

## **CHILD PROTECTION COUNCIL, INTAKE REVIEW 11/10/15**

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### **BACKGROUND**

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The Child Protection Council (CPC), Statewide Citizen Review Panel, requested to do a case review specific to the Iowa Department of Human Services (IDHS) implementation of Differential Response. The CPC anticipated that the review would address the following:

- Whether or not decisions on pathway assignment are made consistently and correctly, following the criteria identified in Iowa Statute and Iowa Administrative Code (IAC).
- Whether the established intake criteria supports the intent of Differential Response (to engage families in a less adversarial manner), while still maintaining child safety.
- Whether they feel there are any needed policy or practice changes as it relates to the intake process in general and, in particular, the pathway assignment screening criteria.

### **DESIGN STUDY**

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The onsite review included 50 accepted intakes with an allegation of Denial of Critical Care (DCC) from the 1<sup>st</sup> quarter of SFY 2016 (July, Aug, and Sept. 2015). In order to allow reviewers to read an adequate number of cases assigned to each pathway, the distribution of cases included:

- 25 “Child Abuse Assessment (CAA)” intakes, randomly selected from the above parameters (i.e. DCC Allegation only 7/15-9/15), and
- 25 “Family Assessment (FA)” intakes, randomly selected from all possible FAs (7/15-9/15).

A standardized evaluation tool was developed by the Intake Review “Team Leads” (identified at the end of this report) to guide reviewers through the intake process and each required component of an intake, including the pathway screening tool. The tool was tested for inter-reviewer reliability internally with IDHS field supervisors and again with CPC members using a sample case before the onsite review date.

On the actual review day, Nov. 10, 2015, the CPC was broken into small teams of 2 members each, paired with an IDHS field supervisor (teams are identified at the end of this report). Each team reviewed several cases assigned to each pathway (4-5 of each CAAs and FAs), using the standardized tool. Reviewers were also asked to identify 2 strengths and 2 opportunities for improvement for each case reviewed. The small groups then came together in the afternoon to discuss general themes and common strengths and opportunities.

## PROJECT TIMELINE

A timeline of the preparation and activities specific to the evaluation tool development and the onsite review is below. The persons responsible include those team leads identified at the end of this report.

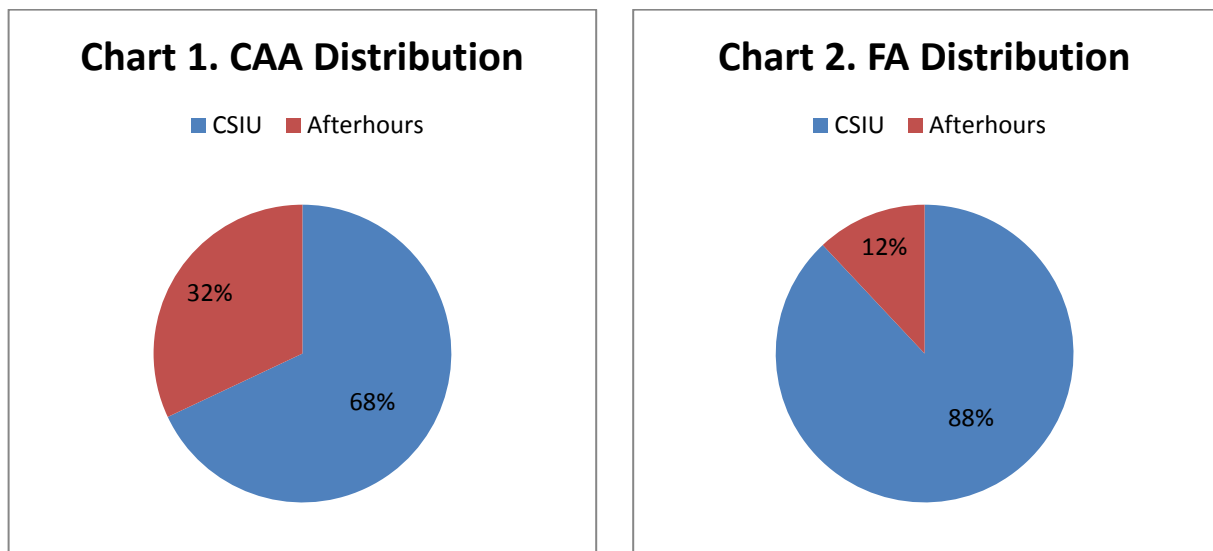
Intake Review Timeline		
Deadline	Task	Person responsible
<b>Tool Development</b>		
<b>2/27/2015</b>	Initial team meeting	LB, MG, JR, JG
<b>March</b>	Draft changes to tool	LB
<b>4/10/2015</b>	Review draft tool/timeline	LB, MG, JR, JG
<b>4/20/2015</b>	Tool/timeline due	LB, MG, JR, JG
<b>July</b>	Feedback to finalize tool	SBT
<b>September</b>	Tool finalized	LB
<b>Review</b>		
<b>5/12/2015</b>	CPC meeting - discuss plan and expectations (i.e. must attend both Sept/Nov meetings)	LB
<b>July</b>	Identify field supervisors to participate in Sept/Nov CPC meetings	SBT
<b>July</b>	Plan for Sept/Nov CPC Meetings	LB, MG, JR, JG
<b>August</b>	Pull sample case for internal inter-reviewer reliability	JR (DOFO)
<b>8/11/2015</b>	Team meets w/ field reps on tool and does an internal inter-reviewer reliability	LB, MG, JR, JG, RR, Field Reps
<b>9/1/2015</b>	Follow-up call with field reps on revised tool and sample case	LB, MG, JR, JG, RR, Field Reps
<b>9/8/2015</b>	CPC Meeting-training on CPS process in AM and inter-reviewer reliability activity in PM	LB, MG, JR, JG, RR, Field Reps
<b>9/29/2015</b>	Review team meets to finalize discussion questions and debrief sample review	LB, MG, JR, JG, RR
<b>October</b>	Pull case samples from July, Aug, and Sept 2015 - review for associated cases and pull; copy and make case files	LB, MG, JR, JG, RR
<b>10/19/2015</b>	Follow-up call with field reps before review and conduct another sample case review	LB, MG, JR, JG, RR, Field Reps
<b>10/26/2015</b>	Review cases pulled	LB, MG, JR, JG, RR
<b>11/10/2015</b>	Onsite - refresher on tool in AM and then group review and large group discussion	LB, MG, JR, JG, RR, Field Reps
<b>Nov-Dec</b>	Prepare a report of findings	LB, MG, JR, JG, RR
<b>1/12/2016</b>	Discuss recommendations with CPC	LB (others TBD)
<b>Jan-Feb</b>	Reviewer data validation and finalize report	LB

## REVIEW FINDINGS - QUANTITATIVE DATA

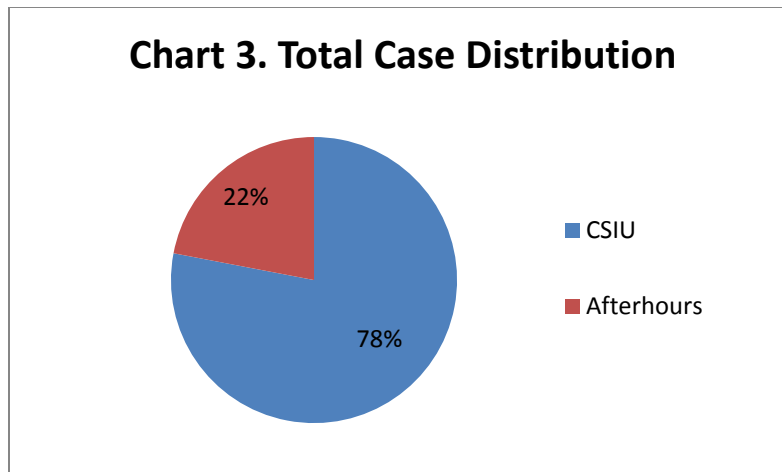
The review results were initially analyzed from a quantitative lens, looking only at whether the various intake criteria were met (i.e., yes or no). It was also determined, in looking at the data, that it was necessary to consider the various subsets. For example, although both pathways were equally distributed in the pull (25/25), it became relevant to review the data in terms of the cases that were accepted for intake by the Centralized Service Intake Unit (Mon-Fri 8:00am-4:30pm) and those accepted Afterhours, as there were some distinct differences in whether certain criteria was met.

It should also be noted that there was a significant difference in the distribution of cases by pathway, depending on when they were called in. For example, allegations called in to CSIU were much more likely to be assigned as a FA when compared to allegations called in Afterhours. This is not to suggest that there are differences in practice, but more likely a result of the nature of Afterhours calls commonly arising from “emergency situations” (i.e. referrals from law enforcement, emergency departments, etc.).

Charts 1 and 2 below illustrate this difference. For example, of the 25 randomly pulled intakes that were assigned as a Child Abuse Assessment, 68% of them came in to CSIU and 32% came in Afterhours. However, for those assigned as Family Assessments, 88% were called in during regular business hours and only 12% of them were assigned as the result of an Afterhours report.



Because of this significant difference it was determined that it was important to look not only at the decision process and compliance levels based on the *pathway*, but also to consider *when* the intake was accepted. Chart 3 illustrates the combined total distribution for all 50 cases.



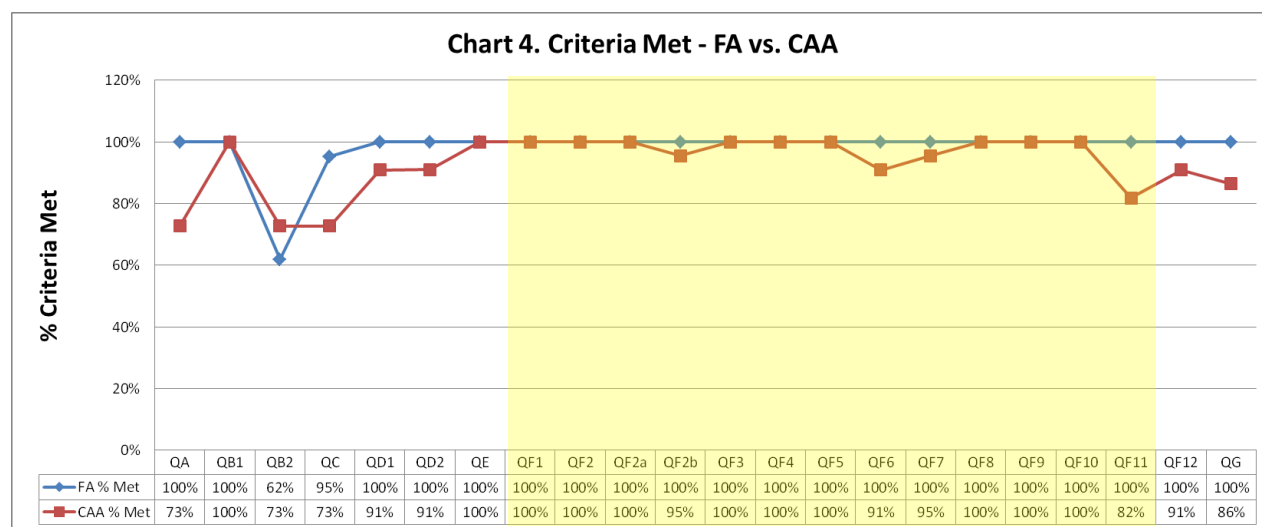
Reviewers were not able to complete the tool on all 50 cases during the time allotted, but each group did get through the majority of their cases. In all, a total of 43 of the 50 cases were fully reviewed (22 CAAs and 21 FAs) and had evaluation tools completed. Following the review all data points on the 43 cases completed were compiled to look at statistics regarding the various criteria being met. During the initial compilation of data it became apparent that there were some obvious reviewer errors in the items marked on the evaluation tool. As a result, it was determined that IDHS staff would do a full review of the 43 completed cases to validate whether the “criteria met” answers were correct.

In a few situations, reviewers mistakenly said “no”, a criterion was not met. In many situations that had to do with the questions regarding the “intake screening tool” portion used within each intake to determine the assessment type. For example, if the condition was NOT present (i.e. “the alleged abuse type includes a category other than DCC”, and the box was NOT checked, then the criteria was actually met because the tool was used correctly (so should have been marked as “yes”). Some reviewers interpreted this as “no”, the condition was not present, so answered “no” criteria not met. Follow-up clarification occurred with the reviewers who did this and those reviewers confirmed they intended to state that the condition was not present vs. indicating that the criteria was not met. Therefore, those items were changed to accurately reflect the fact that the criteria were met

In other situations, errors were made due to a lack of understanding the expectations, or because reviewers had not fully read the tool guidance. For example, as long as the required information was in the intake (even the “additional information” section), the criteria should have been marked “yes”. In other words, if collaterals and contact information are identified in the additional information section (vs. the full box for collateral name, phone, address, etc.), the criteria was still met and should have been marked “yes”. In another situation, one team of reviewers took “examples” of possible child safety issues (listed on the tool) as questions that were *required* to be asked on all intakes. For example, they marked “no” because not every reporter was specifically asked about a child’s “medical needs” or “environmental hazards”. These are not required questions, but rather examples of potential safety concerns. Although some reporters may know this information, many will not. Therefore, these errors were also

corrected (i.e., when the criteria were met in accordance with intake policy and practice but marked as “no”).

Of the 22 criteria, 14 of them were specific to the intake screening tool (QF1-QF11). This becomes particularly relevant when looking at the level of compliance based on pathway decision. Chart 4, below, shows that on all FAs that were fully reviewed (N=21), the intake screening tool criteria (QF-QF11) was met 100% of the time. In other words, when a case was selected to go down a Family Assessment pathway, decisions were made correctly on each tool question 100% of the time. This varies somewhat with CAAs, in that when asked if all items on the tool were checked correctly (QF11), reviewers only answered “yes” 82% of the time.

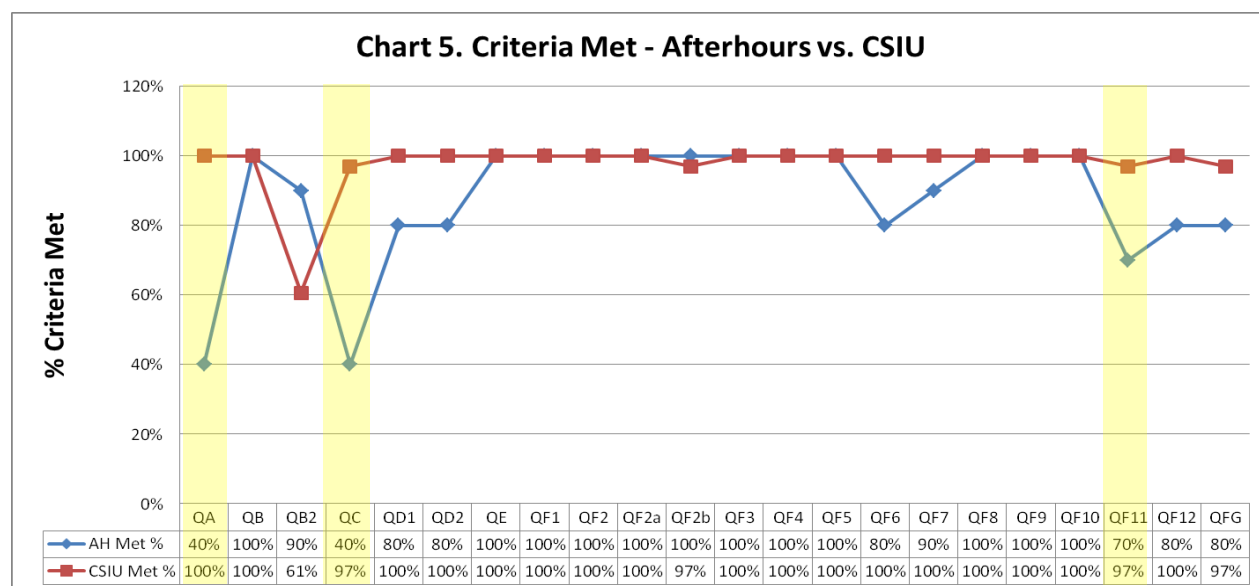


There were a total of 4 cases, of the 22 CAAs that were reviewed, where the tool was reportedly used incorrectly. 2 of the cases were a result of choosing the correct pathway, but not selecting ALL of the correct boxes, while the other 2 were cases where reviewers were uncertain about whether the case should have actually been assigned as a FA vs. a CAA. Both of these situations had to do with the prior TPR (Termination of Parental Rights) box being checked, but with no indication from the lookups (i.e., FACS or ICAR) or narrative documentation as to where this information was obtained from and/or which caretaker had a prior TPR. Reviewers felt that without this information documented in the intake it was difficult to determine whether the box should have, in fact, been checked.

Upon a more in-depth review of the cases involving TPRs it became clear that one case was the result of specific information stated by the reporter (who believed a father had his parental rights terminated), but nothing was confirmed before assigning as a CAA. The other case appeared to have been a result of a system entry error. It is assumed that the reason the TPR box was checked was a result of “transfer to adoption worker” being listed on an “event list” (in FACS) on a child in the household. Upon review by IDHS staff, it appears this was a mistake in FACS, as the family had never had juvenile court involvement and the child was still a member of the home. In this case, the

assessment, according to policy, could have been assigned as a FA. As a result of both of these situations, related to TPRs, it is recommended that practice guidance be reviewed to clearly indicate what is considered a reliable source of information to assign as a CAA for the reason of TPR and how/where this information should be documented.

In reviewing the compliance level of other intake criterion, it was easier to see the trends when looking at *when* the call came in vs. the *pathway*. For example, on evaluation tool question QA (“Collect adequate information on all involved parties”) and QC (“Complete all relevant system look-ups”) there were significant differences in whether the criteria was met based on when the intake was accepted, with QA criterion met 100% (CSIU) vs. 40% (Afterhours), and QC criterion met 97% (CSIU) vs. 40% (Afterhours). In addition, 3 of the 4 CAA errors mentioned in the preceding section also occurred during Afterhours, with Q11 criterion (“all items appropriately checked”) met 97% (CSIU) vs. 70% (Afterhours). This is illustrated in the highlighted sections below. This discrepancy was also addressed in the qualitative feedback discussed later.



One surprising finding was QB2 (“Whether the person alleged responsible has access to the child.”). It was determined that this was only being checked correctly in 61% of the CSIU cases and 90% of the Afterhours cases. It was discovered during the review, by a CSIU Supervisor who was one of the field reps, that this was the result of an automated programming issue in the system. If a worker attempted to proceed through the intake screen without answering that particular question, the system would automatically default to “No”, indicating the alleged perpetrator did not have access to the child. This then was often conflicting with what the narrative suggested. Since the review this system issue has already been brought to the attention of CWIS (Child Welfare Information System) staff and been addressed in field worker training.

## REVIEW FINDINGS - QUALITATIVE DATA

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In addition to the quantitative data, reviewers had the opportunity to indicate 2 strengths and 2 opportunities for improvement on each case that was reviewed.

Some of the most common **strengths** included the following:

- Documentation
  - Good/thorough narrative descriptions and/or additional information
- Pathway assignment applied correctly, based on tool
- Lookups completed and/or indicated “nothing found”
- “Huge” growth in the intake process (from 2009 review done by CPC)

Similarly, many of the things identified as strengths in some cases were also noted as **opportunities for improvement** on other cases, including:

- Documentation – inadequate or missing information (particularly on Afterhours intakes), examples:
  - System look-ups, additional information, documentation of where TPR info was found, etc.
  - Child safety – not clear if intake worker is asking questions to solicit this information at time of intake. If so, not always documented.
- System issues (i.e., Perpetrator access question) mentioned several times in reviewer comments.

## GENERAL COMMENTS/QUESTIONS

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Reviewers were also asked to discuss their general thoughts, perceptions, following the process. Some of the themes identified included the following:

- The tool was used correctly, but are we serving the child's actual needs?
- Particular concern for children with intellectual/developmental disabilities, as a high risk population for abuse, and considering that abuse is often a contributing factor to delays.
  - In discussion it was noted that, in the past (before DR), all substantiated reports of abuse were automatically sent a referral for Early Access. Some of the questions raised included the following:
    - With Family Assessments, are CPWs doing any ID/DD screening? What about Community Care?
- “Afterhours intakes have a decided lack of information” – this was mentioned several times and is clear in the quantitative analysis as well. In particular, system look-ups and required additional information questions were often incomplete.
- Concerns regarding the high prevalence of substance abuse and domestic violence in FAs and whether these should be viewed as more than just a supervision issue.



## RECOMMENDATIONS & NEXT STEPS/ACTION TAKEN

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- **Recommendation:** The IDHS should address system changes on “allows access” question by addressing the auto default to “NO”.
  - **Next steps/Action taken:** Jason Geyer has brought this to the attention of CWIS (Child Welfare Information System) staff. In addition, this has been discussed in new worker training and with CSIU staff.
- **Recommendation:** The IDHS should provide clarification on: 1) What specific information is required for TPR to be the reason for assignment to a CAA, and 2) How the information should be documented within the intake. For example, is “hearsay” from the reporter (not confirmed by FACS or another state’s system) reason enough to assign as a CAA? Also, what specific “events” should be looked for in FACS to confirm that a TPR did, in fact, occur?
  - **Next steps/Action taken:** This report will be shared with the internal IDHS “Intake Advisory Council”, made up of CSIU staff/sups, field staff/sups, and IDHS child protective service help desk staff. The group will discuss recommendations and decide what, if any, action needs to occur.
- **Recommendation:** The CPC would like to conduct an additional review to look at the actual “assessments” related to these intakes, particularly those FAs that changed pathways, to determine if there were indications at intake to suggest these were not appropriate for a FA. If trends do become evident (i.e., things at intake that appear “predictive” of reassignment), the CPC would like the IDHS to consider changes to the intake screening tool.
  - **Next steps/Action taken:** IDHS CJA Program Manager will explore options for a future review by the CPC in the coming year.
- **Recommendation:** The IDHS should look closer at how ID/DD screening occurs during the assessment process and consider additional ways to support families of children with disabilities in getting appropriate screening and service referrals.
  - **Next steps/Action taken:** IDHS is currently mandated by federal law (Child Abuse Prevention and Treatment Act or CAPTA) to refer all children 0-3 with a “substantiated” case of abuse for ID/DD screening. The way this has been done is primarily through an automated referral system to Early Access. The IDHS and the IDOE (Iowa Department of Education) are currently exploring ways to better engage families in this process.
- **Recommendation:** The IDHS should work towards increasing consistency on system lookups, particularly for intakes done Afterhours.
  - **Next steps/Action taken:** This report will be shared with the internal IDHS “Intake Advisory Council”, made up of CSIU staff/sups, field staff/sups, and IDHS child protective service help desk staff. The group will discuss recommendations and decide what, if any, action needs to occur.
- **Recommendation:** The IDHS should explore issues of substance abuse and domestic violence (as these were the most prevalent concerns in FAs) and whether there are indications of “imminent danger” in some cases that make them inappropriate for a FA.



- **Next steps/Action taken:** As a result of this concern brought up by a number of reviewers, IDHS staff reviewed all FAs to determine the number/percentage of the 25 randomly chosen cases that included allegations of domestic violence and/or substance abuse (to determine the true extent of these issues in FA intakes) and the findings indicated that:
  - **Domestic Violence:** 16 of the 25 FAs chosen at random specifically included allegations of violence between adult caretakers (64%). The vast majority of these were IPV (Intimate Partner Violence) situations, although one allegation included a physical altercation between a mother and grandmother.
  - **Substance Abuse:** 7 of the 25 FAs chosen at random specifically included allegations of substance abuse (28%). However, in also looking at the narrative “Additional Information” sections of the 25 intakes, another 7 indicated some form of concern by the reporter of possible drug and/or alcohol abuse, even if not rising to the level of being an allegation itself. Therefore substance abuse was, at minimum, mentioned in 14 of the 25 intakes or 56%.
  - **One or both:** In total, all but 4 of the 25 cases (88%) included concerns of domestic violence and/or substance, either within the allegation itself or within the additional information section.
- **Next steps/Action taken:** The IDHS is aware of the common issues and family dynamics that often correlate with the majority of child abuse cases (i.e., mental illness, substance abuse, and domestic violence). In order to address some of these things, the IDHS has done the following:
  - The IDHS recently implemented the [Safe & Together Model](#), a perpetrator pattern based, child centered, and survivor strengths approach to working with domestic violence. All field staff have received this training and CSIU staff will be receiving soon.
  - The IDHS continues to look at how the term “imminent danger” is defined and how it is used in practice and convened an internal workgroup on the topic in 2015.
  - The IDHS is currently reviewing additional tools and guidance and is in the process of developing training for field staff to assist in the screening process for issues related to mental illness, substance abuse, and domestic violence.

## **IDHS INTAKE REVIEW TEAM LEADS**

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- Lisa Bender/Roxanne Riesberg – Adult, Children and Family Services
- Jason Geyer –Social Work Administrator (CSIU)
- Michelle Gonzalez – Quality Improvement Coordinator
- Jana Rhoads – Field Operations Support Unit/Training

## **IDHS FIELD SUPERVISORS & CPC MEMBER TEAMS**

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- Megan Christner, Eastern Service Area
  - CPC Members: Regina Butteris & Jerry Foxhoven
- Chad Hargin, Des Moines Service Area
  - CPC Members: Cheryll Jones & Barbara Small
- Travis Heaton, Western Service Area
  - CPC Members: Resmiye Oral & Chaney Yeast
- Suzanne Laurence, Centralized Service Intake Unit (CSIU)
  - CPC Members: Kenneth McCann & Beverly Saboe
- Heather Lietz, Cedar Rapids Service Area
  - CPC Members: RaeAnn Barnhart & James Hennessey
- Doug Sedgwick, Northern Service Area
  - CPC Members: Sylvia Lewis & Stephen Scott