

CHILDREN'S PROTECTIVE SERVICES— REDUCING THE RISK OF ABUSE AND NEGLECT



SUMMARY

A citizen complaint was made to the Grand Jury alleging that children were at risk of abuse because Child Protective Services (CPS) staff was not always making the needed personal contacts with children, not fully looking at former investigation reports and that management's lack of leadership led to insufficient case evaluations. In 2010, CPS received over 11,000 contacts from citizens suggesting that one or more children were being neglected or abused, and of those inquiries, 2,645 complaints received an in-person investigation. Child Protective Services in Sonoma County is officially the Family, Youth, and Children's Division of the Human Services Department. The Division provides services by investigating emergencies, providing court services for children who need to be removed from their homes, offers reunification services to parents and children who have been separated due to abuse and neglect, and provides long term foster care and independent living skills for children whose parents

are unable to successfully complete the reunification program. The Grand Jury investigated the complaint by interviewing Division staff, inspecting documents and concentrating on the Emergency Response (ER) Program, which is responsible for investigating the allegations of child abuse and neglect.

In that ER Program, we found a need for improvement in the social worker's assessments, procedures for closing cases and management's oversight. On the other hand, we also saw positives in the Division. It has a new and pleasant Valley of the Moon Children's Home for those children who are removed from their homes, a state of the art sexual abuse interviewing facility called the Redwood Children's Center, and a current System Improvement Plan. It has hired eight additional social workers to cope with the large number of citizens' and professionals' allegations of abuse, is using a new decision making tool to improve social workers' assessments, and is revising its ER Program policies and procedures to help solve problems related to the complaint received by the Grand Jury.

In addition to the positive changes that the Division has made, the Grand Jury is recommending changes in: 1) the method used to evaluate the success of its in-person investigative procedures, 2) an additional coding system for marking how serious each case is, 3) improved communication between the Emergency Response manager, supervisors and the case workers, especially concerning their assessments and decisions to close cases, and 4) procedures to help see that the Division's new three- year System Improvement Plan is implemented.

In conclusion, our investigation validated the nature of the complaint made to the Grand Jury. However, we found that the Family, Youth, and Children's Division has made improvements related to the complaint during the time that the Grand Jury was investigating.

GLOSSARY

CPS –Child Protective Services, which is a common name for FYC.

FYC—Family, Youth and Children's Division.

ER—Emergency Response Program.

SDM—Structured Decision Making assessment tool.

Final Risk Level - case social worker's decisions in the SDM as to risks being Low, Moderate, High or Very High.

BACKGROUND

A citizen complaint was made in July 2010 to the Grand Jury alleging a lack of proper management in the Family, Youth and Children's Division (FYC, often referred to as Children's Protective Services or CPS) of the Sonoma County Human Services Department. The complaint indicated that assessments by social workers were not complete and that the oversight by supervisors and their managers was lacking in ensuring that full assessments were done as needed before the allegations were judged to be what is termed to be, by state law, as "unfounded," "substantiated" or "inconclusive." These deficiencies were said to lead to children being potentially exposed to further abuse.

INVESTIGATIVE PROCEDURES

The Sonoma County Civil Grand Jury investigated the citizen's complaint by studying the written policies and other documents of the FYC, touring the Valley of the Moon Children's Home and the Redwood Children's Center at the Los Guilicos county complex, and interviewing the complainant and eight of the FYC staff including managers, supervisors and social workers. As the investigation proceeded, the jury narrowed its focus to the Initial Services Section and more specifically to the Emergency Response Program (ER). Its employees, who are social workers with advanced college degrees, do an initial review and investigate the allegations of abuse and neglect.

NARRATIVE

The Grand Jury investigation discovered the following:

- In 2010, ER received over 11,000 calls and of those, 2,645 led to in-person investigations by social workers. The State of California requires that cases be investigated and decided within 30 days. Social workers feel pressured to close cases within the limit. It has been estimated by interviewees that about 10% of the cases do not get a sufficient review, including a closer look at history and parent contact before deciding to close a case. A short list of standards is provided by the State of California regulations on making decisions when closing cases.
- There are different opinions among managers, supervisors and social workers as to classifying the case allegations as "unfounded," "substantiated" or the evidence as "inconclusive," as required by the state regulations (Penal Code 11165).
- Working with time constraints, cases have been closed as "inconclusive" when the ER management has instructed social workers that their attempt to visit the home, parent and/or child two or three times and leaving a business card, without success, constitutes sufficient action. A different approach, or an additional visit, might have made the needed contact. For example, the social worker could try to visit later in the day or on the weekend.
- In re-opening cases because of new allegations, sometimes social workers see that there are deficiencies in the assessments of cases, which have been closed. The closed case could have had insufficient information leading to closing it, a history not fully reviewed, a parent not interviewed, etc. which then appear to have had a negative effect on a child. For example, in one reopened case for a referred, unrelated complaint, the case social worker did not recognize that a child had been previously abused by her relative and thus did not question the child. Subsequently, the child reported to another social worker that she had been sexually abused continuously and the previous case social worker should have questioned her. The case social worker who reopened the case did not know about the abuse because she did not read the entire history in the formerly completed assessment before doing her interviews as part of her own assessment. In another case referred to in the citizen complaint, the younger children in a family were given marijuana and physically abused by an older child. Additionally, the vision of one of the children was endangered by the lack of parents obtaining medical services. Although there were several previous allegations related to the family, a review of the case by FYC suggested that a more thorough social worker contact and assessment probably would have prevented these abuses.
- Morale in ER has been moderately low. On a scale of 1 to 10, the average rating from interviewees was 5.
- Interviewees from ER questioned whether the ER manager was effective because the ER manager was said to put too much emphasis on closing cases, did not fully understand the duties of caseworkers, nor the need for consistency between the ER supervisors and supervisors' communication with caseworkers.

- FYC Policy/Procedure “II-16 B. General” requires supervisors to randomly choose 20 cases per year in their unit for review (in addition to their regular reviews leading to case closure). There is no procedure to substantiate whether supervisors do these reviews. In 2009, the Division, along with the Sonoma County Probation Department, formally assessed themselves, and in 2010, developed a System Improvement Plan. The self-assessment and resulting plan are State of California requirements.
- The Division has hired eight new social workers to cope with the large number of cases, two of whom have been assigned to ER to lessen individual workloads that require investigating and deciding cases within 30 days.

FINDINGS

- F1. Although the state provides some guidance, its standards or guidelines are not clear about when a case should be closed. This causes considerable variance between supervisors’ judgments and opinions as to when cases are to be closed. Some supervisors are more lax and some are more stringent. Supervisors and their social workers are entrenched in doing things their own way with regard to closing cases. As a group, supervisors are inconsistent in interpreting rules, regulations and codes.
- F2. If a closed case is later re-opened because of a new allegation, there are no written procedures and no encouragement for a social worker or supervisor to request that the closed case be reviewed if it is thought that the assessment or the case closure decision was lacking.
- F3. In a small, but important number of cases, children have suffered the consequences of inadequate case assessment. However, the FYC director appears to be conscientious and is striving to remove inadequacies in case management and is to be commended. FYC has adopted the Structured Decision Making tool (SDM) and, based on recommendations from an in-house committee, it is revising all of its ER policies and procedures to improve assessment and case closure decisions. It appears that the SDM will help meet the needs for improving assessment and decision making about, and the management of, child safety, risk and parental adequacy.
- F4. With regard to FYC’s self assessment and the three-year System Improvement Plan that resulted from it, the work and input received from various people and groups are very commendable, but the social work staff appears to have little awareness or memory of either the self-assessment process or the plan except for the change to using the SDM tool.
- F5. Conscientious employees in ER are at risk of having low morale and being exhausted, partially due to inadequate supervision and management, time pressure to close cases, inconsistencies in interpretation of regulations for case closures, as well as the many cases that require investigation. However, the FYC’s implementation of new ER policies and procedures and the hiring of case social workers could reduce this risk.
- F6. FYC Policy/Procedure “II-16 B. General” concerning the subsequent review of randomly selected cases was not known to managers or supervisors who were interviewed and is not followed. It appears that no one looks to see if this policy is followed.

RECOMMENDATIONS

- R1. Re: F1, F2, F3 and F6 above: Currently, using the SDM process, referrals must be prioritized and coded to require investigations within either 24 hours or 10 days. Each referral/case also should be coded when the case is closed on a “seriousness scale” as a means of alerting staff if and when a case has to be re-reviewed or might

be reopened. The coding can be based on the SDM Final Risk Levels.

- R2. Re: F1: Once the new ER policies and procedures are developed by FYC, there should be an ongoing evaluation of their implementation and its results for improving the outcomes for children and the closing of cases.
- R3. Re: F2: Through policy and training, the social workers should be encouraged to bring forth previously closed cases, or cases which are forwarded to another section in the Division, and appear to have deficiencies in assessment or other decision-making, e.g., case closure or inadequate assessment. This is one means of training social workers to do more thorough assessments.
- R4. Re: F1 and F5: A written procedure, including guidelines, should be developed allowing a case to stay open beyond the 30 day limit and requiring a follow up by supervisors after a pre-determined time.
- R5. Re: F6: The procedure for a random review of cases should be carried out by section managers rather than, or in addition to, supervisors as a way to make section managers more familiar with the actions of their supervisors and social workers. Cases that were judged to be high risk should be a priority for re-review. A process for evaluating the implementation of the procedure needs to be established.
- R6. Re: F4: The FYC Director should develop a means for better informing staff of the Division's self-assessment and the System Improvement Plan and giving periodic reports on their results over the plan's three-year lifespan. For example, since there are regular staff meetings where these topics can be discussed, they can be addressed at the beginning of the meeting.

REQUIRED FOR RESPONSES

- From the FYC Division Director: F5, and R1 through R6.

BIBLIOGRAPHY

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- "Back to the Basics": Update and Implementation of ER Policies and Procedures, 10-29-10.