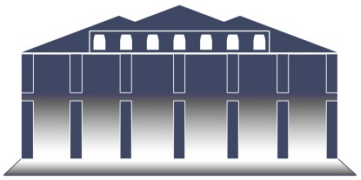
Child Protective Services Intake Screening Lacks Consistency

Final Report to the Joint Legislative Program Evaluation Oversight Committee

Report Number 2019-10

November 20, 2019



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John W. Turcotte
Director

November 20, 2019

Senator Brent Jackson, Co-Chair, Joint Legislative Program Evaluation Oversight Committee
Representative Craig Horn, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

North Carolina General Assembly
Legislative Building
16 West Jones Street
Raleigh, NC 27601

Honorable Co-Chairs:

The Joint Legislative Program Evaluation Oversight Committee's 2018–19 Work Plan directed the Program Evaluation Division to examine the effectiveness of the child protective screening process used by county departments of social services and determine whether there are differences in how counties screen the need for a child protection response.

I am pleased to report that the Department of Health and Human Services cooperated with us fully and was at all times courteous to our evaluators during the evaluation.

Sincerely,

John W. Turcotte
Director

Mandatory Evaluation Components

Report 2019-10: Child Protective Services Intake Screening Lacks Consistency

N.C. Gen. § 120-36.14 requires the Program Evaluation Division to include certain components in each of its evaluation reports, unless exempted by the Joint Legislative Program Evaluation Oversight Committee. The table below fulfills this requirement and, when applicable, provides a reference to the page numbers(s) where the component is discussed in the report.

N.C. Gen. § 120-36.14 Specific Provision	Component	Program Evaluation Division Determination	Report Page
(b)(1)	Findings concerning the merits of the program or activity based on whether the program or activity		
(b)(1)(a)	Is efficient	This evaluation was **not able to determine** if county Child Protective Services (CPS) intake screening is efficient. The Department of Health and Human Services (DHHS) was unable to provide data regarding the amount of funding devoted to intake screening activities by county. Lacking county-specific activity information, the Program Evaluation Division was unable to calculate a unit cost for comparing counties.	p. 4
(b)(1)(b)	Is effective	Ideally, county intake screening procedures would consistently identify allegations that meet state criteria for potential maltreatment while rejecting claims that do not meet these criteria. **When given a survey containing 12 hypothetical scenarios of maltreatment, county workers screened allegations correctly 71% of the time.**	p. 10, pp. 18-20
(b)(1)(c)	Aligns with entity mission	Maltreatment screening is a responsibility of county departments of social services as described in N.C. Gen. Stat. § 7B-300. DHHS is the single administrative agency that provides supervision to counties. **Maltreatment screening aligns with DHHS's mission** to provide essential services to improve the health, safety, and well-being of all North Carolinians.	pp. 4–10
(b)(1)(d)	Operates in accordance with law	DHHS **operates in accordance** with N.C. Gen. Stat. § 108A-71.	
(b)(1)(e)	Does not duplicate another program or activity	This evaluation **did not find any evidence of duplication**.	
(b)(1a)	Quantitative indicators used to determine whether the program or activity		
(b)(1a)(a)	Is efficient	This evaluation was **not able to determine** if county CPS intake screening is efficient. DHHS was unable to provide data regarding the amount of funding devoted to intake screening activities by county. Lacking county-specific activity information, the Program Evaluation Division was unable to calculate a unit cost for comparing counties.	p. 4
(b)(1a)(b)	Is effective	Intake screening is routinely performed in county departments of social services. Barriers to effective screening identified in Findings 1 and 2 include **use of local policies in addition to state policy, ineffective training and lack of retraining requirements, inconsistent and untimely state guidance, and a lack of worker skill assessment.** Structural factors that negatively impact program effectiveness include **use of an outdated structured decision-making intake tool and the lack**	p. 5, pp. 12–18, pp. 21–32

		of a uniform case management system such as NC FAST for recording allegations (Findings 3 and 5). Unless changes are made to the current data system and measurable performance benchmarks, effective oversight of county activities cannot occur.	
(b)(1b)	Cost of the program or activity broken out by activities performed	**In total, the federal, state, and local governments spent $94 million on child welfare activities in Fiscal Year 2019–20.** These activities include intake and assessment of abuse, neglect, and dependency reports; initiation of and participation in court proceedings; and provision of reunification and permanency planning services. DHHS was unable to differentiate expenses by specific activities. In total, the State spent $14 million on Child Welfare programs in Fiscal Year 2019–20.	pp. 4–5
(b)(2)	Recommendations for making the program or activity more efficient or effective	The General Assembly should disallow use of local intake screening policies and direct DHHS to: • improve consistency and timeliness of state advice on difficult screening cases by creating a rapid response telephone line; • use hypothetical vignettes to assess worker policy comprehension and training needs and require periodic and additional retraining in intake screening; • revise the structured decision-making intake tool with assistance from the Children's Research Center and recertify this tool every five years; and • establish measurable intake screening benchmarks and implement more robust program monitoring.	pp. 32–35
(b)(2a)	Recommendations for eliminating any duplication	None	
(b)(4)	Estimated costs or savings from implementing recommendations	None	

PROGRAM EVALUATION DIVISION
NORTH CAROLINA GENERAL ASSEMBLY

November 2019 Report No. 2019-10

Child Protective Services Intake Screening Lacks Consistency

Highlights

IN BRIEF: County social services workers receive referrals of potential child maltreatment at the community level. Workers screen each allegation to decide if a more in-depth assessment should be conducted. County offices vary substantially in the rates of initial referrals that are screened in or out. County Division of Social Services (DSS) directors surveyed by PED attributed this variation to differing local policies, lack of staff familiarity with intake screening procedures, and an absence of consistent and timely central guidance by the Department of Health and Human Services (DHHS). The Program Evaluation Division (PED) found that the current structured intake tool makes the reporting process lengthy and redundant and may also contribute to screening inconsistency.

Background: The Joint Legislative Program Evaluation Oversight Committee directed PED to determine whether there are differences in how county departments of social services screen maltreatment allegations for assessment. Child maltreatment has profound and often lasting negative effects on psychological and physical health and risk behaviors, which lead to long-term maladies at taxpayer expense. County DSS workers receive referrals of potential child maltreatment at the community level. These workers, along with their supervisors, must determine if reports should be forwarded for an assessment (screened in) or screened out, which means that child protective services (CPS) will not investigate the allegation.

The state average for screened-out reports is 36%, yet individual county screen-out rates range from 12% to more than 60%. Reasons for inconsistency may include use of local supplemental policies, a lack of worker assessment and training, and inconsistent statewide guidance by DHHS.

Counties Rely on a Variety of Resources in Making Screening Decisions

Source	Yes	No	Don't Know
North Carolina Statutes	86%	13%	1%
Written County Guidance	15%	82%	2%
Other Policies, Guidelines, or Criteria	23%	70%	6%

Recommendation:
The General Assembly should disallow use of local intake screening policies and direct DHHS to improve consistency and timeliness of state advice on difficult screening cases by creating a rapid response telephone line.

Highlights

When PED presented county workers with 12 hypothetical vignettes of child maltreatment created by DHHS, workers correctly screened cases 71% of the time. A vignette is a hypothetical report of potential child abuse. First, workers had to determine if a report should be screened in for assessment. Next, workers had to assign any screened-in reports to the correct assessment track, either investigative or family. An investigative assessment occurs in response to a report of abuse or serious neglect whereas a family response focuses on engaging the family in efforts to better provide care for the affected child or children. Finally, workers had to select the correct response time frame. Cases of reported abuse must be initiated immediately or within 24 hours, and cases of neglect must be initiated within 72 hours.

County Workers Correctly Accepted or Rejected Maltreatment Allegations 71% of the Time

	Accept or Reject Report	Assessment Track	Response Time Frame	Total Correct
County social workers (n=226)	71.1%	65.9%	61.4%	66.1%
County social work supervisors (n=162)	76.5%	70.6%	66.0%	71.1%
DHHS workers (n=4)	87.5%	85.4%	68.8%	81.0%

PED found attendance at intake screening training sessions did not improve vignette scores. After workers and supervisors meet the initial screening training requirement, there is no requirement to re-attend training. Further, DHHS does not routinely test workers to determine how well they are implementing state intake screening policies.

Recommendation:
The General Assembly should direct DHHS to use hypothetical vignettes to assess worker policy comprehension and training needs, provide more intake training opportunities for county workers, and require periodic worker retraining.

PED identified deficiencies in the structured intake tool used by county workers to screen allegations and with state monitoring of the screening process. DHHS revisions to accommodate changes in state and federal law have weakened the effectiveness of the form-based screening tool by making it long and redundant.

Recommendation:
The General Assembly should direct DHHS to revise the structured intake screening tool with assistance from the Children's Research Center and recertify the tool every five years.

In addition, PED found other issues with how DHHS performs oversight of county child welfare programs. DHHS uses insufficient sample sizes when conducting program monitoring, increasing the likelihood problems will not be identified. The absence of accurate county-level data also hinders statewide monitoring.

Recommendation:
The General Assembly should direct DHHS to establish measurable intake screening benchmarks and implement more robust program monitoring.

Purpose and Scope

The Joint Legislative Program Evaluation Oversight Committee's 2018–19 Work Plan directed the Program Evaluation Division to examine the effectiveness of the child protective screening process used by county departments of social services and determine whether there are differences in how counties screen the need for a child protection response.

This evaluation addressed three research questions:

1. To what extent does North Carolina have effective, consistent practices for screening reports of child maltreatment?
2. Is there variation in rates of child maltreatment reports that are screened in across county/tribal social service departments; if so, what might explain the variation?
3. What changes are needed to improve the consistency and effectiveness of the child protective services screening process?

This evaluation will focus solely on the initial steps in the child protective services (CPS) process, namely from reporting an allegation of maltreatment through the screening of that report. Steps that follow the screening phase, such as assessment and response, are excluded from this study.

The Program Evaluation Division collected data from several sources including

- survey of county directors of social services;
- survey of professional mandated reporters, or individuals who because of their work with vulnerable populations have the responsibility to report suspected child maltreatment;
- survey of county social workers and social worker supervisors who screen child protective services reports of child maltreatment;
- interviews and direct observation of workers in 11 counties: Caswell, Craven, Cumberland, Guilford, Henderson, Mecklenburg, Pitt, Sampson, Swain, Wake, and Washington;
- interviews with the Department of Health and Human Services;
- interviews with departments of social services in Colorado, Minnesota, and Ohio; and
- interviews with subject area experts in private industry, non-profits, and the federal government.

Background

Neglect, abuse, and dependency are all forms of child maltreatment. Children are among North Carolina's most vulnerable citizens. It has long been a national goal to prevent, identify, and treat victims of child maltreatment. In North Carolina, county departments of social services screen initial allegations of child maltreatment to determine if they warrant an assessment. Child maltreatment includes all types of neglect and abuse of a child under the age of 18 by a parent, caregiver, or another person in a custodial role.[1] Exhibit 1 provides more extensive definitions of the three primary forms of child maltreatment.

Exhibit 1: North Carolina's Definitions of Neglect, Abuse, and Dependency

Maltreatment Type	Definition	Examples
Neglect	Occurs when a child: • does not receive proper care, supervision, or discipline from their parent, guardian, custodian, or caretaker; • has been abandoned; • is not provided necessary medical care; • is not provided necessary remedial care; • lives in an environment that is injurious to their welfare; or • has been placed for care or adoption in violation of law.	• Failure to provide for a child's basic needs. • Willful failure to enroll a child in school. • Failure to provide proper medical care. • Living in a setting that could be injurious to the child's welfare.
Abuse	Occurs when a child whose parent, guardian, custodian, or caretaker inflicts or allows someone else to inflict a serious, non-accidental physical injury. Abuse is also considered to have taken place if one of these people creates or allows to be created a substantial risk of serious injury to the child by other than accidental means.	• Use of cruel or grossly inappropriate disciplinary methods, or emotional abuse. • Taking indecent liberties with a child. • Human trafficking, involuntary servitude, or sexual servitude.
Dependency	Occurs when a child needs assistance or placement because there is no parent, guardian, or custodian responsible for the juvenile's care or supervision, or the child's parent, guardian, or custodian is unable to provide for their care or supervision.	• A parent's failure to find someone to provide care for their child when the parent is unable to do so.

Source: Program Evaluation Division based on information from DHHS, Division of Social Services.

Child maltreatment has profound and often lasting negative effects on psychological and physical health, relational skills, and risk behaviors, which lead to long-term maladies at taxpayer expense. There are high social and physical costs associated with child maltreatment. Abused children often suffer physical injuries including burns, bruises, cuts, and broken bones. In addition, maltreatment causes stress that can disrupt early brain development and the maturation of the nervous and immune systems. For this reason, abused or neglected children are at higher risk for health problems as adults. These problems include alcoholism, depression, drug abuse, eating disorders, obesity, high-risk sexual behaviors, smoking,

[1] A caretaker is defined as any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. Potential persons responsible for a juvenile's health and welfare include stepparents, foster parents, potential adoptive parents when a juvenile is visiting or is in trial placement, an adult member of the juvenile's household, an adult relative entrusted with the juvenile's care, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services.

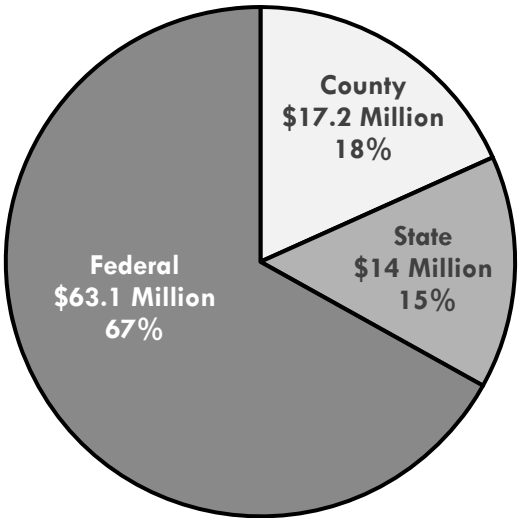
suicide, and certain chronic diseases. The financial cost of child maltreatment, which is estimated by the Centers for Disease Control at more than $210,000 per victim, includes treatment of physical injuries, future loss of productivity due to injuries, as well as lower levels of education and future income. Child abuse also is associated with higher health costs in adulthood.

Identifying, preventing, and providing services for victims of child maltreatment is a national goal. Congress approved the Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247) in 1974 to increase understanding of child abuse and neglect and improve the response to its occurrence by establishing the National Center on Child Abuse and Neglect (now known as the Office on Child Abuse and Neglect) within the Children's Bureau. CAPTA established federal definitions of child maltreatment, created state reporting requirements, and offered funds to states for prevention, assessment, investigation, prosecution, and treatment activities, as well as grants to public agencies and nonprofit organizations for demonstration programs and projects. To receive grant funding through the CAPTA program, states are required to have a statewide program that includes procedures for receiving and screening referrals of known or suspected child abuse and neglect, as well as procedures for investigation.

The federal government provides most of the funding for child protection activities. The federal Administration on Children, Youth and Families provides several funding streams to support child welfare activities. As Exhibit 2 shows, in Fiscal Year 2019–20, $63 million (67%) of $94 million in child welfare funding came from the federal government.

Exhibit 2

Federal Government Provides Two-Thirds of the $94 Million Used to Support Child Welfare Programs in North Carolina



Source: Program Evaluation Division based on information from the DHHS, Division of Social Services.

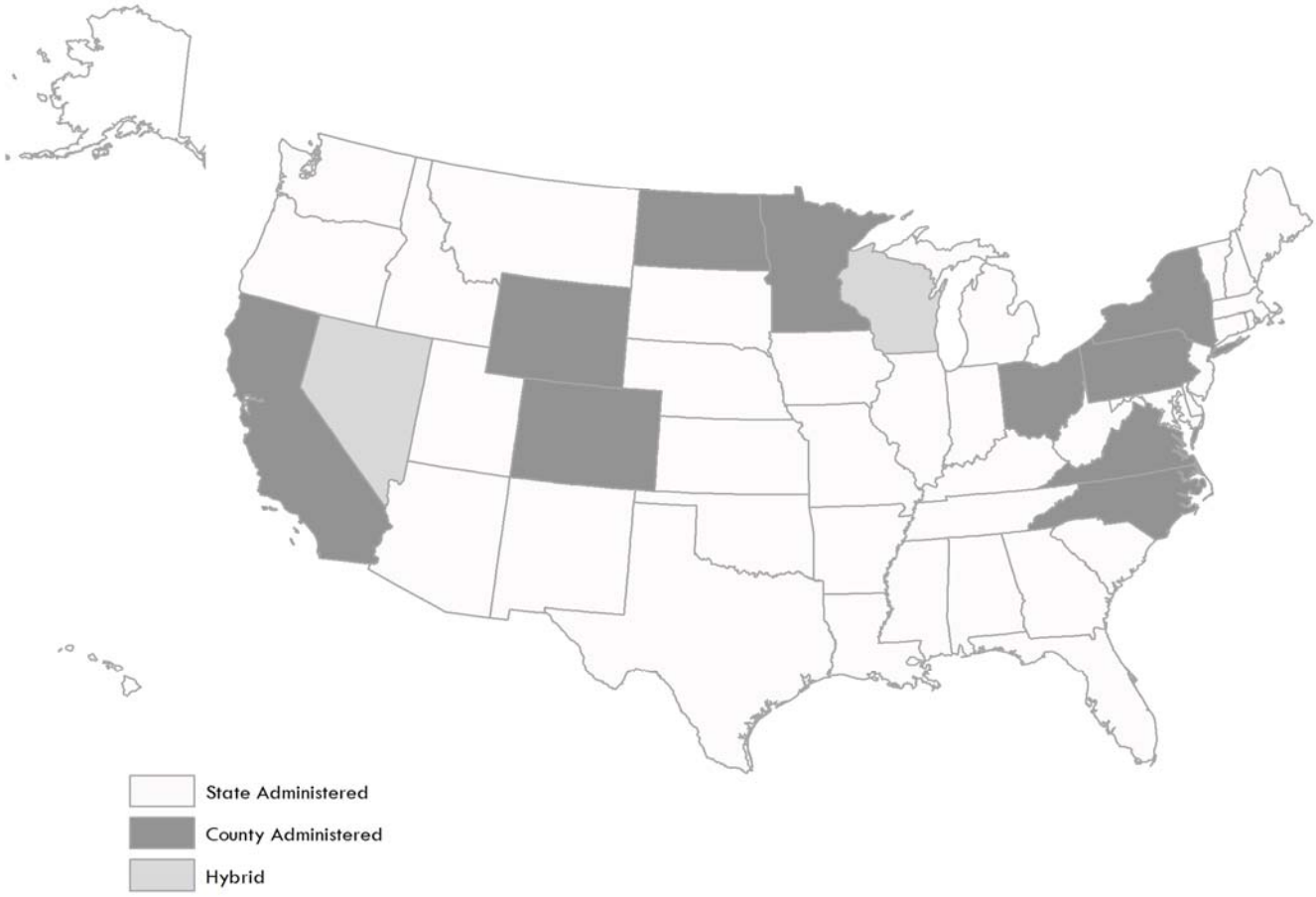
North Carolina maintains a county-administered, state-supervised Child Protective Services system. In North Carolina, child protective services (CPS) are provided through a county-administered, state-supervised social services system. These services include:

- intake and assessment of abuse, neglect, and dependency reports;

- initiation of and participation in court proceedings; and
- provision of reunification and permanency planning services.

Each county has either a department of social services (DSS) or a consolidated human services agency that provides child welfare services, including CPS, foster care and other placement services, and adoption services.[2] North Carolina is one of 10 states that uses a county-administered, state-supervised delivery model. Thirty-eight states use a centralized state-administered system and two states use a hybrid model, meaning they are partially administered by the state and partially administered by counties. Establishing best practices in a county-administered, state-supervised system may be more challenging compared to other administrative structures because the State needs to have agreement and cooperation from all counties operating programs. Exhibit 3 illustrates CPS administrative structures used by each state.

Exhibit 3: North Carolina is One of Ten States with County-Administered, State-Supervised Child Protective Services



Source: Program Evaluation Division based on information from the U.S. Department of Health and Human Services Administration for Children and Families, 2017.

[2] Effective March 1, 2019, counties may create a regional social services department that includes more than one county with the option of incorporating all or only selected programs and services, such as child welfare.

The North Carolina Department of Health and Human Services (DHHS) is the single administrative agency that provides supervision to counties. Through its Division of Social Services, DHHS provides oversight, technical assistance, and training to county departments. The Division of Social Services has a Child Welfare Section that develops extensive state child welfare policies, provides consultations, and monitors counties' compliance and performance. In extreme situations in which a county department is not providing or making reasonable efforts to provide child welfare services in accordance with North Carolina statutes and regulations, DHHS has the authority to implement a corrective action plan and ultimately may withhold state and federal child welfare funds and assume responsibility for delivery of services if necessary.

Child maltreatment is usually first identified by people who interact with children and their families either in a formal or social manner. North Carolina requires that anyone who suspects child abuse, neglect, or dependency must report their concerns to their county child welfare services agency. Some groups of people, due to their occupations and contact with vulnerable individuals, are considered professional reporters. Doctors, teachers, social workers, and police are all examples of professional reporters.

County workers in DSS offices receive reports of potential child maltreatment and make screening decisions that determine whether a report is accepted for assessment. In Fiscal Year 2018, more than 130,000 allegations of potential child maltreatment were made to county department of social services (DSS) offices across the state. County workers screened in 83,636 (64%) of these claims for an assessment.[3] An assessment is the process undertaken subsequent to a decision to screen in a report wherein the county DSS office seeks to determine if the child(ren) is/are abused, neglected, and/or dependent, or if the family is in need of services, and what level of intervention is necessary to ensure safety.

County child welfare agencies must receive and screen all reports of abuse, neglect, or dependency. Each county child welfare services agency must follow state procedures for receiving child protective services (CPS) reports and for providing supervisory decision making 24 hours a day. However, county DSS offices only perform a CPS assessment in cases in which the allegations, if true, would constitute child maltreatment as defined in North Carolina General Statutes. For this reason, county DSS workers must perform a report intake and screening process to determine if intervention is warranted based on the information provided by the reporter. This process is the focus of this evaluation.

There are five steps to the child protective services intake and screening process.

Step 1: Complete the structured intake form with the person reporting the allegation. When a county DSS office receives a report of potential child maltreatment, the county child welfare worker must first collect information by completing the structured intake form with the person

[3] Subsequently, more than 29,000 children were found to have experienced maltreatment.

reporting the allegation. During the report-taking process, the county child welfare worker will document information about the allegation by creating a new CPS intake in the North Carolina Families Accessing Services through Technology (NC FAST) system or by using the North Carolina Division of Social Service's Structured Intake Form (DSS-1402). The county child welfare worker must gather information from the reporter sufficient to be able to

- identify and locate the child(ren), parents, or primary caretaker;
- determine if the report meets the statutory guidelines for child maltreatment;
- assess the seriousness of the child's situation; and
- understand the relationship of the reporter to the family and the motives of the reporter.

The county child welfare worker also must check county agency records to determine if the family or child has previously been reported/known to the agency.

Step 2: Make a screening decision. Once an allegation of maltreatment is received, the second step is to determine whether to accept the report for a response by CPS, wherein the report is considered "screened in," or to screen it out, meaning no further action is taken. A critical part of this process involves knowing the statutory definitions of "child abuse," "neglect," "dependency," and "caretaker." A county child welfare agency has the authority to intervene only when the alleged victim, if the allegations are true, would fit into the statutory definition of "abused juvenile," "neglected juvenile," or "dependent juvenile."

A report concerning any situation or person not covered by one of these definitions will be screened out, and the DSS office will not conduct an assessment. North Carolina law requires a two-level decision-making process for every allegation received by county DSS offices. Decisions to screen in or screen out reports must include a discussion between the CPS intake worker and a supervisor (or an individual in some other management position) about the tools consulted, the response priority, the type of assessment response, and a justification for those decisions.

For reports that have been screened in, the following three steps also are taken in conjunction with the screening decision:

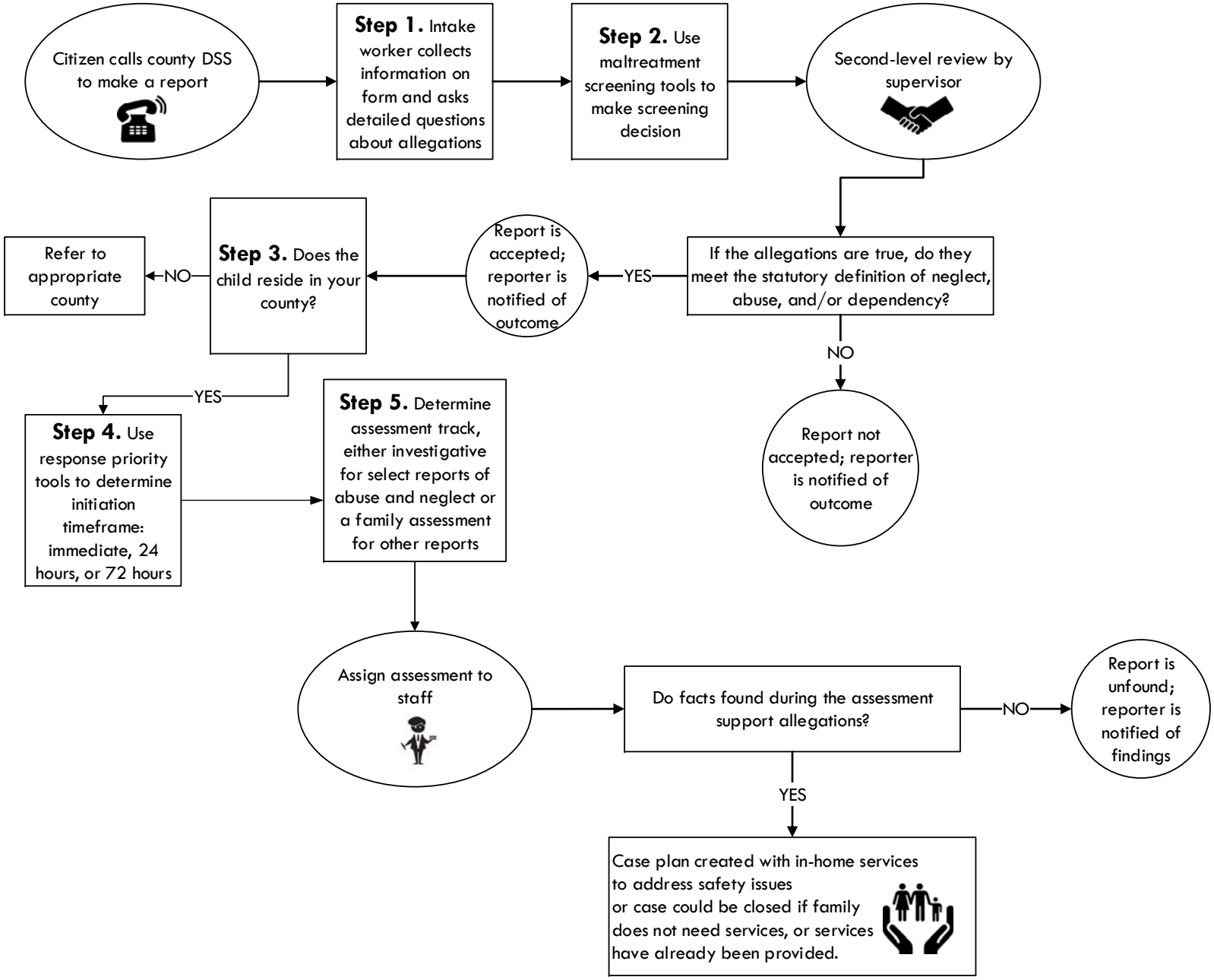
Step 3: Determine residency and the county responsible for completing the CPS assessment. County child welfare workers must determine which county or state is responsible for completing the CPS assessment. All information must be provided to the county in which the child resides in order to determine the CPS assessment response time frame and track assignment and then complete the CPS assessment.

Step 4: Consult response priority tools to determine initiation time frame. The time frame covering receipt of the initial report, decision to screen in the report, and assignment of the case to an assessment social worker is based on the level of risk present. Cases of reported abuse must be initiated immediately or within 24 hours, and cases of neglect must be initiated within 72 hours.

Step 5: Determine appropriate assessment track—investigative or family. The final step of the intake and assessment process is to decide what type of assessment should be pursued, investigative or family. An investigative assessment occurs in response to a report of abuse or serious neglect. These cases present serious safety issues and/or possible criminal charges. A family assessment response focuses on identifying a family's strengths and needs and engaging the family in efforts to become better able to provide care for the child or children.

The child protective services intake and screening process is summarized in Exhibit 4.

Exhibit 4: Child Protective Services Report Intake and Screening Process



Source: Program Evaluation Division based on information from the DHHS, Division of Social Services.

The greatest risk to counties and the State is a case of actual maltreatment that is not screened in for assessment. Ideally, county intake screening procedures would always correctly identify allegations that meet all the criteria for potential maltreatment while simultaneously rejecting claims that do not meet these criteria. The four possible intake screening outcomes are summarized in Exhibit 5. The greatest risk to counties and the State is a case of actual maltreatment that is not screened in for assessment. In this situation, a child or multiple children are at risk for additional maltreatment or even death. A second form of improper screening occurs when maltreatment does not exist and yet an assessment is conducted anyway. Overly cautious approaches to intake screening may result in expending county resources on assessments that do not identify any maltreatment and subjecting families to unnecessary county intervention.

Exhibit 5: Potential Mistakes Associated with Child Maltreatment Screening

		Maltreatment is Not Occurring	**Maltreatment is Occurring**
Screening Decision	**Screen Out**	Screened Correctly ✓	Incorrect Rejection ✗
	Screen In	Incorrect Acceptance ✗	Screened Correctly ✓

Source: Program Evaluation Division.

There is a considerable amount of interstate variability in CPS intake screening rates. In Federal Fiscal Year (FFY) 2016–17, states received an estimated 4.1 million allegations of child maltreatment. Nationally, 57% of these allegations were screened in for assessment and 43% were screened out. Screen-out rates varied significantly by state, from a high of 84.4% in South Dakota to a low of 1.7% in Alabama. Reasons for this variability include the use of different screening tools, policies, and state processes. For instance, Vermont considers every call to its state hotline to be a referral for child maltreatment even though individuals may call the hotline for other reasons or may report the same allegation multiple times. This definition of reporting makes the state's number of referrals seem very high; consequently, the screen-out rate (78.1%) is artificially high. Meanwhile, it is a requirement in Indiana to screen in all allegations of abuse and neglect involving children under the age of three. States also require different levels of proof in determining whether to accept a report. Some states require direct knowledge or observation of child maltreatment, whereas other states only require the reporter to suspect or have a

reasonable belief that abuse is occurring. For these reasons, state rates for child maltreatment referral screening are difficult to compare.

A substantial amount of change is taking place within North Carolina's child welfare programs that is intended to improve outcomes. The Program Evaluation Division conducted this evaluation simultaneously with several transformational activities being undertaken by the General Assembly, DHHS, and local partners to reform child welfare services. A recent federal Child and Family Services Review and statewide CPS evaluation determined North Carolina's child welfare system failed to meet national standards or provide adequate measures and services for the protection of children and their families. In response, the General Assembly approved measures for system improvements.[4] Reforms included

- directing DHHS to establish regional offices by March 1, 2020 to perform oversight and supervision of local social services offices;
- contracting with a consultant to develop a plan to reform the State's supervision of and accountability for the social services system, including child welfare, adult protective services and guardianship, public assistance, and child support enforcement;
- requiring DSS to enter into a written agreement each year specifically mandating performance requirements and administrative responsibilities for all social services programs; and
- establishing a time-limited Child-Well Being Transformation Council to ensure the collaboration, communication, and coordination of all departments offering services to children.

North Carolina is implementing North Carolina Families Accessing Services through Technology (NC FAST) for child welfare activities. In addition, DHHS is in the process of transitioning all counties from using paper forms or county data systems to record maltreatment reports to using the North Carolina Families Accessing Services through Technology (NC FAST) system for conducting child protection intake and screening processes. As of September 2019, 29 of 100 North Carolina counties use NC FAST for intake and screening.

Although intake screening only represents one portion of the overall activities encompassing child welfare services, it is a critical process in ensuring child safety. Consistency in intake screening is important because ideally a child should receive the same CPS response to similar allegations of maltreatment no matter where the child lives in North Carolina. As the oversight agency, DHHS must ensure that the decision of whether to investigate a child maltreatment report is made according to policy, and that policy is applied consistently between workers and across local offices. This evaluation examines methods to measure intake screening variation and explores potential reasons that variation exists.

[4] S.L. 2017-41.

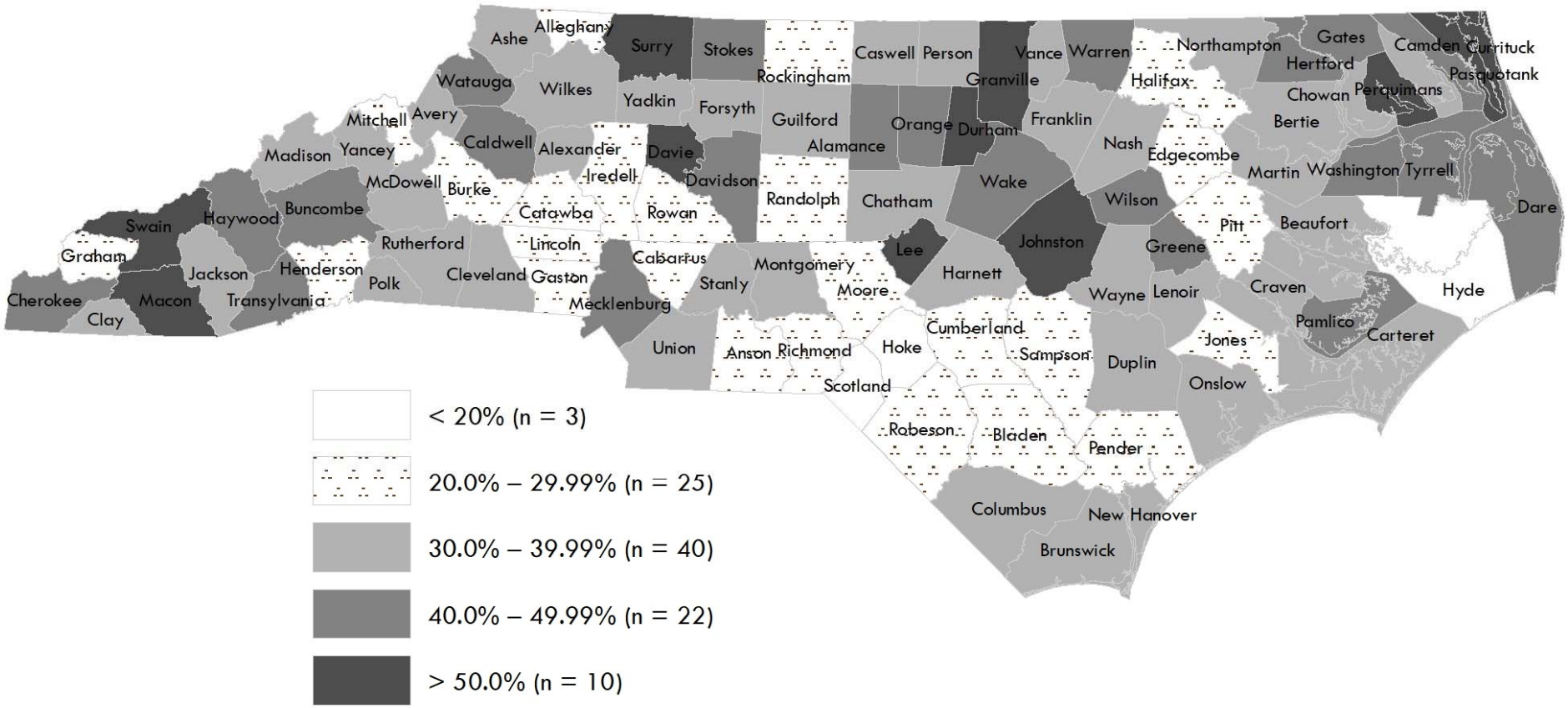
Findings

Finding 1. There is substantial variation among North Carolina child protective services offices in screening child maltreatment reports; county department of social services (DSS) directors indicate that local policies, lack of staff familiarity with intake screening procedures, and an absence of consistent and timely state guidance contribute to intake screening variation.

Recent data from the 2018 Child Welfare Staffing Survey show substantial variation across counties in the percentages of child protective services (CPS) intake reports that are screened out.[5] The State's average screen-out rate in 2018 was 36.1%. Counties ranged from screening out 11.8% of all reports to 60.2%. As depicted in Exhibit 6, variations in report screen-out rates do not seem to be associated with any particular geographic region of the state. County-specific information about CPS intake screening is presented in Appendix A.

[5] The Child Welfare Staffing Survey is completed by county social services offices and sent quarterly to the Division of Social Services. The survey contains measures of workload and staffing such as number of reports screened by month and the number of staff budgeted for intake activities.

Exhibit 6: Percentage of Child Maltreatment Reports Screened Out by County in 2018



Source: Program Evaluation Division based on data from the Department of Health and Human Services, Division of Social Services.

This county-by-county variation has been noted in another recent report about North Carolina's child welfare system. The North Carolina Child Welfare Reform Plan, produced by the Center for the Support of Families, indicated that state leadership was aware counties are not consistent regarding the rates at which they screen in and screen out reports and found a distribution of 2017 screen-out rates by county similar to the results reported for 2018 and shown in Exhibit 6. The report further notes that counties appear to differ substantially in how they interpret law and policy regarding what constitutes a report that should be screened in for assessment.

The Department of Health and Human Services' (DHHS) program monitoring team asserts that county screening decisions agree with state policy more than 92% of the time. However, as detailed in Finding 4, the samples sizes used by DHHS's program monitoring division may be too small to draw reasonable conclusions about the quality of intake screening at county and state levels.

Some variation among county intake screening is to be expected. Decisions regarding the safety of children can vary significantly from worker to worker, even among those considered to be child welfare experts. The inherent presence of some level of subjectivity is further complicated by the fact that screening occurs at the initial intake phase, when it is most difficult for child welfare workers to reach the most accurate conclusions about the likelihood of maltreatment having occurred because these decisions are often based on preliminary information and little or no contact with the reported family. Location-specific issues also may make it reasonable for one county to have a significantly lower or higher screen-out rate than another county. For example, areas with acute drug problems may see more cases of neglect and areas adjacent to major interstates may experience more cases of human trafficking. For these reasons, it is difficult to know if screen-out rates of individual counties are too high, too low, or acceptable.

A survey of county DSS directors indicates that local policies, lack of staff familiarity with intake screening procedures, and an absence of consistent and timely state guidance also contribute to intake screening variation. Individuals interviewed for this evaluation mentioned that factors such as worker skillsets, office workload, and county policies used to supplement state policies affect the consistency of intake screening. As part of this evaluation, the Program Evaluation Division created a survey for directors of county social service agencies.[6] The DSS directors' survey provides further insight into factors affecting intake screening, including use of county-specific policies, lack of consistent and timely state guidance, difficulty obtaining worker training, and differences in perception of risk.

Individual county policies may address specific concerns but reduce overall screening consistency. One of the survey questions provided to DSS directors asked, "Other than the state screening policy, protocol, and

[6] Ninety-six county directors of social services fully completed the survey; the four other directors either did not attempt the survey (Columbus, Edgecombe, and Gaston Counties) or only provided a partial response (Harnett County).

guidance, please indicate whether your agency uses criteria, guidelines, or policies from the following sources to assist with screening child protection reports." As shown in Exhibit 7, at least 23% of reporting counties (22 out of 96 responses) utilize additional written county policies or other forms of guidance in addition to state screening policies. For instance, in at least one county, every case of domestic violence that references children is identified and considered a referral. In another county, any referral that comes from a judge is automatically assessed. Some county workers also use community standards documents to help determine when children are able to provide supervision to other children and to determine the minimum standards that must be present in a home to make it a safe environment.[7] DHHS does not have a copy of each county policy document being used in addition to state policies for intake screening, nor does state law require the department to review these documents before use.

Exhibit 7:

Counties Rely on a Variety of Resources in Making Screening Decisions

Source	Yes	No	Don't Know
North Carolina Statutes	86%	13%	1%
Written County Guidance	15%	82%	2%
Other Policies, Guidelines, or Criteria	23%	70%	6%

Note: Percentages may not equal 100 due to rounding.

Source: Program Evaluation Division based on survey of DSS directors.

DSS directors perceive issues with state guidance and lack of staff familiarity with child protective screening procedures as being the factors most responsible for intake screening variation. Directors were asked "Which factors affect your ability to maintain consistent screening criteria from year to year (that is, screening in child maltreatment reports of the same type and level of seriousness.)?" As shown in Exhibit 8, the leading factors that directors identified were issues with state guidance and staff familiarity with child protection screening protocol. Other factors judged to be affecting consistency to a lesser extent were staff turnover and state technical assistance. Budget constraints and organizational priorities were the factors deemed to have the least effect on maintaining consistent screening.

[7] Community standards documents seek to define terms used in state statutes related to child neglect, abuse, and dependency. They provide county workers with more clarity and examples of terms such as "proper discipline."

Exhibit 8

State Guidance and Staff CPS Familiarity Most Affect County Ability to Maintain Consistent Screening Criteria

Factors Affecting County Ability to Maintain Consistent Screening Criteria	Not at All to Only a Little	To Some Extent	Rather to Very Much
State guidance	63%	27%	10%
Staff familiarity with child protection screening	69%	25%	6%
State support such as technical assistance	73%	22%	5%
Staff turnover	71%	21%	8%
Organizational priorities	94%	4%	2%
Budget constraints	93%	6%	1%

Source: Program Evaluation Division based on survey of DSS directors.

Lack of staff familiarity with CPS procedures could be exacerbated by infrequency of state training. DHHS offers training for new and existing child protective services workers. New workers must receive three weeks of training before being permitted to make direct contact with clients, and all workers are required to complete 24 hours of continuing education each year. More specifically, training for intake screening must be completed during the first year of employment or within three months of assuming responsibility for intake screening. The Program Evaluation Division's survey of county DSS directors sought perceptions of certain DHHS services intended to ensure the quality and consistency of child maltreatment screening decisions by counties. As shown in Exhibit 9, 66% of responding directors disagree that DHHS provides training for intake workers with sufficient frequency. This perceived deficiency of regular training opportunities may tie directly into county directors' beliefs that lack of staff familiarity with CPS practices affects the consistency of decision making. Issues with staff intake training are further explored in Finding 2.

Exhibit 9: County Directors of Social Services Believe DHHS Does Not Provide Frequent Enough Training

Perceptions of DHHS Services Related to Child Protection Screening	Disagree	Neither Agree nor Disagree	Agree
DHHS's training for intake workers is offered frequently enough so staff can receive training as needed	66%	11%	23%
DHHS materials for mandated reporters have helped my agency inform mandated-reporter groups	27%	42%	31%
DHHS Children's Program Representatives provide accurate guidance on state policies and protocol for child maltreatment report intake and screening	20%	22%	58%
The Intake in Child Welfare Services training for child welfare workers has helped improve the screening skills of our child protection staff	4%	16%	80%

Source: Program Evaluation Division based on a survey on county DSS offices.

County DSS directors reported that DHHS provides accurate policy guidance in general but that guidance about specific intake situations may not be consistent or offered in a timely manner. Other survey questions probed DHHS's policy guidance to counties. As also depicted in Exhibit 9, 58% of responding county social services directors agree that DHHS Children's Program Representatives provide accurate guidance on state policies and protocol for child maltreatment report intake and screening.

Eighty-five percent of counties surveyed have asked DHHS for guidance on specific screening cases. Of directors who had asked for guidance on specific screening decisions, survey results indicated that DHHS's advice was helpful and informative. However, as Exhibit 10 shows, directors rated the consistency and timeliness of advice more poorly. Interviews with county staff and survey comments also noted DHHS shortcomings in terms of the ability of state staff to respond to county questions within the specified screening time frame with regards to situation-specific guidance.

Exhibit 10

Although Helpful and Informative, County DSS Directors Perceive DHHS Guidance on Specific Intake Cases to Be Less Consistent and Timely

Perception of DHHS Guidance on Specific Intake Cases	Not at All to Only a Little	To Some Extent	Rather to Very Much
Helpful	16%	37%	48%
Informative	18%	37%	45%
Timely	22%	38%	40%
Consistent	29%	29%	41%

Note: Percentages may not equal 100 due to rounding.

Source: Program Evaluation Division based survey of county Department of Social Services directors.

In a 2011 study, the Minnesota Office of Legislative Auditor noted a similar lack of consistency in state guidance. After a highly publicized child death, then-Governor Mark Dayton created a task force to reform child welfare services. One task force recommendation directed the Minnesota Department of Human Services to implement a Rapid Consultation system to provide consultation to county and tribal child welfare agency staff when making intake screening decisions regarding the safety of children, especially in challenging situations. The Rapid Consultation line is coordinated by a department child safety consultant and each call includes at least two state workers. County caseworkers, their supervisors, and/or the screening team can dial a dedicated toll-free phone number to schedule a consultation time. Once a request for consultation is received, a consultation will be scheduled for the earliest time possible, but no later than within 24 hours of receiving the initial request. Child protection caseworkers and their supervisors are encouraged to access Rapid Consultation as needed to help guide decision making in challenging case situations.[8]

In summary, surveying county DSS directors revealed that directors believe local policies, infrequent training, and a lack of consistent and timely state guidance contribute to intake screening variation. Currently, DHHS does not have any awareness of or oversight for local policies that are being used in addition to state policy in 22 counties. Two-thirds of directors do not believe DHHS's intake training class is being offered frequently enough to meet county needs. Although DSS directors believe state guidance for specific intake screening cases is helpful and informative, consistency and timeliness of advice could be improved. In Minnesota, the creation of a Rapid Consultation system has improved consistency and timeliness of state guidance to counties for intake screening.

[8] The Rapid Consultation phone line is not a centralized hotline for receiving child maltreatment reports. Instead, it serves as a tool for county staff to get quick access to state advice when making screening decisions.

Finding 2. County worker performance on hypothetical vignettes was mixed; training deficiencies and a lack of worker skill assessments were identified as factors affecting intake screening.

Hypothetical decision-making vignette instruments for county workers offer another method of examining inter-county intake screening variation. The State of Minnesota used such an instrument with hypothetical stories of alleged child maltreatment in 2011 to assess county intake screening variation and to explore possible reasons variation exists. Unlike statewide sampling, vignettes can pinpoint individual or county differences in intake screening. This evaluation used a similar approach to examine screening variability in North Carolina. The Program Evaluation Division sent the vignette instrument to county social workers and social work supervisors who perform intake screening.[9] The exercise also was sent to four state Division of Social Services workers so that their performance could be compared to that of county workers.[10]

The decision-making vignette instrument contained 12 hypothetical reports of alleged child maltreatment produced by DHHS staff; six vignettes were classified as easy questions and six were deemed more challenging. Each question had three measurement points. First, workers had to determine if a report should be screened in for assessment. Next, the workers had to assign the report to the correct assessment track, either investigative or family. Finally, workers had to select the correct response time frame. The highest possible score was 36. The vignettes and correct responses are presented in Appendix B.

In addition, this evaluation included a separate survey for professional reporters, or individuals who, because their occupation involves frequent interaction with vulnerable populations, often report suspected child maltreatment.

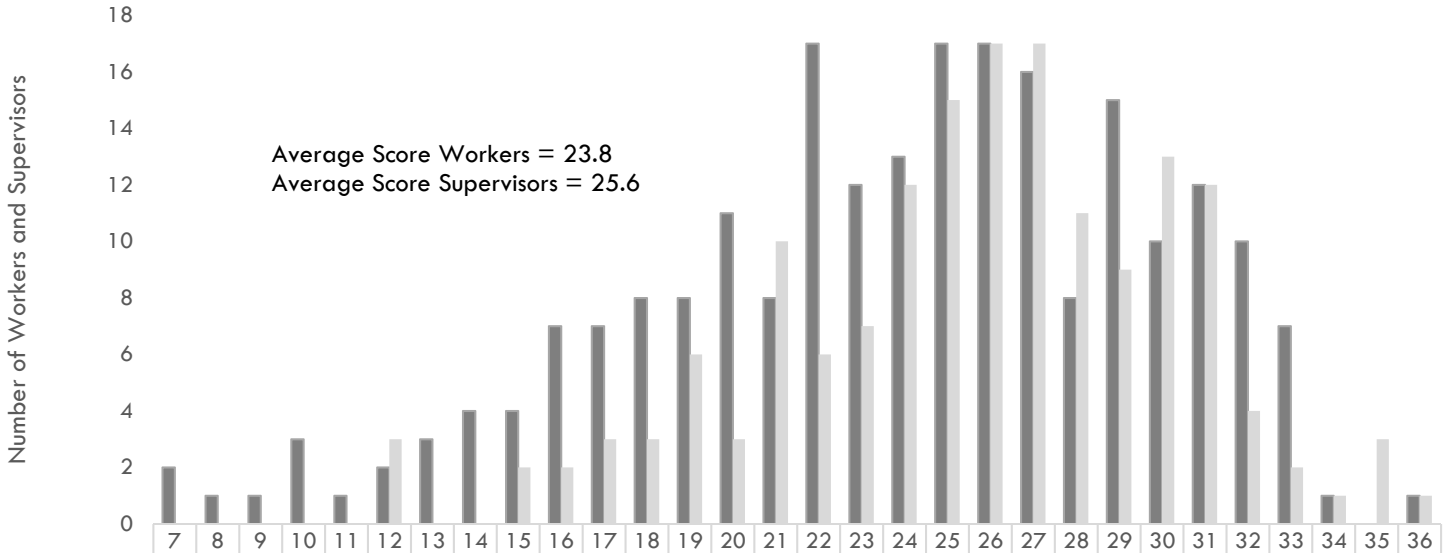
As depicted in Exhibit 11, the distribution of scores for county workers and supervisors ranged from 7 to 36, with one worker and one supervisor achieving a perfect score. The average score for workers was 23.8 whereas supervisors achieved an average of 25.6. This difference in average scores was statistically significant at the 99% confidence level.[11] The long left-sided tail on the distribution of worker and supervisor scores means there was a larger number of below-average scores than one would expect to see in a normal distribution.

[9] The Program Evaluation Division received at least one response from every county and a maximum of 24 responses from a single county. The Program Evaluation Division received a total of 388 responses, 226 from county social workers and 162 from county social work supervisors. Twenty-three percent of respondents had been performing CPS intake for less than a year, and 37% performed intake for fewer than 20 hours per month.

[10] Currently there are a total of eight filled Children's Program Representative positions.

[11] Confidence level is a measure of how sure one can be. It is expressed as a percentage and refers to the percentage of all possible samples that can be expected to include the true population parameter. Most researchers use the 95% confidence level although 90% may be used with smaller samples.

Exhibit 11: Distribution of County Worker and Supervisor Vignette Scores Shows Larger-Than-Expected Number of Below-Average Scores



	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Workers	2	1	1	3	1	2	3	4	4	7	7	8	8	11	8	17	12	13	17	17	16	8	15	10	12	10	7	1		1
Supervisors						3			2	2	3	3	6	3	10	6	7	12	15	17	17	11	9	13	12	4	2	1	3	1

Source: Program Evaluation Division based on vignette provided to county DSS workers and supervisors.

Examining screening according to the three specific actions performed by intake workers and supervisors may help determine where screening knowledge deficiencies exist. Exhibit 12 shows county social workers correctly accepted or rejected reports of child maltreatment 71% of the time. County social worker supervisors and state workers scored better.

Exhibit 12

County Workers Correctly Accepted or Rejected Maltreatment Allegations 71% of the Time

	Accept or Reject Report	Assessment Track	Response Time Frame	Total Correct
County social workers (n=226)	71.1%	65.9%	61.4%	66.1%
County social work supervisors (n=162)	76.5%	70.6%	66.0%	71.1%
DHHS workers (n=4)	87.5%	85.4%	68.8%	81.0%

Note: Figures for DHHS should be interpreted with caution because the Program Evaluation Division sampled a small number of workers.

Source: Program Evaluation Division based on survey of county social workers and social work supervisors.

Correctly choosing whether to accept or reject the vignette for screening directly affected the following decisions and subsequent scores. If a worker failed to screen the vignette correctly, the assessment track and response time frame questions also would be incorrect. Thus, the data were re-examined to see how county workers and supervisors performed in

identifying the correct assessment and response time frames when they had already made the correct screening decision. Social workers and social worker supervisors who correctly screened reports also selected the correct assessment track approximately 89% of the time and determined the appropriate response time frame in 82% of scenarios. Combined, these data suggest that county workers could use state intervention to improve their ability to accept or reject initial reports as well as assistance in assigning the correct response time frame to reports.

The four DHHS staff members who completed the vignette instrument performed better overall than county social workers and social worker supervisors. However, due to the small number of DHHS staff who made up this sample, these results should be interpreted with caution.

Attendance at intake screening training sessions did not improve survey scores. Importantly, attending DHHS's intake training course is not correlated with achieving better performance on the vignettes. This finding is counter-intuitive; the expectation is that individuals with specific training would perform better than workers without training. One problem might be that intake training is not offered frequently enough for new workers to receive training before beginning to perform intake screening on the job.

In addition to attempting to gauge intake screening proficiency, the survey also asked county workers about training. Seventeen percent of workers who took the county worker survey indicated that they had not received intake training although they were actively performing intake screening. As discussed in Finding 1, 66% of respondents to the directors' survey disagreed with the statement "DHHS's training for intake workers is offered frequently enough so staff can receive training as needed." Difficulty in obtaining training also was noted in the 2016 Public Consulting Group's evaluation of North Carolina's Child Protective Services.

There are no requirements for workers and supervisors to re-attend intake screening training once the initial training requirement has been met. Once a worker has gone through intake training, there is no requirement to repeat intake training to improve screening skills at any point in time. Workers and supervisors who are not required to complete ongoing training may not understand how to correctly apply subsequent policy changes. For instance, recent policy changes concerning substance-affected infants and human trafficking directly affect intake screening. As one worker noted, "I would recommend that this course be taken at least every other year as policy is consistently changing." Another option would be for DHHS to begin offering an intermediate intake training.

DHHS does not conduct routine testing of social workers or social worker supervisors who perform intake screening to determine how well they are implementing state policy. Currently, the State's intake training class does not test participants before and after completing the course in order to measure potential improvement in screening hypothetical vignettes. In addition, DHHS does not presently administer a mechanism to determine how well staff and supervisors are following general state intake policies or new policies that may be introduced. This lack of a

method for measuring staff proficiency means DHHS is unable to determine the effectiveness of specific intake training components or achieve a more holistic understanding of potential gaps in staff competency regarding intake screening policy and protocol.

In summary, a survey of county intake workers and supervisors that contained an instrument asking workers to make screening decisions based on hypothetical vignettes yielded a range of scores that was wider on the low end than would be expected if the scores had been normally distributed. Workers indicated that it was difficult to secure a slot in the intake screening class offered by DHHS and that no additional training is required once the initial class has been completed despite ongoing policy changes. Finally, DHHS does not conduct comprehensive assessments of worker intake screening proficiency, either via the training offered or in other ways.

Finding 3. Deficiencies with the current structured intake tool make the reporting process lengthy and redundant and may contribute to a lack of screening consistency.

In 2002, North Carolina adopted a Structured Decision Making model developed by the Children's Research Center as part of the State's federal program improvement plan.[12] The Structured Decision Making system consists of a set of six research-based assessments or tools that help caseworkers make consistent and equitable service decisions for families. The objective of a structured approach to case management is to increase the consistency, validity, utility, and equity of decisions at every agency level. Workers complete assessments at key decision points in a child protection case, and each assessment is designed to inform the relevant decision. Such standardization helps ensure that all workers consider the same information when making a decision and that assessment findings inform service delivery and prioritization.

All county workers in North Carolina use the same basic form to record reports of alleged child maltreatment. This structured intake form is a version of an intake tool originally used by the State of Minnesota and modified to accommodate North Carolina-specific laws and definitions. The intake screening tool is the same for all counties regardless of whether they use paper forms, use North Carolina Families Accessing Services through Technology (NC FAST) to perform intake, or use other electronic case management systems. The screening section of the intake tool consists of a set of ordered questions meant to help workers determine if the current report meets statutory definitions and rises to the level that a CPS assessment is warranted. The response priority section helps workers determine how swiftly an investigation must be initiated for those reports accepted for assessment. Counties may add content to the intake tool but

[12] The Children's Research Center (CRC) was established in 1993 as part of the National Council on Crime and Delinquency, which is a nonprofit social research organization that works to help protect children from abuse and neglect.

are not allowed to remove any questions. The screening tool is presented in full in Appendix C.

Revisions to accommodate new laws have made the child maltreatment tool less effective. Throughout the years, the structured intake tool has been modified to accommodate changes to federal and state laws. For example, DHHS has altered the intake tool to accommodate policy changes involving the definition of "caretaker," substance-affected infant laws, and new human trafficking laws. When making modifications, DHHS also changed the question order of the tool. The logic behind Structured Decision Making in general holds that looking at a set of facts leads to making a specific decision that leads directly to the next decision node. Changes to the intake tool's question order may lead to inconsistency and divergent decision making.

DHHS-driven modifications have made the current intake tool long and redundant. The first five pages of the intake tool serve to establish the foundation of the report. Only if the caller reports a specific type of abuse should the responder follow up with certain more specific questions. However, during direct observation the Program Evaluation Division noticed county workers asking callers certain questions at the beginning of the intake process and then asking them again later even though the respondent had not identified relevant concerns. For example, a caller reporting child truancy would be asked, "Are you concerned about a family member's drug/alcohol use?" and answer in the negative. Then, later in the interview, the caller would again be asked if substance abuse was a concern for the family even though it had already been determined that the particular report was not related to substance abuse.

In response to a Program Evaluation Division survey, individuals who report maltreatment as part of their professional work and some county DSS workers commented on the tool's length and cumbersome questions therein.

- *"The process to report takes a LONG time and questions are redundant. The process makes me (the professional) feel as though I am the one who is "in trouble."*
- *"The interview tool used is way too long. Some counties are very efficient, and others can literally keep you on the phone for an hour. Often, I feel like I've given all the info I have in the first 10 minutes. Anything after that would be me saying 'I don't know' or 'I'm not aware of that.' I would love to be able to enter my own reports online."*
- *"The interview process for making a report is very extensive and long and repetitive. Once the details are given, it should not have to be repeated several different times reworded in a different question. It takes way too long to make a report and is a deterrent to some people who would maybe make one."*

Again, Appendix C reproduces the tool in full and thus demonstrates its considerable length.

These challenges also were noted by Program Evaluation Division staff during direct observations of county staff using the structured intake tool to receive child maltreatment referrals. Reporters seemed confused by questions, frustrated by the amount of time needed to make a report, and uncertain as to what specific questions were asking.

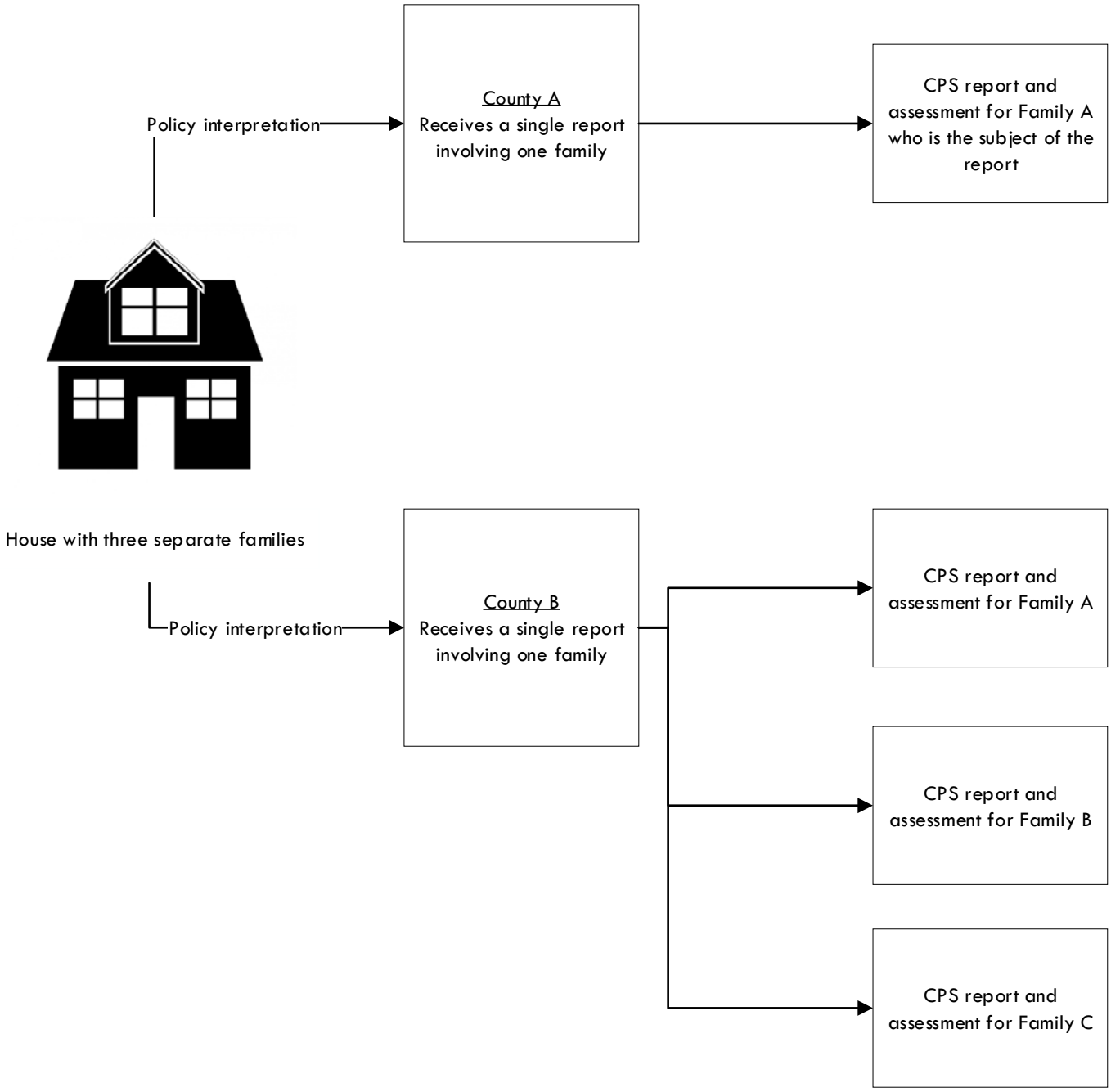
Other issues identified with the structured intake tool include unclear definitions, overly extensive lists of examples, and overreliance on 24-hour response times. Unclear or poorly described definitions were another problem noted with the intake form, including those for "caretaker," "family," and "household." Additionally, Children's Research Center staff noted the tool lists too many examples of abuse and neglect, which often has the opposite of the intended effect. Specifically, some screeners come to rely on lists as exhaustive rather than simply as a collection of examples and hence may not select an item even when they should because the specific situation being reported is not on the list. There are 17 different types of maltreatment listed on the report form, which is four times more maltreatment types than used by the Children's Research Center in its most recent Structured Decision Making intake tool. Finally, response priority decision trees, which are a series of questions designed to help workers determine the appropriate response time frame, are directing most cases toward a 24-hour response. As a result, counties underuse the 72-hour option that would allow for better workload management. Using the current decision-tree logic, response time is based more on allegation type than whether the child is in harm's way.

Counties interpret intake tool definitions differently, further lowering screening consistency. Failure to provide definitions with sufficient specificity leaves workers to interpret certain terms on their own and thereby jeopardizes the consistency of decision making. One example is counties using differing interpretations of state guidance in handling companion cases. A companion case arises when more than one family lives in the same house. One county ("County A" in this example) defined "caretaker" as only being inclusive of the immediate family that was reported to CPS, whereas another county ("County B") defined "caretaker" to include all adults in the dwelling. When County A would receive a report of suspected child maltreatment and determine it should be screened in for an assessment, the office would undertake a single assessment of the family that was the subject of the complaint while ensuring that the children in each of the three families that lived in the dwelling were interviewed. County B, on the other hand, would create a separate assessment for each family occupying the dwelling even when only one family was the subject of the report. As depicted in Exhibit 13, this inconsistency in county-by-county interpretation of the definition of "caretaker" led to County B conducting many more assessments than necessary. This type of additional work resulted in few, if any, further substantiations of child maltreatment.

Most troubling, it was not DHHS that identified this difference in interpretation between counties. Rather, a nonprofit noted it while assisting the counties. Once this difference was noted, County B changed the way it performed assessments for companion cases to be consistent with County

A's interpretation. The DHHS Children's Program Representative objected to this change in policy for County B despite this interpretation being the approach used by County A.

Exhibit 13: Different Counties Interpret Multiple Familiies Living in a Single Dwelling Differently



Source: Program Evaluation Division based on interviews with counties and the Annie E. Casey Foundation.

DHHS is in the contracting process with the Children's Research Center to modify the intake tool to ensure that it continues to meet federal and state requirements and can be utilized statewide to ensure consistency across counties. It is important that this update takes place because the

intake form currently being used in county department of social services offices to record allegations of child maltreatment and determine whether to screen in or screen out reports has numerous deficiencies. Revisions to the form have made it long and redundant. Other challenges include unclear definitions, overly lengthy lists of examples of abuse and neglect, and decision trees that promote overreliance on 24-hour response times. Further, differing county interpretations of state policy via the intake tool can lead to substantial differences in child welfare practices.

Finding 4. Child Protective Services program monitoring lacks statistical validity and fails to ascertain the quality of county-level intake screening.

Program monitoring refers to the systematic documentation of measures indicative of whether the program is functioning according to appropriate standards. Monitoring usually considers both processes and program outcomes. Statute requires the Department of Health and Human Services, through the Division of Social Services, to "ensure the delivery of child welfare services in accordance with state laws and applicable rules." In order to fulfill this mandate, the General Assembly allocated nine positions to the Division of Social Services in 2014 "to enhance oversight of child welfare services in county departments of social services." The General Assembly further specified that "these positions shall be used to monitor, train, and provide technical assistance to the county departments of social services to ensure children and families are provided services that address the safety, permanency, and well-being of children served by child welfare services."

The Division of Social Services subsequently established program monitoring for Child Welfare Services in 2015. In 2015, the Program Monitoring Team began evaluating county child welfare programs. These evaluations have resulted in the development and implementation of a Program Development Plan for each of the 100 county child welfare agencies. The Program Development Plan addresses agency practice issues identified in the evaluations and is used as a guide for technical assistance provided by DHHS. Program monitoring should benefit counties by giving them a clearer understanding of requirements and best practices in child welfare work and by providing an opportunity to work with data to analyze their processes in order to enhance efficiency.

There are no established benchmarks for intake screening. The federal government does not maintain any benchmarks for intake screening in the Child and Family Services Reviews (CFSR). Instead, states have autonomy to develop performance standards and monitoring programs for this activity. Most states, including North Carolina, use two methods to determine if counties are performing intake screening in accordance with state guidance. First, cases that were screened in for an assessment are reviewed as part of assessment case reviews. Reports that were screened out for assessment are also periodically reviewed. During the case review process, performance monitoring staff are attempting to answer the

following five questions to determine if counties are performing intake screening correctly:

- Was the report screened appropriately according to policy?
- For screened-out reports, is justification provided for why the report did not meet the criteria for acceptance?
- Was the most appropriate assessment track assigned?
- Was the response time frame appropriate to the allegations?
- Was a letter sent to the reporter within five days?

As is the case with the federal government, DHHS has not established performance benchmarks for intake screening case reviews. An example of a screening benchmark would be "All counties will screen at least 95% of all reports according to state policy." Instead, DHHS encourages counties to make incremental improvements to screening practices and then shifts the goal when these incremental improvements are achieved. DHHS encourages counties to incorporate intake screening in their program development plans if deemed necessary, yet the lack of benchmarks makes this determination subjective. Counties ultimately decide which performance issues will be addressed in their development plans.

Counties reported that intake screening sample sizes vary widely. Sample size refers here to the number of reports of potential child maltreatment reviewed by program monitors to determine if counties are conducting screening procedures in accordance with state policies. Interviews conducted by the Program Evaluation Division with county workers indicate variation in the number of cases reviewed in a sample. DHHS reports that it seeks to achieve a confidence level of 80% and a margin of error of 7.7% for individual counties.

Since the federal CFSR does not measure intake screening, the State could better oversee intake screening by performing valid sampling and performance monitoring at the county level. Another county DSS staff member told the Program Evaluation Division that the total sample size for intake screening is 20 cases out of an average of about 700 intake reports received each month. This sample is too small to be representative of a county's entire population of intake cases. To achieve a confidence level of 80% and a margin of error of 7.7%, at least 63 reports would need to be reviewed. Meanwhile, a sample size of 248 would be needed to achieve standard levels of statistical validity[13] As sample size increases, the sample becomes more representative of the underlying population. Without a large-enough sample size, DHHS cannot ensure that the results from its case reviews are valid representations of each county's intake screening practices. In other words, the State's sample may misidentify certain problems and miss other actual problems entirely.

[13] The margin of error expresses the maximum expected difference between the true population parameter and a sample estimate of that parameter. If a researcher uses a margin of error of 4 and 47% of the sample selects a particular answer to a question, the researcher can be "sure" that if they had asked the question of the entire relevant population, between 43% (47 minus 4) and 51% (47 plus 4) of individuals would have chosen that answer. When you put the confidence level and the margin of error together, you can say that you are 95% sure that the true percentage of the population selecting that answer is between 43% and 51%.

These problems with sample size also have been noted in another recent evaluation of other child protective services such as assessment and permanency planning which are monitored by the federal government. In its Child Welfare Preliminary Reform Plan submitted to the Office of State Budget and Management on August 31, 2018, the Center for the Support of Families stated the following about North Carolina's federal Child and Family Services Review:

> *First, the methodology with which counties are selected for review, or the number of cases selected in each county to be reviewed, does not seem to be uniform or proportional based on the size of the county. Second, the number of cases presented are not representative of the State and cannot be extrapolated as such.*

Intake screening evaluation intervals vary between counties. Child welfare services consist of three program areas that may be reviewed as part of a program evaluation.[14] On average, program evaluations are conducted once every 18 months. Depending on the size of a county, all three program areas might be reviewed every 18 months, whereas in another county only one area, such as permanency planning, might be reviewed during the first evaluation with a second area, such as in-home services, reviewed 18 months later. In such cases, intake and assessment would only be subjected to review during one out of every three evaluations, or once every 4.5 years.

In addition, the periodic review of screened-out reports is done sporadically and in such low volume that no meaningful interpretations can be gleaned. DHHS does not have statewide data for screened-out reports sufficient to perform proper sampling. When the P4 module in NC FAST is adopted statewide (discussed in greater detail in Finding 5), DHHS should be able to conduct more comprehensive reviews of screened-out reports.

Other states with county-administered, state-supervised systems similar to North Carolina have more robust program monitoring. The Program Evaluation Division interviewed three states to compare the rigor of their program monitoring for intake screening to North Carolina's oversight. Each of these states, Minnesota, Ohio, and Colorado, also uses a county-administered, state-supervised system. Each of these states examines intake screening at more frequent intervals than North Carolina. In these states, intake screening review, when done as part of a case review process, is conducted between every six months and every two years. Colorado and Ohio use larger sample sizes for their case reviews, thereby generating higher levels of confidence. Confidence levels ranged from 90 to 95% and margins of error were between 1% and 10%. Finally, both Colorado and Minnesota do monthly and biannual reviews of screened-out reports for each county; hence, if deficiencies are noted, county workers can implement changes to their practices in a timely manner.

DHHS plans to implement program monitoring improvements for Child Protective Services by 2024. DHHS is aware of the deficiencies in the

[14] The three program areas are intake and assessment, in-home services, and permanency planning.

current program monitoring system. In its new strategic plan issued in June 2019, DHHS made the following commitment to Continuous Quality Improvement:

> *"County child welfare agencies will have the supports needed to implement and consistently apply all policies, protocols, practices, and procedures, including the information required to make data-driven decisions."*

The following three targets are cited in the strategic plan:

1. By 2024, North Carolina will have a statewide continuous quality improvement model that aligns both county and statewide efforts.
2. By 2024, North Carolina will ensure that state and county child welfare leaders and staff have access to reliable data to use in the continuous quality improvement process.
3. By 2024, North Carolina will have a statewide case management system that captures all federal- and state-required data and increases efficiencies for users.

Each of these goals has specific metrics that DHHS intends to implement by 2024. However, the metrics themselves may need to be more detailed to better measure annual progress. For instance, the metric associated with the second goal is, "There will be a 20% increase (or up to 90% of all employees, whichever is less) of NC county child welfare employees having access to reliable data to use in the CQI process by 2024 via survey of employees through the NC Child Welfare Listserv." Ideally, all employees should have access to reliable data. Further, this metric should be expanded to assess data reliability in ways other than through employee perceptions. Quantifiable measures could include the number of data revisions requested by counties or consistency between reported county and state numbers.

In summary, North Carolina's program monitoring for intake screening lacks established benchmarks for county performance. In addition, the sampling sizes used when conducting monitoring activities are too small in many cases to make appropriate inferences about screening quality. DHHS is aware of the deficiencies in its program monitoring system and has set goals to improve data for use in continuous quality improvement. DHHS's ability to do more robust program monitoring hinges on future implementation of NC FAST.

Finding 5. The absence of accurate program data compromises the Department of Health and Human Services' ability to oversee county Child Protective Services.

Full implementation of the North Carolina Families Accessing Services through Technology (NC FAST) system would give state and county DSS workers the ability to view screening and intake cases electronically and review records in a central location in real time to ensure data is correct and complies with federal requirements. These upgrades also mean that

the State's program monitoring division should be able to easily access more information about screened-in and screened-out reports to determine if intake screening policies are being applied correctly in specific cases. With better access to county-level data, the State will be able to perform more robust program monitoring with larger sample sizes that generate valid representations of performance for both counties and the State as a whole.

In the absence of an efficient statewide data information system, the Department of Health and Human Services (DHHS) cannot consistently or adequately collect and analyze data on key Child Protective Services (CPS) issues. The development and implementation of an information management system and data collection tool ensures that federal and state requirements are met and additionally informs management decisions and supports caseworkers' interactions with children, youth, and families. An efficient information management system also ensures the organization is collecting valid and reliable data to use in accomplishing its goals.

In August 2012, North Carolina began implementing NC FAST, an enterprise software system. Once fully implemented, NC FAST will replace 20 different legacy systems used in health and human services. NC FAST consists of numerous modules customized for specific social services tasks such as Food and Nutrition Services, Medicaid, Temporary Assistance for Needy Families (TANF), Special Assistance, Refugee Assistance, Child Care, and Energy programs.

There have been significant challenges associated with rollout of the child welfare module of NC FAST. The child welfare component of NC FAST is called Project 4 (P4). The State began implementing P4 in August 2017 to collect and monitor data and provide real-time case management information to assist caseworkers and other CPS staff in making informed decisions. At present there are 29 counties using NC FAST for CPS Intake and Assessment and 11 pilot counties using NC FAST for additional services such as CPS In-Home Services, Permanency Planning, and Adoption. Shortly following rollout of P4, several problems with the module were identified. Based on the feedback of the pilot counties, DHHS delayed further rollout to allow for refinement and improvement of system functionality. DHHS performed an in-depth analysis of P4 functionality and worked with the pilot counties and IBM to completely redesign the process beginning with the intake and assessment functions.

County child welfare agencies continue to be concerned about securing

- full, around-the-clock access to the system that will allow for read and write functionality (as opposed to read-only) when the system is down for upgrades,
- a more streamlined process for entering families into the system, and
- data dashboards that show real-time access to information.

Additional concerns about NC FAST were detailed in the 2018 Center for Support of Families evaluation.

- One concern is the lack of consistency among counties entering data into the system. Whereas some counties strictly follow state guidelines when entering data, other counties (such as Wake County) have directed social workers to enter additional details during the intake phase. These discrepancies in data gathering and data entry challenge the usefulness and ease of applicability of this information.

- A second concern is that counties have little access to standardized data reports, and as a result do not rely on data to monitor performance or to strategize to improve program performance. The only publicly available DHHS summaries of county or state intake screening data are from 2008. These reports are essential to helping counties perform monitoring and to identify areas needing improvement.

- Finally, during interviews with the Program Evaluation Division, county staff indicated that (1) they had noticed errors in their data, (2) they were unable to make corrections to the data, and (3) they do not consult or rely on the State's data resources. County staff noted these concerns about data quality existed prior to NC FAST and also have been present during its implementation. As a result, many county departments are not using data to measure their performance or make improvements to their intake processes.

The Program Evaluation Division found that North Carolina submits less data to the federal government than most other states. The federally mandated Child Abuse Prevention and Treatment Act (CAPTA) requires states to submit data reports "to the maximum extent practicable" on child abuse and neglect on an annual basis.[15] In 2017, North Carolina submitted a smaller amount of data compared to most other states. Whereas DHHS was able to report the number of substantiated and unsubstantiated cases that received an assessment or alternative response, it was unable to provide the number of screened-out referrals and percentage of total reports that were screened in for an assessment. The State also failed to include data points such as malicious reports, workforce information, and the number of children who received preventative services. These gaps in data are the direct result of North Carolina's failure to fully implement NC FAST.

NC Fast includes a version of the intake screening tool that is out of date. As discussed in Finding 3, there are serious concerns with the existing intake tool. Despite knowledge of these problems, the State programmed the P4 module with the current version of the tool. NC FAST will need to be reprogrammed as soon as it is implemented statewide in order to address the deficiencies noted in Finding 3 and to include an assessment of parental

[15] National Child Abuse and Neglect Data System (NCANDS) is a federally sponsored effort that collects and analyzes annual data on child abuse and neglect. States submit data to NCANDS voluntarily, and NCANDS is a critical source of information for many publications, reports, and activities of the federal government and other groups.

capacity to protect children. At present, DHHS is negotiating with the Children's Research Center to update the intake screening tool.

NC FAST P4 has cost $92 million. To date, the State has spent $42 million on the NC FAST module for child welfare; the federal government has contributed $50 million. Furthermore, county and state DHHS workers continue to allocate a considerable amount of time and effort towards supporting the development and improvement of the system as it progresses through each phase. Until the problems detailed above are resolved and NC FAST or a similar system is adopted by all 100 counties, North Carolina will continue to exist in a "data desert" for child welfare programs.

Federal sanctions for delayed NC FAST implementation are unlikely. The 2015 CFSR for North Carolina found the State was not in substantial compliance with any of seven outcomes or seven systematic factors. States can be fined if they do not address the concerns raised by the review in a performance improvement plan (PIP). One goal in the State's current PIP is to strengthen its statewide information system through the development of a child welfare module within NC FAST to improve data quality, consistency, and access to timely statewide data. Although North Carolina was out of compliance and potentially faced a $750,000 fine, the PIP has been amended to accommodate the delayed implementation of the NC FAST system. DHHS also has suggested that delayed implementation of NC FAST may trigger the federal government to request payback of $52 million of federal funds used to build the system. However, federal representatives indicated that so long as the State still has a plan to implement NC FAST and is making adequate progress towards implementation, a request for payback is unlikely.

In summary, the delayed implementation of NC FAST P4 for child protective services has led to several challenges for the State. Without an efficient statewide data information system, the Division of Social Services cannot consistently or adequately collect and analyze data on key issues including those affecting child safety. DHHS uses the Child Welfare Staffing Surveys to obtain self-reports from counties, but this practice does not ensure accurate, timely, or comprehensive information. As a result, the State cannot provide sufficient oversight of county activities or produce standardized management reports to help improve county CPS programs. This finding does not have any associated recommendations because DHHS is currently undertaking efforts to implement P4 statewide.

Recommendations

Recommendation 1. The General Assembly should modify state law to specify that counties are not permitted to use county intake screening policies in addition to state policy.

As discussed in Finding 1, some counties supplement formal state policy with internal policies when screening reports of child maltreatment. These policies tend to arise from location-specific situations and problems that counties are eager to address, such as findings from child fatality reports. Given that North Carolina maintains a county-administered, state-supervised system for child welfare services, the Department of Health and Human Services (DHHS) has a responsibility to ensure that all counties are using consistent intake screening policies and processes. For this reason, the General Assembly should specify in law that counties may not use any policies other than those contained in the Child Welfare Policy Manual.

Recommendation 2. The General Assembly should direct the Department of Health and Human Services to adopt a rapid response line to improve the timeliness and consistency of state-level advising provided to counties.

As detailed in Finding 1, some county directors of social services believe that state guidance for specific intake screening cases is inconsistent and not sufficiently timely. To improve the State's intake screening guidance to counties, the General Assembly should direct the Department of Health and Human Services (DHHS) to implement a Rapid Consultation system to provide consultation to county welfare agency staff when making decisions regarding the safety of children, especially in challenging situations. Currently, this type of system is being used in Minnesota to support county staff decision making during the intake screening process. The Rapid Consultation system should consist of a telephone line that county workers or supervisors could call at any time when they are uncertain about the correct screening decision, assessment track, and/or response time frame for a specific case. At least two state workers should consult on each call so that advice is consistent. In addition, consultations should be performed within 24 hours of a request.

Although counties are ultimately responsible for intake screening decisions, DHHS has a responsibility as the State's supervisory entity to provide accurate, consistent, and timely advice to counties to help them make the best decisions possible. The Rapid Consultation system should be implemented by December 31, 2020. DHHS should report to the Joint Legislative Oversight Committee for Health and Human Services on progress in implementing the Rapid Consultation system by June 30, 2021.

Recommendation 3. The General Assembly should direct the Department of Health and Human Services to periodically assess county workers' policy comprehension and training needs through the use of hypothetical vignettes, provide more intake training opportunities for county workers, and require periodic worker retraining.

As presented in Finding 3, hypothetical vignettes such as those used in the Program Evaluation Division's worker survey can provide useful information to the Department of Health and Human Services (DHHS) regarding how well county workers and supervisors are following statewide child protective services policies to screen reports of alleged child maltreatment. Each aspect of the screening process—screening decision making, assignment of assessment track, and selection of response time frame—can be measured with vignettes.

In particular, using vignettes can help the State measure how well CPS workers are comprehending and correctly implementing new state policies. By incorporating vignettes, training sessions can measure competency in addition to disseminating information. Further, cross-referencing vignette performance by county could help assess specific training needs. For example, if entire county staffs are performing poorly on specific vignettes or types of vignettes, the State should be trying to actively engage the entire staff, including workers and supervisors, in additional training.

In addition to strengthening its assessment of worker skills with vignettes in addition to other assessment tools, DHHS should increase the frequency of intake training, develop an intermediate intake screening course, and require county social workers and supervisors to complete intake screening training at least every three years.

DHHS's implementation of hypothetical training vignettes and changes to training offerings and requirements should be completed by December 31, 2020. DHHS should report to the Joint Legislative Oversight Committee for Health and Human Services on the use of vignettes by June 30, 2021.

Recommendation 4. The General Assembly should direct the Department of Health and Human Services to revise the structured intake screening tool with assistance from the Children's Research Center and require the tool to be recertified every five years.

Finding 3 describes existing deficiencies with the current structured intake screening tool used by county workers. The Department of Health and Human Services (DHHS) is currently in the process of securing a new contract with the Children's Research Center to redesign the tool. The General Assembly should direct DHHS to report to the Joint Legislative Oversight Committee for Health and Human Services on this process every six months, starting by January 30, 2020, until completion. In addition, the General Assembly should require DHHS to recertify the structured intake screening tool every five years and to consult with the Children's Research Center in any instance in which legislative or policy changes require modifications to the tool.

Recommendation 5. The General Assembly should direct the Department of Health and Human Services to establish measurable performance benchmarks and implement statistically valid program monitoring for county intake screening. As discussed in Finding 4, the

Department of Health and Human Services has not established any measurable intake screening performance benchmarks. Because the federal Child and Family Services Review does not measure intake screening, the State should be overseeing intake screening by performing valid sampling and performance monitoring at the county level. The current program monitoring system is statistically unsound for the purposes of evaluating individual counties.

DHHS is currently undertaking revisions to its program monitoring system. As part of this process, the General Assembly should direct DHHS to establish measurable and consistent intake screening benchmarks that are applied to all counties. In addition, the General Assembly should direct DHHS to ensure that program monitoring intake screening reviews collect large-enough sample sizes to achieve a county confidence level of 90% with a margin of error of +/- 5%. County data reviews for intake screening should be performed no less frequently than once per year starting by December 31, 2024. DHHS should report to the Joint Legislative Oversight Committee for Health and Human Services at least annually on progress toward improved program monitoring and continuous quality improvement starting by June 30, 2021.

Appendices

Appendix A: Child Welfare Screening by County for 2018

Appendix B: Answers to the Vignette Survey Questions

Appendix C: Child Protective Services Structured Intake Form

Agency Response

A draft of this report was submitted to the Department of Health and Human Services to review and respond. Their responses are provided following the appendices.

Program Evaluation Division Contact and Acknowledgments

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Staff members who made key contributions to this report include Jim Horne, Carol Shaw, and Sidney Thomas. John W. Turcotte is the director of the Program Evaluation Division.

Appendix A: Child Welfare Screening by County for 2018

County	Number of Allegations	Number of Reports Accepted for Assessment	Screen-In Rate	Screen-Out Rate
Alamance	2,167	1,216	56%	44%
Alexander	769	491	64%	36%
Alleghany	274	207	63%	37%
Anson	249	182	73%	27%
Ashe	442	278	63%	37%
Avery	248	159	64%	36%
Beaufort	642	398	62%	38%
Bertie	96	63	66%	34%
Bladen	330	242	73%	27%
Brunswick	1,345	843	63%	37%
Buncombe	4,335	2,284	53%	47%
Burke	1,482	1,134	77%	23%
Cabarrus	2,936	2,147	73%	27%
Caldwell	1,618	890	55%	45%
Camden	57	34	60%	40%
Carteret	827	524	63%	37%
Caswell	268	168	63%	37%
Catawba	3,183	2,301	72%	28%
Chatham	506	305	60%	40%
Cherokee	686	392	57%	43%
Chowan	146	90	62%	38%
Clay	207	128	62%	38%
Cleveland	1,844	1,152	62%	38%
Columbus	652	412	63%	37%
Craven	1,139	729	64%	36%
Cumberland	5,347	3,873	72%	28%
Currituck	468	216	46%	54%
Dare	376	202	54%	46%
Davidson	2,895	1,503	52%	48%
Davie	608	284	47%	53%
Duplin	728	490	67%	33%
Durham	3,176	1,507	47%	53%
Edgecombe	832	627	75%	25%
Forsyth	5,536	3,602	65%	35%
Franklin	666	444	67%	33%
Gaston	4,553	3,608	79%	21%
Gates	57	29	51%	49%
Graham	224	175	78%	22%
Granville	697	296	42%	58%
Greene	207	123	59%	41%
Guilford	4,441	2,953	66%	34%
Halifax	564	396	70%	30%
Harnett	1,490	959	64%	36%
Haywood	1,157	584	50%	50%
Henderson	1,767	1,319	75%	25%

County	Number of Allegations	Number of Reports Accepted for Assessment	Screen-In Rate	Screen-Out Rate
Hertford	156	88	56%	44%
Hoke	827	710	86%	14%
Hyde	17	15	88%	12%
Iredell	1,909	1,381	72%	28%
Jackson	703	459	65%	35%
Johnston	3,599	1,604	45%	55%
Jones	100	73	73%	27%
Lee	663	309	47%	53%
Lenoir	731	481	66%	34%
Lincoln	1,280	916	72%	28%
Macon	612	304	50%	50%
Madison	258	160	62%	38%
Martin	292	189	65%	35%
McDowell	824	570	69%	31%
Mecklenburg	16,862	9,945	59%	41%
Mitchell	340	242	71%	29%
Montgomery	462	319	69%	31%
Moore	1,230	874	71%	29%
Nash	1,022	625	61%	39%
New Hanover	3,818	2,447	64%	36%
Northampton	84	55	65%	35%
Onslow	2,925	1,974	67%	33%
Orange	1,101	649	59%	41%
Pamlico	133	72	54%	46%
Pasquotank	459	280	61%	39%
Pender	792	563	71%	29%
Perquimans	136	65	48%	52%
Person	496	298	60%	40%
Pitt	1,592	1,128	71%	29%
Polk	291	203	70%	30%
Randolph	1,660	1,279	77%	23%
Richmond	963	747	78%	22%
Robeson	2,697	2,116	78%	22%
Rockingham	1,115	878	79%	21%
Rowan	2,689	2,006	75%	25%
Rutherford	1,355	872	64%	36%
Sampson	622	459	74%	26%
Scotland	513	421	82%	18%
Stanly	794	502	63%	37%
Stokes	583	323	55%	45%
Surry	769	356	46%	54%
Swain	382	152	40%	60%
Transylvania	748	408	55%	45%
Tyrrell	40	23	58%	43%
Union	1,917	1,339	70%	30%
Vance	783	519	66%	34%
Wake	6,905	4,100	59%	41%

County	Number of Allegations	Number of Reports Accepted for Assessment	Screen-In Rate	Screen-Out Rate
Warren	97	58	60%	40%
Washington	129	65	50%	50%
Watauga	395	225	57%	43%
Wayne	1,481	902	61%	39%
Wilkes	1,145	741	65%	35%
Wilson	885	525	59%	41%
Yadkin	312	213	68%	32%
Yancey	237	162	68%	32%
State	135,167	86,348	64%	36%

Source: Program Evaluation Division based on information from the Department of Health and Human Services, Division of Social Services.

Appendix B: Answers to the Vignette Survey Questions

Vignette 1 (Hard)

A parent calls in a report about a child on their son's baseball team. The reporter says the child he is calling about is named Jameson and he is 12 years old. Jameson's father is the coach of the baseball team and Jameson is the star pitcher. Last week after the game the reporter was walking to the parking lot. He saw the coach yelling and berating Jameson, telling him he was a sorry pitcher and his 3 year old sister could have thrown a better game than he did. Jameson just looked down with his head hung low. Caller said he just felt awful for Jameson. Said Jameson is normally a really good pitcher but he did have a bad game but he didn't think his father should emotionally abuse him like that.

Information from DHHS: Emotional abuse is usually a difficult report to screen. Screen out.

Correct Answers for Survey: Screen out, Screened out report, Screened out report

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	92%	95.7%	93.6%
Assessment	100%	90.7%	94.4%	92.3%
Time frame	100%	90.7%	94.4%	92.3%

Vignette 2 (Easy)

CPS Intake gest a call from a Food and Nutrition Services (FNS) Case manager within the agency. The worker stated that a parent calls DSS asking to speak with her FNS Case manager. When the parent got connected, she was very irate that her food stamps had not been added to her account. The FNS worker told her that there had been a glitch in the system and they should show up no later than tomorrow. The parent screamed at the worker and said that she had 4 children in the home ages 4, 3, 2, 1 and there was no food in the home. The parent asked the worker what she was supposed to do to feed those kids today.

Information from DHHS: This is an easy screen in, policy states if the only information is there is no food in the home, this report would be accepted and a CPS Assessment would be conducted. Improper Care FA Immediate

Correct Answer for Survey: Screen in for neglect, Family assessment (FA), Immediate

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	75%	73.0%	75.9%	74.2%
Assessment	75%	73.9%	75.9%	74.7%
Time frame	75%	58.4%	59.3%	58.8%

Vignette 3 (Easy)

CPS After-Hours receives a call from Law Enforcement. They have just pulled over a man and charged him with DUI. The man, DeQuan Smith, reported to him that he was at a late business meeting and was headed home to relieve his children's babysitter. Reporter is concerned for 2 reasons: 1) The father was drinking and was going to be caring for his children when he got home (but now he will be going to jail) and 2) There is no one to relieve the babysitter.

Information from DHHS: This is an easy screen out. The children were not in the car and were not in danger. The father is communicating with the officer and is capable of making a plan for the care of his children.

Correct Answers for Survey: Screen out, Screened out report, Screened out report

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	63.3%	69.1%	65.7%
Assessment	100%	62.8%	68.5%	65.2%
Time frame	100%	63.3%	68.5%	65.5%

Vignette 4 (Easy)

The school social worker called in a report concerning siblings Linda age 8 and Charles age 11. The reporter said that Linda's best friend told the reporter that Charles messed with her. When asked for more details, the best friend didn't have any. The reporter met with Linda and asked her some general things about how things were going at home. Linda eventually volunteered that last weekend, Charles asked her to play doctor with him. She said they were playing games in his room like they usually do when he asked about playing doctor. She thought it was a new game so she said yes. She said Charles was the doctor and he gave her an exam. She said she didn't like the game because he touched her pee-pee and her mommy told her that only the real doctor should touch your pee-pee. Linda told Charles she didn't want to play that game anymore. Reporter asked Linda if she told her mom about the game and she said no because they started playing their fun games again. Reporter called the mother to tell her about this information. The mother and father immediately met at the school and asked about resources for both of their children. They said they will look into services immediately and asked about how to make sure this doesn't happen again.

Information from DHHS: This is an easy screen out, policy says if the parents respond in a protective manner a CPS Assessment is not required.

Correct Answers for Survey: Screen out, Screened out report, Screened out report

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	78.8%	90.1%	83.5%
Assessment	100%	78.8%	89.5%	83.2%
Time frame	100%	78.8%	89.5%	83.2%

Vignette 5 (Easy)

The mother of 7 year-old Angela called to make a CPS report. She alleged that her daughter had just disclosed to her that the minister of their church has been touching her private parts while she is in Sunday School classes with him on Tuesday nights. She said this has been going on for a long time and it happens when they go into the special room to prepare to confess. Angela also reported that she is not the only child that gets to go to the special room.

Information from DHHS: This is an easy screen out because this case does not meet the definition for caretaker.

Correct Answers for Survey: Screen out, Screened out report, Screened out report

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	83.2%	90.7%	86.3%
Assessment	100%	82.7%	90.1%	85.8%
Time frame	100%	82.7%	90.1%	85.8%

Vignette 6 (Hard)

Terry Jones is the reporter. Ms. Jones is the downstairs neighbor to the Smith family which consists of: Mr. Smith, Mrs. Smith and their two children: Andrew age 11 months and James age 1 month. This morning Mrs. Smith came to the reporter's apartment because she needed someone to talk to. Mrs. Smith related an incident that occurred last night. She said that Mr. Smith was yelling and screaming at her, he grabbed her by the arms and squeezed her causing bruising on her upper arms. He later pushed her into the wall and she has a tender spot on her head. She also said that he slapped her in the face, but there are no marks or bruises on her face. Mrs. Smith said the children were in their cribs asleep in the other room when this occurred, and she assures Ms. Jones that they were never in danger. Mrs. Smith said that usually when they fight he only grabs her and shakes her, the squeezing her and slapping and pushing her into the wall are new. She said they never used to fight before James was born, he was a surprise and the added expense has put a real burden on the family budget. Mr. Smith works hard to support the family and he is the only one working now. Mrs. Smith got upset with the reporter when she suggested going to a shelter or calling social services and begged her not to do this. Mrs. Smith said she loves her husband and he would never hurt the children and she really wasn't hurt last night, she should have just cleaned the house like he asked her to. Reporter stated she did hear fussing last night and this is the first time she has ever heard anything like that in the home.

Information from DHHS: This scenario might be difficult to screen due to the ages of the children and the question about whether or not they were really present or had knowledge of the domestic violence incident.

Correct answers for survey: Screen in for neglect, Family Assessment (FA), 72 hours

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	86.7%	95.7%	90.5%
Assessment	100%	82.3%	86.4%	84.0%
Time frame	75%	64.2%	72.8%	67.8%

Vignette 7 (Hard)

Reporter is the school social worker, Ms. Karen. Ms. Karen got a call from a parent today. This parent witnessed an incident last night that she wanted to share with the social worker. The parent's child plays soccer with Juan, who is 9 years old. Last night after the game, Juan's father was seen yelling at him and shoving Juan into the back of the car really hard. Today at the bus stop, the parent saw that Juan had a black eye. She asked Juan what happened, and he said he got hit with the soccer ball last night during the game and woke up with a black eye this morning. The parent says it was a rough soccer game last night. She didn't notice any other injuries on Juan.

Information from DHHS: This scenario can be hard to screen because people will be tempted to connect the injury to the incident, not to the child's statement.

Correct Answers for Survey: Screen out, Screened out report, Screened out report

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	41.2%	55.6%	47.2%
Assessment	100%	41.2%	54.3%	46.6%
Time frame	100%	40.7%	54.3%	46.4%

Vignette 8 (Hard)

A self-reported nosy neighbor calls intake to make a report on her neighbor, Ms. Ingle and her two daughters, Laura age 6 and Mary age 8. The reporter stated that Ms. Ingle just allowed a man to move into the apartment she shares with her daughters. This man, Garrett Canady, white male age 47 is listed on the sex offender registry as a predatory sex offender with charges against him for sexual assault of a child under the age of 12. According to the registry he served time for this crime and does have to register as a sex offender. He was recently released from prison. Ms. Ingle stated that she met on a Christian on-line dating service, so she knows he is a good man. She said he is currently looking for a job so he will be a big help to her caring for the girls after-school while she works her second shift job. Reporter is scared for the children.

Information from DHHS: This scenario can be difficult to screen because of the policy guidance about assessing current risk.

Correct Answers for Survey: Screen in for neglect, Family Assessment (FA), 72 hours or 24 hours

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	81.0%	87.7%	83.8%
Assessment	100%	66.8%	78.4%	71.6%
Time frame	75%	62.4%	70.4%	65.7%

Vignette 9 (Hard)

Intake receives a call from the mother of a 2 month old child. Mom reports that she and her soon to be ex-husband are involved in a bitter custody dispute. Reporter states that the father never did anything for her while she was pregnant and wasn't even there when the baby was born. Now all the sudden he wants to have equal custody of her child and he has never even taken care of a baby before. The court mandated her to allow him weekend visits. This weekend was his second weekend with the baby. Reporter said it was terrible for her, she was just worried sick about her baby. She called the father several times over the weekend but he never answered her call. The father finally returned the baby to her last night (Sunday) at 6:30, 30 minutes late. He also didn't return her favorite toy. Last night while reporter was giving the child a bath she noticed a bruise on the child's left cheek. She immediately called the father who said it was no big deal and to not try to make a big issue out of this. The father did not state how the child got the bruise.

Information from DHHS: This will be a difficult scenario to screen because people will get caught up in the custody battle and not in the risk factors to the infant with a bruise on her face.

Correct Answers for Survey: Screen In for abuse, Investigative Assessment (IA), Immediate

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	50%	43.8%	44.4%	44.1%
Assessment	50%	43.8%	46.9%	45.1%
Time frame	0%	36.7%	34.0%	35.6%

Vignette 10 (Easy)

An uncle reports his nephew and nephew's girlfriend for not taking proper care of their two- month-old baby. He looks in on the family every other day. Since he was last there two days ago, the couple ran out of formula and so they gave the baby whole milk. The baby is crying constantly and he believes the baby is constipated and

having stomach pains. The couple shows no indication of going to get more formula because it is too expensive and they think the baby will adjust to the regular milk in a few days. He reported that the mother was also giving the baby over the counter medicine that is inappropriate for the baby's age to stop her from crying and make her sleep. Uncle says parents do not appear bonded with the baby, they do not hold her or comfort her, and seem unconcerned about her care. The baby was crying and lethargic when he visited today and he is concerned for the child's safety.

Information from DHHS: Child is being given medicine that is not prescribed to her and is inappropriate for her age as well as the concern about the proper milk/formula for the child.

Correct answers for survey: Screen in for neglect, Family assessment (FA), Immediate

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	92.5%	92.0%	92.3%
Assessment	100%	80.1%	82.7%	81.2%
Time frame	75%	74.3%	79.0%	76.3%

Vignette 11 (Easy)

Woman reports that during an argument last night, her sister's husband got drunk, grabbed a gun, and threatened his wife and child by putting a gun to his wife's head in front of the child and threatening to pull the trigger. This is not the first time it has happened. In fact, this is the second time this month the reporter is aware of. The man has been arrested for assault on his wife twice in the past year but she keeps dropping the charges. He is very violent toward his wife and child. The caller has seen been bruises on the child in the past that she suspected was inflicted by his father but the mother claimed the child fell and hurt himself. The boy is only 5 years of age and always trying to stop his dad from hitting his mother. Caller is afraid the man is going to shoot his wife or son either on purpose or accidentally especially when the fighting occurs after he has been drinking. She has encouraged her sister to leave her husband and has provided a safe house for them on several occasions, but her sister always returns to her husband.

Information from DHHS: This is an easy screen in using the Domestic Violence screening tool: there are weapons present, a history of domestic violence, child is trying to intervene, etc.

Correct answers for survey: Screen in for neglect, Family assessment (FA), 24 hours or 72 hours

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	100%	67.3%	70.4%	68.6%
Assessment	75%	37.2%	28.4%	33.5%
Time frame	0%	33.6%	29.0%	31.7%

Vignette 12 (Hard)

Intake receives a call from a hospital social worker stating that a mother tested positive for heroin and cocaine at the time of the birth of her daughter. The child's urine and meconium were negative for drugs. This is the mother's third child. She gave up the other two for adoption at the time of their birth. The mother tested positive for both heroin and cocaine during both of those pregnancies (2 and 4 years ago). The mother appears to be bonding to this child as evidenced by her singing to the child, feeding her, wanting to hold and change her. The mother stated that she does not have a lot of supplies for the child because she considered placing her for adoption but she does have a job so she can purchase the necessary supplies. The mother does not have her own

housing but a friend has arrived at the hospital and has said the mother and baby can stay at her house as long as she needs to. The mother is young, 23 years old, and although she lost touch with her parents when she dropped out of college with her first pregnancy, she did call them and they are going to come to the hospital.

Information from DHHS: This scenario is difficult because it is tempting to look at the mother's history and make the screening decision based on that history.

Correct Answers for Survey: Screen out, Screened out report, Screened out report

Results:

	DHHS Workers	Social Workers	Social Worker Supervisors	Total County DSS
Screening	25%	50.4%	51.2%	50.8%
Assessment	25%	50.4%	51.2%	50.8%
Time frame	25%	50.4%	51.2%	50.8%

Source: Program Evaluation Division based on information from the Department of Health and Human Services and a survey of county Department of Social Services workers.

Appendix C: Child Protective Services Structured Intake Form

Section I: Demographics

Date: _____ Time: _____

Received by (Name): _____ County: _____

Screening Decision: _____ Referred Due to Residency: _____

Assigned to: (County/Worker Name) _____

Referred to: (County Name) _____ Date/Time: _____

Confirmed with: _____

Was Safety Assessed Yes ☐ Date: _____ By: _____

No ☐ Reason: _____

Type of Report: Abuse ☐ Neglect ☐ Dependency ☐

If referring to another county for assessment, do not complete the information below:

Family Assessment ☐ Investigative Assessment ☐

Initiation Response Time: Immediate ☐ 24 Hours ☐ 72 Hours ☐

Case Name: _____ Case Number: _____

This report involves: Conflict of Interest ☐ Out of Home Placement ☐ Request for Assistance ☐

Substance Affected Infant notification by a healthcare provider ☐

Please refer to the Child Protective Services Structured Intake Form Instructions (DSS-1402ins) for guidance and additional information on conducting a thorough intake interview and filling out this form.

Section II: Reporter Information

Name: _____ Relationship: _____

Address: _____

Phone Number: _____

Reporter waives right to notification? Yes ☐ No ☐

Is the reporter available to provide further information, if needed? Yes ☐ No ☐

Section III: Maltreatment Information

Children's Information

Name (include nicknames)	Sex	Race	Age/DOB	School/ Child Care	Relationship to Perpetrator A	Relationship to Perpetrator B

Parent/Caretaker's Information

Name (include aliases/nicknames)	Sex	Race	Age/DOB	Employment/School

Alleged Perpetrator's Information

Name (include aliases/nicknames)	Sex	Race	Age/DOB	Employment/School
A.				
B.				

Other Household Members

Name (include aliases/nicknames)	Sex	Race	Age/ DOB	Employment/ School	Relationship

Is the alleged perpetrator a relative who lives outside of the home? ☐ Yes ☐ No

Does the relative entrusted with the care of the child have a significant degree of parental-type responsibility for the child? ☐ Yes ☐ No

If yes, what is the duration of the care provided by the adult relative?

If yes, what is the frequency of the care provided by the adult relative?

What is the location in which that care is provided?

What is the decision-making authority that has been granted to that adult relative?

Address and phone number(s) of all household members, including the length of time at current address, include former addresses if the family is new to the area:

Driving Directions:

List any information about the family's American Indian Heritage:

List any information about the parent(s) or caretaker(s) Military Service:

Family's Primary Language:

Collateral Contacts: Others who may have knowledge of the situation (include name, address, and phone number):

Do you have any information about the children's other maternal or paternal relatives (include name, address, and phone number)?

Has the family ever been involved with this agency or any other community agency? Do you know of other reports about the family?

What

What happened to the child(ren), in simple terms?

Did you see physical evidence of abuse or neglect? If yes, please describe.

Is there anything that makes you believe the child(ren) is/are in immediate danger?

Has there been any occurrence of domestic violence in the home? _____

Are you concerned about a family member's drug/alcohol use? _____

Human trafficking occurs when individuals buy, sell, trade, or exchange people for the purposes of sex or labor. To your knowledge, has the child been a victim of trafficking? ☐ Yes ☐ No

If yes, describe _____

Does the child have any distinguishing characteristics (physical or other)? ☐ Yes ☐ No

If yes, describe _____

When

Approximately when did this incident occur? _____

When was the last time you saw the child(ren)? _____

Where

Current location of child(ren), parent/caretaker, perpetrator? _____

How

How do you know what happened to the family? _____

How long has this being going on? _____

Section IV: Family Strengths

What are the strengths of this family? Tell me anything good about this family. _____

How do family members usually solve this problem? What have you seen them do in the past? _____

What is it about this family's culture that is important to know? _____

Section V: Safety Factors

Are you aware of any safety problems with a social worker going to the home? If so, what? _____

Calling DSS is a big step, what do you think can be done with the family to make the child(ren) safer?

Is there anything you can do to help this family? _____

Has anything happened recently that prompted you to call today? _____

Section VI: Health Insurance Information

Does the child(ren) have health insurance? If yes, what type?

☐ Medicaid ☐ Private Insurance/HMO ☐ Health Choice ☐ Other ☐ No Insurance

Where does the child(ren) receive regular health care?

☐ Health Department ☐ Hospital Clinic ☐ Community Health Center ☐ Private Doctor/HMO ☐ Other

☐ No Regular Care

The following questions are intended as a guide. These questions are not meant to replace the narrative already completed in this report. If the questions that correspond with the specific allegations earlier in this report have already been answered, then that information should not be repeated. When these categories are not relevant to the allegations reported, indicate this by checking the N/A (not applicable) box above the first question in each category.

Section VII: Abuse, Neglect, and Dependency

☐ N/A **Physical Abuse**

Where was the child(ren) when the abuse occurred? _____

_____

_____

Describe the injury. For example; Thursday, May 23, 2016, a.m. or p.m., red and blue mark, 1'' by 4'' shaped like a belt mark, fresh or fading, etc.

_____

_____

_____

What part of the body was injured? _____

_____

Is there need for medical treatment? _____

What is the parent/caretaker's explanation? _____

_____

What is the child(ren)'s explanation? _____

_____

What led to the child(ren)'s disclosure or brought the child(ren) to your attention? _____

_____

Did anyone witness the abuse? _____

Are any family members taking protective action? _____

Have you had previous concerns about this family? _____

_____

Is/are the child(ren) currently afraid of the alleged perpetrator? How do you know this?

_____

_____

Is/are the child(ren) afraid to go home? How do you know this? _____

_____

☐ N/A **Moral Turpitude**

Does the parent/caretaker encourage, direct, or approve of the child(ren) participating in illegal activities such as shoplifting, fraud, selling drugs/alcohol? If so, what activity or activities is the child(ren) participating in that the parent is allowing?

_____

_____

☐ N/A **Sexual Abuse**

Where was the child(ren) when the abuse occurred? _____

_____

To whom did the child(ren) disclose the abuse? _____

_____

Did the child(ren) disclose directly to the reporter? _____

What is the age of the alleged perpetrator and his/her relationship to the child(ren)? _____

_____

What is the alleged perpetrator's access to the victim and other children? _____

_____

What steps are being taken to prevent further contact between the perpetrator and the child(ren)? _____

_____

_____

Has the child(ren) had a medical exam? _____

☐ N/A **Human Trafficking**

General

Does the child have any distinguishing marks or tattoos? ☐ Yes ☐ No ☐ Unknown

If yes, describe _____

_____

Sex Trafficking and Labor Trafficking

Is the child a victim of sex trafficking or labor trafficking? ☐ Yes ☐ No ☐ Unknown

If so, who are the people involved? _____

How often have you observed the activities or behaviors that make you suspect trafficking of the child? _____

Do you know where this is happening? ☐ Yes ☐ No ☐ Unknown

If yes, describe _____

Is anyone else involved in the trafficking? ☐ Yes ☐ No ☐ Unknown

If so, who? Who is benefiting from the trafficking? _____

Is a parent or caretaker involved? ☐ Yes ☐ No ☐ Unknown

If yes, how? _____

Is the child being exchanged for something of value or to pay a debt? ☐ Yes ☐ No ☐ Unknown

Tell me what you know about how the child is being trafficked.

Labor Trafficking

Is the child working long hours for little or no pay? ☐ Yes ☐ No ☐ Unknown

If yes, describe _____

Residency and Movement

Has the child been promised things, such as a job, money, or improved circumstances, in exchange for moving from one location to another, whether residence, community, city, state, or country? ☐ Yes ☐ No ☐ Unknown

If yes, what was promised? _____

Is the child a resident of North Carolina? ☐ Yes ☐ No ☐ Unknown

If no, where is the child from and how did they get to North Carolina?

Is the child traveling with an adult to whom they are not related or with whom their relationship is unclear?

☐ N/A **Emotional Abuse**

How does the child(ren) function in school?

What symptoms does the child(ren) have that would indicate psychological, emotional, social impairment?

Are there any psychological or psychiatric evaluations of the child(ren)?

Is the child(ren) failing to thrive or developmentally delayed?

Is there a bond between the parent/caretaker and the child(ren)?

What has the parent/caretaker done that is harmful?

How long has this situation been going on and what changes have been observed?

☐ N/A **Domestic / Family Violence**

Has the child ever called 911, intervened, or been physically harmed during violent incidents between adults?

Has anyone in the family been hurt or assaulted? If so, describe the assault or harm (what and when). If so, who has been hurt? Who is hurting the child and other family members? Please describe the injuries specifically.

Can you describe how the violence is affecting the child(ren)?

Is the child fearful for his/her life, for the lives of other family members including pets, or fearful for the non-offending adult victim's life?

Is there a history of domestic violence? Is the violence increasing in frequency?

Have the police ever been called to the house to stop assaults against either the adults or the child(ren)? Was anyone arrested? Were charges filed?

Are there weapons present or have weapons been used?

Are there power and control dynamics that pose risk to a child's well-being?

Does the batterer interfere with the non-offending parent/adult victim's ability to meet the child's well-being needs?

Where is the child(ren) when the violent incidents occur?

Has any family member stalked another family member? Has a family member taken another family member hostage?

Do you know who is caring for and protecting the child(ren) right now?

What is the non-offending parent/adult victim's ability to protect him/herself and the child(ren)?

What steps were taken to prevent the perpetrator's access to the home? (shelter, police, restraining order)

Can you provide information on how to contact the non-offending parent/adult victim alone?

☐ N/A **Substance Abuse**

What specific drugs are being used by the parent/caretaker?

What is the frequency of use?

Do the child(ren) have knowledge of the drug use?

How does their substance abuse affect their ability to care for the child(ren)?

Are there drugs, legal or illegal, in the home? If so, where are they located?

Do the children have access to the drugs? _____

_____

Has the parent ever experienced blackouts? _____

Is there adequate food in the house? _____

Have the children been exposed to a Methamphetamine or other drug manufacturing laboratory? Are chemicals accessible to the children? Have the children been present during a cook? What have you seen that makes you think there is a Methamphetamine or other drug manufacturing laboratory in the home?

_____

_____

_____

_____

☐ N/A **Substance Affected Infant**

Has the infant been identified as substance affected by the health care provider involved in his/her delivery or care?

_____

_____

Did the infant have a positive drug toxicology? If yes, for what substances? _____

Is the infant experiencing drug or alcohol withdrawal symptoms? What is the present physical condition of the infant?

_____

Is the infant's exposure to substances related to the mother's prescribed and appropriate use of medications? If yes, what is the medication and for what condition is it treating? Have you verified with the prescribing provider?

_____

Has the infant been diagnosed with Fetal Alcohol Syndrome (FAS), Partial FAS, Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (NDPAE) or an alcohol related birth defect?

_____

_____

Did the mother have a positive drug or alcohol toxicology screen during the pregnancy or at the time of the birth? Was there a medical evaluation or behavioral health assessment that indicated she had an active substance use disorder during the pregnancy or at the time of birth?

Is the substance use having an impact on the mother's ability to care for the infant? If so, what behaviors have you seen that demonstrate this?

What is the attitude of the mother or other caretakers toward the infant?

Are you aware of the family having any history that indicates there is an unresolved substance use disorder related to a prior case of child abuse and neglect?

If the infant is in the hospital, when is he/she scheduled to be released?

Based on what you know about the infant and family, would they benefit from any of the following services/resources?

- ☐ Evidence-Based Parenting Programs
- ☐ Mental health provider (LME/MCO)
- ☐ Home visiting programs, if available
- ☐ Housing resources
- ☐ Food resources (WIC, SNAP, food pantries)
- ☐ Assistance with transportation
- ☐ Identification of appropriate childcare resources
- ☐ Other:

☐ N/A **Abandonment**

How long has the parent/caretaker been gone?

Did the parent/caretaker say when they would return?

Did the parent/caretaker make arrangements with someone to care for the child(ren)?

Are the alternative caretakers adequate? Do they wish to continue to provide care for the child(ren)?

Have they been in recent contact with the parent/caretaker?

Is your concern that the child(ren) were abandoned or that the caretaker is not an adequate provider?

☐ N/A **Supervision**

Is the child(ren) left alone? If yes, how long is the child(ren) unsupervised, what is the age and developmental status of the child(ren), what is the child(ren)'s ability to contact emergency personnel, is the child(ren) caring for siblings or other children, is the child(ren) afraid to be left alone, what time of day is the child(ren) left alone?

How is the parent/caretaker's ability to provide supervision compromised? Including information regarding the use of substances and mental health issues.

What are your supervision concerns?

☐ N/A **Injurious Environment**

What is it about the child(ren)'s living environment that makes it unsafe?

☐ N/A **Illegal Placement for Adoption**

Is the parent/caretaker placing the child for adoption in exchange for money or other compensation?

Is the parent/caretaker placing the child for adoption without executing a consent for adoption?

Is the parent/caretaker placing the child in violation of the Interstate Compact on the Placement of Children?

☐ N/A **Improper Discipline**

If the child(ren) is injured from discipline, please describe the injuries in specific detail; also describe any instrument used to discipline.

Does the parent/caretaker have a pattern of disciplining inappropriately? _____

Is the child(ren) fearful of the parent/caretaker? _____

Do you know what prompted the parent/caretaker to discipline the child(ren)? _____

☐ N/A **Improper Care / Improper Medical / Improper Remedial Care**

Does the parent/caretaker provide adequate food, clothing, or shelter? If you feel the parent/caretaker is failing to provide the child(ren) with proper care, describe in detail what the child(ren) is lacking.

Is the parent/caretaker ensuring the child(ren) received necessary medical/remedial care? _____

Is the parent/caretaker ensuring the child(ren) receives a basic education? _____

Is the parent/caretaker providing drugs/alcohol to the child(ren)? _____

☐ N/A **Dependency**

Is the child without a parent/caretaker? _____

Is the parent/caretaker lacking capacity or unavailable to provide care and supervision to the child without having an appropriate alternative child care arrangement?

What other circumstances may make the child(ren) dependent?

Section VIII: Maltreatment Screening Tools

Indicate which of the following screening tools were consulted in the screening of this report:

Abuse:
- ☐ Physical Injury
- ☐ Emotional Abuse
- ☐ Cruel/Grossly Inappropriate Behavior Modification
- ☐ Sexual Abuse
- ☐ Moral Turpitude
- ☐ Human Trafficking

Neglect:
- ☐ Improper Care
- ☐ Improper Supervision
- ☐ Improper Discipline
- ☐ Improper Medical/Remedial Care
- ☐ Illegal Placement/Adoption
- ☐ Injurious Environment
- ☐ Abandonment

☐ **Dependency**

And/Or
- ☐ Substance Abuse
- ☐ Substance Affected Infant
- ☐ Domestic Violence

Response Priority Decision Tree

After consulting the appropriate Maltreatment Screening Tool(s), if the decision is to accept the report, then consult the Response Priority Decision Tree(s). Indicate which of the following Response Priority Decision Tree(s) were consulted and the response required (immediate, 24 hours, 72 hours).

☐ Physical Abuse ☐ Sexual Abuse ☐ Human Trafficking ☐ Moral Turpitude ☐ Neglect

☐ Dependency ☐ Emotional Abuse

This report is being accepted for:

☐ **Abuse:**
- ☐ Physical Injury
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Moral Turpitude

Human Trafficking:
- ☐ Sex Trafficking
- ☐ Labor Trafficking

☐ **Neglect:**
- ☐ Improper Care
- ☐ Improper Supervision
- ☐ Improper Discipline
- ☐ Improper Medical/Remedial Care
- ☐ Illegal Placement/Adoption
- ☐ Injurious Environment
- ☐ Abandonment

And/Or
- ☐ Substance Abuse
- ☐ Domestic Violence

☐ **Dependency**

Response Time

☐ Immediate ☐ 24 Hours ☐ 72 Hours

Report Not Accepted

If the report was not accepted, explain the reason(s): _____

_____

_____

If referrals were made for outreach, services or other agencies:

_____

Section IX: Mandated Reports

This report involves a child care setting. Allegations were reported to the Division of Child

Development and Early Education (staff)_____on (date)_____. Division of

Child Development and Early Education (DCDEE) contact information:

Phone: 919-527-6500 Fax: 919-715-1013

This report involves a residential facility. Allegations were reported to the Division of Health Services

Regulation (staff)_____on (date)_____.

Division of Health Services Regulation (DHSR) contact information:

Phone: 1-800-624-3004 Fax: 919-715-7724

This report involves a foster parent licensed by a county child welfare agency or a private foster care agency. Allegations were reported to the Division of Social Services, Regulatory and Licensing Office

(staff)_____on (date)_____.

Phone: 828-669-3388 Fax: 828-669-3365

Allegations of criminal maltreatment reported to the DA and law enforcement on the following dates:

Oral Report: _____Written Report: _____

Section X: Signatures

A two-level review was given by (include name, position, and date):

Name/Signature: _____ Position: _____ Date: _____

Name/Signature: _____ Position: _____ Date: _____

Source: Program Evaluation Division based on information from the Department of Health and Human Services, Division of Social Services.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
SUSAN OSBORNE • Assistant Secretary for County Operations for Human Services

October 22, 2019

John W. Turcotte, Director
Program Evaluation Division
300 N. Salisbury Street, Suite 100
Raleigh, NC 27603-5925

Dear Mr. Turcotte:

This letter serves as the formal response from the NC Department of Health and Human Services (NCDHHS) regarding the Program Evaluation Division (PED) Final Report No. 2019-10, dated November 2019. Thank you and your team for evaluating child protective services (CPS) intake in North Carolina. Intake is critical to safety for children across the state and NCDHHS welcomes input on strategies to bolster consistency, strengthen practice and consultation, and enhance tools to help further safety in NC.

Preliminary Findings:

The report identified several challenges with the current child protective services intake system. First, PED notes a lack of consistency across the state related to the screening of reports of child maltreatment based upon data reflecting a variance of screen out rates from 11% to more than 60% across North Carolina. PED notes that some counties supplement the NCDHHS structured intake tool with locally created policies which contain additional or different criteria than the State tool. Concerns are also raised about State consultation with counties around intake screening. Additionally, the issue of training and re-training workers across the state in the intake policy and use of the tool was noted as a concern. Finally, enhancing continuous quality improvement related to oversight of screening, as well as establishing measurable benchmarks were also found as needs.

DHHS Response:

NCDHHS is currently implementing child welfare reform through several integrated strategies. With the recent submission and approval of our federal 2020-2024 Child & Family Service Plan (CFSP) as the guiding strategic plan, North Carolina is shifting of its approach to county supervision, consultation, support, training, and continuous quality improvement. The CFSP contains a structure by which NCDHHS will focus its Child Welfare Program in five specific areas: Safety, Permanence, Well-being, Continuous Quality Improvement, and Workforce/Training.

Session Law 2017-41 and subsequent recommendations by the Social Services Working Group identifies the need for a regional approach to providing state supervision, oversight and support to counties across child welfare and all social services. A regional structure, if fully funded, will support consultants and trainers with expertise in each of the five CFSP areas who will provide on the ground support to counties through regional offices and home-based staff. Regional consultants will be able to see trends within their counties, and tailor specialized training related to identified needs.

NCDHHS has begun to take first steps towards regionalization by reorganizing current staffing to align to regions and utilizing home-based staff located in regions to deliver consultation and training. The additional eleven positions, allocated within the current pending fiscal year budget, would further support improvements in the delivery of timely, accurate child welfare training and consultation.

As noted in the Plan for Regional Support of Social Services and Child Welfare programs provided by NCDHHS to the Joint Legislative Oversight Committee on Health and Human Services in February 2019, an additional 32 new positions will need to be allocated and funded within the next two fiscal years to fully implement regional support by March 2020.

Additionally, NCDHHS, in collaboration with the North Carolina Association of County Directors, adopted a practice model for child welfare in June of 2019. Practice models define and describe the values, principles, approaches and techniques used by caseworkers to enable children and families to achieve goals of safety, stability, permanence and well-being. Without a practice model, consistent delivery of services is impossible to achieve across 100 counties. North Carolina began exploration of three practice models in 2013; however, a model was not selected until June 2019. The model selected, Safety Organized Practice, is a widely accepted best practice model that utilizes structured decision-making tools to make decisions in child welfare cases, this includes child protective services intake.

Finally, to move NCDHHS towards a more robust, integrated, and regionally based system of supervision and support, we are re-tooling the current training system. Many of the concerns raised by PED can be addressed through these strategies already underway. Below, we outline solutions and considerations related to the implementation of the proposed recommendations.

Recommendation Strategies

Recommendation 1 and 4:

Without a single, consistent intake policy that is utilized across counties, children across North Carolina will not be equally and fairly protected from child abuse and neglect. As stated above, North Carolina has adopted a practice model, Safety Organized Practice, which requires consistent use of tools that guide decision making in child protective services cases. One of these tools will be a structured intake tool certified to ensure that it accurately captures information needed to make decisions when child protective reports are received by county departments of social services. The integrity of such a tool relies on using the tool as designed and would not allow for individualized screening approaches by counties. Therefore, NCDHHS does not support allowing counties to create individualized intake methods. NCDHHS instead suggests that a workgroup of county DSS Directors or their designees, the Children's Research Center, and NCDHHS staff convene to discuss and redesign one structured, certified intake screening tool based on the Safety Organized Practice model for use in all counties to reduce redundancy, focus on crucial information for decision making, and reduce the length of an intake. NCDHHS supports counties making screening decisions in accordance with North Carolina Child Welfare Policy Manual, Administrative Rule and Law.

Recommendation 2:
NCDHHS agrees that timely and consistent consultation and advice needs to be enhanced. A Rapid Consultation system could be a positive addition to the oversight functions of the state; however, further exploration would be needed to determine the scope and protocols for how such a system would operate, as well as the staffing requirements and resources needed. We suggest that a workgroup of county DSS Directors or their designees and NCDHHS staff work together to explore this strategy as a potential enhancement to regional support services, which we believe will be the most effective enhancement to improved timeliness of consistent consultation and advice.

NCDHHS also recommends that the General Assembly direct NCDHHS to work with a qualified external consultant to conduct a thorough and rigorous study of other states with state-supervised, county-administered child welfare systems that have implemented successful (as evidenced by data) strategies to improve quality and consistency of child welfare intake, assessment, safety, permanence and well-being. The study should include staffing models at both the state and county levels (qualifications, compensation, staffing levels, organization and responsibilities and authorities), among other considerations.

Further, it should be noted that two previous evaluations recommended a state child protective services hotline as a solution for consistent screening. These prior evaluations are (1) the North Carolina Statewide Child Protective Services Evaluation, submitted by PCG March 1, 2016, and (2) the Social Services Reform Plan submitted by Center for the Support of Families (CSF) May 6, 2019. Given these prior recommendations and the limited information in this PED report regarding consideration of a state hotline, DHHS believes the study should consider both the cost and the return on investment of such a hotline.

Recommendation 3:
As noted above, NCDHHS is in the beginning stages of redeveloping our training curriculum and evaluating how to enhance the availability of training sessions across the state. The redevelopment of our child welfare training program includes improvements in training directly related to assessment of child safety during intake. NCDHHS is exploring several options to transform our approach to training, including: the use of synchronous and asynchronous sessions through a technology platform; simulation labs in pre-service and the entire training continuum (including intake); virtual reality training modalities; real-time coaching; and on-demand online and in-person training. NCDHHS believes a competency-based training approach, which provides for both knowledge and skill acquisition and effective application of newly learned practices is necessary for all child welfare staff across the State.

Recommendation 5:
If fully implemented by the General Assembly, NCDHHS will move to a regional model of supervision, consultation, technical assistance, and continuous quality improvement to better serve counties by March 2020. There will be increased on-site visits to supervise and consult with counties related to intake and other safety, permanence, and well-being performance measures. Additionally, there will be ongoing continuous quality improvement related to several issues, including intake. Through this regional model, NCDHHS will be able to better monitor, consult with, and support counties to promote consistency in intake screening, and provide measurable performance metrics. As stated above, additional positions and infrastructure are required to fully implement a regional model.

Summary

In state supervised, county administered social services systems, consistency in service delivery can be a challenge. This challenge is particularly present in North Carolina where our state consists of 100 counties, each responsible for administering social services programs in the county. The PED study focuses specifically on the intake and assessment process for Child Welfare programs across the state. In 2002, in an effort to promote consistency, NCDHHS adopted a structured intake tool to be used by counties to guide the initial assessment during the intake process. However, as the PED draft report concludes, and as NCDHHS acknowledges, inconsistencies in the intake process remain across the state and the intake tool must be updated to reflect current best practices in alignment with the newly adopted Safety Organized practice model. This new tool must be coupled with high-quality, accessible training and consultation for new and experienced staff to ensure it is used consistently and appropriately across the state. NCDHHS is committed to moving forward to improve the child welfare system to ensure the health, safety and welfare of our State's children.

Thank you and your team for conducting this evaluation.

Sincerely,

Lisa Cauley, Child Welfare Director

Susan G. Osborne, Asst. Secretary of County Operations

cc: Tara Myers, Deputy Secretary for Human Services

Angela Pittman, Senior Director - Child, Family and Adult Services