children to be served.

1.15 Provide better policy and guidance to field staff on the handling of preventive service referrals.

1.16 Improve the understanding of the child abuse and neglect system by mandated reporters and the public by improving the quality and quantity of detailed information easily available. The DFS should increase efforts to explain what can be expected from the system.

1.17 Send responses to mandated reporters on the outcome of every call and the reasons for action or inaction.

1.18 Ensure that hotline unit call takers make clear to mandated reporters what action can be expected based on the information provided.

1.19 Develop methods to identify and disseminate best practices throughout the DFS system.

1.20 Ensure DFS children's services goals are valid and measurable.

Division of Family Services Comments

The Division provided a response that indicated general agreement with the recommendations and contained reasonable implementation dates. Some responses were not clear or adequate and these will be followed up on during our followup process. The Division's detailed comments are found at Appendix VII, page 62, and the State Auditor's Office detailed comments are found at Appendix VIII, page 63.

2. DFS Senior Officials Need to Invest in Their Field Staff to Ensure They Have The Best Opportunity to Accomplish Their Duties

DFS Central Office has not been as supportive of field staff as they need to be. Field staffs are expected to carry unreasonable workloads while at the same time they have not received competitive salaries, modern tools, and training that could alleviate some of their burden. Audit tests disclosed overdue Child Abuse and Neglect Reports and morale problems. We attribute these problems to workers not being provided with adequate:

- Pay. Missouri ranks 45th out of the 50 states in basic pay. Supervisory pay level differentials are miniscule compared to salary structures in surrounding states.
- Equipment such as computers, cell phones, dictation machines or transcription services, and telephone voice mail.
- Training on the two-track approach (Investigation/Family Assessment).
- Specialized training on case development and presentation to appeal boards.

As a result, field staff cannot (i) complete tasks within established timeframes, (ii) accomplish tasks efficiently, (iii) have confidence in decision-making, or (iv) ensure that DFS has the best opportunity to prevail in appeal hearings.

One Third of the Child Abuse and Neglect Reports in 1999 were not completed in a timely manner

Many child abuse and neglect reports are overdue

Audit tests showed that as of February 3, 2000, there were a total of 4,482 overdue child abuse and neglect reports, and 36 percent of the overdue reports were more than 3 months overdue.

The DFS local county offices are responsible for conducting an investigation or family assessment review for each child abuse and neglect report received from the Child Abuse and Neglect Hotline, and under Section 210.145 (12), RSMo, the resulting child abuse and neglect reports must be completed within 30 days and the results entered into the computer record system.

(See Appendix II, page 37, for a more detailed description of the statutory requirements.)

The following table shows the number and percentage of overdue reports by state geographic area.

Overdue Reports by Area as of 2/3/00

Area	*Location*	*Number Overdue*	*Percent Overdue*
1	St. Joseph	109	3
2	Fulton	827	19
3	Cape Girardeau	139	3
4	Springfield	1,453	32
5	Jackson County	776	17
6	St. Louis City	323	7
7	St. Louis County	855	19
Total		4,482	100

The DFS officials attribute this high volume of overdue reports to the high volume of new child abuse and neglect reports received and to low staffing levels, causing the paperwork on previous reports to be preempted by work needed to review the new child abuse and neglect reports of children at risk.

The DFS officials reduced the number of overdue reports to just over 3,000 by May. Officials accomplished this decrease in overdue reports after some areas and counties requested permission from management to pay overtime for extra workdays for workers to catch up on the overdue reports. Area and local management staff had to ask for paid overtime because the workers often have already accumulated compensatory time they cannot take because of their heavy caseloads.

The decrease in the number of overdue reports was only temporary because by October the volume increased again. These increases are occurring because of staffing and workload imbalances. This is most evident in Area 4 (Springfield area). Area 4 was responsible for 46 percent of the child abuse and neglect reports over 3 months overdue and for 73 percent of all DFS case reports over 1 year overdue. Even with the reduction of the number of overdue reports, Area 4 increased in percentage of overdue reports from 32 percent to 43 percent. This indicates an imbalance in the workload and staffing of Area 4 compared to the rest of the state. As the above table shows, similar imbalances are occurring in Areas 2, 5, and 7.

DFS does not consider relevant information when allocating staff

DFS staffing approach causes case overloading

The DFS method of determining worker position allocation has caused several counties to be severely understaffed while other locations have open positions they cannot fill by hiring more workers. For example, during April 2000, St. Louis County (Area 7) had 60 open positions they could not fill, while Greene and Jasper counties (Area 4) were only authorized at 64 and 33 percent respectively of the staff position allocations needed to meet Council on Accreditation standards. (*See Appendix III, page 51, for discussion of the council and its mission and requirements).* This has contributed to Area 4 worker overload and the highest level of overdue reports in the state. The St. Louis County DFS administration explained the 60 positions could not be filled because competing organizations, including the state of Illinois, paid better and had more

manageable workloads. The Greene County administration said they do not have as much difficulty filling their allocations.

The maximum caseload for a social worker recommended by the council is 15 new cases at one time, or continuing services on 30 prior cases, or a combination of the two. Additionally, the council recommends that organizations such as DFS adjust their protective services worker caseload to allow for variations in complexity of cases, range of family support services available to augment the worker's role, number of cases per worker at any one time involving investigation or intensive intervention, and travel and other non-direct service time required to fulfill the workers' responsibilities. DFS managers do not make such adjustments. Instead, they determine staffing allocations by dividing the number of cases an area had the previous year by the council's suggested maximum workload per worker.

DFS managers have not performed a workload or time study to determine the necessary time required to complete each type of case, and, in several instances, could not or would not provide adequate related information we requested to perform a staffing analysis.

DFS managers need to perform time and work load studies to determine the necessary worker time required for each type of case taking into consideration all the factors mentioned above. Careful analysis of such factors would help the DFS identify staffing needs and pinpoint problem areas that would warrant attention. A workload and staffing analysis, properly used, could reduce case handling delays and improve the quality and timing of services provided to children. It would serve as the basis for deciding which areas need staff or whether a special team of workers would be needed to serve as "hotspot" specialists, deployed as needed wherever the workload approaches imbalance in the local field offices.

Based on a request for more staff to meet the accreditation standards, DFS increased staff after April 30. However, without the proper development of workload and staff analyses, DFS managers will not be able to effectively deploy staff and efficiently manage the workload.

Social worker compensation needs to be more competitive to enable DFS to hire and retain qualified workers

DFS officials have difficulty recruiting and retaining the social workers needed to deal with child abuse and neglect, because Missouri's base salary for a beginning social worker is too low to compete with private industry and other surrounding states. Missouri ranks 45th in the nation in base salary ahead of only South Carolina, Louisiana, Kentucky, Tennessee and New Hampshire. Missouri does not compare favorably with contiguous states. The following table compares Missouri DFS social worker and supervisor base salaries with the salaries paid by four states contiguous to Missouri.

Salary Comparison to Contiguous States					
	Base Salary	Amount of Raise to	Base Salary	Amount of Raise to	Base Salary
State	**SW I**	**SW II**	**SW II**	**Sup I**	**Sup I**
Missouri	$22,248	$2,208	$24,456	$984	$25,440
Arkansas	$23,433	$1,498	$24,931	$3,358	$28,289
Illinois	$25,836	$2,292	$28,128	$4,152	$32,280
Kansas	$26,000	$2,704	$28,704	$4,493	$33,197
Oklahoma	$26,083	$2,592	$28,675	$5,803	$34,478

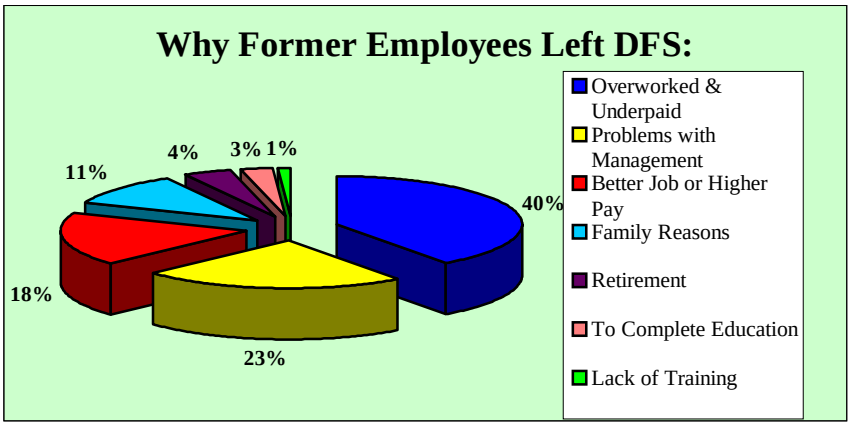
These low pay rates make it difficult for the Missouri DFS to compete effectively with contiguous states for social workers and supervisors. This is particularly true for Missouri's two major metropolitan areas. For example, both St. Louis City and County DFS officials voiced concerns over not being able to fill all their 122 unfilled open positions as of April 2000. They explained they could not compete with the pay level of Illinois (a difference of $3,588 in starting salary) or private organizations because of the state's low salary and heavy caseload for workers. Even when they are successful in hiring workers, the workers often do not stay with the DFS. In comparison to competing employers, DFS workers in the St. Louis area are expected to handle double the caseload because of the shortage of workers protecting Missouri's children.

DFS unable to fill 122 open positions in St. Louis

Because of low worker and supervisor pay levels, the Missouri DFS is often considered only a temporary position that allows workers to gain social work experience, before moving on to better paying positions. Given the disparity in supervisor pay between Missouri and the contiguous states, there is little incentive for workers seeking advancement to supervisory level positions to stay with the DFS.

Low DFS pay causes high worker turnover

We asked former employees why they left DFS Children's Services. As shown by the following chart, 58 percent of the respondents said they left because of low pay and/or high caseloads (overworked/underpaid and better job/higher pay).



Financial incentives for obtaining advanced degrees and licensing is needed to obtain and retain qualified staff

DFS officials do not pay additional salary to staff that obtain a Master's degree. Similarly, they do not require workers to be licensed social workers and do not provide any increased compensation for achieving professional licensing. Our audit research of pay practices in other states showed several states give salary increases to workers with a Master's degree and similarly require and pay more for workers to be licensed. One former DFS supervisor told us when she transferred to Missouri, she had to take a $10,000 per year pay cut to work in the Missouri DFS even though she was licensed in four states and held a Master's degree.

Inadequate compensation may keep DFS from meeting accreditation goals

Missouri is currently applying for accreditation by the Council on Accreditation for Family and Children's Services, Inc. The council accomplishes its mission by developing standards of best practice, delivering a program of provider recognition and accreditation, providing educational and technical assistance programs, and advocating for policies that promote high quality services for families and children.

To be accredited the council recommends that:

- Supervisors of child protective workers monitor no more than seven experienced and professionally trained workers.
- Caseloads not exceed 15 new cases or continuing services on 30 prior cases or a combination of the two at one time.
- All social worker supervisors have a Master's degree.

Audit tests showed that:

- The DFS meets the supervision ratio in most areas of the state.
- State legislators have supported the accreditation process by increasing staffing allocations.
- The DFS plans to meet the supervisor education goal by making social work specialists, who have their Master's degrees, available for consultation with supervisors who do not have a Master's degree.

According to our discussions with St. Louis County officials and other DFS staff, and reviews of former and present employee questionnaires, DFS may not be able to fully meet the accreditation case load to staffing ratio goals without providing increased pay, better staffing allocation, and compensation for advanced degrees.

Current technologies could be put to better use to allow workers to use their time more efficiently and effectively

Efficiency could be improved

The audit found many workers do not have ready access to computers or must share computers, must type or handwrite their own reports on manual forms and share or provide their own cell phones. Sharing or using personal cell phones limits worker efficiency that state owned cell phones would alleviate. Workers could perform their jobs more efficiently, effectively and safely if they were provided with laptop computers, dictation equipment and transcription services, computerized forms, voice mail and cellular phones. The lack of this modern technology contributes to the inability to complete timely reports and directly impacts the rate of overdue reports and stress on the workers for not completing reports on time.

In addition to the morale problems caused by not having proper technology and increasing pressure to meet unreasonable deadlines, the outcome of overdue reports and improperly prepared reports affects the ultimate outcome of resolution of the child abuse case. As discussed in Result 1 in this report, untimely reports can cause overturns of substantiated cases by the review board. Untimely reports could have an impact on the availability to the call taker of a prior record on the perpetrator. Therefore, it is incumbent upon senior managers to make sure the field staff have the best equipment and technology to improve the product that field staff produce and to improve employee morale, which will ultimately improve staff retention rates.

Social workers, supervisors and county directors need more training to be comfortable with their decisions

A total of 76 of 524 (15%) social workers and supervisors in our survey stated they had concerns about the adequacy of the training they received. New social workers are given 3 weeks of formal training in a classroom setting to provide an overview of what their job will entail. Each local office determines what additional formal training (if any) is needed, before the worker starts actual on-the-job training. Beyond the initial training, the central office provides no additional specific training on how child abuse and neglect investigators should ensure their assigned cases are properly screened and assessed or investigated. Similarly there is no guidance from central office managers on how investigations should be documented and presented so decisions can withstand appeal or prevail in court proceedings.

Training on the two-track system was not adequate

DFS left children at risk of continued abuse or death because training on the two-track (Investigation/Family Assessment) system was not adequate. With the two-track system, DFS intended to shift the focus toward a greater preventive effort, rather than only performing investigations as were previously done. The Family Assessment approach requires a thorough study of the family's strengths, weaknesses and needs. The study involves the family and is intended to provide preventive services that would prevent abuse, or additional abuse by first time perpetrators of less serious abuse and/or neglect. However, our field visits, questionnaires, and discussions with DFS employees and employees of other organizations showed that children are often left at risk by:

- Incorrect screenings of child abuse and neglect calls as Assessments when they should have been Investigations. (*Refer to examples previously discussed on pages 3 and 4)*

- Staffs being more likely to screen child abuse and neglect calls as Assessments because they are viewed as easier and quicker than Investigations, while DFS officials correctly state that Assessments, when done correctly, should be just as thorough and effective, if not more so, than Investigations.

- Staffs not performing complete Assessments.

- Workers not being comfortable with their decisions. Sixty-five percent of the workers polled in our questionnaires stated they did not receive enough training on the two-track system to always make accurate and correct decisions.

Interviews and questionnaires revealed that county directors, supervisors, and social workers often believed training on how central office management expected the two-track (Investigation vs. Family Assessment) system to be used was not adequate. Significantly, the DFS has not performed adequate quality control checks or peer reviews to determine if the two-track system worked correctly and consistently when it went statewide in May 1999.

The DFS should provide additional training to staff on the two-track system's purposes, goals and procedures. Additionally, in the future, DFS should ensure staffs receive adequate training and use quality control and peer review programs to ensure correct and consistent implementation of the new tools.

Specialized investigation training is needed to reduce overturns of decisions because of poor investigations

Our review of overturned decisions and discussions with present and former review board members revealed probable cause conclusions are often overturned because of poor investigation procedures or lack of adequate documentation. For fiscal year 1999, the review board overturned on appeal 40 percent of cases that were initially found as substantiated abuse or neglect. Following are examples of the review board's reasons for overturns during fiscal year 1999 and 2000 appeals hearings:

- "Despite compelling evidence that the girls were victims of sexual abuse, there was insufficient evidence to support the finding that the (alleged) perpetrator was involved."

- "Perpetrator is likely guilty, but the DFS report had too many discrepancies!!! The DFS report was incomplete and no effort was made to clarify discrepancies. The victim was never evaluated medically for rape."

- "There was insufficient evidence to support the DFS investigator's failure to see the child in a timely manner (one month after child's injuries), and the Investigator did not talk to the accused perpetrator."

As discussed in Result 1, proper case development by DFS investigators was of major concern to the review board. The DFS should provide specialized training to workers performing investigations to ensure substantiated cases will withstand administrative appeal and criminal court proceedings. An alternative would be for the DFS to hire workers having a criminal justice education or experience background to perform investigations of child abuse and neglect, similar to practices in Arkansas.

Workers are not always receiving adequate supervisory guidance

Half of the DFS employees (current and former) responding to our questionnaires stated they did not always receive adequate guidance from supervisors. The Children's Services social workers face very difficult decisions every day, and often feel a need for supervisory assistance and direction. Many of these directors and supervisors do not have a Social Work degree or child abuse and neglect investigation experience, and thus are not always able to give adequate support and supervision to their Children's Services social workers.

Half of workers wanted more guidance

Several county directors and supervisors, who have backgrounds in Income Maintenance, instead of children services indicated through questionnaires that they are uncomfortable with their role of supervising social workers because their experience and background is in Income Maintenance instead of Children's Services. One county director said, "I am not a social worker however, I am a County Director who is responsible for the direct supervision of two social workers and all other staff in our county office. I do not have any degree and do not feel that I have had the proper training to do my job as it should be done." That director went on to say he does not know what will happen once the experienced social workers retire because he cannot provide the necessary direct guidance to less experienced social workers. Problems such as this typically occur in smaller population counties where social workers must handle all types of Children's Services. These duties include child abuse and neglect investigations and family assessments, adoptions, foster care, independent living, residential treatment services, and ongoing family centered services. Low population counties typically lack adequate staffing levels to allow assignment of specialized investigators and supervisors.

Supervisors said they need more training

A staffing best practice was instituted in Area 4 where Pulaski, Texas, Maries, and Phelps counties joined forces to form an Investigation Team responsible for performing all investigations in the 4-county area. The team consists of seven investigators and one supervisor. This approach allows these lower population counties to designate specialized investigators who work under an adequately trained and experienced supervisor. This approach should be considered for other rural county groups throughout the state.

DFS managers need to better manage the accumulation and use of compensatory time

As of April 5, 2000, social workers had a total compensatory time balance of over 102,700 hours with a resulting payoff liability of nearly $1.4 million. This results in an average of over 65 hours and over $880 per worker. Below is a summary of compensatory time averages by state area.

DFS owes $1.4 million in compensatory time

Average Compensatory Time Balances

Area	*Avg Hours Per Worker*	*Avg Liability Per Worker*
St. Joseph	87	$1,182
Fulton	66	875
Cape Girardeau	58	772
Springfield	56	771
Jackson County	81	1,095
St. Louis City	52	729
St. Louis County	61	859

Saline County has the highest average per worker, totaling 240 hours and an average liability of over $3,118 per worker. The worker having the highest balance works in Jackson County (Area 5). That worker accumulated 872 hours or nearly 6 months' compensatory time and a resulting liability for the DFS of over $11,981.

The DFS policies regulating compensatory time earnings and use are not adequate. DFS compensatory time policy provides for workers to accumulate compensatory time and then be paid for it when they separate from service. There are no requirements for when compensatory time should be taken or priority of compensatory time leave over other types of leave. For example, other agencies set maximum allowable compensatory time balances and workers must use their compensatory time before they use accumulated Annual Leave. The payoff policy does not encourage workers to take the time they earned and could result in an incentive to separate from service if the employee is considering other employment. The compensatory time payoff could be a determining factor in whether they accept the new opportunity.

The DFS managers do not effectively use a monitoring system to manage workers' accumulation and use of compensatory time. While reports of compensatory time are generated, central office personnel do not use them in planning, staffing or identifying problems. In addition, the reports are not sent to county directors who told us such reports would be very useful. This lack of adequate monitoring has led to some social workers accumulating excessive compensatory time balances.

Recommendations

We recommend that DFS management:

2.1 Ensure that the child abuse and neglect investigations and/or assessments are completed within the required time frame.

2.2 Ensure all accreditation council and other appropriate standards available as staffing planning tools are used to establish staffing allocations and future needs and goals.

2.3 Perform time and workload studies to help determine needed staff allocations.

2.4 Relocate open staff positions from areas unable to fill positions to areas where the positions can be filled, when necessary or beneficial.

2.5 Develop a special team of investigators to assist "problem" areas and help ease the local offices' caseloads. This team could be sent to help counties who are having problems completing child abuse and neglect cases and making initial contacts on cases within the required time frames.

2.6 Increase salaries for both social worker and supervisor positions to make DFS jobs more competitive with surrounding states and private organizations who hire social workers.

2.7 Provide increased financial compensation to workers who obtain advanced degrees or certifications.

2.8 Ensure that each full time Children's Services social worker is provided with a state-owned cellular phone.

2.9 Provide Children's Services social workers with laptop computers and standard automated forms and letters, and/or dictation equipment and transcription services.

2.10 Provide specialized training for:

- Front line staff and supervisors on how to use the two track (Investigation/Family Assessment) system to achieve the best possible results and to meet DFS management goals for the system.

- Staff involved in child abuse and neglect investigations. This training should teach staff to adequately investigate, document and present investigation cases, increasing child safety and decreasing overturns on alleged perpetrator appeals.

- Supervisors and county directors who supervise child abuse and neglect Investigations and Family Assessments, but have no clinical experience in protective services.

2.11 Develop Investigative teams for low population county groups to ensure specially trained workers and supervisors handle child abuse and neglect cases. These employees should not have other duties that interfere with their primary children's services functions.

2.12 Make better use of the compensatory time monitoring system to more effectively manage its accumulation and use. Compensatory time should be:

- Used before annual leave.
- Used within a reasonable time frame.
- Monitored for purposes of planning future staff allocations and identifying staffing problems or inequities.

Division of Family Services Comments

The Division provided a response that indicated general agreement with the recommendations and contained reasonable implementation dates. Some responses were not clear or adequate and these will be followed up on during our followup process. The Division's detailed comments are found at Appendix VII, page 62, and the State Auditor's Office detailed comments are found at Appendix VIII, page 63.

APPENDIX I

OBJECTIVE, SCOPE AND METHODOLOGY

OBJECTIVE

The objective of the audit was to determine whether calls reporting child abuse/neglect received by the DFS Child Abuse/Neglect Hotline were properly documented, processed, referred to the appropriate local DFS city or county office, and whether those offices made certain the child or children were adequately protected and the calls were handled in accordance with the Missouri statutes, Code of State Regulations, and division policy.

Scope and Methodology

Audit fieldwork started during late calendar year 1999 and continued through late summer 2000. Most of the calls reporting child abuse and neglect and related case records reviewed were currently active during or just prior to that time period. The audit staff:

- Reviewed the year 2000 revisions to Section 210 RSMo and evaluated the apparent appropriateness of related DFS policy changes but did not test the effectiveness of those changes.

- Reviewed applicable state statutes, code of state regulations, division policies and procedures, division training programs, and child and family case files.

- Interviewed area and local employees, supervisors, and other local, area and state level administrative officials.

- Attended a DFS training session on child abuse and neglect procedures and participated in home visits with DFS social workers.

- Discussed child abuse concerns with various groups and individuals who often come in contact with abused and neglected children.

- Solicited information from current and former DFS social workers, supervisors and county directors, and from mandated reporters of child abuse such as police officers, juvenile officers, school employees and officials and hospital employees.

- Listened to calls from concerned citizens.

- Contacted officials of similar protective agencies in other states to obtain information regarding child abuse and neglect practices and procedures.

- Traveled to another state to view a child abuse decision making system and discussed the system in detail with a variety of front line, supervisory, and state level officials.

- Listened to child abuse hotline calls, reviewed individual case files to evaluate the adequacy and timeliness of responses to calls reporting child abuse and neglect, and reviewed internal DFS reporting systems.

- Reviewed actions of the Child Abuse and Neglect Review Boards and interviewed various board officials.

The audit was made in accordance with applicable generally accepted government auditing standards and included such tests of the procedures and records as were considered appropriate under the circumstances.

APPENDIX II

STATUTES AND CODE OF STATE REGULATIONS

The State of Missouri's commitment to protecting children from child abuse and neglect is evidenced by various statutes and rules under the Code of State Regulations. The ultimate intent of these laws and regulations is to protect children who cannot adequately protect themselves from abuse and neglect by those responsible for their care and protection (often parents). These laws and rules provide the framework within which DFS constructs operating policy and procedures to guide employee social workers responding to reports of incidents of alleged child abuse and neglect for the purpose of preventing future incidents of abuse and neglect. Section 210.109 and Sections 210.110 through 210.183 RSMo and 13 CSR 40-31 are the principal laws and rules, respectively governing the handling of child abuse and neglect.

Section 210.109**,** RSMo required the Division of Family Services to establish a child protection system for the entire state designed to promote the safety of children and the integrity and preservation of their families by conducting investigations or family assessments in response to reports of child abuse or neglect. The system was to endeavor to coordinate community resources and provide assistance or services to child and families identified to be at risk, and to prevent and remedy child abuse and neglect.

Definitions

Section 210.110 provides several key definitions to set the framework within which DFS must operate in meeting the mandates established by Section 210.109, RSMo.

"Abuse" is any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for the child's care, custody, and control, except that discipline including spanking, administered in a reasonable manner, shall not be construed to be abuse.

"Central Registry" is a registry of persons where the division has found probable cause to believe or a court has substantiated through court adjudication that the individual has committed child abuse or neglect or the person has pled guilty or has been found guilty of a crime under various sections if the victim is a child less than eighteen years of age and the perpetrator is twenty-one years of age or older, or has attempted to commit any such crimes.

"Child" is any person, regardless of physical or mental condition, under eighteen years of age.

"Investigation" is the collection of physical and verbal evidence to determine if a child has been abused or neglected.

"Neglect" is failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for the child's well-being.

"Probable cause" condition of available facts when viewed in the light of surrounding circumstances which would cause a ***reasonable person*** (emphasis added) to believe a child was abused or neglected.

"Those responsible for the care, custody, and control of the child" including but not limited to the parents or guardian of a child, other members of the child's household, or those exercising supervision over a child for any part of a twenty-four-hour day. Those responsible for the care, custody and control shall also include any adult who, based on relationship to the parents of the child, members of the child's household or the family, has access to the child.

"Family assessment and services" is an approach . . . developed by the DFS which will provide for a prompt assessment of a child who has been reported to the division as a victim of abuse or neglect by a person responsible for that child's care, custody or control and of that child's family, including risk of abuse and neglect and, if necessary, the provision of community-based services to reduce the risk and support the family.

STATUTES

Section 210.115 prescribes that physicians, dentists, other physical and mental health care providers, day care workers, law enforcement officers, teachers, and many others in responsible or professional positions in contact with children and who have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or who observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect shall immediately report the abuse to the DFS using the child abuse and neglect hotline. These persons required to report are commonly referred to as ***Mandated*** reporters. As used in this section, the term "abuse" is not limited to abuse inflicted by a person responsible for the child's care, custody and control, but shall also include abuse inflicted by any other person. Any person or individual required to report may also report the suspicion of abuse or neglect to any law enforcement agency or juvenile office. Such report shall not, however, take the place of reporting to the division.

This statute provides that DFS is allowed to make reasonable exception to the normal abuse and neglect provisions in instances of any child who does not receive specified medical treatment by reason of the legitimate practice of the religious belief of the child's parents, guardian, or other legally responsible person.

This statute also provides that any other person, that is, any ***non-mandated*** person, with reason to suspect that a child has been or may be subjected to abuse or neglect may also report to the DFS hotline.

Section 210.125 provides that a police officer, law enforcement official, or a physician who has reasonable cause to suspect that a child is suffering from illness or injury or is in danger of personal harm by reason of his surroundings and that a case of child abuse or neglect exists, may request that the juvenile officer take the child into protective custody under chapter 211, RSMo. In instances where these persons have reasonable cause to believe a child is in imminent danger of suffering serious harm, it provides authority to take protective custody of a child for up to twenty-four hours, without the consent of the child's parents, guardian or others legally responsible for his care.

In no event is an employee of the division, acting upon his own, allowed to remove a child under the provisions of this act.

Section 210.130 establishes that oral reports of abuse or neglect shall be made to the division by telephone or otherwise. In addition, that the reports shall include the names and addresses of the child and his parents or other persons responsible for his care, if known; the child's age, sex, and race; the nature and extent of the child's injuries, type of abuse, or neglect; and much other additional information, including the name and address of the person responsible for the injuries, abuse or neglect, whenever available to allow the division to identify and locate the child and his family.

Section 210.135 provides that any person, official, or institution complying with the provisions of sections 210.110 to 210.165 in the making of a report, the taking of color photographs, or the making of radiologic examinations pursuant to sections 210.110 to 210.165, or the removal or retaining a child pursuant to sections 210.110 to 210.165, or in cooperating with the division, or any other law enforcement agency, juvenile office, court, or child-protective service agency in any of the activities pursuant to sections 210.110 to 210.165, or any other allegation of child abuse, neglect or assault, pursuant to sections 568.045 to 568.060, RSMo, shall have immunity from any liability, civil or criminal, that otherwise might result by reason of such actions. Exception is provided for intentionally filing a false report, acting in bad faith, or with ill intent. This section also provides the same immunity with respect to participation in any judicial proceeding resulting from the report.

Section 210.140 provides that any legally recognized privileged communication, except that between attorney and client, shall not apply to situations involving known or suspected child abuse or neglect and shall not constitute grounds for failure to report as required or permitted by sections 210.110 to 210.165, to cooperate with the division in any of its activities pursuant to sections 210.110 to 210.165, or to give or accept evidence in any judicial proceeding relating to child abuse or neglect. As a result, privileged communications are not recognized for many mandated child abuse reporters.

Section 210.145 prescribes that the division shall establish and maintain an information system operating at all times, capable of receiving and maintaining reports. This information system shall have the ability to receive reports over a single, statewide toll-free number. Such information system shall maintain the results of all investigations, family assessments and services, and other relevant information.

The section prescribes that the division shall maintain a central registry.

The section prescribes that although reports may be made anonymously, the division shall in all cases attempt to obtain the name and address of any person making a report.

Section 210.145 also prescribes that upon receipt of a report, the division shall immediately communicate such report to its appropriate local office, after a check has been made with the information system to determine whether previous reports have been made regarding actual or suspected abuse or neglect of the subject child, of any siblings, and the perpetrator. Upon receipt of a report, which, if true, would constitute violation of several criminal sections against a child, and the perpetrator is twenty-one years of age or older, or an attempt to commit any such crimes, the local office shall contact the appropriate law enforcement agency and provide such agency with a detailed description of the report received. In such cases the local division office shall request the assistance of the local law enforcement agency in all aspects of the investigation of the complaint. The appropriate law enforcement agency shall assist the division in the investigation or provide the division, within a reasonable time, an explanation in writing detailing the reasons why it is unable to assist.

In addition, the local office of the division shall cause a thorough investigation to be initiated immediately or no later than within twenty-four hours of receipt of the report from the division, except in cases where the sole basis for the report is educational neglect, in which case the investigation shall be initiated within seventy-two hours of receipt of the report. If the report indicates the child is in danger of serious physical harm or threat to life, an investigation shall include direct observation of the subject child within twenty-four hours of the receipt of the report.

The investigation shall include but not be limited to the nature, extent, and cause of the abuse or neglect; the identity and age of the person responsible, the names and conditions of other children in the home, the home environment and the relationship of the subject child to the parents or other persons responsible for the child's care; any indication of incidents of physical violence against any other household or family member; and other pertinent data. The record shall contain the facts ascertained which support the determination as well as the facts that do not support the determination.

The section prescribes that when a report has been made by a mandated reporter, the division shall contact the person who made such report within forty-eight hours of the receipt of the report in order to ensure that full information has been received and to obtain any additional information or medical records, or both, that may be pertinent.

The section prescribes that upon completion of the investigation, if the division suspects that the report was made maliciously or for the purpose of harassment, the division shall refer the report and any evidence of malice or harassment to the local prosecuting or circuit attorney.

The section prescribes that protective or preventive social services shall be provided by the division to the family and subject child and to others in the home to prevent abuse or neglect, to

safeguard their health and welfare, and to help preserve and stabilize the family whenever possible. The juvenile court shall cooperate with the division in providing such services.

The section prescribes that multidisciplinary services shall be used whenever possible in conducting the investigation and in providing protective or preventive social services, including the services of law enforcement, the juvenile officer, the juvenile court, and other agencies, both public and private. The division shall cooperate with law enforcement agencies and juvenile courts to develop training programs to increase the ability of division personnel, juvenile officers and law enforcement officers to investigate suspected cases of abuse and neglect.

The section prescribes that within thirty days of an oral report of abuse or neglect, the local office shall update the information in the information system with the determination made as a result of the investigation, identifying information on the subjects of the report, those responsible for the care of the subject child and other relevant dispositional information. The division shall complete all investigations within thirty days, unless good cause for the failure to complete the investigation is documented in the information system and if not completed within thirty days, the information system shall be updated at regular intervals and upon the completion of the investigation. In addition, the information shall be updated to reflect any subsequent findings, including any changes to the findings based on an administrative or judicial hearing on the matter.

The statute prescribes that a mandated reporter shall be informed by the division of his right to obtain information concerning the disposition of his report from the local office, and if requested, shall respond to the request within forty-five days.

Section 210.150 prescribes that the division shall ensure the confidentiality of all reports and records of child abuse and neglect made and maintained by the division, its local offices, the central registry, and other appropriate persons, officials, and institutions. To protect the rights of the family and the child, the division of family services shall ensure that any disclosure of information concerning the abuse and neglect involving that child is made only to persons or agencies that have a right to such information, such as appropriate federal, state or local criminal justice agency personnel, a physician or a designated agent, appropriate staff of the division, or a multidisciplinary provider of professional treatment services for a child referred to the provider, and others as specified.

The statute requires that any alleged perpetrator named in the report shall have access to information and records of the results of the division's investigation, but the names of reporters shall not be furnished to persons in this category. However, the investigation reports will not be released to any alleged perpetrator with pending criminal charges arising out of the facts and circumstances named in the investigation records until an indictment is returned or an information filed.

The statute provides that after a period of two years following a finding by the division, any person who is the subject of a report where there is insufficient evidence of abuse or neglect shall have the records removed from the division and destroyed.

The statute provides that any person who knowingly violates the provisions of this section, or who permits or encourages the unauthorized dissemination of information contained in the information system or the central registry and in reports and records made pursuant to sections 210.109 to 210.183, shall be guilty of a class A misdemeanor.

Section 210.152 sets record keeping retention time frames for information from reports of child abuse and neglect and related investigations. The specified retention time varies depending on whether evidence of abuse or neglect was sufficient or insufficient for a finding conclusion of probable cause to believe the abuse occurred. The results of the investigative or family assessment and services approach reports shall include any exculpatory evidence (of innocence) known by the division, including exculpatory evidence obtained after the closing of the case.

The section prescribes that within ninety days after receipt of a report of abuse or neglect that is investigated, the alleged perpetrator named in the report and the parents of the child named in the report, if the alleged perpetrator is not a parent, shall be notified in writing of any determination made by the division based on the investigation. The notice shall advise either that the division has determined that there is probable cause to suspect abuse or neglect exists or there is insufficient probable cause of abuse or neglect. When there is a finding of probable cause, the division is to notify the alleged perpetrator he has sixty days from the date of receipt of the notice to seek reversal of the division's determination through an administrative appeal review by the child abuse and neglect review board.

The section prescribes that such request for review shall be made within sixty days of notification of the division's decision under this section. In those cases where criminal charges arising out of facts of the investigation are pending, the request review shall be made within sixty days from the court's final disposition or dismissal of the charges. In any such action for administrative review, the child abuse and neglect review board shall sustain the division's determination if such determination is supported by evidence of probable cause and is not against the weight of such evidence. In any such action for administrative review the child abuse and neglect review board shall notify the child or the parent, guardian or legal representative of the child that a review has been requested.

The section further provides that if the alleged perpetrator is aggrieved by the decision of the child abuse and neglect review board, he may seek de novo judicial review in the circuit court in the county in which he resides. The request for a judicial review shall be made within sixty days of the notification of the decision of the child abuse and neglect review board decision.

Section 210.153 provides for creation in the department of social services the "Child Abuse and Neglect Review Board", which shall provide an independent review of child abuse and neglect

determinations in instances in which the alleged perpetrator is aggrieved by the decision of the division of family services, except findings of probable cause which are substantiated by court adjudication. The division may establish more than one board to assure timely review of the determination. Each board shall consist of nine members, who shall be appointed by the governor with the advice and consent of the senate, and shall include a physician, nurse or other medical professional, a licensed child or family psychologist, counselor or social worker, an attorney who has acted as a guardian ad litem or other attorney who has represented a subject of a child abuse and neglect report, and a representative from law enforcement or a juvenile office.

In addition, other members of the board may be selected from a person from another profession or field who has an interest in child abuse or neglect, a college or university professor or elementary or secondary teacher, a child advocate, or a parent, foster parent or grandparent. The members of the board serve without compensation.

The section prescribes others who may participate in a child abuse and neglect review board review, including appropriate division of family services staff and legal counsel for the department, the alleged perpetrator, who may be represented, and witnesses providing information on behalf of the child, the alleged perpetrator or the department. The alleged perpetrator's presence is not required for the review to be conducted, and he may submit a written statement for the board's consideration in lieu of personal appearance.

The section prescribes that the department shall promulgate rules and regulations governing the operation of the child abuse and neglect review board except as otherwise provided for in this section. These rules and regulations shall, at a minimum, describe the length of terms, the selection of the chairperson, confidentiality, notification of parties and time frames for the completion of the review.

Section 210.155 prescribes that the division shall, on a continuing basis, undertake and maintain programs to inform all persons required to report abuse or neglect pursuant to sections 210.110 to 210.165 and the public of the nature, problem, and extent of abuse and neglect, and of the remedial and therapeutic services available to children and their families; and to encourage self-reporting and the voluntary acceptance of such services. In addition, those mandated to report pursuant to this act shall be informed by the division of their duties, options, and responsibilities in accordance with this act.

The section provides that the division shall conduct ongoing training programs in relation to sections 210.110 to 210.165 for agency staff and shall continuously publicize to mandated reporters of abuse or neglect and to the public the existence and the number of the twenty-four hour, statewide toll free telephone service to receive reports of abuse or neglect.

Section 210.167 prescribes that if an investigation reveals that the only basis for action involves a question of an alleged violation of the compulsory school attendance law, the local office of the division shall send the report to the school district in which the child resides.

Section 210.180 prescribes that each employee of the division who is responsible for the investigation or family assessment of reports of suspected child abuse or neglect shall receive not less than forty hours of preservice training on the identification and treatment of child abuse and neglect. In addition to such preservice training such employee shall also receive not less than twenty hours of inservice training each year on the subject of the identification and treatment of child abuse and neglect.

Section 210.183 prescribes that at the time of the initial investigation of a report of child abuse or neglect, the division employee conducting the investigation shall provide the alleged perpetrator with a written description of the investigation process and provides the prescribed content of the notice to be provided.

The section provides similar guidance for notification of the alleged perpetrator if the division uses the family assessment approach, including the possible services available and expectations of the family.

CODE OF STATE REGULATIONS

13 CSR 40-31.025 establishes a child abuse and neglect review process for a review of child abuse and neglect determinations where an alleged perpetrator disagrees with the division's decision of probable cause. The alleged perpetrator must request the administrative review in writing within sixty days of the probable cause determination. Within fifteen days of receipt of the request the county director is required to review all appropriate material and determine whether the decision of the division should be upheld or reversed. The county director is to provide written notice of the decision to uphold or reverse the original finding and how to request further review by the child abuse and neglect review board, if he disagrees with the decision.

This rule also establishes the length of terms of the nine members of the child abuse neglect and review board, the review process, requires the division to be represented by local and area staff and/or legal counsel, requires the board decision be made within seven days of the review, and written finding notice within thirty-five days to the alleged perpetrator, division director, and local division office.

APPENDIX III

BACKGROUND

The Division of Family Services must deal with children and their families who are faced with problems coping with everyday life in addition to the reported abuse or neglect. Many of these families are poor, illiterate, unemployed, and addicted to drugs and alcohol. Children coming from these environments may have been abused or neglected by adults who went through the same cycle of abuse and neglect when they were children. This audit—and the problems we have identified—should be viewed within this environmental context.

Social workers and others involved in the day-to-day lives of abused children and their families must make decisions on a daily basis about what course of action they think is in the best interest of each child. Sometimes those interests are competing, such as trying to balance the safety and well being of children with the rights of families, and the alternatives often are not perfect. Often the decisions they make work out well; sometimes they do not. No child abuse response system can prevent all abuse or tragic results from occurring, but properly administered and handled it must keep such instances to an absolute minimum and protect children shown to be at risk. To accomplish these very difficult tasks, the social workers that are at the heart of the system, need the best resources and training the state can provide.

At the same time, program staff are to be commended for working in a very difficult program in which social workers are expected to confront openly hostile parents and suspected perpetrators of child abuse and/or neglect on a daily basis and attempt to document whether abuse or neglect occurred. Where necessary, they must take appropriate action to prevent additional abuse to children in their highly vulnerable situations.

Mission Statement of Division of Family Service (DFS)

To maintain or improve the quality of life for the people of Missouri by providing the best possible services to the public, with respect, responsiveness and accountability, which will enable individuals and families to better fulfill their potential.

As of January 2000, the Division of Family Services employed 5,627 full time employees (FTE) including 3,329 working in Children's Services. The Division of Family Service's Children Service unit is responsible for coordinating programs to provide assistance to children and their parents. The Children's Services Programs include Adoption, Foster Care, Child Abuse and Neglect, Treatment Services, Independent Living, Residential Program, Parental Stress Helpline and other programs. Our audit focused on the Child Abuse and Neglect system which is responsible for receiving hotline calls of suspected abuse or neglect and determining if the calls meet statutory or policy requirements to be sent to the local county DFS office as either Child Abuse and Neglect reports or referrals for services. The local county offices evaluate each report received to determine if it should be investigated or if the family assessment approach would benefit the family more. In cases of referrals, the local offices determine what steps need to be taken to help address the family's needs. In all cases, the safety and risk of harm to the child is to be an overriding concern.

Structure

The governor appoints the Director of Social Services who in turn appoints the Director of Family Services. The Family Service Director appoints the Children's Services Director. The Children's Services central office is located in Jefferson City, and the state is divided into seven geographic areas for administrative purposes. The state's 114 counties are clustered into these geographic areas, except for St. Louis City, St. Louis County, and Jackson County, which make up their own areas. The following are the area headquarters locations:

- **Area 1 –** St. Joseph
- **Area 2 –** Fulton
- **Area 3 –** Cape Girardeau
- **Area 4 –** Springfield
- **Area 5 –** Jackson County
- **Area 6 –** St. Louis City
- **Area 7 –** St. Louis County

Child Abuse/Neglect Reports

The Child Abuse/Neglect Hotline Unit is operated year-round on a 24-hour per day, seven days per week basis by approximately 50 social workers. Missouri's toll-free number for reporting child abuse/neglect is 1-800-392-3738.

The volume of hotline calls received for 1999 and 1998 and their classifications are shown below:

VOLUME OF CALLS HANDLED BY DFS		
Call Classification:	Calendar Year 1999	Calendar Year 1998
Child Abuse and Neglect	48,769	47,954
New Born Crisis Assessments (A Referrals)	1,092	934
Mandated Reporter Referrals (M Referrals)	13,948	11,562
Preventive Service Referrals (P Referrals)	5,694	4,822
Non-Caretaker Referrals (N Referrals)	1,208	1,093
Unable to Investigate	24,767	24,910

The hotline unit receives calls of suspected abuse and/or neglect from permissive and mandated (certain professionals mandated by statute to report) callers. When a call is received at the hotline unit, the call taker must evaluate the information to determine whether the conditions reported meet the Child Abuse and Neglect criteria listed below.

- The child is under age 18.
- The alleged perpetrator has care, custody, and control of the child.
- The alleged abusive or neglectful treatment is having an adverse effect on the child.
- The report meets the definition of abuse/neglect described in state statues.

If the call meets the above criteria it is considered a child abuse and neglect report. Within moments of deciding a call is a child abuse and neglect report, the information is forwarded electronically to the appropriate county office where the victim lives. The county office personnel retrieve the report from the electronic automated retrieval system (list of cases from the hotline unit) and give it to the appropriate screener (determined by the local county offices) who determines whether the report should be handled as an Investigation or Family Assessment.

The DFS implemented a new two track approach (Investigation or Family Assessment) statewide in May 1999, to recognize different families have different intervention needs and require flexible responses from Children's Protective Services and the community, to protect children and meet family needs.

Investigation Approach

The investigation track is chosen by the screener if the following are alleged:

- Serious physical, medical or emotional abuse and serious neglect where criminal investigation is warranted;
- All reports of sexual abuse;
- All other reports that if confirmed would be a (criminal) violation of certain sections of Chapters 565 – 568 and 573 RSMo;
- Reports, indicating the child is in danger at the time of the report and law enforcement involvement is needed;
- All reports referred to the Out-of-Home Investigation (OHI) unit or non-relative/non-household member caretaker reports investigated by county staff.

If the report is classified as an investigation, it is assigned to a social worker, who must initiate the report and have face-to-face contact with the child(ren) within 24 hours of receiving the report. In most cases, law enforcement is called to conduct a joint investigation. The investigator's role includes the responsibility to ensure services are provided to a family when service needs are immediate during the investigation. The social worker has 30 days to complete the investigation and to prepare the related documents and reports. The following are the possible investigation conclusions:

- Court Adjudicated
- Probable Cause
- Unsubstantiated – Preventive services indicated
- Unsubstantiated
- Unable to Locate
- Inappropriate Report
- Located out of State

The alleged perpetrator and victim(s) are to receive written notification as to the decision determined by the local division office. If the finding is probable cause, the notification must contain a notice that if the alleged perpetrator disagrees with the probable cause decision, s/he has 60 days from the date of receipt of the notification to request an administrative review. The local county director conducts the administrative review. If the director upholds the office's decision and the perpetrator wishes to continue the process, the County Director must notify the Child Abuse and Neglect Review Board Liaison within 10 days. The Liaison schedules a hearing for the case and notifies the involved parties of the date.

There are currently three review boards composed of nine members each. The board members are appointed by the governor and are made up of independent citizens, some of whom must be from mandated professions such as law enforcement and child health care. The boards review the investigation case records and may hear testimony from involved parties. The Chairpersons submit a written decision to the liaison within 7 days of the review. The liaison provides a written decision notice to all parties within 30 days of receiving the recommendations from the review board. For cases that are overturned, the DFS also must change the investigation conclusion recorded in the case file and in the computer system.

Family Assessment Approach

The screener chooses the family assessment track if the following conditions are alleged:

- Mild, moderate, or first-time non-criminal reports of physical abuse or neglect (including medical neglect);
- Mild or moderate reports of emotional maltreatment; and
- Educational neglect reports.

If the report is classified as a Family Assessment, it is assigned to a social worker who contacts the family and conducts a thorough family assessment. Family assessments must be initiated within the first 24 hours. An exception is if the only allegation is educational neglect in which case it should be initiated within 72 hours. If the children are not seen within the first 24 hours, documentation must be recorded in the assessment form explaining how safety was determined. The Social Worker can either schedule this contact with the family or make an unannounced home visit. The goal of the family assessment is to:

- determine any risk to the child's safety;
- determine if the family needs assistance from the division or the community; and
- identify service needs of the family.

During the family assessment process, workers use the forms provided as tools to help accomplish the goals listed above. If the family refuses to cooperate in the family assessment process and there is risk to the child, the report must be changed to place it on the investigation track, giving the worker more authority to deal with the situation.

The worker has 30 days to complete the family assessment and to prepare the related documents and reports. The family must be notified of the conclusion reached. The following are the possible family assessment conclusions:

- Services Needed
- Services Not Needed
- Non-Cooperative/Child Safe (Police Involvement)
- Services Needed (Family Declined)
- Services Needed (Linked in 30 days)
- Unable to Locate
- Inappropriate Report
- Located out of State
- Home Schooling

Referrals

In instances when a call taken by the hotline unit does not meet the child abuse and neglect criteria, the hotline unit call taker must determine if the call meets the criteria for one of the four referral types (Mandated Reporter, New Born Crisis Assessment, Non-Caretaker, and Preventative Service Referrals). Like child abuse and neglect reports, once a call has been classified as a referral by the hotline unit it is forwarded electronically to the appropriate local county office.

Mandated Reporter Referrals

The state child abuse and neglect law requires certain professional people known as mandated reporters to make a report to DFS when they have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect. In an effort to recognize the importance of Mandated Reporters, the division has a policy to accept referrals of concerns that do not rise to the level of a child abuse and neglect report. The division refers to these calls as Mandated Reporter or "M" Referrals. Non-anonymous mandated reporters, acting in their professional capacity, and reporting family situations, must make these referrals.

Local personnel pull off the referral from the automated referral system and give it to the appropriate worker (as determined by local office policy). In most cases, new social workers or supervisors are assigned to the M Referrals. With one exception in the Central Office, local county offices set all policies regarding M referrals.

Central DFS policy requires local DFS staff to contact the mandated reporter within 3 working days of the referral (or the next working day if received on a Friday), to discuss the situation with the mandated reporter and to mutually determine the most appropriate response. In most

situations, the DFS staff does not visit the family but advises the reporter of services the community and DFS can offer the family and suggests the reporter inform the family of those services.

Newborn Crisis Assessments

These referrals are cases in which medical personnel are referring a newborn. There are two types of newborn referrals--drug-involved and non-drug-involved. For drug-involved referrals there must be signs and symptoms of drug/alcohol involvement in the newborn at birth. For non-drug-involved referrals there must be allegations of potential serious risk of abuse/neglect upon release of the newborn from the hospital and must be called to the hotline unit prior to the newborn's discharge. These calls are coded as "A" referrals and forwarded electronically to the local county office to be handled as emergencies. Local personnel pull the referral off the automated referral system and give it to the appropriate worker as determined by local office policy. Policy requires the worker to start the Newborn assessment immediately after receiving the report.

Non-Caretaker Referrals

Permissive reporters (persons not mandated) identifying possible abuse/neglect where the alleged perpetrator has no care, custody, or control of the child are advised that the hotline unit will make an "N" referral to the county office, but that it is not considered a child abuse/neglect report. The referral is forwarded electronically to the local county office. Local personnel pull the referral off the automated referral system and give it to the appropriate worker for handling. The worker then decides whether to act on the case himself or herself or to refer the case to other agencies such as law enforcement or juvenile authorities.

Preventive Service Referrals

Preventive Service Referrals are calls made by permissive reporters (those not mandated) where no actual abuse or neglect has occurred, but where the actions of the child, caretaker, another juvenile or adult demonstrates the need for intervention and possible service delivery to prevent child abuse and neglect from occurring. The following are the only instances the hotline unit will take as Preventive Service Referrals:

- Family requests services.
- Caretaker is ill, hospitalized and no appropriate child care plan.
- Caretaker requesting placement of child, but no child abuse and neglect.
- Caretaker or child is suicidal.
- Child exhibiting extreme maladaptive behavior; or
- Domestic violence in the home and child is witness to violence.
- New information reported to the hotline unit which would be important for the local county office to have available on a currently open Preventive Services case.
- Non child abuse and neglect fatality referrals from permissive reporters.
- G.L. vs. Stangler referrals from permissive reporters (relates to a Jackson County court order).

- Ex-parte orders (legal proceeding) with no child abuse/neglect allegations.
- Calls regarding children over 18 who remain in DFS custody.

Hotline unit personnel inform the permissive reporter that a "P" referral is being sent to the local office, but that it is not considered a child abuse/neglect report. The DFS policy manual guides the worker to the family assessment procedures for handling "P" referrals. All other policy concerning "P" referrals is set by each local office.

Unable to Investigate

In instances when the call taken by the hotline unit does not meet either child abuse and neglect or referral criteria or if no identifying information can be obtained, the information is coded unable-to-investigate. The hotline unit unable-to-investigate worksheet must clearly show the reasons for the call being classified as unable-to-investigate and include the information provided by the caller. No action is taken on calls coded unable-to-investigate, there is no computer record of these calls, and the hotline unit keeps the paper worksheet for only 2 months before being destroyed. The following situations are classified as unable-to-investigate:

- Victim is 18 years old or older
- No child abuse/neglect allegations
- Out of state reports from non-mandated reporters
- No address, direction, or other means of locating the family
- Prior Checks (allows certain mandated reporters to check for possible prior reports on abuse or neglect of a child or family).

Accreditation

The DFS is currently in the application phase of seeking accreditation by the Council on Accreditation of Services for Families and Children, Inc. The council is a leading independent accreditor of the full range of behavioral healthcare, social, and community services. According to their internet website, the council's mission is to "actively promote and improve the quality of social and mental health services that support and improve the lives of families and children and the well-being of society." The council accomplishes its mission by developing standards of best practice, by delivering a program of provider recognition and accreditation, by providing educational and technical assistance programs, and by advocating for policies that promote high quality services for families and children.

The council recommends certain caseload standards that will allow staff to more effectively work with families and children. Also, the council recommends that the supervisor of child protective workers only have responsibility for the direction of no more than seven experienced and professionally trained workers. DFS has been allocated additional social worker positions for FY2001 to help achieve the council staffing and caseload requirements.

APPENDIX III

For more information and statistics on the Child Abuse and Neglect System readers may go to the DFS Internet Website at ***http://www.dss.state.mo.us/dfs/dfs.htm***.

APPENDIX IV

SUMMARY OF BEST PRACTICES

During the course of our field work we identified various best practices that could be implemented by DFS on a statewide basis. Some of these best practices originated from within DFS but have not been disseminated beyond a few local areas. Others were identified while studying child abuse and neglect practices used in other states. The importance of ensuring the state maintains a compendium of the best and most effective practices in preventing and responding to reports of child abuse and neglect cannot be overstated. Many nations are struggling with the problem of child abuse and neglect and the problem is seen as growing in significance as drug and other substance abuse, for one example, reaches near epidemic proportions. It is imperative that new, improved and proven practices should be adopted and disseminated by the DFS in its efforts to respond to child abuse and neglect throughout Missouri. The practices shown below are worthy of serious consideration by the DFS for methodologies to improve various practices in Missouri.

Best practices from other states:

Arkansas

The Arkansas State Police operates a Family Protection Unit that handles 1/3 of the Child abuse and neglect reports received each year. The unit was established in 1997 to enhance the effectiveness of Arkansas child abuse and neglect investigations by using personnel trained in proper investigation procedures and documentation and to help ensure cases against perpetrators of child abuse could be effectively prosecuted. Unit personnel have arrest powers and may carry firearms. The unit works in joint venture with the Children Services Unit in handling child abuse cases and if a child must be removed from the family home, the Children Services Unit handles the placement.

Iowa

In Iowa, the position of child abuse investigator is the highest possible level a social worker can achieve before becoming a supervisor. It is also the highest paid position social workers can attain and continue to work with children.

Illinois

The state of Illinois will require all their Department of Children and Family Services social workers to be licensed by January 1, 2001. All those social workers will be required to pass a certification test to work as a social worker in Illinois.

Kansas

In Kansas, social workers are required to be licensed prior to being hired by the state.

Oklahoma

In Oklahoma, the social workers receive a 2.5% salary increase for having obtained a Master's Degree education level.

Washington

In Washington State, statutes require that conclusion notices to perpetrators must be sent by registered mail. The conclusion notices inform the alleged perpetrators of the abuse finding and the right to appeal the finding to an appellate organization much like the Missouri Child Abuse and Neglect Review Boards. In Missouri these appeal rights notices are sent by regular mail, allowing perpetrators to claim they never received the required notice and thus allowing them to force an appeal long after the rights have actually expired.

Michigan

In some counties, records of calls screened out as Unable to Investigate because of the low level of claimed abuse and not considered significant or worthy of investigation or review are kept in the computer system and also in paper files.

However, when three such calls have accumulated on the same family, social workers visit the family because of the high likelihood of real problems. This practice provides the children's services agency an opportunity to initiate preventive services, if needed.

The state has established several procedures intended to protect the safety of social workers. Examples include checking for any prior criminal history or child abuse and neglect records on any family members in the subject household prior to the family visit, each social worker is provided a cell phone and pager and provided state owned vehicles equipped with personal alarms and remote entry mechanisms. These and other safety procedures were established after a worker responding to a report of child abuse was murdered at the child's home.

A statewide Peer Review program has been developed to ensure consistency and appropriateness of the handling of all facets of children's protective services provided and in implementing departmental policies and procedures.

Social workers are paid a more competitive salary.

Increased compensation is given to workers who have obtained a Master's degree.

Various forms used in handling children's cases and perpetrator notification letters are maintained as master documents and are computer generated on demand as needed, thus saving worker time.

Mandated Reporter's are notified of the outcome of calls reporting child abuse and neglect.

Florida

Florida state has developed and posted on their Children and Families web page an outstanding policy guideline giving callers the standards of courtesy and professionalism the state child abuse hotline call takers are expected to follow. The guidelines also explain how callers can contact hotline supervisors if the standards were not followed. The Missouri DFS has similar policies but the information on what to do if the call is not handled properly is not publicly posted on the web site as in Florida. Posting this information in Missouri would improve communications with child abuse reporters and would allow them a mechanism to question the hotline worker's decision if they believe it is wrong. It could also provide a mechanism to alert management when problems develop.

Best practices within Missouri:

St. Louis City

The DFS (Area #6, St. Louis City) has developed a substance abuse specialist to accept referrals from workers with the purpose of assisting the workers in identification of substance abuse during their home visits and family conferences. The position duties include: consultation, assessment & screening of families, chemical dependency evaluation, psychological evaluations, attending family meetings & court hearings, pre-treatment counseling and education, training and workshops, and practicum opportunities. Common issues for families include: co-dependency, treatment referral & availability, support groups, breaking through barriers such as denial, enabling, reaching out for help, family violence, and mental health.

APPENDIX IV

St. Louis City has also developed a way to identify and treat chronic neglect families. Chronic Neglect work is a relatively new approach in the United States, and St. Louis City is the only DFS office with their own specialist on staff. The Chronic neglect approach does not focus so much on the particular incident, but on the pattern and the "accumulation of harm." Chronic Neglect is defined as a persistent pattern of family functioning in which the caregiver has not sustained and/or met the basic needs of the child, which results in harm, and the behavior may result in an accumulation of harm. Accumulation of harm is a heightened risk to children when the caretaker shows a repeated pattern of failing to meet a child's basic needs.

The Chronic Neglect Specialist reviews every hotline call sent to the county. The specialist not only reviews the current incident, but looks at all prior involvement with the family (substantiated or not, referrals, information obtained regarding neglect while investigating an incident, etc.). St. Louis City chose to use 10 prior incidents as a starting point to classify a family as in a state of chronic neglect. The city staff has been asked to give presentations in other states and at CA/N conferences throughout the U.S. The DFS should develop policies for all local offices to help them better identify and treat chronic neglect families.

St. Louis City has taken a preventive approach to educational neglect. The DFS hotline unit does not take calls reporting education neglect unless the reporter shows exhaustive effort on the part of the school to correct the problem and the child has missed a great deal of school. In contrast, St. Louis City DFS arranged for schools to send a fax notice when a child has missed 10 days of school. This allows the local office to initiate early preventive or intervention efforts before the problem becomes more serious.

APPENDIX V

SUMMARY OF SURVEY QUESTIONNAIRE RESULTS

A survey questionnaire was sent to 1,183 current and former employees of DFS, Children's Services. A total of 514 responded to the questionnaires giving a response rate of 43%. The results of this survey are as follows:

Question	Always	Sometimes	Never
Do you feel that you received enough training to make accurate and correct decisions on handling child abuse and neglect reports in the two-track (Investigation/Assessment) system?	153	238	46
Is your caseload such that you feel you are able to successfully manage your cases?	52	206	187
Does your workload allow you to act on a child abuse and neglect report in a timely manner?	159	221	39
Do you feel that you are unable to do enough investigative work on a child abuse and neglect report due to time constraints?	72	260	74
Have there been times that you could not include fully accurate records and details because of time limitations?	40	287	106
Have you had any problems getting child abuse and neglect reports or any other information from the Central Registry Unit?	14	173	238
Are there times when child abuse and neglect calls are made to the local county office and not reported to the Central Registry Unit?	7	171	221
Does your supervisor provide adequate instruction and support?	221	192	31
Is it necessary to vary from DFS procedures and policy to serve the best interest of the child?	23	304	114
Has a lack of Out-of-Home resources been the reason for keeping a child in a dangerous home situation?	14	166	259
Do you believe mandated reporter calls are given the proper classification and treatment?	127	252	54
Is the name of the reporter ever given to the family?	1	29	414
Are intensive In-Home services effective in keeping children safe?	58	369	15
Do you contact mandated reporters within 3 days of their call?	286	117	7
Do you feel you have the full needed cooperation of the other agencies shown below?			
The Department of Health?	181	225	31
The Department of Mental Health?	75	263	109
The Juvenile Office?	141	291	26
The Courts?	117	301	31
Law Enforcement Agencies?	173	257	15

Question	Yes	No	% Yes
Are available state resources adequate to address the problems causing abuse?	102	347	23

We asked DFS social workers what they felt was the main cause of men and women abusing their children. The following are the main causes given in the survey responses**:**

- Single Parent, Stress, Economics, No Support System, Anger, Control Issues
- Drug and Alcohol Abuse
- Lack of Parenting Skills/Education
- The way they were raised, poor role models, cycle of abuse

A survey questionnaire was sent to 803 mandated facilities including Police Departments, Juvenile Offices, Schools, and Hospitals. We received 1,530 responses, a 191% response rate. Many of the facilities made multiple questionnaire copies so more employees who make calls to the Child Abuse and Neglect Hotline could respond to the survey, thus causing a very high response rate. The results of this survey are as follows:

Question	Yes	No	% Yes
Were you able to provide all of the information you wanted to give to the hotline worker?	1,371	108	93
Have you ever had to exaggerate the condition of the child in order to get the hotline's attention?	234	1,230	16
Did the DFS county worker discuss fully your concerns for the family/children?	1,064	352	75
Has any alleged perpetrator confronted you about turning them in to the hotline?	695	775	47
Overall, are you satisfied with the way your calls are handled by hotline personnel?	1,126	305	79
Overall, are you satisfied with the local field office's handling of the cases you call about?	900	466	66

Question	Always	Sometimes	Never
Do you report all suspected child abuse/neglect to the Child Abuse Neglect Hotline Unit?	1,268	231	1
Do you feel once you report the abuse the problem will be taken care of?	281	1,156	66
Was the hotline worker courteous and tactful in your discussions?	988	471	6
After you reported to the hotline, did you see subsequent improvement in the child's physical and/or mental condition?	63	1,244	122
From your calls, did cases receive action you considered appropriate?	311	1092	77

Question	Within 24 hours	Within 48 hours	Within 72 hours	No Contact	Other
Did the DFS county worker contact you after your initial call to the hotline?	552	167	108	205	245

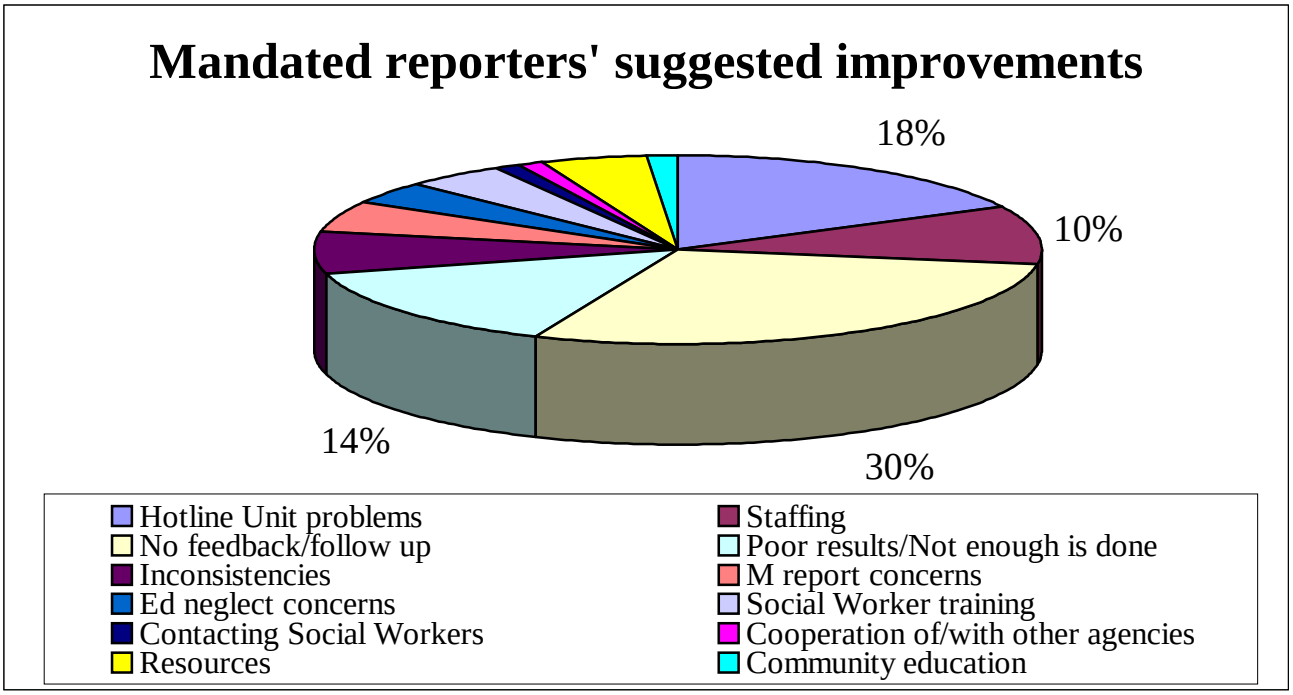
APPENDIX V

Question	1-3	4-6	7-10	Over 10	Over 20
How many times have you, as a mandated reporter, called the Child Abuse Neglect Hotline?	316	316	204	272	346

Question	Never	Occasionally	Often
Do you contact your local DFS office for informal consultations or assistance?	180	936	357

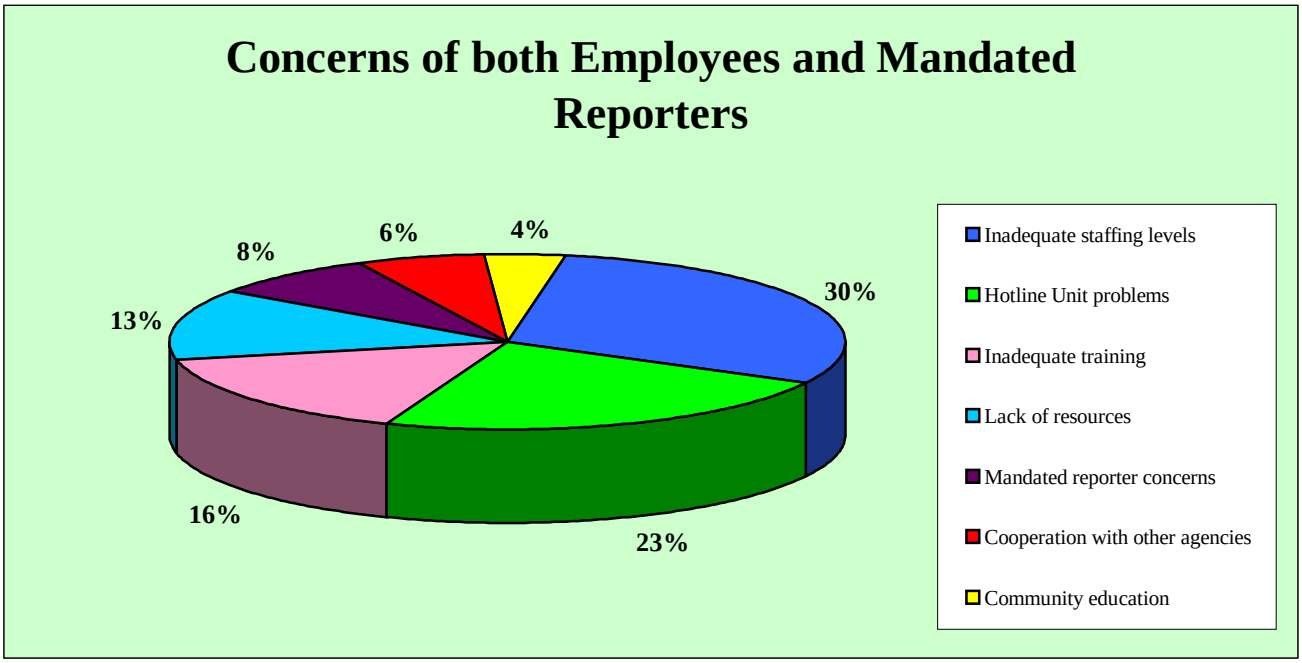
Question	Not Applicable	Never	Occasionally	Often
Do you find your local DFS office helpful and responsive to your request(s) when you contact them?	76	43	636	716

We asked Mandated reporters what could be done to improve the handling of their calls reporting alleged Child Abuse and Neglect. The following chart shows their responses regarding the areas for improvement.



APPENDIX V

We tallied the comments made by both employees and mandated reporters to identify areas of concern. The concerns and the level of importance based on the number of mentions are shown below:



APPENDIX VI

RESULTS OF CALLS CLASSIFIED UNABLE TO INVESTIGATE

The audit included a test of the justification for categorizing 1,984 calls received in December 1999 and January 2000 as unable to investigate to determine if they were properly categorized. Audit results showed that 50 of these calls were not properly categorized and some action could have been taken to assist an endangered child—a child who could still be at risk. Our test disclosed the following issues of concern.

Didn't meet the criteria to be unable-to-investigate

Testing Dates	Number of Erro	Total Tested	% Error Rate
December 11 & 15	10	104	10
January 1 – 31	40	1880	2

Call taker didn't explain why the call was unable-to-investigate

Testing Dates	Number of Errors	Total Tested	% Error Rate
December 11 & 15	Not tested	Not tested	Not tested
January 1 – 31	79	1880	4

No supervisory approval on unable-to-investigate worksheets

Testing Dates	Number of Errors	Total Tested	% Error Rate
December 11 & 15	12	104	12
January 1 – 31	34	1880	2

Call taker didn't document a prior child abuse and neglect record check

Testing Dates	Number of Errors	Total Tested	% Error Rate
December 11 & 15	23	70	33
January 1 – 31	265	812	33

DFS computer system record didn't agree with call taker's prior record check notation

Testing Dates	Number of Errors	Total Tested	% Error Rate
December 15	8	66	12
January 1 – 31	132	267	49

A later report or referral was taken on the same allegation as the unable-to-investigate*

Testing Dates	Number of Errors	Total Tested	% Error Rate
December 15	2	66	3
January 1 – 31	16	265	6

* A call giving the same allegation of abuse was accepted as valid for referral and handling

APPENDIX VII

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF FAMILY SERVICES

Department of Social Services
Division of Family Services
Audit Of Child Abuse and Neglect Response System
Response to Recommendations

We take our commitment to protecting children very seriously and are proud of the improvements made in the last several years. While there is always room for improvement, we feel this document borders on audit by anecdote and takes an overly simplified approach to an extremely complicated system.

Protecting children is difficult and vastly more challenging than designing the perfect system. Our staff is faced daily with making more serious judgment calls in people's lives than most people ever face in their lifetime. The standard they are held to is perfection, which is virtually unattainable.

For the record, we wish to register a strong disagreement with the harsh accusations and inflammatory generalizations used in the narrative. We will attempt to address the recommendations individually as listed below.

While Missouri's child protection system is better than most and has steadily continued to improve, we know intuitively that even with more staff, increased money and tougher laws, some children will still be lost to tragic circumstances. That is why solutions should involve more than one system. They include communities, parents, relatives, teachers, neighbors, law enforcement, health care professionals and many others beyond the Child Abuse and Neglect Reporting and Response system.

1.1 Implement a structured decision making tool to increase consistency and accuracy in making intake, screening, risk assessment, service and placement decisions.

In April 2000, the division began working with Children's Research Center, a division of the National Council of Crime and Delinquency in Madison, Wisconsin, to explore the adaptability of a specific structured decision-making model to our system. The first phase would focus on enhancing the current decision making tools used at two points in the system: the hotline, to classify calls received, and in the county office to determine if the report will be treated as an assessment or investigation. Further exploration will take place over the next year regarding other decision points in the system.

1.2 Require that hotline unit call takers check DFS records for prior reports of abuse on the child or family and document that check.

Currently social service workers at the hotline do check DFS records for priors on all calls (approximately 75,000 annually) except those classified as Unable To Investigate (UTI). DFS will work with the Division of Data Processing to implement a tracking system for these types of reports, which will include a check for priors when enough information is known from the caller to determine specific persons' identities. It should be noted that many UTIs do not

contain adequate information for clear data collections. Implementation will be expected by April 2001.

1.3 Ensure unable to investigate worksheets document completely and appropriately the phone reports of abuse received by the hotline unit.

The division is implementing a policy that hotline supervisors will read worksheets and listen to tapes of 10% (as consistent with Council on Accreditation (COA) expectations for peer reviews) of all calls classified as Unable To Investigate. Supervisors will review the work of staff other than those in their own unit. It should be noted that currently supervisors consult frequently with staff, especially new social service workers, when they are making a decision to classify a report as Unable To Investigate. Staff often seek consultation while the caller is still on the phone. It is also believed that implementing a Structured Decision Making model at the Hotline Unit may further enhance staff decision making. Finally, we are in the process of implementing changes to the MIS database system which will require more complete documentation for data entry and conclusion on reports classified as unable to investigate.

1.4 Improve the hotline unit quality control review process to ensure unable to investigate decisions are appropriate.

See #1.3

1.5 Enter unable to investigate records into the automated Production System and retain them.

See #1.2. Records will be maintained for one year.

1.6 Retain tape recordings of hotline calls for possible use in future criminal prosecutions or for review board hearings.

Currently the division keeps tapes of all calls for six months and cooperates by supplying copies of tapes as requested by prosecutors within that time frame. Rarely has the Child Abuse and Neglect Review Board (CANRB) requested a tape and most reviews are held within six months of the finding. Effective January 1, 2001 the division will keep tape recordings of all calls for one year. This will be done as a one-year pilot during which time, records will be kept regarding the number and type of requests made for copies of the tapes. At the end of one year this practice will be reevaluated.

1.7 Ensure reports are retrieved and acted on by field office staff by establishing a quality control system that requires the hotline unit to reconcile reports sent to field offices to reports printed and taken off the system for action.

As noted in the audit report, the division has made changes to ensure reports are retrieved from the system. Reports are sent from the central registry to the county offices electronically. There is an audio cue from the printer when the report first comes in. Staff check for new reports several times per day in case the audio alert is missed. The ALOG system has been enhanced

so that reports remain on the list indefinitely in case the daily checks miss one. In addition, local supervisors are charged with checking the system twice weekly for any that might have been missed and central office staff checks the system twice monthly to be sure all reports have been assigned. No further action is needed.

1.8 Establish a peer review quality control system to ensure policies and practices are consistently followed and applied throughout the DFS child abuse and neglect response system.

As a part of the statewide accreditation process begun prior to this review, each year DFS performs a Practice Development Review (PDR) in a judicial circuit in each of the four rural administrative areas of the state, and in each of the three metro areas. The PDR looks at all parts of the child protection system rather than just the division's work. These reviews include comprehensive interviews with the children and family members, as well as other people important in the treatment planning for each family. In addition, interviews are held with community stakeholders, including mandated reporters, to gain a more complete picture of how the system functions.

Regular peer reviews of all Children's Services programs begin March 2001, as part of the already established accreditation process. This review entails staff at all levels reading records for 10% of all families served by DFS Children's Services. At the hotline, supervisors will read 10% of the reports taken by staff other than those assigned to the supervisor's unit.

1.9 Readdress the DFS study of overturns by the Child Abuse and Neglect Review Board on appeal of probable cause findings and take appropriate corrective action as suggested in the report.

It should be noted that the division's overturn rate on appeals is lower than many other states, including Michigan, which is highlighted for best practices.

DFS will review the report noted above, regarding overturns and determine what action should be taken. A significant error occurred in the report. It states, in FY97 the overturn rate was 44%. In fact the overturn rate was 30%.

The division has already engaged the boards as one of the federally required Citizen Review Panels. In this capacity, the boards will have the opportunity to review files of reports that do not come before them for review, both probable cause and unsubstantiated. There will also be a team within DFS that will read recent CANRB decisions. This will facilitate discussion between the boards and the division regarding decisions made by both parties. Through this dialogue action steps will be identified by April 1, 2001.

1.10 Establish quality controls that ensure the child abuse central registry and the local case records are appropriately corrected to remove the probable cause finding when the alleged perpetrator wins an overturn on appeal.

Effective January 1, 2001, the central office staff supporting the Child Abuse and Neglect Review Board (CANRB) will make the necessary change for each alleged perpetrator in the central registry, when the CANRB overturns an investigation. Local offices will continue to be notified to make the necessary changes in the local file and send out corrected notification letters. This will be ensured through inclusion in the peer review done quarterly for other Children's Services Programs as part of accreditation. Unsubstantiated reports will continue to be expunged according to law.

1.11 Develop a quality control system to ensure DFS is represented at Child Abuse and Neglect Review Board hearings as required by statute.

At present the division staff participate in 95% of the hearings. DFS policy regarding participation in review board hearings will be reaffirmed in a memo to all staff.

1.12 Ensure Children's Service workers are provided adequate guidance and training on their responsibility to make appropriate decisions on whether to represent DFS custody children in probable cause finding appeal hearings.

Children should always be represented at hearings by virtue of the division's participation in the review. In 95% of the cases children were represented. For the 5% of the reviews where staff did not participate county directors will implement a backup plan to ensure representation.

1.13 Send perpetrator notification letters by certified return receipt requested mail.

Contacts with other states have indicated many states do not use certified mail and those that do continue to receive complaints regarding failure to receive notice.

1.14 Redefine hotline unit criteria definitions for preventive service referral classifications to better allow for the best interest of children to be served.

We believe the current system offers better than average preventive services that are in the best interest of the children. Missouri delivers preventive services to children at a rate of 35.9 children per 1,000. Comparatively, Illinois's child protective services system offers 12.4 children per 1,000 and Michigan's child protective services system serves only 3.9 children per 1,000. (National Child Abuse and Neglect Data System, Child Maltreatment 1998).

1.15 Provide better policy and guidance to field staff on the handling of preventive service referrals.

Effective November 15, 2000, the division implemented a data collection system for all referral categories. Through this mechanism DFS will have specific information, rather than anecdotal, about the actions field staff took with preventive service referrals. The division will analyze the first six months of data to determine what if any guidance is needed for staff by June 2001.

1.16 Improve the understanding of the child abuse and neglect system by mandated reporters and the public by improving the quality and quantity of detailed information easily available. The DFS should increase efforts to explain what can be expected from the system.

The division was already working on steps to increase the quality and quantity of information available to mandated reporters and the public at large. In March of 2000, DFS policy was implemented for social service workers to contact mandated reporters to share information about the findings and plan how they might work together to provide services for the family.

Changes in legislation strengthened mandated reporter contacts by creating a communication link with schools through a specified liaison within each school district so that information is shared on a regular basis. All of the language in RSMo 210 supports the concept of a strong connection among DFS and all of the other community partners on behalf of children.

Additionally, the division has updated its information packet, made available to all school districts throughout the state, with changes in law and practice. These packets have been available since 1995, and updated as needed.

The central office and local offices participate in innumerable training sessions and community education meetings every year. DFS is also the primary sponsor of a Child Abuse and Neglect Conference held bi-annually which attracts over 1,200 participants. The focus of the conference is on the detection, investigation and treatment of child abuse and neglect as a priority for all community partners.

The division partners with the Children's Justice Task Force and Prevent Child Abuse Missouri to promote professional awareness of Child Abuse and Neglect through the quarterly publication of the "Colleagues for Children" newsletter. This newsletter specifically written for mandated reporters is distributed to 25,000 professionals across the state. Presently, the division has information available on the DSS web site. The number of website visits to the Child Abuse and Neglect page has increased over the last year.

1.17 Send responses to mandated reporter on the outcome of every call and the reasons for action or inaction.

Action is taken on every mandated reporter call. Current policy dictates staff to contact the mandated reporter within five days of reaching a conclusion regarding the report. At this time, the social service worker discusses the outcome, reason for it and most importantly how the mandated reporter might assist the family.

1.18 Ensure that hotline unit call takers make clear to mandated reporters what action can be expected based on the information provided.

This is existing policy and is included as part of the desk guide check list used by all social service workers at the hotline to ensure appropriate steps are taken with each call. This checklist was developed in December 1999 and all staff received training on its use. There have been

numerous reminders for staff regarding this issue. Memos were sent November 5, 1999 and September 14, 2000 and it was a specific agenda item for a meeting of the hotline supervisors in June 2000. In order to monitor this on an ongoing basis, it will be included in the hotline peer review process mentioned in #1.8.

1.19 Develop methods to identify and disseminate best practices throughout the DFS system.

Through an initiative which began in 1996 to promote community based child protection, supported through the Edna McConnell Clark Foundation, the division is participating in the development of a "Best Practices Tool Kit" along with the Family Investment Trust, the Children's Trust Fund and Citizens for Missouri's Children. This package will give ideas to all community members, including DFS, to help ensure that an overall community system is in place to help protect children. The "Tool Kit" should tentatively be available in the summer of 2001.

Area staff meets monthly with central office staff to discuss policy and procedures, new initiatives and areas of concern. Quarterly Continuous Quality Improvement (CQI) meetings, which is part of the accreditation process, offer an opportunity to share ideas and to learn from each other. The PDR and peer review processes present further learning experiences.

1.20 Ensure DFS Children's Services goals are valid and measurable.

The auditor's report notes a single discrepancy. This was corrected prior to their review.

2.1 Ensure that the child abuse and neglect investigations and/or assessment are completed within the required timeframe.

DFS acknowledges the need to address overdue reports. Area office staff report that contacts have been completed with families to ensure that children are safe and services have been provided. The overdue reports reflect a need for system updates and documentation of actions taken. Current practices identify monthly each overdue report for each county by incident number. Central office has allowed overtime for staff to complete necessary documentation and system updates, and has worked with area staff to make a plan for each area of the state. The additional staff allocations received in the FY 2000 and 2001 budgets and requested in the FY 2002 budget will greatly enhance the ability of the agency to address this important issue. The division will monitor this monthly with the area offices and make corrective action plans.

2.2 Ensure all accreditation council and other appropriate standards available as staffing planning tools are used to establish staffing allocations and future needs and goals.

Current practice.

2.3 Perform time and workload studies to help determine needed staff allocations.

The division uses standards established through the Council on Accreditation.

2.4 Relocate open staff positions from areas unable to fill positions to areas where the positions can be filled, when necessary or beneficial.

The division has conscientiously worked to assure the protection of all children in Missouri. In 1999, a new staffing request for 174 social service workers, was made as part of the statewide accreditation process and was appropriated. These allocations were specifically identified in the budget for the three metro areas where need is the greatest. These areas represent 35% of the population of children in Missouri and 31% of all hotline reports.

DFS continues to request more staff for other areas of the state, including this year's 2000 appropriation request for 105 social service workers and 143 new social services workers for FY 2001.

2.5 Develop a special team of investigators to assist "problem" areas and help ease the local offices' caseloads. This team could be sent to help counties who are having problems completing child abuse and neglect cases and making initial contacts on cases within the required time frames.

The division believes a special team would not be necessary if staffed at COA standards.

2.6 Increase salaries for both social worker and supervisor positions to make DFS jobs more competitive with surrounding states and private organizations who hire social workers.

The division continues to support salary increases for all staff as revenue resources allow.

2.7 Provide increased financial compensation to workers who obtain advanced degrees or certifications.

The division supports educational advancement for staff by paying tuition, books, and fees for employees working on MSW degrees, as well as accommodating flexible work schedules.

2.8 Ensure that each full time Children's Services social worker is provided with a state-owned cellular phone.

The division has made 629 cell phones available statewide for staff to use when out of the office and on call.

2.9 Provide Children's Services social workers with laptop computers and standard automated forms and letters and/or dictation equipment and transcription services.

The division has been working on a comprehensive management information system and by April 2001, all staff will have computers. Approximately 763 of the available computers are laptops.

Through the rest of this fiscal year the division will be testing a case management application that will include standard automated forms, letters, and other enhancements.

2.10 Provide specialized training for:

- **Front line staff and supervisors on how to use the two track (Investigation/Family Assessment) system to achieve the best possible results and to meet DFS management goals for the system.**

  The division began implementing the two track system in 1995. An evaluation was performed and necessary changes in legislation occurred in order to make this statewide practice. Counties adopted the new practice incrementally and each county received training prior to their individual implementation. The practice was in place in all counties by June 1999.

  The division has training planned for spring 2001 that will focus on supervisors and their ability to provide consultation and support to their staff. The supervisors, with consultation from central office training and policy staff, will in turn present training to the social service workers. Section 210 RSMo provides for annual training for staff.

- **Staff involved in child abuse and neglect investigations. This training should teach staff to adequately investigate, document and present investigation cases, increasing child safety and decreasing overturns on alleged perpetrators appeals.**

  It should be noted that the division's overturn rate on appeals is lower than many other states, including Michigan, which is highlighted for best practices. A new decision item in the FY 2002 budget addresses the need for additional training staff. These trainers would provide skill building regarding the subjects mentioned above as well as other issues involved in the division's services to children and families.

2.11 Develop Investigation teams for low population county groups to ensure specially trained workers and supervisors handle child abuse and neglect cases. These employees should not have other duties that interfere with their primary children's services functions.

The cost of this recommendation is prohibitive. In many rural judicial circuits, the number of reports is so low, it would be difficult to justify the number of full time staff necessary to also ensure adequate coverage for a large geographic area. For example, Circuit 4 includes the five counties of Atchison, Gentry, Holt, Nodaway and Worth. In a three-month period from July through September 2000, these counties received a combined total of 57 reports, or monthly average of 19. This would imply the need for just over one full time worker. The large geographic area and the unpredictable nature of hotline reports, coupled with the need to have staff available for emergencies 24 hours every day makes it impossible to staff with only one part time and one full time person.

The division has other mandated responsibilities for children in addition to investigations and assessments. All of which are primary functions for social service workers. We now staff smaller counties with social service workers who are responsible for a variety of duties. Services to families are often more consistent when the same worker can remain involved with a given family instead of reassigning staff after different phases of work are accomplished. By

combining functions the division makes better use of personnel and provides a more holistic approach to assuring safety and permanency for children. It is important that caseload sizes are appropriate as consistent with COA and the division continues to advocate for full staffing in all counties.

2.12 Make better use of compensatory time monitoring system to more effectively manage its accumulation and use. Compensatory time should be:

- **Used before annual leave.**

  DSS administrative policy 2-108 indicates supervisors may not require employees to use their compensatory time after the workweek…unless prior approval from the division personnel officer is received. Many social service workers have accrued maximum annual leave and would lose annual leave if forced to use compensatory time instead.

- **Used within a reasonable time frame.**

  DFS encourages staff to use compensatory time within the week it is earned. County directors and supervisors work with staff to try to arrange this. In many instances however, this is not possible. DFS will continue to follow DSS policy regarding earning and using compensatory time. Full staffing would help alleviate the need for earning compensatory time.

- **Monitored for purposes of planning future staff allocations and identifying staffing problems or inequities.**

  Compensatory time is tracked through the attendance process that also includes sick leave and vacation. Each county office has responsibility for approving and tracking earned and used time for each worker based in the county.

APPENDIX VIII

STATE AUDITOR OFFICE'S RESPONSE

The audit findings only highlight problems we found to be systemic and significant, and any examples used in the report were used for the purpose of illustrating the significant problems found. The overriding issues in the report identify significant breakdowns in quality controls and staff support. Stating the audit addressed anecdotal issues cannot dismiss the seriousness of these issues because they are systemic, and incidents will happen again if not corrected.

Although the Division did not state agreement or disagreement with the recommendations, their comments generally indicate agreement and they provided reasonable implementation dates. Some of their comments for corrective action are dependent upon receiving additional staffing. If this additional staffing is not received (and we support getting additional staffing) some corrective action as suggested by the audit will need to be taken. In this regard, we will follow-up with the Division to determine if they received the necessary staffing or if they have implemented interim corrective action. There are a few comments where the division neither agreed nor disagreed and therefore, we will also follow-up on them.

Recommendation 1.13. Send perpetrator notification letters by certified return receipt requested mail. The response stated that other states do not use certified return receipts and those that do, still get complaints that they were not received. The Division did not state whether they would or would not use certified return receipts. The point of the recommendation was to establish a cutoff time so late appeals do not have to be honored.

Recommendation 1.14. Redefine hotline unit criteria definitions for preventive service referral classifications to better allow for the best interest of the children to be served. The response stated that the Division provides better than average preventive services. This response misses the point. The recommendation is directly related to the incidents of categorizing cases as unable-to-investigate rather than considering preventive services; and that the cause for this action was that the Division had too narrow of an interpretation of what can be referred as preventive services.

Recommendations 2.2 and 2.3 address staffing allocation methodologies. The response stated that current practice and use of the Council on Accreditation standards satisfy the intent of our recommendations. In order for this to be true, the Division will have to acquire the staffing they need. In the absence of getting such staffing, our recommendations to develop staffing standards and contingency plans for allocating staff are still appropriate.

Recommendation 2.7. Provide increased financial compensation to workers who obtain advanced degrees or certifications. The response stated that the Division provides monetary assistance for social workers who want to obtain their Masters Degrees. However, it does not address the new hire social worker who already has a Masters Degree. By not providing additional salary compensation for individuals with higher-level degrees, the Division is vulnerable to turnover of their most qualified staff.