September 17, 2001

Members of the Health and Human Services Interim Committee
Members of the Child Welfare Legislative Oversight Panel
Utah State Capitol Bldg
Salt Lake City UT 84114

Subject: Child Welfare Referrals and Cases (Report 2001-08)

Dear Legislators:

In accordance with ***Utah Code*** 62A-4a-118, our office has conducted its annual audit of a sample of child welfare referrals to and cases handled by the Division of Child and Family Services (DCFS). Because of recent statutory changes, this report differs from our prior annual reviews of the Office of Services Review (OSR) by looking more directly at DCFS activities We examined a sub-sample of foster care cases included in OSR's case process review, looked at the removal process, reviewed caseworker training requirements, and reviewed OSR's qualitative review tool. The main conclusions of this report are

- case process review can benefit from caseworker involvement
- removal statistics raise concerns but process seems reasonable
- DCFS training delivery needs improvement
- qualitative review tool looks promising

Statutory Changes Direct New Audit Approach

The 2000 Legislature made a number of changes to the statutory section that requires this report. The Child Welfare Reform Act of 1994 required the Department of Human Services to annually review child welfare cases and required us to audit their review. Thus, we have completed regular audits of OSR since 1995. At the same time, the federal court has monitored the state's performance on child welfare cases under the *David C* lawsuit settlement agreement. Despite all the reviews, audits, and monitoring of child welfare

issues, there has been widespread perception that little improvement has occurred? Dissatisfaction with the pace of improvement at DCFS led the 2000 Legislature to change our responsibilities.

House Bill 175 (2000) included three important changes for us: First, the bill requires us to look more directly at child welfare issues, rather than completing an audit of the OSR review as previously required. Thus, the language directing us to "audit a sub-sample of the cases reviewed" by OSR was replaced by language directing us to "audit a sample of child welfare referrals to and cases handled" by DCFS. Second, the bill specifically added the word "removals" to the statute, indicating the great public interest in appropriately deciding whether to remove a child from its family. Third, the bill asks us to make "a determination regarding whether the department's review process is effecting beneficial change within the division."

Since House Bill 175 broadened the range of issues for us to review, we needed to limit the scope of our work to what we could complete in the time available. The areas that we included in this audit are described below.

Case Process Review. We audited a subsample of foster care cases included in OSR's case process review. We only audited foster care cases because OSR reported poorer performance and less improvement in foster care cases than other types of cases. In addition, our last review included CPS and in-home cases, but not foster care. We also discussed the results of OSR's case process review with individual workers who had responsibility for each case. Therefore, by choosing foster care, we wanted to determine why the scores are low and what feedback the caseworkers have received from the review process.

Removal Statistics and Procedure Review. We reviewed data on child removals from their families by DCFS, and we reviewed removal procedures because of recent public and legislative concern. As mentioned earlier, our responsibility to audit removals was specifically added to statute by the 2000 Legislature. It was beyond the scope of this audit to evaluate specific removal decisions, but we studied state policy on removals and looked at removal procedures in other states.

Caseworker Training. We reviewed some caseworker training issues because as we conducted our work, we were often told that caseworkers don't always receive adequate training before being assigned a full caseload. We interviewed foster care workers and CPS caseworkers to determine if caseworkers have received required training. Also, we wanted to ascertain what system DCFS has in place for tracking training hours to ensure that workers receive sufficient training to be proficient in their field.

Qualitative Case Review. In previous audits we have recommended that OSR develop a qualitative review. Now that it has been developed, we have been assessing it as part of our audit work.

Case Process Review Can Benefit From Caseworker Involvement

After reviewing a sample of foster care cases with the caseworkers, we believe that OSR would benefit from involving the caseworkers. By considering the caseworkers' perspective, OSR can improve the accuracy of the case process review, and their involvement may help the scores improve. Also, DCFS should review caseworker expectations to ensure the caseworkers' work load is manageable.

For the 2000 review, OSR scored 189 foster care cases for the review period July-December 1999. The case process review consists of 64 questions. OSR reviews the case file to determine whether specific procedural requirements are completed. From the scored foster care cases, 49 questions, or 76 percent, resulted in a lower score compared to the 1999 review. Ten questions, or 16 percent, resulted in a higher score, and there were 5 new questions that were added to the 2000 review. The targeted exit goal is 85 percent, but from the 2000 review, only 7 questions, or 11 percent, met or exceeded the exit goal.

Our prior audits have all found that OSR scoring is generally accurate and unbiased. OSR now checks its own work by having selected cases read a second time by a second staff to see if it is scored the same. We looked at OSR's internal double read scores of foster care cases and they were averaging a 96 percent agreement rate. In addition, the Child Welfare Policy and Practice Group (CWPPG) double reads a sample of OSR cases. CWPPG double read scores were averaging a 92 percent agreement rate.

In response to the legislative changes discussed earlier, and since the double read scores are consistent, we made some changes in our audit methods. We did not focus on our own assessment of the accuracy of OSR's scoring of cases. Instead, we interviewed the caseworker responsible for each case to get his or her reaction to OSR's review. Then, in each instance where case work did not meet standards, we discussed the reasons why the caseworker was not able to meet the standard. Similar to our prior audits, we limited our sample of foster care cases to two regions to increase the efficiency of our work. We sampled cases from the Salt Lake Valley Region and Eastern Region so we had a mix of cases from urban and rural areas of the state.

Besides discussing specific cases with some caseworkers, we sent out a mail survey to all foster care caseworkers in DCFS. The survey gave each caseworker the opportunity to express his or her view on the case process review instrument, the feedback from the process, and monthly visits. Thirty-five percent of the surveys were returned. From the survey there were four main issues that caseworkers addressed. They feel that caseloads are too high, a minimum of two visits per month is too many, there is too much paperwork, and overtime is necessary to do the job.

We Obtained Caseworker Responses To OSR Scores

Because of our concern with low scores and a lack of improvement in foster care case process review, we met with the caseworkers to focus on why questions were scored as "no" or "partial" (counted as a "no") by OSR. We also reviewed the questions scored "yes" to determine if the caseworkers agreed with those scores. If a caseworker felt the question was scored correctly but the score was a "no" or a "partial," then we asked the caseworker why the work pertaining to that question wasn't completed so we could determine why the foster care scores were low. If a caseworker felt a question was scored incorrectly, we gathered evidence from the case file and reviewed it with OSR to help us more thoroughly understand the requirements and the causes of the disagreements.

The 20 cases we sampled from the foster care case process review consisted of 875 scored questions. OSR scored 511 questions "yes" meeting the requirements for a performance rate of 58 percent. The number of scored questions varies per case because some questions are not applicable on some cases. Because 58 percent is a low performance rate, we focused on the 42 percent of questions that received a "no" or "partial" score. Of those 364 questions, we categorized the responses given by caseworkers as to why the score was a "no" or "partial" into three general areas:

- **Work Not Completed.** In 39 percent of the instances that OSR scored workers as not completing requirements, caseworkers acknowledged that they had not completed required work.

- **Work Completed but Not Documented.** In 31 percent of the instances, workers claimed they had completed required work, but they acknowledged it was not properly documented in the case file.

- **Thought Requirement Was Met.** In 30 percent of the instances, workers felt that they had adequately completed and documented required work. After discussing the cases with them, caseworkers sometimes realized they had not clearly understood the case process requirements, but in other instances they showed us documentation indicating that OSR had incorrectly scored the question.

Below is a summary of our foster care case sample. For each case, Figure 1 shows the caseworker's response to OSR's scoring that required case work was not completed.

Figure 1. Summary of our foster care case sample. We asked caseworkers to respond to each question scored by OSR. The figure lists the reasons why questions were scored no or partial.

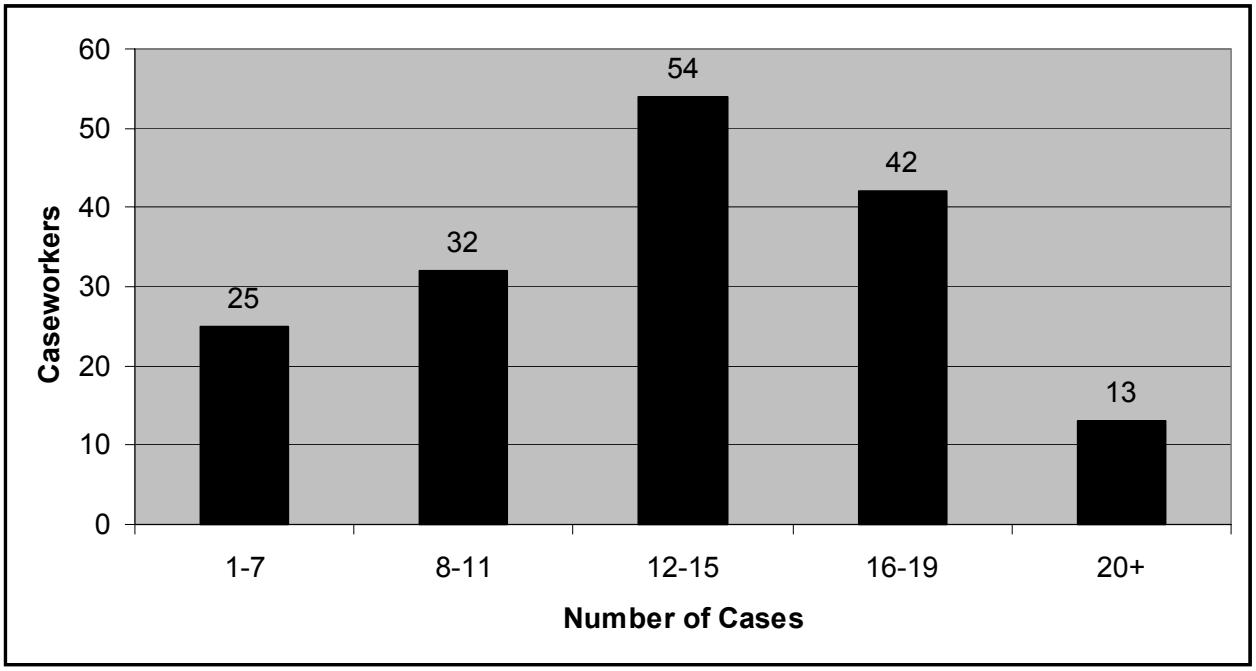
	OSR Case Process Review Results			Caseworker Response to No or Partial Scores		
Case	Applicable Questions	Yes Score	No or Partial Score	Work Not Completed	Work Completed But Not Documented	Thought Requirement Was Met
1	44	26	18	11	1	6
2	54	27	27	14	2	11
3	35	24	11	3	2	6
4	50	28	22	5	15	2
5	46	28	18	14	3	1
6	48	14	34	0	30	4
7	47	20	27	25	1	1
8	51	40	11	2	2	7
9	16	8	8	2	0	6
10	54	34	20	10	0	10
11	49	22	27	20	2	5
12	50	32	18	8	0	10
13	48	22	26	4	21	1
14	49	19	30	6	12	12
15	49	45	4	0	1	3
16	47	27	20	1	12	7
17	37	19	18	6	2	10
18	21	14	7	3	1	3
19	41	32	9	4	3	2
20	39	30	9	3	4	2
Totals	**875**	**511**	**364**	**141**	**114**	**109**

Caseworkers Express a Variety of Concerns

As we discussed specific cases and review questions with caseworkers, they raised many concerns. Five issues came up frequently.

Case Loads Are Too High. Most of the foster care workers we interviewed complained of high caseloads. The main reason that caseworkers are not able to complete the required work is the lack of time. Excluding workers with less than 8 cases, we calculated that the average caseload for foster care workers is approximately 15, but many workers have over 15 cases. As caseload increases, it becomes more difficult to complete all the required tasks. Some workers only have a few cases with other responsibilities and some workers are part-time, but of the foster care workers within the division that have 8 or more cases and at least 50 percent of their cases in foster care, 39 percent are assigned more than 15 cases as shown below in Figure 2.

Figure 2. Distribution of cases among foster care workers. Fifty-five workers have more than 15 cases. As caseloads increase it becomes more difficult for workers to complete required tasks.



Every foster care case is different and every child has different levels of needs. From our audit work, a majority of foster care workers believe that they do not have time to adequately manage each case, ensuring that children and families are being provided with appropriate services. When we interviewed caseworkers, many of them told us that they work over 40 hours a week in order to get more work completed. In contrast, several workers stated that if they had only 15 cases, it would be a manageable caseload to meet all the requirements including two child visits a month and the required paperwork.

Visit Policy Is Too Inflexible. DCFS policy requires foster care workers to visit children a minimum of twice a month, but that standard is seldom met. From our sample, only 15 percent of the caseworkers were able to make two visits for the entire review period (July through December). More caseworkers made the first visit, but they were not able to make the second visit. Caseworkers often said they did not have time to make all of their visits.

One foster care supervisor complained about the lack of flexibility associated with the required visits. A caseworker may have one child in a crisis situation who needs more than two visits a month. A situation can occur where a caseworker has another child that is stable and doing well in his or her placement, but hasn't had a second visit. The crisis child needs help now, but can a caseworker tell that child to wait because two visits have already occurred, and the stable child still needs a second visit?

Other comments from caseworkers regarding the two visits per month are illustrative. "I have had 17-36 cases. I don't have the time. Additionally, some families require more than two visits – some less." Another caseworker commented, "Most of my caseload is youth between 16-18 who lead very busy lives (i.e. going to school, working, keeping therapy appointments). It is sometimes hard to schedule more than 1 visit per month; however, I talk to most of them 10-15 times each month."

Some Case Process Requirements Aren't Clear. Caseworkers thought they understood what was required, but after interviewing workers, some realized they didn't clearly understand the requirements. From our review, we summarized some of their comments regarding the case process questions:

- I didn't know that I had to have two private conversations a month. I thought it was only one.

- I don't know what the out-of-home placement form is, or that it needed to be in the file.
- I don't understand the strengths question.
- I thought the strengths question was only for re-unification purposes.
- I didn't know I still needed to do a monthly visit if the child is placed in a home more than two hours away.
- I thought that if the child was over 16, it was up to their discretion to visit their parents.
- I thought the family team approach wasn't required to be documented for the 1999 review.

Caseworkers thought they understood the policy until we interviewed them. These examples show, however, that some caseworkers don't clearly understand policy, OSR requirements, and/or lack sufficient training.

OSR Scoring Isn't Always Reasonable. Caseworkers feel that the case process review expectations are not always reasonable. If caseworkers make reasonable efforts to ensure that children and families are receiving adequate and appropriate services, then they feel they should receive credit for that work.

One question in the case process review is currently worded "Did the worker initiate services for the family/child as identified in the service plans which are current during the review period?" On one case that question was scored "partial" by OSR even though the worker felt she had not only initiated services but also actively encouraged the parent to follow-through on objectives in the plan. From the caseworker's perspective, how can she compel a parent to abide by the service plan? While OSR scored this question "partial" (which is equivalent to a "no"), the caseworker felt that the question should have been scored "yes." Caseworkers feel that some of the scoring guidelines are set at such a high standard that caseworkers are not able to comply with the fulfillment of all the individual requirements in every case.

Some Questions Are Scored Incorrectly. Caseworkers pointed out that for some of the questions the caseworker did meet the requirements, but OSR had scored the questions incorrectly—a reviewer error. In a number of instances, the caseworker showed us documentation in the case file that supported their claim. In discussing reviewer errors with OSR staff, we were occasionally told that documentation in the files can be missed by the

reviewer. On the other hand, sometimes caseworkers said that OSR had scored questions incorrectly, but we later determined that OSR had actually scored the questions correctly.

In summary, when we discussed the case process review scores of specific cases with caseworkers, they expressed a variety of concerns. Some of their concerns dealt with the reasonableness of performance expectations given existing workloads. While it was beyond the scope of this audit to evaluate those concerns, we feel DCFS should review caseworker expectations as discussed later. Other caseworker concerns either involved a misunderstanding about specific procedural requirements or a disagreement about how OSR scored their cases. As discussed in the next section, we feel OSR should consider redesigning the case process review to address valid caseworker concerns.

OSR Should Redesign the Case Process Review

We question if the case process review (CPR), as currently structured is effective. ***Utah Code*** directs us to determine "whether the department's review process is effecting beneficial change within the division and accomplishing the mission established by the Legislature and the department for that review." Despite all the effort and resources put into the case process review, it does not appear to foster improvements or meet current legislative intent for the review. One option to consider is to eliminate the CPR and rely on the qualitative case review (discussed later) instead to test for performance and outcomes. Alternatively, the CPR could be scaled back and combined with the QCR. At the very least, we think OSR needs to restructure the review by involving caseworkers in the review process.

Usefulness of Case Process Review Is Questionable. According to the Milestone Plan, OSR conducts case process reviews in compliance with ***Utah Code***. However, with the changes made by the 2000 Legislature, we don't feel the CPR adequately meets the statutory intent of the review. However, OSR feels the CPR provides valuable information that contributes to casework improvements.

According to statute as amended in 2000, the purpose of the OSR review is "to assess whether the division is adequately protecting children and providing appropriate services to families." In addition, "the review shall focus directly on the outcome of cases to children and families, and not simply on procedural compliance with specified criteria." The focus of the CPR, however, is on procedural compliance. The review relies solely on case file documentation to determine whether prescribed case practices are completed. In addition,

the CPR is quite limited in its ability to completely reflect system performance and may not accurately reflect caseworker performance. In contrast, OSR's qualitative case review discussed in the last section of this report appears to evaluate system performance much more effectively and directly as well as child and family outcomes.

The continued low scores in foster care also indicate that the CPR is not promoting improvement by the division. As discussed earlier, many caseworkers we spoke with expressed a variety of concerns with the CPR scores we showed them. In addition to having limited knowledge about the review, a majority of the caseworkers did not seem to feel the scores were very important. Most caseworkers are just trying to keep up with the daily demands of their jobs. In addition, as we stated in our 1995 and 1998 reports, and as we re-confirmed during this review, the compliance score "does not necessarily relate to how well the worker protected the child, provided services, or preserved the family." If the case process review is going to continue to be used, then we feel OSR and DCFS need to re-examine how it is conducted to make it more meaningful to caseworkers.

While OSR agrees that improvements are possible, they feel the CPR provides important information. Because the CPR includes a large number of cases, OSR feels it allows the division to focus on individual workers and teams. OSR staff also state that just because there has not been improvement in the CPR scores, it doesn't mean the CPR has not been successful in improving performance. They feel more time is needed to know if the CPR is helping improve casework practices.

OSR Should Include Caseworkers in Their Review. If the case process review is going to continue, then the review process can be strengthened by including the caseworkers in the review process. Including caseworkers can be beneficial to both DCFS and OSR. Caseworkers should receive feedback soon after the cases are scored by OSR, and OSR should give caseworkers the opportunity to respond to the scoring. If caseworkers, are included, they will be able to improve their performance, and OSR will be able to receive feedback, which may help reduce scoring errors and improve OSR's accuracy.

In the 1998 audit of OSR, we stated that a weakness of the review process was that it only utilized one source of information: child welfare case files, however complete or incomplete they were. Basing reviews on other sources of information, such as interviews with the caseworker, would provide broader, more insightful information and would help reviewers assess overall caseworker performance more accurately.

When the casework is completed but it is not documented in the case file, OSR scores those questions "no." However, not having the documentation completed and placed in the case file does not necessarily indicate that the work was not completed. For example, from our interview with a foster care worker, we learned that one case had a previous caseworker who had quit. The current worker said that the previous worker had completed most of the work but had not documented it before quitting.

We found that caseworkers and supervisors provided important information and an additional perspective that helped us reach a better conclusion about the quality of casework. Again, for the 2000 audit we raise the question: shouldn't OSR interview at least the caseworker to determine if the work was completed and/or give the caseworker an opportunity to respond to the scored case?

Utah Code 62A-4a-118 states "information obtained as a result of the review shall be provided to caseworkers, supervisors, and division personnel involved in the respective cases for the purpose of education, training, and performance evaluation." In accordance with the statute, we feel that caseworkers should receive a copy of the scores along with specific feedback immediately after the scoring of their case. This way the feedback is relevant, caseworkers can see the areas for improvement, and they can correct their mistakes. One caseworker said "The feedback should be provided as soon as OSR finishes with the case review, so the caseworker can implement the suggestions."

If workers receive a copy of the scores immediately following the review and are given the opportunity to respond to OSR, scores may improve. OSR may have made a mistake scoring, or they may not understand a complex situation involved with the case. One caseworker said, "It is good to have the opportunity to voice my opinion if I disagree." By giving workers an opportunity to respond, OSR could look into the disagreements and make sure the cases were scored accurately. If caseworkers promptly respond to OSR and errors are discovered, then those changes can be reflected in the review scores.

DCFS Should Review Caseworker Expectations

We found that many foster care workers are not able to complete or document all their work. A workload analysis should be conducted to determine the appropriate workload standards. The workload analysis should include a review of the foster child visit policy.

DCFS Should Conduct a Workload Analysis. DCFS officials and the Child Welfare Policy and Practice Group (CWPPG) have stated that Utah has low caseloads compared to other states, but caseload is not equal to workload, and it is difficult to compare caseloads between states. However, the more significant questions to be considered are: given the required workload, what should the caseload limit in Utah be; and is the currently required workload necessary to generate good casework and good outcomes? In other words, is the division allocating their resources efficiently?

The Child Welfare League of America (COLA) recommends that every agency conduct a workload analysis to determine the appropriate workload standards. Workload standards developed for caseworkers should be based on the tasks and activities expected within the division. COLA also recommends that the majority of the caseworker's time should be spent in direct contact with families. Caseload size should allow the caseworker to spend enough time with families to help them achieve their goals within the time limitations of service.

We calculated a rough estimate showing that full-time foster care workers spend about 73 percent of their time towards case management activities, which means that if a caseworker has 15 cases, then he or she has about 8 hours of time per case per month for case management activities. This time does not include training or staff/administrative meetings. Case management time does include: two monthly visits and the travel time to make those visits, court time, foster care citizen review board time, qualitative review, utilization review, meetings with the out-of-home providers, the parents, guardian ad litem, therapists, educational representatives, other parties as needed, and the worker overseeing medical, dental, and mental health needs of the child. Case management time also includes the paperwork. One supervisor commented that "80 percent of the job is paperwork." Paperwork can include typing activity logs, service plans, progress reports, and filling out various forms such as foster care payment forms and social security forms.

Paperwork adds to the increase in the workload. Caseworkers in foster care need help to keep up with their paperwork. In one region the administration has hired a number of support staff; they are helpful in alleviating caseworkers from some of their paperwork responsibilities. To find solutions to the challenges with paperwork, DCFS management needs to look into finding ways to add supportive resources. Perhaps additional use of support staff or better use of available technology could reduce the time caseworkers spend with paperwork and increase the time they spend with foster children and their families.

Visit Policy Should Be Reviewed. We were told by DCFS officials that a minimum of two visits per month is required to help reduce risk. We contacted some other states to find out their minimum requirement. Of the ten states we studied, none had their monthly visitation requirements as high as the state of Utah. Six states said their minium requirement for visitations was once every 30 days. One state said once every 45 days, two states said one visit every 90 days, and one state didn't have a specific requirement.

Some states assign a risk factor to families/children to more accurately give agencies and caseworkers the ability to target service resources more efficiently. Low risk families/ children need not receive the same amount of resources as high risk families. This method helps some states make existing service resources reach farther and produce better outcomes.

Of the two visits required in Utah, one visit must occur in the child's out-of-home placement. The results from the 2000 OSR review, as shown in Figure 3 below, indicate that the highest percentage of visits in the out-of-home placement for the review period was 75 percent.

Figure 3. Distribution of the Home Visits for the 2000 OSR Review. Did the worker visit the child in his/her out-of-home placement at least once during each month of the review period?

Month	Sample	Yes	No	Performance Rate
One	165	120	45	72.7%
Two	169	127	42	75.1
Three	171	126	45	73.7
Four	172	115	57	66.9
Five	170	121	49	71.2
Six	164	108	56	65.9

For the second monthly visitation the highest percentage of visits was 69 percent. The statewide average for the second visit is 61 percent (see Figure 4).

Figure 4. Distribution of the Second Monthly Visit for the 2000 OSR Review.
Did the Worker visit the child at least twice during each month of the review period?

Month	Sample	Yes	No	Performance Rate
One	168	108	60	64.3%
Two	172	120	52	69.8
Three	174	108	66	62.1
Four	176	103	73	58.5
Five	180	107	73	59.4
Six	172	89	83	51.7

If DCFS is going to continue to require caseworkers to make two visits a month, the division needs to take steps to develop workload standards and allocate resources so that two quality visits are made. Otherwise DCFS should take other measures to ensure that all foster care children are receiving regular visits. Such measures may mean giving caseworkers some flexibility and allowing them to make some judgements so that caseworkers have quality time with the children and families to help them achieve their goals.

Another issue that surfaced while reviewing cases with foster care workers is that caseworkers have to travel long distances to complete their child visits. Caseworkers will often have one or more children placed in a foster home or in a residential placement outside their region. One worker commented, "I have children all the way from St. George to Bountiful and a few in the middle." It is very time consuming for caseworkers to visit children in distant placements. We asked some foster care workers the number of miles that they travel in a month. They averaged about 500 miles/26 hours of travel time. If a caseworker is located in the Salt Lake Valley Region and has a child placed in Provo or Ogden, then he or she is required to visit that child personally. But when a child is placed more than a 100 miles away, the caseworker can apply for a courtesy worker to make the visits for him or her. However, foster care supervisors have mixed feelings about using courtesy workers; we have been told that some courtesy workers are more responsible than others.

Removal Statistics Raise Concerns But Removal Process Seems Reasonable

As part of this audit, we conducted a limited review of the removal process in DCFS because of public and legislative concern. We reviewed the removal process and removal statistics, but we did not make a determination whether children were appropriately removed or not. In our opinion the ***Utah Code*** and DCFS policy manual clearly outline the removal process. DCFS has some internal controls in place to monitor removals to help ensure that appropriate removal decisions are made. Two offices, Office of Services Review and the Office of Child Protective Ombudsman, review removals. The removal statistics, however, show some rate of removal inconsistency from caseworker to caseworker, which needs to be monitored by DCFS.

Removal Statistics Appear To Show Some Inconsistency

We are concerned about the differences in referral, investigation, and removal statistics among caseworkers and among regions. We found wide variances in percentages between the highest and the lowest removing CPS workers. We obtained data that shows some regional differences. For example, the Northern Region has many more unaccepted referrals than other regions. These variances may be due to external factors, regional differences, or other circumstances that are beyond the control of the division.

Caseworker Statistics Show Inconsistency. We used data obtained from DCFS that shows the number of removals by caseworker. We specifically looked at the caseload and the number of cases removed for 205 CPS workers for calendar year 2000. The way that CPS investigations are assigned to caseworkers vary by office. In a rural office there may be only one CPS worker, so the worker would be assigned all of the cases. In an urban office the CPS workers may be assigned cases on a rotational basis. Also, a supervisor may assign complicated cases to proficient workers whom he or she feels can handle the cases. Figure 5 shows the 10 highest removing CPS workers who had at least 10 cases removed during 2000. Their percentages of removal vary from 43 to 12 percent, which is much higher than the state average of six percent.

Figure 5. The 10 CPS workers with the highest removal percentages, and who have removed at least 10 cases. The data is for calendar year 2000.

CPS Worker	Number of Removals	Number of Cases	Percentage of Removals
1	10	23	43.5%
2	22	67	32.8
3	24	106	22.6
4	25	116	21.6
5	27	146	18.5
6	12	67	17.9
7	25	160	15.6
8	13	96	13.5
9	20	154	13.0
10	13	110	11.8
Averages	19	105	18.2%
State Average			6.0%

On the other hand, we noticed another group of CPS workers who seemed to be less likely to remove children. Figure 6 below presents the 10 CPS workers who investigated at least 100 cases during calendar year 2000 and had the least removal percentages. Their removal rates, which vary between less than one and less than two percent, seem quite low when compared to the state average of six percent. We don't know why some workers have such low removal percentages while other have much higher percentages, but we do not think it results from case assignment practices. Additional study is needed to determine the reasons for the differences.

Figure 6. The 10 CPS workers with the lowest removal percentages, and who have investigated at least 100 cases. The data is for calendar year 2000.

CPS Worker	Number of Removals	Number of Cases	Percentage of Removals
1	1	158	0.6%
2	1	151	0.7
3	1	143	0.7
4	1	117	0.9
5	1	112	0.9
6	1	105	1.0
7	2	171	1.2
8	2	170	1.2
9	2	132	1.5
10	2	124	1.6
Averages	1.4	138	1.0%
State Average			6.0%

Regional Statistics Show Inconsistency. We also obtained data that shows the number of referrals, investigations, and removals by region made in calendar year 2000. Figure 7 shows the regional data on a per 1,000 child basis.

Figure 7. Referral, Investigation, and Removals by Region. Data is per 1,000 children for calendar year 2000.

	Regions					
Description	North	East	West	Southwest	Salt Lake	State Average
Unaccepted Referrals	19	8	9	5	5	10
Accepted Referrals	21	29	15	25	29	24
Substantiated	8	11	5	8	10	8
Unsubstantiated	12	18	10	17	18	15
Removals from CPS Investigation	2.3	2.7	1.7	2.1	2.8	2.2

The region with the highest number of removals from CPS investigations, based on population, is Salt Lake Valley Region (2.8 children removed per every 1,000 children). The region with the lowest number of removals, based on population, is Western region (1.7 children removed per every 1,000 children). Some differences in the number of removals could result from Western region's pilot program called the Family Assessment Program that is described in ***Utah Code*** 62A-4a-202.7. This program requires a family assessment rather than a CPS investigation for referrals that meet certain criteria outlined in ***Utah Code***. It was beyond the scope of our audit to try to determine the reasons for the differences in removals.

The data in Figure 7 also shows regional differences in the number of unacceptable referrals. We are concerned the number of unaccepted referrals for Northern Region is almost twice as high as the state average. We weren't able to investigate the reasons, but DCFS needs to look into the high number of unaccepted referrals.

Utah Code and DCFS Policy Outline Removal Procedures

Although removal statistics raise some concerns, the removal process seems to be well defined in the ***Utah Code*** and in DCFS policy. The removal process also has some internal safeguards in place that help ensure good decisions are made. For example, a safety

assessment tool is used by CPS caseworkers to help guide their decision-making; the assessment tool is similar to those used in other states.

The ***Utah Code*** 62A-4a-202.2 clearly states what information is required to give the parents upon the removal of the child (i.e., notice of the removal, reason for the removal, information regarding parents' right to counsel, information regarding what happens when a child is removed from parents' care, information regarding parents' obligation to pay support, and a telephone number for parents to access further information). We obtained seven packets of information that caseworkers give parents from different offices of DCFS in varying regions of the states. In our opinion, even though the forms may be slightly different, the information given to the parents is consistent and meets the requirements of the law.

Child Welfare Manual Provides Detailed Guidelines to CPS Caseworkers. The manual adequately defines what constitutes abuse, neglect, abandonment, dependency, and emotional maltreatment. The manual describes the intake process and how to classify referrals into priority time frames. It describes the procedure to investigate different types of referrals and how caseworkers should staff cases. The manual describes procedures for emergency situations. It describes the 24-hour multi-disciplinary team staffing and the shelter hearing procedures. The manual also explains the legal rights of children and parents.

Removal Process Has Internal Safeguards. DCFS has some steps in place to help ensure that a child is not removed inappropriately. We realize, however, that no system guarantees a child will not be removed or left in the home inappropriately. Internal safeguards include:

- **Immediate Protection Check-list.** This form is used by caseworkers to help determine the safety of the child and has two sections. The first section lists 13 safety/harm indicators. These indicators are of a serious nature and are assessed by the caseworker during the initial visit. An example of these indicators is "a young child is left alone or substitute caretaker is incapable of caring for child's needs; child is unable to protect self." If caseworkers determine during the initial investigation that one or more of those indicators is present, then caseworkers are required to staff the case with the supervisor and discuss the situation and the children's safety. The second section lists 14 safety/harm factors. These factors are less serious and may indicate that the child is not safe. An example of a factor is "previous incident of

abuse or neglect." If three or more factors are present in the investigation, then caseworkers are required to staff the case.

- **Staffing a Case.** The CPS caseworker does the initial investigation. If the caseworker determines the current situation is unsafe, then the worker staffs the case by contacting their supervisor and/or a family services specialist. Sometimes the staff also talks with an assistant attorney general (AG), and a family preservation worker. The decision to remove is not solely made by the caseworker because the worker staffs the case before a child can be removed; however, the caseworker usually does the initial investigation alone and staffs the case over the phone.

- **24 Hour Multi-disciplinary Team.** According to the ***Utah Code***, the team consists of the removing caseworker; the caseworker assigned to the case; a representative of the school or school district; the peace officer who removed the child from the home; a representative of the appropriate Children's Justice Center, if one is established within the county where the child resides; if appropriate and known to the division, a therapist or counselor who is familiar with the child's circumstances; and any other individuals as determined to be appropriate and necessary. From the team meetings we observed the AG, guardian ad litem (GAL), foster care coordinator, a mental health representative, removing caseworker, and the caseworker's supervisor were the key members of the team. The team must meet within 24 hours after a child has been removed to develop a plan of action.

- **Shelter Hearing.** A judge makes an initial decision whether children should be returned to the parents or remain in the custody of the state based on the evidence that has been gathered. If parents disagree with the decision of the judge, the case can go to trial.

Even though some controls are in place to help ensure that children are adequately protected, if caseworkers don't have reasonable workloads, adequate training, and proper supervision, then the controls won't be effective in adequately protecting children and providing appropriate services.

Other States Use Similar Assessment Tools. We contacted six states to ascertain how other CPS offices assessed the safety of the children. We found that five states are using a safety assessment, which is part of the structured decision making system developed in the early 1990s. This tool places children in one of three categories: unsafe, conditionally safe,

and safe. The safety assessment tool is similar to DCFS's Immediate Protection Check-List, which helps CPS caseworkers assess the safety of the children. One state we contacted is using the Family Decision Making Model. According to this model the family risk assessment is the structured methodology to gather information for all major decision making, such as initial assessments, case planning, and removals. The assessment tools that other states use as well as those used by DCFS are intended to help caseworkers assess safety, but they do not make the decision for them on whether to remove children from the home.

Offices Outside DCFS Monitor Removals

Besides the internal controls to help determine appropriate removals, there are also offices outside the division that monitor removals within the Department of Human Services.

OSR Has Begun Removal Study. OSR took a sample of 60 cases where the children were removed from their homes in 2000 and obtained the judges' orders on all of those cases. One of the cases was a postponement, but of those 59 cases where they had obtained the judges' orders, in one case the judge returned the child to the home. OSR is going to continue to take a sample of removals and report the number of cases where the judge disagreed with DCFS removal of children from the home.

Office of Child Protection Ombudsman Reviews Removals. The Office of Child Protection Ombudsman (CPO) received complaints in 2000 that CPS investigations in the Salt Lake Valley Region were resulting in the failure to remove children at risk. They investigated 113 cases; of those, 40 cases were referred to DCFS for reconsideration. Five of those cases were re-opened for investigation. At the time of this report CPO didn't know the end result of those five investigations. Among those 113 cases, we know of two cases where the children were removed based on subsequent events.

In one of the cases the CPO investigated, the child was removed, but CPO felt that it was more detrimental to remove that child rather than to provide services within the home. The judge had ordered the child to be removed, so CPO is concerned that OSR has only used the judges' orders to determine if a child was appropriately removed. CPO doesn't specifically track whether the removal was appropriate, but they do track cases with delayed or inaccurate assessments that result in inadequate intervention and cases with critical decisions such as removal, placement, and permanency which were made without the input

of the child, family, providers, and/or other stakeholders. From the reporting period of July 1, 2000 through June 20, 2001, CPO conducted 144 investigations. They were concerned with 28 cases with delayed or inaccurate assessments that resulted in inadequate intervention or poor permanency planning.

Additional Study of Removals Is Needed

The limited scope of this review did not include investigating the reasons for inconsistent removal statistics among caseworkers and among regions, and as a result we feel additional research is needed. The decision of whether to remove a child from his or her family is so important that every effort to ensure good decisions needs to be made. Legislative guidance and department policy provide a good framework to CPS workers. However, the inconsistent statistics cause concern. Some inconsistency may simply result from different data collection and reporting practices. We feel that DCFS should analyze the reasons for the differences among caseworkers and regions. Alternatively, we could focus on removals and conduct an in-depth audit of this area in our next review if requested.

Training Delivery Needs To Be Improved

DCFS realizes its training program is not sufficient, and they are working to make improvements. ***Utah Code*** requires that new workers receive core training plus on-the-job training before being assigned full case loads. However, caseworkers and administrators admit that new employees don't always receive required training before being assigned full case loads. Other reasons that new workers may not receive needed training include high turnover of caseworkers and the division's efforts to develop and deliver practice model training. As DCFS works to improve its training program, we feel it needs to develop a state-wide, uniform system for tracking caseworkers' training hours.

Some Caseworkers Lack Sufficient Training

A majority of the newly hired workers in foster care and CPS have not received the required training before assuming significant independent casework responsibilities. We interviewed 18 foster care and CPS workers who have been with DCFS for 12 months or less. We found that 13 of them (or 78 percent) did not meet the training requirement for new caseworkers as prescribed in ***Utah Code***.

Utah Code requires new employees to receive core training plus on-the-job training before assuming significant case load responsibilities. Section 62A-4a-107 of ***Utah Code*** states: "Any child welfare worker who is employed by the division for the first time after July 1, 1999, shall, before assuming significant independent casework responsibilities, successfully complete the core curriculum and on-the-job training that consists of observing and accompanying at least two capable and experienced child welfare workers as they perform work-related functions."

Core training is an introduction to the concepts and basic knowledge of child welfare, consisting of four modules of 32 hours each. DCFS staff recommend caseworkers complete the core training within three months, but they can take up to year. However, DCFS staff recognize there are CPS caseworkers with significant workloads, who have not yet completed the core curriculum.

In foster care we interviewed 10 newly-hired caseworkers. We found that eight of them did not have the appropriate on-the-job training. One of the eight had not completed core training. As required by ***Utah Code***, new workers, depending on their experience, should be assigned to shadow at least two experienced welfare workers (mentors) for two to three months before "assuming significant independent casework responsibilities." We found that many workers never got the mentioning experience as required by the Legislature. Some workers were never assigned to any mentors, others have had only one mentor, and others had a very short time (only a day or a week) to learn from their experienced mentors before assuming significant independent caseloads.

In CPS we interviewed eight new workers. Of them, five lacked the required training. Three workers had not completed core training, and two had not had the on-the-job training. Some of the new employees have taken the core training as part of their college studies, but three of them have not yet completed core training and are already carrying loads of 15-16 cases. Two of these workers from different offices said they did not know about the core curriculum when they were first hired; after they learned of the training, they asked their supervisors to sign them up for the training.

DCFS Is Working to Improve its Training Program. The division is in a development phase of training. We have been told that DCFS is in the process of hiring six new training coordinators one staff for each region and one staff for the state office. The training staff is going to be developing a training curriculum and tracking new employee training. OSR will also be training new employees on the case process review.

Currently, a major focus of DCFS's training effort is developing and delivering practice model training. The practice model training is designed to implement the Milestone Plan which was developed under federal court supervision and has been adopted by DCFS as its strategic plan. Because division's training resources have been focusing on the practice model training, other training areas and tracking caseworker training have not received needed attention.

Another factor that makes it difficult to adequately train caseworkers is high turnover. We found that approximately 60 percent of the caseworkers whom we wanted to interview from our original foster care sample were no longer with DCFS. We have been told by DCFS that it takes about 18 months to 2 years for a caseworker to become proficient in the field, but the high turn-over is a barrier to developing proficient caseworkers.

During the training period, caseworkers should not have full caseloads until they are proficient in the field. The division is developing a building block appropriation request for 37 trainee FT. DCFS should hire enough new caseworkers to handle the workload so that new workers are not placed into full load status before they are ready. If caseworkers are provided adequate training, they will provide children and families with better services.

Statewide Uniform System for Tracking Training Hours Is Needed

DCFS needs a tracking system to make sure that caseworkers receive required training. According to ***Utah Code*** 62A-4a-107(1), the division's Child Welfare Training Coordinator shall "develop child welfare curriculum" and "monitor staff compliance with division training requirements and individual training plans." However, we were unable to obtain any information about specific caseworker's completion of core curriculum or on-the-job training from the division level staff.

Currently, there are several different systems used by DCFS regions to keep track of the training hours of their employees. This variation makes it difficult to exchange information between regions and be monitored on a state level. The training information is now gathered by a regional training manager, and it is used in the particular region only. The training managers do not keep track of the on-the-job training (mentioning) of the new workers. This tracking is left to the supervisors. DCFS needs to keep track of caseworker training to ensure they receive sufficient training to adequately perform their jobs.

Qualitative Review Tool Looks Promising

OSR has been developing a qualitative case review (QCR) process that has many strengths and appears to be more useful than the case process review discussed earlier. QCR directly evaluates whether DCFS is achieving desired outcomes for children and families rather than focusing on compliance with procedures and file documentation. The QCR communicates to caseworkers that focusing on the mission of the child welfare system is vital and may also provide policymakers the information they need to determine how effectively the child welfare system is working.

The QCR tool for foster care and in-home was pilot tested on few cases in all the regions in 1999. Some adjustments and revisions were made before the tool was used for the 2000 review. For the 2000 review, twenty-four cases in each region were selected. A team of reviewers interviewed those parties familiar with the case, including the child, the natural parents, caseworker, therapist, teacher, guardian ad litem, etc. Based on the interviews, the reviewers score system performance and outcomes. The QCR concludes with debriefing and an exit conference. The purpose of the exiting process is to summarize the findings and give constructive feedback to the caseworker, supervisor, regional director, and other administrators. The QCR process takes about two-and-a-half days to complete for each case. OSR is working to develop a QCR process for CPS cases.

QCR Process Has Many Strengths

As part of our audit work, we have participated in the QCR for the past two years. Based on our observations and interviews, we feel that the QCR process has many strengths, especially its focus on the outcomes for children and families. Through interviewing the different parties, the reviewers gain a well-rounded view of the case. The individuals involved in each case share information with the reviewers that might not be known otherwise. Since the review involves the community, it may help create support and additional resources for the children and their families. Reviewers also provide immediate feedback to caseworkers, supervisors, and division administrators that may help them improve services. The drawback of the QCR is the expense involved in such an in-depth review of cases.

QCR Appears More Useful Than the Case Process Review. As mentioned earlier, it's not clear that the case process review is helping improve the child welfare system. In

fact, as discussed in the first section of this letter, we question whether the case process should be continued if it is not redesigned. In contrast, the QCR appears to provide more valuable information both to caseworkers and policymakers.

Because the QCR is thorough and provides caseworkers specific feedback about individual cases, it fosters system improvements. The majority of the caseworkers we interviewed were positive about the QCR process as a whole. For example, one worker said, "It is much more helpful than the case process review. The reviewers get the real picture of what is happening in the case. The reviewers give specific and constructive feedback, telling the caseworker how to improve."

The QCR may also provide useful information to policymakers. According to ***Utah Code*** 62A-4a-118, the OSR review "shall focus directly on the outcome of cases to children and families, and not simply on procedural compliance with specified criteria." The QCR provides information on outcomes as opposed to the case process review which focuses on procedural compliance. For example, the QCR assesses the long-term view of the child and family. A long-term view guides strategic vision, anticipating and defining what the child must have, know, and be able to do in order to be successful following a major developmental or placement transition. Another example is the review of the child's learning progress. The ultimate concern is whether the child is learning and progressing at a rate that will enable him/her to become a responsible, competent, contributing citizen upon completion of public school.

QCR for CPS Is Being Developed and Pilot Tested. Most recently OSR has been working on creating and pilot testing a protocol for assessing CPS investigations in a qualitative manner. The first tests were conducted this year in two regions, and as of June 2001, a total of fifteen cases have been reviewed. The new tool focuses on three main areas: safety, risk assessment, and services provided.

OSR has chosen to use two different approaches to the CPS qualitative review process—one entails shadowing the CPS workers on actual investigations and the other one involves interviewing participants. For the shadowing part the reviewer followed a CPS caseworker on actual interviews with children and their families. The reviewer then followed the investigation on division's computer program until the case was closed. The interviewing part of the CPS qualitative review is similar to the qualitative case review process for in-home and foster care. The reviewers study the file and then interview the main participants, i.e. the CPS caseworker, the ongoing caseworker, the supervisor, the

parents, the referent, etc. The reviewers then rate the three main areas on a scale of one to six. Similar to the QCR for foster and in-home care, the CPS qualitative review ends with an exit interview with the caseworkers and a regional exit conference. At the end of the process, the reviewers write up a one-page summary of the case and present it to the regional director. OSR plans to administer the CPS qualitative review on the same schedule as the QCR for foster and in-home care and have a combined exit conference.

Recommendations:

1. We recommend that OSR provide caseworkers with the results of the scored cases from the case process review as soon as OSR has completed the scoring and give the caseworkers an opportunity to respond.

2. We recommend that OSR review the structure of the case process review instrument and design the questions and scoring guidelines to accurately reflect the purpose of the review.

3. We recommend that DCFS conduct a workload analysis to determine the appropriate workload standards for the caseworkers and review the needed number of child visits by caseworkers.

4. We recommend that DCFS monitor removals by caseworker and investigate the reasons some workers have very high or low removal rates.

5. We recommend that DCFS develop a state-wide, uniform system to monitor caseworker training to ensure that caseworkers receive adequate training.

We hope this letter addresses your concerns in this area. If you would like additional information, please feel free to contact our office.

Sincerely,

Wayne L. Welsh
Auditor General

WLW:WDK/lm

Agency Response

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September 11, 2001

Wayne L. Welsh
Auditor General
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130 State Capitol
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Dear Mr. Welsh:

We have received the Office of Legislative Auditor General's annual audit of child welfare referrals to and cases handled by the Division of Child and Family Services. We have had a brief time to study and discuss, with a small group, the analysis and recommendations that were provided. I want to express the positive sentiments, of those that have seen the report, for auditors that looked intensely into the daily work of front-line child welfare staff and gave them the opportunity to express their views about their work. The report reflects what we know are real issues to be studied and addressed by the two administrations involved in the report (Child and Family Services and the Services Review) and the Department of Human Services. It was refreshing, although always daunting, to read an accurate account of the dilemmas faced daily by child welfare staff. Please express our appreciation to Wayne Kid and Rick Coleman for bringing realities of our work to light in this report.

One overarching goal of Child and Family Services this legislative year is to obtain a building block for the thirty-seven trainee positions, as mentioned and supported in the report, we firmly believe that if staff have better training and mentoring before assuming the complex duties of child welfare, then they will be able to better understand their assignments, be more equipped to manage their work, and the load on existing staff will stay more constant and manageable. As stated in this response, there are other enhancements that Child and Family Services must make, but this one additional resource of trainee positions could alleviate many of the concerns expressed in the report.

We will respond to the report by using the recommendations as the outline for our responses. Responding to the recommendations provides adequate opportunity for addressing the conclusions drawn in the audit and for presenting plans for needed improvements that were identified in the report. As noted below, recommendations were made specifically to either Child and Family Services or Services Review. Recommendations one and two were responded to by Services Review and recommendations three, four and five were responded to by Child and Family Services.

Auditors' Recommendation #1:

"We recommend that OSR provide caseworkers with results of the scored cases from the case process review (CPR) as soon as OSR has completed the scoring and give the caseworker an opportunity to respond."

Division's Response to Recommendation #1:

The Division agrees with this recommendation and the Auditor's analysis, which led to the recommendation for the following reasons:

a. Several of OSR reviewers are former Division caseworkers who could use the caseworker response time as mentoring opportunities. Caseworkers could benefit from the reviewers past casework experience, but also from the knowledge the reviewer gains from reviewing other case files. The OSR reviewer could pass on the best caseworker practices they see, to each caseworker that has a file reviewed.

b. The report points out that a weakness in the case process review is that it's only source of information is the case file. This fact has led the Division and OSR to develop training that helps train workers to pass the CPR. This training teaches caseworkers to include specific words in their documentation such as "interviewed the child alone." These specific words help OSR find the specific requirement to interview a foster child outside the presence of the foster parent once a month. Without these words the OSR may miss the requirement if the worker documents some like "asked the child about the conditions of the foster home while driving the child to visit their parents." Core Training, Practice Model Training, Mentoring, Targeted Case Management, and SAFE computer training are all training requirements the Division is providing to caseworkers. A mentoring type training response would be a much more efficient and effective method of improving the quality of casework and improving how that casework is documented.

c. If OSR were to include caseworkers in their reviews, both OSR and the caseworkers would receive immediate feedback on whether the questions on review tools clearly express the type of activity required of the caseworker. If OSR found that caseworkers were interpreting a question to require a different activity than OSR intended, OSR could restate the question clarifying it meaning.

We recommend that OSR provide caseworkers with results of the scored cases from the case process review as soon as OSR has completed the scoring and give the caseworker an opportunity to respond.

OSR believes this is an excellent suggestion. Implementing this suggestion will not only give us another check on the accuracy of our scores, it will also provide the opportunity to train caseworkers on the requirements. OSR will work closely with the regions so that when a reviewer is in the field reading a case, the appropriate caseworker will likewise be available to receive feedback. At this meeting with the caseworker, our reviewer can give the caseworker suggestions on what has worked in other regions, review the policies and guidelines and refer the caseworker to other sources for help if needed. Hopefully, if the caseworker implements these suggestions, performance will improve.

Auditors' Recommendation #2:

"We recommend that OSR review the structure of the case process review CPR instrument and design the questions and scoring guidelines to accurately reflect purpose of the review."

Division's Response to Recommendation #2:

The Division agrees with this recommendation and the Auditor's analysis, which led to the recommendation. The Auditor's report questions whether the Case Process Review (CPR) meets the legislative mandate in Utah Code. Because the Case Process Review uses only an examination of the case file to determine compliance, the review makes no determination as to whether the Division's action adequately protected the children in the case or whether the appropriate service were provided to family in the case.

The Division would propose a three-pronged approach to meeting OSR's statutory requirements:

1. OSR will continue to work with the Division and CWPPG to complete the Qualitative Case Review (QCR) as currently implemented.

2. OSR will complete a CPR on only those cases selected for a QCR. This process would make the connection between the procedural compliance focus of CPR and the outcome focused process of the QCR. In addition, since a caseworker interview is a natural part of QCR, the Auditor's recommendation to include the caseworker in the information gathering of CPR would also be accomplished.
3. Will use data generated from the SAFE management information system to measure the compliance elements measured by the CPR on all cases being reviewed within a region. A comparison of the data generated from SAFE with the data collected in the CPRIQCR will provide a more complete picture of the region's service delivery. This method also provides CPR data on a regional basis, where under the current CPR process only statewide data is available (if one region were to fail to comply with one CPR requirement, the score for the whole state could be heavily impacted). This situation makes if difficult for regions to set individual target training for caseworkers.

OSR will continue to review the case process review instrument and modify the instrument and guidelines as appropriate. OSR has made substantial changes in the review process over the years to improve the accuracy of data collection and reflect the changing needs of policy-makers. OSR will likewise continue to analyze the correlation between case process and outcomes. Some preliminary analyses show that visiting scores on the CPR are linked to stability and health scores on the qualitative review. OSR will likewise explore the possibility of even greater modifications to the CPR to complement the Qualitative Case Review.

The results of the CPR will continue to be given to the division. The division gets the scores broken out by region, office, team and worker. The information is given to all regions. Further, correlation analyses are given to the regions.

In addition to responding to the recommendations above, OSR would like to give more information on the value of the Case Process Review. This will give policy-makers and other interested stakeholders a broader understanding of the rationale for the CPR. Our comments are as follows:

It is really too soon to tell if the case process review has failed to foster improvements. The Auditor's report correctly points out that scores have dropped over the years. Further, the Auditors indicate that the continued low scores indicate that the CPR is not promoting improvement by the

division. Prior to the Milestone Plan, the Settlement Agreement was in place since 1995. In May 1999, when the Milestone Plan was implemented, the Division Director's main focus was implementing the Practice Model in the regions and developing the Qualitative Review. We have made the Case Process Review (CPR) a major focus for our administration, and our focus on the Practice model and quality improvement has fostered changes within the regions.

Encouraging signs are: The participation in the Quality Assurance project, an on-going sampling of cases for adherence to CPR requirement, has increased several factors over prior years. The number of training sessions conducted by OSR to train on protocols have more than doubled this year compared with last year, in addition to which, there are Milestone Plan coordinators in each region; these positions did not exist last year, and they have Case Process Review as one of their specific assignments. Further, the information reported in the auditors' report concerns data that is now two years old. There have been policy changes since then with corresponding guideline changes. Worker comments are likely based on current policy. I firmly believe that practice has improved over the past two years.

Lack of improvement in the scores does not necessarily mean that the case process review has not been successful in improving performance in the Qualitative Review. DCFS management believes the CPR is important in reinforcing Practice Model Principles with caseworkers. For instance, one Practice Model skill is "Engaging", which is the skill of "effectively establishing a relationship with children, parents and essential individuals for the purpose of sustaining the work that is to be accomplished together." In order to "engage" the family, the caseworker must visit the child and family regularly. The Case Process Review assesses whether the caseworker visited the child and family regularly. Visiting not only helps to "engage" the family, but also helps to evaluate other important factors such as the child's safety. Because OSR has been measuring caseworker visiting through the CPR, it is possible that some of the scores in the Qualitative Review have improved. A preliminary correlation analysis shows a correlation between visiting on the case process scores and stability scores on the qualitative review.

Experts in child welfare—Utah's Court Monitor, the Division Director, other states and the Child Welfare League endorse a Case Process Review. Child welfare experts in Utah and other states believe a Case Process Review is important. Utah's Milestone Plan requires that a Case Process Review be conducted and reported to the Court. Utah's Court Monitor believes it is important because case process requirements are linked to good practice. Also, he believes that because the Case Process Review is statistically reliable, it provides another check on practice within the system. The Division Director believes that because the CPR is very specific in its review of cases and reviews a large number of cases, it allows the Division to track what is happening with individual workers and teams.

Paul Vincent, our Court Monitor recently stated at a DCFS Board Meeting: "If the state continues with its progress in implementing the Milestone Plan, in a reasonably timely way, I think you'll be one of the best child welfare systems in the country. It's rare that public agencies want to work on the right things — on improving the quality of what happens between a worker and a family. Bureaucrats and other systems love to work on everything else - policy, throwing resources at families, information systems - they'll focus on one thing that's going to be the magic bullet, all of which are important, but they don't focus on this with any intensity, and I think that's what is a characteristic of the current work on the Milestone Plan. Even though we're helping implement it, I would feel that way about any system. Our biggest frustration is working in systems that are supposedly involved with reform, but just want to tinker with things around the margins." Dr. Corwin said he was wishing there was somebody here from the media to hear. Paul said he had actually said that to the press before, and that he would make a note and make sure that gets in their report to the court. He said he thinks it was a wise and courageous thing for the state to do,

and ultimately it's the right, the only thing, we should do if we're really going to pick a system. He says he thinks we will see on the practice end some noticeable improvements, that where they've seen this used intensely (and it's not been in many places) and measured over time, you see the scores go up dramatically. They've seen some of that in the past year, and expect to see more."

Other locations such as Washington, Colorado, Illinois, Missouri, New York City and New Mexico use a Case Process Review to assist in measuring caseworker performance. Further, a case process review is required in order for the state to be certified through the Child Welfare League of America.

Even though the scores for the state as a whole have declined; two regions have historically performed well. As previously mentioned, the Auditor's report correctly points out that scores have dropped over the years. Further, the Auditors indicate that the continued low scores indicate that the CPR is not promoting improvement by the division. While scores overall have declined, two regions, Northern and Southwest are performing at about 10% above the average of the other regions. Both of these regions also performed at about or above the average of the Qualitative Review. We have found over the years that these two regions have traditionally put more emphasis on the CPR. As previously noted, the current Division Director is putting a much greater emphasis on the CPR. These are positive signs that the regions can score well on the CPR and there is a good chance that they will score well on the upcoming review.

Finally, the report notes that OSR is generally accurate in their review of cases. Prior audit reports and the Court Monitor give OSR over 90 percent accuracy rates.

The report also indicates that caseworkers feel that OSR scoring is not always reasonable and cite a case where the caseworker was unable to get a parent to follow-through on some services. Because the caseworker was unable to get the parent to follow-through, the caseworker believes that OSR incorrectly scored this case as a "Partial", which is the equivalent of a "No" on the overall scoring. The caseworker's characterization of the score is incorrect. On the example cited, OSR looks for evidence that the worker *initiated* service with the parent. OSR scörès the question as "Yes" if the caseworker provided the family with information as to where to get services or in some other way helped the family receive needed services. If the caseworker did initiate the services, the case is scored "Yes", regardless of whether or not the family followed through with getting the services. In this case, the case record indicated the caseworker had followed up with the bulk of the services listed on the Service Plan but had not initiated two services—Medication management and Parenting classes. This was the only example cited in the report and there is no indication as to how many times "unreasonable" scoring occurred in the cases auditors reviewed.

The report indicates that caseworkers believe that some questions are scored incorrectly and these claims were sometimes supported and sometimes not supported. The report does not indicate an overall accuracy rate as in prior reports. OSR reviewed auditors' scores on this review and found questions where we agreed with the auditors and other questions where auditors had missed documentation or were unaware of a particular requirement. The auditors appeared to accept OSR's analysis. Based on these discussions, OSR is under the impression that accuracy is still within the low to mid 90 percent range.

Auditor's Recommendation #3:

"We recommend that DCFS conduct a workload analysis to determine the appropriate workload standards for the caseworkers and review the needed number of child visits by caseworkers."

Division's Response to Recommendation #3:

The Division agrees with this recommendation and the Auditor's analysis, which led to the recommendation. The Division appreciates the Auditor's report drawing a distinction between caseload and workload. The fact that the majority of Utah's caseloads are within standards set by the Child Welfare League of America and lower than the majority of other states, fails to recognizes that Utah's case activities requirements set by statute, Division policy, and Milestone plan are more detailed than other states. These activities contribute to the workload while not increasing the caseload. In addition, most workers are also required to carry cases other than their primary-type cases and act as secondary workers on other cases. Due to overall division caseloads, and a lack of capacity to allow new staff enough training time before assuming a full caseload, new workers are required to carry average caseloads long before they have completed their training and mentoring requirements. Were these new workers' cases allocated over the trained staff only, the average caseload would be much higher. This is the reason for the Division building flock request for 37 FTE to be in trainee positions only.

The Division periodically completes its own analysis of caseload size and how that corresponds to a caseworkers ability to comply with policy and statutory requirements. These analyses reveal that once a caseworker's caseload reach fifteen cases they began to fall behind in casework activities. With the data available from SAFE the Division has been able to develop a more accurate analyses of workload related to caseloads at the Division, Region, supervisor and caseworker levels. However, the detail required to provide completely meaningful workload statistics considering the complexity of one service-type case vs another of the same service-type would require data beyond that readily available in the system. Contacts with the Child Welfare League and other states indicate this type analysis has not been done elsewhere at the level that would include all pertinent factors. The Division will continue to develop more realistic workload data using information beyond simple caseload numbers.

The Auditor's report also calls into question the appropriateness of the Divisibñ's caseworker visit policy. The Auditor's report suggests that more flexibility should be built into policy that allows caseworkers to use discretion when determining the number of visits needed based upon the needs of the child and family in each case. The Division completely agrees with this recommendation and analysis as well.

To address the both the workload issue and visitation issue, the Division proposes the following action plan.

1. Specifically, the required amount of visitation to children in out of home placements will be discussed with the court monitor for the purpose of adjusting the workload of front line foster care workers, while still maintaining safety and support of children in care. Examples of options that will be addressed are: other members of the child and family team making the second visit, a phone call sufficing for a second visit or a decision model for determining which children need two visits (or more) and which children need only one visit.

2. The Division is currently in the process of up-dating policies for Child Protective Services, Home-Based Services, Out-of-Home Care, and Kinship Care. The Division will request the committees writing these policies to review the policy to ensure that policy is not an undoable case activities that is required in every case but that may not be appropriate in every case, and build in guidelines that will assist the caseworker to make decision regarding when case activities should and should not be completed.

3. The Division will continue Practice Model training, specifically focusing on the development of Child and Family team meetings, teaching caseworkers methods to engage other members of the Child and Family team to monitor the stability and protection of the child so that a decrease of mandated policy does not mean less protection for children.

4. The Division will use input from varied sources including a Child and Family Team meeting to conduct a more complete workload analysis in order to develop standards for achievable duties for Division caseworkers.

Auditors' Recommendation #4:

"We recommend that DCFS monitor removals by case worker and investigate the reasons some workers have very high or low removal rates."

Division's Response to Recommendation #4:

DCFS agrees that removals by caseworkers need to be monitored. There are several ways that the Division has and will continue to do this. First, Utah Code 62A-4a-202.1 requires that prior to the removal of a child the worker must review the reason for the removal of the child and other options available with a Family Service Specialist. Second, changes in the way that DCFS practice is trained in the Practice Model Training are also a safeguard. This training included Child and Family Team meetings where the case is discussed with individuals identified by the family who are involved with them, also functional assessments that look at both the strengths and the underlying needs of the family and not just the behavior, allow for discussion of the situation with those involved. Third, the Qualitative Case Reviews administered by The Office of Services Review is beginning the review of Child Protective Service cases this year. *

Monitoring must take into consideration the types of cases that each of the workers experiencing high or low removal rates are assigned. A cursory review of the cases from the audit handled by the worker removing at the highest and the caseworker removing at the lowest rate was revealing. Of the ten removals done by the worker with the highest removal rate, six of the cases had parent(s) that were arrested and taken into custody. There was no kin available to take the children so they were placed in shelter care. Two additional cases of the ten were cases where the child was abandoned or lost. The child was not able to tell authorities where they lived or who their parent was. The final two cases involved children who were in danger of being returned to parents who had previously abused them. These instances were very clearly not much of a judgment call for the worker and, most likely, would have been removed by any CPS worker. In looking at the cases handled by the worker with the lowest removal rate it was found that all of the cases handled were sex abuse cases. Most of the cases involved out of home perpetrators who no longer had access to the child. In cases where the perpetrator was in the home the child was kept safe by eliminating contact with the perpetrator through the use of safety plans involving the non-offending parent.

From this cursory review it is easy to see that the facts of the case must be considered when a review is done and not merely a statistical comparison between workers. Each case is unique and decisions are made on a case by case basis based on the facts of the case. Any monitoring or review must be done this way as well. With the SAFE system we have the capability of generating a number of reports that will enable us to quickly review case facts. These reports include one similar to that used by the auditors. These reports show which cases involved the removal of a

child, what specific allegations were substantiated and a case closure summary that lists the factors of the case.

DCFS will incorporate a more comprehensive review of removals by caseworkers on a regular basis. We are considering setting a threshold of high and low removals at which point an additional review would be made of individual worker and supervisory decisions. It is the goal of the division to decrease removals while increasing child safety statewide.

Auditor's Recommendation #5:

"We recommend that DCFS develop a statewide, uniform system to monitor caseworker training to ensure that caseworkers receive adequate training."

Division's Response to Recommendation #5:

The Division agrees with the auditor's recommendation. Information on training delivered and received must be reportable at the state level. Mentoring or on-the-job training also needs to be reportable readily available and detailed. Tracking and reporting are important parts of the training system that create accountability and allay risk. The Division would like to respond in this area by completing several proposed changes that were in process prior to the audit.

a. A computerized tracking system will provide course, class and individual tracking for DCFS through its management information system in the planning stages, SAFE. This system would track the "lifetime" of training for each employee and provide reports on training delivered. Mentoring training would also be recorded and reported. The SAFE system is accessible to employees in a way that would allow for easier data entry and tracking than previous systems that have been used to accumulate this information.

b. In order to make mentoring or on-the-job training reportable, a system of discrete mentoring tasks is required. A mentoring system which defines mentoring tasks for each training curriculum is currently in the planning stages. A detailed proposal for mentoring in the Child and Family Services Practice Model curriculum is expected in December. Current work in mentoring by supervisors will also be made reportable within the SAFE system.

c. New employee training is the priority curriculum task for training in the Division. Six new trainers were recently hired whose job it will be to track new employees as they move through the first two years of work at the Division. Curriculum is being developed for new employees, in addition to CORE (a basic overview of child welfare) and the Practice Model training (skills development course) currently being offered. A detailed training plan for new caseworker entry to the Division is expected in December.

d. Offering an expanded curriculum for new caseworkers and tracking their progress are closely tied. Tracking will include computerized reporting and direct contact with the new employee and their supervisor to plan and monitor the employee's training, mentoring, and progress.

e. Last year, the Division moved the state trainers to the regions and designated these positions as regional training managers. The responsibilities of this group include oversight of all regional training. Of late, these positions have almost solely focused on the development and training of the new Practice Model as required by the federal court-ordered Milestone Performance Plan.

In conclusion, the audit this year has provided informative and solution-oriented information to the Division of Child and Family Services. We are an agency in transition with the implementation of a new model for frontline practice and a business plan (the Milestone Performance Plan) that is changing the culture of work in Child and Family Services. We have been and remain open to recommendations that will improve our abilities to meet the mission of protecting children and adults (domestic violence) while preserving and supporting families in their processes for improvement. We will respond to requests and directions for improvements as a model for the families and children we serve. We can only honestly ask them to consider improvements in their lives as we model the same in our organizations.

Thank you for this audit and the forward-looking recommendations.

Sincerely,

Richard J. Anderson
Director, Division of Child and Family Services

Craig Monson
Director, Office of Service Review