EVIDENT CHANGE

Inform Systems. Transform Lives.

MEMORANDUM

TO: Adele Gray and Julie Waters, California Department of Social Services
CC: Kelly Winston, CDSS
FROM: Evident Change
SUBJECT: Findings and Recommendations From Pre-Implementation and Discovery Analysis for Congregate Care Safety Assessment
DATE: July 6, 2022

In 2021, the California Department of Social Services (CDSS) contracted with Evident Change to customize the California Structured Decision Making® (SDM) safety assessment to support the consistent, accurate, and equitable assessment of child safety when maltreatment is alleged in group home and congregate care (CC) settings. Currently, California counties use SDM® safety assessments designed for use either in a parent/caregiver's household or for use in a substitute care provider (SCP) home when there are allegations in foster and kinship homes. However, the current assessments leave a gap in safety assessment when allegations arise in CC settings. Evident Change and CDSS are partnering to eliminate this gap by modifying the existing SDM safety assessments to include guidance for assessing safety in these contexts.

When abuse or neglect is alleged while a child is in out-of-home care, including CC settings, California child welfare agencies are required to evaluate whether an in-person response is needed. State policy clarifies that the child welfare agency is responsible for investigating the suspected abuse or neglect as necessary to

protect and ensure the immediate safety of children in placement, regardless of whether an agency such as congregate care licensing (CCL) is investigating the same allegation.[1]

To support design and modification of the SDM safety assessment that will be responsive to the unique context, policy, and practice in group home and CC settings, initial project work focused on a robust discovery and analysis phase, which lasted from August 2021 to February 2022. This process occurred in consultation with CDSS and a safety assessment development team composed of critical stakeholders including county child welfare services (CWS) staff, supervisors, and policy analysts; probation staff; CCL representatives; residential providers; young adults with lived experience; and tribal partners. This group helped Evident Change identify a set of critical questions where answers were needed to support the updated safety assessment's customization and implementation. Discovery questions were categorized into three topic areas.

- Context, which focused on understanding current California policy and practice related to responding to allegations in CC settings.
- Assessment structure, which explored trends and research around the characteristics of incidents and investigations that occur in these settings (e.g., allegations, identified safety concerns, alleged victim and alleged perpetrator profiles) to inform the safety assessment's content.
- Implementation, which began to identify what supports would be needed for successful implementation of the new safety assessment.

The following sections describe the discovery methods used, key findings, and recommendations that CDSS should consider to ensure successful safety assessment implementation in this setting. To ensure fidelity in the assessment tool's implementation, Evident Change recommends that the state only move forward with this implementation if attention can be focused on the areas of concern listed below.

---

[1] California Code of Regulations. CCR 11 § 930.52 (1991). https://govt.westlaw.com/calregs/Document/I8A81DEA0D45111DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=DocumentItem&contextData=%28sc.Default%29; California Department of Social Services. (2005). *Reporting and investigation requirements for child abuse allegations regarding children in out-of-home placements* (ACL No. 05-09). https://cdss.ca.gov/lettersnotices/entres/getinfo/acl05/pdf/05-09.pdf; California Department of Social Services. (2018). *Assessing child safety and appropriate monitoring of safety plans* (ACL No. 17-107). https://www.cdss.ca.gov/Portals/9/ACL/2017/17-107.pdf?ver=2019-06-26-152901-400

DISCOVERY METHODS

Evident Change developed a discovery plan to review the three key areas listed above. The mixed methods approach for data collection included the following.

- A thorough review of guiding California state statutes and policy.
- An academic literature review related to safety and assessment of safety in congregate settings.
- Key informant interviews to gain understanding about current practice and help inform questions on the statewide staff survey.
- Administrative data analyses using information in California's Child Welfare Services Case Management System (CWS/CMS) to examine the characteristics of children, adults, and facilities involved in investigations of allegations in congregate settings as well as characteristics of those investigations, including allegation types, findings, location, etc.
- A case review of 86 investigations across multiple counties involving a child in a CC facility to learn more about the types of safety concerns and interventions used in CC settings.
- A statewide survey of county CWS staff who conduct investigations in CC settings to gather their perspectives on their understanding of policy, the investigative process, and the types of safety concerns and responses available in those settings. The statewide survey was distributed through the safety assessment development team and the SDM core team; 101 staff responded.
- A survey of tribal social workers who conduct or partner on investigations of allegations in CC settings.

DISCOVERY FINDINGS

Through the discovery activities, questions across all three areas described above (context, assessment structure, and implementation) were answered. This memo focuses only on the areas identified as most critical for state and county attention to ensure successful implementation (i.e., used with consistency and fidelity) of the modified SDM safety assessment for its use in CC settings.

1. NOT ALL COUNTY CHILD WELFARE AGENCIES ARE EVALUATING REFERRALS OF MALTREATMENT IN CC FOR AN IN-PERSON CWS RESPONSE TO ASSESS CHILD SAFETY.

California policy directs that when an allegation of suspected abuse or neglect is made regarding a child in a licensed out-of-home care setting, the child welfare agency is responsible for investigating the suspected abuse or neglect as necessary to protect and ensure the safety of the children in placement. Policy clarifies that child welfare agencies are required to conduct these investigations regardless of whether another agency such as CCL or law enforcement is also investigating the allegation and that it is not appropriate for a referral of abuse or neglect that requires an immediate response or an in-person investigation to be "evaluated out" and left to the responsibility of CCL. [2]

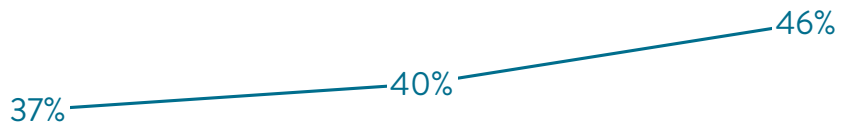
Information shared through key informant interviews, the county survey, and discussions during development team meetings confirmed that not all counties are aware of, or practicing, in alignment with the requirement for CWS response to allegations in CC settings. Counties may be sending these reports to licensing without evaluating them for in-person CWS response to assess for safety.

[2] California Department of Social Services, *Reporting and investigation requirements for child abuse allegations regarding children in out-of-home placements* (ACL No. 05-09)

The administrative data analysis showed variation in the proportion of reports involving CC facilities that were screened in across the state. CWS/CMS data for fiscal year (FY) 2020–21 showed that 46% of all referrals identified by Evident Change as alleging maltreatment in CC settings were assigned for an in-person CWS response to assess child safety. The rate of in-person responses had increased by nearly 10 percentage points since FY 2018–19 (Figure 1). This investigation rate can be considered in the context of how often referrals are accepted for an in-person response in California overall; in 2020, 58% of referrals with completed SDM hotline tools were accepted for an in-person response.[3]

Figure 1

Referral Investigation Rate by Fiscal Year



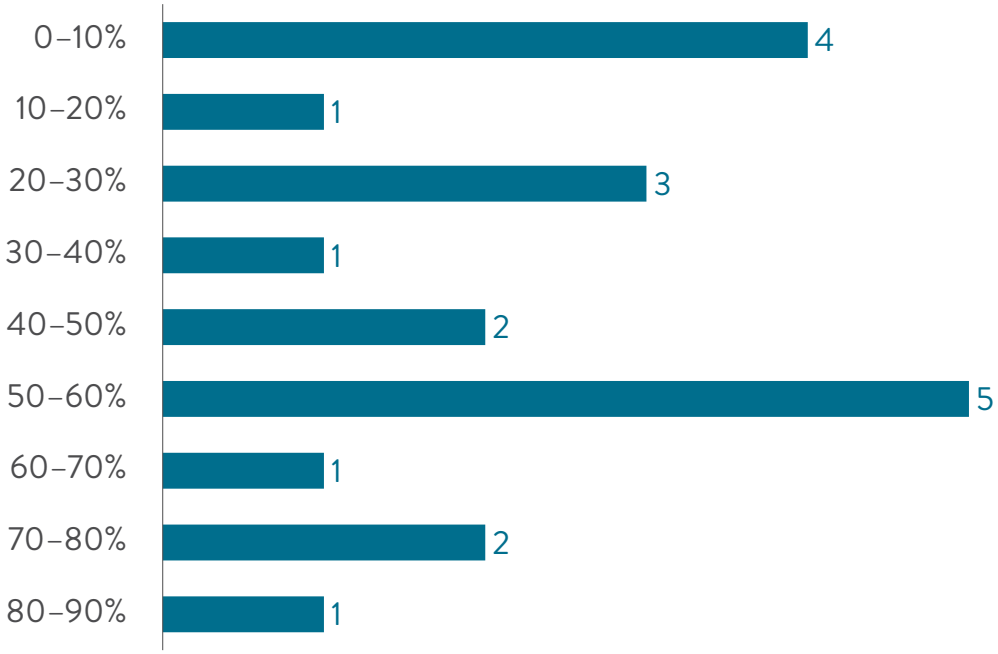
FY 2018–19	FY 2019–20	FY 2020–21
N = 1,612	N = 1,480	N = 1,502

[3] Evident Change. (2021). *The Structured Decision Making system in child welfare services*. https://docs.evidentchange.org/Pages/cacoreteam/Content/CDSS%20SDM%20Report%202020.pdf

Data analysis also showed that the in-person response rate varies considerably by county. For example, four counties evaluated out over 90% of referrals alleging maltreatment in CC settings, five counties screened in 50–60%, and some screened in over 80% (Figure 2). Over all three fiscal years combined, the in-person response rate range for CC referrals in counties with 10 or more was 2–85% (not shown).

Figure 2

Number of Counties by CC Referral Screen-In Rate: FY 2018–19 to FY 2020–21



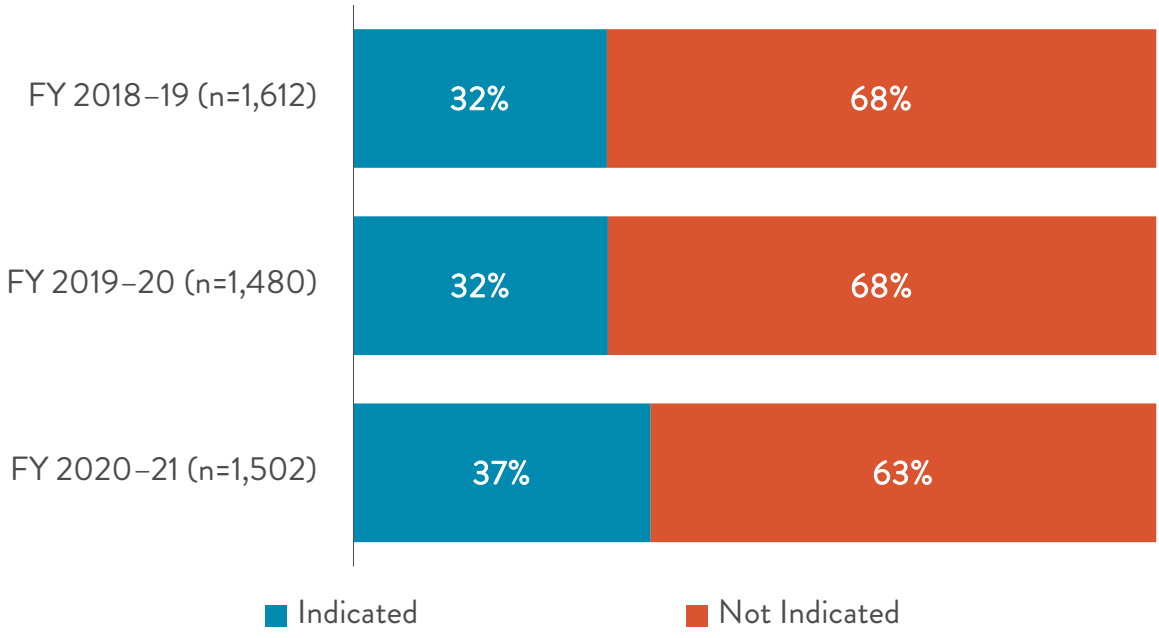
Note: Includes only counties with more than 10 CC setting referrals during the year.

2. CURRENT DATA QUALITY, DOCUMENTATION GUIDANCE, AND INFRASTRUCTURE IN CWS/CMS FOR DOCUMENTING ALLEGATIONS IN CC SETTINGS IS LIMITED AND MAY COMPROMISE THE ABILITY TO IMPLEMENT A SAFETY ASSESSMENT IN THESE SETTINGS CONSISTENTLY AND WITH FIDELITY.

Clear guidance and infrastructure for CWS/CMS documentation on allegations of abuse or neglect that involve CC settings are lacking, which limits the ability to accurately and consistently track referrals and investigations that pertain to CC facilities. CWS/CMS currently includes fields in the allegation notebook to

record whether the alleged perpetrator was a substitute care provider and whether the allegation occurred in a placement facility. However, policy does not clearly stipulate how county staff should use these fields, and during the discovery process, Evident Change repeatedly observed and heard that these fields are used inconsistently. For example, in the administrative data review, Evident Change used a multi-step process to identify allegations likely pertaining to a CC facility. This process considered factors such as the alleged perpetrator's relationship to the alleged victim(s), address of the referral compared to CC home addresses, text analysis of the referral name, and identification of allegations in CC facilities using allegation notebook fields. Evident Change identified a total of 4,594 referrals in FY 2018–19 through FY 2020–21 that likely pertained to allegations on a CC facility; of those, only 32% indicated in the allegation notebook that the allegation pertained to a CC facility (not shown). The proportion with an allegation notebook indicator was only slightly higher in FY 2020–21 (Figure 3).

Figure 3
Proportion of Referrals Involving Allegations in CC Facilities With an Indicator in the CWS/CMS Allegation Notebook



In 2003, CDSS issued county guidance on documenting allegations in out-of-home care using the non-protecting parent code in the allegation notebook.[4] while this guidance provided support for identifying allegations in which a substitute care provider was involved, there does not appear to have been a way to document the specific type of home in which allegations occurred. Acknowledging structural limitations in CWS/CMS for consistently documenting that allegations occurred in CC, 2005 guidance from CDSS instructed staff to use the work-around of a temporary naming convention, using the facility type as the first name and facility name as the last name.[5] Data recorded in CWS/CMS show that a placement facility type field was added to the allegation notebook around 2005 or 2006 to document the child's placement type at the time of the allegation. To Evident Change's knowledge, subsequent policy guidance was never released to clarify or replace the temporary naming convention. Survey respondents indicated significant confusion about how to document allegations related to maltreatment in CC settings, including how to enter the alleged perpetrator if they are facility staff. The documentation strategy described above also creates difficulty in reporting, as mining the data stored in text fields is time intensive and prone to errors. The limitations of current CDSS guidance on documenting allegations in CC, combined with the lack of consistent screening practice, raise concerns for larger data quality issues, including the accurate reporting of maltreatment rates in out-of-home care. It is critical to ensure the accurate reporting of this federal outcome measure, which is intended to support the accountability of states to keep children safe from further harm while under their care.

Addressing current data quality concerns will be foundational to the state's efforts to support consistent assessment of safety in these settings. Tracking the safety assessment's use in CC settings will be important to continuous quality improvement (CQI) and monitoring assessment fidelity, highlighting the importance of being able to systematically identify investigations that pertain to CC settings with confidence. Without this, it will not be possible to determine whether the required safety assessment is completed, whether the assessment is completed in a timely manner, and whether workers adhere to the assessment's guidance. The data quality concerns also may affect other performance and CQI metrics; for example, if an investigation is not identified as pertaining to a CC setting, completion metrics for the current SDM safety and risk

---

[4] California Department of Social Services. (2003). *CWS/CMS data entry* (ACL No. 03-61). https://cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-61.pdf

[5] California Department of Social Services, *Reporting and investigation requirements for child abuse allegations regarding children in out-of-home placements* (ACL No. 05-09).

assessments may be inaccurate (e.g., an investigation may appear to be missing these assessments when in fact it does not require them).

3. STATE POLICY ON INVESTIGATING ALLEGATIONS IN CC IS NOT CENTRALIZED OR CONSISTENTLY IMPLEMENTED.

Various state policies and regulations describe the requirements for investigating allegations involving CC settings in most key areas of practice; however, the guidance is currently dispersed across many documents and hosted in multiple places. Evident Change's policy review identified critical guidance on the topic in over 20 different citations, dispersed throughout ACLs, All County Information Notices, the Welfare and Institutions Code, the California Code of Regulations, and Licensing Standards. However, no comprehensive state guidance consolidates all aspects of expected practice for investigating allegations in CC settings, which likely contributes to inconsistencies in current practice across counties.

4. CURRENT PRACTICE DOES NOT ALIGN WITH WRITTEN POLICY, AND STATE INFRASTRUCTURE DOES NOT APPEAR TO SUPPORT REGULAR REVIEW OR FOLLOW-UP FOR AREAS OF LOCAL PRACTICE THAT ARE OUT OF COMPLIANCE WITH STATE REGULATIONS.

Survey findings and case reading results demonstrate that practitioners across the state are unclear about statutory and regulatory requirements related to investigations in congregate settings, including these critical areas of practice.

Role Clarity Between Agencies

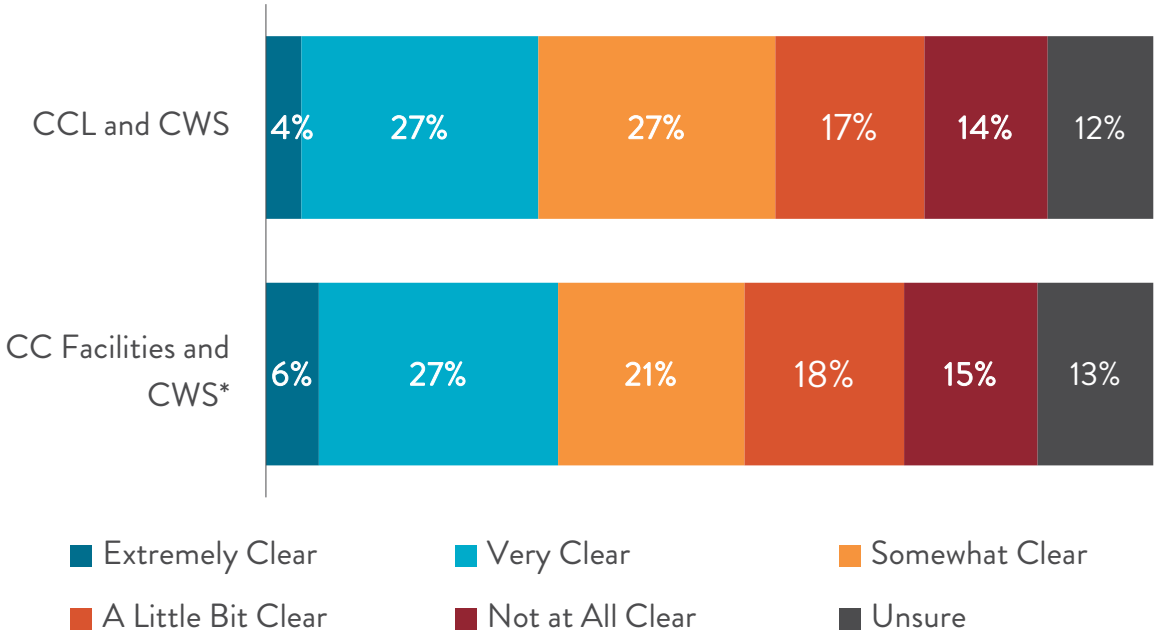
Policy describes the distinct roles and responsibilities of CWS, licensing, law enforcement and probation in responding to allegations of child abuse and neglect in CC. For example, CCR Title 11 § 930.52 states that the primary role of CWS is to investigate suspected abuse as necessary to protect and ensure safety of children in placement and coordinate an assessment or investigation with law enforcement and the licensing agency. ACL No. 05-09 clarifies that investigations by CCL and CWS have two different statutory responsibilities, timelines for response, and goals.

Despite clarity in written policies, CWS survey responses indicated that many staff are unclear on their role. About 30% of respondents indicated that they were not at all clear or only a little bit clear on the distinct roles of CCL and CWS. Results about role clarity between CC facilities and CWS were similar (Figure 4). Note that survey responses were limited to 101 participants statewide and cannot be generalized to all CWS staff. However, the opinions shared by those who participated indicate a need to increase awareness of and clarity around these policies.

Figure 4

How clear are roles between staff when investigating allegations in CC settings?

N = 101 Survey Responses



*One missing response not shown.

Avoiding Conflicts of Interest

CCR conflicts of interest policy requires Law Enforcement, county probation, county welfare, and licensing agencies to ensure that the investigation of child abuse in an out-of-home care facility is carried out in an unbiased and impartial manner. In support of this, section 930.54 (b) requires that "an individual child protective service worker or official who actually places the alleged child abuse victim, or has a direct

personal relationship with the facility, the suspected abuser, or the alleged child abuse victim, which creates a conflict of interest, shall not be involved in or responsible for any part of the investigation or assessment of child abuse in that facility."[6] Manual of Policies and Procedures (MPP) Section 31-101.2 also requires that the worker responding to a referral must be skilled in emergency response.[7] As stated in ACL 17-27, "for this reason, and to avoid impacting an ongoing case worker's relationship with a family or caregiver, counties shall ensure that family maintenance, family reunification, licensing, and adoptions workers are not tasked with responding to referrals and investigating allegations."[8] Case reading results indicated that of the 86 investigations reviewed, 16 (19%) were conducted by the case-carrying social worker. This is in conflict with guidance seeking to ensure the responding worker is both skilled in emergency response and free of conflict of interests.

Tribal Representation and Collaboration for Culturally Informed Assessment

Strong collaboration between tribal and county social workers can strengthen culturally informed assessment. Information gathered during discovery indicates that this practice is currently inconsistent. Responses to a qualitative survey of tribal social workers across the state suggested varying degrees of tribal staff involvement in investigations of allegations concerning tribal youth in CC settings. Some tribal staff reported a lack of consistent and timely ongoing communication throughout an investigation, while others reported strong collaboration and involvement as co-investigators. Survey respondents described the critical roles of the tribal representative during an investigation, including providing cultural collaboration for each child and family involved in an investigation, providing access to culturally appropriate services, providing information related to assessment, and supporting county staff in understanding cultural practices.

---

[6] California Code of Regulations. 11 CCR § 930.54 (2021). https://casetext.com/regulation/california-code-of-regulations/title-11-law/division-1-attorney-general/chapter-9-report-of-child-abuse/duties-and-responsibilities/section-93054-conflict-of-interests

[7] California Department of Social Services. (2017). *Manual of policies and procedures: Child welfare services* (Section 31-101.2). https://www.cdss.ca.gov/Portals/9/Additional-Resources/Legislation-and-Regulations/MPP/Child-Welfare-Services/Child%20Welfare%20Services%20Manual%20cws2.pdf?ver=2020-01-22-114911-740

[8] California Department of Social Services. (2017). *Investigating, assessing, and documenting a new referral of child abuse or neglect in an open investigation or case* (ACL No. 17-27). https://www.cdss.ca.gov/Portals/9/ACL/2017/17-27.pdf?ver=2019-06-25-135241-527

Assessing Immediate Safety

State policy clearly indicates that CWS is responsible for assessing immediate child safety. Specifically, ACL No. 17-27 states, "During the initial in-person investigation, caseworkers must determine whether the child(ren) may remain in the home or current placement or determine whether immediate removal is necessary by conducting a safety assessment, as defined in MPP Section 31-002 (s)(1)" and further clarifies "Caseworkers must assess for child safety and identify any immediate safety threats prior to leaving any child in the home or placement."[9] While MPP Section 31-002 (s)(1) defines safety assessment as documented information from all parties that assesses present dangers or imminent threats of serious harm/maltreatment while holding values of different cultures, it does not provide guidance on the process or tools for assessing safety based on different settings (e.g., in a family home versus a foster family home or a CC setting).[10]

Responses to the statewide worker survey suggest that local county policy describing expectations for assessing safety in these settings may be limited. Of 101 survey responses, 66 indicated that their county has local policy on assessing safety. Even when that policy exists, it is not always clear. When asked whether local policy explicitly addresses assessing child safety in CC settings, 31% of the 66 respondents said that local policy addresses assessing safety somewhat or not at all; 41% said that local policy mostly addresses this topic and 27% said that local policy completely addresses this topic. Note that survey findings represent a limited sample of 101 workers from across the state. Additionally, because individual information was not collected, it is possible that results overrepresent CWS staff from some counties. Therefore, results cannot be generalized to all counties or all workers but may point to an area for further review.

When asked what they use to support decision making when assessing safety in CC settings, responses ranged from using the SDM safety assessment for parent/caregiver homes (35%) and SDM safety assessment for SCP homes (26%) to no structured tool (12%). The SDM safety assessments for parent/caregiver and SCP homes are not designed for use in CC settings, as the safety concerns in those settings may differ from those identified in family or SCP homes. These findings suggest that clear practice guidance on assessing safety in different contexts could be helpful; themes from the worker survey included

[9] Ibid.

[10] California Department of Social Services. (2017). *Manual of policies and procedures: Child welfare services* (Section 31-002 (s)(1)). https://www.cdss.ca.gov/Portals/9/Regs/cws1.pdf?ver=2019-01-29-130847-963

asking for additional clarification on how to account for the safety of children in the facility who are not named as alleged victims in the referral.

RECOMMENDATIONS

Based on the findings documented above and conversations with discovery team stakeholders, Evident Change recommends the following to CDSS. While alternate next steps may be identified, it is critical that the concerns highlighted above be addressed prior to implementing a safety assessment for CC settings.

1. **Strongly consider releasing another ACL when the updated assessment is near implementation that re-states CDSS policy expectations regarding screening and investigation for referrals involving allegations in CC settings.** We also recommend that CDSS join Evident Change during the implementation phase for a series of statewide webinars and trainings to continue to emphasize these expectations.

2. **Identify and engage county child welfare agencies that are out of compliance with requirements for responding to and tracking disposition of allegations in CC settings.** Conduct targeted review and outreach as soon as possible to counties that appear to be out of compliance with state and federal requirements for responding to allegations of maltreatment of children in CC settings. Outreach may involve ensuring awareness of existing policies, identifying current barriers to child welfare agency response, and providing support for immediate actions to reach compliance if needed. Such outreach could be targeted using the provided data on current rates of evaluated-out referrals, county survey responses, or direct discussion with county directors.

3. **Develop both immediate and long-term plans to address data quality and CWS/CMS documentation issues related to tracking referrals involving allegations in CC settings.** Accurate reporting of abuse or neglect in care, as well as ensuring timely assessment of child safety, requires appropriate screening and the ability to accurately identify and flag referrals in these settings. Immediate guidance should be distributed statewide to ensure consistent, accurate documentation of referrals in CC facilities in CWS/CMS. While imperfect, existing fields and flags in CWS/CMS and in the allegation notebook can be used to support accurate and systematic data collection for allegations on CC settings; CDSS should leverage these existing fields to strengthen data collection until a more permanent electronic solution exists.

Due to the low percentage of CC referrals that are appropriately identified in CWS/CMS, Evident Change recommends a more thorough review of inappropriately flagged referrals to understand the impact of these data quality issues on federal reporting and outcome data.

4. **Strengthen related policy guidance and dissemination.** Develop one comprehensive ACL that consolidates statutes, policies, and regulations on responding to allegations of maltreatment in CC settings. In addition to developing clear, comprehensive guidance that consolidates existing policy, CDSS should identify and address larger statewide challenges with policy dissemination that affect gaps Prior to developing a finalized ACL that consolidates guidance on investigations in CC settings, CDSS should establish a plan to reinforce expected practice for investigating allegations in these settings; distribution of the Congregate Care Safety Assessment Policy Scan, targeted discussions with the Child Welfare Directors Association of California, or other methods may be useful. The policy scan includes a comprehensive review of current statutes and policies and can be used by county leaders, policy departments, and practitioners to review county practice and ensure compliance with state guidance.

5. **Identify CQI strategies used to track statewide uptake and awareness of current and updated policy into practice over time and proactively identify, in the state agency's oversight capacity, county agencies that do not meet legal standards of care.** Federal guidance on establishing and maintaining effective CQI systems in state child welfare agencies highlights the importance of state agencies being proactive in the continuous evaluation of process and outcomes related to safety.[11] CDSS should clarify and strengthen the administrative structure used to ensure and support county compliance with existing federal and state mandates, beyond Child and Family Service Reviews (CFSRs). While the state's role in monitoring and supporting system accountability and county compliance is critical at all times, it is paramount in the case of keeping children who have been separated from their families in the name of safety protected from further harm while in the care of the system. Counties that are identified to fall below the legal standard for practice should be both identified proactively by the state agency and immediately be targeted for technical assistance and resources to address the areas of concern. Critical information from that process should be used to guide continuous system improvements.

---

[11] Administration for Children and Families. (2012). *Establishing and maintaining continuous quality improvement (CQI) systems in state child welfare agencies* (ACYF-CB-IM-12-07). https://www.acf.hhs.gov/sites/default/files/documents/cb/im1207.pdf

NEXT STEPS

Throughout spring of 2022, Evident Change collaborated with the safety assessment development team to design, customize, and update the SDM safety assessment for CC settings in California. While this document focuses more narrowly on the areas identified during discovery and analysis for state follow-up, the sum of the information gathered has been foundational to inform context and data for customizing an assessment that aligns with federal and state policy, research, and best practice. Following assessment customization, should CDSS and Evident Change decide to move forward, California counties will pilot the assessment for up to six months prior to statewide implementation.

The implementation of a safety assessment customized for CC settings should not move forward without careful review and attention to the areas described above. To ensure all counties and the state are prepared to implement the CC safety assessment with fidelity, Evident Change recommends that CDSS develop targeted strategies to address the areas of concern and recommendations as soon as possible and prior to implementation of the new assessment.