CHILD WELFARE: INTAKE, ALTERNATIVE RESPONSE, AND CHILD PROTECTION ACTIVITIES

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

PERFORMANCE AUDIT
ISSUED APRIL 9, 2014

LOUISIANA LEGISLATIVE AUDITOR
1600 NORTH THIRD STREET
POST OFFICE BOX 94397
BATON ROUGE, LOUISIANA 70804-9397

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

FIRST ASSISTANT LEGISLATIVE AUDITOR
AND STATE AUDIT SERVICES
PAUL E. PENDAS, CPA

DIRECTOR OF PERFORMANCE AUDIT SERVICES
NICOLE B. EDMONSON, CIA, CGAP, MPA

FOR QUESTIONS RELATED TO THIS PERFORMANCE AUDIT, CONTACT
KAREN LEBLANC, PERFORMANCE AUDIT MANAGER,
AT 225-339-3800.

LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

April 9, 2014

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Charles E. "Chuck" Kleckley,
Speaker of the House of Representatives

Dear Senator Alario and Representative Kleckley:

This report provides the results of our performance audit on child welfare activities within the Department of Children and Family Services (DCFS). The purpose of this audit was to determine whether DCFS conducted its intake, alternative response, and child protection investigation activities in accordance with policies and other requirements and to assess the challenges DCFS faces in meeting these requirements. We also researched what additional tools DCFS management could use to evaluate the effectiveness of its child welfare activities.

The report contains our findings, conclusions and recommendations. Appendix A contains DCFS's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of DCFS for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

CHILD WELFARE 2014

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Child Welfare: Intake, Alternative Response, and Child Protection Activities
Department of Children and Family Services

April 2014

Audit Control # 40120015

Introduction

The purpose of this audit was to determine whether the Department of Children and Family Services (DCFS) conducted its intake, alternative response (AR) and child protection investigation (CPI) activities in compliance with policies and other requirements. We also assessed the challenges DCFS faces in meeting these requirements and assessed how DCFS could better evaluate the effectiveness of its child welfare activities. We focused on intake, AR, and CPI activities because these are the first steps in identifying and assessing the risk of harm to children and subsequently preventing repeat cases of abuse and neglect.

Centralized Intake began in July 2011 and processes all reports of abuse or neglect statewide and determines whether and how DCFS parish office staff will respond.

Alternative Response Family Assessment (AR) is a less adversarial response for low risk cases that focuses on family engagement to address weaknesses and mitigate risk of harm.

Child Protection Investigation (CPI) is the traditional response for medium and high risk cases that involves caseworkers investigating claims of abuse or neglect, determining whether abuse or neglect occurred (i.e., validating the case), and recommending the family for further involvement with the agency.

The goal of child welfare is to promote the safety, permanency and well-being of children and youth who are at-risk of or have been abused or neglected through a high-quality, comprehensive child welfare program. From fiscal years 2009 to 2013, DCFS responded to a total of 130,186 cases of child abuse and neglect including 192 child fatalities (see Appendix D). Therefore, it is important that DCFS ensures that caseworkers are referring cases appropriately, that cases are investigated timely, and that DCFS uses repeat maltreatment and repeat referrals as methods to measure the effectiveness of child welfare activities.

We obtained five years of data (fiscal years 2009 through 2013) from various DCFS data systems and combined these data sets to evaluate child welfare activities. We also reviewed case files and conducted a survey of caseworkers and stakeholders. Our audit objectives were as follows:

1. **Did DCFS conduct its intake, alternative response, and child protection investigation activities in accordance with its policies and other requirements during fiscal years 2009 through 2013?**

2. What challenges does DCFS face in conducting child welfare activities in accordance with its policies and other requirements?

3. What additional tools could DCFS use to evaluate the effectiveness of its intake, alternative response, and child protection investigation activities?

Overall, we found that DCFS did not always conduct its child welfare activities in accordance with its policies and other requirements. However, according to some DCFS caseworkers and stakeholders, decreased staff, higher caseloads, turnover, and lack of available services affect the department's ability to conduct these activities. We also found that DCFS could better evaluate the effectiveness of its child welfare activities by conducting more comprehensive data analyses to identify the prevalence of repeat maltreatment and repeat referrals. Appendix A contains DCFS's response to this report, Appendix B contains our scope and methodology, and Appendix C contains relevant background information. Appendix I contains child welfare statistics by region and parish.

Objective 1: Did DCFS conduct its intake, alternative response, and child protection investigation activities in accordance with its policies and other requirements during fiscal years 2009 through 2013?

Overall, data from fiscal years 2009 through 2013 shows that DCFS did not always conduct its intake, alternative response (AR), and child protection investigation (CPI) activities in accordance with its policies and other requirements. Specifically, DCFS data showed the following:

- DCFS intake staff improperly referred 2,602 (2.8%) of 95,178 victims and perpetrators to AR, which is intended for low risk individuals, instead of to CPI. As a result, these individuals may not have received services consistent with their risk level and needs.
- DCFS caseworkers did not properly or timely refer 3,611 (56%) of 6,473 individuals in AR to CPI and 560 (31%) of 1,784 individuals in AR to Family Services when they determined that these cases were higher risk or needed ongoing monitoring. As a result, these cases may not have been investigated as required or may not have received appropriate services.
- Although DCFS has decreased its average response time for cases from an average of 7.26 days in fiscal year 2009 to 2.79 days in fiscal year 2013, it took caseworkers over 60 days to respond to 1,195 (1.34%) of 88,956 cases.
- DCFS investigation caseworkers lowered the intake response priority for 544 (1.5%) of 36,356 cases in fiscal years 2012 through 2013, thereby lengthening the timeframe in which they were required to respond to cases. Such unauthorized overrides by investigation caseworkers are prohibited by DCFS.
- Since authorized overrides to response priorities by centralized intake staff have increased from 4,115 (9.6%) of 42,824 in fiscal year 2011 to 7,785 (16.0%) of 48,641 in fiscal year 2013, DCFS management should monitor and evaluate whether overrides are done in accordance with policy.
- Although DCFS caseworkers increased the percentage of timely safety and risk assessments since fiscal year 2009, more improvement is needed. During fiscal year 2013, 4,167 (37%) of 11,134 safety assessments and 9,696 (51%) of 19,042 risk assessments were not conducted within required timeframes.
- DCFS caseworkers did not always assess household risk factors consistently which may affect the accuracy and effectiveness of the Structured Decision-Making (SDM) tool. Scores on these risk assessments drive caseworker decisions about whether families receive services.

These issues are summarized in more detail on the following pages.

DCFS intake staff improperly referred 2,602 (2.8%) of 95,178 victims and perpetrators to AR, which is intended for low risk individuals, instead of to CPI.

DCFS intake staff did not appropriately refer victims and perpetrators to AR in accordance with policy and state law. In 2008, DCFS implemented the Alternative Response Family Assessment (AR) program. The goal of AR is to identify the root cause that triggered an allegation of abuse and neglect and to prevent future contact with the child welfare system. AR is a less adversarial approach than child protection investigation (CPI) and does not substantiate whether abuse or neglect actually occurred. It includes a family assessment to determine the safety of the child, the risk of future abuse/neglect, and identifies the family's needs and strengths. In AR, caseworkers may provide direct services or refer the family to resources in the community.

According to Article 612A(3) of Louisiana's Children's Code, only cases with low levels of risk can be assigned to AR. DCFS policy also outlines specific conditions when AR is not appropriate, such as when there has been a valid child protection investigation case within the previous two years, when either the victim or perpetrator had a prior foster care or services to parents[1] case, or when the perpetrator has had two or more allegations of abuse or neglect in the prior year. However, from fiscal years 2009 through 2013, we found 2,602 (2.8%) of 95,178 individuals with AR cases who did not meet these criteria or were medium to high risk but were referred to AR instead of to CPI. While this represents a small percentage of the total referrals made to the AR program, it also represents 2,602 victims and perpetrators who were improperly referred. Exhibit 1 summarizes this information.

Exhibit 1
Number of Individuals Improperly Referred to AR Despite Meeting Exclusion Criteria
Fiscal Years 2009 through 2013

Criteria	Number (Individuals)
Had a valid CPI record opened within 2 years of the AR accepted date	1,641
Had a foster care or services to parents case prior to the AR case	533
Had 2 or more AR or CPI cases opened within 1 year of the AR accepted date	354
Listed as high or medium risk*	74
Total Individuals Referred to AR Incorrectly	**2,602**

*Represent intake cases which likely include more than one person but counted once in this analysis.
Source: Prepared by legislative auditor's staff using data from DCFS.

[1] Services to Parents is a program where DCFS provides services to parents while children are in foster care if the family's goal is reunification with the child.

Appropriate referrals are important in ensuring that individuals receive interventions consistent with their risk level and their needs. For example, in one case, a parent and child had a validated claim for physical abuse in April 2012, and the same parent and child victim were reported again for another instance of physical abuse later that year. In this case, the individuals should have been referred to CPI but were instead assigned to AR which violates policy.

Recommendation 1: DCFS should ensure that intake staff follow policy when assigning cases to AR and monitor staff for patterns of noncompliance.

Summary of Management's Response: DCFS stated that improvements made within its risk assessment and determination system render this recommendation obsolete because the department is merging the Alternative Response Family Assessment Program and Child Protection Investigation Program into one activity. See Appendix A for DCFS's full response.

LLA's Additional Comments: After we received DCFS's response on April 2, we verified it has not yet finalized a plan to merge these two programs. In addition, regardless of what policy changes are made to the programs, DCFS still needs to ensure that it collects sufficient and appropriate information to monitor compliance with policies.

DCFS caseworkers did not properly or timely refer 3,611 (56%) of 6,473 individuals in AR to CPI and 560 (31%) of 1,784 individuals in AR to Family Services when they determined that these cases were higher risk or needed ongoing monitoring.

DCFS caseworkers did not appropriately refer individuals to CPI when they determined that the AR case was higher risk. When an AR caseworker becomes aware of circumstances, such as sexual abuse in the household, which require an investigation rather than assessment, DCFS policy requires that the caseworker reassign the case to CPI as soon as possible. However, from fiscal years 2009 through 2013, of the 6,473 individuals with an AR case closed and identified as higher risk and in need of an investigation, 2,193 (34%) were not subsequently referred to CPI for investigation, and 1,418 (22%) were not referred timely[2] as required by policy. As a result, these individuals may not have been investigated as required.

DCFS caseworkers also did not appropriately refer individuals in AR to Family Services when caseworkers determined additional monitoring was necessary. When the AR caseworker closes a case with a safety concern that requires ongoing monitoring, DCFS policy requires that the case be transferred to Family Services.[3] A case may also be referred to Family Services when the risk assessment results in a high to very high risk level. From fiscal years 2009

[2] Policy requires caseworkers to refer as soon as possible. Therefore, we used 31 days or greater to determine timeliness since safety and risk assessments are required to be completed on these cases within 30 days.

[3] Families are referred to Family Services if abuse or neglect is substantiated, but it does not warrant removing a child from their home. This is a voluntary program that provides the family with support and services.

through 2013, of the 1,784 individuals with AR cases that needed to be referred to Family Services, 560 (31.4%) were not referred as required by policy. As a result, these individuals may not have received services relevant to their needs.

In addition, while DCFS collects data as to when and why AR cases are closed, it does not collect data on whether its AR program is in compliance with policies. Specifically, DCFS does not collect data regarding why the family was referred to AR or what services or interventions the caseworker recommended for the family while in the program. In addition, DCFS does not collect whether required contacts and assessments were done timely. Without this information, DCFS cannot determine compliance with all AR referral policies or with required response times. Because the number of referrals to AR has increased from 11,600 cases in fiscal year 2009 to 22,960 in fiscal year 2013, it is important that DCFS develop a process to collect sufficient information on this program to help ensure that referrals, timeframes, and assessments are in compliance with policy and that appropriate services were provided.

Recommendation 2: DCFS should monitor AR case closures to ensure that they are referred to CPI and Family Services according to policy.

Recommendation 3: DCFS should collect AR data, such as allegation information and contact and assessment dates, to enable it to evaluate compliance with policies.

Summary of Management's Response: DCFS stated that improvements made within its risk assessment and determination system render these recommendations obsolete because the department is merging the Alternative Response Family Assessment Program and Child Protection Investigation Program into one activity. See Appendix A for DCFS's full response.

LLA's Additional Comments: After we received DCFS's response on April 2, we verified it has not yet finalized a plan to merge these two programs. In addition, regardless of what policy changes are made to the programs, DCFS still needs to ensure that it collects sufficient and appropriate information to monitor compliance with policies.

Although DCFS has decreased its average response time for cases from an average of 7.26 days in fiscal year 2009 to 2.79 days in fiscal year 2013, it took caseworkers over 60 days to respond to 1,195 (1.34%) of 88,956 cases.

The CPI process begins when centralized intake receives an allegation and assigns the case to the parish office. Intake's response priority determines how quickly a caseworker must make face-to-face contact with a family. The response priority and the required timeframes are as follows:

- Immediate - within 24 hours

- High Priority - within 3 days
- Non-Emergency - within 5 days

States report their average response time in hours to the Children's Bureau within the U.S. Department of Health and Human Services (DHHS). Using the data DCFS provided, we calculated an average response time in days for fiscal years 2009 through 2013. In fiscal year 2011, the national average response time was 2.96 days and in Louisiana it was 5.02. Since fiscal year 2011, DCFS has improved its overall average response time to 3.13 days in fiscal year 2012 and 2.79 days in fiscal year 2013. Exhibit 2 summarizes DCFS's average response times in days from fiscal years 2009 through 2013 and includes the national averages for fiscal year 2009 through 2011. National response times from fiscal years 2012 and 2013 are not yet calculated by DHHS.

Exhibit 2
Response Times in Average Days by Response Priority
Fiscal Years 2009 through 2013

Response Priority	2009	2010	2011	2012	2013
Immediate (24 hours)	3.61	3.37	3.01	1.31	0.92
High (3 days)	6.96	7.66	6.82	4.50	3.87
Non-Emergency (5 days)	9.44	11.45	8.70	6.07	5.29
Overall Total	**7.26**	**7.82**	**5.02**	**3.13**	**2.79**
National Average	**2.88**	**2.92**	**2.96**	**Not yet reported**	

Source: Prepared by legislative auditor's staff using data provided by DCFS and statistics published by DHHS.

Although caseworkers responded to 77,825 (87%) of 88,956 cases within five days from fiscal years 2009 through 2013, there were 1,195 (1.34%) cases where caseworkers took over 60 days to make initial contact, with 787 (65.8%) of these 1,195 cases being immediate or high priority cases. Timeliness of making contact with families is vital for ensuring the immediate safety of children. For example, 104 of these untimely cases involved sexual abuse and three involved death. In one case a father sexually molested his son and was previously charged with raping his daughter but was never indicted. For this case, it took DCFS 117 days to make contact with the family. Per case documentation, the delay was due to DCFS not reassigning the case when the assigned worker resigned and the case supervisor was out on extended leave. In other cases we reviewed, delays were due to law enforcement or there was no explanation for the delay.

Recommendation 4: DCFS should ensure that caseworkers make initial contact with families in a timely manner as required by DCFS policy. Specifically, DCFS should review these cases to identify the causes for delays and develop strategies to address them.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

DCFS investigation caseworkers lowered the intake response priority for 544 (1.5%) of 36,356 cases in fiscal years 2012 through 2013, thereby lengthening the timeframe in which they were required to respond to cases. Such unauthorized overrides by caseworkers are prohibited by DCFS.

From fiscal years 2012 through 2013,[4] DCFS caseworkers lowered the intake response priority for 544 cases, thereby increasing the timeframe in which they were required to respond to the cases. Although this represents a small percentage of the 36,356 total intake cases (1.5%) for this time period, DCFS policy prohibits investigation caseworkers from overriding centralized intake's decision. According to DCFS, sometimes investigation caseworkers override the intake response priority once it is assigned because they think the intake assessment is incorrect. In these instances, there is an appeals process where investigation caseworkers request that intake staff review the response priority. However, the computer system does not have a control in place to prevent an investigation caseworker from editing intake response priorities. Lowering the response priority gives caseworkers more time to make initial face to face contacts and could also compromise a child's immediate safety. Exhibit 3 summarizes the number of cases where caseworkers lowered the response priority from a higher to a lower priority against policy.

Exhibit 3
Decreases to Response Priority Levels
Fiscal Years 2012 through 2013

Fiscal Year	High to Low	% Total Investigations	Total Investigations
2012	268	1.5%	17,426
2013	276	1.5%	18,930
Total	**544**	**1.5%**	**36,356**

Source: Prepared by legislative auditor's staff using data from DCFS.

These 544 cases consisted of 1,607 allegations. These allegations primarily included allegations of neglect (1,103 or 69%) although physical abuse and sexual abuse accounted for 348 (22%) and 140 (9%) of the allegations respectively. We reviewed the case records for some of these decreases and found that some included an explanation. For the cases with explanations, it appears from the file documentation that the response priority was overridden based on the caseworker's judgment that the perpetrator no longer had access to the victim.

Recommendation 5: DCFS should implement a control in its computer system that helps ensure investigation caseworkers cannot override intake response priorities.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

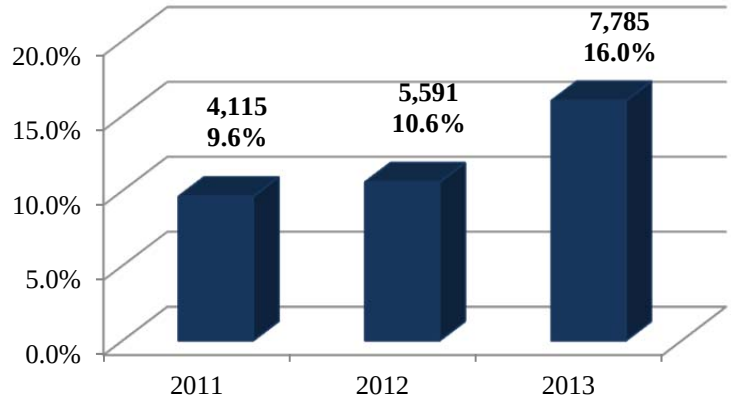
[4] Centralized intake was implemented in July 2011.

Since authorized overrides to response priorities by centralized intake staff have increased from 4,115 (9.6%) of 42,824 in fiscal year 2011 to 7,785 (16.0%) of 48,641 in fiscal year 2013, DCFS management should monitor and evaluate whether overrides are done in accordance with policy.

Statewide centralized intake began in July 2011 with the launch of a child abuse/neglect hotline. Currently, DCFS management monitors certain intake activities, such as wait times, average length of call, and busiest call times. However, management does not have a formal process to evaluate whether overrides are performed in accordance with policy. As mentioned earlier, intake staff assigns a case to one of three different response priorities (immediate, high priority, and non-emergency) depending on the results of the intake decision making tool. However, intake staff may override the results of the intake tool under certain situations. For example, intake staff can increase a response priority to immediate if there is a risk that the family will flee with the child. Intake staff can also decrease a case from immediate to high priority if the child is in a safe location for at least three days. There are also discretionary overrides that can be made, but intake staff must include a description of the reason for the override. All overrides made by intake staff are reviewed and approved by the intake supervisor on an individual basis.

According to the data provided by DCFS, the use of overrides to response priorities has increased from 4,115 (9.6%) of 42,824 intake cases in fiscal year 2011 to 7,785 (16.0%) of 48,641 intake cases in fiscal year 2013. Exhibit 4 summarizes the percentage of overrides by fiscal year.

Exhibit 4
Percent of Overrides
Fiscal Years 2011 through 2013



Source: Prepared by legislative auditor's staff using data provided by DCFS.

Of the 17,491 overrides from fiscal years 2011 to 2013, 8,823 (50.4%) were used to lower the response priority based on the intake worker's discretion. Although policy allows intake staff to override based on their discretion, policy also requires that intake staff provide an explanation. However, we found only limited information provided in the data as most had "not in immediate or impending danger" with no other reason given. Exhibit 5 shows the number and reason for overrides from fiscal years 2011 through 2013.

Exhibit 5
Override Reasons
Fiscal Years 2011 through 2013

Override Reason	Total	%
Decrease - Discretionary	8,823	50.4%
Decrease to High Priority - Child in safe location	3,243	18.5%
Increase - Discretionary	4,417	25.3%
Increase to Immediate - Family may flee	26	0.1%
Increase to Immediate - Forensic investigation would be compromised	15	0.1%
Increase to Immediate - Law enforcement requests immediate response	343	2.0%
Increase to Immediate - Prior death of a child in household due to abuse/neglect	6	0.0%
Outside of Home/High Priority	434	2.5%
Outside of Home/Immediate	18	0.1%
Outside of Home/Non-emergency	166	0.9%
Total	**17,491**	**100.0%**

Source: Prepared by legislative auditor's staff using data from Intake.

The Children's Research Center (CRC)[5] recommends that overrides be allowed in certain situations; however, reasons should be documented, approved by supervisors, and monitored systematically to determine their role in the case management process. According to DCFS, although intake supervisors review and approve each override, there is currently no process in place for management to track and review the system-wide use of overrides. Monitoring the use of overrides would help DCFS determine if they were done in accordance with policy. Monitoring overrides would also help DCFS detect trends and patterns among caseworkers. For example, we found that 13 (2.0%) of the 649 intake staff in the data set made 5,048 (28.8%) of the 17,491 overrides.

Recommendation 6: DCFS should review intake override data to determine compliance with policies and other trends and patterns.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

[5] The CRC developed the structured decision making (SDM) tool used by DCFS in its investigations. In addition, DCFS consulted with the CRC to develop the decision making trees used in intake.

During fiscal year 2013, 4,167 (37%) of 11,134 safety assessments and 9,696 (51%) of 19,042 risk assessments were not conducted within required timeframes.

During the investigation process, DCFS requires that investigation caseworkers conduct safety and risk assessments within required timeframes. Safety assessments, which are used to determine whether the child is in present or impending danger, must be completed within five days. Risk assessments, which are used to determine the future risk of harm, must be completed within 30 days. We reviewed the timeliness of these assessments for all cases within fiscal years 2009 through 2013 and found that while DCFS has decreased the percentage of untimely cases, more improvement is needed. Exhibit 6 summarizes the percentage of untimely assessments in fiscal years 2009, 2011, and 2013.

Exhibit 6
Number and Percentage of Untimely Assessments
Fiscal Years 2009, 2011, and 2013

Activity	Purpose	Required Timeframe	2009	2011	2013
Safety Assessment	To determine whether the child is in present or impending danger	Within 5 days of making initial contact with the family	11,891 (74%)	6,966 (57%)	4,167 (37%)
Risk Assessment	To determine the future risk of harm and help inform whether to close a case and what services should be offered	Within 30 days of receiving the case	n/a*	14,385 (57%)	9,696 (51%)

*Risk assessments were captured electronically starting in October 2009.
Source: Prepared by legislative auditor's staff using DCFS data.

As the exhibit shows, although DCFS has improved the timeliness of these assessments, a large percentage of the activities are still not compliant with timeframes required by policy.

DCFS caseworkers did not always assess household risk factors consistently which may affect the accuracy and effectiveness of the SDM tool.

DCFS caseworkers use the SDM risk assessment tool, which is a best practice tool, on each household to assess and score several risk factors, such as whether families had previous substance abuse or mental health issues and whether families had previous DCFS child welfare cases. Accurate scoring of these risk factors is important since scores determine the level of risk and whether cases receive services or are closed. One goal of this tool is to reduce repeat maltreatment to children by identifying and addressing those risk factors which are most likely to result in repeat abuse or neglect. However, the effectiveness of the SDM is contingent upon proper and accurate use of the tool, effective caseworker judgment, and honest responses on the part of the family. Some risk factors, such as prior history of abuse, are objective as they can be

verified, while others, such as mental health issues, may require more professional judgment. Sources of information the caseworker can use to assess risk factors include statements by the child, caregiver, or collateral persons, worker observations, reports, or other sources.

We evaluated responses to questions for 10,017 perpetrators who had two cases by comparing the risk factors that caseworkers identified on the first assessment to the risk factors identified on the second assessment. We found instances where caseworkers had different results for case characteristics that should generally remain the same. For example, if a caseworker cited that a perpetrator was abused as a child on the first assessment then the second one should also include the same information since this information should not change. However, for 637 (6.4%) of 10,017 perpetrators with two SDM risk assessments, this information was not included on the second assessment even though it was included on the first one. Accurately completing risk assessments is important since scores on these assessments drive caseworker decisions about what services families should receive. Exhibit 7 summarizes the questions with different responses and the number and percentage of individuals with assessments that differed.

Exhibit 7
Different Responses on SDM Risk Assessment
Fiscal Years 2010 through 2013

Question	Number with "Yes" Response on 1st Assessment and "No" Response on 2nd Assessment	Percent Different
Prior History		
Prior Investigations	422	4.2%
Prior Injury	527	5.3%
Prior Case	417	4.2%
Child Characteristics		
Positive Screen	204	2.0%
Physical Disability	119	1.2%
Mental Health	588	5.9%
Medically Fragile	136	1.4%
Developmental Disability	354	3.5%
Delinquency	202	2.0%
Perpetrator Characteristics		
Criminal History	947	9.5%
Domestic Violence	448	4.5%
Prior Abuse as Child	637	6.4%
Drug History	558	5.6%
Alcohol History	235	2.4%
Mental Health	566	5.7%

Source: Prepared by legislative auditor's staff using SDM data.

To determine the potential impact of inconsistent responses, we reviewed the responses to risk assessments for individuals with two cases. Out of the 420 cases that were scored at a low to moderate risk level, we found that 22 (5%) assessments would have scored at a high or very high risk level if the caseworker had entered the same response on the second assessment that was entered on the first assessment. This means that the family should have been recommended for some type of service based on the risks identified.

Because this analysis was limited only to perpetrators with two cases, we also looked at whether the SDM is producing its intended results as an additional test for whether caseworkers were implementing the SDM tool consistently. According to SDM guidance, cases that are scored low to moderate are less likely to have a repeat referral while cases scored as high to very high are more likely to have a repeat referral. If caseworkers are implementing the SDM tool with fidelity (i.e., implemented in accordance with the tool's guidance and design), then the majority of individuals with only one interaction with DCFS should have been scored as low to moderate risk. Similarly, the majority of individuals with more than one DCFS interaction should have been scored as high to very high. However, we found that 68% of individuals that had more than one interaction with DCFS were scored low to moderate as shown in Exhibit 8.

Exhibit 8
Comparison of Results

Population	Results if SDM Tool Implemented in Accordance with Guidance	Actual Results
One Interaction with DCFS (37,657 perpetrators)	Majority would be low to moderate risk	31,625 (84%) low to moderate 6,032 (16%) high to very high
More than One Interaction with DCFS (21,295 perpetrators)	Majority would be high to very high risk	14,430 (68%) low to moderate 6,865 (32%) high to very high

Source: Prepared by legislative auditor's staff using SDM guidance and SDM data.

DCFS also found issues with how caseworkers are implementing the SDM tool in its internal quality control of cases. DCFS reviews a sample of cases each quarter to determine strengths and areas needing improvement in different outcome areas. DCFS cited issues with the SDM in all of its quarterly reviews. Issues cited include incorrect use of SDM, incomplete or missing SDMs, all risks were not being cited, and improper scoring, such as scoring a household as moderate when it should have been scored very high.

Recommendation 7: DCFS should analyze SDM data to evaluate compliance with policies and accuracy of caseworker responses and incorporate the results of their evaluation into training for caseworkers on how to accurately use the tool.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

Objective 2: What challenges does DCFS face in conducting child welfare activities in accordance with policies and other requirements?

According to stakeholders and caseworkers, DCFS faces a variety of challenges, from budget cuts and staffing shortages to worker turnover and stress. We interviewed various stakeholders including advocacy groups, physicians, law enforcement, school counselors, service providers, and judges to obtain their opinion on challenges facing child welfare. We also conducted a statewide survey of 868 child welfare caseworkers and received responses from 506 (58%) on job satisfaction and the challenges they face in providing appropriate and effective child welfare services. We included actual responses from caseworkers in this section to help illustrate these challenges.

According to caseworker responses, the number one factor in caseworker satisfaction was helping families, followed by appreciation and support, and having the necessary services and resources to be effective.

> "The most important factor in my job satisfaction is the quality of service, care and guidance that I'm able to provide to my families to help improve their lives."
>
> **Source:** Caseworker survey

Caseworkers also cited several challenges in being able to provide quality services. For example, 274 (58%) of the 476[6] caseworkers who responded noted caseload size and time management as their greatest challenge, followed by lack of resources and services, and not feeling supported by the state office. Based on caseworker and stakeholder comments, we performed additional analysis to corroborate the challenges they cited and identified the following:

- The number of DCFS caseworkers decreased by 19%, from 1,008 caseworkers in fiscal year 2009 to 816 caseworkers in fiscal year 2013.
- Annual caseloads have increased by 18.1%, from 138 cases per caseworker in fiscal year 2009 to 163 cases per caseworker in fiscal year 2013.
- External turnover (i.e., employees leaving the agency) has increased from 15.1% in fiscal year 2009 to 21.3% in fiscal year 2013. Internal turnover (i.e., employees changing positions within the agency) has increased from 17.5% in fiscal year 2009 to 33.8% in fiscal year 2013.
- Lack of available services and resources was one of the most prevalent challenges caseworkers identified, yet some stakeholders said that caseworkers may not be aware of existing services.

[6] We received 506 responses although not all respondents answered every question. Therefore, results presented regarding the survey include the total number of respondents answering that specific question. Also, the survey included several open-ended questions where caseworkers could provide comments. We have included some of these comments in the blue text boxes throughout this section.

- External factors beyond DCFS control, such as law enforcement and the judicial system, also affect DCFS's ability to provide appropriate child welfare services.

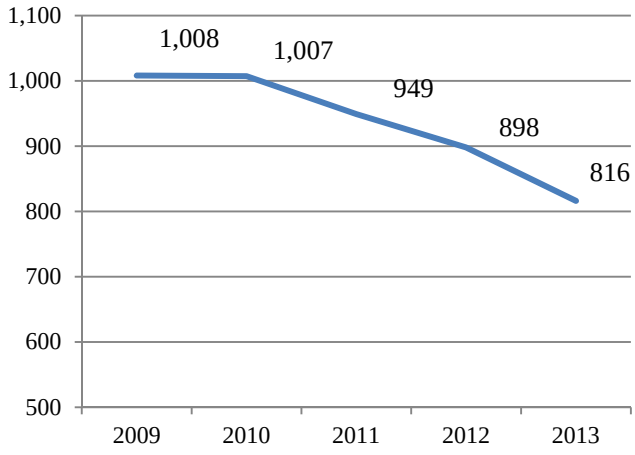
- Multiple data systems result in inefficiencies and limit management's ability to evaluate the compliance and effectiveness of child welfare activities.

These challenges are discussed in more detail below.

The number of DCFS caseworkers decreased by 19%, from 1,008 caseworkers in fiscal year 2009 to 816 caseworkers in fiscal year 2013.

DCFS has reduced child welfare caseworkers by 19% since fiscal year 2009. In fiscal year 2009, DCFS had 1,008 child welfare caseworkers. In fiscal year 2013, the number of child welfare caseworkers decreased to 816, a 19% reduction overall. In its 2012 annual report, DCFS states that employees report feeling more stressed than ever before because of the reduction of positions and vacancy freezes creating more work for remaining staff. Exhibit 8 summarizes the number of caseworkers from fiscal year 2009 to 2013.

Exhibit 8
Child Welfare Caseworkers
Fiscal Years 2009 to 2013



Source: Prepared by legislative auditor's staff using human resource data from LaGOV. Numbers are snapshots as of June 30 for each fiscal year and do not include child welfare trainees.

Annual caseloads have increased by 18%, from 138 cases per caseworker in fiscal year 2009 to 163 cases per caseworker in fiscal year 2013.

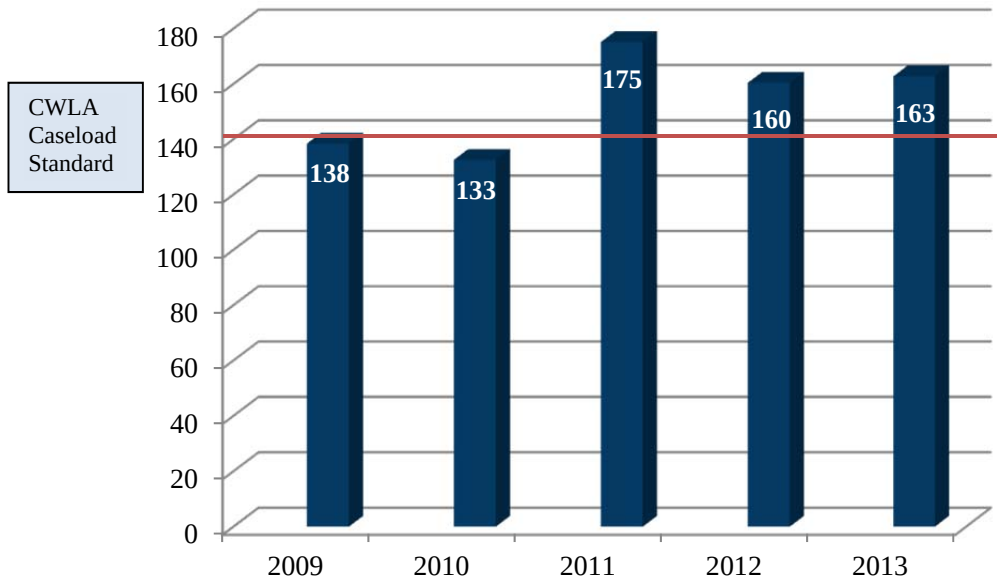
According to our caseworker survey, high caseload was cited most frequently by caseworkers as their greatest challenge in providing appropriate and effective child welfare services. In addition, a total of 366 (75%) of 487 caseworkers either disagreed or strongly disagreed with the statement that their caseload allows them sufficient time to provide children and families with the quality services they need.

"I have a very high case count which prohibits me from giving my clients the time they deserve… My documentation tends to fall behind. I am working two programs and still expected to produce reports quickly. I find myself working on the weekends to meet deadlines and not submitting k-time requests due to my already high k-time balance. More workers would be helpful."

Source: Caseworker survey

According to the Child Welfare League of America, CPI caseworkers should have 12 cases per month or approximately 144 cases per year. According to DCFS policy, CPI caseworkers are assigned on average 10 but no more than 20 new cases per calendar month, which would equal an annual caseload between 120 to 240 cases. Overall, we found that caseloads for CPI have increased from 138 cases per person in fiscal year 2009 to 163 cases in fiscal year 2013. Exhibit 9 summarizes this information.

Exhibit 9
Caseload Size Estimates CPI and AR Caseworkers
Fiscal Years 2009 through 2013



Source: Prepared by legislative auditor's staff using human resources data from LaGOV and data provided by DCFS.

According to DCFS's 2013 annual report, the number of child welfare workers has not kept pace with the increase in cases which has resulted in an increase in the amount of overtime hours earned by DCFS staff. According to DCFS calculations, overtime has increased by 54% in the last three years. The average annual amount of overtime hours per employee increased from 66.23 hours per employee in calendar year 2009 to 88.73 hours in calendar year 2011.

Recommendation 8: DCFS should consider revising its caseload standard to be consistent with what the Child Welfare League recommends. If DCFS determines that it does not have sufficient staff to handle the caseload, it should request more staff from the legislature through the budget process.

Summary of Management's Response: DCFS does not agree with this recommendation and states that the current caseload standard is ten new Child Protection cases per month, but they allow up to twenty cases per month when necessary. DCFS also states that they do not have flexibility once the budget has been adopted to add additional staff. According to DCFS, even if there were greater capacity to do so, it would require approximately two new staff in order to replace an experienced one. In addition, DCFS Operations Management is responsible for monitoring caseloads and taking steps as necessary to assure adequate caseload coverage.

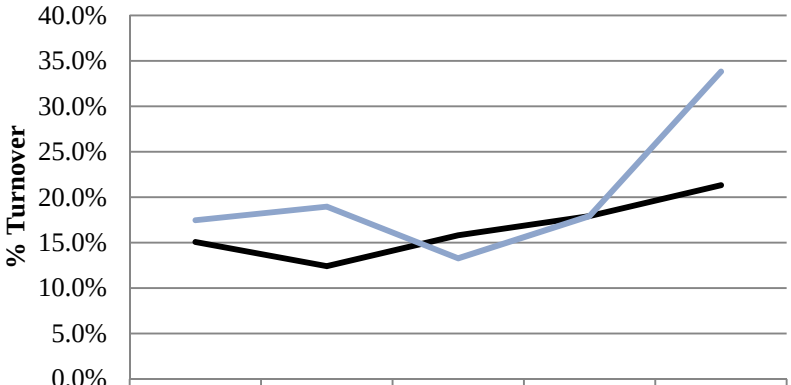
LLA's Additional Comments: Our recommendation was for DCFS to consider requesting more staff through the budget process, not after the budget has been adopted. DCFS's average caseload is higher than what best practices recommend. In addition, caseload was the most prevalent challenge identified by caseworkers on the survey. Approximately 75% of caseworkers who responded to our survey stated that high caseloads did not allow them the time they needed to provide quality services to families.

External turnover has increased from 15.1% in fiscal year 2009 to 21.3% in fiscal year 2013. Internal turnover within child welfare positions has increased from 17.5% in fiscal year 2009 to 33.8% in fiscal year 2013.

According to the Children's Defense Fund, caseworker turnover results in families receiving fewer services and is a major factor in the success of efforts to reunify families. In fiscal year 2013, DCFS experienced caseworker turnover ranging from 21.3% to 55.1% depending on how turnover is defined. Turnover is traditionally defined by human resources departments as people separating from employment. We also defined turnover as any movement of staff that results in a skill or knowledge gap related to casework. Therefore, we calculated turnover in terms of external turnover (staff leaving agency) and internal turnover (staff transferring or promoted within agency) and found that both external and internal turnover have increased. Exhibit 10 summarizes the results using these different definitions.

> "When we say that we want to help heal the hurts by teaching people how to handle life in a healthy way and make it safe for a child to be a part of a family, there needs to be time to do that. Band-Aids don't help when a cast is needed."
>
> **Source:** Caseworker survey

Exhibit 10
External and Internal Turnover
Fiscal Years 2009 through 2013



	2009	2010	2011	2012	2013
External	15.1%	12.4%	15.8%	17.9%	21.3%
Internal	17.5%	19.0%	13.3%	17.9%	33.8%

Source: Prepared by legislative auditor's staff using human resources data from LaGOV.

The overall rate of turnover, including both internal and external turnover was 32.6% in fiscal year 2009 and 55.1% in fiscal year 2013.

Recommendation 9: DCFS should determine the causes for the increase in internal and external turnover and develop retention strategies to address the causes.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

Lack of available services and resources was one of the most prevalent challenges caseworkers identified, yet some stakeholders said that caseworkers may not be aware of existing services.

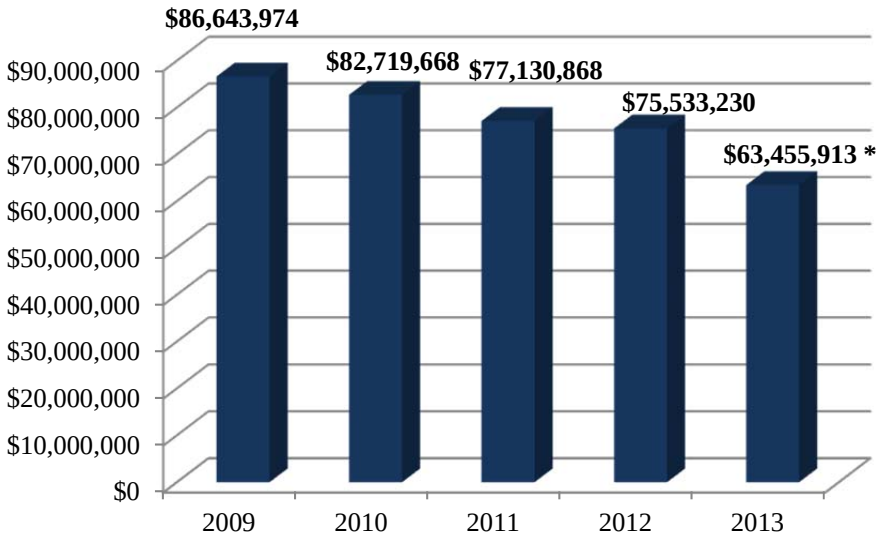
Both stakeholder interviews and caseworker survey responses cited the lack of available services, including those provided by the state and those provided by community resources, as a major challenge. Specifically, respondents noted that mental health and substance abuse services have been cut significantly but are the services most needed for child welfare families. According to DCFS's

"We have fewer resources for individuals with greater needs than ever before. Workers are frustrated because it now becomes about affordability and not about the best interest of the children."

Source: Caseworker survey

Tracking Information Payment System (TIPS),[7] payments for all child welfare services have decreased by 26.7%, from $86.6 million in fiscal year 2009 to $63.5 million in fiscal year 2013. Exhibit 11 summarizes the total amount of TIPS expenditures for child welfare services fiscal years 2009 through 2013.

Exhibit 11
TIPS Payments
Fiscal Years 2009 through 2013



*This amount does not include $11 million of Medicaid payments provided through Magellan.
Source: Prepared by legislative auditor's staff using data provided by DCFS.

In fiscal year 2013, Magellan also provided approximately $11 million in services paid through Medicaid to child welfare clients.[8] Appendix E provides a summary of the TIPS service amounts and Magellan service amounts by parish. Although funding for services has decreased since fiscal year 2009, some stakeholders stated that caseworkers are often not aware of services, resulting in few referrals. In interviews with stakeholders, including providers with contracts for child welfare services, many providers said that caseworkers were not referring clients to them. According to these stakeholders, caseworkers may not be aware of what services exist in their areas. Contracted service providers received 825 referrals from caseworkers in federal fiscal year 2012. However, DCFS data showed approximately 2,420 Family Services cases that could have been referred for services during the same timeframe.

In addition, DCFS's own quality control case review system also found issues with caseworkers not making service referrals. Reviewers consistently cited lack of service referrals

[7] TIPS is DCFS's system for tracking payments to vendors and clients.
[8] DHH's Louisiana Behavioral Health Partnership contracts with Magellan to provide behavioral health services statewide. Because DCFS staff reported irregularities with how Magellan determines payments associated with Medicaid versus child welfare services, we excluded Magellan payments from Exhibit 11.

or improper service referrals as an area needing improvement. Examples of issues cited include the following:

- "Agency did not provide identified services or referrals to services as needed."
- "Referrals and services provided to families do not always match the needs identified in the assessments."
- "In-home cases remained open for long periods of time without services."
- "Substance exposed newborn infants and mothers are not receiving services per policy."

One reason caseworkers may not be referring child welfare clients to existing services is that DCFS has not developed an inventory or resource document that outlines what services are available in each region. Given the amount of caseworker turnover, a document that can be used as a reference for caseworkers for referrals is important.

Recommendation 10: DCFS should develop a resource manual or services inventory listing by region that caseworkers can use to help them refer clients to appropriate services.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

External factors beyond DCFS control, such as law enforcement and the judicial system, also affect DCFS's ability to provide appropriate child welfare services.

According to stakeholders and caseworkers, external factors beyond DCFS control can also affect timeliness and outcome of cases. For CPI investigations involving criminal activity, caseworkers must work with law enforcement to gather information without compromising the integrity of the criminal investigation. Because the criminal investigation takes precedence, a caseworker may not always be able to meet required timeframes. For example, in our review of case files, we observed notations where information requested from law enforcement was delayed or withheld due to the sensitivity of the criminal investigation. Similarly, case records referenced law enforcement requests to refrain from contacting certain parties until the criminal investigation was complete.

Case workers must also regularly interact with judicial systems. Once a caseworker has determined that it is not safe for a child to continue in the custody of their parent, a judge, who ultimately is not bound by DCFS policy, makes the final decision concerning whether the child will be placed in state's custody or continue in their parent's custody. As a result, some cases where DCFS's safety assessment indicated the child should be removed and placed in foster care were referred to Family Services instead.

For example, in August 2010, a mother had a validated case (i.e., the caseworker determined abuse and/or neglect occurred) for physical abuse and neglect due to excessive corporal punishment and not providing sufficient food for her children. The children were placed in foster care, and although DCFS did not recommend reunification, the children were returned to the mother due to a legal technicality. In August 2011, the mother had another valid case for physical abuse due to excessive corporal punishment. Again, the children were placed in foster care, but returned to the mother a few months later by the judge. In January 2012, the mother had another valid case for physical abuse, and the children were again placed in foster care. This family currently has another open neglect case.

Recommendation 11: DCFS should develop a process to track cases where decisions and timeframes were affected by external factors such as judicial systems and law enforcement issues so these effects may be measured and considered in evaluating the agency's effectiveness.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

Multiple data systems result in inefficiencies and limit management's ability to evaluate compliance and effectiveness of child welfare activities.

DCFS does not have a centralized or integrated child welfare information system. Having a centralized system that captures data on every program would help DCFS evaluate its child welfare activities more efficiently and comprehensively. Currently, DCFS collects data in various systems, including the following:

- Tracking Information Payment System (TIPS) includes summary information on all clients serviced through child welfare by program and includes payment details for services as well as CPI outcomes. The system's primary use is to track payments made to DCFS clients and service providers under various federal programs.
- A Comprehensive Enterprise Social Services System (ACESS) includes information on all intake and investigation cases.
- Family Assessment Tracking System (FATS) includes case documentation and visits made primarily for Foster Care, Family Services and Adoptions.

Having multiple data systems also results in caseworkers spending time entering case information in multiple places. Only 106 (22%) of 487 caseworkers surveyed either agree or strongly agree that DCFS provides them with technological support that allows them to balance their documentation responsibilities with time spent serving children and families. Many caseworkers also cited paperwork and duplication of data entry as a challenge.

Recommendation 12: DCFS should consider integrating its multiple child welfare data systems. This would allow DCFS to better evaluate compliance and effectiveness of its activities and reduce duplicate data entry for caseworkers.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

Objective 3: What additional tools could DCFS use to evaluate the effectiveness of its intake, alternative response, and child protection investigation activities?

Overall, we found that DCFS could improve how it evaluates the effectiveness of its intake, alternative response, and child protection investigation activities by using a variety of data analyses to supplement its current evaluation activities. Currently, DCFS's primary measure of effectiveness is the federally required measure for repeat maltreatment associated with the Child and Family Services Review (CFSR). This measure defines repeat maltreatment as families who have a valid claim of abuse or neglect and return within 6 months with another valid claim. DCFS also conducts qualitative file reviews to address federal Program Improvement Plan (PIP) requirements based on CFSR results, although these reviews do not address all child welfare activities.[9] In addition to these qualitative reviews, conducting system-wide quantitative analysis using data may allow DCFS to better target its qualitative reviews to address issues with specific policies and practices.

The National Resource Center on Child Maltreatment (NRCCM)[10] acknowledges the limitations of the federal measure and recommends that states analyze their data in various ways to develop multiple methods to evaluate effectiveness, including calculating repeat maltreatment and repeat referrals[11] by individual child welfare activity and service, calculating the prevalence of repeat maltreatment[12] over longer periods of time, and identifying and targeting risk factors associated with repeat maltreatment and repeat referral. We analyzed child welfare data using methodologies identified in best practice literature to identify additional ways DCFS could evaluate its activities and found the following:

- Comprehensively tracking who receives child welfare services provided by contract providers could help DCFS determine what services and which providers are more effective at reducing repeat maltreatment.
- Reviewing repeat referrals could help DCFS evaluate the appropriateness of centralized intake decisions.
- Reviewing repeat maltreatment and repeat referrals over varying lengths of time could help DCFS identify short-term and long-term trends for individuals in the child welfare system.
- DCFS could evaluate the success of specific interventions by evaluating repeat maltreatment and repeat referrals by child welfare activity.

[9] PIP reviews focus on samples of foster care and Family Services cases. Some aspects of investigation and intake may be reviewed, but PIP reviews do not evaluate CPI and intake decisions that did not result in a foster care or Family Services cases. In addition, AR cases are not included in PIP reviews.
[10] NRCCM is a service of the Children's Bureau, U.S. Department of Health and Human Services.
[11] Repeat referral is defined as multiple interactions with the child welfare system whether the case is valid or not.
[12] Repeat maltreatment is defined as having a valid case of abuse or neglect and then subsequently returning with another valid case.

- DCFS could use risk assessment data to evaluate risk factors that affect repeat maltreatment and repeat referrals since perpetrators with repeat maltreatment had a higher incidence of risk factors in the areas of substance abuse and mental health.

Comprehensively tracking who receives child welfare services provided by contract providers could help DCFS determine what services and which providers are more effective at reducing repeat maltreatment.

DCFS provides services to child welfare victims and perpetrators in various ways. Caseworkers may provide direct services to clients and may also refer clients to contracted providers. For fiscal year 2014, DCFS has 24 contracts totaling $18.5 million with various providers to provide child welfare services. These providers include Family Resource Centers,[13] infant mental health services, independent living services, education training vouchers, family treatment court, and others. However, DCFS does not track which specific clients receive these contracted services for all programs provided by contractors.[14] As a result, DCFS does not know who received what service and cannot evaluate whether services had any impact on repeat referrals or repeat maltreatment. If DCFS tracked who received services and evaluated which service providers were more successful at preventing repeat referrals and repeat maltreatment, it could use this information to inform subsequent contracting decisions. DCFS does receive annual reports from these contracted providers, but these reports only include total numbers of referrals and participants.

The only services DCFS tracks are those that are purchased by DCFS for child welfare clients through various vendors. Payments to vendors are tracked in the Tracking Information Payment System (TIPS). These payments primarily consist of foster care and adoption subsidies. Vendors provide, for example, psychological evaluations, treatment services, sexual abuse exams, and intensive home-based services. Exhibit 12 summarizes the total expenditures in TIPS for all child welfare activities for fiscal years 2009 through 2013.

[13] Family Resource Centers provide services such as the Nurturing Parenting, Visit Coaching, and Family Skills Building programs.

[14] According to DCFS, they capture information on clients who attend the Nurturing Parent Program at Family Resource Centers; however, this information is a separate Access database and is not integrated into their child welfare case data.

Exhibit 12 TIPS Expenditures by Child Welfare Program Fiscal Years 2009 through 2013		
Program	**Amount**	**%**
Adoption	$127,083,979	33.0%
CPI	3,942,889	1.0%
Foster Care	237,253,473	61.5%
Family Services	5,052,138	1.3%
Guardian Subsidy	883,214	0.2%
Services to Parents	4,546,591	1.2%
Young Adult Program	6,759,612	1.8%
Total	**$385,521,895**	
Source: Prepared by legislative auditor's staff using data provided by DCFS.		

As the exhibit shows, most expenditures were for the Adoption and Foster Care programs. Most services provided through the other programs are either provided by the caseworker directly or through contracted providers. Therefore, it is important to track which clients receive these services in order to determine the effectiveness of these services.

Recommendation 13: DCFS should consider developing a more comprehensive process to track which clients receive which specific services from contracted providers. This would enable DCFS to compare repeat referrals and repeat maltreatment among clients and providers and shift resources to more effective services and providers.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

Reviewing repeat referrals could help DCFS evaluate the appropriateness of centralized intake decisions.

As mentioned in Objective 1, DCFS implemented centralized intake in July 2011. While DCFS has monitored call volume and wait times and conducted some case reviews, it has not comprehensively used intake data to evaluate whether intake is resulting in better decision-making. One way DCFS could evaluate the appropriateness of intake decisions is to measure repeat referral rates for cases not accepted for investigation. Repeat referrals are defined as victims or perpetrators who have multiple interactions with the child welfare system regardless of the validity of their cases. Although repeat referral does not definitively indicate that a decision was inappropriate, collecting and reviewing this information may better inform management decision-making regarding intake policy and practice. For example, we found that of the 64,597 cases that intake did not accept for investigation, 7,597 (11.8%) cases were later accepted for investigation. Of these 7,597 that were later accepted, 3,925 (51.7%) resulted in a valid finding (i.e., the caseworker confirmed that abuse or neglect actually occurred). Exhibit 13

summarizes the valid allegations for these 3,925 cases, including why they were originally not accepted.

Exhibit 13
Reason Prior Intake Was Not Accepted for Subsequent Valid Allegations
Fiscal Years 2009 through 2013

Element of Report Not Met in Original Case	Death	Maltreatment	Neglect	Physical Abuse	Sexual Abuse	Total
Not Caretaker, Not Abuse or Neglect, Not within Timeframe	16	16	4,487	675	246	**5,440**
No information captured for these not accepted allegations	11	24	3,528	549	184	**4,296**
Not Abuse or Neglect, Not within Timeframe		11	1,386	189	77	**1,663**
Not Abuse or Neglect	2	2	297	27	9	**337**
Not within Timeframe	1	2	238	37	3	**281**
All Criteria Met			72	7	3	**82**
Not Caretaker			21	7	2	**30**
Not Caretaker, Not within Timeframe			23		4	**27**
Not Caretaker, Not Abuse or Neglect			19	3	1	**23**
Total	**30**	**55**	**10,071**	**1,494**	**529**	**12,179**

Source: Prepared by legislative auditor's staff using intake data provided by DCFS.

Periodically tracking repeat referral rates for "not accepted" reports, as well as the reasons why they were not accepted, allows DCFS to review the relevancy of intake criteria and the implementation of those criteria. Monitoring trends in criteria commonly not met for families who are later accepted may indicate a weakness in the policy or inconsistencies in staff interpretation of that policy. Significant changes in these trends over time may indicate that a specific policy is no longer relevant.

Recommendation 14: DCFS should consider using repeat referral rates for intake cases that are not accepted for investigation and use this information to review intake decisions and make any modifications to policy if necessary.

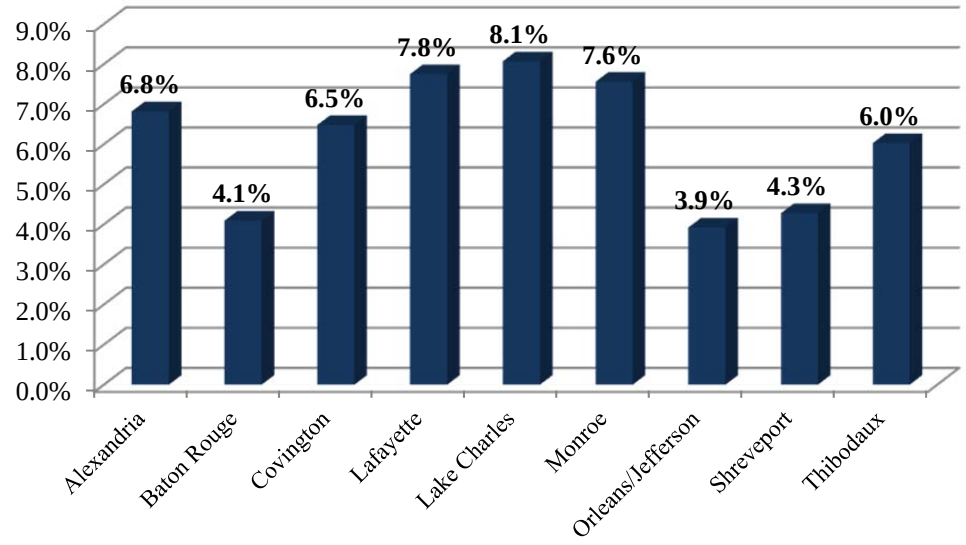
Summary of Management's Response: DCFS agrees with this recommendation in part and states that intake staff do consider recent "non-reports" in their decision making. See Appendix A for DCFS's full response.

LLA's Additional Comments: While DCFS states that it does consider recent non-reports, these reports are considered on an individual basis and not system-wide. As noted in the report, DCFS has not comprehensively used intake data to evaluate whether intake is resulting in better decision-making.

Reviewing repeat maltreatment and repeat referrals over varying lengths of time could help DCFS identify short-term and long-term trends for individuals in the child welfare system.

Currently, DCFS's primary measure of effectiveness is the federally required measure for repeat maltreatment associated with the Children and Family Services Review (CFSR). The federal measure defines repeat maltreatment as families who have a valid claim of abuse or neglect and later return with another valid claim within six months. DCFS reports its six-month repeat maltreatment rate as required by the CFSR. In Louisiana, the percentage of repeat maltreatment for victims at six months as of July 1, 2012, was 6.0% (272 of 4,559 individuals) which is higher than the federal standard of 5.4%. In addition, six of the nine regions in the state were over the standard as shown in Exhibit 14.

Exhibit 14
Repeat Maltreatment Within Six Months by Region
As of July 2012



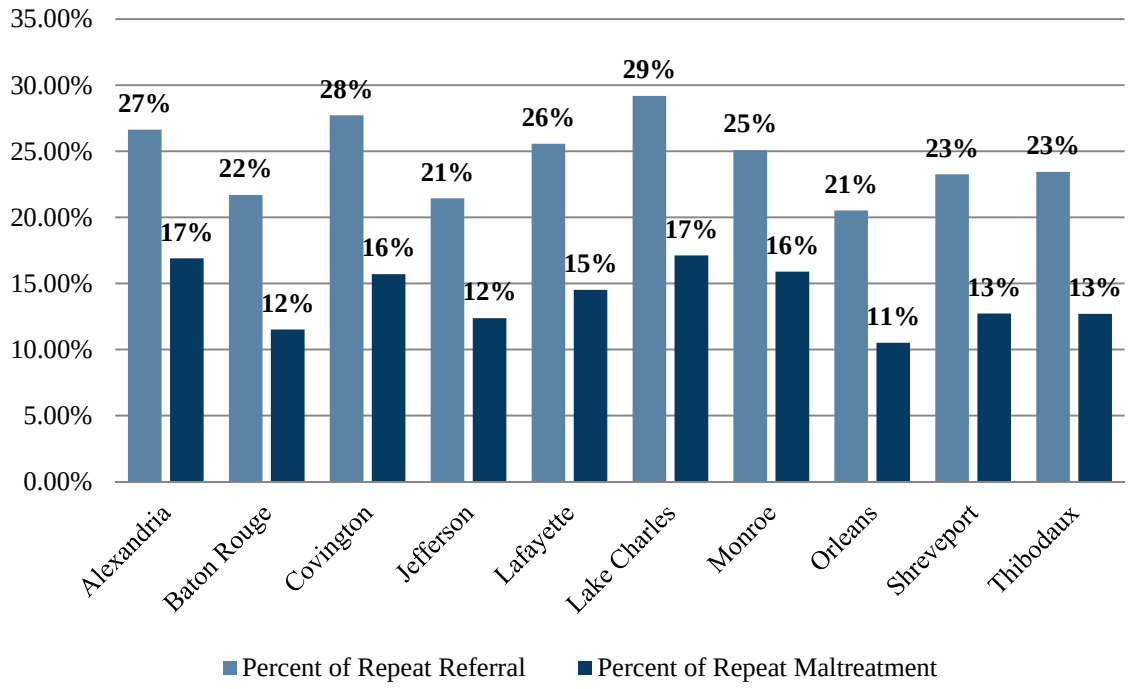
Source: Prepared by legislative auditor's staff using data provided by DCFS.

According to the NRCCM study "Child Maltreatment Recurrence," although the six-month federal measure has been found to be a valid measure over several years and across states, it provides a limited view of the factors associated with repeat referral and maltreatment. The study identifies the six-month measure as "a good starting point" and recommends that states also develop alternative methods to evaluate repeat referral and repeat maltreatment over varying lengths of time. However, there are no federal standards or DCFS benchmarks for repeat maltreatment or repeat referrals over longer periods of time. Therefore, DCFS should evaluate repeat maltreatment, as well as repeat referrals, over longer periods of time and consider

developing its own benchmarks for what percentage of repeat maltreatment and repeat referrals it considers acceptable.

We calculated the percentage of repeat maltreatment and repeat referrals over five fiscal years and found that from fiscal years 2009 through 2013, 14.4% of individuals experienced repeat maltreatment and 24.8% had repeat referrals. Exhibit 15 summarizes repeat maltreatment and repeat referrals by region. See Appendices F and G for repeat maltreatment and repeat referrals by parish office.

Exhibit 15
Repeat Maltreatment and Repeat Referrals by Region
Fiscal Years 2009 through 2013



Source: Prepared by legislative auditor's staff using data provided by DCFS.

While the six-month repeat maltreatment rate provides valuable information on short-term outcomes, it is also important to review recurrence over longer periods of time because re-entry cycles for families may span several years. For example, during the five years of data reviewed, there were 4,593 (1.6%) of 280,750 victims and perpetrators that had five or more cases. Therefore, reviewing these cases may help DCFS identify risk factors and other characteristics of families with repeat involvement in the child welfare system. In addition, with the shift to differential response strategies such as AR that do not validate allegations of abuse or neglect, repeat referrals rates over varying lengths of time may also inform both short-term and long-term strategies.

Recommendation 15: DCFS should evaluate both repeat maltreatment and repeat referrals over longer periods of time for all individuals in the system and develop benchmarks for acceptable percentages over these timeframes.

Summary of Management's Response: DCFS agrees that is appropriate to evaluate repeat referrals (if accepted for investigation) and repeat maltreatment over various periods of time and currently does track repeat maltreatment in 6, 12, and 18 month time increments in Child Protection and Family Services cases. However, DCFS stated that it has not been able to identify any best practices or research that indicates that a five-year increment of evaluation is recommended. See Appendix A for DCFS's full response.

LLA's Additional Comments: The report recommendation states that DCFS should consider evaluating repeat referrals and repeat maltreatment over longer periods of time. It did not specify a particular timeframe. Our review, which included five years of data, showed that 4,593 families had five or more cases during this timeframe. Therefore, reviewing these cases may help DCFS identify risk factors and other characteristics of families with repeat involvement with the child welfare system.

DCFS could evaluate the success of specific interventions by evaluating repeat maltreatment and repeat referrals by child welfare activity.

In addition to using repeat maltreatment and repeat referrals over longer periods of time, DCFS could also use these measures to determine the effectiveness of specific child welfare activities, such as AR and CPI, as well as any interventions that individuals may receive. We calculated the percentage of repeat maltreatment and repeat referrals for the AR and CPI activities and any relevant interventions as summarized below. However, as mentioned earlier, there are no federal or state benchmarks that would allow us to determine whether these current percentages are acceptable.

Alternative Response Activity. As mentioned earlier, the goal of AR is to identify the underlying root cause that triggered an allegation of abuse or neglect and to prevent future contact with the child welfare system. Since AR cases are not validated to determine if the abuse or neglect actually occurred, the only measure to evaluate the success of AR is repeat referral. However, we found that of the 89,795 individuals in the AR program from fiscal years 2009 through 2013, 17,312 (19.3%) individuals had a total of 26,295 subsequent referrals. Of the subsequent referrals, 18,490 (70.3%) were referred to CPI.

Child Protection Investigation Activity and Interventions. We calculated repeat maltreatment and repeat referrals for individuals with invalid (i.e., the caseworker determined that abuse or neglect did not occur) and valid CPI cases by intervention. Exhibit 16 summarizes this information.

Exhibit 16
Prevalence of Repeat Referrals and Repeat Maltreatment
Fiscal Years 2009 through 2013

CPI Decision	Intervention	Number of Clients	Clients with Repeat Referral	Percent Repeat Referral	Clients with Repeat Maltreatment	Percent Repeat Maltreatment
Invalid	None	142,682	41,114	28.8%	N/A	
Valid	Family Services	17,522	6,835	39.0%	3,609	20.6%
	Foster Care (victims)	13,151	3,530	26.8%	1,481	11.3%
	Services to Parents (perpetrators)	9,601	2,380	24.8%	1,223	12.7%

Source: Prepared by legislative auditor's staff using data from DCFS.

Evaluating repeat maltreatment and repeat referrals can help DCFS evaluate what is working and what is not. For example, in May 2012, a mother who had an extensive history with the agency was reported for neglect for not providing adequate food and providing her children with marijuana. The mother and daughter both tested positive although the case was validated only for the inadequate food allegation. The family was referred to Family Services as a result. Later that year while in Family Services, the family had another validated case for neglect and sexual abuse. The daughter was sexually abused by the father and again tested positive for drugs which she claimed were forced on her by her father. The family had another case for neglect opened in 2013 when the youngest, an 8-year-old child, was reported for coming to school "stoned." In this third case, all three children tested positive for drugs and were finally placed in foster care. Families often have multiple interactions with the child welfare system and examining recurrence can help DCFS identify trends and challenges that may better inform future decisions.

Recommendation 16: DCFS should consider evaluating repeat referrals and repeat maltreatment in all its programs and interventions over various time periods and develop benchmarks to help determine whether these programs are effective.

Summary of Management's Response: DCFS agrees that is appropriate to evaluate repeat referrals (if accepted for investigation) and repeat maltreatment over various periods of time and currently does track repeat maltreatment in 6, 12, and 18 month time increments in Child Protection and Family Services cases. However, DCFS stated that it has not been able to identify any best practices or research that indicates that a five-year increment of evaluation is recommended. See Appendix A for DCFS's full response.

LLA's Additional Comments: The report recommendation states that DCFS should consider evaluating repeat referrals and repeat maltreatment over longer periods of time. It did not specify a particular timeframe. Our review, which included five years of data, showed that 4,593 families had five or more cases during this timeframe. Therefore,

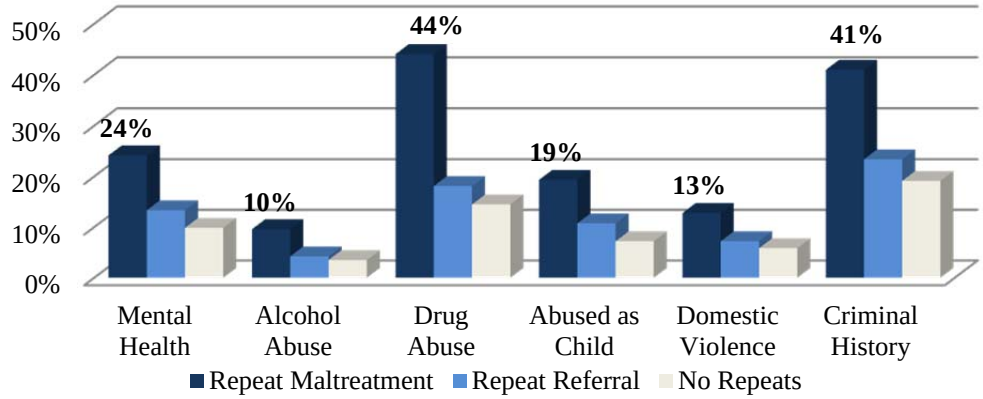
reviewing these cases may help DCFS identify risk factors and other characteristics of families with repeat involvement with the child welfare system.

DCFS could use risk assessment data to evaluate risk factors that affect repeat maltreatment and repeat referrals since perpetrators with repeat maltreatment had a higher incidence of substance abuse and mental health issues.

Research[15] shows that various risk factors increase the likelihood of repeat maltreatment. These risk factors include household/caregiver characteristics such as substance abuse, mental health issues, criminal history, domestic violence, and whether caregivers were abused as children. Although DCFS conducts a risk assessment that captures this information for each case, DCFS does not routinely analyze statewide data on risk factors to determine their impact on repeat maltreatment and repeat referrals.

Risk Factors. We analyzed risk assessment data on perpetrators with SDM data from fiscal years 2009 through 2013, comparing those with repeat maltreatment, those with repeat referrals, and those with no subsequent child welfare cases. As Exhibit 17 shows, in Louisiana, perpetrators with repeat maltreatment had a higher percentage of risk factors than the others, particularly in the areas of mental health, drug abuse, criminal history, and abuse as a child.

Exhibit 17
Percentage of Risk Factors by Outcome for Perpetrator Characteristics
Fiscal Years 2009 through 2013



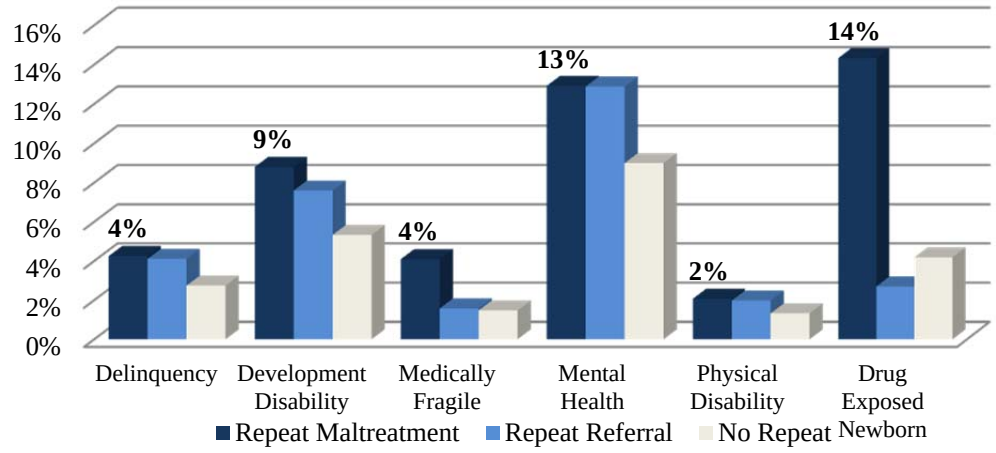
Source: Prepared by legislative auditor's staff using SDM data provided by DCFS.

Research also shows that certain child characteristics have been linked to repeat maltreatment, including children with physical or developmental disabilities and younger

[15] For example, see "Families with Repeat Involvement with Child Welfare Systems: The Current Knowledge Base and Needed Next Steps" published by the Center for Community Partnership in Child Welfare of the Center for the Study of Social Policy in 2006.

children. Exhibit 18 summarizes risk factors for children. As the exhibit shows, in Louisiana, perpetrators with children who are born drug exposed or children with mental health issues or developmental disabilities are more likely to experience repeat maltreatment.

Exhibit 18
Percentage of Risk Factors by Outcome for Child Characteristics
Fiscal Years 2009 through 2013



Source: Prepared by legislative auditor's staff using SDM data provided by DCFS.

Appendix H contains our analysis on the prevalence of risk factors by parish.

Recommendation 17: DCFS should analyze available SDM risk assessment data to identify the prevalence of risk factors and use this information to target services in specific areas.

Summary of Management's Response: DCFS agrees with this recommendation. See Appendix A for DCFS's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

Department of Children & Family Services
Building a Stronger Louisiana

Executive Division
627 North 4th Street
Post Office Box 3776
Baton Rouge, LA 70821

(O) 225.342.0286
(F) 225.342.8636
www.dcfs.la.gov

Bobby Jindal, Governor
Suzy Sonnier, Secretary

April 1, 2014

Daryl G. Purpera, CPA, CFE
Legislative Auditor
Office of the Louisiana Legislative Auditor
P.O. Box 94397
Baton Rouge, LA 70804-9397
Attn: Nicole B. Edmonson, CIA, CGAP, MPA

RE: DCFS Child Welfare: Intake, Alternative Response, and Child Protection Activities

Dear Mr. Purpera:

The following is submitted in response to your request to the aforementioned audit. Please know that the Department of Children and Family Services (DCFS) is committed to continuously evaluating how we can improve the system that protects our most vulnerable citizens. We work in partnership with state, local and national organizations to identify and implement best-practice solutions to ensure that children are safe, that families are strengthened and that permanency for children is prioritized.

This particular audit reflects data over the last five years. During such time a number of positive system changes have been implemented by the Department including the following:

- In July 2011, DCFS implemented a Centralized Intake Program to provide greater consistency regarding reports of potential child abuse or neglect and oversight over intake decision-making. Prior to that time, various staff in local offices received such reports and determined the appropriate response. More than 316,692 calls have been taken since its launch.

- In 2012, DCFS initiated the Advanced Safety Model, with the assistance of the National Resource Center for Child Protection, with a pilot in Child Protection Investigations in three regions. By December 2013, all DCFS staff in Centralized Intake, Child Protection Investigations, Family Services and Foster Care Services had been trained and were actively using the Advance Safety Model for safety and risk assessment as well as decision making.

- In 2012, DCFS partnered with the Department of Health and Hospitals, Department of Education and the Office of Juvenile Justice to support the Louisiana Behavioral Health Partnership and the Coordinated System of Care, leveraging resources to provide services to at-risk children.

- Within the past year, DCFS implemented a comprehensive Continuous Quality Improvement (CQI) program that is based on best practice and guidance from the Administration for Children and Families. As part of the CQI process, highly qualified staff will monitor social service practice in the field while providing valuable feedback to supervisors, managers and executive team that will result in continued practice improvements.

- DCFS has recently made a strong commitment to staff development through a partnership with the Pelican Center for Children and Families, Southeastern State University, and the Title IVE University Partnership to develop a child welfare training academy for staff and community partners.

- The Department was awarded interim accreditation from the International Council on Accreditation earlier this year. DCFS has maintained such accreditation since 2003 and is one of only four states in the country to have an accredited child welfare program.

Recommendation 1: DCFS should ensure that intake staff follow policy when assigning cases to AR and monitor staff for patterns of noncompliance.

Recommendation 2: DCFS should monitor AR case closures to ensure that they are referred to CPI and Family Services according to policy.

Recommendation 3: DCFS should collect AR data, such as allegation information and contact and assessment dates, to enable it to evaluate compliance with policies.

Improvements made within our risk assessment and determination system render these recommendations obsolete. As part of the continued implementation of Advanced Safety Focused Practice (Advanced Safety), and at the recommendation of the National Resource Center for Child Protection, DCFS is merging the Alternative Response Family Assessment Program and Child Protection Investigation Program into one activity that will be called Child Protection Services. All cases, meeting the criteria of child abuse or neglect, regardless of risk level, will be assessed using the same safety and risk assessment instruments and documentation protocols to determine safety, risk and service needs of the family. The Department will no longer distinguish between Alternate Response and Investigation cases at Intake.

Cases with safety threats and higher levels of risk identified that previously would have required referral from Alternate Response to Child Protection Investigations will no longer be necessary as referrals will move directly from Centralized Intake to Child Protection Services. All cases with identified safety threats that can be managed with in-home safety plans will be transferred from Child Protection Services to Family Services. Where an in-home safety plan is not possible, DCFS will request out of home placement to provide for safety of the child(ren).

All cases will be documented in ACESS, DCFS's automated case record system for Child Protection Services. DCFS will evaluate compliance with policies as part of its on-going evaluation of the Child Protection Services program through review of aggregate data from the ACESS reporting environment and the CQI process. ACESS is a robust system that allows for routine and ad-hoc reporting as management tools.

Centralized Intake Managers already routinely monitor staff compliance with policy expectations through daily inquiry mailbox management and monthly case review and this will continue in Child Protection Services. Supervisors and Managers of field staff are also already expected to review all intake cases assigned to them to assure appropriate assignment. Additional monitoring is provided as part of the CQI process wherein highly qualified staff will review for appropriate referral of cases.

Recommendation 4: DCFS should ensure that caseworkers make initial contact with families in a timely manner as required by DCFS policy. Specifically, DCFS should review these cases to identify the causes for delays and develop strategies to address them.

DCFS concurs with this recommendation and already has processes in place to monitor. The median time to investigation, which is the number of hours until an investigation is started, has decreased from 48 hours to 23.42 hours since 2008. Currently, as part of Federal Program Improvement Plan activities, DCFS reviews and reinforces the importance of timely initial contact through monthly meetings with

state and regional performance measurement staff along with field management staff. In addition, supervisors are expected to monitor casework, including all activities as well as timeliness, of their direct reports and include such reviews in quarterly performance evaluations. Policy provides guidance regarding those families that are difficult or unable to locate as well as those families that are non-compliant which should enable staff to meet appropriate timeliness.

Continued improvements are expected as a result of staff retention efforts, enhanced training and regular performance reviews. DCFS is developing a data dashboard report that provides greater transparency regarding case referrals and can easily be monitored by field supervisors to ensure consistency with policy.

The Children's Bureau analysis of DCFS' investigation data reflects consistent improvement in mean and median time to investigation over the previous 5 federal fiscal years.

Recommendation 5: DCFS should implement a control in its computer system that helps ensure investigation caseworkers cannot override intake response priorities.

DCFS concurs with this recommendation and has processes in place to monitor. In April 2013, DCFS Intake Policy was revised to clarify that centralized intake staff maintained sole responsibility for all intake decision-making, including response priorities. Centralized intake staff are the staff that actually receive any report of potential abuse or neglect. Field investigation staff may appeal to centralized intake staff if they disagree with the response priority, however are not authorized to override the recommendation of centralized intake. Two statewide webinars were held to review and reinforce the policy. In addition, a DCFS Operations Memorandum was issued in late December 2013 to codify policy expectations. DCFS has since developed reports to monitor compliance with this policy and review of these reports reflects a steady decrease in field driven changes to response priorities.

To ensure the policy cannot be superseded, controls will be implemented through the ACESS system to prevent field level staff from overriding response priorities assigned by Centralized Intake.

Recommendation 6: DCFS should review intake override data to determine compliance with policies and other trends and patterns.

DCFS concurs with this recommendation and has processes in place to support. All overrides by intake staff are reviewed by Centralized Intake Supervisors or Managers prior to acceptance. Centralized Intake Managers conduct monthly case reviews of cases approved by supervisory staff. Case reviews are also conducted daily through the inquiry mailbox. As an additional support, DCFS will develop an override report which Centralized Intake management can utilize to assess policy compliance, identify other trends and patterns and evaluate the predictability of the current decision tree.

The Department's policy regarding response priority decision is a national best-practice, based on the Structured Decision Making Screening and Response Assessment Policy and Procedures Manual. Structured Decision Making provides a decision tree, which upon completion suggests a response. Per DCFS policy, the information in the report (allegation, condition of the child, screening and family strengths) along with family history must also be considered. Policy states when there are indications another response is more appropriate, an override of the suggested response may be used by the staff receiving the report to increase or decrease the response by one level.

In addition, the Advanced Safety Model provides additional screening for danger during intake and allows for a higher standard of safety assessment. Fifty percent of the overrides identified were downgrades because no impending danger was identified. The downgrade rate is a reflection that the Department has intentionally set the intake priority decision process to be overly cautious and much of this movement is the Department downgrading false positives. This could reflect that the alleged perpetrator was incarcerated and no longer a safety risk to the child or that the child was in a safe place such as living with a relative or caregiver.

Recommendation 7: DCFS should analyze SDM data to evaluate compliance with policies and accuracy of caseworker responses and incorporate the results of their evaluation into training for caseworkers on how to accurately use the tool.

DCFS concurs with this recommendation and has reinforced the implementation of Structured Decision Making through ongoing analysis and training. Beginning in January 2014, a Structured Decision Making review instrument was incorporated into the CQI case review process for the Family Services and Foster Care programs. Consistency of Structured Decision Making assessment in Child Protection Services cases is also being reviewed through the CQI process. As of the end of March, 2014, DCFS Program staff will have completed refresher Structured Decision Making training to key child welfare staff in each region based on issues identified through quarterly and ad hoc case reviews.

Monthly webinars with field staff on Advanced Safety Focused Practice are ongoing to reinforce quality safety practice, including identifying the specific items on the Structured Decision Making risk assessment tool that are linked to the safety assessment. These webinars are recorded and posted on the Intranet for staff to review. The university-based Child Welfare Training academy will incorporate results into ongoing training.

Recommendation 8: DCFS should consider revising its caseload standard to be consistent with what the Child Welfare League recommends. If DCFS determines that it does not have sufficient staff to handle the caseload, it should request more staff from the legislature through the budget process.

DCFS does not concur with this recommendation. The current DCFS caseload standard is ten (10) new Child Protection cases per month, but allowing up to twenty (20) cases per month when necessary. The Department strives to maintain alignment with caseload recommendations by the Child Welfare League as well the International Council on Accreditation. DCFS does not have flexibility once the budget has been adopted to add additional staff in regions that experience an increase in reports. Even if there was greater capacity to do so, new Child Welfare staff are not given full caseloads until they have been sufficiently trained and have received additional experience, requiring approximately two new staff in order to replace an experienced one. DCFS Operations Management are responsible for monitoring caseloads and taking steps as necessary, within the confines of the staff allocated, to assure adequate caseload coverage.

Recommendation 9: DCFS should determine the causes for the increase in internal and external turnover and develop retention strategies to address the causes.

DCFS concurs with this recommendation and has implemented targeted strategies over the last year in response to feedback provide by staff as well as recommendations from National research. Since June 2012, DCFS has taken a number of steps to understand the causes of turnover and to implement strategies to curb turnover. Some of these strategies include staff appreciation events, technology

improvements, performance/merit increases, Critical Incident Stress Management (CISM) support to address secondary trauma, additional training targeting child welfare supervisors, development of the Child Welfare Training Academy, and field visits from the DCFS Secretary to hear directly from staff about the challenges they face and ideas for improving these challenging conditions. Turnover in child welfare staff is a nationwide struggle for state agencies due to the difficulty of the profession; we appreciate the dedication of DCFS' staff to work tirelessly for the safety of children and are committed to continuing efforts to increase retention.

Recommendation 10: DCFS should develop a resource manual or services inventory listing by region that caseworkers can use to help them refer clients to appropriate services.

DCFS concurs with this recommendation. In is inherent in the work of child welfare staff to know and understand community resources that may be available to the children and families they encounter. All staff are referred to the policy management system for any questions related to their work including procedures, best practices and assistance with decision making. DCFS will add resources contracted for by the Department such as the Family Resource Centers and Independent Living Providers to the online policy management system, making it readily available for staff. In addition the online policy management system will include information regarding services offered through other state agencies, and information on how to access community-based services and non-profit organizations through the United Way 211 directories. Magellan, the state's managed care provider for the Louisiana Behavioral Health Partnership, has recently added a provider search function on their home page that is accessible and serves as a an additional resource to staff.

Recommendation 11: DCFS should develop a process to track cases where decisions and timeframes were affected by external factors such as judicial systems and law enforcement issues so these effects may be measured and considered in evaluating the agency's effectiveness.

DCFS concurs with this recommendation and currently relies on the CQI review process to identify and track cases where decisions and timeframes were affected by external factors. DCFS is committed to engaging all child welfare stakeholders, including courts, law enforcement, education partners, foster parents, and the medical community, to assure positive outcomes for children and families. Issues are referred to the Court Improvement Program or discussed in collaborative meetings with law enforcement as appropriate. DCFS will explore possible approaches in its automated systems for capturing externally driven delays and will include such in Phase 2 of the Transformation project, focusing on the development of a single comprehensive Child Welfare Information Technology system.

Recommendation 12: DCFS should consider integrating its multiple child welfare data systems. This would allow DCFS to better evaluate compliance and effectiveness of its activities and reduce duplicate data entry for caseworkers.

DCFS concurs with this recommendation. DCFS continues to improve its data systems and is actively exploring the development of a single comprehensive Child Welfare Information System building upon the current Transformation project. The Child Welfare initiative is considered Phase 2 of Transformation and will begin more in depth planning at the completion of current activities which are scheduled to be completed in June 2014. A preliminary Advanced Planning Document was submitted to our federal partners earlier this year and we are in the process of identifying appropriate resources.

Recommendation 13: DCFS should consider developing a more comprehensive process to track which clients receive which specific services from contracted providers. This would enable DCFS to compare repeat referrals and repeat maltreatment among clients and providers and shift resources to more effective services and providers.

DCFS concurs with this recommendation and will include in the development of the single comprehensive Child Welfare Information system. In the interim, DCFS is developing an enhanced approach to tracking Family Resource Center and other contracted services that will enable DCFS to link to outcome data in its mainframe automated systems. DCFS is also evaluating strategies for integrating data from the Louisiana Behavioral Health Partnership into the DCFS data warehouse to support analysis of utilization and outcomes related to behavioral health services. The university partnerships as part of the Child Welfare Training Academy will provide additional capacity for enhanced evaluation.

Recommendation 14: DCFS should consider using repeat referral rates for intake cases that are not accepted for investigation and use this information to review intake decisions and make any modifications to policy if necessary.

DCFS concurs with this recommendation in part, and does consider recent "non-reports" in intake decision making. Centralized Intake was implemented July 11, 2011. Since that time additional training has been provided to intake staff resulting in greater information being collected. This information is directly associated with improved decision making and response assignment. High-level supervisors and experienced managers are involved in decision making on all intake cases received statewide. Current procedure requires an intake manager (2 supervisory levels above intake staff) to review any intake case that meets criteria for non-acceptance and has two or more recent non-accepted intake reports in the history. Based on this procedure all intake reports with two recent non-reports are reviewed by management.

Recommendation 15: DCFS should evaluate both repeat maltreatment and repeat referrals over longer periods of time for all individuals in the system and develop benchmarks for acceptable percentages over these timeframes.

Recommendation 16: DCFS should consider evaluating repeat referrals and repeat maltreatment in all of its programs and interventions over various periods and develop benchmarks to help determine whether these programs are effective.

DCFS concurs that it is appropriate to evaluate repeat referrals (if accepted for investigation) and repeat maltreatment over various periods of time and currently does track repeat maltreatment in 6, 12, and 18 month time increments in Child Protection and Family Services cases. We have not been able to identify any best practices or research that indicates that a five-year increment of evaluation is recommended. It is suspected that this is due to the complexity and ever changing nature of these families.

The U.S. Children's Bureau has established a benchmark for acceptable percentages at the six month increment. DCFS has exceeded federal benchmark on Repeat Maltreatment for each of the last three federal fiscal years.

Standard	FFY 20101	FFY 2011	FFY 2012
94.6	95.4	94.8	94.7

DCFS is exploring using current entry cohorts looking backwards to provide a more robust evaluation of recently implemented best practices. DCFS is also revising performance reports to better track repeat accepted referrals and repeat maltreatment, as well as repeat maltreatment after foster care exits.

In addition, the Administration for Children and Families (ACF) released Child and Family Services Review Technical Bulletin #7 on March 14, 2014 which includes plans to modify national safety indicators. DCFS will modify its Repeat Maltreatment dashboard reporting to reflect federal revisions as these recommendations are finalized.

Recommendation 17: DCFS should analyze available SDM risk assessment data to identify the prevalence of risk factors and use this information to target services in specific areas.

DCFS concurs with this recommendation and has explored contracting with Children's Research Center to evaluate risk assessment data collected within the Louisiana Structured Decision Making host site and to make recommendations for on-going dashboard reports to inform service delivery needs.

Please ensure that the Department has information regarding any particular case discussed within the audit in order to complete an additional review. We appreciate the opportunity to partner with the Louisiana Legislative Auditor regarding this performance evaluation. Please advise if additional clarification and/or information is requested.

Sincerely,

Suzy Sonnier
Secretary

cc: Brent Villemarette, Deputy Secretary-Programs
Lisa Andry, Assistant Deputy Secretary-Programs
Sharon Tucker, Deputy Secretary-Operations
Sandra Broussard, Assistant Deputy Secretary-Operations
Etta Harris, Undersecretary
Kaaren Hebert, Policy Advisor
Charlie Dirks, Executive Counsel
Tia Embaugh, Chief of Staff and Director, Bureau of Communications & Governmental Affairs
Bridget Depland, Interim Director, Bureau of Audit & Compliance Services/ DCFS Audit Liaison
Karen Leblanc, CIA, CGAP, LLA Performance Audit Manager

APPENDIX B: SCOPE AND METHODOLOGY

We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit covered the time period July 1, 2008 through June 30, 2013. The audit objectives were as follows:

1. **Did DCFS conduct its intake, alternative response, and child protection investigation activities in accordance with policies and other requirements during fiscal years 2009 through 2013?**

2. **What challenges does DCFS face in conducting child welfare activities in accordance with policies and other requirements?**

3. **What additional tools could DCFS use to evaluate the effectiveness of its intake, alternative response, and child protection investigation activities?**

We conducted this performance audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. To answer our objectives, we reviewed internal controls relevant to the audit objectives and performed the following audit steps:

- Researched and reviewed relevant federal and state legal statutes, agency policies, and best practices criteria related to intake, AR, and CPI process.
- Interviewed DCFS program staff at state and local levels as well as other stakeholders in the CPI process including law enforcement, service providers, non-profit community organizations, representatives of court systems such as judges and district attorneys, medical professionals, school board personnel, CASA and Child Advocacy Center staff to identify issues and challenges in the CPI process.
- Developed and conducted a survey of DCFS child welfare caseworkers to identify caseworker perceptions regarding challenges, workload, and management practices.
- Obtained five years of data from DCFS regarding client and program records as well as expenditures from their Child Protection Investigation activities. Conducted reliability testing on the data and analyzed the data to test for compliance with policy and develop alternative measures for performance.
- Conducted file reviews of electronic case records for additional detail related to results of data analyses described above.

APPENDIX C: CHILD WELFARE BACKGROUND

Child Welfare Overview. R.S. 36:471 charges the Department of Children and Family Services (DCFS) with providing child welfare functions, including prevention services related to child abuse and neglect, protective child services, and voluntary family strengthening and support services. DCFS carries out these duties through a variety of child welfare activities, including intake and screening of allegations, investigating allegations of abuse and neglect, and conducting various risk and safety assessments that help determine appropriate interventions for children and families. We focused on intake, alternative response, and child protection investigation activities because they are the first step in identifying and assessing the risk of harm to children and subsequently preventing repeat cases of abuse and neglect. A description of these activities is summarized below.

- **Centralized Intake.** Beginning in fiscal year 2012, DCFS implemented a centralized intake unit to accept and screen calls received from its child abuse hotline. The purpose of this unit is to screen all calls, determine if the criteria for abuse or neglect is met, and determine how the agency will respond to the allegation. Prior to 2012, parish office staff performed these functions. DCFS uses the following criteria to determine whether a case is accepted:

    1. A child (defined as a person under 18) is the victim of abuse/neglect.

    2. A parent or caretaker is the perpetrator of abuse/neglect. Caretakers are defined as a person who maintains an interpersonal relationship to a parent, or an adult who lives in the same residence as the caregiver.

    3. The reporter must have first-hand knowledge of the abuse/neglect.

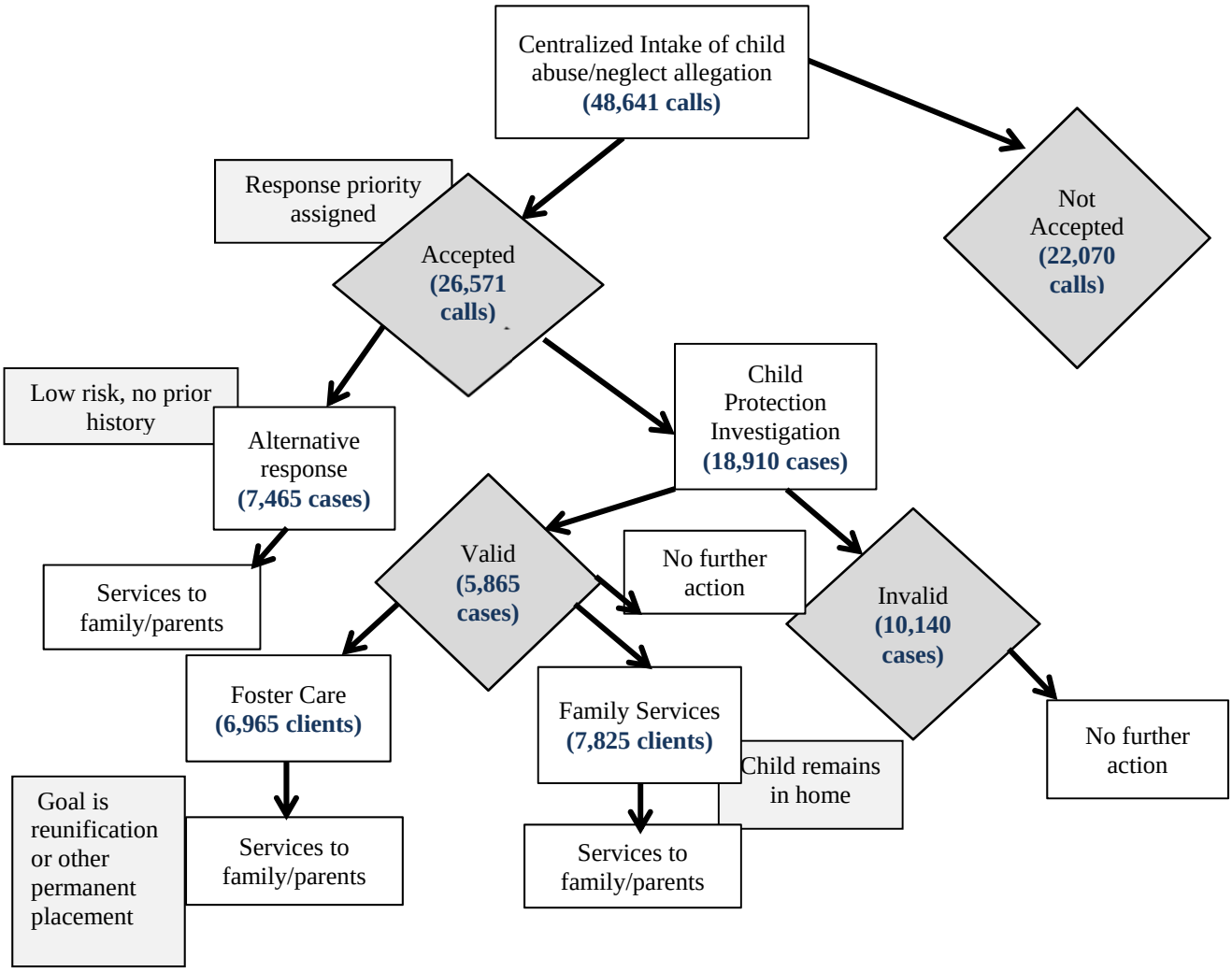
    4. The allegation must fall within the following timeframes: physical abuse must have occurred within 12 months; neglect must have occurred within one month; sexual abuse has no time limit if the perpetrator has access to the victim, and within 12 months if there is no access.

- **Alternative Response (AR).** AR is a differential response track intended for low-risk cases where intake staff does not expect that DCFS needs to remove the child from the home. AR workers assess the home and recommend appropriate services for the family.

- **Child Protection and Investigation (CPI).** CPI is for moderate and high risk cases. Workers conduct an investigation to assess the safety of the child and determine if abuse/neglect occurred. Once CPI workers make a validity determination, the child either stays in the home and the case may be transferred to Family Services, or the child is removed from the home and the case is transferred to Foster Care.

The chart below summarizes the overall child welfare process, including fiscal year 2013 statistics on cases.

Child Welfare Process Overview with Fiscal Year 2013 Statistics[16]



Source: Prepared by legislative auditor's staff using policies and data provided by DCFS.

[16] Invalid cases also include inconclusive cases--there were also 2,905 cases with "other" as their disposition, including unable to locate, client non-cooperation, etc. For Foster Care and Family Services, we included the number of clients because that is how DCFS counts them. Foster Care statistics includes Services to Parents.

APPENDIX D: CHILD FATALITIES

From fiscal years 2009 through 2013, there were 192 child fatalities resulting from validated cases of abuse or neglect. Most of these fatalities resulted from physical abuse, such as skull fractures, burns, internal lacerations, and shaken babies. There were a total of 244 perpetrators involved with the 192 child fatalities.

Child Fatalities by Cause and Fiscal Year
Fiscal Years 2009 through 2013

Cause	2009	2010	2011	2012	2013	Total	Percent of Total
Physical Abuse	8	6	11	14	12	51	26.6%
Unsafe sleeping	6	12	10	4	7	39	20.3%
Drowning, Neglect	3	4	6	4	0	17	8.9%
Medical Neglect/Overdose	3	1	2	3	4	13	6.8%
Intentional Murder	7	0	0	3	2	12	6.3%
Physical Abuse, shaken baby	4	3	2	2	0	11	5.7%
Fire, Neglect	2	0	0	4	2	8	4.2%
Heat exposure/left in car, Neglect	0	2	3	2	0	7	3.6%
Gunshot, Neglect	1	1	1	1	2	6	3.1%
Hit by car, Neglect	2	1	1	1	1	6	3.1%
Undetermined neglect	3	2	0	0	0	5	2.6%
DUI car accident	2	1	0	1	1	5	2.6%
Undetermined Physical Abuse	0	0	3	0	0	3	1.6%
Lack of supervision, Neglect	1	0	0	1	0	2	1.0%
Physical and Sexual Abuse	2	0	0	0	0	2	1.0%
Sexual Abuse/Human Trafficking	0	0	0	2	0	2	1.0%
Suicide, Neglect	0	0	1	0	0	1	0.5%
Unsafe living conditions, Neglect	0	1	0	0	0	1	0.5%
Starvation, Neglect	0	0	0	1	0	1	0.5%
Total	**44**	**34**	**40**	**43**	**31**	**192**	100.0%

Source: Prepared by legislative auditor's staff using data provided by DCFS.

DCFS has established various processes to review all child fatalities. For example, executive management holds monthly meetings to discuss circumstances around child fatalities; DCFS's general counsel also conducts case crises reviews on fatalities that cover the entire family's history in the child welfare system; and DCFS serves on the Department of Health and Hospital's Child Death Review Panel.

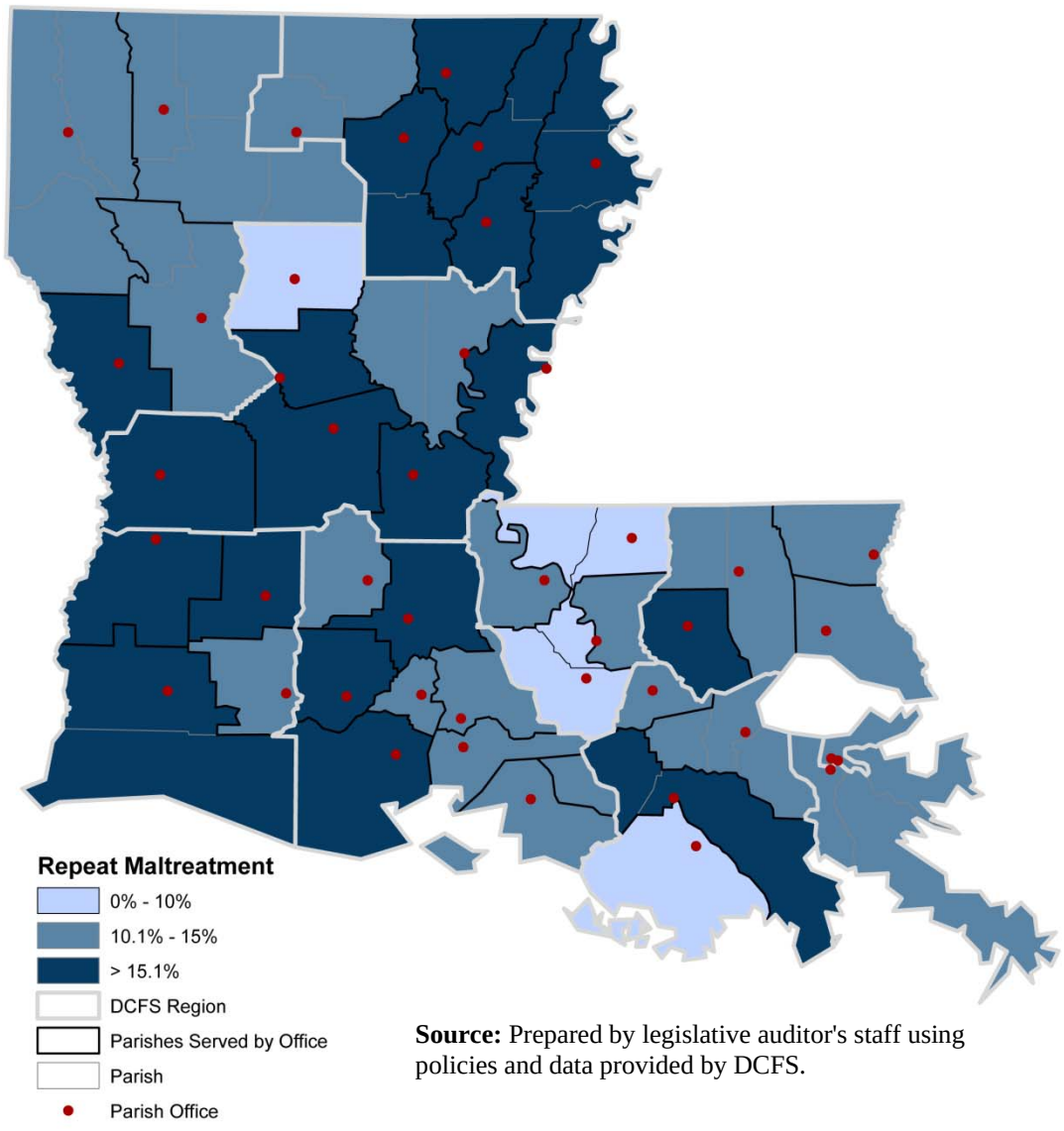
APPENDIX E: SERVICE EXPENDITURES BY PARISH - TIPS AND MAGELLAN

Expenditures for Child Welfare Activities: TIPS and Magellan Fiscal Year 2013		
Parish	**DCFS TIPS Services**	**Magellan Services**
Acadia	$863,092	$409
Allen	819,543	8,123
Ascension	815,828	48,160
Assumption	152,439	351
Avoyelles	670,711	965
Beauregard	577,342	1,010
Bienville	227,072	0
Bossier	1,033,567	89,874
Caddo	1,929,370	1,289,778
Calcasieu	2,952,277	1,056,634
Caldwell	60,084	0
Cameron	53,577	0
Catahoula	106,453	65
Claiborne	208,847	0
Concordia	404,474	3,247
DeSoto	198,172	9,018
East Baton Rouge	3,877,075	835,123
East Carroll	213,917	0
East Feliciana	55,335	24,515
Evangeline	544,198	25,203
Franklin	216,571	69
Grant	495,184	0
Iberia	787,701	17,988
Iberville	314,297	0
Jackson	123,562	199
Jefferson	3,570,184	383,948
Jefferson Davis	496,389	281
Lafayette	2,826,887	625,068
Lafourche	837,281	162,603
LaSalle	281,418	0
Lincoln	3,097,275	3,059,528
Livingston	1,735,511	68,373

Expenditures for Child Welfare Activities: TIPS and Magellan Fiscal Year 2013		
Parish	**DCFS TIPS Services**	**Magellan Services**
Madison	$168,177	$72,851
Morehouse	330,319	314,832
Natchitoches	2,022,878	105,361
Orleans	3,832,475	783,802
Ouachita	1,593,973	518,654
Plaquemines	136,267	0
Pointe Coupee	109,686	233
Rapides	2,914,265	448,990
Red River	163,057	357
Richland	173,329	4,031
Sabine	337,425	22,100
St. Bernard	361,922	43,007
St. Charles	373,341	12,662
St. Helena	277,531	24,603
St. James	114,058	0
St. John	435,086	20,017
St. Landry	1,415,301	33,536
St. Martin	723,550	5,254
St. Mary	687,136	14,530
St. Tammany	3,732,573	329,397
Tangipahoa	2,475,738	211,565
Tensas	50,322	8,056
Terrebonne	1,794,251	76,886
Union	154,108	0
Vermilion	339,712	1,977
Vernon	472,094	638
Washington	2,148,326	37,624
Webster	358,487	21,486
West Baton Rouge	182,084	0
West Carroll	218,630	654
West Feliciana	43,776	0
Winn	89,971	0
Total	**$58,775,480**	**$10,823,634**

Note 1: These expenditures are for all child welfare programs, including foster care and adoptions.
Note 2: These figures are based on rounded numbers.
Source: Prepared by legislative auditor's staff using data from TIPS and DCFS.

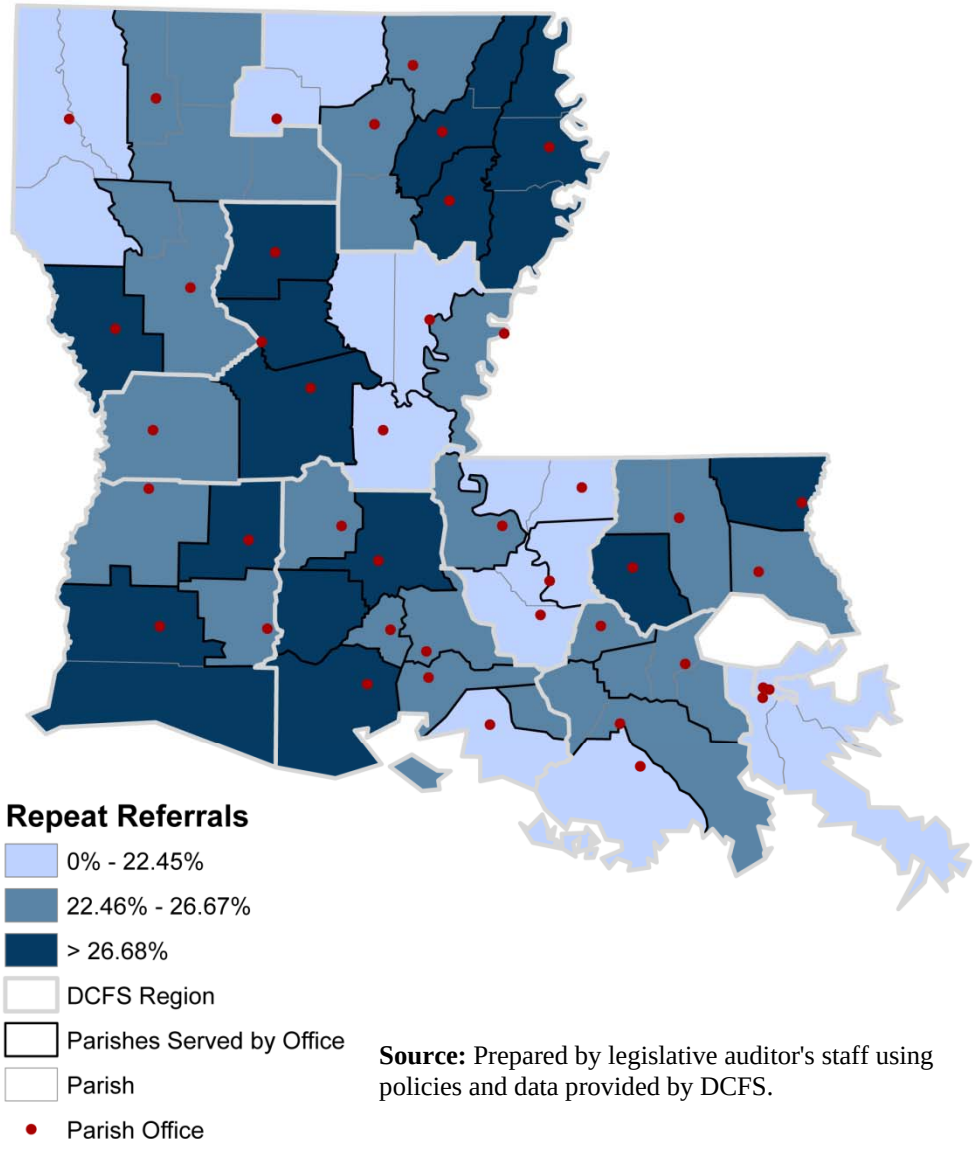
APPENDIX F: REPEAT MALTREATMENT BY PARISH, FISCAL YEARS 2009 THROUGH 2013



Source: Prepared by legislative auditor's staff using policies and data provided by DCFS.

Parish Office	Percent Repeat Maltreatment
Acadia	16.43%
Allen	20.96%
Ascension	12.58%
Avoyelles	17.11%
Beauregard	15.29%
Caddo/Bossier/DeSoto	12.35%
Calcasieu/Cameron	17.11%
Catahoula/LaSalle	11.78%
Concordia	16.32%
East Baton Rouge	11.82%
East Feliciana/West Feliciana	7.77%
Evangeline	11.15%
Franklin	15.85%
Grant	24.02%
Iberia	11.98%
Iberville/West Baton Rouge	9.46%
Jefferson Davis	14.87%
Jefferson/St. Bernard/Plaquemines	12.25%
Lafayette	13.17%
Lafourche/Assumption	16.06%
Lincoln/Union	14.45%
Livingston	21.55%
Madison/East Carroll/Tensas	16.48%
Morehouse	16.67%
Natchitoches/Red River	11.31%
Orleans	10.46%
Ouachita/Caldwell	15.85%
Pointe Coupee	14.58%
Rapides	17.35%
Richland/West Carroll	16.20%
Sabine	15.06%
St. John/St. James/St. Charles	12.60%
St. Landry	16.06%
St. Martin	11.97%
St. Mary	12.93%
St. Tammany	11.53%
Tangipahoa/St. Helena	12.81%
Terrebonne	9.85%
Vermilion	19.73%
Vernon	16.84%
Washington	13.52%
Webster/Jackson/Claiborne/Bienville	14.05%
Winn	9.13%
State Total	**14.36%**

APPENDIX G: REPEAT REFERRALS BY PARISH, FISCAL YEARS 2009 THROUGH 2013



Source: Prepared by legislative auditor's staff using policies and data provided by DCFS.

Parish Office	Percent Repeat
Acadia	28.70%
Allen	28.96%
Ascension	24.62%
Avoyelles	21.97%
Beauregard	26.06%
Caddo/Bossier/DeSoto	22.45%
Calcasieu/Cameron	30.07%
Catahoula/LaSalle	21.43%
Concordia	25.72%
East Baton Rouge	22.32%
East Feliciana/West Feliciana	17.81%
Evangeline	24.13%
Franklin	28.85%
Grant	33.92%
Iberia	26.44%
Iberville/West Baton Rouge	18.87%
Jefferson Davis	26.67%
Jefferson/St. Bernard/Plaquemines	21.43%
Lafayette	23.21%
Lafourche/Assumption	24.91%
Lincoln/Union	22.10%
Livingston	32.00%
Madison/East Carroll/Tensas	30.14%
Morehouse	24.35%
Natchitoches/Red River	26.15%
Orleans	20.54%
Ouachita/Caldwell	24.03%
Pointe Coupee	23.83%
Rapides	27.80%
Richland/West Carroll	29.99%
Sabine	29.09%
St. John/St. James/St. Charles	23.55%
St. Landry	27.93%
St. Martin	24.73%
St. Mary	22.32%
St. Tammany	24.97%
Tangipahoa/St. Helena	25.73%
Terrebonne	20.76%
Vermilion	27.30%
Vernon	25.76%
Washington	28.12%
Webster/Jackson/Claiborne/Bienville	24.02%
Winn	27.25%
State Total	**24.78%**

APPENDIX H: PREVALENCE OF RISK FACTORS, BY PARISH

Perpetrator Characteristics					
Parish	**Mental Health**	**Substance Abuse**	**Abuse History**	**Domestic Violence**	**Criminal History**
Acadia	12.07%	23.57%	10.70%	7.39%	21.63%
Allen	16.62%	37.61%	12.54%	17.20%	27.99%
Ascension	16.32%	17.69%	5.25%	7.03%	17.45%
Avoyelles	12.43%	21.22%	8.60%	5.54%	25.81%
Beauregard	9.98%	22.16%	9.78%	6.79%	28.34%
Bienville	22.22%	28.65%	15.20%	6.43%	39.18%
Bossier	8.47%	18.29%	6.35%	8.30%	18.97%
Caddo	7.23%	18.01%	9.45%	6.71%	20.63%
Calcasieu	12.80%	23.10%	11.08%	7.13%	22.09%
Caldwell	13.82%	30.08%	11.38%	8.94%	19.51%
Cameron	21.43%	21.43%	7.14%	0.00%	21.43%
Catahoula	2.94%	20.59%	4.41%	5.15%	10.29%
Claiborne	15.48%	29.76%	13.10%	7.14%	27.98%
Concordia	5.29%	21.16%	9.52%	8.99%	24.34%
DeSoto	7.16%	23.69%	10.74%	5.79%	25.07%
East Baton Rouge	9.65%	17.01%	8.08%	4.50%	17.98%
East Carroll	9.09%	18.18%	15.15%	1.01%	9.09%
East Feliciana	10.11%	25.84%	9.55%	7.30%	17.98%
Evangeline	10.16%	17.77%	8.98%	3.52%	18.16%
Franklin	10.83%	28.88%	18.41%	6.86%	25.27%
Grant	22.12%	41.52%	8.18%	6.36%	43.64%
Iberia	11.43%	14.46%	7.86%	6.70%	15.71%
Iberville	9.06%	19.06%	6.25%	2.81%	12.50%
Jackson	12.65%	25.90%	10.24%	9.04%	37.35%
Jefferson (East Bank)	15.77%	24.06%	9.63%	8.45%	26.70%
Jefferson (West Bank)	10.99%	17.55%	7.38%	5.24%	17.04%
Jefferson Davis	11.24%	28.40%	7.50%	4.34%	15.58%
Lafayette	16.80%	24.83%	9.96%	8.97%	25.77%
Lafourche	14.91%	20.27%	9.75%	5.56%	25.83%
LaSalle	1.35%	11.49%	5.41%	4.05%	12.16%
Lincoln	9.23%	18.67%	9.66%	6.65%	22.96%

Perpetrator Characteristics					
Parish	**Mental Health**	**Substance Abuse**	**Abuse History**	**Domestic Violence**	**Criminal History**
Livingston	16.58%	38.28%	10.19%	10.24%	33.33%
Madison	8.56%	15.51%	11.23%	5.35%	10.70%
Morehouse	9.30%	18.02%	10.76%	6.69%	23.26%
Natchitoches	8.41%	24.69%	9.81%	8.06%	14.36%
Orleans	6.17%	11.70%	4.40%	2.07%	11.12%
Ouachita	10.28%	22.90%	8.14%	8.10%	24.38%
Plaquemines	11.54%	10.00%	8.46%	8.46%	11.54%
Pointe Coupee	13.21%	23.02%	10.57%	7.92%	12.83%
Rapides	11.77%	20.23%	10.98%	5.57%	21.45%
Red River	13.11%	22.95%	9.84%	9.84%	14.75%
Richland	9.55%	23.03%	8.99%	5.62%	23.03%
Sabine	13.60%	34.26%	11.08%	13.60%	30.48%
St. Bernard	20.05%	35.32%	9.55%	14.32%	47.02%
St. Charles	13.10%	18.62%	8.97%	5.98%	22.30%
St. Helena	13.04%	26.09%	4.35%	0.00%	10.87%
St. James	15.49%	16.20%	8.45%	3.52%	17.61%
St. John	10.48%	19.65%	11.35%	6.55%	20.09%
St. Landry	15.52%	20.32%	8.08%	7.20%	22.88%
St. Martin	10.42%	26.89%	7.73%	6.89%	22.35%
St. Mary	8.68%	13.95%	6.32%	3.82%	23.03%
St. Tammany	16.27%	24.50%	11.08%	8.56%	30.83%
Tangipahoa	8.43%	19.58%	6.69%	5.00%	15.88%
Tensas	0.00%	12.50%	12.50%	2.50%	10.00%
Terrebonne	8.93%	17.67%	7.57%	5.05%	14.47%
Union	6.81%	16.23%	5.24%	5.24%	24.61%
Vermilion	19.30%	28.28%	10.99%	9.25%	29.09%
Vernon	13.52%	14.41%	9.79%	6.67%	17.08%
Washington	15.43%	31.11%	11.30%	8.38%	28.68%
Webster	19.91%	27.99%	11.35%	6.84%	36.39%
West Baton Rouge	10.18%	23.45%	6.19%	7.52%	14.16%
West Carroll	12.88%	25.76%	10.61%	8.33%	23.48%
West Feliciana	13.33%	11.11%	8.89%	2.22%	15.56%
Winn	7.39%	23.30%	8.52%	3.41%	20.45%
Statewide Total	11.84%	21.58%	9.06%	6.69%	21.82%

Source: Prepared by legislative auditor's staff using data provided by DCFS.

Child Characteristics						
Parish	**Delinquency**	**Developmental Disability**	**Medically Fragile**	**Mental Health**	**Physical Disability**	**Tox Screen**
Acadia	3.62%	5.15%	2.01%	9.49%	1.56%	4.79%
Allen	6.71%	4.96%	1.17%	13.99%	1.46%	5.83%
Ascension	1.78%	6.62%	1.21%	9.69%	1.37%	3.07%
Avoyelles	1.34%	4.78%	2.49%	11.66%	2.10%	4.21%
Beauregard	3.19%	6.19%	1.00%	10.98%	1.80%	2.20%
Bienville	2.34%	10.53%	2.92%	12.28%	2.34%	5.26%
Bossier	2.79%	3.90%	1.44%	10.25%	1.19%	3.56%
Caddo	3.69%	3.83%	2.54%	6.89%	1.61%	3.57%
Calcasieu	5.41%	9.75%	1.33%	13.83%	2.43%	2.53%
Caldwell	1.63%	13.82%	3.25%	10.57%	1.63%	0.00%
Cameron	0.00%	7.14%	0.00%	0.00%	0.00%	0.00%
Catahoula	1.47%	2.21%	0.00%	1.47%	0.74%	4.41%
Claiborne	2.38%	15.48%	4.17%	14.88%	3.57%	7.14%
Concordia	0.53%	7.94%	0.53%	2.65%	1.59%	2.12%
DeSoto	1.10%	3.86%	1.10%	7.44%	1.10%	1.65%
East Baton Rouge	1.75%	6.12%	2.34%	14.05%	1.65%	7.49%
East Carroll	4.04%	10.10%	5.05%	10.10%	1.01%	3.03%
East Feliciana	1.12%	6.18%	3.93%	6.74%	2.81%	5.62%
Evangeline	1.56%	8.01%	1.76%	8.98%	2.15%	5.47%
Franklin	4.69%	6.50%	3.61%	9.39%	0.72%	1.44%
Grant	5.15%	7.27%	3.03%	14.85%	2.12%	6.67%
Iberia	2.23%	3.66%	1.34%	7.41%	1.34%	5.98%
Iberville	0.63%	4.06%	1.56%	8.13%	1.88%	5.31%
Jackson	3.01%	13.25%	3.01%	14.46%	1.81%	4.82%
Jefferson (East Bank)	3.61%	7.89%	0.56%	12.68%	1.41%	3.49%
Jefferson (West Bank)	3.22%	4.21%	0.99%	11.85%	0.90%	3.82%
Jefferson Davis	2.56%	11.05%	1.18%	5.72%	2.17%	6.11%
Lafayette	4.33%	6.94%	2.09%	15.23%	1.56%	6.47%
Lafourche	4.48%	4.68%	1.75%	13.74%	2.05%	3.41%
LaSalle	0.00%	0.68%	0.00%	1.35%	0.00%	1.35%
Lincoln	1.93%	5.15%	2.58%	5.36%	1.29%	2.36%
Livingston	3.32%	5.38%	1.14%	8.62%	1.57%	4.51%
Madison	7.49%	14.97%	3.21%	8.56%	2.67%	3.74%
Morehouse	1.74%	4.36%	1.74%	6.10%	2.33%	2.91%
Natchitoches	1.40%	5.95%	0.88%	4.03%	1.40%	2.63%
Orleans	1.77%	4.12%	1.08%	7.13%	0.88%	5.45%
Ouachita	3.70%	8.22%	2.30%	9.70%	2.14%	2.14%
Plaquemines	1.54%	3.85%	0.00%	12.31%	0.77%	0.77%

Child Characteristics						
Parish	**Delinquency**	**Developmental Disability**	**Medically Fragile**	**Mental Health**	**Physical Disability**	**Tox Screen**
Pointe Coupee	4.15%	9.06%	3.02%	12.83%	3.77%	4.53%
Rapides	3.85%	6.58%	2.05%	9.89%	1.89%	4.99%
Red River	0.00%	6.56%	1.64%	6.56%	1.64%	1.64%
Richland	6.74%	11.80%	2.81%	10.11%	2.81%	1.12%
Sabine	3.78%	3.27%	2.52%	8.06%	1.76%	3.27%
St. Bernard	2.15%	10.02%	0.72%	14.32%	0.24%	5.01%
St. Charles	9.43%	17.47%	1.61%	15.40%	1.84%	4.14%
St. Helena	4.35%	2.17%	0.00%	15.22%	0.00%	8.70%
St. James	7.04%	10.56%	3.52%	14.79%	1.41%	4.23%
St. John	5.68%	15.50%	2.40%	13.97%	1.53%	3.49%
St. Landry	2.64%	8.72%	1.28%	11.20%	1.44%	2.64%
St. Martin	2.18%	2.18%	0.34%	8.57%	0.84%	9.08%
St. Mary	1.97%	5.79%	0.53%	9.21%	1.71%	3.29%
St. Tammany	3.85%	7.30%	0.97%	14.20%	1.66%	4.62%
Tangipahoa	3.75%	4.62%	1.47%	11.31%	1.03%	5.49%
Tensas	0.00%	15.00%	2.50%	5.00%	2.50%	2.50%
Terrebonne	2.72%	3.98%	1.26%	9.71%	1.36%	4.47%
Union	1.57%	4.71%	1.05%	5.24%	1.05%	1.57%
Vermilion	3.49%	5.50%	1.34%	7.37%	1.21%	5.23%
Vernon	1.51%	6.32%	1.33%	3.74%	0.98%	1.51%
Washington	5.71%	5.10%	2.92%	13.97%	2.07%	5.83%
Webster	3.42%	11.98%	1.09%	19.75%	2.33%	2.80%
West Baton Rouge	1.33%	3.54%	3.10%	7.96%	1.77%	4.87%
West Carroll	6.82%	17.42%	3.79%	11.36%	0.76%	3.03%
West Feliciana	1.11%	6.67%	1.11%	8.89%	0.00%	2.22%
Winn	0.57%	1.14%	0.57%	2.27%	1.70%	3.98%
Statewide Total	3.26%	6.25%	1.67%	10.44%	1.58%	4.37%

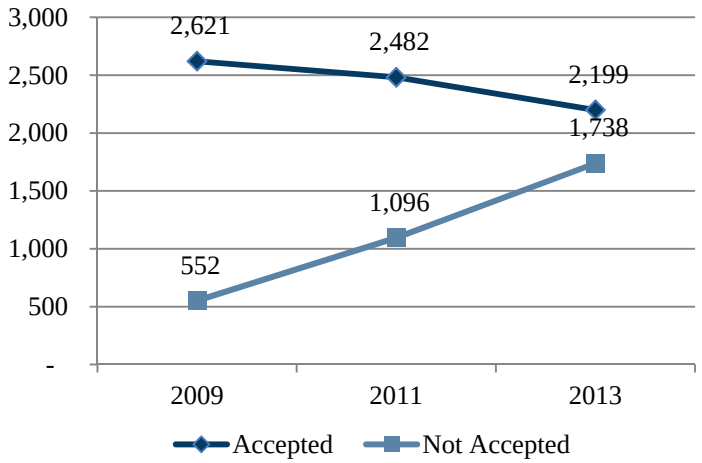
Source: Prepared by legislative auditor's staff using data provided by DCFS.

APPENDIX I: REGIONAL AND PARISH FACT SHEETS

Alexandria Region

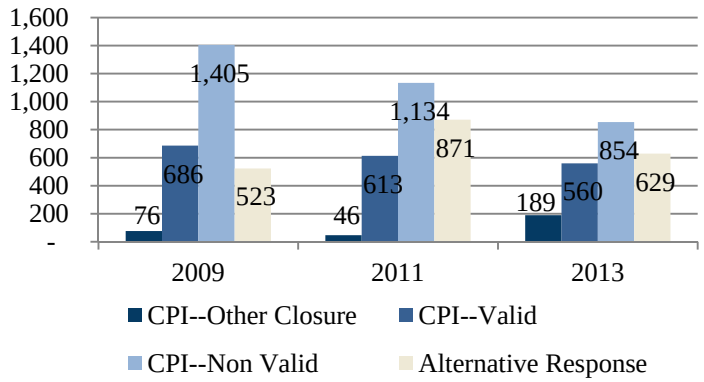
2010 Census Population: 309,761

Accepted vs. Not Accepted Intake Reports



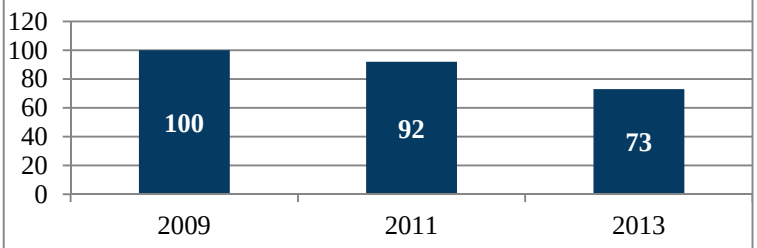
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Number of Cases with Closure Type



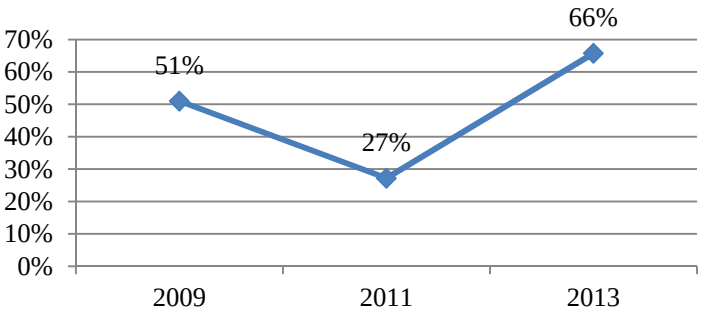
Source: Prepared by legislative auditor's staff using data provided by DCFS.
Non Valid Closures include Invalid and Inconclusive. Other Closures include Unable to Locate, Client Noncooperation, or open cases.

Annual Child Welfare Caseworker Headcount



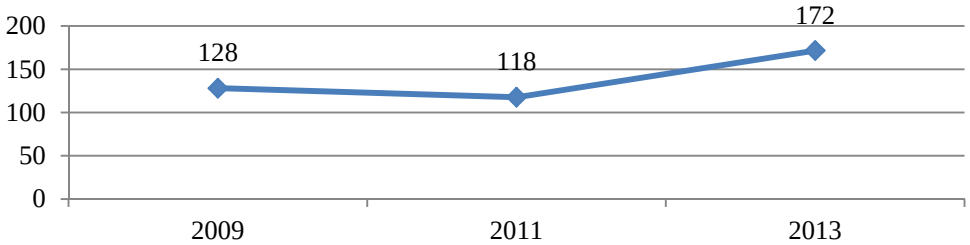
Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.

Annual Child Welfare Turnover



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.

Annual CPI/AR Caseload



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Alexandria Region

2010 Census Population: 309,761

Number of Valid Allegations by Type Per Parish Office									
Parish Offices	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/ Drug Exposed Newborns	Maltreatment*	Death	Total
Avoyelles	Avoyelles	2009	238	78	38	10	4	0	368
		2011	168	38	52	14	4	0	276
		2013	240	64	20	32	2	0	358
Catahoula	Catahoula, LaSalle	2009	202	52	20	0	0	0	274
		2011	260	4	4	8	0	0	276
		2013	242	30	10	4	0	0	286
Concordia	Concordia	2009	150	60	2	0	0	0	212
		2011	130	26	0	2	0	0	158
		2013	106	16	4	4	0	0	130
Grant	Grant	2009	310	40	8	0	0	0	358
		2011	136	16	14	12	0	0	178
		2013	0	0	0	0	0	0	0
Rapides	Rapides	2009	1,256	258	138	30	6	4	1,692
		2011	1,278	254	72	76	4	12	1,696
		2013	1,458	158	100	136	4	4	1,860
Vernon	Vernon	2009	466	226	38	6	0	0	736
		2011	506	74	22	2	4	0	608
		2013	272	50	34	10	2	2	370
Winn	Winn	2009	66	14	4	0	0	0	84
		2011	66	26	8	8	0	0	108
		2013	40	18	6	10	0	0	74
Alexandria Region Total			**7,590**	**1,502**	**594**	**364**	**30**	**22**	**10,102**
Percent of Region Total			**75.13%**	**14.87%**	**5.88%**	**3.60%**	**0.30%**	**0.22%**	**100.00%**

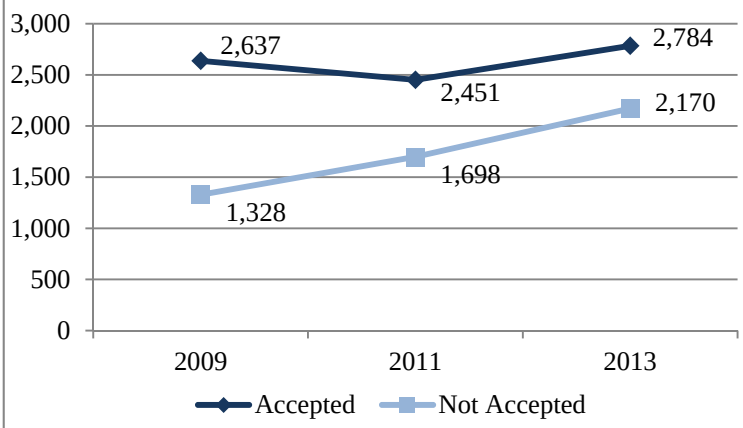
*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

Source: Prepared by legislative auditor's staff using data provided by DCFS.

Baton Rouge Region

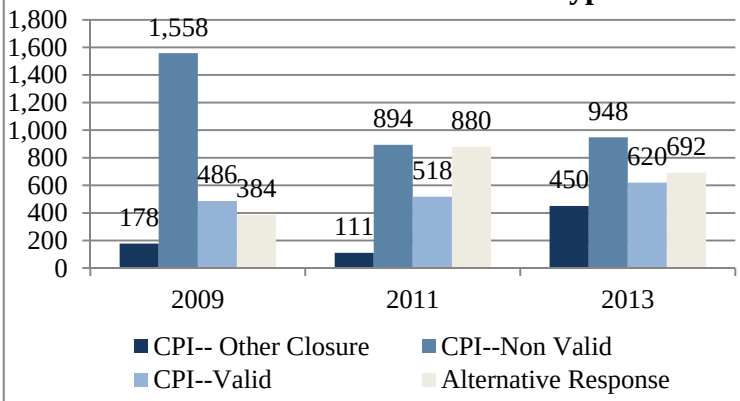
2010 Census Population: 556,040

Accepted vs. Not Accepted Intake Reports



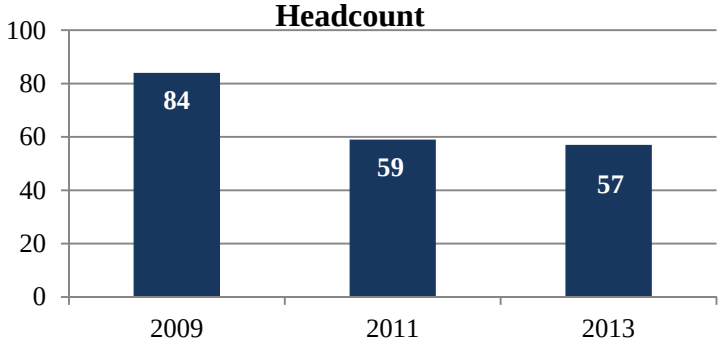
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Number of Cases with Closure Types



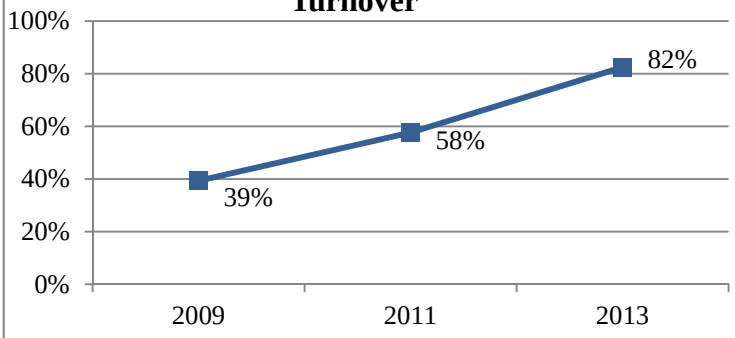
Source: Prepared by legisative auditor's staff using data provided by DCFS.
Non Valid Closures include Invalid and Inconclusive. Other Closures include Unable to Locate, Client Noncooperation, or open cases.

Annual Child Welfare Caseworker Headcount



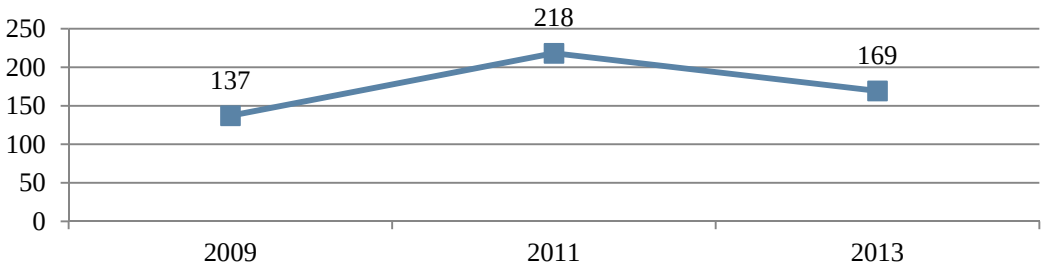
Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.

Annual Child Welfare Caseworker Turnover



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.

Annual CPI/AR Caseload



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Baton Rouge Region

2010 Census Population: 556,040

Number of Valid Allegations by Type Per Parish Office									
Parish Office	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/Drug Exposed Newborn	Death	Maltreatment	Total
East Baton Rouge Parish	East Baton Rouge, West Baton Rouge	2009	912	384	108	72	6	4	1,486
		2011	738	408	186	156	6	14	1,508
		2013	1,152	580	140	226	8	2	2,108
East Feliciana Parish	East Feliciana, West Feliciana	2009	16	14	2	4	0	0	36
		2011	74	40	30	10	0	0	154
		2013	88	18	12	8	2	4	132
Iberville Parish	Iberville	2009	350	38	20	8	2	10	428
		2011	258	50	26	28	0	0	362
		2013	236	58	12	40	0	4	350
Pointe Coupee Parish	Pointe Coupee	2009	116	32	4	6	0	2	160
		2011	124	34	30	4	0	2	194
		2013	228	36	12	20	0	2	298
EBR Region Total			**4,292**	**1,692**	**582**	**582**	**24**	**44**	**7,216**
Percent of Region Total			**59.48%**	**23.45%**	**8.07%**	**8.07%**	**0.33%**	**0.61%**	**100.00%**

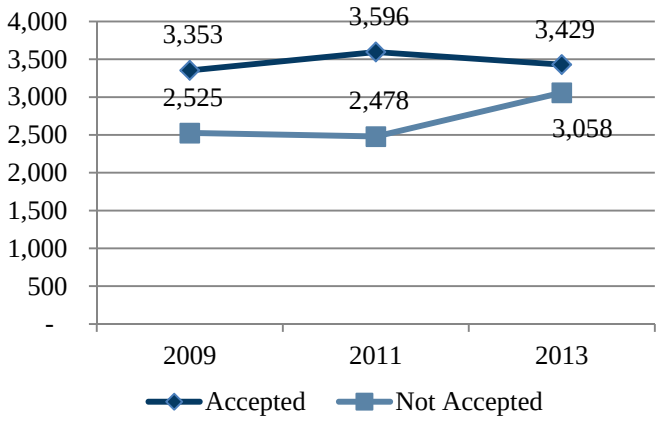
*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

Source: Prepared by legislative auditor's staff using data provided by DCFS.

Covington Region

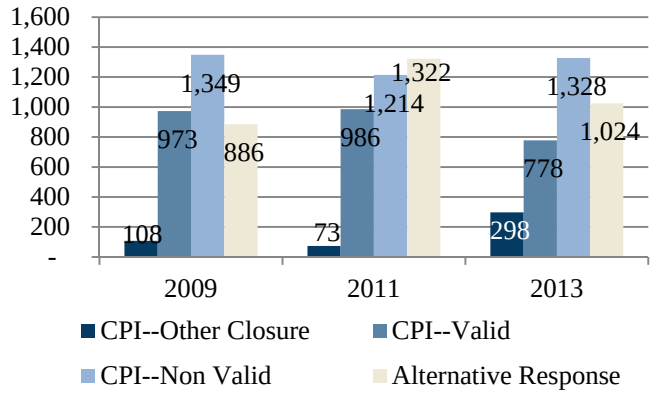
2010 Census Population: 541,234

Accepted vs. Not Accepted Intake Reports



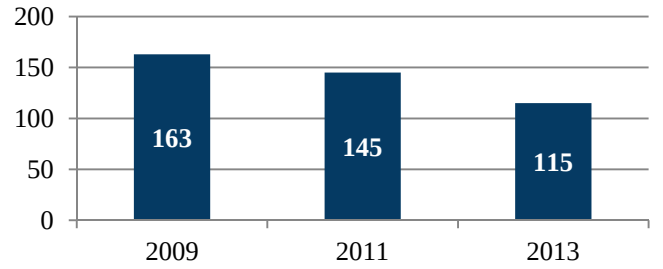
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Number of Cases with Closure Type



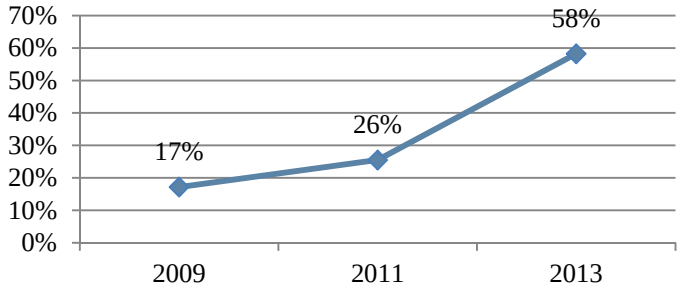
Source: Prepared by legisative auditor's staff using data provided by DCFS.
Non Valid Closures include Invalid and Inconclusive. Other Closures include Unable to Locate, Client Noncooperation, or open cases.

Annual Child Welfare Caseworker Headcount



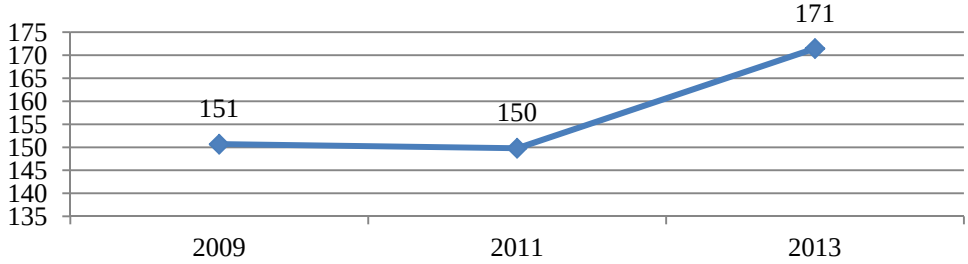
Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.

Annual Child Welfare Turnover



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.

Annual CPI/AR Caseload



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Covington Region

2010 Census Population: 541,234

Number of Valid Allegations by Type Per Parish Office									
Parish Offices	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/ Drug Exposed Newborns	Maltreatment*	Death	Total
Livingston	Livingston	2009	2,508	266	170	52	62	0	3,058
		2011	2,736	292	138	70	14	0	3,250
		2013	1,574	162	68	70	12	8	1,894
St. Tammany	St. Tammany	2009	1,306	184	102	36	4	6	1,638
		2011	1,012	110	50	84	2	6	1,264
		2013	1,352	188	126	58	0	2	1,726
Tangipahoa	Tangipahoa, St. Helena	2009	698	122	36	78	0	0	934
		2011	902	166	72	88	0	0	1,228
		2013	877	142	70	54	8	0	1,151
Washington	Washington	2009	1,010	36	18	44	10	0	1,118
		2011	880	80	6	40	4	0	1,010
		2013	532	80	28	14	4	0	658
Covington Region Total			**15,387**	**1,828**	**884**	**688**	**120**	**22**	**18,929**
Percent of Region Total			**81.29%**	**9.66%**	**4.67%**	**3.63%**	**0.63%**	**0.12%**	**100.00%**

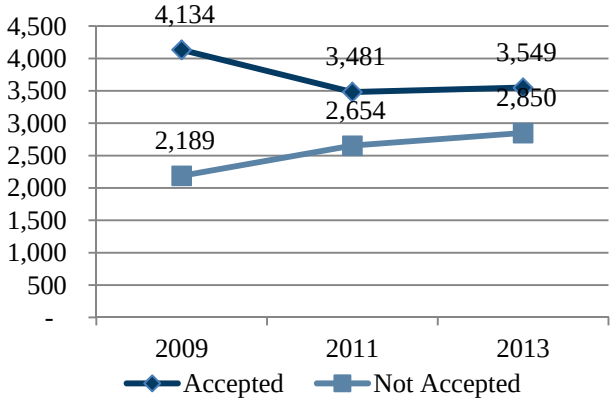
*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

Source: Prepared by legislative auditor's staff using data provided by DCFS.

Lafayette Region

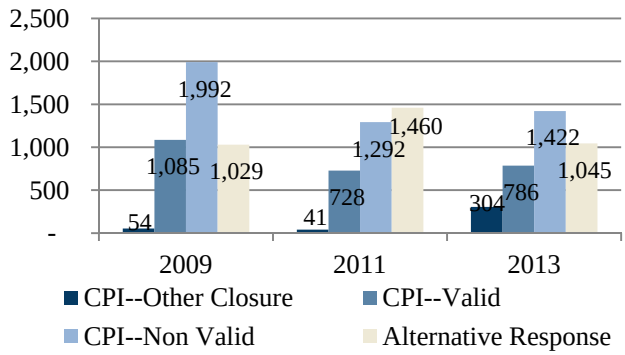
2010 Census Population: 638,728

Accepted vs Not Accepted Intake Reports



Source: Prepared by legislative auditor's staff using data provided by DCFS.

Number of Cases with Closure Type



Source: Prepared by legislative auditor's staff using data provided by DCFS.
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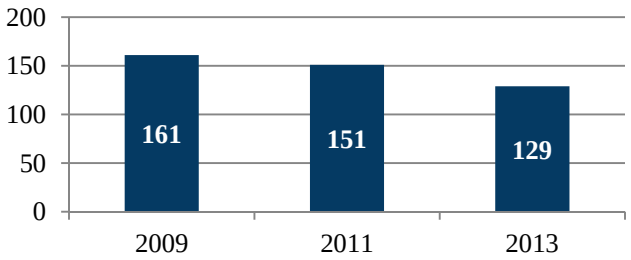
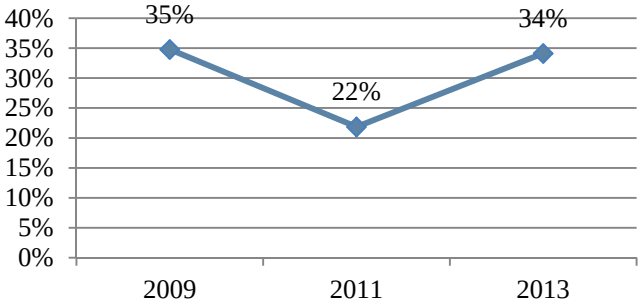
Annual Child Welfare Caseworker Headcount



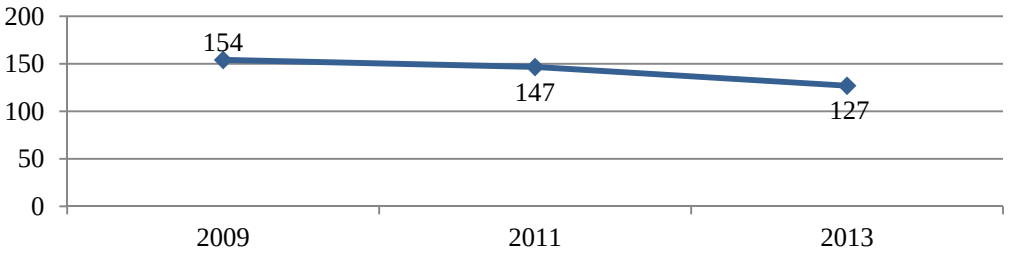
Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.

Annual Child Welfare Turnover



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.

Annual CPI/AR Caseload



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Lafayette Region

2010 Census Population: 638,728

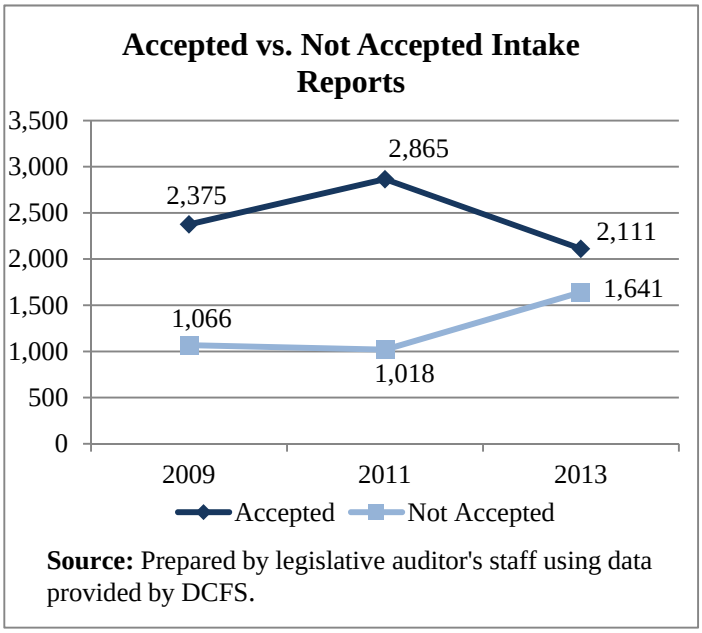
Number of Valid Allegations by Type Per Parish Office									
Parish Offices	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/ Drug Exposed Newborns	Death	Maltreatment*	Total
Acadia	Acadia	2009	364	134	50	48	2	0	598
		2011	506	116	30	26	0	2	680
		2013	645	74	40	22	0	2	783
Evangeline	Evangeline	2009	140	70	24	4	4	0	242
		2011	50	46	10	14	0	0	120
		2013	248	50	18	44	6	0	366
Iberia	New Iberia	2009	464	138	34	30	0	12	678
		2011	398	118	50	52	8	4	630
		2013	220	56	50	38	2	0	366
Lafayette	Lafayette	2009	882	174	88	48	16	2	1,210
		2011	646	128	140	84	4	6	1,008
		2013	911	218	36	120	6	0	1,291
St. Landry	St. Landry	2009	1,042	148	24	38	4	2	1,258
		2011	362	88	254	36	4	6	750
		2013	342	90	4	42	0	6	484
St. Martin	St. Martin	2009	256	74	10	14	0	0	354
		2011	88	52	18	22	0	2	182
		2013	90	20	6	46	0	0	162
St. Mary	St. Mary	2009	466	62	14	4	0	0	546
		2011	160	88	46	18	2	0	314
		2013	186	36	2	24	0	0	248
Vermilion	Vermilion	2009	556	210	50	28	0	0	844
		2011	436	34	36	28	0	0	534
		2013	348	32	4	24	6	0	414
Lafayette Region Total			**9,806**	**2,256**	**1,038**	**854**	**64**	**44**	**14,062**
Percent of Region Total			**69.73%**	**16.04%**	**7.38%**	**6.07%**	**0.46%**	**0.31%**	**100.00%**

*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

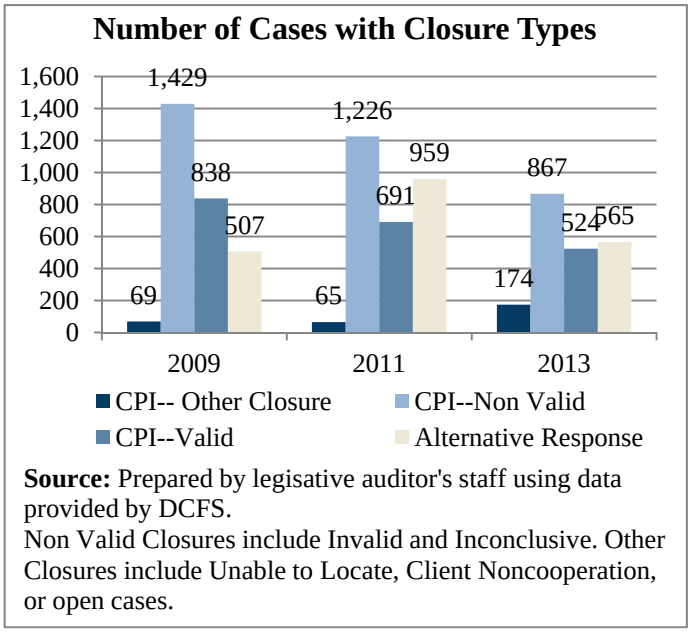
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Lake Charles Region

2010 Census Population: 292,619



Source: Prepared by legislative auditor's staff using data provided by DCFS.



Source: Prepared by legislative auditor's staff using data provided by DCFS.
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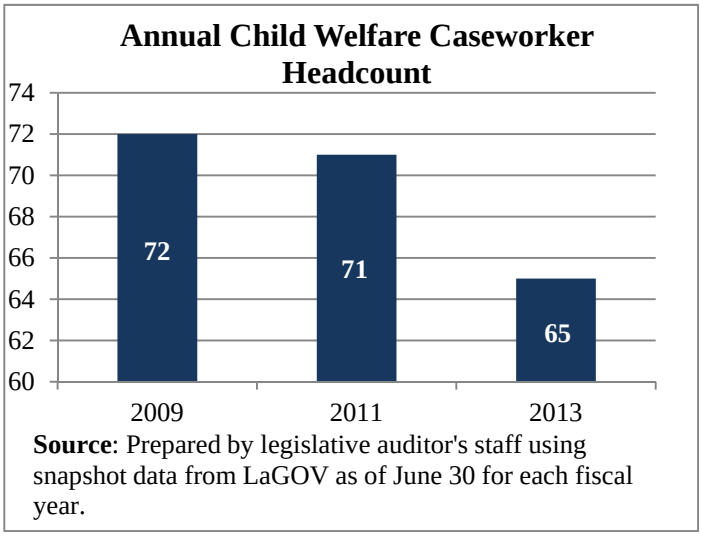
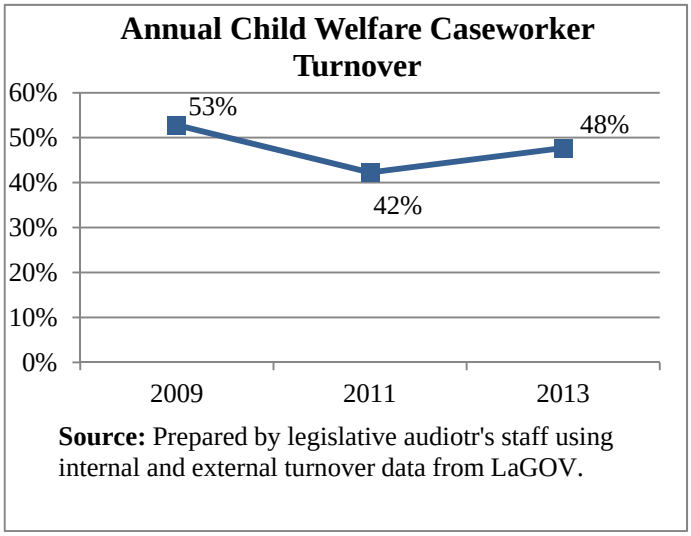
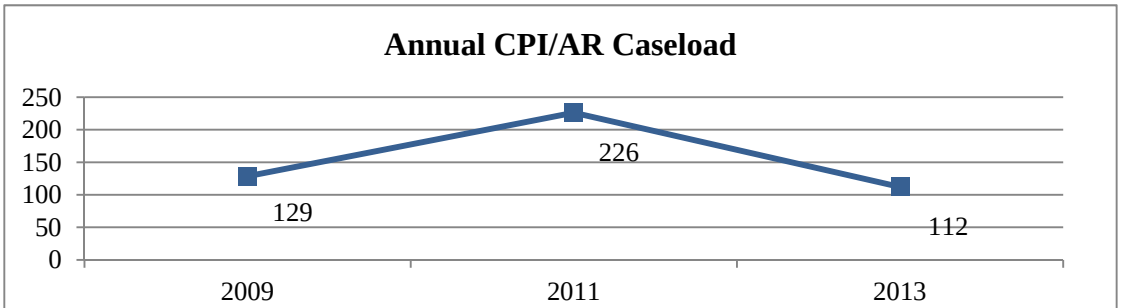


Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.



Source: Prepared by legislative audiotr's staff using internal and external turnover data from LaGOV.



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Lake Charles Region

2010 Census Population: 292,619

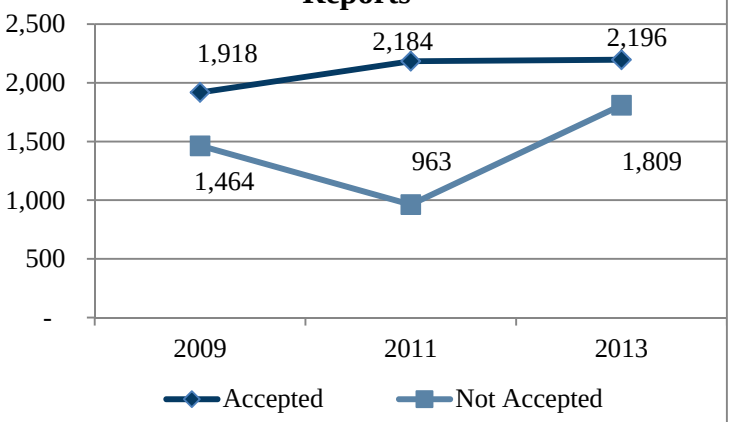
Number of Valid Allegations by Type Per Parish Office									
Parish Office	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/Drug Exposed Newborn	Maltreatment*	Death	Total
Allen	Allen	2009	304	86	40	18	2	0	450
		2011	114	84	20	12	0	0	230
		2013	292	52	24	12	0	0	380
Beauregard	Beauregard	2009	292	84	58	2	6	4	446
		2011	252	88	20	10	0	0	370
		2013	210	62	34	10	6	0	322
Calcasieu	Calcasieu, Cameron	2009	1,940	484	238	60	10	16	2,748
		2011	2,112	582	314	82	0	8	3,098
		2013	1,404	292	100	52	12	0	1,860
Jefferson Davis	Jefferson Davis	2009	146	56	2	2	0	0	206
		2011	174	64	18	12	0	0	268
		2013	112	68	32	24	2	2	240
Lake Charles Region Total			**7,352**	**2,002**	**900**	**296**	**38**	**30**	**10,618**
Percent of Region Total			**69.24%**	**18.85%**	**8.48%**	**2.79%**	**0.36%**	**0.28%**	**100.00%**

*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

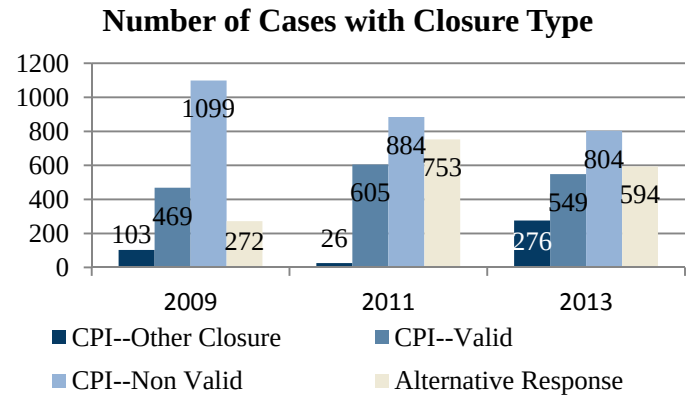
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Monroe Region

2010 Census Population: 339,487



Source: Prepared by legislative auditor's staff using data provided by DCFS.



Source: Prepared by legislative auditor's staff using data provided by DCFS.
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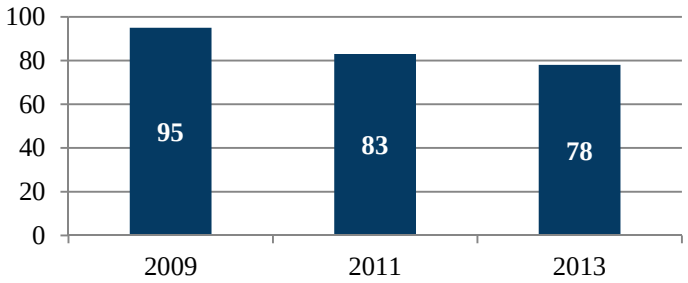
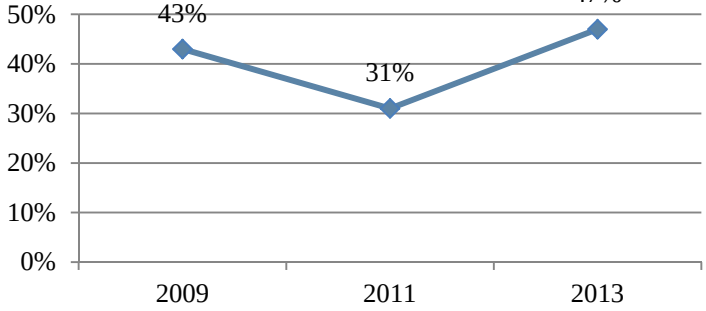
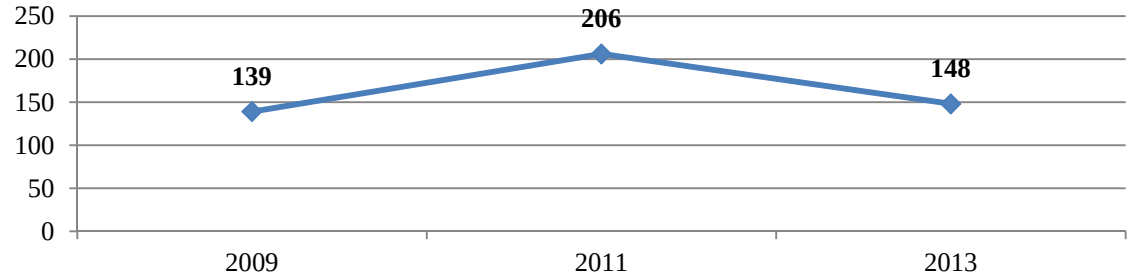


Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Monroe Region

2010 Census Population: 339,487

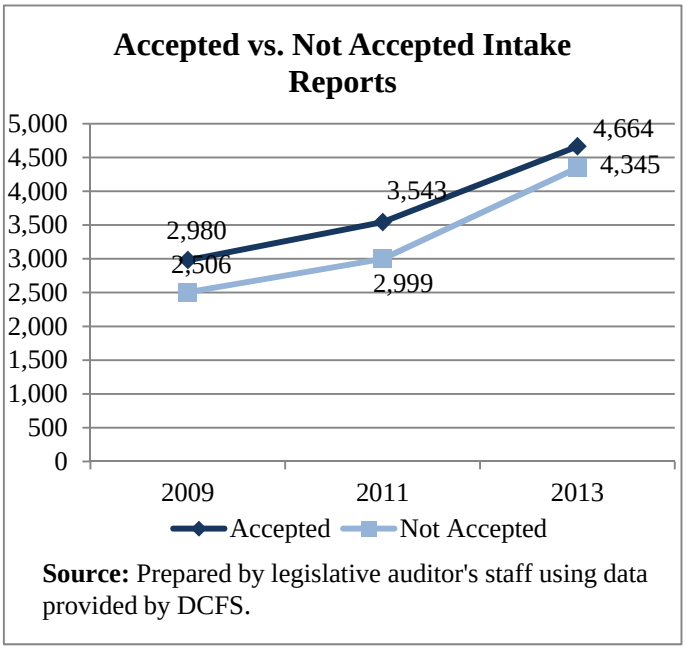
Number of Valid Allegations by Type Per Parish Office									
Parish Offices	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/ Drug Exposed Newborns	Death	Maltreatment*	Total
Franklin	Franklin	2009	158	64	52	2	0	6	282
		2011	188	122	2	2	0	0	314
		2013	131	56	16	8	2	0	213
Lincoln	Lincoln, Union	2009	298	104	52	4	2	0	460
		2011	358	118	52	8	2	2	540
		2013	374	110	50	20	4	0	558
Madison	Madison, East Carroll, Tensas	2009	176	40	14	2	2	0	234
		2011	180	58	28	6	4	0	276
		2013	182	36	16	4	0	0	238
Morehouse	Morehouse	2009	106	20	6	8	2	0	142
		2011	206	74	24	8	2	0	314
		2013	286	40	20	14	4	0	364
Ouachita	Ouachita, Caldwell	2009	1,030	234	106	10	12	6	1,398
		2011	1,240	448	82	24	12	0	1,806
		2013	958	392	46	68	10	2	1,476
Richland	Richland, West Carroll	2009	66	68	8	2	0	0	144
		2011	164	46	18	2	0	0	230
		2013	322	92	44	6	6	0	470
Monroe Region Total			**6,423**	**2,122**	**636**	**198**	**64**	**16**	**9,459**
Percent of Region Total			**67.90%**	**22.43%**	**6.72%**	**2.09%**	**0.68%**	**0.17%**	**100%**

*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

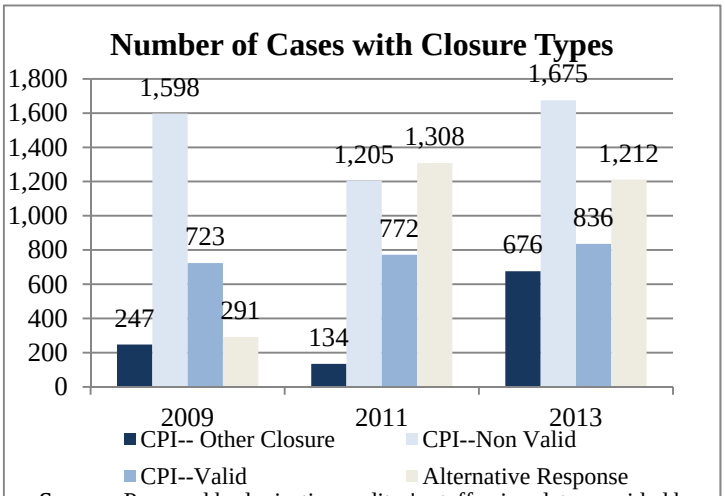
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Orleans Region

2010 Census Population: 835,320



Source: Prepared by legislative auditor's staff using data provided by DCFS.



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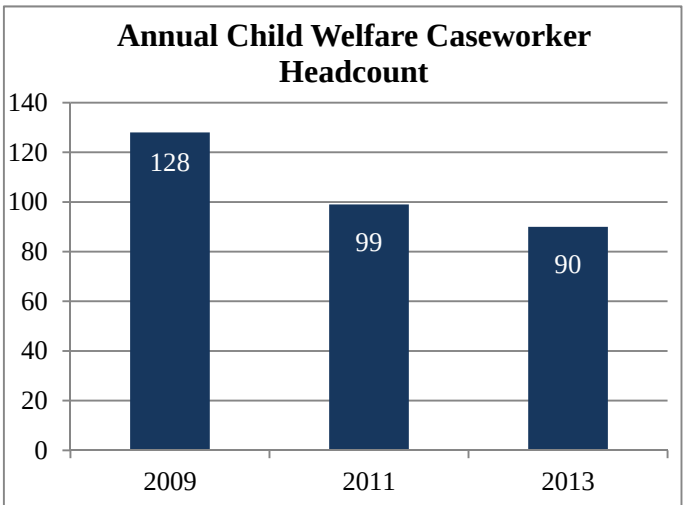
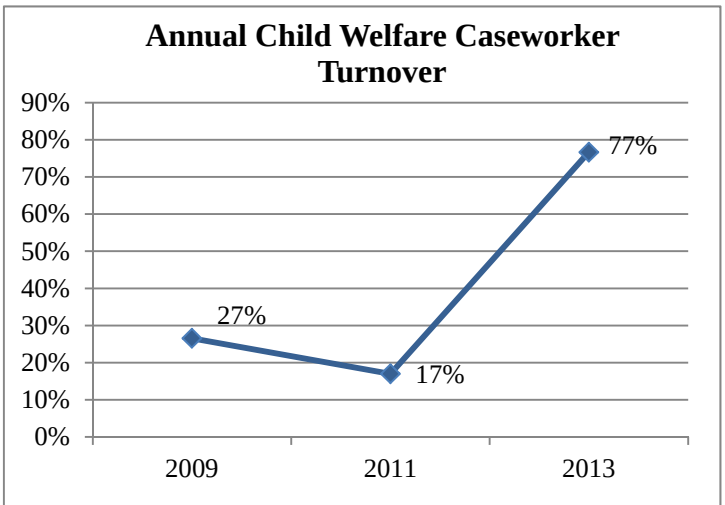
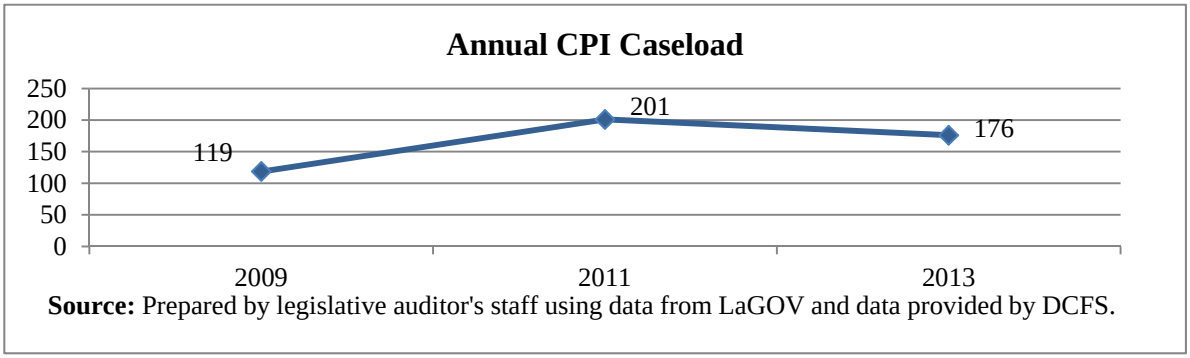


Source: Prepared by legislative auditor's staff using data from LaGOV as of June 30 for each fiscal year.



Source: Prepared by legislative audiotr's staff using data from LaGOV.



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Orleans Region

2010 Census Population: 835,320

Number of Valid Allegations by Type Per Parish Office									
Parish Office	**Parishes Served**	**Fiscal Year**	**Neglect**	**Physical Abuse**	**Alcohol/Drug Exposed Newborn**	**Sexual Abuse**	**Death**	**Maltreatment***	**Total**
Orleans	Orleans	2009	802	174	134	60	6	0	1,176
		2011	874	338	112	92	4	0	1,420
		2013	822	418	120	48	8	14	1,430
Jefferson	East Jefferson, Plaquemines, St. Bernard, West Jefferson	2009	1,444	375	148	72	10	6	2,055
		2011	2,110	382	98	180	0	12	2,782
		2013	2,032	362	150	140	8	2	2,694
Orleans Region Total			**8,084**	**2,049**	**762**	**592**	**36**	**34**	**11,557**
Percent of Region Total			**69.95%**	**17.73%**	**6.59%**	**5.12%**	**0.31%**	**0.29%**	**100.00%**

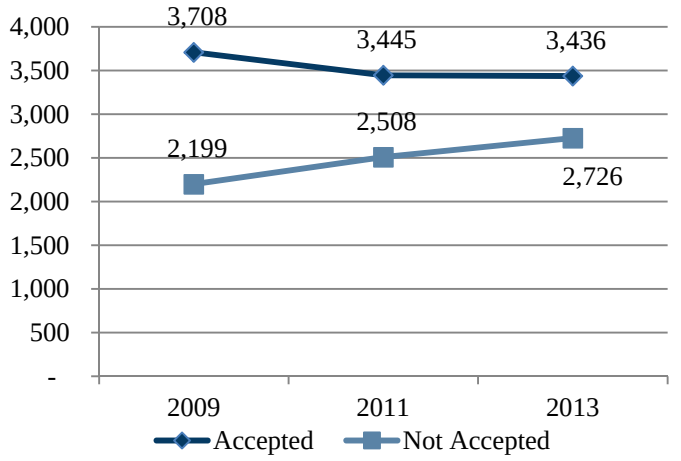
*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

Source: Prepared by legislative auditor's staff using data provided by DCFS.

Shreveport Region

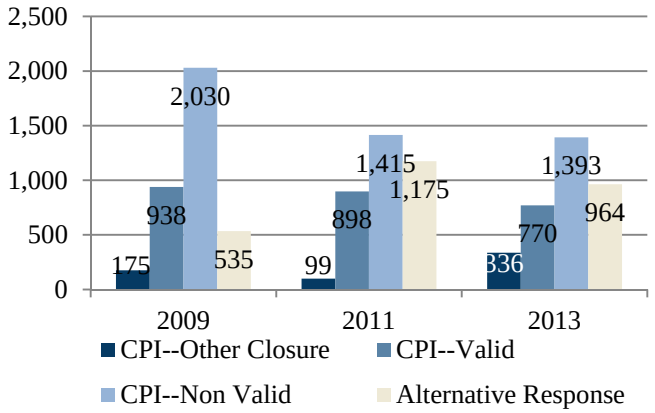
2010 Census Population: 560,523

Accepted vs. Not Accepted Intake Reports



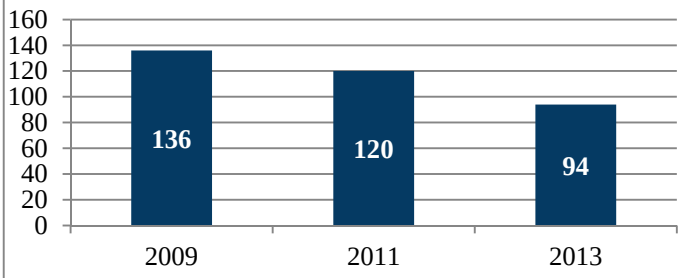
Source: Prepared by legislative auditor's staff using data provided by DCFS.

Number of Cases with Closure Type



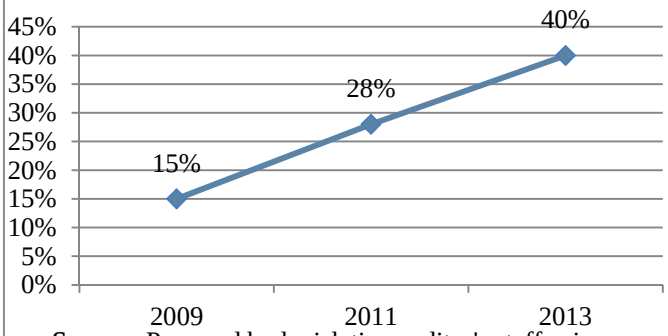
Source: Prepared by legislative auditor's staff using data provided by DCFS.
Non Valid Closures include Invalid and Inconclusive. Other Closures include Unable to Locate, Client Noncooperation, or open cases.

Annual Child Welfare Caseworker Headcount



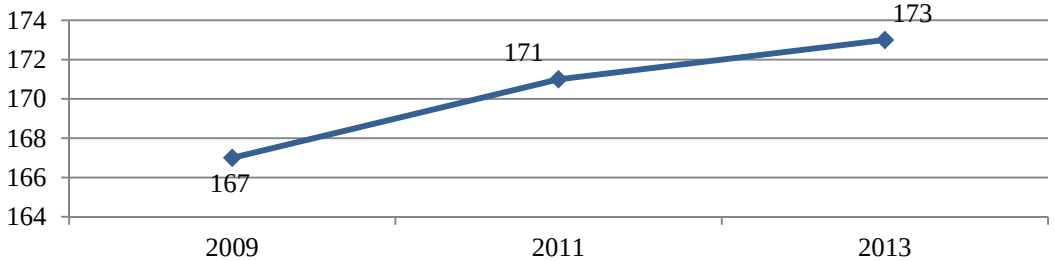
Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.

Annual Child Welfare Turnover



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.

Annual CPI/AR Caseload



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Shreveport Region

2010 Census Population: 560,523

Number of Valid Allegations by Type Per Parish Office									
Parish Offices	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/ Drug Exposed Newborns	Maltreatment*	Death	Total
Caddo	Bossier, Caddo, DeSoto	2009	2,292	736	228	66	10	4	3,336
		2011	1,894	592	250	122	18	10	2,886
		2013	2,013	498	170	222	4	2	2,909
Natchitoches	Natchitoches, Red River	2009	218	58	28	18	0	2	324
		2011	146	60	24	16	0	6	252
		2013	90	24	22	20	0	4	160
Sabine	Sabine	2009	90	18	6	10	2	0	126
		2011	232	82	66	10	2	0	392
		2013	202	58	28	10	2	0	300
Webster	Bienville, Claiborne, Jackson, Webster	2009	688	182	52	22	0	4	948
		2011	496	140	90	36	2	4	768
		2013	476	114	56	20	6	0	672
Shreveport Region Total			**8,837**	**2,562**	**1,020**	**572**	**46**	**36**	**13,073**
Percent of Region Total			**67.60%**	**19.60%**	**7.80%**	**4.38%**	**0.35%**	**0.28%**	**100.00%**

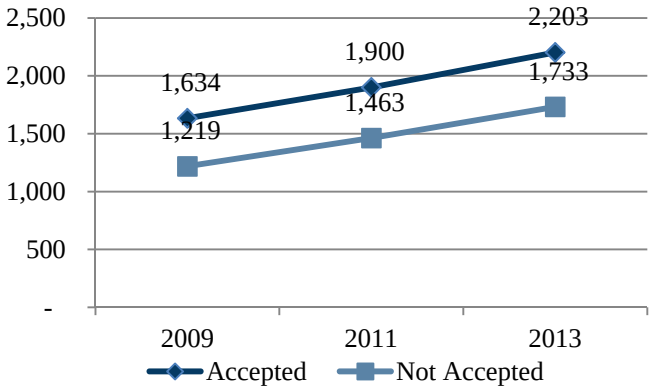
*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

Source: Prepared by legislative auditor's staff using data provided by DCFS.

Thibodaux Region

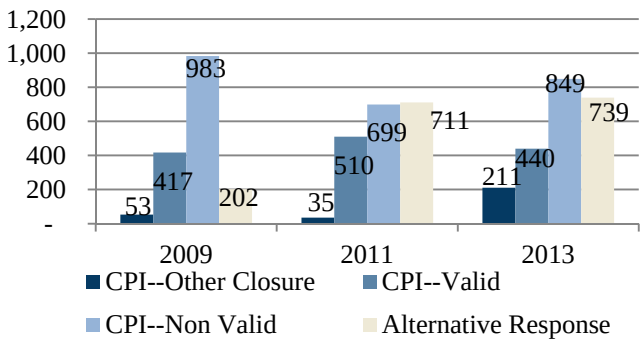
2010 Census Population: 459,620

Accepted vs. Not Accepted Intake Reports



Source: Prepared by legisative auditor's staff using data provided by DCFS.

Number of Cases with Closure Type



Source: Prepared by legisative auditor's staff using data provided by DCFS.
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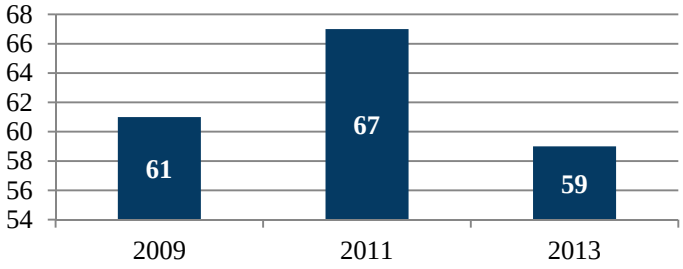
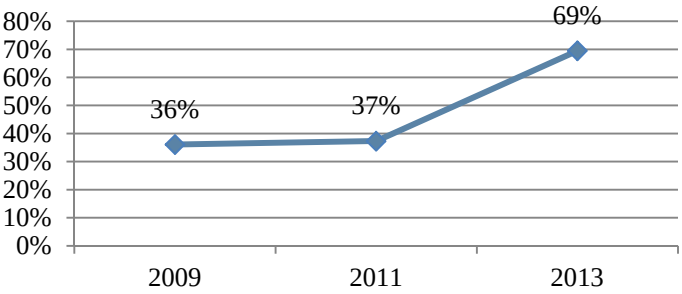
Annual Child Welfare Caseworker Headcount



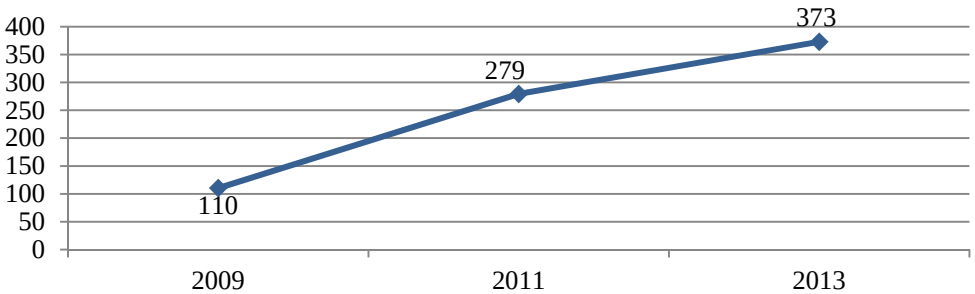
Source: Prepared by legislative auditor's staff using snapshot data from LaGOV as of June 30 for each fiscal year.

Annual Child Welfare Turnover



Source: Prepared by legislative auditor's staff using internal and external turnover data from LaGOV.

Annual CPI/AR Caseload



Source: Prepared by legislative auditor's staff using data from LaGOV and data provided by DCFS.

Thibodaux Region

2010 Census Population: 459,620

Number of Valid Allegations by Type Per Parish Office									
Parish Offices	Parishes Served	Fiscal Year	Neglect	Physical Abuse	Sexual Abuse	Alcohol/ Drug Exposed Newborns	Death	Maltreatment*	Total
Ascension	Ascension	2009	298	80	12	20	0	0	410
		2011	454	184	50	40	8	0	736
		2013	286	54	32	42	0	4	418
Lafourche	Lafourche, Assumption	2009	594	150	95	20	0	0	859
		2011	390	102	50	22	0	0	564
		2013	276	78	40	16	0	0	410
St. John	St. John, St. Charles, St. James	2009	358	84	14	24	6	0	486
		2011	610	78	40	24	8	2	762
		2013	450	82	34	28	0	0	594
Terrebonne	Terrebonne	2009	206	38	36	14	0	0	294
		2011	416	70	46	36	2	8	578
		2013	654	128	44	36	0	0	862
Thibodaux Region Total			**4,992**	**1,128**	**493**	**322**	**24**	**14**	**6,973**
Percent of Region Total			**71.59%**	**16.18%**	**7.07%**	**4.62%**	**0.34%**	**0.20%**	**100.00%**

*DCFS workers use the Maltreatment code inconsistently. In some cases, this code appears to be used when it is unclear whether the case is a result of abuse or neglect.

Source: Prepared by legislative auditor's staff using data provided by DCFS.