Selected Findings and Recommendations

From the

Child Welfare League of America Quality Improvement Report

To

Governor Deval Patrick

Secretary John Polanowicz

Background

Good Afternoon, I am pleased to be here today to share highlights from the findings and recommendations for CWLA's Quality Improvement Review of the Massachusetts Department of Social Services. As you know in January of 2014, the Massachusetts Executive Office of Health and Human Services (EOHHS) requested an objective third-party review of the Child Welfare League of America (CWLA) in response to concerns regarding the safety of children served by the Department of Children and Families (DCF).

In conducting this review, CWLA was asked to examine the appropriateness, comprehensiveness, and consistency of certain agency policies and practices in the context of the Jeremiah Oliver case and through the lens of nationally recognized standards and best practices. Paramount to this Quality Improvement Review is the determination that Jeremiah Oliver's legacy should be that, in his

memory, Massachusetts makes lasting improvements that increase child protection, and give children of the Commonwealth and their families increased supports and services to help them to flourish.

The CWLA Review methodology is focused on understanding, educating and improving the quality of agency case practice and operations. Our review was focused, extensive and included an examination of:

- **DCF Policies, Procedures, Guidelines and training materials related to the protection of children** and including materials related to substance abuse, domestic violence, Structured Decision Making (a tool used to assess a child's safety and risk), and DCF's Integrated Case Practice Model.
- **Numerous prior reports conducted regarding DCF** including the 2007 Massachusetts Legislative Report issued by the House Committee on Child Abuse and Neglect;
- **An array of routine management reports** related to screening/ investigations/ assessments, home visitation, case management, supervision, criminal records checks, and caseloads.
- The memorandum of Understanding (MOU) and other agreements between Service Employees International Union (SEIU) local 509 and DCF regarding caseloads and caseload weighting
- **Reports, materials and interviews specific to the North Central Office and the Oliver Case**

- **Six focus groups across the state including approximately 160 individuals** representing:
    - 13 sister state agencies
    - professionals including court personnel, and representatives from the advocacy and provider community (Court Appointed Special Advocates, Massachusetts Provider's Council and the Children's League of Massachusetts)
    - Former foster youth/young adults;
    - Members of the DCF Parents' Advisory Committee; and the DCF Fatherhood Initiative.
    - Parent support organizations, birth parents and extended family members, foster families, adoptive families, kinship families.

- A **26 question staff survey which generated more than 1,100 responses** from all levels of DCF staff in Central Office, and all Area and Regional Offices.
- **More than fifty phone calls and emails from the community** including birth parents, foster parents, DCF staff, foster youth, former foster youth, and numerous "interested and concerned" individuals across Massachusetts.

Context for The Review

It is a perennial challenge for child welfare organizations to make the right decisions when questioning whether or not a family is in need of

assistance, whether a family can care for children, whether children can remain in the home safely, and whether it is necessary to remove children from their home to protect them from child abuse and neglect. A common thread in discourse about the deaths of children known to child welfare organizations is that "the pendulum has swung too far" – that there is too much emphasis on preserving families and not enough emphasis on protecting children – as if there is a choice between one or the other. CWLA believes that is a false dichotomy.

In fact, DCF must do both, and its regulations at once recognize the difficulty of the dual mission and require the dual mission. Central tenets of the CWLA National Blueprint for Excellence in Child Welfare, which guide CWLA's findings and recommendations, are that *children's rights are human rights, that it is the right of each child to be protected and have decisions made in his/her best interests. It is also the responsibility of all members of society to uphold the rights of children.*

Selected Findings and Recommendations

The full report includes detailed findings regarding these items and the many pivotal agency policies and procedures examined during the review, including home visitation, criminal records and background checks for foster parents and other caregivers, medical screening, and technology supports. I encourage the media and key stakeholders to review the full report to understand the scope of its findings, and the specific recommendations needed to strengthen child safety.

The Oliver Case

The Oliver case and other high profile cases highlighted in the media during the period of CWLA's Quality Improvement Review point to a number of issues within DCF, multi-systemic (across EOHHS, other agencies, and systems), and societal challenges.

In particular, the CWLA Team identified a number of significant issues concerning case practice in the Oliver case. We did not conclude, however, that DCF was responsible for Jeremiah's death or that DCF could have prevented the tragic outcome for this little boy. While there is significant evidence that some DCF staff did not do their jobs in the Oliver case, there is not evidence that DCF's actions and failures caused Jeremiah's death. DCF and many of the adults in Jeremiah's life failed to protect him.

We are pleased to report that, since Jeremiah's siblings were removed from their home and placed in the custody of DCF, they have received excellent supports and services. There has been exceptional social work and extraordinary teamwork within DCF and among DCF, schools, and community providers to ensure that the children's privacy is protected, and that they receive everything they need to overcome the trauma of their experiences and the loss of their brother.

Inconsistent Case Practice Across Regions and Area Offices

Grounded in the concerns identified in Jeremiah's case, *The CWLA team found that DCF case practice policies and protocols are largely*

out-of-date. In many instances optional case practice guidelines have been used to guide staff in lieu of policy updates. This patchwork of guidance has been unevenly implemented, inadequately monitored, and has resulted in inconsistent practice across DCF Regional and Area Offices. We have recommended that:

- DCF leadership verify that certain child protection protocols including Structured Decision Making and safety assessment tools are in use statewide, are consistently applied and monitored.
- DCF should complete the updating of it agencies policies. This includes fully integration of child safety protocols with home visitation policies.
- DCF should also revamp its approval policies for relative caregivers and other child specific placements to comply with recently developed national guidance.

Refining and Implementing the Integrated Case Practice Model (ICPM)

DCF's Integrated Case Practice Model (ICPM), rolled out in 2009, is at a crossroads in its development and use. Facing challenges due to significant budget cuts, limited staff buy-in, union/management differences, and growing caseloads, the ICPM has been poorly supported (staffing), and not well-integrated into practice or well-received in many DCF Area Offices across the state.

- A cross section of DCF staff and the Child Welfare Training Institute (including policy staff), and stakeholders should identify the strengths of the ICPM, state desired outcomes of the

model, and determine what is missing or incomplete (data, forms instructions, etc.,), and fully integrate the ICPM with new policies.

- Over the next 30 days, CWLA will also work with this team to:
    - Identify challenges and solutions to full adoption and implementation of the model;
    - Create a plan for seeking input from those staff not part of the cross-section group;
    - Use current research on risk factors associated with the 0-5 age group to ensure practice protocols for this population are built into the re-tooling of the ICPM;

Strengthening and Supporting the Workforce

DCF is currently serving more children than it has at anytime in the last 20 years, and current caseload/workload demands far outstrip the department's current workforce capacity. Family stressors in cases involving young children with safety concerns related to substance exposure, mental health concerns, and domestic violence have contributed to this growth. Community factors including increased reporting from the community, heightened vigilance within DCF, and increased staff turnover are also factors in caseload growth.

CWLA recommends a comprehensive workforce strategy (outlined in our Progress Update recommendations) including adequate allocation of frontline, supervisory, and managerial staff to stabilize the caseload; the use of specialized substance abuse, health, mental

health and domestic violence staff in each area office; along with credentialing, training, hiring, & workforce supports including a statewide program to address secondary trauma.

DCF staff lacks adequate access to technology including cells phones and handheld devices to provide caseworkers with immediate access to supervisory support and real time case information, along with the capacity to input information regarding key case activities in the i-FamilyNet data system.

We have been informed that EOHHS and the Department have completed an initial pilot of new handheld technology with on call supervisors, and plans to roll out devices statewide this summer.

Quality Improvement

DCF does not currently have a formalized, agency-wide quality improvement process. A wide variety of data-dense reports are generated monthly and/or quarterly, but these reports do not provide real time data, are not user friendly, or built to measure the effectiveness of DCF's practices.

DCF should build on existing protocols including the new Federal Child and Family Service Review (CFSR) process, and the Council on Accreditation's (COA) public agency standards for Performance and Quality Improvement to implement a comprehensive quality improvement process that will assure accountability, build trust in the community, and contribute to improved collaborative relationships.

Data should be shared regularly and periodic reports should be available for public consumption.

Community Education and Communications Plan

DCF and its staff have been exposed to prolonged negative media exposure. Few stories have highlighted the challenges of the work and the many committed, excellent DCF staff, or the families who have truly been strengthened by their involvement

EOHHS and DCF leadership staff must develop a unified, year-round, formal community education and communications plan to highlight messages that:

- Strength community understanding of the issues and concerns associated with protecting children.
- Promote child abuse prevention and educate regarding the community's role and responsibility for children and their welfare;
  - Establishes regular communication with the public, staff and stakeholders and provides increased transparency regarding the work of the department both when it succeeds and in instances of the high profile cases.

Conclusions

Addressing issues such as child abuse and neglect, domestic violence, chronic mental health challenges, drug abuse and addiction, multi-generational challenges, poor parenting choices, homelessness, cultural differences, disproportionality, parental

incarceration, and poverty **require diligence and coordination. It is not a once and done endeavor.** To prevent the deaths of children, like Jeremiah, who come to the attention of DCF because of allegations of abuse and neglect, we must look beyond DCF itself; we must address the core issues that lead children and families to need DCF's intervention and services.

For many years, Massachusetts has not been attentive enough to these issues. These are problems that can be changed only when all individuals, communities, and organizations are ready to examine their roles and take responsibility for their contributions to tragic case outcomes such as Jeremiah's death, and when they are willing to work collaboratively to make improvements. Everyone must be ready to advocate for overhaul of the parts of the system that do not protect children adequately, and for providing appropriate levels of services and funding.

In closing, I would like to thank Governor Patrick, Secretary Polanowicz, and their staffs for their commitment to this review. I must also express our deep gratitude to the many advocates, social workers, professionals, families and youth in the community and especially within DCF whose commitment to the children of the Commonwealth was apparent throughout this review. Their passion should serve as a resource as DCF goes forward, and as a source of hope for a safer future for children.