

OPEGA Evaluation of Child Protective Services Investigations

Presentation of Final Report

March 25, 2022

Report to the Government Oversight Committee (GOC)
by the Office of Program Evaluation and Government Accountability (OPEGA)

Key Terms

DHHS = Department of Health and Human Services

OCFS = Office of Child and Family Services

CPS = Child Protective Services

Road Map

A. Project Overview

B. Key Takeaways

✓ Seven sections

C. Issues, Recommendations & Considerations

Overview - CPS Review

Oversight of CPS - Information Brief (January 2022)

 **CPS Investigations – Evaluation Report (March 2022)**

CPS Reunification & Permanency - Evaluation Report
(September 2022)

Overview - Assigned Topics

1. How investigations are designed and conducted
2. How well investigations are performed
3. How OCFS assures quality of investigations
4. Roles & coordination between key parties
5. How stakeholders communicate & share information
6. Perspectives of staff & stakeholders

Overview - Methods

Document Review: Agency rules, policies, and procedures, state and federal laws

5 Surveys: OCFS investigations caseworkers, OCFS supervisors, law enforcement, school professionals, medical professionals

Interviews: OCFS staff, various stakeholders

Case Review: Analysis of results 109 QA case reviews

Overview – Child Protective Services

- Child and Family Services & Child Protection Act
- DHHS/OCFS, Child Welfare Services
- 8 Regional Districts & Central Intake
- Focus on **Investigations**:
 - Dedicated Staff: 150 Caseworkers, 33 Supervisors
 - # of investigations: **9,783** in 2021

Key Takeaways

1. Misconceptions about Child Welfare
2. Child Welfare Philosophy and the Pendulum Swing
3. Investigation Process Design
4. Caseworker Training and Supervision
5. Quality Assurance Case Reviews
6. Perspectives on Elements Impacting Investigations
7. Family Perspectives and Service Needs

← Questions

← Questions

Misconceptions about Child Welfare

1. Caseworkers alone make child safety decisions

▶ **Decisions are made through collaboration between CPS staff and use of Structured Decision Making tools**

2. OCFS decides on its own whether a child is removed from their home

▶ **The removal of a child is a legal action, ordered by the Court.**

3. Caseworkers have authority to enter a home and compel parents to cooperate with investigation

▶ **In most cases, participation in a CPS investigation is voluntary.**

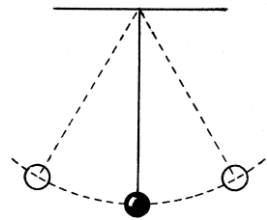
Misconceptions about Child Welfare

4. Caseworkers have ready access to timely, accurate information on cases
 - ▶ **Caseworkers are often working with limited information**

5. Adverse outcomes are the fault of caseworker error or flawed processes
 - ▶ **Adverse outcomes occur for complex reasons**

Child Welfare Philosophy and “Pendulum Swing”

- Philosophy continuum – varies in degree of emphasis on



○ **child safety** ---- ● ---- **family preservation** ○

- **Pendulum swing:** shifts in policy and practice between different ends of continuum; however, shifts not smooth
- Regardless of prevailing philosophy, each case is unique requires thorough **investigation** to make best decisions

Investigation Process

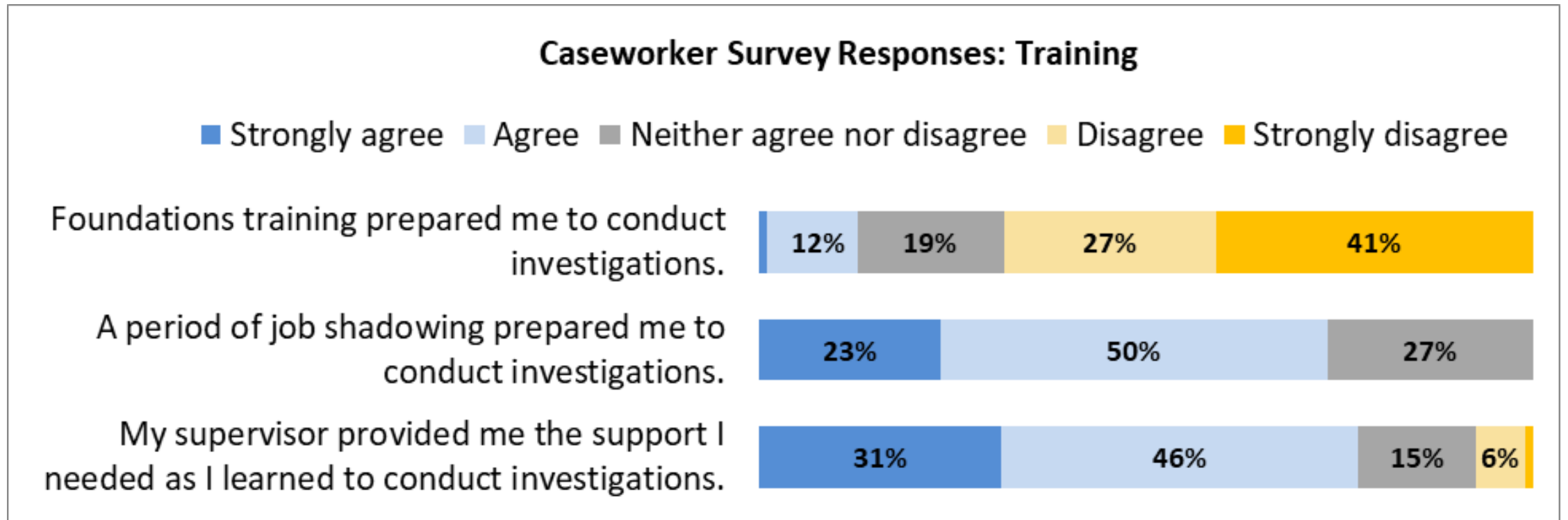
- 35-day timeframe
- Process well-defined & comprehensive
- Structured Decision Making tools at key points
- Is practice sufficiently thorough?

Investigation Process

- A. Report assignment
- B. Activities prior to going out in the field
- C. Initial contact with critical case members
- D. Preliminary Safety Decision
- E. Safety Plan
- F. Continued investigation activities
- G. Investigation findings
- H. Conclusion: risk assessment & disposition of case

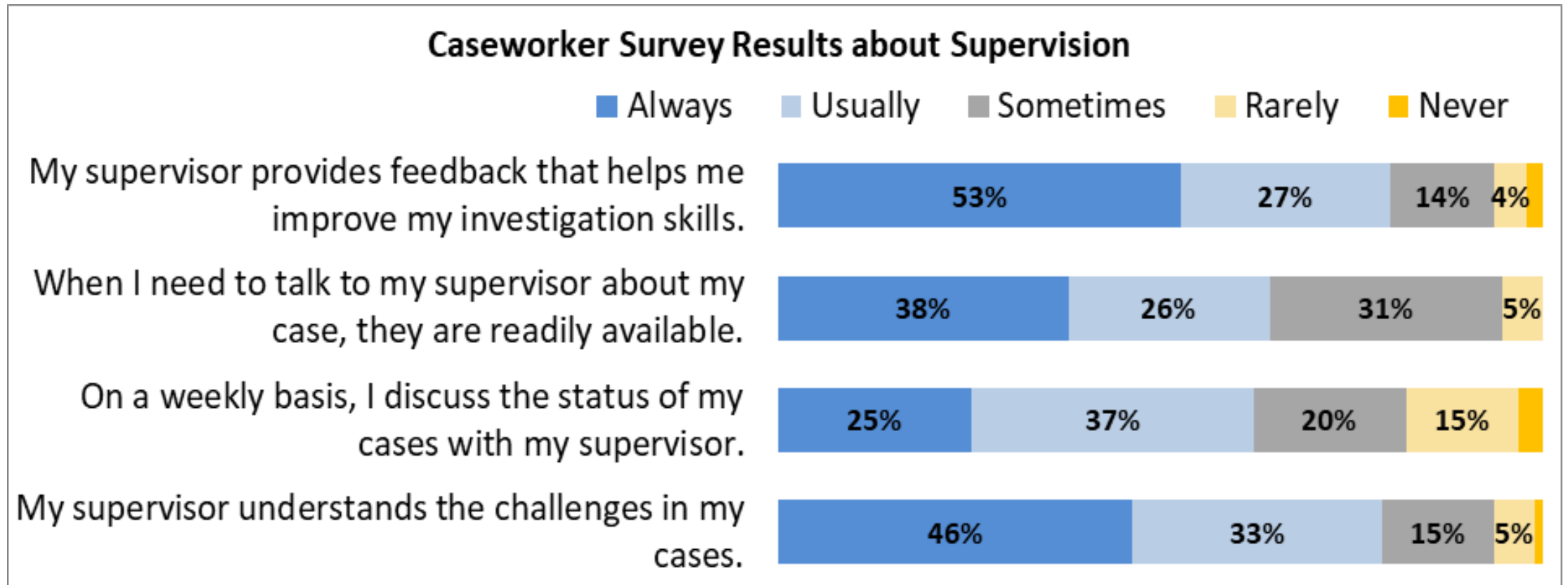
Training & Supervision of Caseworkers

- New Foundations training launched January 2022



Training & Supervision of Caseworkers

- Supervisors: support, mentoring, oversight throughout investigation



Question Break

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Quality Assurance Case Reviews

- QA uses federally prescribed methodology
 - ✓ Random selection: 65 cases every 6 months
 - ✓ On-Site Review Instrument
 - ✓ Review of case file documentation & interviews
- Requires exceptionally thorough & comprehensive work to evaluate risks

For this evaluation:

- 109 QA Case Reviews with Investigations
- Analysis of QA results: numeric & narrative responses

QA Case Reviews

Items Examined			
Item	Description	Purpose: To determine whether	Maine Status
1	Timeliness of Initiating Investigations of Reports of Child Maltreatment	Responses to all accepted child maltreatment reports received were initiated, and face-to-face contact with the child(ren) made, within the timeframes established by agency policies or state statutes.	Federal Goal Met
3	Risk and Safety Assessment and Management	Agency made concerted efforts to assess and address the risk and safety concerns relating to the child(ren) in their own homes or while in foster care.	In Progress
14	Caseworker Visits with Child	Frequency and quality of visits between caseworkers and the child(ren) in the case are sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals.	In Progress

QA Case Reviews

Review of Questions that Contribute to Item Ratings		
Question	Cases	Positive Result
<u>3A) Risk and Safety Assessment:</u> Did the agency conduct an initial assessment that accurately assessed all risk and safety concerns for the target child in foster care and/or any child(ren) in the family remaining in the home?	109	35%
<u>3C) Safety Plan:</u> During the period under review, if safety concerns were present, did the agency: 1) develop an appropriate safety plan with the family and 2) continually monitor and update the safety plan as needed, including monitoring family engagement in any safety-related services?	86	14%
<u>3D) Safety Concerns Addressed</u> During the period under review, were there safety concerns pertaining to the target child in foster care and/or any child(ren) in the family remaining in the home that were not adequately or appropriately addressed by the agency?	82	29%
<u>14B) Quality of Child Visits:</u> During the period under review, was the quality of visits between the caseworker and the child(ren) sufficient to address issues pertaining to safety, permanency, and well-being of the child & promote achievement of case goals?	106	24%

QA Case Reviews - Observations

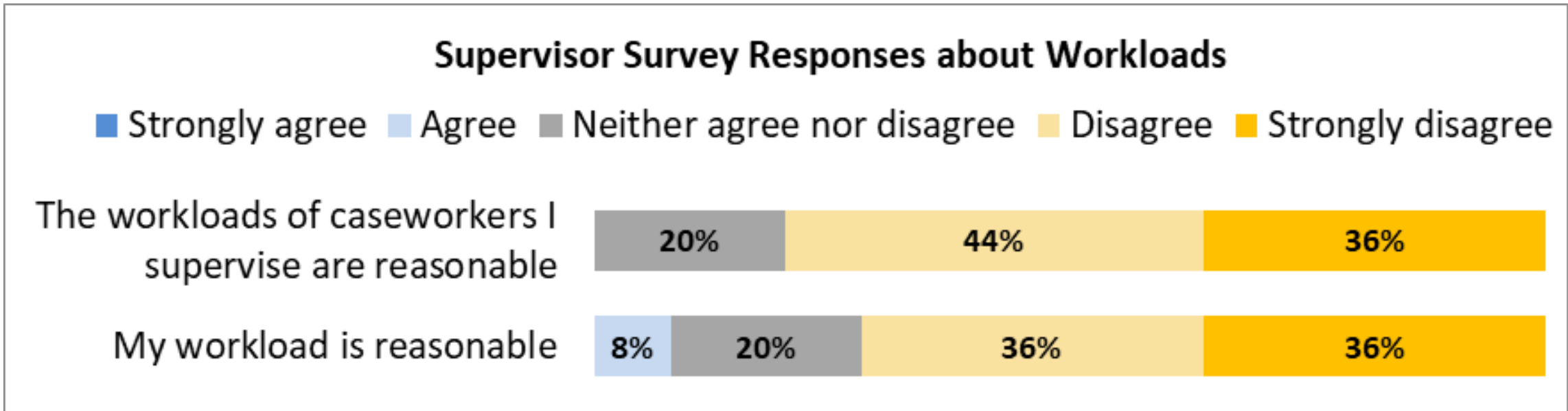
- 1) Lack of thoroughness and completeness in investigation practice:
 - Not assessing all individuals expected
 - Not exploring all potential risks and safety concerns
 - Safety Plan development and monitoring

- 2) Caseworkers *are* thorough and complete in assessing the:
 - Most critical/relevant individuals associated with allegation
 - Most critical/relevant risk and safety concerns

- 3) **Contributing Factors:** Workloads & Other practice concerns

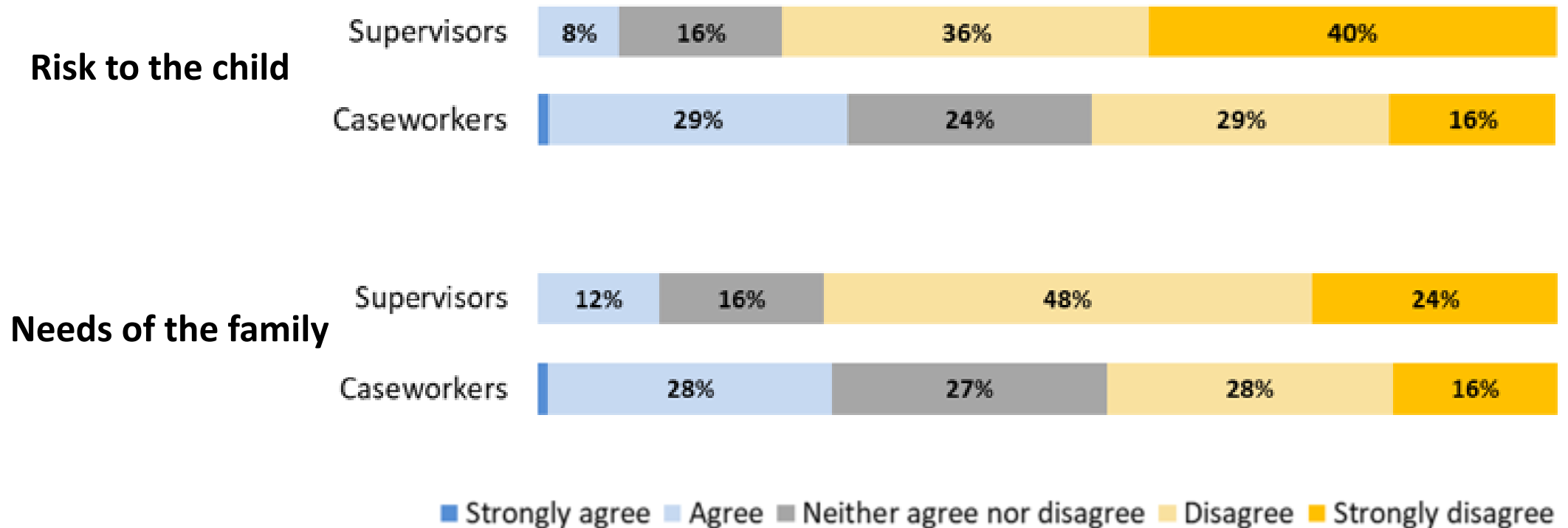
Perspectives: Workloads

- No supervisors agree that caseworkers have reasonable workload



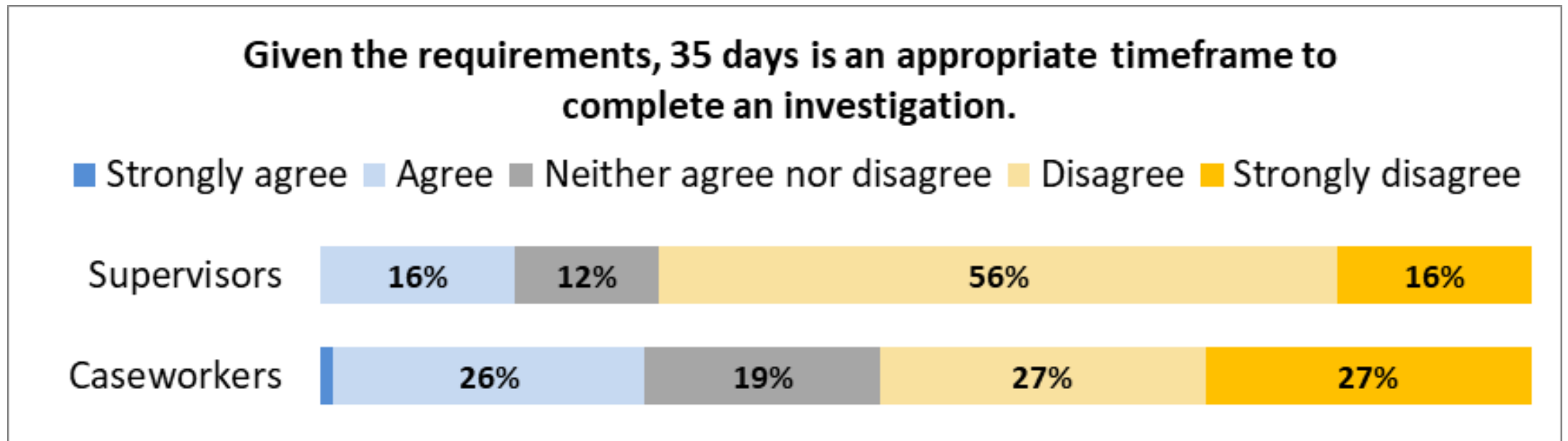
Perspective: Workloads

Given workloads, caseworkers have a reasonable amount of time to understand:



Perspectives: Timeframes

- 35 days is not viewed as an appropriate timeframe

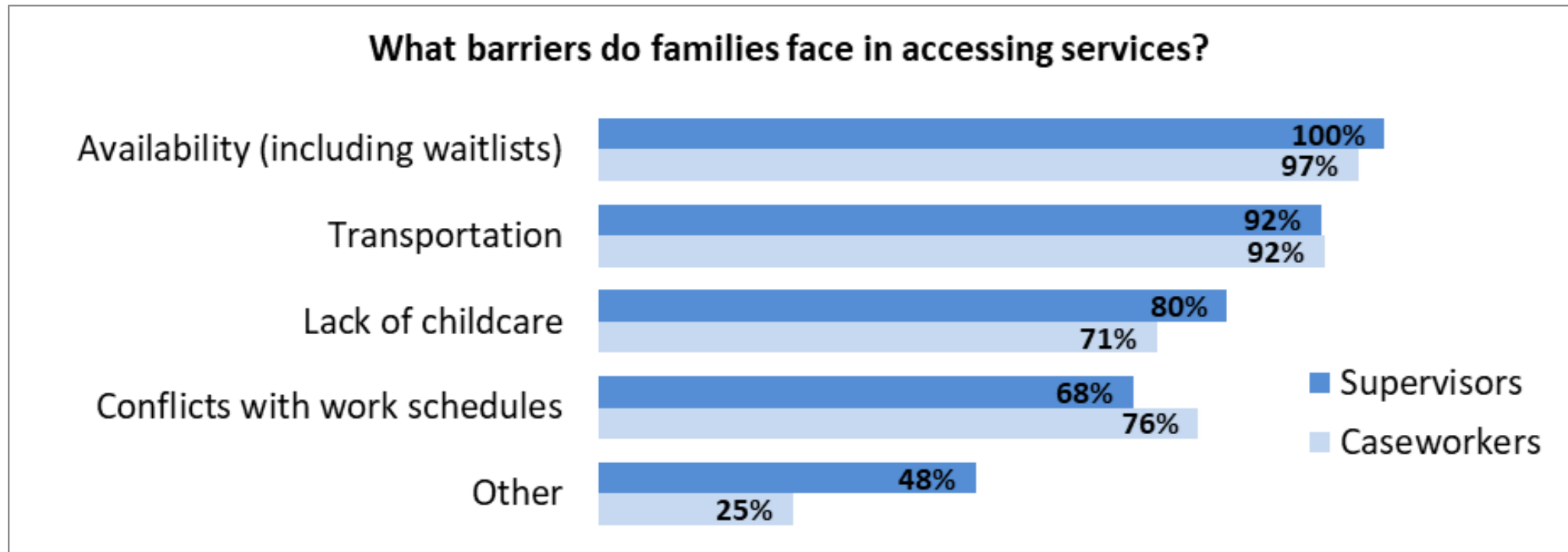


Perspectives: Communication with mandated reporters

- **Law enforcement and school staff** — able to share specific information about child safety with CPS. None reported they could rarely or never share that information.
- **Medical providers** – less able to share, very limited without a signed release
 - **Even with a signed release**, reported not able to share or discuss parent’s medical information:
 - 30% never able to provide parent records
 - 21% never able to discuss parent medical history/treatment
- **Substance use and mental health providers** – OCFS staff reported biggest challenges in getting information from these

Family Perspectives and Service Needs

- Support for families was identified as a need
- Access and availability of services are barriers



Question Break

A. Project Overview

B. Key Takeaways

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C. Issues, Recommendations & Considerations

Issues

Three Key Issues

1: High workloads

2: After hours staffing

3: Practice concerns

 *Recommendations*

Issue 1: Workloads

High workloads impact the thoroughness of investigations

Factors: demand, staffing, tasks, timeframes

➔ OCFS should take steps to ensure staff have the time necessary to conduct thorough investigations

Issue 2: After hours

After hours demands pose risks for quality and effectiveness of investigations and for staff turnover

➔ OCFS should: (1) evaluate after-hours demands and risks created, and (2) make policy and program changes to address risks; restructure delivery of Children's Emergency Services

Issue 3: Practice

Caseworker practice concerns

(not workload related)

Areas: interviews and information gathering;
decision making; safety assessment & plans

➔ OCFS should enhance QA system to better identify & address practice concerns in a timely manner, in all districts, and link to feedback/training

Other Considerations

OCFS

- New workers
- Access to information

GOC

- Services for families
- Prevention

Other Considerations for OCFS

1. New worker training & case assignments

- Foundations Training concerns
- Full caseloads very early on

2. Access to records & treatment information

- Barrier to complete & thorough investigations
- Medical, mental health, substance use

Other Considerations for the GOC

1. Services for families

- Service needs
- Lack of availability and barriers to access

2. Prevention of Child Abuse and Neglect

- Investment in prevention efforts
- Primary, secondary, tertiary prevention

Acknowledgements

- Department of Health and Human Services,
Office of Child and Family Services
- Law enforcement, schools, medical providers
- Other stakeholders, parent organizations

Next Steps

Report posted on OPEGA website

<https://legislature.maine.gov/opega/opega-reports/9149>

Government Oversight Committee

- Public Comment (April 8)
- Work Session

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