Follow-Up Audit of the Child Protective Services System

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 03-12
August 2003

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

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OVERVIEW

Follow-Up Audit of the Child Protective Services System

Report No. 03-12, August 2003

Summary

Every child deserves to live in an environment that is both safe and secure. To help ensure that Hawaii's children are given this opportunity, the Department of Human Services, through its Child Welfare Services Branch, provides protection to children at risk of abuse or neglect. A number of issues affecting the Department of Human Services' ability to achieve this responsibility have been raised in the past. In January 1999, our office released an *Audit of the Child Protective Services System* (Report No. 99-5) criticizing the department's communication and decision-making processes, which could ultimately affect the children's safety and well-being. These issues are so paramount that it prompted us to conduct this follow-up audit to ascertain the department's efforts to address the findings and recommendations of our 1999 audit. Despite the department's efforts to improve overall delivery of child protective services, significant problems persist and there is no evidence that children are better off today than they were four years ago.

In our current audit of the child protective services system, we found that many of the deficiencies revealed in our 1999 audit continue today. The crux of these problems stem from a lack or disregard of department management controls. We found that supervisory oversight and review—a critical department control—is inadequate and results in inconsistent enforcement if intake and investigation procedures, poor communication with Family Court and the Honolulu Police Department, and untimely permanency planning. In addition, the department did not always use or properly review its risk assessment matrices, which are tools that promote systematic and consistent decision-making. Errors and discrepancies in matrix use may result from a lack of in-depth matrix training.

We found that the Child Protective Services System, the State's child abuse and neglect database, remains unreliable, resulting in inaccurate, incomplete, and outdated case information for decision-makers. Moreover, the department does not consistently inform Family Court of pending expirations of voluntary foster custody agreements. We found six instances where children remained in voluntary placement beyond the 90-day statutory limit. In one of these cases, a child was placed in foster custody for five months before the department petitioned the court for jurisdiction. Lastly, inconsistent communication is further evidenced through the department's failure to comply with Hawaii's mandated reporting law, which requires all cases of abuse and neglect to be referred to the appropriate county police departments for criminal investigation.

We found that the department failed to plan for permanency by the twelfth month of a child's out-of-home care in nearly half of the cases reviewed (23 of 49).

Moreover, a family's inability to follow through with service plans was repeatedly disregarded in decision-making, leading to additional, similar plans being offered and resulting in permanency planning delays.

We also found that weak contract management practices may waste funds designated for services to children because service providers cannot ensure that clients receive the services billed for. Inadequate contract monitoring resulted in numerous overpayments to service providers. In one case, a service provider was overpaid $13,000. We also found that welfare families continue to receive assistance benefits after children are placed in foster custody. Finally, we found that foster families were also paid for foster care services without adequate proof of the child being present in the home. In our sample, we found over $11,000 in questionable payments because of inadequate documentation.

Recommendations and Response

We made a number of recommendations to the Department of Human Services to correct the problems identified. In its written response the department agreed with our basic findings that the Child Welfare Services Branch has not met all the benchmarks set out in our 1999 audit report. The department also provided clarifications regarding what it saw as errors or misunderstandings in the report.

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Follow-Up Audit of the Child Protective Services System

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 03-12
August 2003

Foreword

This is a report of our follow-up audit of the child protective services system. This follow-up audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

We wish to express our appreciation for the cooperation and assistance extended to us by the Department of Human Services, Judiciary, county police departments, and others whom we contacted during the course of the audit.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

Enabling children at risk of abuse or neglect to live in a safe and secure environment is not only a matter of public policy, but also the mission of the Department of Human Services through its Child Welfare Services Branch. The driving force behind our January 1999 *Audit of the Child Protective Services System* (Report No. 99-5) was criticism of poor interagency communication and decision-making processes, together with legislative concern that family reunification efforts were preceding children's safety. The importance of resolving these issues prompted this review of the branch's response to the findings and recommendations of our 1999 audit. Despite the department's efforts to improve overall delivery of child protective services, significant problems persist, and there is no evidence that children are better off today than they were four years ago.

The Office of the Auditor conducts follow-up audits to inform the Legislature and the governor of actions taken by state agencies resulting from our prior audits. This audit follows up on our 1999 report and was performed in accordance with Section 23-4, Hawaii Revised Statutes (HRS), which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions. Appendix A of the report summarizes key recommendations from our 1999 *Audit of the Child Protective Services System*, Report No. 99-5, and our current findings on their disposition.

Background on Child Protective Services

No community is immune from the possibility and impact of child abuse or neglect. In 1998, when we conducted fieldwork for our 1999 audit, there were 4,762 reports of child abuse or neglect investigated by the department. By 2001, the number of reports had increased 51 percent, to 7,210 reports. The department's budget for child protective services also grew by 76 percent during this period; yet abuse and neglect of Hawaii's children continues to escalate. A larger budget has not reduced the risk of child abuse or neglect for Hawaii's children.

Chapter 350, HRS, defines child abuse or neglect as an act or omission by any person or legal entity related to, residing with, or otherwise responsible for the care of a child that results in physical or psychological harm or risk of harm to a child under age 18. Child abuse and neglect can include physical harm resulting in fractures, burns, internal bleeding, and bruising; psychological abuse manifested as

extreme mental distress; medical neglect or inadequate provision of food, clothing, or shelter causing a failure to thrive; provision of harmful drugs to a minor without prescription; and sexual abuse.

To help protect children from harm, Chapter 350, HRS, requires individuals in certain professions to immediately report any abuse or neglect, or substantial foreseeable risk of such, to the Department of Human Services or a county police department. Individuals mandated to report abuse and neglect include school employees, health professionals, law enforcement employees, and employees of public and private agencies providing financial assistance. The law also allows others—(i.e., non-mandated reporters) to make such reports.

Department of Human Services is the lead agency

Section 346-14, HRS, makes the Department of Human Services the lead agency for establishing, extending, and strengthening services for the protection and care of abused or neglected children. The Social Services Division's Child Welfare Services Branch focuses on child protection, foster care, and adoption services to protect the safety and well-being of children and to assist in placing children in permanent, safe homes.

The Child Protective Act, Chapter 587, HRS, makes the department responsible for investigating reported cases of abuse and neglect, assuming temporary foster custody of children as necessary, and petitioning the Family Court for child protective cases.

Since 1967, the Department of Human Services has maintained a central registry of reported incidences of child abuse and neglect. The registry is required by state law and is part of the department's automated Child Protective Services System (CPSS), a comprehensive integrated database designed to track clients, record case data and client services, and make payments linked to these services. During 2001, the department investigated 7,210 reported cases of alleged abuse or neglect and confirmed 3,930, or 55 percent, of those cases. Both the number of reported cases that are investigated and those that are confirmed as abuse or neglect have increased since 1998, when we conducted fieldwork for our previous audit. Exhibit 1.1 compares the number of cases investigated and confirmed in 1998 and 2001, showing increases of 51 and 75 percent, respectively.

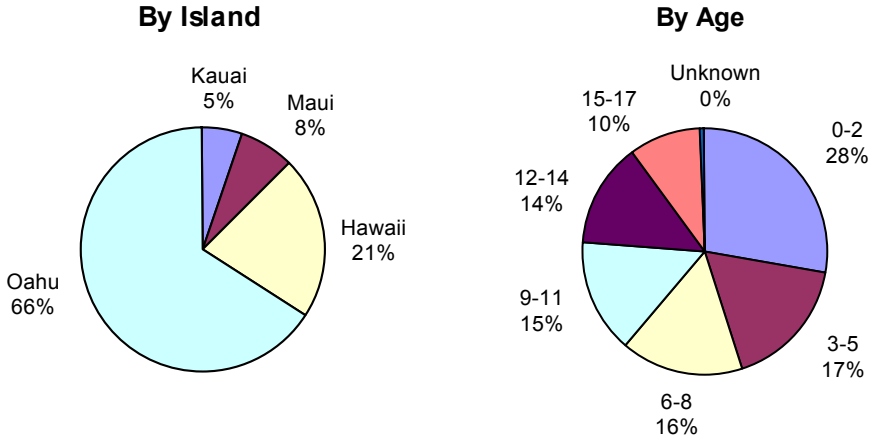
Exhibit 1.1
Child Abuse and Neglect Reports Investigated and Confirmed, Calendar Year 1998 Versus 2001

	1998	2001	Percentage Increase 1998 to 2001
Number of Reports Investigated	4,762	7,210	51%
Number of Reports Confirmed	2,242	3,930	75%
Percentage of Reports Confirmed	47%	55%	—

Source: Department of Human Services Management Services Office, *A Statistical Report on Child Abuse and Neglect in Hawaii, 2001,* p. 8.

For both years, Oahu had the most confirmed child abuse and neglect cases. The most confirmed cases statewide involved children aged two and under. Exhibit 1.2 shows the percentage of abuse and neglect reports the department confirmed by island and by age group in 2001.

Exhibit 1.2
Confirmed Child Abuse and Neglect Reports by Island and Age, Calendar Year 2001



Source: Department of Human Services Management Services Office, *A Statistical Report on Child Abuse and Neglect in Hawaii, 2001,* pp. 5, 11.

Organization of the Child Welfare Services Branch

The Child Welfare Services Branch is comprised of eight sections and 32 units statewide and employs about 440 workers. Of the total staff, 224 social workers and an additional 95 social services aides and family service assistants help provide home-based services. The average caseload for each social worker (excluding supervisors) is 20 cases. The branch also employs nine income maintenance workers who identify whether or not children placed in foster care are eligible for federal funds. Exhibit 1.3 shows the existing organizational structure of the Child Welfare Services Branch.

In 1994, the Legislature created a Blueprint for Change task force, a child welfare services reform group charged with developing a plan for reforming child protective services in the state. The task force recommended that a centralized, statewide intake unit be established to foster greater consistency and standardization at intake. Based on this recommendation, the Child Welfare Services Branch is proposing a reorganization, which is scheduled to be complete by July 2003. The reorganized branch will add a ninth section, called the Statewide CWS Section, create an assistant branch administrator position, and add a third unit in East Hawaii to serve the Puna area. The newly created section will incorporate four units, including centralized intake and federal fund determination units. Exhibit 1.4 shows the proposed organizational structure of the Child Welfare Services Branch.

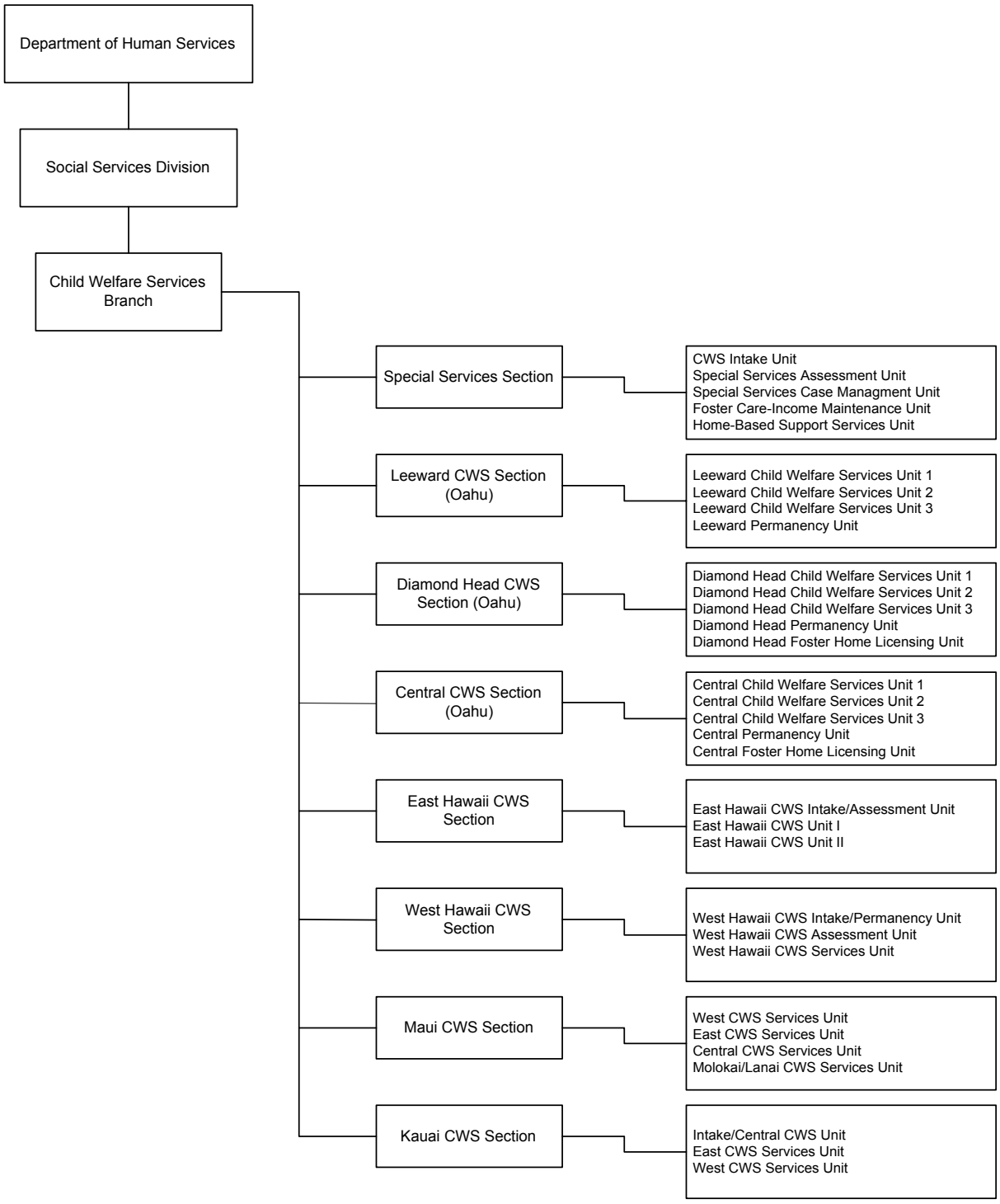
Functions of the Child Welfare Services Branch

The Child Welfare Services Branch manages development and implementation of plans, policies, procedures and regulations of the State's child welfare services program. Services include protection of at-risk children, facilitation of adoption, and management of existing abuse cases.

The Child Welfare Services Branch also provides abused or neglected children and their families with contracted support and treatment services, including emergency shelters, individual and family counseling, sex abuse treatment, and home-based and outreach services. These services are often required by court-ordered service plans directed at facilitating a child's return to, or maintenance in, a safe family home.

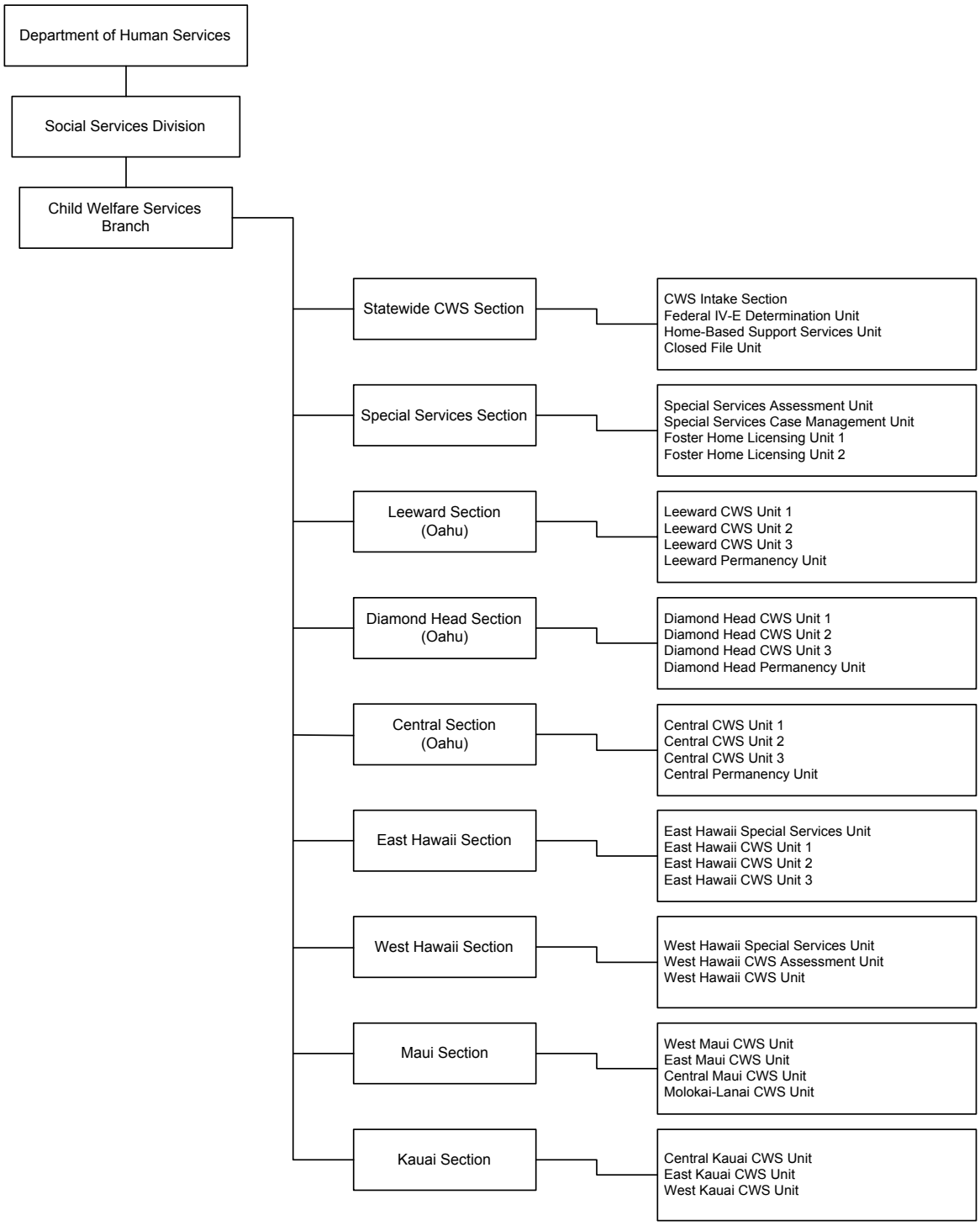
Currently, the Child Welfare Services Branch provides intake services on Oahu, Hawaii, Kauai, Maui, Molokai, and Lanai. Intake units determine a child's eligibility for welfare services according to established departmental policies and procedures; the units also receive, assess, and process all reports of child abuse and neglect 24 hours a day, seven days a week.

Exhibit 1.3
Organization of Child Welfare Services Branch in the Department of Human Services



Source: Department of Budget and Finance

Exhibit 1.4
Proposed Organization of Child Welfare Services Branch in the Department of Human Services



Source: Child Welfare Services Branch

Although the Foster Care-Income Maintenance Unit is based on Oahu, income maintenance workers are also located on Hawaii and Maui. Income maintenance workers determine, through referrals from social services staff, children's eligibility for federal funding; they also initiate reviews of ongoing eligibility for federal and state child welfare benefits and payment programs.

Child welfare services sections on each island provide assessment, case management, and permanency services through child welfare services units in specific geographic areas. Assessment units evaluate reports of child abuse and neglect, provide short-term counseling services, and work with local law enforcement and others to investigate reports and initiate appropriate intervention. Case management units provide outreach services to prevent further abuse or neglect of children. These units also prepare and present cases for court hearings when necessary. Permanency units provide casework services to children in foster care to facilitate permanent substitute placements and enhance their independent living skills. These units also provide pre-adoption, adoption, and post-adoption services to children and families.

State and federal resources

Over $82 million in state and federal funds were appropriated to the Department of Human Services for child protective services during FY2001-02: $43 million in general funds, $37 million in federal funds, $425,000 in revolving funds, and $300,000 in special funds. This total represents an increase of 76 percent over the $46 million appropriated to the department for child protective services in FY1997-98. Exhibit 1.5 shows appropriations by type for both FY1997-98 and FY2001-02.

The department's annual appropriation for child welfare services includes funds for contracted services and payments for foster care. During FY2001-02, the department spent $15 million on contracted services and over $34 million in foster care payments. By comparison, during FY1997-98, the department spent $8 million on contracted services and $20 million in foster care payments.

As shown in Exhibit 1.5, the department receives federal funds through Titles IV-E, IV-B, and XX of the Social Security Act. Title IV-E provides funds for children who are in foster care as a result of child abuse or neglect and are eligible based on family income level and other criteria at the time of removal from the family. Title IV-E also provides funds to families adopting special needs children and to teens who have reached the age of majority and remain in school or job training. Title IV-B funds provide families with treatment services that promote reunification or maintain a child in a safe family home. Title XX, the Social Services Block Grant, assists states in preventing or remedying child abuse and neglect and in preserving or reuniting families.

Exhibit 1.5
Program Appropriations to the Department of Human Services for Child Protective Services, FY1997-98 and FY2001-02

Source of Funds	FY1997-98 Appropriations (Act 328, 1997)	FY2001-02 Appropriations (Act 259, 2001)
General	$29,240,773	$43,945,247
Federal		
Title IV-E	$9,599,907	$29,048,752
Title IV-B	$1,963,548	$2,522,717
Title XX	$4,987,658	$4,349,814
Child Abuse Prevention & Treatment Act (CAPTA)	$130,215	$95,700
Other	$609,089	$1,574,740
Subtotal (Federal)	$17,290,417	$37,591,723
Special	$100,000	$300,000
Revolving	$0	$425,000
TOTAL	$46,631,190	$82,261,970

Source: Session Laws of Hawaii 1997 and 2001

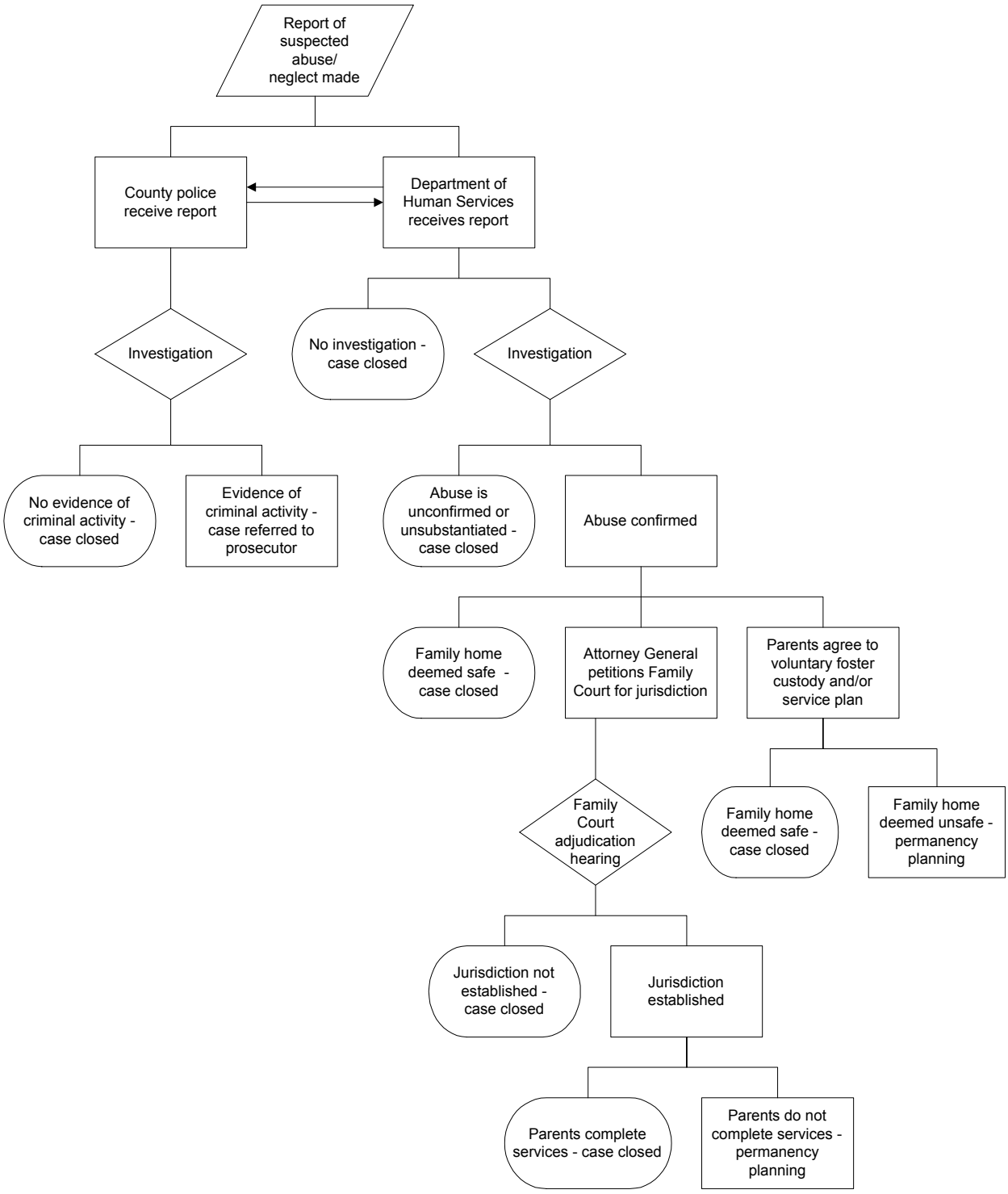
The department also receives basic state grants through Title I of the federal Child Abuse Prevention and Treatment Act (CAPTA). These funds are to be used for the improvement of child protective services systems, including areas such as intake, assessments, and case management.

Interagency roles and responsibilities

Other key agencies work with the Department of Human Services from case intake through case closure. These agencies include county police departments and prosecutors, the Department of the Attorney General, and the Family Court. The role of each agency is illustrated in Exhibit 1.6 below.

Although the Department of Human Services is the lead agency for the intake and investigation of child abuse and neglect reports, county police departments also play a key role. Police respond to reports of abuse and neglect and also inform the department of these reports, as required by Hawaii's mandated reporting law. Similarly, the law directs the

Exhibit 1.6
Some Key Decision-Making Points in Child Protective Services



Note: This flowchart is intended as an overview of a decision-making process that is more complex than shown.

department to inform police of reports of child abuse and neglect that it receives. Section 587-22, HRS, authorizes police to take protective custody of a child deemed to be in imminent harm in the absence of either a court order or family consent. Upon taking protective custody of the child, police are required to immediately transfer temporary custody to the Department of Human Services. Police are responsible for conducting criminal investigations and arresting perpetrators of child abuse who may be criminally prosecuted.

County prosecutors decide whether parents will be criminally charged in child abuse and neglect cases; however, responsibility for petitioning courts for a child's removal from the family home and for establishing a court-ordered service plan remains with the Department of Human Services.

The role of the Family Court is primarily set forth in HRS Section 587-11 (Jurisdiction) and Chapter 571 (Family Courts). Family Court judges hold several types of hearings related to child protection, including temporary foster custody hearings to determine whether a child should remain in out-of-home placement or be returned to the family. The number of children in foster care during FY2001-02 was 4,827—a 45 percent increase from FY1997-98.

Return and adjudication hearings are held to decide jurisdiction over a child. The court reviews departmental reports assessing the safety of a family home when determining whether harm or the risk of harm exists and whether court jurisdiction over a child is required. Disposition hearings allow the court to review the appropriateness of a child's placement as well as the family service plan developed to address a family's problems.

The court also conducts review hearings every six months for each child under its jurisdiction to review the appropriateness of the child's placement and his or her family service plan. At these hearings, the court may order changes to the placement or plan. At permanency planning hearings, the court decides whether to terminate parental rights. Both state law and the federal Adoption and Safe Families Act require that cases be set for permanency planning within 12 months from the time a child is placed in foster care. As of October 2002, 1,968 child protective cases were before the court.

The Department of the Attorney General represents the Department of Human Services in all court petitions filed. The attorney general also represents the department in lawsuits filed against the State for placing a child in foster care where harm occurred and for failing to remove a child from a home where harm is imminent.

Previous Reports

Prior to our 1999 audit of child protective services, which serves as the basis for this follow-up audit, we issued a number of reports related to child protective services.

In 1990, we issued a consultant report, *Study of Foster Care in Hawaii*, which found among other things that Hawaii could increase the amount of federal Title IV-E funding it received by establishing a system to document the eligibility of individual children for foster care and adoption assistance.

In 1994, our *Study of Family Preservation Services and the Families Together Initiative*, Report No. 94-2, found that the department had allowed private providers to develop and implement assessment tools for determining the effectiveness of their own services. Another of our 1994 reports, *Management and Financial Audit of the Foster Board Payment Program*, Report No. 94-28, found that the department lacked guidelines to control expenditures and that complete and consistent data on foster children did not exist.

In 1995, our *Study of the Families Together Initiative, Final Report*, Report No. 95-6, also noted that the department needed to improve its ability to monitor the success of its family preservation services.

In 1997, our *Management Audit of the Department of Human Services*, Report No. 97-18, found that the foster board payment program was being administered with little regard for fiscal constraints. Expenditures for services, other than flat monthly board payments, were made largely at the discretion of individual social workers.

Our 1999 audit of the child protective services system assessed the adequacy of decision-making processes and communication from case intake through closure. Our report revealed that the department did not ensure all child abuse and neglect reports were investigated when appropriate. We also found that the department's communication within its Child Welfare Services Branch and with the county police and Family Court was ineffective. As a result, the department had not ensured that decision-makers had access to necessary information, that criminal proceedings began when warranted, or that Family Court jurisdiction was sought when required. In addition, we found that untimely permanency planning unnecessarily increased foster care costs.

Our 1999 audit also assessed the adequacy of the department's contract management and its oversight of federal IV-E funds and foster care payments. We reported that the department had not adjusted future contract amounts to account for current low service usage, as allowed in

its purchase of service contracts, or ensured that services paid for were received and effective. We found that although the department had made progress in increasing Title IV-E reimbursements, the timeliness in determining eligibility could be improved. We also identified a lack of management controls to prevent unnecessary foster care and general assistance payments.

Objectives of the Audit

1. Assess the extent to which findings and recommendations contained in Report No. 99-5, *Audit of the Child Protective Services System*, are being addressed.

2. Make recommendations as appropriate.

Scope and Methodology

We examined the Department of Human Services' efforts in addressing previous audit findings and implementing previous audit recommendations from Report No. 99-5, *Audit of the Child Protective Services System.* We focused on communication and decision-making processes within the Child Welfare Services Branch and assessed whether adequate improvements have been made from case intake through case closure. We also reviewed the roles of the Family Court and county police as applicable in intake, investigation, case management, and closure. In addition, we assessed whether the branch implemented controls and procedures to ensure the proper management of contracted services, federal funding, and foster care payments.

We reviewed pertinent state and federal laws and rules, interviewed staff from each of the agencies and other stakeholders, and reviewed case files and intake logs from the islands of Oahu, Hawaii, Maui, and Kauai. We also reviewed records in the Child Protective Services System (CPSS) database. We judgmentally sampled case files and records by randomly selecting our samples from universe listings provided by the department that matched our criteria, which included time period, island breakout, and case status.

We also reviewed records and events during FY2001-02. We reviewed earlier periods as needed when assessing compliance with permanency planning requirements, foster care payments, and contract utilization reviews. Our review of contracted services included contracts effective July 1, 2000 through June 30, 2002.

Our work was performed from October 2002 through May 2003 in accordance with generally accepted government auditing standards.

Chapter 2

Significant Problems Persist in Child Protective Services, Keeping Children and Funds at Risk

This chapter assesses the follow-up of our 1999 audit findings and recommendations by the Department of Human Services' Child Welfare Services Branch, the lead agency for the State's child protective services system. We found that many of the deficiencies that were uncovered by our 1999 audit continue today.

The problems center on management controls. Management controls are an integral component of an organization that provides reasonable assurance that objectives, such as operational effectiveness and compliance with applicable laws and regulations, are being achieved. It comprises the plans, methods, and procedures used to meet missions, goals, and objectives. Moreover, although the responsibility for good management controls rests with managers, all personnel in an organization play important roles in making it happen.

Staff within the department's Child Welfare Services Branch are predominantly social workers. As members of a helping profession, their role is to be compassionate and caring. However, compassion alone is not enough. Compassion cannot ensure that the branch has fulfilled its responsibility to abused and neglected children. When the stakes are high, as they are in child protection, additional assurances must be provided to the community that every reasonable action is being taken to guard the safety of vulnerable children. Complying with and enforcing management controls, which are lacking at both the branch and division levels, provides this assurance.

Summary of Findings

1. Inadequate supervision of social workers by supervisors and administrators continues to place children at risk of harm.

2. Management fails to ensure that available funds are being maximized.

Inadequate Supervisory Oversight and Review Result in Inconsistent Enforcement, Poor Communications, and Untimely Permanency Planning

The Department of Human Services' Child Welfare Services Branch has failed to adequately supervise its workers and the work they perform. As a result, both application and enforcement of policies and procedures have been inconsistent. In addition, the branch's unreliable database and ineffective communication with Family Court and the Honolulu Police Department hinder the decision-making process for child abuse and neglect case investigation and monitoring. Finally, the branch's disregard for a family's failure to comply with service plans and sloppy record-keeping contribute to delays in placing children in safe homes.

Inconsistent enforcement of intake and investigation procedures can jeopardize children's safety

Supervisory review of key decisions regarding the safety of children ensures that no single individual is allowed to make such decisions unilaterally. In the past, individual workers made decisions alone. The department admits that some workers were skilled decision-makers, while others were less so. To minimize this decision-making risk, the department implemented a requirement that an experienced supervisor review individual workers' decisions when assessing child safety.

Case intake and investigation are two critical points at which department staff make key decisions affecting children's safety. However, supervisory review has been inconsistent, enabling staff to disregard established procedures when assessing risk of harm regarding reports of suspected abuse and neglect. The same deficiencies reported in our last child protective services audit, Report No. 99-5, still exist. We again found that risk assessment matrices are not always completed, reviewed, or supported; case dispositions are untimely; and dispositions lack supervisory approval.

Based on interviews with department staff and a review of the department's quality assurance reports, we conclude that administrators and supervisors are unclear and skeptical about management controls, such as those mandating a risk assessment matrix. For example, administrators within the Social Services Division and the Child Welfare Services Branch are split over whether administrative rules *require* the use of a risk assessment matrix. Moreover, both section administrators and unit supervisors view some procedures as duplicative or questionable and do not enforce matrix and disposition requirements. Given the lack of agreement among supervisors, along with the questionable value they place on this management control, it is no wonder that implementation and enforcement of department procedures have been inconsistent.

Risk assessment matrices are not always used or reviewed

According to the National Council on Crime and Delinquency's Children's Research Center, the central issue facing child protection agencies is decision-making. Studies have shown that decisions regarding the safety of children vary significantly among workers, often resulting in inappropriate actions that are difficult to defend. In many agencies, child protection can best be described as a loosely affiliated group of workers asked to make extremely difficult decisions with very little guidance or training. Case decisions are based on the education, intuition, and biases of individual workers, with potentially enormous consequences. Consequently, families that could be saved are sometimes split up, and children who should be removed may remain at home and therefore at risk of abuse or neglect.

Risk assessment matrices are decision-making tools designed to promote the effective, thorough, and consistent collection and organization of known case facts. Matrices systematically help evaluate the need for an urgent response, risk of future harm, and continuing need for departmental intervention. In 1998, the department's Management Services Office comprehensively tested and validated the branch's matrix as meeting national standards for rater agreement. Rater agreement is established by having a number of readers evaluate the same material and comparing their ratings to determine the extent to which they agree on the level of risk each case represents. Since October 1998, the Child Welfare Services Branch procedures manual has required the risk assessment matrix to be completed during intake, investigation, and case management.

However, we found that a significant number of risk assessment matrices were not completed or properly reviewed, compromising the matrix's effectiveness and allowing staff to base decisions on individual judgment. Of 50 cases we reviewed statewide, 12 percent (six of 50) of intake matrices and 74 percent (37 of 50) of investigation matrices were not completed. Moreover, when used, risk assessment matrices lacked consistent supervisory review. Of 44 cases where a risk assessment matrix was completed at intake, 30 percent (13 of 44) were not reviewed by a supervisor.

We also found that risk assessment matrices were completed incorrectly. Fifty percent (five of 10) of the matrices we reviewed should have concluded a higher level of harm based on the matrix's own guidelines and weighted factors. In three specific cases, a social worker had determined level of harm to be moderate to high, while our determination was high to severe. We asked a branch administrator to reconcile these disparities by explaining staff's assessments. The administrator neither

provided an explanation nor challenged our assessment; she answered that discrepancies resulted from variations in individual social workers' judgment.

This response downplays the value of the risk assessment matrix as a tool for promoting systematic and consistent decision-making. Matrices are necessary to show how information in case records was organized; they also serve an important purpose—distinct from intake or any other type of document in the case file. A properly completed matrix provides evidence of how a social worker and supervisor evaluated the information collected and justifies the department's actions. The department must be able to support its matrix assessments, especially if a case disposition is challenged.

Risk assessment matrix training is poor. Errors and discrepancies in risk assessment matrices identified by our review prompted us to inquire about staff training on the use of the matrix. We found that training is provided by Staff Development Services personnel from the Social Services Division's Support Services Office. A training schedule for FY2002-03 shows two classes that include matrix training, but no follow-up or class dedicated to the use of risk assessment matrices. Moreover, there is no continuing education requirement for branch social workers.

Prior to implementation of the risk assessment matrix in 1998, staff received training on its use. Since then, new social workers have been required to take the two classes that include matrix training. Staff may, but generally do not, retake these classes. During FY2002-03, no social workers retook these classes.

Other states utilize continuing education. Child Protective Services agencies in other states emphasize the need for and value of training, including training related to risk assessment and risk assessment tools. For example, Georgia requires all workers to complete advanced risk assessment training; Texas certifies workers who have completed risk assessment training, advanced investigation training, and training on its Advanced Evaluation Assessment Instrument. North Carolina, which has codified its requirements in law, mandates training minimums of 90 hours for new child protective services workers, which includes intake and investigative assessment training, 126 hours for new supervisors, and at least 24 hours of annual continuing education for all workers.

An enhanced training program is needed to reduce Hawaii's error rate in using the risk assessment matrix. Improved and required training with refresher and advanced modules would likely promote proper use and enhance the validity of the matrix as a decision-making tool.

Supervisory review would help reinforce worker training by identifying and correcting any remaining errors, since supervisors are ultimately responsible for ensuring that matrices are properly completed and reviewed.

Untimely dispositions continue to occur

Timely disposition of child abuse and neglect cases is required by the state Child Protective Act (Chapter 587, HRS) and the department's rules. The act states that prompt identification, reporting, investigation, services, treatment, adjudication, and disposition of cases involving children who have been harmed or are threatened with harm are in the children's, their families', and society's best interests because children are defenseless, exploitable, and vulnerable. Chapter 17-920.1 of the Hawaii Administrative Rules requires the department to make a decision within 60 days of the intake report date as to whether abuse or neglect occurred. The branch procedures manual requires that updates of case records be timely.

Departmental investigators are guided by the Child Protective Act and the department's rules in determining whether abuse or neglect occurred. Unless an investigation concludes that abuse or neglect occurred, reports remain unconfirmed. Reports remain unconfirmed under the following circumstances: the report was not referred to investigation; the investigator was unable to clearly determine that abuse or neglect occurred; the evidence clearly indicated abuse or neglect did not occur; or the report was made in bad faith and was therefore unsubstantiated. Investigation outcomes, known as dispositions, are key because they can result in the department either offering (or referring the family to) intervention services or closing the case. Supervisors are required to review case records after disposition to ensure support for outcomes and completeness of case documentation.

We reviewed case dispositions for timeliness and found that the department has continued to allow untimely case dispositions to occur. In 22 percent (11 of 50) of the statewide cases we reviewed, a determination of whether abuse or neglect occurred was not made within 60 calendar days of receiving the report, as required by the department's rules; some dispositions exceeded 100 days. A branch administrator told us that many dispositions occur within 60 days but are not immediately entered into the database due to increasing caseloads and insufficient staff. The administrator also said that when late dispositions do occur, it is often because victims, parents, or witnesses cannot be located, which delays the investigation.

Regardless of the cause, untimely dispositions hinder supervisory review, which occurs after an investigator makes a disposition. For example, one supervisor could not review a case until it was disposed of more than 100 days after the report date.

Our 1999 audit reviewed these timeliness issues and recommended that the department ensure dispositions are made within 60 days. In November 1999, the department responded that section administrators and unit supervisors would utilize a report to monitor deadlines. In April 2003, we followed up on the department's actions and found that a report is being used. However, a branch administrator indicated that the report is not used to ensure dispositions occur within 60 days, but rather as a means to enforce timely data input. Thus, section administrators and supervisors dismiss the report as a data entry reminder of low priority, which renders it ineffective in focusing efforts on making timely dispositions. As a result of this perception, a management control that should be used to ensure timely dispositions is instead perceived as a housekeeping chore of lesser value, especially when compared to competing demands to meet with families or attend court proceedings.

A branch administrator noted that the date of documentation does not reflect the date that services are provided, meaning that delays are mostly based on data entry dates rather than actual service delivery. However, since the administrator admits that dispositions themselves occur later than 60 days, the lateness of data entry cannot be blamed for delays in every case. Late dispositions violate the Child Protective Act's purpose of providing prompt investigations and dispositions, as well as the department's own rules and procedures relating to timeliness. Thus, even with adequate management controls in place, the department cannot ensure that all child abuse and neglect reports are investigated promptly. Unless management controls are complied with and enforced by supervisors and administrators throughout the case disposition process, timely dispositions will not be achieved.

Formal case dispositions lack supervisory approval

Reports accepted by the department must be confirmed as the result of an investigation, or remain unconfirmed. The department gathers information in order to determine whether a child has been harmed or threatened with harm and what departmental response will be necessary to ensure the child's safety. Investigative supervisors must review and document their agreement or disagreement with each investigative disposition.

Despite the importance of investigative dispositions, supervisory review was not documented by unit supervisors in 54 percent (27 of 50) of the statewide cases we reviewed. In addition, the branch's procedures

manual does not identify a specific screen in the child protective services database where supervisors should document their review. Lack of formal procedures for documentation of supervisory review results in inconsistencies among the various islands and units, and, in some cases, no documentation of supervisory reviews.

A branch administrator reports that because only supervisors can transfer or close cases, the fact that a case has been transferred or closed is in itself evidence of supervisory review. The administrator believes that the absence of specific screen documentation of supervisory reviews is not a problem. We disagree. A transferred or closed case does not provide evidence that a review has occurred. Supervisory reviews should be uniformly documented to provide written evidence that dispositions were reviewed and approved. This is yet another instance of supervisory disregard of a management control that defeats the purpose of the control.

Inconsistent information regarding a case's disposition could adversely affect future dealings with an alleged perpetrator or victim. In reviewing 50 cases statewide, we found that two West Hawaii and three East Hawaii cases reported conflicting harm information on two different system screens. In this instance, the same administrator who stated that the absence of specific screen documentation of supervisory reviews is not a problem reported that supervisors *should* document their review. The administrator went on to say that, as part of their review, supervisors should ensure that the various Child Protective Services System screens related to a single case reflect the same level of harm. The West Hawaii and East Hawaii units responsible for these cases report they have since corrected the discrepancies we identified. Had we not brought these cases to their attention, they may not have been corrected, especially since three were already closed. This example underscores that adequate management controls must be in place and uniformly enforced to ensure supervisory review and consistency of information.

Poor communications affect decision-making and place the State at risk

In our 1999 *Audit of the Child Protective Services System*, Report No. 99-5, we found that communication was ineffective both within the Department of Human Services' Child Welfare Services Branch and with county police departments and the Family Court. As a result, there was no assurance that decision-makers had access to necessary information to investigate and monitor cases of child abuse and neglect. We also found that the department did not provide sufficient oversight over children placed in voluntary foster custody and failed to communicate all reports involving possible criminal activity to the police.

Currently, we found these same problems continue to exist. The Child Protective Services System, the State's child abuse and neglect database,

remains unreliable, resulting in inaccurate, incomplete, and outdated information for decision-makers. In addition, the Department of Human Services does not consistently inform the Family Court of pending expirations of voluntary foster custody agreements, and fails to report cases of abuse and neglect to the Honolulu Police Department.

The State's child abuse and neglect database remains unreliable

In 1999, we found that the Child Protective Services System (CPSS) database was unreliable because not all child abuse and neglect cases were registered in the database, thus limiting the department's intra-agency communication and failing to ensure that the risk of harm would be considered during key decision-making. Today, the CPSS database remains unreliable, though for different reasons.

Chapter 350, HRS, requires the department to maintain a central registry of child abuse and neglect cases. Case records, which consist of both hard copy and electronic information, are required to contain standardized basic information in the form of dictation, intake data, computer entries, and documents. Case records serve many functions, including assisting social workers in completing assessments; providing a record of service delivery to, and efforts made by, families; serving as the basis for evaluating service effectiveness; helping social workers in case planning; documenting compliance with state and federal mandates; providing a family's history; and acting as a tool for supervisors to evaluate social workers. The branch procedures manual requires that all case records be maintained in a timely manner, and that system updates be performed on a timely basis.

Furthermore, the federal government requires states to have a data reporting system that electronically maintains certain data regarding children in foster care and adoption. Data on each child in foster care and each child adopted during the reporting period is transmitted semi-annually to the federal government and must meet reporting requirements of the Adoption and Foster Care Analysis and Reporting System (AFCARS). Monetary penalties may be assessed for failure to meet standards.

We reviewed the Child Protective Services System database, case records, and branch documents for accuracy, completeness, and timeliness, and found numerous deficiencies. For example, in reviewing the branch's permanency planning operations, we found 22 percent (11 of 49) of cases where caseworkers failed to update the system with proper court dates. Our review of overpayments revealed that in 13 percent (six of 45) of cases, forms containing necessary information to update the system were missing from case files, resulting in outdated

system records. Furthermore, in reviewing case dispositions, we found 10 percent (five of 50) of cases where different Child Protective Services System screens associated with the same case reflected conflicting reports of harm to the child.

Equally telling are the department's own Quality Assurance Reports. In a report dated March 2000, all 20 of the cases internally reviewed contained misfiled documents and database errors that required corrective action. According to the reports, "a great number of Child Protective Services System corrections were required on the screens vital for compliance with federal Adoption and Foster Care Analysis and Reporting System reporting requirements." Although the branch's management controls require proper and timely documentation of case records, unit supervisors questioned the branch's case filing procedures and were uncertain of the benefit to the branch. Even the division's quality assurance supervisor reported that filing is not a priority task.

Timely filing and database input are management controls for accurate case file and database maintenance. The failure to properly document case files impacts a database's reliability. An unreliable database means that decision-makers may lack key information at crucial times, placing children, families, resources, and the State at risk.

In addition, in 1999, federal AFCARS penalties in the amount of $31,199 were assessed (but later suspended) on the department because of missing and untimely data submissions. Although the federal government decided in April 2002 to forego assessment of penalties on states that are noncompliant with AFCARS requirements, it reserved the right to assess penalties in the future upon notifying the states. The mere threat of loss of federal funding or assessment of penalty behooves the department to achieve and maintain a reliable database.

Family Court is not consistently informed of pending expiration of custody agreements

The Department of Human Services is required to communicate with the Family Court when a family is unable or unwilling to make a home safe for a child. Hawaii Administrative Rules require the department to petition the Family Court for jurisdiction when children placed in voluntary foster custody are not returned to a safe family home within 90 days. The Voluntary Foster Custody agreement form—the document that grants foster custody to the department—clearly specifies the beginning and end dates of a 90-day placement. Without judicial intervention, continuing to maintain custody of the child beyond the ending date in a custody agreement exposes the department to claims of illegal custody.

We found that the department continues to violate its obligation to seek Family Court jurisdiction when required. In our review of 43 children placed in voluntary foster care, six children remained in voluntary placement beyond 90 days without evidence of ohana conferencing or a court order granting temporary foster custody, putting the State at risk of liability. In one case, a child was placed in foster custody for five months before the department petitioned the court for jurisdiction.

We pressed for reasons why the department fails to seek Family Court jurisdiction when required. According to a Support Services Office supervisor, a child may end up in foster custody beyond the terms of a voluntary foster custody agreement when a social worker feels the child should remain in protective custody, but simply has not filed a court petition to extend the child's stay. Agreeing that this is wrong, the supervisor stated that it is the responsibility of the social worker and supervisor to ensure that children are not kept in foster custody beyond the limits of agreements. Again, even if well-intended, this illustrates social workers circumventing existing management controls with the concurrence of their supervisors.

In addition, when children are not provided permanency planning within the 12-month timeframe, the State can incur additional temporary foster care costs. Although payments would continue under guardianship or adoption arrangements until a child reaches 18 years old, reunification with the child's biological parents would terminate the temporary foster care payments. Foster care services cost the State approximately $529 per month, per child. In the 23 cases we reviewed where children remained in foster care beyond 12 months because of tardy permanency planning, we estimate the State paid more than $44,000 that could have possibly been avoided.

The department fails to report all child abuse and neglect cases to the Honolulu Police Department

Chapter 350, HRS, requires the Department of Human Services to inform the police department of all child abuse and neglect reports. In addition, Hawaii Administrative Rules require the department to refer to the police all cases in which criminal prosecution may be necessary.

In our review of child abuse and neglect reports on the island of Oahu, we found that not all reports are being cross-reported to the Honolulu Police Department. We reviewed a total of 50 Oahu reports received by the Child and Welfare Services Branch during the month of November 2002 and found that 26 percent (13 of 50) of the reports were not reported to the Honolulu Police Department.

Failing to communicate all reports of child abuse and neglect to the Honolulu Police Department puts the department in noncompliance with

Hawaii's child abuse laws and rules. More importantly, children may be placed at risk if criminal investigations are not commenced when warranted.

Untimely permanency planning delays children from entering safe homes

In our 1999 *Audit of the Child Protective Services System*, Report No. 99-5, we found delays in permanency planning within the timeframes required by the federal government. Our current review continued to find that permanency planning is untimely.

Permanency plans set forth as a goal the adoption, guardianship, or permanent custody of a child. The federal Adoption and Safe Families Act of 1997 reduced the timeframe for permanency planning from 18 to 12 months in recognition that child safety is sometimes jeopardized by family reunification goals. The state Child Protective Act also requires permanency planning for any child residing outside a family home for 12 consecutive months, unless the child's family can convince the court otherwise.

Although planning for permanency must begin by the twelfth month of out-of-home care, we found that nearly half the cases we reviewed did not meet the 12-month deadline. In addition, a family's inability to follow through with service plans—for whatever reason—was too often disregarded in decision-making, leading to additional, similar plans being offered and resulting in delays in permanency planning. Finally, we found that poor record-keeping may contribute to additional delays.

Half of cases fail to meet 12-month timeframe

Pursuant to federal and state laws, the department must file a motion for permanent custody by the twelfth month. The only exception is if a court ruling delays filing of a permanency motion, either because a child would be harmed by such action, or the department failed to make reasonable efforts to reunify the family.

Social workers manage assigned cases and are responsible for initiating permanency planning when warranted. Unit supervisors are responsible for reviewing case files to ensure permanency planning is timely and that proper documentation exists. In reviewing a statewide sample of cases, we found 47 percent (23 of 49) of cases were late in planning for permanency. In one case, a child entered foster care in October 2001, but was not scheduled for a permanent plan hearing until June 2003. The child remained in foster care for 20 months.

A Support Services Office supervisor asserted that the 12-month timeframe is sometimes exceeded when social workers or supervisors feel that reunification would still be possible if a family member

attended drug treatment, counseling, or parenting classes. However, federal law reduced the timeframe for permanency planning to 12 months precisely because child safety may be jeopardized by family reunification goals. Moreover, only the courts can delay filing of a permanency motion. Until social workers and supervisors comply with federal and state laws, as well as their own management controls, the department cannot ensure that children enter safe homes as soon as possible. Children who are not in safe homes remain at risk. Such high stakes emphasize the need for compliance with and enforcement of permanency planning procedures by social workers and their supervisors.

In addition, when children are not provided permanency planning within the 12-month timeframe, the State incurs additional costs to maintain them in temporary foster care. Foster care services cost the State approximately $529 per month, per child. In the 23 cases we reviewed where children remained in foster care beyond 12 months because of tardy permanency planning, we estimate the State paid more than $44,000 for additional foster care.

Family failure to comply with service plans is disregarded

After a report of child abuse or neglect has been confirmed and the department decides to provide services to a child and his or her family, a Child Welfare Services social worker develops a case plan with the goal of providing a safe, permanent home for the child. Unless permanent custody has already been awarded to the department, every case plan consists of a description of the safety and risk factors in the family home, and a service plan stating how the family will address and resolve these factors through recommended services.

Family service plans (service plans) are instruments through which the department assures permanent protection of a child by detailing family goals, tasks, and outcomes designed to prevent the child's removal or reunify a family after a child has been removed. If parents are unwilling or unable to provide a child with a safe family home even with the assistance of a service plan, the department and courts are required to develop and implement a permanent plan. When a family has been totally noncompliant with its service plans, the department is required to motion the court for permanent custody.

In our statewide review, 73 percent (36 of 49) of cases had families that were deemed by social workers as noncompliant with service plans. In 42 percent (15 of 36) of these cases, the department did not file a motion for custody. In one case, five similar service plans were offered to a family over 18 months. The family failed to comply with each service plan. In addition, 43 percent (21 of 49) of the cases we reviewed were both noncompliant with service plans and late in permanency planning.

Although a Support Services Office supervisor stated that in some cases the department files for permanent custody but is overruled by the court and ordered to continue a service plan, this was not so in any of the cases we reviewed. Furthermore, this supervisor told us that in other cases, social workers feel reunification is still possible even when a parent ignores a service plan.

Once again, compassion alone is not enough to make responsible decisions. When social workers allow compassion to supercede established procedures, failed service plans will be repeated (and repeatedly failed), resulting in permanency planning delays.

Poor record-keeping contributes to delays

Properly maintained case records serve many functions, including assisting in assessments, providing a record of service delivery and family efforts, and helping social workers in planning. The branch procedures manual requires that all case records be maintained in a timely manner and that Child Protective Services System updates be performed on a timely basis.

For permanency planning, papers such as plans, court orders, and reports are filed in case files to document children's cases. Caseworkers are also responsible for updating the database with important court dates and other information. Unit supervisors review case files and database screens to sign off on plans, orders, and reports in files. This supervisory review and approval of work acts as a control to minimize delays in permanency planning due to missing information.

We reviewed 49 cases statewide. Thirty-six percent (18 of 49) were missing service plans, court orders, or court reports in the case file. In 22 percent (11 of 49) of cases, CPSS did not contain updated court dates. Confusion associated with missing service plans may result in the filing of additional, unnecessary plans that inadvertently lengthen the time to permanency planning. Moreover, missing court orders and reports may result in a failure to take into account important information when making decisions on permanency planning. Ultimately, missing information of this type can contribute to delays in permanency planning, prolong temporary foster custody, and prevent a child's timely entry into a safe home.

When asked why poor record-keeping existed throughout the branch, one unit supervisor explained that standardized record-keeping is not required among islands, sections, and units. We were informed that it is up to individual social workers and supervisors to organize filing systems. This validates our concerns regarding neglect of management controls for record-keeping throughout the branch. Unless social

workers and supervisors comply with standardized procedures, there can be no assurance that case files and database information are accurate, timely, and complete, or that permanency planning is timely.

Weak Contract Management, Numerous Overpayments, and Tardy Eligibility Determinations Place State and Federal Funds at Risk of Waste or Loss

The Department of Human Services' Child Welfare Services Branch cannot ensure its resources are maximized, protected from loss, or spent effectively and efficiently. The agency's weak contract management has failed to ensure funds are used for authorized clients and that children and families are receiving needed services. In addition, the agency's failure to perform timely contract reviews has resulted in the inefficient use of taxpayer dollars.

Overpayments to families receiving financial aid and to foster care providers can add up over time and reduce funds available to children and providers who should be receiving such assistance. Uncollected overpayments are written off the agency's books and lost. The Child Welfare Services Branch has been unsuccessful in preventing overpayments from occurring, thereby placing these funds at risk of loss.

Finally, untimely eligibility determinations jeopardize federal reimbursements. At best, tardy eligibility determinations result in delays in receiving federal reimbursements. At worst, funds can be permanently lost.

Weak contract management may waste funds designated for services to children

During FY2000-01 and FY2001-02, the Child Welfare Services Branch contracted with 38 private organizations to provide the needed services to abused and neglected children and their families. The contracts, which range from July 1999 to June 2003, totaled $31.5 million. Services include domestic violence shelter and support assistance that helps victims break the cycle of violence in their lives; emergency shelters for children that offer basic sanctuary, treatment, and counseling services; and comprehensive counseling and support services that include family counseling, parent education, and clinical therapy.

The department's continued commitment to providing needed services is shown by the significant portion of the child welfare services total budget for FY2001-02 (about 21 percent) dedicated to contracted services. However, as we first reported in our 1999 audit, the department has failed to ensure clients receive the services for which the department is billed. We found that this continues to be the case. Moreover, the department still does not consistently review the utilization of provider services on a timely basis, which may result in contract overpayments.

Service providers cannot ensure clients received billed-for services

In our 1999 *Audit of the Child Protective Services System*, Report No. 99-5, we found that the department's inadequate fiscal management of contracted services could result in wasted state funds. The department was not ensuring the accuracy of invoices from private providers who billed for services to clients.

Currently, we found that the department continues to pay for billed services without ensuring the accuracy of invoices or that services were actually rendered. We reviewed case files of 50 clients from five private providers holding contracts with the department. Twenty-six percent (13 of 50) of these clients' files lacked adequate documentation to demonstrate that services were received. In one case, the private provider billed the department for 16.55 units of service rendered but could show proof of only 2.35 units provided. In three other cases, providers billed for services rendered but could not show any proof that services were provided to the clients. Only two of five contractors were able to show proof of services rendered to all of their clients reviewed.

Lack of accountability is compounded by our finding that the department does not have a master list of all clients eligible to receive services from private providers. Without a master list, there is no assurance that clients receiving services are in fact eligible for those services.

Sound contract management ensures that an agency pays only for those services authorized and received. To achieve this, the department must be able to identify those clients it refers to each service provider and ascertain whether the clients actually participated in the services. The absence of a master list and the inability to ensure that the department has authorized clients receiving services means that funds for legitimate clients may instead be spent on unauthorized persons. In addition, failing to ensure the accuracy of provider invoices for services may result in the department paying for services never received by its clients, a waste of state funds, and a disservice to clients who need these services.

The division's Purchase of Services (POS) supervisor reported that Purchase of Services staff have also found discrepancies between what was charged to the department and the services provided. However, discrepancies are tolerated if they do not exceed five to 10 percent of the amount billed since providers are paid a flat fee for their services. (By contract, a provider is paid a budgeted amount regardless of the actual amount of services provided.) Because of this, if the Purchase of Services Office deems a discrepancy to be insignificant, it will not take further action.

Even if amounts are not significant, the fact that clients may not be receiving services billed for by providers means that children and families may be lacking needed services. The Purchase of Services supervisor also noted that in crisis situations, the focus is on getting people needed services, rather than ensuring proper authorizations are in place. In other words, compliance and enforcement of management controls are conveniently ignored at staff's discretion and tolerated by supervisors.

Untimely contract reviews may result in provider overpayments

The department is required to conduct a utilization review of services received from providers either at the end of the ninth month of each fiscal year or at the State's discretion. "Utilization reviews" include a reconciliation of annual contract payments (which are based on the contract budget) and actual expenditures. If the department paid the provider more than the provider spent, the department may increase the amount of contracted services or reduce future payments. In other words, the department can carry over additional payments and apply them to future services or recover moneys by reducing future payments.

Four of the five provider contracts we reviewed lacked documentation showing annual utilization reviews had been completed. In one case, a provider was paid approximately $377,000 more than it spent in FY2000-01, but there was no evidence of a utilization review authorizing unspent funds to be carried over or recouped. It was not until FY2001-02, when department staff reconciled the FY1999-2000, FY2000-01, and FY2001-02 payments and expenditures, that the unspent funds were approved for carry over. We also found that one provider was overpaid approximately $13,000, but this was overlooked by department staff until our office alerted them to it.

We found that the department has no formal guidelines to ensure annual utilization reviews are routinely conducted, properly documented, or reviewed by a supervisor. In fact, no written procedures for utilization reviews existed at all until department staff, prompted by our scheduled meeting on December 3, 2002, presented us with a three-page document drafted that morning. Moreover, because contract language allows the department to use discretion regarding the timing of utilization reviews, the department has no deadlines to meet, resulting in untimely contract reviews. The continued practice of untimely contract reviews may result in ongoing provider overpayments and wasted funds.

Numerous overpayments and questionable payments continue

In 1999, we reported that the department had not established sufficient management controls to ensure foster care payments end when children leave foster homes. Similarly, controls preventing continued payments to families receiving general assistance once a child is removed to foster care were also lacking. Our current review found that overpayments to welfare families continue, and questionable payments to foster care providers still exist.

Welfare families continue to receive payments after children are removed to foster custody

Temporary Assistance to Needy Families (TANF) is financial assistance for families that meet income, family size, and other guidelines. When a child is removed from a family receiving TANF and placed in foster care, the TANF benefit is adjusted to reflect a smaller family size.

TANF is paid in advance for a full month. Federal regulations require partial-month benefits to be classified as overpayments and recovered when a child is removed from a home receiving TANF and placed in foster care paid for by the State. When a child is placed in foster care, the branch social worker must notify the Foster Care—Income Maintenance Unit to determine if the family is receiving TANF benefits. If so, an income maintenance worker in the Benefit, Employment and Support Services Division is notified to make benefit adjustments. When necessary, the Benefit, Employment and Support Services Division worker also flags the benefit as an overpayment in the Hawaii Automated Welfare Information (HAWI) system, which tracks financial assistance. This process is designed to ensure that the department's recovery system includes the overpayment in its automated recovery efforts. We found, however, that the department's controls are still ineffective in ensuring TANF is adjusted when children are placed in foster care.

Child Welfare Services social workers are required to inform the Foster Care-Income Maintenance Unit of a child's removal from the home within two working days of the removal. This allows the unit worker to determine whether TANF benefits are still being made and if so, to notify the Benefit, Employment and Support Services Division to adjust payments accordingly. However, division-level income maintenance workers responsible for issuing TANF payments do not always receive the necessary information from the Child Welfare Services Branch in a timely manner.

We reviewed 40 cases statewide in which TANF families had at least one child removed from the family for placement in foster care. In 32 percent (13 of 40) of these cases, branch-level social workers exceeded the two working days deadline. Average notification time for these 13

cases was almost ten days; two cases were not reported for 22 and 23 days, respectively. While this struck us as excessive, according to a June 6, 2002 internal departmental communication, Benefit, Employment and Support Services Division staff affirmed that it is common for several months to pass before Child Welfare Services staff notifies them of a child's removal from home.

When branch social workers fail to notify Foster Care-Income Maintenance Unit workers in a timely fashion, the Foster Care-Income Maintenance Unit workers in turn become delayed in notifying division staff of a child's removal from the family. This results in TANF overpayments and time-consuming collections processes. Until compliance with and enforcement of management controls is made a priority, the branch cannot ensure that it is preventing or minimizing overpayments to families receiving financial assistance.

Moreover, when information is received (timely or not), division-level income maintenance workers do not routinely adjust assistance payments and flag overpayments, which exacerbates the problem. Without timely adjustments and notice of overpayments, the recovery of such overpayments becomes improbable.

Of 40 families receiving TANF payments from the department, 30 percent (12 of 40) continued to receive the same benefits after their children were placed in foster care, resulting in overpayments of about $46,000 altogether. Furthermore, in eight of these 12 cases, adjustments in HAWI were not flagged, and the overpayments will not be recouped. In the remaining four cases, adjustments have been made in HAWI, but the overpayments have yet to be recovered. In one case, a family owes approximately $38,000 in overpayments dating back to 1993. Even if pursued, recovery of these overpayments is unlikely.

Foster care providers receive questionable payments

Foster care payments to a foster parent or provider should be made only for the time a child actually resides in the foster home. When children are moved from one foster home to another, the department should accurately track each move to ensure appropriate payments to each foster parent or provider. The department established a management control within the Child Protective Services System that permits only one payment to be issued for each child in foster care. However, controls to ensure that payments to foster home providers are verified are inadequate.

Child Welfare Services staff are responsible for documenting the date of placement and removal of a child on a special form. Branch-level social workers then update the Child Protective Services System database by

adjusting the foster care payment, and the form is placed in the child's case file as documentation of the placement/removal. We reviewed 45 case files statewide to locate this form and confirm the date of removal. In 13 percent (six of 45) of cases the form was missing, but payments to foster care providers were still made. Thus, we were unable to verify the date these six children were removed from foster care homes, resulting in questionable payments of over $11,000 to foster care providers.

A Support Services Office supervisor confirmed that although it is the social worker's responsibility to report the removal of a child from a foster care provider using the specified form, a social worker may forget to use the form and enter information directly into the system database later. However, we note that failure to use the form means that any date entered in the database cannot be verified as accurate. When the required form is missing from the case file, there is no way to confirm or verify the date of removal, and thus the correct amount of any payments. Since 1999, the Child Welfare Services Branch has written off more than $71,000 in overpayments, many to foster care providers. Unless branch social workers use and file the designated form, future overpayments to foster care providers may occur.

Tardy eligibility determinations place federal funds at risk

The Department of Human Services is eligible to receive federal funds for foster care under Title IV, Parts B and E of the Social Security Act. Title IV-E allows federal reimbursements for foster care maintenance payments (foster board and care costs), adoption assistance payments to parents who adopt children with special needs, child welfare training costs, and costs related to the administration of the foster care program. There is no limit to the amount of IV-E funds that can be claimed if the state is eligible, costs are allowable, and state matching funds are available.

To be eligible for IV-E funds, a child must have received or been eligible for federal assistance at the time of removal from the family home and placement in foster care. The child must also be less than 18 years old, under the department's placement responsibility when removed from the home, and live in a licensed foster home. In addition, the Family Court must find that living in the family home is contrary to the child's best interest, and that reasonable efforts were made to prevent removal and reunify the family.

Title IV-E reimbursements may be claimed after eligibility is determined. The department has two working days in which to notify the income maintenance unit of a child's placement into foster care, and 180 days in which to determine the child's eligibility for Title IV-E funds.

In our 1999 *Audit of the Child Protective Services System*, Report No. 99-5, we reported the department needed to improve its untimely Title IV-E determination process. While the department has made improvements in securing and increasing federal reimbursements for Title IV-E funds, eligibility determinations are still late and place the State at risk of losing valuable federal reimbursements. Since FY1997-98, the department has made significant progress by increasing federal reimbursements for Title IV-E funds. In FY1997-98 federal reimbursements totaled approximately $12 million. This figure has more than doubled in FY2001-02, to $26 million. However, inadequacies in the timely processing of Title IV-E determinations suggest that additional federal reimbursements could be captured.

We reviewed 39 cases statewide and found that branch social workers did not provide income maintenance units with timely notification of a child's placement in foster care in 41 percent (16 of 39) of those cases. Delinquencies ranged from one day to one week. Furthermore, once income maintenance units received notification of a child's placement in foster care, we also found that eligibility determinations were late 30 percent of the time (12 of 39 cases). In three of these cases, children were placed into foster care in January 2002, but eligibility had yet to be determined as of March 2003.

Child Welfare Services Branch staff report that delays can be due to: difficulties in documenting financial assistance eligibility; lack of judicial determination of reasonable efforts; and failure to identify all children who have not been screened for eligibility. With respect to the last, the Title IV-E eligibility unit supervisor told us that because the Child Protective Services System database is not always accurate and sometimes loses track of children, she has created her own database to identify children in foster care and independently tracks their eligibility determinations.

Failure to refer children for timely eligibility screening reduces the period for income maintenance workers to determine eligibility. In addition, delays in completing eligibility determination can also stall federal reimbursements. Retroactive eligibility claims can be made, but are generally limited to about two years after the first foster care payment. Once a case's deadline has lapsed, federal reimbursements are permanently lost.

Although the sample of cases we reviewed did not reveal evidence that federal reimbursements had been lost, the department's own quality assurance reports noted concerns and at least one concrete loss. A report dated November 1999 stated that children placed in voluntary foster custody are becoming ineligible due to the lack of a judicial determination prior to the 180th day of placement. In one case, this resulted in a loss of about $30,000 per year for three children.

Conclusion

Although compassion is evident within the Child Welfare Services Branch, it must coincide with a commitment to complying with and enforcing management controls. Without this, the branch cannot ensure it is living up to its responsibility to enable children at risk of abuse and neglect to live in secure environments.

Currently, deficiencies in supervision, decision-making, and communication cause children to remain at risk of abuse or neglect and increase the State's risk of liability. Inadequate financial management also results in ineffective and inefficient use of funds, overpayments to ineligible families and providers, and the potential loss of federal funding. Finally, the threat of future AFCARS penalties underscores the need for a reliable, current, and accurate child abuse and neglect database. Overall, children at risk of abuse and neglect are no better off today than they were in 1999.

Recommendations

1. The Department of Human Services should clarify, strengthen, and enforce existing management controls to ensure that all child abuse and neglect reports are investigated as appropriate. Specifically, the department should:

    a. Provide training to all Child Welfare Services Branch administrators, supervisors, and staff on the necessity of management controls;

    b. Provide and require increased training and oversight to ensure that risk assessment matrices are properly and consistently used during case intake, assessment, and case management. Supervisors should hold social workers accountable when matrices are not used as required;

    c. Track all cases referred to investigation and ensure that dispositions are made within 60 days. Supervisors should hold investigators who fail to comply with this policy accountable;

    d. Clarify that all supervisory reviews of dispositions must be indicated on only one CPSS screen to eliminate confusion and errors, and to promote consistency; and

    e. Ensure that section administrators hold supervisors accountable for monitoring and reviewing intake reports, risk assessment matrices, 60-day disposition deadlines, and case dispositions.

2. The Child Welfare Services Branch should improve intra-agency and interagency communication. Specifically, the branch should:

    a. Hold supervisors accountable for monitoring and reviewing case records, including electronic records;

    b. Carefully monitor voluntary foster custody placements to ensure that Family Court jurisdiction is sought when required. Supervisors should be held accountable for ensuring all voluntary foster custody agreements are properly executed; and

    c. Ensure all cases that may involve criminal activity are referred to the appropriate county police department.

3. The department should initiate filing for permanency hearings when families are unwilling or unable to complete family service plans. In addition, the department must ensure that permanency planning begins within 12 months after a child's placement in foster care.

4. The department should improve its management of contracted services. Specifically, the department should:

    a. Identify in a monthly master list all children and families authorized to receive services from each private provider. Contract monitors should reconcile this list to contractor's invoices and activity reports prior to authorizing payments;

    b. Compel caseworkers to track all children and families receiving services and require that regular progress reports be submitted by service providers and reviewed by caseworkers; and

    c. Review utilization levels for each private provider annually after the first contract year and make adjustments for the upcoming contract year to ensure that costs do not exceed usage.

5. The department should hold staff from the Child Welfare Services Branch and the Benefit, Employment and Support Services Division accountable for preventing overpayments of temporary assistance to families whose children are placed in foster care, and payments to foster care providers when children are removed from their care. Specifically, the department should:

    a. Enforce the requirement that Child Welfare Services staff notify Foster Care-Income Maintenance Unit workers within two working days of a child's removal from the family. Require Foster Care-Income Maintenance Unit workers to notify Benefit, Employment and Support Services Division income maintenance

workers within two working days of a child's removal from the family home when the family is receiving Temporary Assistance to Needy Families. Moreover, ensure that Benefit, Employment and Support Services Division income maintenance workers adjust assistance payments and flag overpayments on HAWI; and

b. Enforce the requirement that social workers document children's foster care placement and removal in their case files, and update CPSS with placement information. In addition, require social workers to routinely contact foster children to ensure that payments do not continue to families after a child has left a foster home.

6. The department should ensure that all potential Title IV-E funds are captured and not lost. Specifically, the department should:

   a. Provide ongoing training to Title IV-E staff to ensure that procedures are followed, deadlines are emphasized, and new methodologies are incorporated for all components of Title IV-E determination; and

   b. Track all children placed in foster care to ensure they are referred for Title IV-E eligibility determination within two days and those determinations do not exceed the 180-day limit.

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Appendix A
Status of Key 1999 Recommendations

Audit of the Child Protective Services System, Report No. 99-5 Key Recommendations	Current Follow-Up Findings
1. Ensure that supervisors review and document in a timely manner all cases of abuse, unconfirmed or otherwise.	Supervisory review of investigative dispositions is still lacking.
2. Track all cases referred to investigation and ensure that dispositions are made within 60 days.	Supervisors use a monitoring report, but continue to permit untimely dispositions.
3. Provide training and oversight to ensure that the risk assessment matrix is properly used during case intake and assessment.	Inadequate supervision and training have resulted in the failure to properly use matrices during case intake and assessment.
4. Comply with the Hawaii Administrative Rules requirement that the department refer all cases involving criminal activity to the county police.	The agency has failed to report all child abuse and neglect cases that may indicate criminal activity to the Honolulu Police Department.
5. Carefully monitor voluntary foster custody placement and service plan compliance to ensure that Family Court jurisdiction is sought when required, and the department has legal authority for each child voluntarily placed in foster care.	Voluntary foster custody agreements are not properly executed and have been allowed to expire without seeking Family Court jurisdiction. In addition, service plan compliance has often been disregarded.
6. Move for permanency hearings when families are unwilling or unable to complete court-ordered service plans that are available and appropriate.	The agency continues to disregard a family's noncompliance of service plans in decisions regarding permanency planning.
7. Identify in a monthly master list all children and families authorized to receive services.	The agency does not have a master list of families authorized to receive services.
8. Track all children and families receiving contracted provider services.	There is no assurance that children and families are receiving billed services.
9. Consistently review utilization levels for each private provider after the first contract year and make adjustments in contract levels for the upcoming contract year to ensure that costs do not exceed usage.	Utilization reviews have not been consistently performed after the first contract year. In addition, adjustments in contract levels or payments have not been regularly made, resulting in overpayments.
10. Track all children placed in foster care to ensure that they are referred for Title IV-E eligibility determination within two days.	Foster care children are still not consistently referred for Title IV-E eligibility within the required timeframe.

Audit of the Child Protective Services System, Report No. 99-5 Key Recommendations	Current Follow-Up Findings
11. Properly identify in CPSS each child placed in foster care and their eligibility for Title IV-E reimbursement.	The agency remains unable to accurately and reliably identify these children and their eligibility status.
12. Require social workers to update the CPSS database with foster care placement information and to contact foster children to ensure that payments do not continue to families after a child has left a foster home.	Although social workers update CPSS, a required form is missing in some children's files. As a result, the department is unable to verify these children's placements and has issued questionable payments.
13. Require that CWS staff notify income maintenance workers of a child's removal from the family home when the family is receiving TANF.	CWS staff has not always notified BESSD income maintenance workers in a timely manner.
14. Require income maintenance workers to flag all overpayments for temporary assistance in HAWI to ensure that these overpayments will be included in recovery efforts.	Even when information is received, BESSD income maintenance workers have not routinely adjusted assistance payments or flagged overpayments.

Response of the Affected Agency

Comments on Agency Response

We transmitted drafts of this report to the director of the Department of Human Services on July 11, 2003. A copy of the transmittal letter to the Department of Human Services is included as Attachment 1. The response of the Department of Human Services is included as Attachment 2.

In its response, the department agreed with our basic findings that the Child Welfare Services Branch has not met all the benchmarks set out in our 1999 audit report and appreciated our input regarding the child welfare system. The department also agreed that it needs to improve its documentation and controls over its decision and intervention processes. The department intends to address the report findings within the context of the department's federal child and family services review.

The department expressed disappointment at what it believed to be many errors and misunderstanding in the draft report. However, in its response, the department did not provide evidence to support the so-called errors and misunderstandings. The department said we did not provide any comparative figures from the cases reviewed in our 1999 audit with this audit. However, our report includes a table that compares the 1999 audit recommendations with this audit's findings. Although this table does not include comparative figures, it clearly indicates the areas that still need improvement.

The department asserted that our office drew broad conclusions based on limited information. This is not the case. Our samples were not statistical, and, thus, we did not project our findings to the population. Rather, our samples were statewide and included up to 50 cases. We concluded on the cases reviewed and provided possible outcomes that could result based on the deficiencies identified.

The department also indicated that our office refused to disclose the specific cases we examined. This statement is disingenuous because the department was aware of the cases we reviewed during the audit. Hence, there is nothing to disclose. The department and our office staff worked together to go through the department's redacted confidential records for each case reviewed. The department had firsthand knowledge of the cases reviewed and the findings we identified during our fieldwork.

The department said the number of cases it reported to us for 1998 was incorrect. It claimed the corrected number of reports investigated is 3,568 versus 4,762 resulting in a 102 percent versus 51 percent increase

in cases, but these new amounts have not been verified by our office. The department also claimed that we did not accurately reflect the average caseload per worker. However, the reported figure was provided by a Child Welfare Services Branch administrator.

The department further asserted that our office overstated 2001 funds, which it said appeared to be 2002 funds. Our figures are in fact for FY2001-02, as indicated in the report's Exhibit 1.5. The department also stated the child protective service funds were for FY2001-02 while the cases were for FY2000-01. The department is mistaken. The number of cases was for calendar year 2001 and not FY2001-02. The department further claimed that our calculation of appropriations having increased by 76 percent from FY1997-98 to FY2001-02 was incorrect. However, we stand by our calculation of 76 percent [($85,261,970 - $46,631,190 = $35,630,780)/$46,631,190].

The department stated that the third East Hawaii unit to serve Puna already exists. However, in a November 2002 interview with the branch administrator, we were told that this third unit was part of the reorganization.

The department said that our statement that "risk assessment training is poor" is incorrect because our audit only reviewed staff training on the risk assessment matrix. Our report clearly indicates that our finding relates to the training on the matrix, not risk management in general; however, we clarified the relevant report section's heading to include the word "matrix."

The department claimed that our statement that 26 percent of Oahu intake reports during November 2002 were not reported to the Honolulu Police Department appeared inaccurate. However, our report states that we reviewed 50 of the November 2002 intake reports versus all of the November intakes. The department believed the reports identified included reports not accepted and logged as calls. This is incorrect. The intake reports we reviewed were either referred to investigation or registered but not assigned for investigation. The department also thought we only reviewed one source at the Honolulu Police Department; however, we reviewed all available sources.

Although the department said written procedures exist on how case record documents should be filed, we found numerous errors of missing documents and presented our documented findings in the report.

The department claimed there is no evidence of incomplete or untimely utilization reviews. We disagree. Four of the five provider contracts we reviewed lacked documentation showing that annual utilization reviews were completed. In one case, the overpayment of approximately

$377,000 was not identified until the FY1999-2000, FY2000-01, and FY2001-02 payments and expenditures were reconciled in FY2001-02. This contract was not reconciled annually.

The department further stated that the three-page document the department provided to us, which detailed the utilization review process, was provided to our office as a courtesy and intended to help us understand a very complex process. Precisely because of the complexity of the utilization review process, we were surprised the department had no written guidelines until our scheduled meeting with our department staff. The department also claimed that contract language requires an annual review of contract utilization as it related to funding; however, the five contracts reviewed allowed these reviews to be conducted at the State's discretion and were not required.

The department also claimed there is no basis for the statement that the department has failed to ensure that clients receive services for which the department is billed. However, 26 percent (13 of 50) of the client files reviewed lacked adequate documentation to demonstrate services were received. Although providers are paid for approved expenses versus units of service provided, it is still important that the department ensure that clients receive contracted-for services. This allows the department to evaluate whether payments made to providers are justified.

Finally, we made some minor changes to the draft report for the purposes of accuracy and clarity.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

July 11, 2003

COPY

The Honorable Lillian B. Koller, Director
Department of Human Services
Queen Liliuokalani Building
1390 Miller Street
Honolulu, Hawaii 96813

Dear Ms. Koller:

Enclosed for your information are three copies, numbered 6 to 8, of our confidential draft report, *Follow-Up Audit of the Child Protective Services System.* We ask that you telephone us by Tuesday, July 15, 2003, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, July 22, 2003.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this confidential draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Maria BJ Chun

for Marion M. Higa
State Auditor

Enclosures

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
PAGE O. Box 339
Honolulu, Hawaii 96809-0339

July 25, 2003

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for this opportunity to comment on your draft *Follow-Up Audit of the Child Protective Services System*" dated July 11, 2003. Under the Administration's new leadership, we are currently actively engaged in effective reform of the Child Welfare Services Branch (CWSB) of the Social Services Division in the Department of Human Services. We are committed to substantially improving the lives of our children and families.

To that end, we quickly overcame past access barriers so that our staff is now working well with your staff, expediting your access to redacted confidential records that your staff needs to do their job. We appreciate receiving input from your office as we do from the many other stakeholders in our State's complex child welfare system. Our expectation is that your staff will always provide us with a fair and accurate management assessment to help us improve CWSB for the sake of our children and families.

It is thus with some disappointment that we found so many errors and misunderstandings in the draft follow-up audit. We raised some of these concerns to your staff in our exit conference on July 9, 2003, but the audit report does not include any of our recommended revisions. Now we have no choice but to take the time to point out our concerns in this formal response to the audit report.

Please be assured that we mean no disrespect by detailing our concerns. We value and respect the authority and capacity of your office to provide us with a critical management tool. We are also working closely with our federal partner, the U. S. Department of Health and Human Services, Administration on Children and Families, with whom we have been engaged for the past two years in a comprehensive federal Child and Family Services Review (CFSR).

We intend to address the concerns identified in your audit report within the broader context of the ongoing federal CFSR and the development of realistic strategies and outcome measures for our Program Improvement Plan (PIP). As you know, the federal CFSR exit conference was just completed on July 18, 2003. We should have a federally approved PIP in place by the end of 2003

to measurably improve, over the next two years, our performance related to the new national standards for the safety, permanency, and well-being of children and families.

The details of the errors and misunderstandings in the follow-up audit report are contained in Attachment "A" which is incorporated herein by reference.

Thank you for allowing us the opportunity to comment on the draft audit report.

Sincerely,

Lillian B. Koller, Esq.
Director

ATTACHMENT "A"

ADDITIONAL DHS COMMENTS ON
FOLLOW-UP AUDIT REPORT OF CWSB

1. The Department agrees with the basic findings of the follow-up audit that our CWSB has not been able to fully meet all of the benchmarks set out in the 1999 audit. We have made significant improvements in many areas. Unfortunately, the follow-up audit does not reflect our improvements since 1999 because the audit does not provide any comparative figures from the cases that were reviewed in 1999 and those reviewed this year. Without the comparative figures, the follow-up audit does not present an accurate picture of whether or not CWSB is effectively addressing the concerns identified in the 1999 audit. We requested this comparative information at the exit conference because, without it, the follow-up audit is not useful as a management tool could be to help us improve our CWSB performance.

2. The follow-up audit also draws broad conclusions based on limited information. For example, in some identified areas of concern, the audit reviewed as few as 10 cases out of over 7,000 active CWSB cases. The conclusions drawn may be unreliable. Also, since the auditors refuse to disclose to us the specific cases that they examined, we cannot readily determine where management needs to take corrective action and where errors in the audit's analysis may have occurred.

3. The Department agrees that we need to improve our documentation of the actions that are taken in each case. Improved control over each decision and intervention would strengthen the entire system. This is, of course, challenging given the very high caseloads and demands in CWSB.

4. The number of cases reported to the auditors for 1998 was in error. The corrected number as reported to the federal government reduces the number of cases to 3,568. This corrects the figures on page 3 to an increase of 102% for the cases handled in 2001.

5. On page 4, the report states that there is an average of 20 cases per worker, but this does not accurately reflect the volume of work for multiple children per family case. It is not an accurate reflection of the caseload because it does not account for vacancies, staff on leave, and staff turnover resulting in lesser-trained individuals who cannot carry a full caseload. Even the audit's reported average of 20 cases per worker is not low enough based on the Child Welfare League of America standards which are 12 cases per worker for assessment and 17 cases per worker for case management.

6. The funds available to the Department in 2001 have been overstated on page 8. It appears that the figures are for Fiscal Year 2002, while the cases counted are for Fiscal Year 2001. If 2001 fiscal year figures are used, the funds increased by approximately 43%, not the 76% indicated on page 7. If Fiscal Year 2002 is used, they increased by approximately 59%, not 76%. Both funding figure increases are considerably lower than the 102% increase in cases between 1998 and 2001, and the 105% increase in cases between 1999 and 2002.

7. Also on page 8, the audit report uses gross funding "ceilings" that overstate the funds available to DHS and include federal funds that are allocated for other departments (DOH, DOE, AG) which DHS simply passes through to them and cannot access for CWSB. Also, a large portion of the additional funds was for the increased foster board costs related to additional children in foster care. Collective bargaining also increased our DHS budget without significantly increasing the number of staff or services for CWSB.

8. Page 4 indicates that the proposed reorganization of the Child Welfare Services Branch will provide a unit for the Puna district in the East Hawaii section, but this unit already exists.

9. The statement on page16 that "risk assessment training is poor" is inaccurate because the audit only counted our staff training to use a specific risk assessment tool, namely, the "matrix". While staff may benefit from more training in relation to this matrix, risk assessment training is a much broader concept. The Department currently mandates 105 hours of training for all new child welfare social workers. Approximately one-third of this training can be properly identified as risk assessment training.

10. The statement on page 22 that 26% of Oahu intake reports during November 2002 were not reported to the Honolulu Police Department (HPD) appears to be inaccurate. While we cannot identify exactly what the auditors saw since they will not reveal the records that they used, we believe that the cases selected may have included those not accepted as reports but logged as calls. These calls that do not rise to the level of a report based on statutory requirements are not forwarded to HPD and may account for the discrepancy in the HPD and DHS records reviewed by the auditors. Another factor that caused this discrepancy is that the auditors only went to one source in HPD and not the other sources, e.g., Sex Crimes Detail and HPD active cases, which are not reflected on the HPD assignment log.

11. The statement on page 31 that "tardy eligibility determinations place federal funds at risk" is exaggerated. Timely eligibility determinations are important to achieve; however, the two-day notification timeline and the 180-day eligibility determination deadline are not regulatory for financial determinations. The two-day notification timeline is an internal procedure, and the 180-day eligibility determination deadline refers only to court documents, not to the overall eligibility determination that can be accomplished within a two-year period for claiming federal funds. As noted on page 32, there is no evidence that federal reimbursements have been lost. We have also recently implemented explicit measures to expedite eligibility determinations in order to improve our access to federal funds.

12. The assertion on page 23 that "untimely permanency planning delays children from entering safe homes" is a misstatement of the intent of the federal regulation to determine a permanency plan for children within 12 months. The intent is not to prematurely force children into permanent guardianship or adoption instead of family reunification when a period longer than 12 months would allow the original family to live together. The plans that allow families more than 12 months are not necessarily outside the federal guidelines. In addition to plans beyond 12 months being in the best interests of some children, these efforts save our State money. See number 13 below.

13. The second paragraph on page 24 asserts that "tardy permanency planning" causes the State to unnecessarily incur "additional foster care" costs. This suggests a basic misunderstanding about foster care payments. The only way we can save our State money is by reuniting children with their biological parents. Guardianship and adoption do not result in a termination of the foster care payments. The State continues to make payments as permanency assistance or adoption assistance in these permanency options until the children become 18 years old (or 21 years old with disabilities).

14. On page 22, the audit also incorrectly states that our voluntary foster custody cases exceeding 90 days put our State "at risk of liability". To the contrary, it is acceptable, for example, in Ohana Conferencing cases to exceed 90 days before the federal regulations allow 180 days. Also, although the Department's procedures set a 90-day internal deadline for non-Ohana Conferencing cases, this is only to ensure that the federal timeline of 180 days is met with all of the paperwork completed.

15. On page 28, the audit recounts that a supervisor said, "Standardized record-keeping is not required", to raise a concern about our management controls. If the supervisor said this, he/she is mistaken because there are written procedures for how to file documents in the case records, and these are available in every unit.

16. The conclusions on page 30 regarding over-payments appear exaggerated and cannot be validated without knowing the specific cases reviewed. For example, over-payments may occur regardless of timely notification to TANF staff because there are specific requirements for advance notice to families of intended reductions. This timeline means that the check may have to be released and then recovered. In a second example, the amount of over-payment attributed to one family seems unlikely to have been caused, as the audit contends, by delayed reporting of a child's removal from the home or by untimely action on that report.

17. The assertion on page 28 that "management controls are ignored at staff's discretion and tolerated by supervisors" is an exaggeration. It is true that our staff focuses on procuring and delivering services to clients and do not always document how they arrive at decisions. The payment method used in our purchase of service contracts was developed to ensure availability of services on demand. This method usually entails reconciliation in the third or fourth quarter. On-going contract monitoring is accomplished through multiple sources, including provider reports and staff reports of service delivery. With few exceptions, contracts are limited to DHS referrals only which may be made by phone before the referral form is sent. Funds are shifted from under-utilized contracts to over-utilized contracts through specific meetings with program staff to be sure that needs are met as much as possible on a statewide basis.

18. In paragraph 4 on page 26, the number of CWS contracts and the funding for those contracts during the period under review is inaccurate. There were actually 53 CWS contracts each year totaling approximately $16,500,000 per year during FY2000-01 and FY2001-02. Only 38 of those contracts were in effect for both years of this audit and were subject to this review. Most of these 38 contracts started on July 1, 1999. The figure of $31.5 million cited in the audit is the total funding from the beginning of these contracts through the review period. In most cases this total includes funding for FY1999-00 which was outside the period under review.

19. There is no evidence to support the claim in paragraph 5 on page 26 that the Department does not consistently review the utilization of provider services on a timely basis. Utilization is reviewed quarterly based on Quarterly Activity Reports required in every contract, and all contract payments are subject to a final reconciliation at the end of the contract which can cover the entire term of the contract. Any unspent funds that were not recouped annually are recouped at the end of the contract.

It should be noted that providers are required to submit quarterly Client Eligibility Lists (CELs) detailing the level of services provided to each client. These CELs are distributed to social workers as documentation of services provided, and the accuracy of this documentation is checked during annual monitoring by POS staff. Thus, there is no basis for the statement in paragraph 5 that the Department has failed to ensure that clients receive services for which the Department is billed.

20. Regarding provider case reviews discussed in paragraph 2 on page 27, the audit fails to mention that in FY2001-02 the Department cited these providers for these inaccuracies and required corrective actions that would not yet have been implemented during the period under the audit's review. Documentation of the Department's actions was provided to the Legislative Auditor's staff, and it is misleading not to mention it in this report.

We also need to emphasize that none of these providers bill the Department for units of service delivered. Under the terms of the contract, these providers bill for approved expenses and are paid the same annualized monthly amount each month. This is an important distinction when discussing the accuracy of invoices in this paragraph. Accuracy of invoices is always verified by POS staff according to the terms of the contract before any payments are authorized. Billing for approved expenses versus documentation of units of service provided (a.k.a. utilization) are separate issues under the contracts that were reviewed. This basic misunderstanding is prevalent throughout this section of the audit that addresses contract management.

21. In paragraph 3 on page 27, the report recommends that the Department keep a master list of eligible clients in order to assure that clients receiving services are in fact eligible for those services. While the Department considered implementing this 1999 recommendation, we concluded that we already have multiple methods implemented to ensure the eligibility of clients receiving services. The DHS social worker is the gatekeeper in terms of appropriate and eligible referrals of DHS clients. Documentation of a DHS referral and DHS Form 1504 in the providers' case records provide assurance that the client is eligible. The Department also determined that the DHS social worker who makes a service referral would be the same person who would log that client onto a master list if we had one, so this work would be duplicative and unnecessary. Also, the Client Eligibility Lists (CELs) from providers serving DHS clients are circulated to staff as another form of documenting appropriate service provision to eligible clients. Each client on the CELs can be verified in the Department's automated Child Protective Services System. Client assessments, progress reports, and discharge reports are other, required forms of documentation by the provider that services have indeed been rendered to eligible clients as requested.

22. The statement in paragraph 5 on page 27 that discrepancies of 5%–10% are tolerated by the Department reflects a misunderstanding of information provided by the POS supervisor. It should be noted in this regard that the Legislative Auditor's staff specifically asked POS how we handle a marginal discrepancy of 5%-10%. In cases like this where program utilization lags behind program expenditures by 5%-10%, it may be preferable to maintain service capacity until the Department can determine the cause of the discrepancy. Sometimes the discrepancy is due to systemic factors beyond the provider's control which need to be rectified by the Department, or sometimes the discrepancy is seasonal. Cutting service capacity prematurely only to restore it again could result in clients not receiving critical services.

23. It is true as stated in paragraph 1 on page 28 that in crisis situations the focus is on getting people needed services rather than ensuring that proper authorizations are in place first. The "proper authorization" referred to is DHS Form 1504 which documents for the client and the provider that services have been authorized. Often services need to be provided immediately (e.g., in-home crisis response or emergency shelter home services) to ensure the safety of a child even before the social worker can generate this written authorization. This does not mean that the authorization will not be done, and it certainly does not mean that a telephone referral has not been made by the DHS social worker followed by essential written information documenting the crisis and the Department's case plan. This type of flexibility in service initiation should be seen as a strength which can prevent unnecessary out-of-home placements, saves our State unnecessary foster board payments, and even save lives. Prompt service delivery was seen as a strength during the recent federal CRSR review of the Department's child welfare services system. Seen in this light, it is inaccurate to state that management controls are conveniently ignored at staff discretion and tolerated by supervisors when in reality rapid service initiation is in the best interests of children and families.

24. It is misleading to state in paragraph 3 on page 28 that contracts lack documentation of utilization reviews. Each of our contracts includes the same Exhibit "B", the Compensation and Payment Schedule, which requires quarterly activity and expenditure reports from providers. These reports are the basis for utilization reviews. Budgets are approved and quarterly payments are made to providers based on these reports. POS staff informed the Legislative Auditor's staff that budget approvals and payment authorizations constitute documentation of the outcome of utilization reviews. Also, POS offered documentation of over-payments that were recovered in FY2000-01 and FY2001-02 as a result of our effective utilization reviews. In FY2001-02 alone $1,217,446 was recovered. While it is true that carry-over has been allowed in some instances and that $13,000 was overlooked until this audit, it is premature to conclude that unspent money over the life of these contracts would not be recovered at the end of the contracts.

25. The 3-page document referenced in paragraph 4 on page 28 which detailed procedures for utilization reviews was provided to the Legislative Auditor's team as a courtesy. It was intended to help the team understand a very complex process. The legal basis and procedures for utilization reviews are specified in all our contracts as Exhibit "B", the Compensation and Payment Schedule. Exhibit "B" details timelines and required documentation, and a copy of this language was also provided to the Legislative Auditor's staff. It is inaccurate to state that the Department has no deadlines to meet resulting in untimely utilization reviews when the contract language is very clear about quarterly reviews driving payment authorizations as well as the need for at least an annual review of contract utilization as it relates to funding. Also, the audit did not look at any contracts that ended during the period under review. Thus, there is no documentation to substantiate the claim in this paragraph that funds may be wasted.