2015 MASSACHUSETTS FAMILY IMPACT SEMINAR

MISSION CRITICAL:
Reforming Foster Care and Child Protective Services

CLARK UNIVERSITY

MOSAKOWSKI INSTITUTE
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Mission Critical:
Reforming Foster Care and Child Protective Services in Massachusetts

2015 MASSACHUSETTS FAMILY IMPACT SEMINAR

BRIEFING REPORT

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- Annie E. Casey Foundation

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The Massachusetts Family Impact Seminars are a project of
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Mission Critical: Reforming Foster Care and Child Protective Services

Purpose and Presenters

In 2009, Clark University was accepted to represent Massachusetts in the Family Impact Institute at the University of Wisconsin — Madison (familyimpactseminars.org), an organization of universities nationwide that conduct Family Impact Seminars. In 2014, the Family Impact Institute moved its host site to Purdue University.

Family Impact Seminars are a series of annual seminars, briefing reports, and discussion sessions that provide up-to-date, solution-oriented research on current issues for state legislators and their aides. The seminars provide objective, nonpartisan research on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

Mission Critical: Reforming Foster Care and Child Protective Services is the sixth Massachusetts Family Impact Seminar. It is designed to emphasize a family perspective in policymaking on issues related to reforming foster care and child protective services in the Commonwealth. In general, Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

THIS SEMINAR FEATURES THE FOLLOWING SPEAKERS:

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Introduction

By Denise A. Hines, Ph.D.

One major topic of debate during the 2014 gubernatorial elections was the functioning of the Department of Children and Families (DCF) in Massachusetts. Prior to the debates and subsequently as well, the media has highlighted some challenges and issues that plague DCF, and several high-profile cases have sparked not only the attention of our state government, but the public at large as well.

After consultation with legislators, we decided that our 2015 Massachusetts Family Impact Seminar would focus on this crisis. The title of our seminar in March of 2015 was "Mission Critical: Reforming Foster Care and Child Protective Services," and we brought in three experts to speak about the problems that DCF faces and ways to improve its functioning. This briefing report represents a summary of that seminar.

Our three experts were Emily M. Douglas, Ph.D. of Bridgewater State University, who spoke about child maltreatment fatalities and what our workers in the child protection system do and do not know about this issue; Melinda Gushwa, Ph.D., of Rhode Island College, who spoke about research on the daily lives of child protective service workers so that we can gain an understanding of which reforms may work and how to make them work; and Martha J. Henry, Ph.D., of MJ Henry and Associates, who spoke about using solid data to inform decision-making in DCF.

This briefing report contains the transcripts and slides of the three talks from our seminar. It also contains three policy briefs written by each of our experts that were distributed at the seminar. There is also a summary of how DCF functions in the Commonwealth, written by Mickayla Aboujaoude, an undergraduate student working at the Mosakowski Institute for Public Enterprise. Finally, the report contains a policy report, "Every Kid Needs a Family," from one of the funders for this year's seminar, the Annie E. Casey Foundation.

The Massachusetts Family Impact Seminars are a project supported by the Mosakowski Institute of Public Enterprise at Clark University. The mission of the Mosakowski Institute is to improve the effectiveness of government and other institutions in addressing social concerns through the successful mobilization of use-inspired research. This year's seminar was also partly funded by the Annie E. Casey Foundation.

The goal of this seminar series is to provide objective high-quality university-based research to state legislators and their staff, who are well-positioned to make decisions based upon that research. Over the past six years, we have received high marks for our objectivity and the quality of the work we present, and we hope to maintain this reputation in years to come.

The Family Impact Seminars are where research meets policy on family issues. We are part of a national network of universities that do Family Impact Seminars in their states, with one university per state designated as the Family Impact Seminar site for that state. Please consult the following webpage for more information regarding the FIS around the country: www.purdue.edu/hhs/hdfs/fii

Overall, these Family Impact Seminars have two goals. First, we try to promote greater use of objective, non-partisan university research in policy decisions, through the presentations themselves; through discussions among the experts, legislators, and other seminar attendees; and through this briefing report.

Second, we try to encourage policymakers to examine the family impact of policies and programs. One way we do this is by encouraging policymakers to ask three questions:

(1) How are families, rather than individuals, affected by the issue?

(2) In what ways, if any, do families contribute to the issue?

(3) Would involving families in the solution result in better policies?

For more information about the Massachusetts Family Impact Seminar, please go to the following webpage: wordpress.clarku.edu/dhines/familyimpactseminars and/or contact me at dhines@clarku.edu.

The Family Impact Guide for Policymakers

VIEWING POLICIES THROUGH THE FAMILY IMPACT LENS

- **Most policymakers would not think of passing a bill without asking, "What's the economic impact?"**
- **This guide encourages policymakers to ask, "What is the impact of this policy on families?" "Would involving families result in more effective and efficient policies?"**

When economic questions arise, economists are routinely consulted for economic data and forecasts. When family questions arise, policymakers can turn to family scientists for data and forecasts to make evidence-informed decisions. The Family Impact Seminars developed this guide to highlight the importance of family impact and to bring the family impact lens to policy decisions.

WHY FAMILY IMPACT IS IMPORTANT TO POLICYMAKERS

Families are the most humane and economical way known for raising the next generation. Families financially support their members and care for those who cannot always care for themselves—the elderly, frail, ill, and disabled. Yet families can be harmed by stressful conditions—the inability to find a job, afford health insurance, secure quality child care, and send their kids to good schools. Innovative policymakers use research evidence to invest in family policies and programs that work, and to cut those that don't. Keeping the family foundation strong today pays off tomorrow. Families are a cornerstone for raising responsible children who become caring, committed contributors in a strong democracy, and competent workers in a sound economy [1].

In polls, state legislative leaders endorsed families as a sure-fire vote winner [2]. Except for two weeks, family-oriented words appeared every week Congress was in session for over a decade; these mentions of family cut across gender and political party [3].The symbol of family appeals to common values that hold the potential to rise above politics and to provide common ground. However, family considerations are not systematically addressed in the normal routines of policymaking.

HOW THE FAMILY IMPACT LENS HAS BENEFITED POLICY DECISIONS

- In one Midwestern state, using the family impact lens revealed differences in program eligibility depending upon marital status. For example, seniors were less apt to be eligible for the state's prescription drug program if they were married than if they were unmarried but living together.
- In a rigorous cost-benefit analysis of 571 criminal justice programs, those most cost-beneficial in reducing future crime were targeted at juveniles. Of these, the five most cost-beneficial rehabilitation programs and the single most cost-beneficial prevention program were family-focused approaches [4].
- For youth substance use prevention, programs that changed family dynamics were found to be, on average, more than nine times more effective than programs that focused only on youth [5].

QUESTIONS POLICYMAKERS CAN ASK TO BRING THE FAMILY IMPACT LENS TO POLICY DECISIONS:

- How are families affected by the issue?
- In what ways, if any, do families contribute to the issue?
- Would involving families result in more effective policies and programs?

HOW POLICYMAKERS CAN EXAMINE FAMILY IMPACTS OF POLICY DECISIONS

Nearly all policy decisions have some effect on family life. Some decisions affect families directly (e.g., child support or long-term care), and some indirectly (e.g., corrections or jobs). The family impact discussion starters below can help policymakers figure out what those impacts are and how family considerations can be taken into account, particularly as policies are being developed.

Family impact discussion starters

How will the policy, program, or practice:

- support rather than substitute for family members' responsibilities to one another?
- reinforce family members' commitments to each other and to the stability of the family unit?
- recognize the power and persistence of family ties, and promote healthy couple, marital, and parental relationships?
- acknowledge and respect the diversity of family life (e.g., different cultural, ethnic, racial, and religious backgrounds; various geographic locations and socio-economic statuses; families with members who have special needs; and families at different stages of the life cycle)?
- engage and work in partnership with families?

Ask for a full Family Impact Analysis

Some issues warrant a full family impact analysis to more deeply examine the intended and unintended consequences of policies on family well-being. To conduct an analysis, use the expertise of both family scientists, who understand families, and policy analysts, who understand the specifics of the issue.

- Family scientists in your state can be found at familyimpactseminars.org
- Policy analysts can be found on your staff, in the legislature's nonpartisan service agencies, at university policy schools, etc.

Apply the Results

Viewing issues through the family impact lens rarely results in overwhelming support for or opposition to a policy or program. Instead, it can identify how specific family types and particular family functions are affected. These results raise considerations that policymakers can use to make decisions that strengthen the many contributions families make for the benefit of their members and the good of society.

ADDITIONAL RESOURCES

Several family impact tools and procedures are available on the website of the Family Impact Institute (familyimpactseminars.org).

1 Bogenschneider, K., & Corbett, T. J. (2010). Family policy: Becoming a field of inquiry and subfield of social policy [Family policy decade review]. *Journal of Marriage and Family,* 72, 783-803.

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Acknowledgements

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Senator Chandler and her staff, especially Laura Paladino, have been particularly helpful with scheduling and coordinating the development of the seminars, and we would like to thank them for their continued support. Each year, they provide valuable input on the topics selected.

We are especially grateful for the support of the Co-Chairs of the Joint Committee on Children, Families and Persons with Disabilities: Rep. Kay Khan and Sen. Jennifer Flanagan. They and their staff members, particularly Ernestina Mendes, provided invaluable input and guidance on the topic selected for this year's seminar.

We would further like to acknowledge the legislators who gave their time to provide opening remarks at this year's seminar: Senate President Stanley Rosenberg, Senate Majority Leader Harriette Chandler, Chairwoman Rep. Kay Khan, Second Assistant Majority Leader Rep. Paul Donato, and Rep. Gloria Fox.

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The Massachusetts Family Impact Seminars are a project of the Mosakowski Institute for Public Enterprise at Clark University. The support of the staff at the Mosakowski Institute has been essential for the execution of the Family Impact Seminars. Our thanks go to Lisa Coakley, Executive Assistant to the Director, Jana Kelnhofer '17, and Mickayla Aboujaoude '17.

Last, but not least, the support and encouragement of Clark University President David Angel, Vice President for Community and Government Affairs Jack Foley, and former Senator Gerry D'Amico were central to the development of the seminar series.

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Crisis or Crossroads: The Child Welfare Profession and Fatal Child Maltreatment

By Emily M. Douglas, Ph.D. | Bridgewater State University

POLICY BRIEF

The assumption is that workers who experience a maltreatment fatality are young, inexperienced, poorly trained, and not educated in the appropriate disciplines.[1,2]

CHILD WELFARE WORKERS WHO EXPERIENCE THE DEATH OF A CLIENT

Research shows that child welfare workers who experienced the death of a child are well-educated, with at least a bachelors degree, and that they had degrees in fields that were appropriate for working in child welfare — social work, human services, and other social sciences. Workers who experience the death of a child client are not young; they are in their 30s and 40s and have worked in child welfare for an average of 4 and 13 years, respectively, for frontline workers and supervisors. Workers had caseloads of about 20 for frontline workers and 90 for supervisors. The victims had been on their caseloads for 2-3 months before the death.[3]

Workers recounted that they felt comfortable handling the case before the fatality, and the majority reported that they received appropriate guidance on handling the case. Only a minority (10%) said that they had wanted to pursue a different treatment plan. Looking back on the fatality, 27% stated that it was unavoidable.[3]

CHILD WELFARE WORKER CONCERN ABOUT AND KNOWLEDGE OF RISK FACTORS FOR FATAL MALTREATMENT

Workers are very concerned about child maltreatment fatalities (CMFs). The majority (93%) report that they assess the risk for fatalities when they work with families and almost three-quarters (72%) worry that a child on their caseloads will die. More than a quarter (28%) have had a parent say that s/he might kill his/her child. The vast majority (93%) report wanting to be trained about risk factors for fatal child maltreatment.[4]

Research shows that workers have gaps in their knowledge about CMFs. Workers are not certain how children die or who is most likely responsible for their deaths. There are deficits in knowledge concerning parental and household risk factors for fatality, although workers have more knowledge about child-level risk factors and the parent-child relationship. Further, training about risk factors has made almost no difference in worker knowledge.[4] Research also shows that workers receive very little training about fatalities as they are entering the child welfare field.[5]

CONCLUSIONS

- Workers who experience the death of a child on their caseloads:
  - are not young and inexperienced. They are mature workers with at least several years of experience.
  - report feeling confident in the lead-up to the child's death.

- Workers have low levels of knowledge with regard to risk factors for CMFs.
- Workers receive very little training on CMFs before entering the field.
- Receipt of training around CMFs does not currently make an impactful difference.

POLICY RECOMMENDATIONS

- Child welfare workers want and need more training on risk factors for CMFs. Workers should receive national-level, research-based information about risk factors for CMFs, along with information that is specific to Massachusetts.
- The efficacy of training about risk factors for CMFs should be examined to determine if it increases workers' knowledge of risk factors.
- This training should be made available to child welfare professionals throughout the Department of Children and Families, to ensure that this knowledge is widespread.
- This information should be infused throughout child welfare practice, especially in the supervision that workers receive. Research shows that the supervisor is a key component in determining the efficacy of child welfare practice.[6-8]
- Understanding the pathways, pivotal moments, and child welfare practice decisions and interventions is key to understanding trends in circumstances under which children die.

ENDNOTES

1 Gelles RJ. Failure to protect: Interview — Richard Gelles. 2003. http://www.pbs.org/wgbh/pages/frontline/shows/fostercare/inside/gelles.html. Accessed February 17, 2007.

2 National Coalition for Child Protection Reform. The real reasons for child abuse deaths. *Issue Paper 8* 2009; http://www.nccpr.org/reports/8Realreasons.pdf.

3 Douglas EM. Child welfare workers who experience the death of a child client. *Administration in Social Work.* 2013/01/01 2012;37(1):59-72.

4 Douglas EM. Child welfare workers' training, knowledge, and practice concerns regarding child maltreatment fatalities: An exploratory, multi-state analysis. *Journal of Public Child Welfare.* 2012/11/01 2012;6(5):659-677.

5 Douglas EM, Mohn BL, Gushwa MK. The presence of maltreatment fatality-related content in pre-service child welfare training curricula: A brief report of 20 states. *Child Adolesc Soc Work J.* 2014/12/30 2014:1-6.

6 Collins-Camargo C, Millar K. The Potential for a More Clinical Approach to Child Welfare Supervision to Promote Practice and Case Outcomes: A Qualitative Study in Four States. *Clinical Supervisor.* 2010;29(2):164-187.

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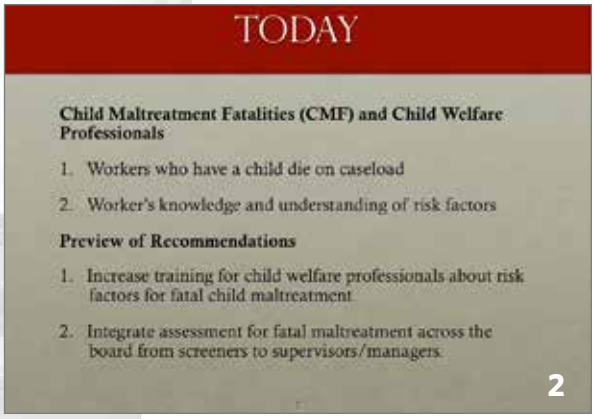
8 Chen S-Y, Scannapieco M. The influence of job satisfaction on child welfare worker's desire to stay: An examination of the interaction effect of self-efficacy and supportive supervision. *Children and Youth Services Review.* 04 2009;32(4):482-486.

Emily M. Douglas, Ph.D. is an Associate Professor of Social Work at Bridgewater State University in Bridgewater, Massachusetts. Her areas of expertise address child and family well-being, and programs and policies that promote positive outcomes. Dr. Douglas's interest in fatal child maltreatment began when she was in graduate school and worked for a Child Death Review Panel. Her work in this area has focused on child death review teams, state policy, and the intersection of the Child Welfare profession and fatal maltreatment. During a 2010-2011 academic year, Dr. Douglas was made the Presidential Fellow at Bridgewater State, during which time she conducted the largest study on child welfare work and fatal child maltreatment. Dr. Douglas has been the recipient of federal funding, is the author/co-author of forty peer-reviewed publications, and three books. In October, 2014, she testified before the National Commission on the Elimination of Child Abuse and Neglect Fatalities. She recently completed her fourth book, this time on policy and responses to maltreatment fatalities, called "Death by Child Abuse or Neglect, U.S. Policy Program, and Other Professional Responses" slated to be released by Springer Publications later this year.



TRANSCRIPT OF DR. DOUGLAS' TALK

So it's certainly an honor to be here, and I'd like to thank Denise Hines and Clark University for inviting me to be a part of this seminar today. It's quite an honor to be here, especially in front of such a group of resilient people who are dedicated to this issue.

So as Denise outlined, I'm going to talk to you about the intersection of the child welfare profession and fatal child maltreatment, and my talk is "Crisis or Crossroads; the Child Welfare Profession and Fatal Child Maltreatment." (slide 1)

Okay, so I'm going to talk to you today primarily about two things: workers who have a child who dies on their caseload, and workers' knowledge and understanding of risk factors for fatal child maltreatment.

And sort of a preview of my recommendations are to increase training for child welfare workers about risk factors for fatal child maltreatment, and then to integrate this in assessment for fatal child maltreatment across the board. (slide 2)

So I'm going to start by just telling you, very briefly, about some research that I did in the 2010-11 academic year. I conducted an online national survey, or nationwide survey — anonymous survey so that workers would — we hope — be more truthful and honest about what they know and their experiences. (slide 3)

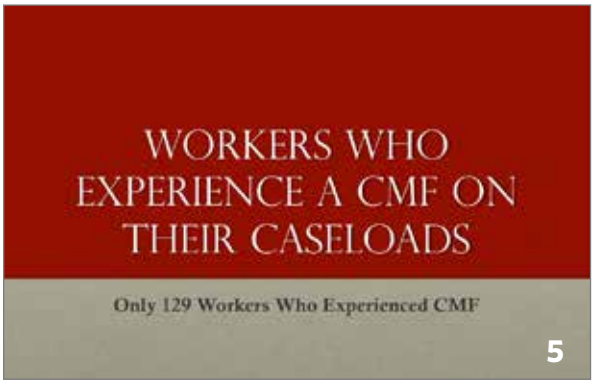
I had 426 workers participate in this. This was both child welfare workers and supervisors. One hundred twenty-nine of those had experienced a child maltreatment fatality. They were largely female; they were well-educated; they were sort of mid-career; there's some racial diversity present, and folks came from all over the country. And these results are relatively comparable to research that's done on nationally-representative samples of child welfare workers. (slide 4)

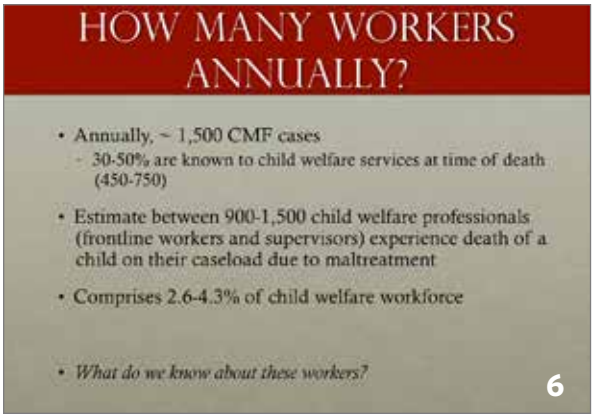
So first I'm going to hone in on just those workers who experienced a maltreatment fatality on their caseload as the first part of my talk. (slide 5) So how many workers, annually, experience a child maltreatment fatality on their caseload? Well the truth is, we don't really know. But we can sort of do some numbers here. (slide 6)

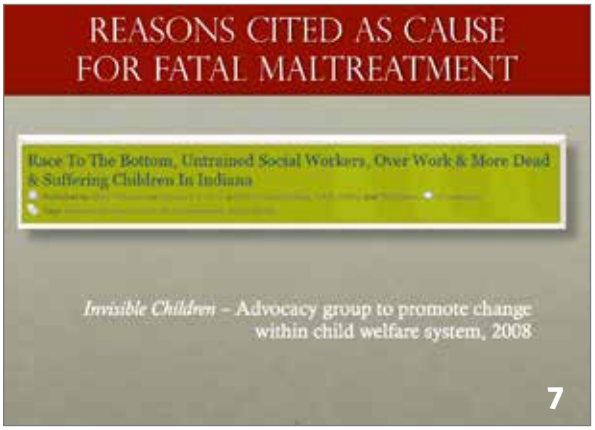
So official statistics tell us that somewhere between 1,500 to 2,000 kids die each year as the result of a maltreatment fatality, and our most recent statistics from the federal government tell us that about 1,500 kids died in 2013. Research shows that of kids who die, 30%-50% of those kids are known to their child welfare agency in some way.

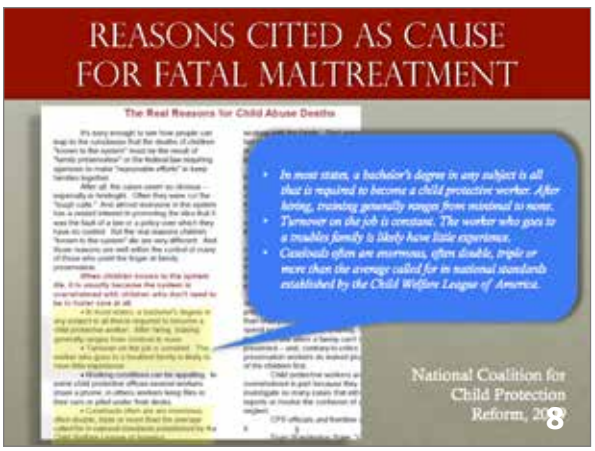
So if you do the math, this means that 450-750 fatality victims were known to child welfare services before their death. If each child has a worker and a supervisor, that means that somewhere between 900 and 1,500 workers and supervisors experienced a maltreatment fatality on their caseload in 2013, which is about 2.5% to just over 4% of workers.

Of course, the reverberation from that goes throughout everybody's office, but this is in terms of the actual workers who experience them. And of course, there are a number of assumptions in this calculation, for









example, a child and family had made it to the point past screening — so they'd actually been assigned a worker. It also assumes that there might have been one worker for multiple children if multiple children died in one family. And that does happen, but that's not usually how it happens.

All right, so what do we know about these workers? The truth is we don't really know a lot about these workers, so I'm just going to walk you through how the media portrays these workers. One headline reads: "Race to the bottom, untrained workers, overwork and more dead and suffering kids in Indiana." (slide 7)

The next headline is from the National Coalition of Child Protection Reform, which is a Family Advocacy Group. In most states, a Bachelors degree in any subject is all that is required to become a child protective worker. After hiring, training generally ranges from minimal to none. Turnover on the job is constant. The worker going to a troubled family is likely to have little experience. Caseloads are often enormous; often double, triple, or more than the average called for in national standards like those from the Child Welfare League of America. (slide 8)

This headline is from The Guardian: "Social workers untrained for violent parents." (slide 9)

And from Washington State's Children Administration, the committee felt assigning high-risk investigations to newly-hired and inexperienced social workers may present risk issues. (slide 10)

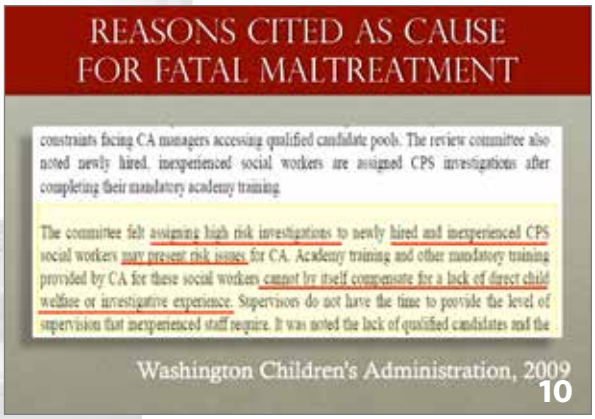
What the media tells us is that workers who experience a death are young, they have inadequate education, inadequate training, they don't have much on-the-job experience. So what does the research tell us?

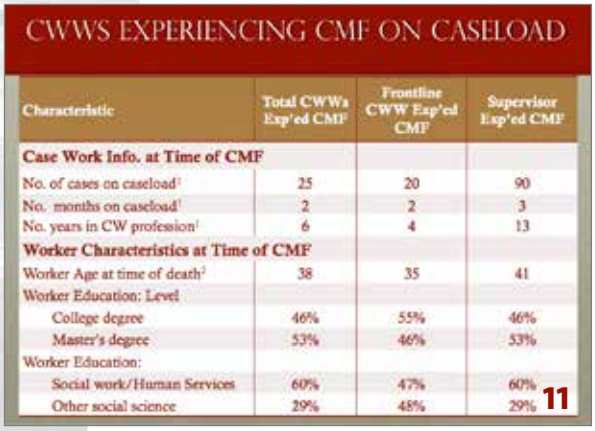
So these are the workers who experienced a fatality. And I'm going to walk you through this slide here. (slide 11) So in the left-hand column, we have characteristics of the workers. And the next column, we have all of the workers — all of child welfare workers who experience a maltreatment fatality. The next column over is the frontline workers who experience a maltreatment fatality. And the far right-hand column are supervisors.

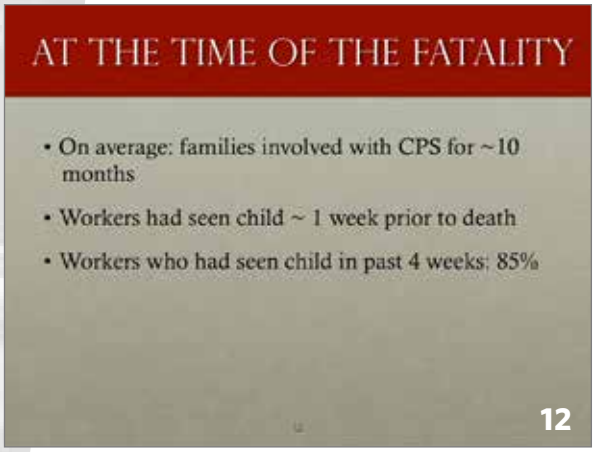
So we see if we take a look at the case worker information at the time of the maltreatment fatality; number of cases on their caseload, overall, it's 25. Frontline workers, it's 20. And supervisors, it's 90. Child Welfare League of America's standards are 17 cases for workers and 85 for supervisors. So it's over; it's not grossly over, it is somewhat over. And we don't know, for example, being over by one caseload; that could be one child or it could be five kids. You just don't know.

So the number of months that that family or that child was on the caseload before the child died was on average 2 months. The number of years in the child welfare profession: 6 years overall, 4 years for frontline workers, 13 years for supervisors.

Worker characteristics at the time of the child maltreatment fatality: The worker age; so they were sort of mid-career age. Their education level — about half of them had a college degree and about half had a Master's degree. Their areas of education — about 60% have a social worker/human services degree overall.







Okay, so these are folks who actually appear to be pretty well-educated. They seem to have had years of experience in the profession, and they don't necessarily match the myths that are out there.

On average, families who are involved with child protection services, 10 months before the death. (slide 12) The workers had seen the child, on average, one week prior to the child's death. And workers who had seen the child in the past four weeks, which is the federal standard, were 85%.

Then I asked them their approach to how they remembered handling the case before the child died. (slide 13) So how many of them felt confident handling the case? The vast majority. Did they conduct a full risk assessment of the family? The vast majority. They themselves received appropriate guidance on how to handle the case. More than 75%.

The family was being closely monitored. Close to 2/3 say this. They said the death was unavoidable. About 1/4 say that the death was unavoidable. What does that mean? We don't really know what that means. Do they mean it really was unavoidable or we did everything that we could? But a 1/4 of them believe that the death was unavoidable.

And then these last three, which is really was about did you want to do something different? You were worried about the family. You wanted to do something different but your supervisor didn't permit it, or didn't encourage it. Agency policy didn't permit it. The state policy didn't permit it. And pretty much that's not the experience that workers are having.

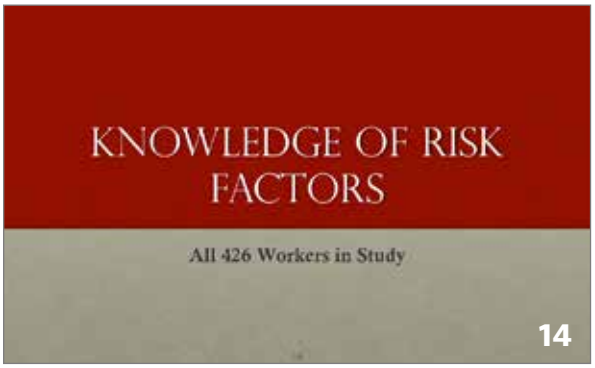
Okay, so now I'd like to shift to all of the workers who I surveyed; so all 426 workers. And I asked them about their knowledge of risk factors. So I asked them about their knowledge for child risk factors, parent risk factors, the parent-child relationship, and also household risk factors. (slide 14)

So I'm going to walk you through this. (slide 15) So what I've got here are the variety of risk factors, and I will walk you through these one at a time. And on the right-hand column, what we have are those who knew that risk factor; 75% of the workers or above knew that this was a risk factor for fatal child maltreatment. The check mark says, yes, that they knew that. And the x means no, that they didn't know that.

So what workers do know is that younger kids are more likely to die. About half of the kids who die from a maltreatment fatality are an infant. And about 75-80% are under the age of four. So these are little kids who die; in general, it's little kids. And workers know that younger kids are more at risk.

Parent mental health is often cited as a risk factor, and workers know that. Parents who have inappropriate age expectations of their child. So this would be, for example, parents who ask a 3-year-old to supervise an 18-month-old in the bathtub. Okay? That's not a good plan, but some parents do this. And so parents who fall into this category; this is also a risk factor. And workers did know this.

But the areas where workers don't know, based on my research, is that more kids die from neglect than from physical abuse. That family members are most likely to be responsible for children's deaths. That mothers are most likely to be responsible for children's deaths, presumably because they do more caregiving. That parents who see their



child as being a difficult child, is having a behavioral problem, as being a struggle to parent, as a struggle to interact with; that that is a risk factor for fatality.

That having non-family members residing with the children in the home; that is a risk factor for fatality and workers didn't know that or didn't meet this 75% or above cut-off that I'm reporting on. And that being a mobile family. Families that just move a lot; that that is a risk factor for a fatality, and workers didn't know that.

Okay, if I would want workers to know any three things, I would want workers to know that little kids die, that kids die from neglect, and that moms are most likely responsible. And workers know one of those things, which is that little kids are most at risk.

I asked workers if they've ever had a parent tell them that he or she might kill their child, and over 25% said that that was the case. (slide 16) How many say that they worry that a child on their caseload will die? 72%. When I work with a family, I look for signs that might cause a child to die? 93%. And I would like additional information, if they'd already had training, about risk factors? The majority.

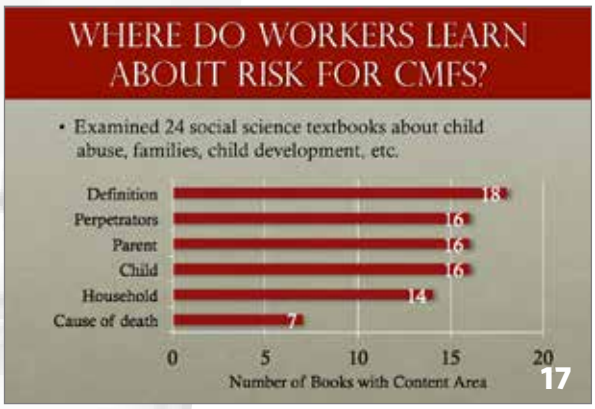
One of the things I should have said on the previous slide was I did ask workers how many of them had received some type of training at some point in their child welfare career, and 75% said that they had. But yet, those who had training did not have higher knowledge of risk factors.

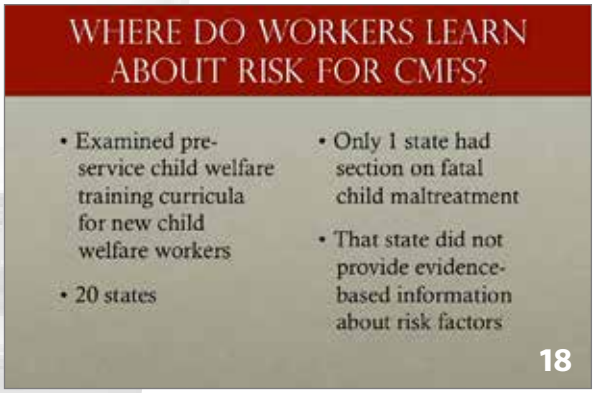
So this got me thinking about, so if workers don't appear to have a high level of knowledge, they want more training, it got me thinking so where is it that they are getting training? (slide 17) So with some colleagues, we gathered together 24 social science textbooks that were about child abuse, families, child development; the kinds of books that future child welfare workers and family support workers would read and would be assigned to. The types of courses that they would take.

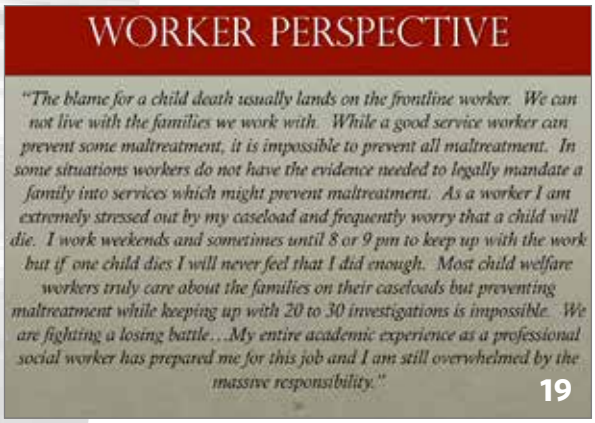
And out of those 24 books, we looked for did they define maltreatment fatality? Did they say who the perpetrators were? Who the child was? Who the parent was? Parent and child risk factors, household risk factors, and causes of death. And so we see that, well, so there's a fair amount of definitions; I'm not sure that that is always particularly useful, but it's of course good to start somewhere. But there isn't necessarily a lot of information that's going on around parent and child risk factors. And then when we get down to cause of death, it's very low.

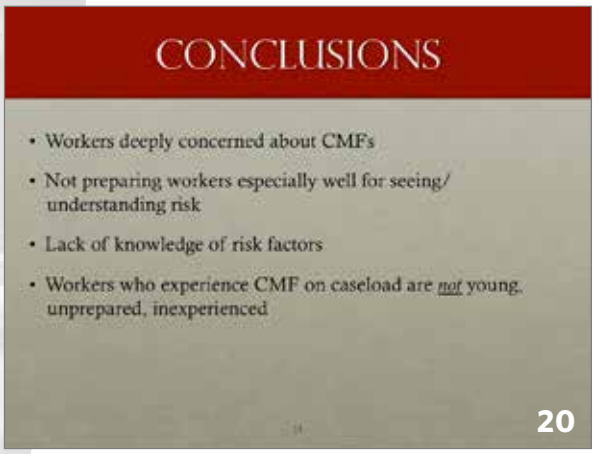
So then at the next phase, actually Melinda worked on this with me, your next speaker. And so we gathered together what's called pre-service training curriculum. (slide 18) So that's the training curricula that workers get before they go out into the field. And from 20 states — some of these were comprehensive curricula that we gathered, others it was just outlines is all that we could get our hands on. And we looked at how many of them include content around child maltreatment fatalities.

We found that only one state had an entire section that was dedicated to maltreatment fatalities. That is the State of Florida, which is in the middle of a major child welfare crisis with many, many children who were known to the system who have died. So what happened in that particular curricula is they just described the demographics of the kids in their state who died,









which is a little bit different than providing evidence-based information from the field about what are the risk factors for maltreatment fatalities.

And I would like to acknowledge that of course this is just the official information that's in the training curricula; what goes on in the sessions in terms of case examples that they bring in or questions that come from workers who are being trained, certainly discussions around maltreatment fatalities may be going on.

So before I move on to my conclusions and recommendations, I want to read to you a quote that was given to me by one of the workers who participated in my research. (slide 19) "The blame for a child's death usually lands on the frontline worker. We cannot live with the families we work with. While a good service worker can prevent some maltreatment, it is impossible to prevent all maltreatment. In some situations, workers do not have the evidence needed to legally mandate a family into services which might prevent maltreatment. As a worker, I am extremely stressed out by my caseload, and frequently worry that a child will die. I work weekends, and sometimes until 8:00 or 9:00 p.m. to keep up with the work. But if one child dies, I will feel that I never did enough. Most child welfare workers truly care about the families on their caseloads, but preventing maltreatment while keeping up with 20 to 30 investigations is impossible. We are fighting a losing battle. My entire academic experience as a professional social worker has prepared me for this job, and I am still overwhelmed by the massive responsibility."

So the conclusions here is that workers are deeply concerned about maltreatment fatalities. (slide 20) I'm not convinced that we are preparing workers especially well for seeing and understanding the risk factors for fatalities. Workers who experience a maltreatment fatality based on my research are not young, they are not inexperienced, and they are not unprepared for the work that they are doing. But there does seem to be a lack of knowledge of risk factors.

So my recommendations are that workers need to be trained in risk factors for fatalities. (slide 21) This needs to be a priority across the board from the legislative level all the way down to supervisors and frontline workers, and it needs to be a part of the daily work that they are doing. And of course, this is in keeping with other things like caseload size, and so forth. I really think that Massachusetts has an opportunity to be a leader in terms of taking a child maltreatment fatality lens to the work that they're doing.

This really from where I sit and where I stand and what I see is going on in the field. I don't really see that this is going on anywhere in other states, that they are taking maltreatment fatality issues and putting them on the front burner.

QUESTION AND ANSWER

Male: So I know that [Casey Bailwick] says the [inaudible], kind of differential responder. Do you think that because kids are now being kept with their biological parents, kind of minimum terms that are being provided, that that's precipitating this curve or increase of child maltreatment fatalities?

Emily Douglas: Well I mean, differential response is a relatively new phenomenon. And the trend line for kids dying from abuse and neglect has been going up for longer than differential response has been around.

And the number, the trend line going up, there's a lot of debate around whether actually more kids are dying or whether or not we're doing a better job of actually identifying kids who die as a result of abuse and neglect. The trend line is often driven by infant deaths, as opposed to older kids.

And we're also re-conceptualizing how we understand a maltreatment fatality. So in many states, an overlay that happens during co-sleeping that results in the death of a child; sometimes that's ruled neglect, in other states, it's not ruled neglect.

And things like substance use and so forth plays a role in whether or not that would be ruled. But thirty years ago, that would never have been ruled as a neglect-related fatality.

So I don't think that we can tie differential response directly to what's going around fatality, but it's a great question.

Female: [Inaudible] know your sample, I mean, value sample is you [inaudible] have a high number of people who have been involved in the child maltreatment fatalities.

Emily Douglas: Right. Yes. And of course it's more a sense, on any given year, it's at most, would be like 4-4.5%. So really I recruited folks, said this is a study about the child welfare profession and child maltreatment fatalities.

So undoubtedly, I probably collected people who were more interested in this topic. Of those who had experienced death on their caseload, 80% of them, it had happened in the past ten years, so a more recent event.

But I don't think that it really biases the results because if they were more interested, I almost feel like they would have done more reading and more schooling and perhaps their knowledge would have been higher.

Female: Was it national?

Emily Douglas: Yep, yep, right. And I recruited folks primarily through direct appeals to state child welfare directors. Yes.

Female: So I noticed in your group of folks who had experienced this, that they had had that family on their caseload for what I would consider a short amount of time; on average it was two months. So that would suggest that they didn't have a lot of it, for many of them, they didn't have a long-term based [appearance] with this family.

But I didn't see that as sort of part of your recommendation in terms of sort of long-term relationship, or more discussion around turnover, and staff retention. So I was just curious if that was sort of an element that you had [inaudible].

Emily Douglas: I actually haven't spent much time thinking about it. But it is, I mean it is — it's sort of an interesting issue. If it's around relationship building.

But I guess one of my thoughts is if the knowledge is there, or risk assessments are being done along the way, does how long a child has been on somebody's case necessarily matter. I'm not sure. I understand what you're saying around relationship building, and I'm not sure. I mean, do you have additional thoughts that I've just not…?

Female: Well I would just think that you, I mean, I'm not a [inaudible].

Emily Douglas: That's okay.

Female: You are. But I just think that you would have a much better ability to assess risk factors the longer that you had worked with a family.

Emily Douglas: Yes.

Female: And so that sort of short-term, to me, would suggest that the worker has less ability to.

Emily Douglas: Right. And that may absolutely be the case. I mean, sort of the flip side of that is, families are being — we hope families are being assessed at all of the points of time that they are involved with the system.

And so certainly risk assessments are done initially, which determines whether or not somebody is brought into the system in general.

Rep. Gloria Fox: …repeat that question for our specific group? We couldn't…

Emily Douglas: Okay.

Rep. Gloria Fox: I'm deaf in one ear, so I read lips as well.

Female: Oh okay. So I just asked the question about I noticed that in the group of social workers who had experienced a child maltreatment fatality, that that family had been on their caseload for on average only two months; so a very short period of time. And I was trying to understand what the relationship might be between a short tenure that they're working with the family, and a risk that was not prevented.

Emily Douglas: Right. But [inaudible] implications of that.

Female: Emily, remind me if workers are — there's investigative workers, and then there's family reunification workers, that some workers only have cases maybe for four to six weeks, so that could drop the mean down.

Because then you might get — I mean, you would, ideally it would be the longest period of time would be eighteen months, but the shortest period of time could be a couple of weeks, so that probably drives down the mean.

Emily Douglas: Yes. Thank you.

Rep. Gloria Fox: Isn't it also the fact that we have families that are in such crisis that if you have an inexperienced social worker, then that's like an accident waiting to happen.

Emily Douglas: Sure. But the research that I've done shows that workers…

Rep. Gloria Fox: I mean, that's what we thought. That they might not know the population. Once again, I have to go back to that [earth spin], all of that.

Emily Douglas: Mm-hm.

Rep. Gloria Fox: You didn't do any stats on race, but I'm sure that that's a factor, too. A reason why we're losing kids after they're on the system.

Before they're on the system, it's because there are so many parents that have not got the experience of parenting in crisis. And many, many young parents are in crisis.

Emily Douglas: Yes.

Rep. Gloria Fox: And can't deal with it.

Emily Douglas: Definitely. Yes.

Female: I just wanted to pick up on your point and make an additional plug for [inaudible] for the child to tell them you were [inaudible] for comprehensive child [inaudible] and youth program and pushing this in our annual report on child [inaudible] for many years now.

And to list and have that sub-group of child maltreatment fatalities within the context of how is that compared with what's happening with the kids, you know, in terms of child [inaudible] generally common [inaudible].

Emily Douglas: Right.

Female: Just like to make a pitch at this time when we really need to better look at it in our state. We're not doing so well here compared to other states.

Emily Douglas: And I can follow-up on your plug. And just to say that the child death review team model that has been used throughout the country has sort of really revolutionized how we look at fatal child maltreatment; how we look at child deaths in general.

But specifically kids who die as the result of abuse and neglect, it's been a major source of where we collect information, where we can understand risk factors.

In the National Center that comes out of Michigan that heads this up, they have a standard data collection tool now that is being widely used across the country that helps providers in the field and decision-makers to understand the barriers and the risk factors that family made.

And it really helps you to identify what were some of the potential gaps in services? What happened with this family? Where did we miss an opportunity to intervene and take protective action? Yeah. Yes.

Senate President Stan Rosenberg: Thank you very much for sharing [inaudible]. I was just curious, a few years ago, when we had a really terrible situation with DCF, and we had a spate of children die.

There was some data that's been — I think it was in [inaudible] that indicated a very disproportionate number of cases that were assigned to the people working in the field.

And is that from your conclusions, you're saying training is lacking. And I was wondering, is that a little high when you leverage investment for the legislature and the policy makers you had, or is it caseload?

Emily Douglas: Well it's not any one thing is the problem. I think, you know, you can give people training, but if they have, you know, if they have many higher caseloads, there isn't much of an opportunity to put that training into action on the ground.

And really the support that the frontline worker receives from the supervisor is so crucial to doing child welfare work. And but if I mean, I think one of the things that does happen in child welfare reform — because whenever a child dies who is known to the system, there's a crisis. And there's reform.

And there are a series of new recommendations that are unrolled, and it's so much for workers to take in. And really getting them to implement that every day on the ground is extremely difficult.

So I would love to say that if we could just give the workers this training, they'd be set to go. But it's part of a package of understanding that their caseloads are part of it, how much knowledge they have, what kind of support they're getting from their supervisor, and I wish I could give you a more simplistic answer, but I don't think there is a more simplistic answer.

But I do think that it's really important to know how; that there are limits in knowledge and that the answers are relatively complex, but workers need support. And they need good supervision to implement these things every day in the work that they're doing.

Female: I think the only clear [inaudible] policy and practice in general for children's welfare we can actually coincide as well.

So to get you back from two months issue and question, if you think about it, two months is not enough time to establish a relationship. And what many folks need to know, and do know, is that families and children are more forthcoming as they start to build a [inaudible] relationship.

So the two month time frame is in and of itself, you know, kind of imminent in getting that relationship established, [inaudible] do a true clinical risk assessment.

Emily Douglas: Yes.

Female: I just wanted to mention one more thing, picking up on the point about the social workers and what are the things that are either interfering with or getting in the way of their ability to do good work?

The legislature commissioned my office, the office of the Child Advocate, with a task that included conducting a survey of all the DCF employees. We will be filing that report with the legislature, making it available to the public by April 1st.

And that terrific response rates, it's 45% of DCF staff responded to the survey, they'd be offering data about caseloads, about training, about relationships with supervisors and managers.

And I think it's — we're putting the whole report out and available so that it will have a wealth of information for people to get a better understanding of what at least the DCF employees feel about their work and how they're going about it and what is healthy and where they need [inaudible].

Male: Do you think that a training — so like everybody always says [inaudible] many people like training, or education, that's going to help better?

But I almost feel like if you do more education, considering what the risk factors are, it may bias judgment as far as like being a frontline worker.

And so do you think [inaudible] need more of an issue would kind of create bias? And if so, like, how would that kind of affect a caseload?

Emily Douglas: So do you say create bias so that they are more likely to remove a child, do you mean, when they...?

I mean, I don't know. I mean, it would just be speculation on my part. I mean, the pendulum is always swinging in child welfare. A child dies in a birth home, and it swings toward removal. A child dies in foster care, swings toward family preservation.

You know, we hope that things can be more, you know, more stable. I mean, that's always the goal in child welfare. Would it create more bias? I don't know. I mean, I would like to see workers know some of the fundamental things about risk factors.

Perhaps it wouldn't necessarily mean more removals. It also could perhaps mean more services or more appropriate services for families. And it might move them from the differential response category into, you know, a more, you know, traditional services.

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I Wouldn't Want Your Job, But I Could Do It Better Than You: Walking the Tightrope of Child Welfare Practice

By Melinda Gushwa, Ph.D., LICSW | Rhode Island College School of Social Work

POLICY BRIEF

The last thirty years of research on the experiences of child welfare workers continues to paint a bleak picture. Over and over, child welfare workers report being overwhelmed by large caseloads, bureaucratic constraints, lack of support in the workplace, and vicarious traumatization, all of which contribute to turnover, burnout, and compromised practice.

NO MATTER HOW HARD THEY WORK, IT'S NOT ENOUGH

While DCF has recently hired hundreds of new staff, the workforce is still hemorrhaging, and gaps remain. Nationally, the average length of stay of child welfare workers is approximately two years, which coincides with the length of time it takes to become proficient in all the facets of child protection practice. Once they figure out how to do the job, many workers are out the door. Outside of the supervisory relationship (and that's no guarantee), workers are rarely applauded or given credit for their expertise, as the public's perception of their work rests on media coverage, which focuses the spotlight on system failures instead of successes.

THE ON-THE-JOB EXPERIENCE

In the wake of several high profile maltreatment fatalities, Massachusetts has placed primacy on workers meeting their monthly in-person contact obligations. But at what cost to workers? A recent national study of child protection workers' activities found that workers across the country spent only half of their allotted work hours in direct contact with children and families. What accounts for the rest of their time? Mostly, documentation (approximately 34%), travel, and preparation for/time in court.

With complex and high-need families, workers spend even more time traveling, more time in court, and more time documenting the multiple challenges facing children and their families. Given high caseloads and constantly changing policies, it becomes nearly impossible for workers to meet expectations, and they can find themselves working off the clock to stem the tide, or delaying much-needed vacations to keep on top of their work—thus exacerbating burnout and job dissatisfaction.

THE TYPICAL ANSWERS... MAY NOT BE THE RIGHT ANSWERS

Typically, agencies respond to system challenges by initiating policy and practice reforms, and implementing training programs for workers to learn about the changes in policy and practice. These seem like logical responses, but these solutions tend to create the conditions that overwhelm workers: increased bureaucratic requirements and time away from meeting with children and families.

Of course, policy updates, practice reforms and training are essential to keep pace with best practices in the field. Yet, how much do administrators and managers really know about the daily struggles of child welfare workers and their equally overburdened supervisors? One look at an overwhelmed, disenfranchised child welfare worker validates all that the research tells us about the bleakness and staggering responsibility of the work. We need to work harder to create conditions where workers are valued and respected by their agencies and their communities.

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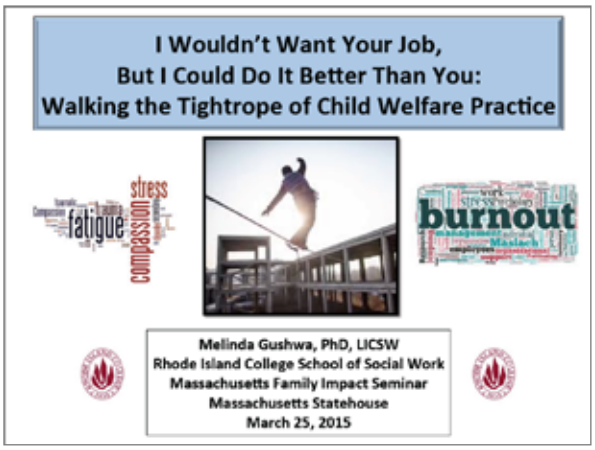
Melinda Gushwa, Ph.D., LICSW, is an Assistant Professor at the Rhode Island College School of Social Work. She has over 20 years of practice experience in the areas of public child welfare, psychotherapy, mental health case management, medical social work, child welfare training, research and education. Her research interests center on child welfare workforce issues, child welfare training, and child welfare practice. Dr. Gushwa regularly provides training to child welfare professionals in all regions of the country, and formerly worked as a full-time trainer at the University of Nevada, Las Vegas School of Social Work. Dr. Gushwa worked for more than five years as a public child welfare worker, did investigations and family reunification, has spent several years as a pediatric emergency room medical social worker with a specialization in forensic child abuse. She continues to remain active as a social work practitioner, currently psychotherapeutic services to consumers with chronic mental illness at community mental health agency.

TRANSCRIPT OF DR. GUSHWA'S TALK



So the title of my presentation comes from my years in Southern California and San Bernardino County, which is the largest county by area in the United States. And at the time that I was working there, it had the most profound methamphetamine problem in the United States, and we had the highest rate of removal without return in the country.

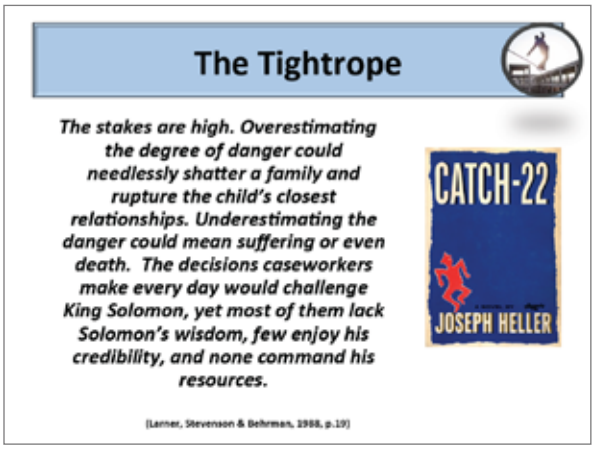
So, "I wouldn't want your job," was what people, when I would be on airplanes; you know you have that conversation, "What do you do?" "I'm a Child Abuse Investigator." The head nod. "Oh, oh I wouldn't want your job. I don't know how you could do it."

The truth is that I loved my work with families. I was just thinking earlier, like what was my greatest moment? And one day — I'd worked with a lot of little boys who had ADHD, and it was really hard to sit down and just talk to them because you can't. And so this one kid, he was about seven, and we would play basketball. And oftentimes, I'd come from court, and I'd say, "Well let's go play basketball." And he'd say, "You can't, because you're in your fancy clothes." And I'd say, "That's okay." And so we'd go out and play basketball, and I would always try to Michael Jordan and fail spectacularly at that.

Then one day, he just looked at me and he goes, "You know what? You're not bad for a white lady." And I thought, this may be the greatest moment of my life, and there were lots of moments like that.

There were great moments where you're working with people at their lowest, at their most vulnerable. At that time, there was more budget available to wrap people in services and make sure that they could go from seeing parenting as an obligation to seeing parenting as something more than that, which is remarkable in those moments.

But then there's that flip side of seeing the worst things that people could do to each other, that you could never imagine that people do. And they do. And that was more tolerable sometimes than all the other things that get in the way of being able to do good work, which had to do with the volume of caseload, the time spent in court, dealing with angry people — oftentimes not the clients or the parents, but other people involved in the system.



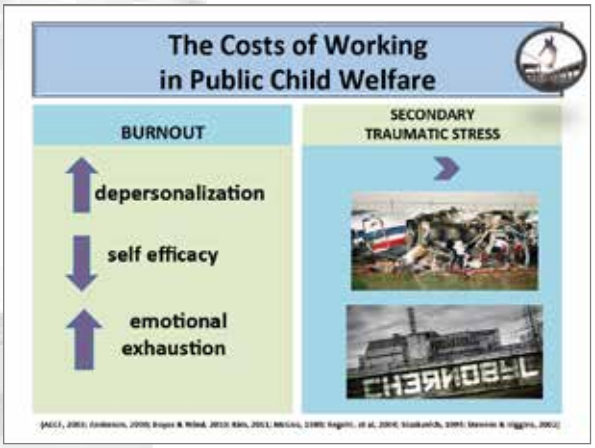
It was incredibly pressure-filled. So that's kind of the story that I want to tell you today. And the "But I Could Do it Better Than You" comes from child welfare workers, the work that they do doesn't get good press. Because a lot of it is related — we can't talk to people about what we do because of confidentiality. But oftentimes, people who would never want our job are able to say, "Well, you know what, I wouldn't have done it that way. You did it wrong." And so there's this huge catch-22 that is involved in this job.

My dissertation was on issues of organizational support, climate, and culture and the impact it had on workers' willingness to implement practice reforms, the best and new practice as we change and grow and develop.

And I read this quote, and I think it really highlights the catch-22 of this work. That the stakes are high. Overestimating the degree of danger could needlessly shatter a family and rupture the child's closest relationships. Underestimating the danger could mean suffering, or even death. The decisions caseworkers make every day would challenge King Solomon, yet most of them lack Solomon's wisdom, yet few enjoy his credibility, and none command his resources.

And I can say that even on your best day, you're feeling the weight of that all of the time. And it's exhausting. It's not an easy job. It's an incredibly complex job. And workers, there's consequences and costs to taking on this job.

When we look at the research on burnout among the helping professions, there's high rates of burnout among all of them. But if you look at just the child welfare workforce, particularly the public child welfare workforce, we see inordinately high rates of burnout.



And burnout is composed of three categories. Depersonalization is when you stop seeing clients as people, and you just sort of see them as case numbers, or stacks of files. We see research that there's high rates of depersonalization among the child welfare workforce, low rates of self-efficacy; and self-efficacy is essentially that sense of "I can do this."

And the irony of this is that's what we're supposed to be transmitting to our parents that we're working with, and the kids that we're working with is, "I can do this." But if you feel like you can't yourself, it's very difficult to translate that to families.

And high rates of emotional exhaustion, and that's just essentially the work sucking the life out of you. And not having regeneration to start the next day, or after the weekend come back Monday and go, "I'm ready."

And then there's also this piece of secondary traumatic stress and compassion fatigue. Compassion fatigue is just that general sense of the work weighing you down and tiring you. Secondary traumatic stress involves taking on the experiences that you see, and in a way, incorporating them and folding them into your own life.

So this is when workers will have nightmares about the abuse that they have experienced, or they'll have nightmares that they themselves are the victims of the abuse. They become, in a way, the kids that they're working to protect.

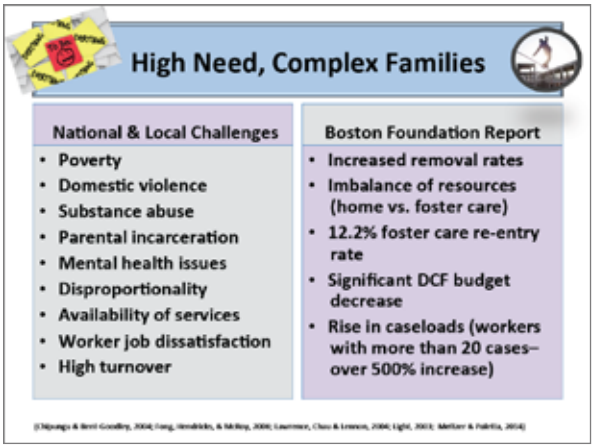
And there's, again, lots of studies in the field of helping that says that this rate is high, but when you look at public child welfare workers in particular, there are astronomical rates of secondary traumatic stress. Everybody has it — when we look at national studies, everybody has it.

Fifty percent of workers have what are known as clinically high rates, and 25% of workers have extremely high rates of secondary traumatic stress. And these pictures here are a representation of one of the best studies I've ever read on the experiences of workers and the measurement of secondary traumatic stress, from a social worker who did a dissertation out of Louisiana State, and she found in a widespread study of secondary traumatic stress that child protective workers experience secondary traumatic stress at greater and more intense rates than people who have survived plane crashes. Think about that. I mean, think about what happens if you survive a plane crash.

But in my mind what I think about is that is a horrific experience; it happens once. But for child welfare workers, it happens every single day. That's why the figures are so much higher. And the other is that child welfare workers experience secondary traumatic stress at greater rates than survivors of nuclear accidents. And that's the photo of Chernobyl there. Think about that as well. Because those accidents involve not only medical, mental health outcomes, but also environmental; lack of safety in the environment. And this is again similar to what child welfare workers experience.

So when I look at these; when I read these figures, I'm like, why does anyone go into this, you know? And when people say, "How could you do that?" I often say it's the best work you can ever do. Because again, there's great rewards in the work.

And when we look at the research that says why do people stay? It's not the money, or the benefits. You know, sometimes, that's what you'll hear. Well, state workers and, you know, they have a union, they get a lot of good things. The number one reason why people stay is the mission; that they are connected to the mission of doing the work and doing what's right for kids.



What we know in the 21st Century, 2015, is that cases that our workers are getting are more and more high-need, and more and more hot and complex issues. And so national and local challenges, poverty, if we could eradicate poverty in the United States, we could probably eradicate almost all neglect and most child abuse; most physical and sexual abuse.

High rates of domestic violence, families that are struggling with substance abuse, lots of parents particularly in Massachusetts who are incarcerated; widespread mental health issues from generations — grandparents, parents, and their kids.

Disproportionality. Every state in the United States has a disproportionate representation of minority youth in the foster care system, and then we also have disproportionality in terms of the workforce. Our workforce does not reflect the kids and the families that they're working with.

There's a paucity of services. You know, when hard times fall upon us, the first things that get cut are services to the most vulnerable folks. And there's also quality services. You know, when I thought about when I used to refer families for family therapy, I had a list of a hundred people, but I would only refer to five because those were the workers or the therapists that I knew would be able to do good work and connect. So there's availability, but then there's also quality.

Worker job dissatisfaction is very high. And again, generally it's not about the working with families. It's about the bureaucratic issues that they're experiencing, and high turnover. You know that there were over 300 workers hired recently, but then about 180 left. We can't keep up with the demand.

The recent publication of the Boston Foundation Report really focused on issues local in Massachusetts that are of almost crisis proportions. Increased removal rates. There's an imbalance of resources when kids stay in their own homes versus foster care, kids will get more services in foster care than they will in home.

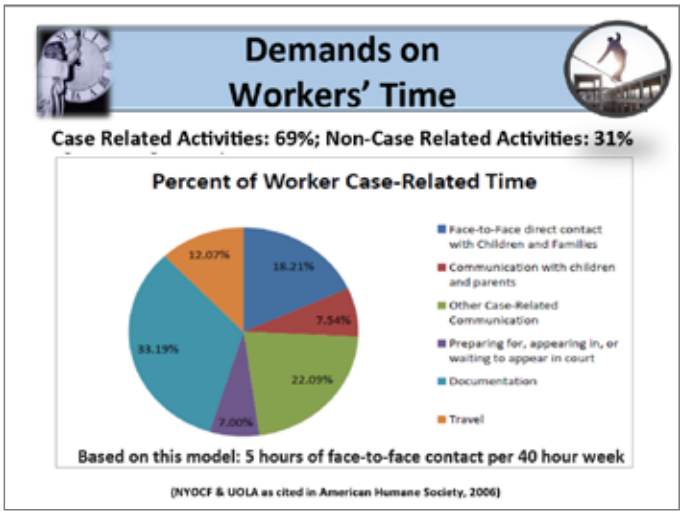
And we know from Emily's research that kids in their — people that they're related to in their own homes pose the greatest risk. There's a 12.2 foster care re-entry rate, which is higher than the national standard of cases being closed and then kids coming back into the system and going back into foster care.

As you know, a significant budget decrease and a massive rise in caseloads. Workers here with more than 20 cases, which is still over the Child Welfare League of America standard; there's been a 500% increase recently in Massachusetts.

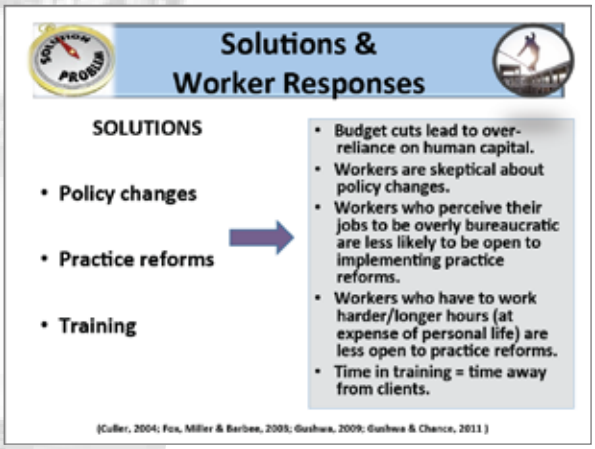
And I have been spending some time speaking with supervisors and workers in DCF, and so I'll share with you along the way some of my experiences and how this plays out in the real world of their work.

But I want to share with you what a worker's day, week, or month looks like. In studies that do time studies, which I remember these. We used to have 5-minute timed studies when I was a worker, where we would have to account for every five minutes that we spent. And there was no place on the time study to put the amount of time spent on the time study.

And then one day, we got a one-minute time study, and I just — I was beside myself. And so my supervisor said, "We'll just do it all at a meeting one day." And we all put the same amount of time. And as a researcher, that kills me. But at the time, it was like, are you kidding me, right?



But in terms of the breakdown, workers are spending just about 70% of their time actually on case-related activities, and the other 30% on non-case related activities. That is dealing with administrative meetings, going to training, and other non-case-related activities.



But in terms of the time that they're working? The 18.21%, up to the top right, that's face-to-face time, right? Face-to-face time with kids and their families. That breaks down to five hours of face-to-face contact per 40-hour work week.

And when you think about what was on the other slide, about how high-need families are? Five hours total to possibly see 30-40 kids and parents, sometimes higher. It's not enough time to be able to adequately assess for the kinds of risk, especially if you're looking through a fatality lens that one would need.

So the fact that we're able to protect any kids from harm is pretty amazing, given the miniscule amount of time that workers are out there in the field actually communicating directly with kids and families. And this is investigation, and it's also ongoing time — workers who do ongoing work with families.

So there are typical solutions when things go wrong, when things aren't going as we would like in the child welfare system. And one of them is policy changes, which is a good idea: let's change the policy so that we can then roll that into practice that better meets the needs or fill these gaps. Practice reforms and training.

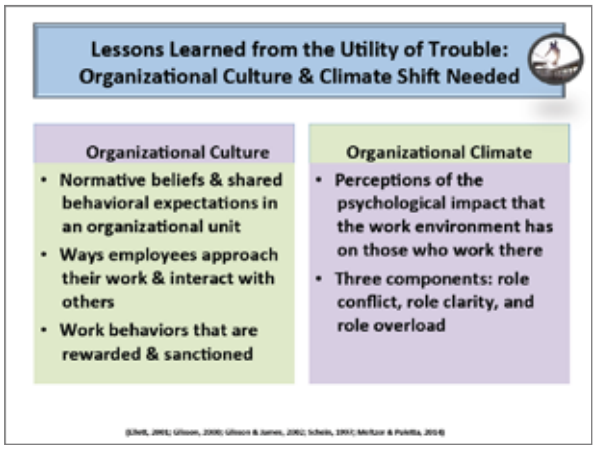
But here's the thing. Budget cuts lead to an over-reliance on human capital. So we're relying on the humans that are doing this work more than ever. And again, the more workers are pressed into service to give more than less, it doesn't really work.

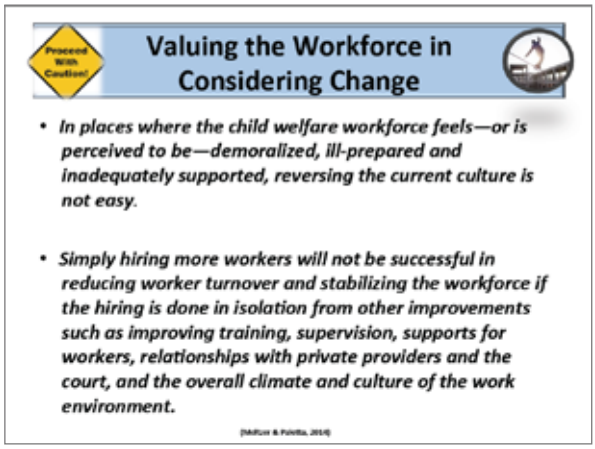
Workers are skeptical about policy changes. They'll revolt when they get five or six policy changes a week and no rationale as to why. In my research of over 400 child welfare workers, what I found is that workers who see their jobs as overly bureaucratic without much explanation, they're less likely to implement the new and the best practice.

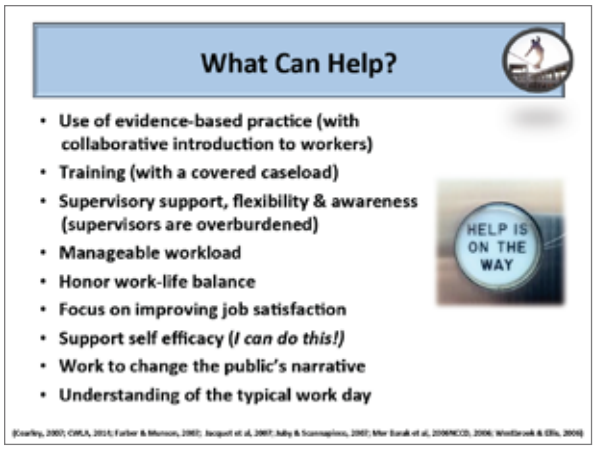
And workers have to work long hours at the expense of their personal lives, they aren't that inclined to implement practice reform. And time in training equals time away from clients. Training is a good idea, but I've never done a training with people who have been in the field where they haven't been pulled away five, six times in a six-hour training, to deal with caseload issues.

And if you only remember 6-8% of what you hear in a six-hour training, that number gets cut and cut and cut. So the training has to be given in a way that people can actually have caseload protection, and focus on the training.

So, the utility of trouble reported out of the Boston Foundation said there needs to be shifts in organizational climate and culture, that workers need to work in places where they feel support and they feel engaged and valued and respected. And hiring more workers won't help if you







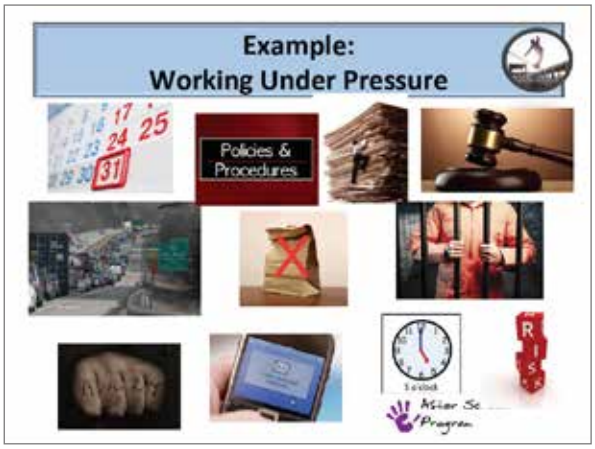
bring them into the same system that doesn't necessarily value them or honor them or honor their struggle. And so we need to work from that perspective.

And so what can help? Use of evidence-based practice, but workers that I've talked to said they need to know why. Why is it good practice? Explain to me; tell me more about it — versus sort of throwing it at me, and they'll be more inclined to want to do it.

Training with caseload coverage. Supervisory support. As supervisors go, so go workers. Supervisors are equally overburdened because they're managing all of these workers who are way over caseload. And when you think about what one person has responsibility for, it's impossible.

Manageable workload. The CWLA standards are there for a reason, and they have to be implemented if you want safer kids in Massachusetts. Honoring the lives of workers. Focusing on job satisfaction. Supporting their self-efficacy. And working to change the public's narrative about what they believe about child welfare workers and what they do, which is going to take some media work. And understanding the typical workday.

So I'm going to close out here with an example of what workers might go through. Let's say it's the end of the month, and you're an investigator, and you've saved your low-risk cases, or your seemingly low-risk cases, for the end of the month because you've done all of your higher risk ones previously.



But on the day that you started, there were four new policies and procedures you had to read before you could get off in the field. So you have to, you know, you're climbing up your pile of cases because you're over caseload.

At the last minute you get called into court. You go to court for two hours, and you never actually get called to testify. But you had these four families that you had to see at the beginning of the day — you get caught in traffic on the Mass Pike. Workers are spending sometimes upwards of 21% of their time travelling.

You don't get to eat lunch because you never do. You go to prison to visit a dad. While you're checking in, there's some issue. It takes you one hour just to actually check in and see the dad. The dad is angry. You have to talk him off the ledge while you're there; it takes longer than you think.

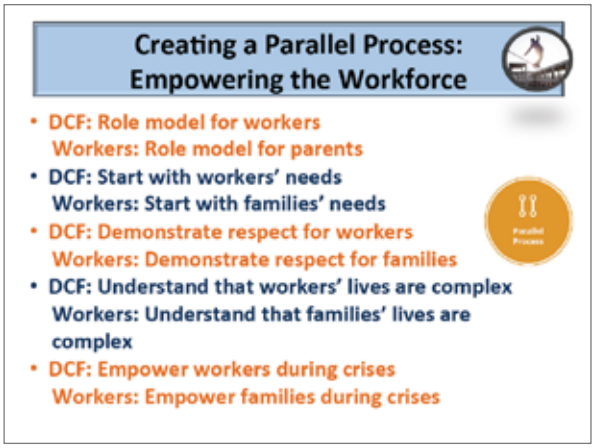
Meanwhile, you're getting massive cell phone messages, texts, from your supervisor, from other families, from collateral contacts that you have to respond to, otherwise it explodes. Sometimes workers report they'll go away for four hours, they'll come back, and they'll have 150 emails.

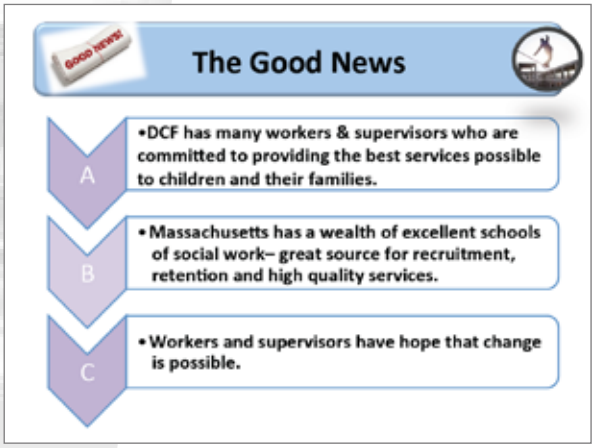
Meanwhile, it's 5:00, and you have to get your own kid back from daycare. And you manage to get to your last assessment, which is low-risk. And the family seems to be doing okay. They're getting along. They seem like they love each other. This is good. You focus on the strengths. But you're so tired and exhausted that you miss some of the risk factors that you would not have if you weren't in this position.

So I think it's important that we understand, this is the lives of workers. And very few people say, hey, sign me up for that. But that's what they're dealing with. And we need to have a parallel process where DCF managers and administrators in particular are role modeling for their supervisors and their supervisors can role model the practice behaviors for these workers.

The three core helping conditions of social work are genuineness, empathy, and respect. And that's what we're supposed to be demonstrating to families, even families that hurt their children or harm their children. But if you're not getting genuineness, empathy, and respect in the workplace, it seems odd that the expectation is that you will demonstrate that all of the time. There really is a parallel process there.

There's good news in Massachusetts, though. In my communication with workers and services, they want to be able to take best practice and implement it. They want to. They really are eager. They just need to know more. And they need to not be so burdened with other things that take away from being able to implement and spending five quality hours a month with their clients.





Massachusetts is a wealth of recruiting for future child welfare workers. We have some of the greatest social work programs in the country. Research indicates that workers with Master's Degrees — their kids spend up to five months less in foster care than workers without Master's Degrees in Social Work. So they're a great resource.

And workers and supervisors have hope that things will change. So there's good news. There's opportunity. But hopefully you'll come away sort of with a better understanding of the lived experience of child welfare workers in this state.

QUESTION AND ANSWER

Female: I just kind of have a comment on [inaudible] also with child welfare recommendation, they talk about secondary trauma with social workers, yet but just as a foster parent in the system, I haven't seen a lot of like look at the secondary trauma for foster parents, yet their work is very similar, obviously. And so this, you know, it's good to think about how this is [inaudible] for social workers, also all players who are supporting kids.

Melinda Gushwa: I absolutely agree with you. Because all the effort is spent on, you know, service to providers and clients. And self-care is the last thing, generally, that people think about. But when you look at it this way, without self-care, we're going to continue to have the same issues. So as the child welfare workers go, so do the foster parents. I think there's a parallel there. Yes.

Male: So I understand like a secondary trauma, like some social workers vote, like [inaudible] syndrome, help avoid shifts and [inaudible]. So like here is one practical thing for self-care that a policy maker can do. Like what can they implement? So there's like one practical thing a policy can do...

Melinda Gushwa: It's one thing with a three-pronged approach. So one would be — what the research shows is that the greatest impact on self-care is when supervisors create opportunities to give workers free time.

So there's lots of studies out there. Supervisors that go up to a worker and say, "Hey, you're really, really having a tough time today. Here's what I want you to do. I want you to go home. And I want you to go home to your family. And I want you to enjoy the rest of the afternoon. And I'm gonna take care of what's going on in your caseload. And I don't want you to call me, and I don't want you to — I'm gonna do that for you."

Those are the things when workers report about job satisfaction and well-being, that's the thing. But that can't be done if everybody in the unit is way over caseload, which means the supervisor is way over caseload, which means the supervisor has many mandates from the next rung up of management.

But those are the things that workers report are the most helpful in terms of job satisfaction and well-being is when they get opportunities like that. The other thing is when they get opportunities to commune as a unit without having to deal with work.

So, it's things like supervisors who have bowling nights, or nights out for workers; or who will take a Wednesday and have everyone go to the park and do something like that. You know, and you might cringe, and go, oh, how — times are hard, how are we paying people to have a picnic? But these are the things that work. They're in a way human capital solutions. But they can't be done unless everyone is well in the system.

Male: I think we all understand that the caseload issue is very real, but you also mentioned that it's not really effective to just throw people into a system that is broken or damaged or needs repair. Do you feel that one needs to take place before the other, or does it need to be at the same time?

Melinda Gushwa: Well I think in my experience as having been both a worker and a trainer, and then someone who sort of takes a look and researches this, is that from that perspective, the biggest challenge we have is around organizational culture and climate of training new workers to best practice. Because it's the new workers — I use the word seasoned as non-new workers and one of my friends used to call them dinosaurs. I'm like that's not very nice. But when you train new workers into best practice, and they're sort of in this bubble of, "Hey, this is the best thing." And then they go out in the field. And there are workers who have been there a long time, and sort of, you know, dissatisfied and we know why that happens, and supervisors that are overwhelmed.

And so the opportunity to engage in the new best practice that's being trained — it doesn't take in the field. And so shortcuts happen, and things fall apart. So I think; and the responsibility often falls on the workers. You know, well let's train them and you know, we'll train the workers.

But I think there needs to be systems change, from administrators — I mean, and this is a great time because the new Commissioner is from the Child Welfare League of America, which is the most comprehensive and worker- and family-empowering institution in our country. That the administration needs to see their role as providing support and well-being for families and workers. They need to pass that down to managers, down to supervisors, and workers so then we're training workers to what's new and what's best.

The entire system embraces the model.

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Collaboration, Communication and Data-Informed Decision-Making: Fostering Systemic Quality Improvements

By Martha J. Henry, Ph.D., President | MJ Henry & Associates, Inc.

POLICY BRIEF

Child welfare is one of our most complex social issues, and one that requires a significant investment from public and private human services and our communities. Often at its root are other complex social issues, including poverty, mental health difficulties, domestic violence, substance abuse, and homelessness.

Having a comprehensive understanding of the functional needs and strengths of the children, youth, and families served by state child welfare is fundamental to informing effective policy and practice, and investing our resources justly. The sheer complexity of the work requires a consistent, standardized measurement that can be communicated simply and effectively across multiple stakeholders. Data resulting from individual assessments must be meaningful to the decision-making process at each level of the system.

Socially complex problems involve multiple stakeholders who often have competing agendas and finite resources. Families involved with the Department of Children and Families frequently also have involvement with multiple service divisions within the state, e.g., court, mental health, education systems, transitional assistance, etc. Conflict is a natural result of well-intentioned stakeholders working with the same clients but who may have differing perspectives.

Conflict resolution requires collaboration, not merely cooperation. At the core of social work is managing conflict and acting as consultants for client transformation. Managing conflict requires creating and communicating a shared vision. In order to offer families services that will be useful in transforming their lives, the services must be tailored to their needs and be informed by a shared understanding of the problems, strengths, resources, and goals.

This shared vision keeps the focus on children, youth, and families to identify effective services, better manage care, and maximize resources. Collaboration among professionals and families is essential to determine effective and ineffective practices at both the individual and system levels. This practice efficiently addresses families' needs and allows for continuous quality improvement that increases effective practices while phasing out ineffective ones.

Collaboration is considered one of the most successful approaches to addressing complex social problems (Keast, et al., 2004). Fundamentally, collaboration is grounded in trusting relationships, effective communication, multiple perspectives, employing collective skills and resources, and developing a shared vision. A trusting relationship allows for information sharing between team members, which includes the family, leading to both shared responsibility and shared accountability. Shared accountability incentivizes the team members to collaborate for quality improvements.

Using an evidence-based assessment — with communication as measurement (i.e., Communimetrics) — that is based on a philosophical framework of Transformational Collaborative Outcomes Management (Lyons, 2009) can provide meaningful data for quality improvements. This approach ensures that:

- families are full partners in the collaborative work;
- the focus is on child and family health, well-being, and functioning;
- measures used are relevant to decisions about approach or proposed impact of interventions; and
- the functional information about children, youth, and families are used in all aspects of managing the system, from individual family planning to supervision, program, and system operations.

Grounded in this framework, a variety of functional assessments for youth, families, and adults (e.g., CANS, FAST, ANSA) has been developed to support quality improvement initiatives within public human services across the United States and Canada.

Data about families' functional needs and strengths can be a rich source of information for multilevel decision-making, progress monitoring, and quality improvement activities. Understanding what is effective for children, youth, and families to achieve better outcomes is fundamental to making systemic improvements.

This requires using standardized data that is meaningful to care planning, workload management, supervision, program improvements, parent and professional development needs, best practice sharing, and system-level resource management. Having a consistent metric for decision-making at multiple levels of the system promotes collaboration, a shared understanding, and responsibility for quality improvement.

We must keep the "human" in human services and build strong relationships with clients and collaborators while moderating human error and bias with an evidence-based assessment. Families who are successful in child welfare services become so because of trusting relationships with providers (Lee and Ayón, 2004). The system must be driven by the demonstrated needs of children, youth, and families, so that all stakeholders can collaborate to ensure that policy, practice, and resources can be matched and appropriately invested to best serve our most vulnerable citizens in need.

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Martha J. Henry, Ph.D. is a developmental psychologist and the President of MJ Henry & Associates. MJ Henry & Associates is a practice-based education consultation firm that specializes in collaborating with individuals, organizations, and state agencies working to support children, youth, and families, especially those who've experienced adversity. In addition to expertise in adoption and foster care, Dr. Henry is nationally recognized for her expertise with the strategic implementation, training, coaching, and practice of communimetrics to foster data and inform decision-making and quality improvement for both child welfare and mental health systems.

TRANSCRIPT OF DR. HENRY'S TALK

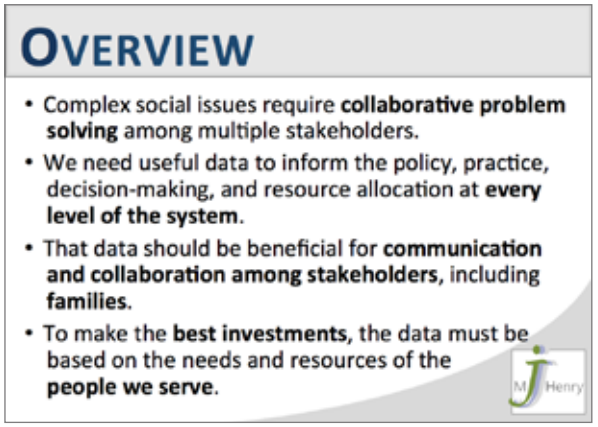
I appreciate the opportunity to meet with you all today. I'm slightly different in that I'm not sitting in an academic position. So a lot of my time is spent taking the amazing work that both Emily and Melinda do, and translating to frontline workers, to system administrators.

So I feel very fortunate that I spend a lot of my time in front of people who are doing the work every single day. And then I get to spend the rest of my time in front of their bosses, who are trying to say, "How do we make this work? I don't have any money. Our system's broken, too." And I get to go all over the country to be able to do that.

So I'm very excited to talk about that work and maybe offer a different perspective of how we go higher up to think about how we can support all the people in our system.

So we're going to talk about — you've heard already, this is complex work. This is really hard work. These are complex, social problems no one division can handle. No one worker can handle it. So we really need to be thinking about a collaborative approach.

To be able to collaborate with multiple stakeholders, and in that I include children, youth, and families. They are part of that stakeholder team. Their voices have value, even if we don't always agree with the way they're parenting their children. They oftentimes know their families better than we could ever know them. So how do we engage them in the process early and often so that we can all really work together and feel some more of a level playing field?



We have to have useful data to inform our policy, our practice, and day-to-day decision making. And I would argue that that data should be the same — Melinda talked about the percentage. What was the percentage for documentation? Pretty high, right? A lot of their time is spent doing documentation.

So how do we streamline the work and the documentation? And how do we make sure that the documentation that we provide is something that can be easily understood at every level of the system? And that we're using the same information at every level of the system to make the decisions that need to be made, at that level — the frontline worker working directly with the family?

A supervisor — I think supervisors are the lynch pin, right? They are the people that are really supporting that frontline staff, and then trying to deal with the policies and mandates that are coming down from above.

So we really need to offer supervisors a way to best and quickly understand the caseloads that their staff are working with. And then using that same kind of information at other levels of the systems so that we create transparency within the system.

So the decisions are being made based on the people we serve, not off competing agendas, not my budget - your budget. Do you have room for that kid, do I have room? But what are the needs and the resources of the families that we serve?

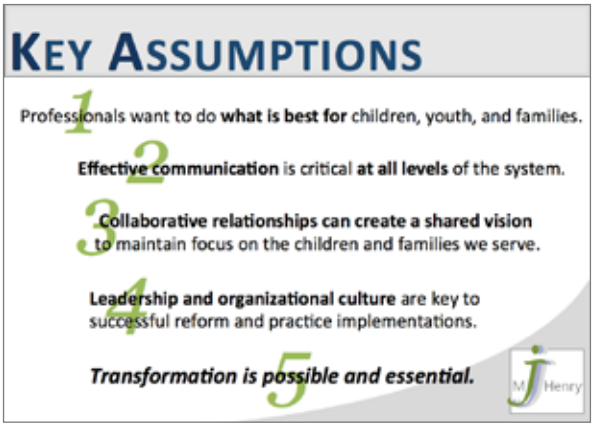
And until we truly understand their needs and strengths, it's going to be really difficult to figure out where we can tinker with the system because there are really effective practices in our system here in Massachusetts. There are some amazing social workers out there who do show up every single day, even though nobody else wants their job. They're not at cocktail parties and people are like, "Ooh, what a great job you have. Tell me all about it." They're not driving fancy cars. They don't go on fancy vacations. They really are doing really difficult work. So how do we make sure that we support them?

So I want to talk about how can we create a data information system that helps both communication and collaboration among all of these stakeholders? And like I said, I have the opportunity in my work to meet directly with folks who do this work every single day. And they will step out of a training multiple times because they have to; because there's a crisis. Sometimes they don't get to come back because they had to go manage that crisis.

So I'm an educator by my passion. I think that training and education are critical, but I don't think they're enough. And I think that supervisory role, the role of a coach, is really an important role that we should start thinking about.

And we want to figure out where to spend our money, right? Because that is part of our problem: how do we make the investments that are the best investments for the families of the Commonwealth? We have to be able to base that information on the needs and the resources of the people we serve.

So I always like to, whenever I talk to anybody, I like to tell people what I believe, because I've been caught in a few situations where the assumptions that people take about what I've said are inaccurate. So I always like to start with, this is what I believe, so you know right up front what I'm thinking.



I think providers are trying to do the very best they can for children, youth, and families. And I mean both public and private providers. In Massachusetts – many of you may know some of these folks – we have private clinicians out in the communities working with our children and families who are involved with DCF.

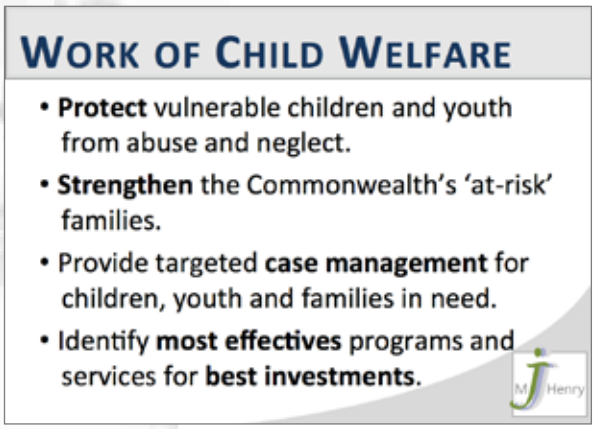
So it's not just the public system; it's also the private system that we want to talk about. I think we have to be able to effectively and transparently communicate at every level of the system if we're going to move the system forward, and really make the right investments.

I believe that collaborative relationships create shared vision. And I'll talk to you about what I mean. But essentially, when we have complex problem-solving, anybody who's at the table has to come to agreement on what is the problem. What are the sort of connections to that problem? What are the sources of those problems? And what are some solutions? What do we have that works in our system? And what is not working? And then, what are solutions that we can collectively agree upon? Anybody who's ever sat at a project management table knows exactly what I'm talking about. That we have a whole industry of folks who bring people together to get along on teams so that we can get projects done and do them in a timely, efficient way.

I really believe that leadership and organizational culture are critical to successful implementations of new practice, or practices that we know are effective, as well as any kind of reform.

So it has to be the right climate, and the right culture, and people want to feel like they get up every day because we're all trying to get to the same page.

And then I believe that transformation is possible. I believe it's possible for individual youth. I believe it's possible for individual families. And I absolutely believe it's possible for our system.



So if we have these ideas in our head, let's talk about how we can get to a better place than where we are today.

Both Emily and Melinda have done a nice job talking about how hard the work is. This is what we expect from child welfare in any state, but particularly here in Massachusetts. We want to make sure that our vulnerable children and youth are protected from abuse and neglect.

We have a mandate in this state to make sure that we strengthen families that are at-risk, right? So we do both foster care and adoption, but we also do a tremendous amount of family support services, so that we can keep children in their families of origin and wrap services around those families so they can be more successful.

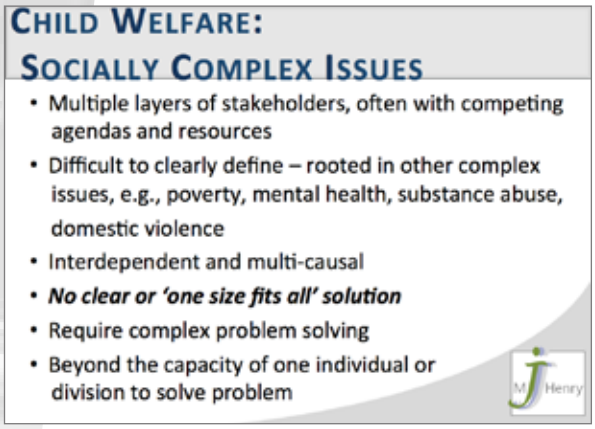
We heard lots of stories this morning from folks here about what it was like to live in that system. I always like to remind folks of the social assets that allow me to stand here in front of you today. My education, my extended family. I have three children. Both my parents are retired and are caring for a five-month-old at home while I can stand here today. If I didn't have that, I would have to go find a really good child care provider, and then find the money to pay for that. I have a tremendous amount of social assets, and I grew up in a very blue-collar, working-class family. And I've had a lot of opportunities that have presented to me along the way that get me here today.

Those are my team. Those are the people who are helping me problem-solve. They're my collaborative relationships. Part of our job in child welfare is to create that structure for families so that hopefully they can build those skills and knowledge and resources so when they meet life's challenges, they can handle them better. Right?

We are always going to need a system like a child welfare system. We are never going to solve all those problems. But how do we work together to strengthen those families along the way?

Our folks in child welfare provide targeted case management. A lot of times, they're not able to provide the direct service. They must rely on partners in the community, or other collaborators, to make sure there are quality services that we're bringing kids and families to. To make sure that they're in the right place; that families have even the transportation to be able to get to that service.

So we want to make sure that those folks have the information they need to do that case management, because a lot of times, what they're recommending is out of their control. And they can't make families do those things.



For those of you who've worked in the field of child welfare, sometimes we say mandated services equals malicious compliance. So how do we move a system from malicious compliance into collaboration? And how do we figure out what works best? How do we spend our money on what works best and start to phase out the things that are not effective?

So we all know this. These are socially complex issues. We have lots of layers of stakeholders. And oftentimes, our families are involved in multiple places in our system. And those places are not always in agreement. They often have competing agendas. She needs to do this over here. She needs to do this over here. Yeah, well, she also needs to do this, this, and this, and families are stuck in the middle of how do I meet all of these mandates.

And we all have different resources. It's complex. It's rooted in poverty, and substance abuse, and domestic violence, and mental health. We have divisions in this state that address lots of those issues. So this cannot be just a child welfare solution. Reform cannot just be about this one department. And if we just fix this department, then we'll have better outcomes for kids and families. It's so much bigger than that.

And if you talk to families, they'll say, "I can't meet with you that day because I have to go meet with my probation officer." Or, "I have to go into Worcester to do community service, from Southbridge, and I got to figure out how I get there." And whether that's really the best for families.

So really acknowledging what we ask families to do; to be able to either retain their parental rights and have their children in their families, or to be able to bring them back to their families.

And then of course there are always going to be children for whom they are not able to return to their families, so how do we strengthen our foster care system? I meet a lot of people who say, "Oh I wouldn't want to do that work." And they'll say to me, "Oh, if we could just get them away from their parents, that would solve the problem." And I always say, "And then where are sending them?"

Because we don't have enough resources to just say, "Oh, you're not good enough? You're not doing it the way we think you should be doing it? Well we'll take your kids away and put them over here." We already know that doesn't work.

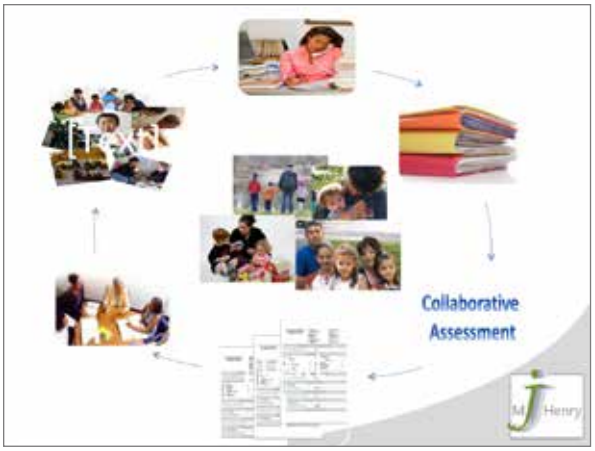
And we have — the fatalities are terrible, but we have hundreds of children in this state who age out, and don't have anywhere to go. To help pay their college bills, or to get a ride to work when their car breaks down. So I want to make sure that we're really acknowledging the complexity in the whole system.

There's no one size fits all, because if there was, we wouldn't be here today. We would have figured this out twenty, thirty years ago. And we can't just put it on one individual, or even one division, to solve the problem.

So in my opinion, what do we need for system reform? It has to be a holistic approach. We have to keep children, youth, and families at the center of the work. They're the reason for the work. We have to figure out a way. How do we collaborate across service providers?

And to be able to collaborate effectively, we have to be able to communicate with one another, and I will get to that piece. And then we want to have a quality improvement focus.

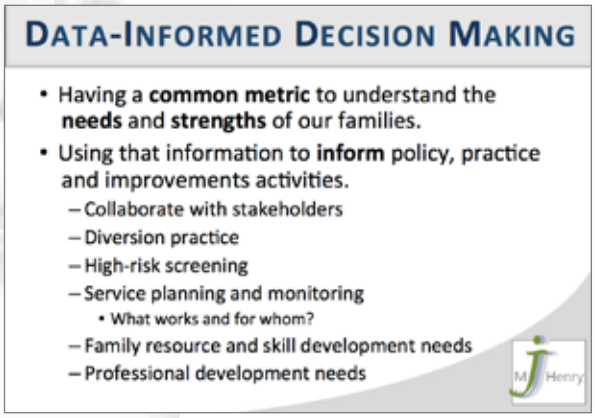
So sometimes in our systems, and this is true for all the systems that I get an opportunity to see, compliance is a driver. And quality improvement takes a back seat. If we swap that and make it about quality improvement, we incentivize collaboration.



If we create shared accountability among each other, that it's not just your problem, DCF, or your problem, individual social worker, then we can incentivize people to work together. But if we're going to work together, we have to be able to talk to each other.

So we've all shown different graphics. So here's my graphic of how hard the work is. All of these folks over here are multiple stakeholders. Some of them are families, teachers, the court system, police officers; all of them are collaborators for that individual social worker. They're getting information from all of those stakeholders, including the youth and family, that they then have to figure out a way to synthesize so that they can then figure out what am I going to do now. What should the plan be? How am I going to keep this child safe? How am I going to get this parent the resources they need to be able to parent them?

And so one of the things that I've been working on across the country, and I actually did some work here in Massachusetts, so we have something that we can work with here, is a collaborative assessment. So it's an assessment that really allows us to look at the needs and the strengths of the kids in the families that we serve, and it allows us to create a common language.



So we take all of this paperwork and we can synthesize it into a couple of pages that says: what are the needs of this family? What are their strengths? And what's the intensity of that need? Where are the priorities? That if we don't hit these things and start addressing them, then things are just going to get worse.

So some of you who've been around may have heard of this before, when I get to it. So I would argue that we need to have a common metric to understand the needs and strengths of the families that we serve. We often have information about demographics. We have how long a child was in the system. We may have information about service receipt. And we have information about what we pay for; what are the services that we pay for.

We don't have consistent information about what are the functional needs of the families and the children we serve. How many have financial needs? How many have extended family that they can call upon? How many have inherent resilience and strength that help them get through every day?

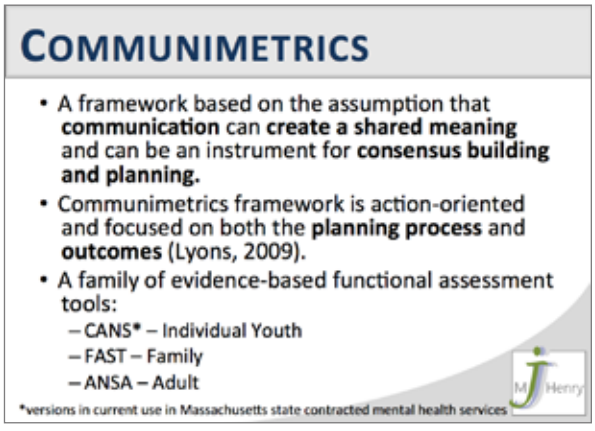
In addition to what are their risk factors? What are their risk needs? What are their mental health needs? What are their functioning needs? Are these people who are not even getting a full night's sleep; who can't get to their job? All of these pieces are really important, so that we can do some of the activities that I've listed here.

We talked a lot about caseload, but I also want to think about workload. So if we understand the needs and resources of families, we can start to figure out: who are our highest need families, and how do we assign families by workload, not just caseload?

Not how many families are you serving, but what do they look like? How intense are they? What are their services look like? And we know that the workers that do a great job get the hardest families.

So what we do is we burn out those workers, and then they go get a job in the private sector, and don't have to worry about the media breathing down their neck. Maybe get paid a little bit more, and don't have people questioning every move they make.

So if we think about how can we respect recommendations around caseload, but also make decisions around workload. What do these families look like? Do we have families that are much easier than other families, and how do we make sure that we're matching those families to the right staff?



So I do a lot of work around the country on tools. Some of you may be familiar with them because we do have a version of CANS in use in Massachusetts, state-contracted mental health services, both through CDHI, through our Mass Health Program, but we also have it through DCF, through our family networks. So any kids that are seeing mental health providers in the community are required to have a CANS done on them.

So that's an individual assessment that uses evidence from that family to figure out what are their needs and strengths. So, it's based on evidence, which I think is a really important piece. There's also a family version and an adult version. So you can have the whole spectrum. I would love to see the family version being used here in Massachusetts.

TRANSFORMING LIVES AND SYSTEMS

A required focus of a ***shared vision*** of the children and families receiving services

For effective services within complex systems the following are a MUST:

1. **Collaboration** of multiple partners often with different mandates, agendas, priorities, and perspectives
2. **Communication** facilitation among all partners, including youth and families
3. **Shared commitment** to serving children and families despite differences
4. **Collective *accountability*** to the child and family

SHARED VISION

A collaborative relationship between stakeholders to develop a shared understanding of identified problems and its sources, assets, a shared goal and a set of actions to achieve that goal.

TRANSFORMATIONAL COLLABORATIVE OUTCOMES MANAGEMENT

- ***Transformational:*** It is embedded in all activities with families as full partners with a focus on positive transformations of their health, well-being, and functioning.
- ***Collaborative:*** Stakeholders are invested in making quality improvements and have consistent data to communicate about the people served across multiple levels of the system.
- ***Outcomes:*** The measures are relevant to decisions about approach or proposed impact of interventions.
- ***Management:*** Information is used to collaboratively improve the quality of the various levels of the system.

TCOM APPROACH LEADS TO

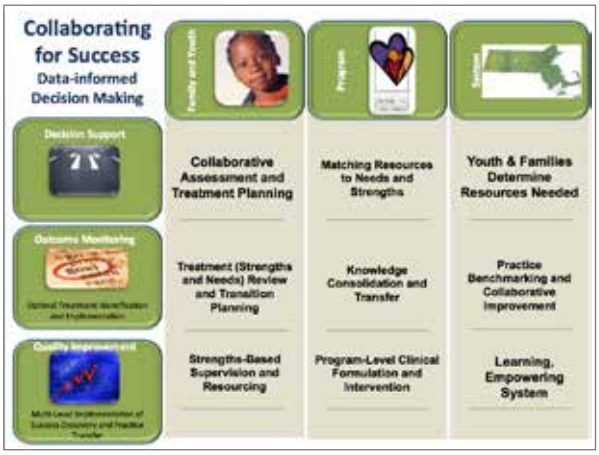
- Identification of at-risk children, youth and families.
- Collaboration and communication across multiple agencies.
- Data-informed decision-making
  - –Decision Support
  - –Outcomes Monitoring
  - –Quality Improvement
- Expansion of best practices and elimination of ineffective practices.

When we take this approach, we say we're going to work on a shared vision, we can use the assessment itself to engage families and build relationships, and ask them, does this make sense? Does this describe your family? Am I missing anything? It's a way to streamline and collate data from lots of stakeholders into one place, that then we all look at in the same way at every level of the system.

So I told you I would tell you what a shared vision is, which we talked about a little bit, and I'm happy to discuss it further in any questions folks have. So the philosophical framework or the theory, it's one of the few assessments — mental health or child welfare — assessments that is grounded in a theory. The idea that we are all partners in the work, including the family.

That this work is about change. If we're not going to measure change, we don't know what's effective. So we need a common way to measure that. We are going to collaborate with each other so that we can have consistent communication across the system.

We're going to focus on what works. And then we're going to be able to use that same data that we collected on individual families at aggregate levels to be able to figure out what works, who does it work for, and how do we replicate what works.

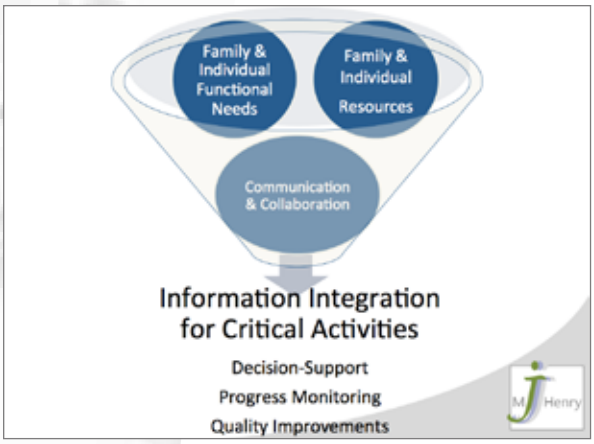


I have this big fancy grid. So we can figure out using this approach: who are the at-risk children, youth, and families and what are they at risk for? Is it mental health? Is it other kind of self-harming behavior?

We can collaborate and communicate with this information across multiple agencies so that we can do decision support, outcome monitoring, and quality improvement. The things that we're supposed to be doing in the system. And then figure out what works.

In this fancy grid, these are all the things you can do with the data. The thing that I really like best is that we can have a collaborative, engaged assessment where the kids and families' voice is represented. And then we can use that to figure out a good plan for them.

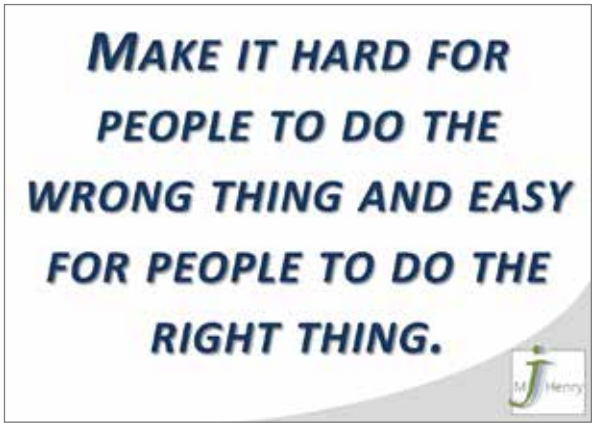
And then when we use that information, supervisors are then able to very quickly understand the workloads of their staff. What kind of families do you have? Who do you need help with? Who should be on a team? What families should have more than one worker? We then are creating a system where the youth and the families we serve actually determine our resource allocation, as opposed to all the other things that can determine resource allocation.



And we want to create a system where we're learning from each other. So if we have a really effective practice out there, that clinician, that clinic, that region of DCF can say, "Hey, we have evidence that this is really effective and it works. You guys should try it too." And this is who it works for.

And so we really want to funnel all the information we can get about kids and families. Communicate and collaborate with each other so that we can do these decision-making activities that are critical to the system. And in a streamlined way.

So essentially, we have to figure out how to provide data at every level of the system to make it easy to do the right thing. To make it hard to mess up. To make it hard to make the wrong choice, and really make it easy to do the right thing.



QUESTION AND ANSWER

Male: What you just said was amazing. I just wanted to let you know that.

Martha Henry: Thank you.

Male: Two things. One, we're rolling out next month [inaudible], as a quality assurance mechanism for social workers to use. So what you were talking about as far as quality improvement, in real time, and actually understanding what's going on in foster homes?

Martha Henry: Yes.

Male: It was just absolutely — it was almost like I was reading — like you — it was amazing. And then the second part is my organization works to [rapid] approach — [inaudible] approach. I understand that human services aspect, having had a governor's pockets, and she just [inaudible].

And so I understand those two things, but as an entrepreneur, I'm more interested in how to get to solutions very quickly. And so we co-created with foster parents, social workers, and foster youth, to actually rapid prototype new concepts, and then bring those to market.

And so like we've been meeting with DCF, flying all over the country, and so like I just want to let you know, this is exactly what I've been working on. And like you were just amazing.

Martha Henry: Thank you very much. I appreciate that. And I will say that I go to systems all over the country that are struggling with the same exact things, and some that are much worse off than we are. Yes, sir.

Male: What you say about, thank you. You had a slide up there where you use the phrase, collective accountability, four or five slides back. Collective accountability to the family, I think. And I thought what Melinda said was amazing, too, and I really appreciate the presentation. But I have had this thought about, okay, what about the individual accountability of the social worker?

It is an incredibly difficult job and incredibly important job, but I'm wondering about how the system of supervision works, because not 100% of the people working in the system are doing their best work.

And I suspect that the supervisory levels are probably strained, too. We hadn't talked much about that. Could you talk something about how we [inaudible] individual accountability, and how the system ought to function to make sure that the street level social workers are on top of their game?

Martha Henry: So one of the things that we have seen with this approach, so we're using an assessment that can be used to engage directly with children and families, that says what's going on for you so I can make a plan.

It offers supervisors a way to say who are the kids and families this person's working with, and where are they doing a good job, and where are they not doing a good job.

So you could probably speak to this more, but typically I hear from supervisors, "I don't have enough time to truly understand all my staff's cases. And I have one or two staff that take up all my time." Or they come in and say, "Let me tell you the great —, latest story about the kid who shaved the cat." And that takes up the entire hour of supervision. And they never get to actually managing it. And then they don't see each other for a whole month.

So we need an approach that has data that's important to the planning process for children and families, that can also be used by those supervisors, their managers, the regional, the APMs can look across and say, "What's our region look like different from the south, different from the west?" Right, anybody who works here knows the west is ignored.

But is the west represented here? What is it that's the same or different? How can we share information? So for me, it's creating a transparent system that says I'm making the same decisions. I'm making decisions based on the same data that you're making.

And that data is about the people we serve. It's not about my budget, or this mandate, or my agenda; it's about these kids and families that we're here for. Who are they? And in a lot of ways, we don't know who they are, beyond demographics and service receipt. We don't really know except anecdotally, who they are, what they're struggling with, what their strengths are.

We cannot do this without collaborating in the community. And there are some amazing people that some of you may have met, who've done a lot of work to create collaborative opportunities, for mostly children in foster care so that we create stronger communities because that's where we're going to be most successful.

We can sort of band-aid this family and band-aid that family, but unless we push it out into communities, and create those resources in communities, and it's hard to build those if you don't know who you're serving.

And interestingly, in Illinois, they use this data assessment system, and then they use geo-mapping. So they're able to say in Illinois, "Hey, you know what? We got a lot of kids who are getting on a bus and a taxi to get to this provider. The next time we do a request for information or a request for proposals, we're going to say if you want to work with our kids, you need to move it to this neighborhood so that transportation isn't a cost — isn't an issue."

So really, how do we drive a system based on the needs and strengths of our families? And there's so many cool things we could do.

Male: Do you know about Casey families' Casebook? If so, do you have an opinion on it?

Martha Henry: I'm not sure what you're referring to. There's lots of Casey pieces out there.

Male: Casey is using sort of individualization to create a casebook, and they rolled it out across, similar to like driven solutions map for caseworkers to use, and it's called the Casebook. So maybe some sort of evaluation on that would be interesting to see; I know they have it in fifteen states right now.

Martha Henry: Okay.

Male: Another question is what about Projects for our Children? They created an entire database on children and family driven policy making decisions. So I felt like that would be another sort of help to evaluate and see like what's the merits and...

Martha Henry: Yeah, what works?

Male: Exactly.

Martha Henry: Perfect. Thank you very much for your time.

CLARK UNIVERSITY
MOSAKOWSKI INSTITUTE FOR PUBLIC ENTERPRISE

Understanding the Department of Children and Families' Role in Protecting Children[1]

By Mickayla Aboujaoude[2]

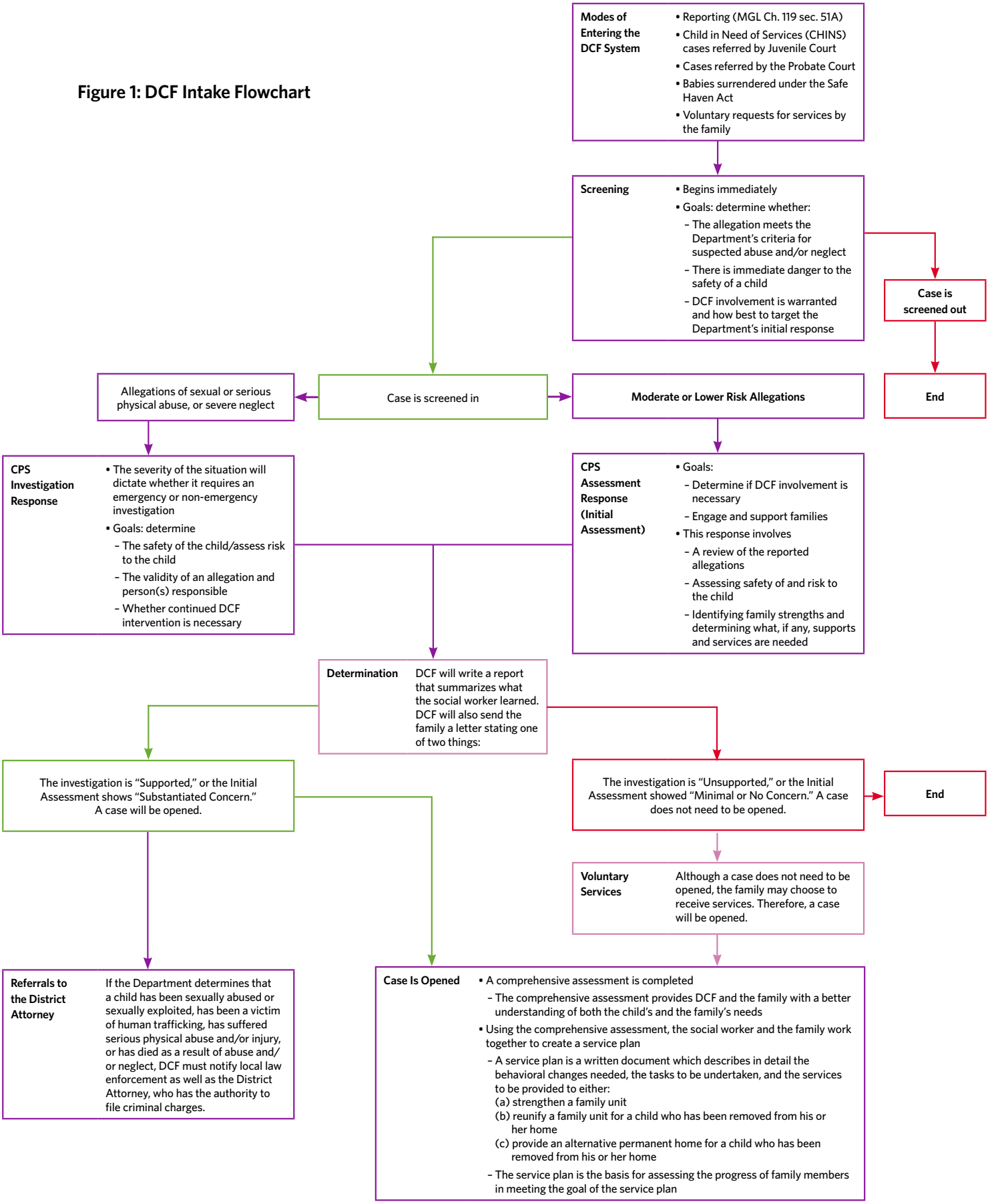
The Department of Children Families (DCF) was created to "work toward establishing the safety, permanency and well-being of the Commonwealth's children by: stabilizing and preserving families; providing quality temporary alternative care when necessary; safely reunifying families; and when necessary and appropriate, creating new families through kinship, guardianship or adoption." The DCF serves children from birth through age 18, as well as those between the ages of 18–21 who were previously involved with DCF.[3] In 2013, the most recent year for which data is available, the DCF had 37,714 children under 18 in its caseload and 7,677 children in placement services.[4] To serve this population, the DCF has one central office in Boston, four regional offices, and 29 area offices across Massachusetts.[5]

Figure 1: DCF Intake Flowchart, shows the process by which a case moves through the Massachusetts DCF system. DCF activities fall into three categories: investigation, service provision, and placement. The **investigation** phase is the beginning of each DCF case;[6] services are provided to those who need them, based on the results of the investigation. Placement is provided to those children who need to be removed from the home. While placement services are technically a subset of service provision, for the purposes of understanding DCF activities, it makes sense to consider them as a separate and distinct category.

Service provision comprises the bulk of activity at the DCF. All families whose cases are not closed during the investigation phase receive services to help the children and families achieve the goals established by their service plans.[7] In order to provide a large variety of services, the Department works in conjunction with outside agencies, both governmental and nongovernmental. The broad categories of services provided are listed below:[8]

- Homemaker services
- Family support services
- Babysitting services
- Respite care
- Parent aide services
- Daycare services
- Counseling and case management services
- Emergency shelter services
- Substitute care
- Adoption
- Guardianship
- Interstate placement services
- Special education services
- Removal from the Home (Foster Care & Adoption)

Figure 1: DCF Intake Flowchart



Foster care organizations are one example of how outside non-governmental agencies come into play. While the DCF has its own foster homes, intensive foster care is supplied by external organizations. These outside agencies are tailored to suit the needs of children who have greater behavioral needs and/or disabilities. The foster parents who work for the external agencies go through the same approval process as typical DCF foster parents, but then can also receive additional training from the agency.

Placement. When a child or family is involved with the DCF, it may be sometimes necessary to remove the child from his/her home. There are two methods by which a child would be removed from the home. The first is when the child is judged to be in immediate danger. If this is the case, courses of action include emergency removal and non-emergency court-ordered removal. Emergency removal happens when a social worker, upon observing the child, makes the following determinations:[9]

a) That a condition of serious abuse or neglect (including abandonment) exists;

b) That, as a result of that condition, removal of the child is necessary in order to avoid the risk of death or serious physical injury of the child; and

c) That the nature of the emergency is such that there is inadequate time to seek a court order for removal.

A court order must be obtained immediately following an emergency removal. Non-emergency court-ordered removal is a somewhat lengthier process wherein a social worker must first get judicial approval in order to remove the child from his/her home.[10, 11] In order to obtain a court order, a social worker must demonstrate that the child is experiencing at least one of the following:

a) The child is without necessary and proper physical or educational care and discipline;

b) Is growing up under conditions or circumstances damaging to the child's sound character development;

c) Lacks proper attention of the parent, guardian with care and custody, or custodian; or

d) Has a parent, guardian, or custodian who is unwilling, incompetent, or unavailable to provide any such care, discipline, or attention.

Prior to the hearing, the legal parents are invited to present their arguments against committing the child to DCF custody, and the child may be summoned before the court to allow the judge to make an informed decision.[12]

The second method for removal is when the family voluntarily places the child in the care of the Department. This can happen either by way of the family voluntarily placing the child in foster care or by surrender for adoption. With a voluntary placement, the child temporarily stays in foster care while remaining in the legal custody of their family.[13, 14, 15]

When placing a child outside of the home, the DCF considers, consistent with the best interests of the child, the following placement resources in the following order:[16]

- Placement with kinship family
- Placement with a child-specific family
- Placement in a family foster care home where the child was previously placed
- Placement in family foster care
- Placement in a shelter/short term program or group home
- Placement in community residential care

Note that 85% of all children receiving DCF services remain in their home.[17]

ENDNOTES

1 This paper and the attached Figure draw upon language found on DCF webpages and in DCF regulations (110 CMR). The author does not claim ownership over the information provided in these documents.

2 Class of 2017, Clark University. Please send comments to MosakowskiInstitute@clarku.edu.

3 http://www.mass.gov/eohhs/gov/departments/dcf/about-the-department-of-children-and-families.html

4 Massachusetts Department of Children and Families Annual Profile 2013

5 See Endnote 3

6 For more information, see the following:
110 CMR 4.00: Intake
http://www.mass.gov/eohhs/gov/departments/dcf/child-abuse-neglect/screening.html
http://www.mass.gov/eohhs/docs/dcf/can-mandated-reporters-guide.pdf
http://www.mass.gov/eohhs/docs/dcf/can-family-guide.pdf

7 For information, see 110 CMR 6.00: Service Plans and Case Reviews

8 110 CMR 7.00: Services

9 110 CMR 4.29: Emergency Removal

10 http://www.mass.gov/eohhs/docs/dcf/can-family-guide.pdf

11 http://www.mass.gov/eohhs/gov/departments/dcf/foster-care/foster-parenting/dss-foster-care-faqs.html#4

12 MGL Ch 119 § 24

13 110 CMR 4.10: Voluntary Placement Agreements - Execution

14 110 CMR 2.00: Glossary

15 110 CMR 4.15: Surrenders for Adoption

16 110 CMR 7.101: Out-of-Home Placements

17 See Endnote 3

CLARK UNIVERSITY
MOSAKOWSKI INSTITUTE FOR PUBLIC ENTERPRISE

Every Kid Needs a Family: Giving Children in the Child Welfare System the Best Chance for Success — *Kids Count Policy Report*

By the Annie E. Casey Foundation

Every kid needs a family. This, we know. We know it when we look at our own children and think about our dreams for them. We know it in our hearts, in our bones and from our own stories. Whether "family" means a mother and father, a single parent, a beloved aunt or uncle, a grandparent or a caring foster or adoptive family, this bond gives meaning to our successes, cushions our hardships and allows us to be most ourselves. A family loves us at our worst and summons our best when nothing else will. A family provides a compass from birth to death. It is the definition of home.

We know that children do best in families. While some children grow up to succeed without a family, we would never willingly choose such a path for our own kids. Yet too many children in the child welfare system are not living in families during the most critical years of their physical, emotional, psychological and social development and the most vulnerable moments of their lives.

The Adoption Assistance and Child Welfare Act of 1980[1] codified our country's belief that children in the child welfare system should grow up in families — cared for in their own homes whenever possible to do so safely and in new permanent homes when it is not. To preserve the well-being of children who enter the system, out-of-home placements must be in the "least restrictive setting" possible — the setting most like a family.[2]

However, one in seven children under the care of the child welfare system is placed in a group setting[3] — even though for more than 40 percent of these children, there is no documented clinical or behavioral need that might warrant placing a child outside a family.[4] Many children — especially teens — are sent to a group placement as their very first experience after being removed from home.[5]

In many cases, a child ends up living in a group placement simply because an agency has not found an appropriate family.[6] Child welfare agencies may not have made diligent enough efforts to find family members or recruited enough foster families with the skills and support to take on older youth. This problem is complicated by the fact that many teenagers enter the child welfare system not because of abuse or neglect, but because they have developed behavioral challenges that their parents or guardians can no longer handle.[7]

Caseworkers may believe teens are better off with peers in a group placement, surmising that these youth should prepare to be on their own.[8] In some cases, teens who already have suffered the trauma of disrupted families request a group placement to avoid further disappointment. But research and data show that these beliefs can be misguided, and teens still can benefit from living with a family.[9] In fact, children report overwhelmingly positive experiences with the foster parents who care for them. More than 90 percent "like who they are living with" and "feel like part of the family." Rates of positive experiences are highest for children who live with kin and lowest for children who experience group placement.[10]

Policymakers, judges and child welfare agencies must ensure that our country's most vulnerable children — those who require the protection of our child welfare systems — receive the loving care they deserve. When these children live in nurturing homes and receive the support services they need, they will have a much better chance to develop and preserve attachments that equip them to stay on the path to a bright future. They will benefit from the extra hugs and the favorite dinner that a relative can provide during a time of instability; a bedroom to decorate with familiar objects from home; a sister or brother to whisper to at night; and a familiar adult who is always there, providing individual nurturing, support and attention.

By their very structure, many group placements simply are not designed to offer such individualized nurturing. Group placements often remove children from the familiar routines of school, neighborhood and activities,[11] and siblings are likely to be separated, especially if they are of facilities were never intended as places for a child in crisis to stay for more than a night or two, but they have morphed into residences of last resort.[12]

To be sure, a small percentage of children who have been removed from their homes have such complex clinical or behavioral needs that they require a shortterm stay in a residential treatment facility. When this kind of care is high quality and customized, it can be lifesaving. Just as an emergency room addresses the acute needs of patients and prepares them to go home as soon as possible, the ultimate goal of residential treatment in child welfare should be to help children heal and prepare to live with a family. Maintaining or building family connections is a key part of treatment for children who need residential care.

We have arrived at an opportunity moment when innovative agency and private-provider practices, effective policy and political will can be harnessed to help many more children live in families during their time in the care of the child welfare system. The overall percentage of children who spend time in group placements has declined, and many jurisdictions have seen significant reductions.[13] As research has shown the clear benefits to children of living in families, practices in the field have begun to evolve.

In states from Maine to Kansas to California, government systems have adopted new ways of working to place children in families while preserving their safety. Improvements, however, are inconsistent, with wide variations from state to state in the percentage of children living in families and in the policies and practices that influence those placements. Good policy and its faithful implementation can make the best strategies permanent and create lasting benefits for generations of children. Private providers are equal partners in the solution as well. Those that adapt their business models according to the latest research will thrive while serving kids in families and communities, not apart from them.

It is important that our country address the underlying conditions that lead to child abuse and neglect, causing children to enter the child welfare system. We also must increase and strengthen the number of adoptive families. While we recognize the critical importance of both reducing the need for child protective services and finding permanent homes for children, this report focuses on the children in the middle — those who have come at least temporarily into the public child welfare system's care.

The way we make decisions about children in the child welfare system has a profound effect on their ultimate life trajectory. This report provides recommendations for policies and practices that will equip decision makers to ensure that many more of these kids grow up in families.

CHILDREN DO BEST IN FAMILIES

Every child deserves to grow up with at least one trusted, committed parental figure — an adult who keeps her safe and serves as a stable, nurturing bedrock. This becomes clear the moment a newborn is handed to her mother and begins to recognize her face and voice. The infant begins to learn to depend on the person who is there day and night. This foundational healthy attachment to a parent or caregiver not only helps a child feel secure, it promotes the development of her brain.[14]

Kids need parental figures at all stages of life to support them as they develop mentally, physically and socially. Nurturing families treat children as individuals, building on their strengths, meeting their needs and encouraging appropriate independence within a caring relationship. A father might find opportunities to draw out his shy 5-year-old, for example, while diplomatically showing the boy's older sister how to keep from interrupting others at the dinner table. A mother might nurture the boy's interest in music while helping him understand math.

FIGURE 1

The Developmental Benefits of Family

Living with at least one parental figure is integral to a child's healthy development and continues to confer benefits that contribute to his success throughout life. Nurturing families treat children as individuals, leveraging their strengths, meeting their needs and encouraging developmentally appropriate independence within a caring relationship.

INFANTS
An infant's brain develops through positively reinforcing interactions with a dependable caregiver.

YOUNG CHILDREN
Young children, treated as individuals, develop self-esteem and learn to form relationships and regulate behavior.

ADOLESCENTS
Adolescents learn independence within healthy boundaries while looking to parents as a moral compass.

YOUNG ADULTS
Young adults draw on family experiences and relationships to support self-reliance and to raise their own children.

SOURCES Center on the Developing Child at Harvard University. (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain (Working Paper 12)*. Cambridge, MA: Author. And, Dozier, M., Kaufman, J., Kobak, R., O'Connor, T. G., Sagi-Schwartz, A., Scott, S., Shauffer, C., Smetana, J., van IJzendoorn, M. H., & Zeanah, C. H. (2014). Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association. *American Journal of Orthopsychiatry, 84*(3), 219–225.

Teenagers and even young adults continue to benefit from the love and support of stable parents and caregivers.[15] As they become increasingly independent and even at times rebellious, adolescents view parents as reliable authorities on how to maintain relationships, develop skills of self-reliance, learn to follow rules and evaluate and avoid risks,[16] such as unprotected sex and underage drinking. The benefits of family relationships extend into adulthood, even affecting how children as adults will treat their own children.[17] The gregarious girl now speaks her mind persuasively and with confidence; the shy boy has come out of his shell enough to deal effectively with customers at work.

Even for children whose families have failed to deliver all of these nurturing benefits and who have entered the child welfare system, research increasingly shows that family is the best medicine. Parents whose stress, substance abuse or mental illness has impaired their caregiving can, with the right resources, become capable of safely parenting their children.[18] Even children who have been abused or neglected and who have not formed secure attachments with birth parents can develop such connections with relatives, close family friends or caring foster parents, no matter what the child's age. It is the responsibility of child welfare systems to make sure that family caregivers are carefully assessed, properly trained and effectively supported as vital assets in helping children recover from traumatic experiences.

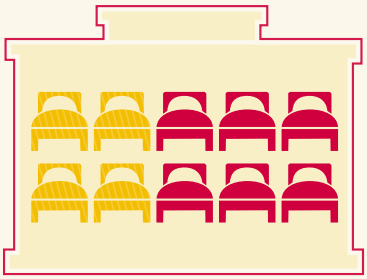
FIGURE 2

Young People in Group Placements

Too many children in the child welfare system are living in group placements, at great cost to taxpayers. While residential treatment is a beneficial, short-term option for a small percentage of young people, we know kids do best in families.

NEARLY **57,000** KIDS
in the care of child welfare systems are living in group placements.

MORE THAN
4 IN **10** CHILDREN
in group placements have no mental health diagnosis, medical disability or behavioral problem that might warrant such a restrictive setting.



Group placements cost
7 TO **10** TIMES
the cost of placing a child with a family.

SOURCES Child Trends' analysis of 2013 Adoption and Foster Care Analysis and Reporting System (AFCARS) data on children from birth to age 20. And, U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2015). *A national look at the use of congregate care in child welfare.* Washington, DC: Author. And, Barth, R. P. (2002). *Institutions vs. foster homes: The empirical base for a century of action.* Chapel Hill, NC: University of North Carolina at Chapel Hill, School of Social Work, Jordan Institute for Families.

Most importantly, family begets family. Research shows that children who live in a family while in the child welfare system are better prepared to eventually thrive in a permanent home, whether that involves a return to their birth parents, permanent placement with kin or non-kin adoption.[19]

Conversely, when children grow up without the protective effects of a loving family, research demonstrates harm.[20] Compared with children placed in the care of families, children in group homes were more likely to test below or far below in basic English and mathematics, more likely to drop out and less likely to graduate from high school.[21] A 2008 study found that youth in group placements were 2.4 times as likely to be arrested, compared with similar youth living with foster families.[22] Furthermore, placing already traumatized children in group settings can put them at greater risk of further physical abuse, when compared with children placed in families.[23]

WHAT THE DATA SHOW

On any given day in the United States, nearly 57,000 young people in the care of the child welfare system — about one in seven children — are living in group placements.[24] For teens in the child welfare system, the ratio jumps to one out of every three.[25] Furthermore, one in five children in out-of-home care will experience a group placement at some point during their time in the system.[26] Forty percent of young people who come into the state's custody as teens spend their first night in a group placement.[27] And when teens are sent to group placements, they often age out of out-ofhome care without ever joining a permanent family.[28] Most troubling is the fact that more than four out of 10 children in group placements have no mental health diagnosis, medical disability or behavioral problem that might warrant such a restrictive setting.[29]

African-American and Latino youth are more likely than white youth to be placed in group settings, and boys are more likely than girls to be in group placements. African-American youth are 18 percent more likely than their white counterparts to be sent to group placements, and boys are 29 percent more likely than girls.[30]

While most young people placed in group settings are between the ages of 13 and 17, nearly 11,000 are younger when placed — a situation of particular developmental concern.[31] Leading experts have concluded that group placements should never be used for young children and that those raised in such settings are at high risk of developing clinical attachment disorders.[32] Yet nearly a third of children who have been placed in group facilities are younger than 13.[33]

TABLE I

Children in Out-of-Home Placements

Kids should live with relatives or foster families when they have been removed from their own families, but one in seven nationally lives in a group placement. State data from 2013, the most recent available, show use of group placements varies widely by state, from 4 percent to 35 percent of children under the system's care.

	Total	Family Placement	Non-Family Placement	Other
Location	Number	Percent	Percent	Percent
United States	402,407	84	14	2
Alabama	4,452	79	18	2
Alaska	1,997	93	6	1
Arizona	14,259	84	14	2
Arkansas	3,829	79	19	1
California	56,767	83	12	4
Colorado	5,801	64	35	1
Connecticut	4,071	74	24	2
Delaware	704	84	15	1
District of Columbia	1,263	84	9	7
Florida	18,039	86	13	1
Georgia	7,648	82	17	0
Hawaii	1,086	92	7	2
Idaho	1,352	92	8	0
Illinois	16,732	83	10	7
Indiana	12,384	90	9	1
Iowa	6,384	79	19	2
Kansas	6,456	93	5	1
Kentucky	7,211	81	18	1
Louisiana	3,990	90	9	1
Maine	1,790	94	5	0
Maryland	4,486	84	14	2
Massachusetts	8,590	81	17	1
Michigan	14,446	77	18	5
Minnesota	5,697	76	21	3
Mississippi	3,728	83	15	1
Missouri	10,659	87	11	1
Montana	2,238	90	9	0
Nebraska	4,593	81	16	3
Nevada	4,801	94	6	1
New Hampshire	815	78	22	0
New Jersey	7,055	91	8	1
New Mexico	2,089	92	6	2
New York	22,867	83	15	2
North Carolina	8,938	87	12	1
North Dakota	1,235	77	22	1
Ohio	12,340	85	14	2
Oklahoma	10,485	90	9	1
Oregon	8,251	94	4	2
Pennsylvania	14,313	76	21	3
Rhode Island	1,803	68	28	4
South Carolina	3,206	76	23	1
South Dakota	1,265	80	20	0
Tennessee	8,228	81	17	1
Texas	29,659	83	16	1
Utah	2,727	84	12	3
Vermont	976	79	20	1
Virginia	4,351	83	16	1
Washington	10,240	94	5	1
West Virginia	4,403	72	27	1
Wisconsin	6,523	86	13	1
Wyoming	991	72	27	1
Puerto Rico	4,194	81	17	2

SOURCE Child Trends' analysis of Adoption and Foster Care Analysis and Reporting System data (2013).
NOTES Placement type might not add up to 100 percent because of rounding. Percentage estimates of children in each placement type are based on children ending the year in foster care, ages birth to 20, where placement type is known. Family placement includes children in relative foster care, non-relative family foster care, trial home visits and pre-adoptive homes. Non-family placement includes children in group or institutional placements. Other includes children identified as runaways or placed in supervised independent living. It is important to note that states vary significantly in their use and coding of certain types of placements (pre-adoptive and supervised independent living placements in particular) as well as whether they include children involved with juvenile justice authorities in their data. Such differences are likely to at least partially explain some of the differences observed across states.

Regardless of a young person's age, group placements are not appropriate as long-term living situations. Although research shows that even those young people who need specialized residential treatment should not be there for longer than three to six months,[34] U.S. children are spending an average of eight to nine months in group placements, according to the U.S. Department of Health and Human Services.[35] More than a third of children remain in such settings even longer.

Data show wide variations among states — and even within states — in the percentage of children living in family versus non-family placements and in the time children spend outside of families.[36] In Oregon, Kansas, Maine and Washington, only 4 percent to 5 percent of young people in out-of-home care are in group placements, compared with more than 25 percent in West Virginia, Wyoming, Rhode Island and Colorado.[37]

Finally, compared with children living in families, group placements are extremely expensive for taxpayers. It can cost seven to 10 times more to care for a child in a group placement than in a family,[38] and in some instances, when children receive additional mental health services or are placed into group settings out of their state of residence, the costs increase even further.

EQUIPPING FAMILIES TO HELP CHILDREN SUCCEED

Helping more children live in families means starting with the families they already have — even if those families are in crisis. Decision making improves when birth parents are engaged as partners. Team Decision Making (TDM), for example, is a collaborative practice that has been used by child welfare agencies from Alaska to Virginia to involve all relevant parties in removal and placement decisions. This process may include representatives of provider agencies, community members, foster parents and even the children themselves.[39] A study of California sites showed that when TDM meetings were held within one day of a referral, children were less likely to experience repeat maltreatment within six months and more likely to return to their families within a year.[40]

If birth parents cannot care for children, relatives can offer an existing relationship and connection to their identity and culture, making an eventual return home easier. Many kinship caregivers take on this responsibility gladly, but with it can come challenges. Kin often are unprepared financially to assume responsibility for the child and need support from child welfare agencies to understand and help ease a young person's trauma.[41] With the right services and support, qualified kin often can be found. Many systems that have placed more children in kinship foster care have seen group placements decline.[42]

Research shows that when kin are not available, foster parents can effectively care for the same kinds of children most frequently placed in group settings.[43] Several studies have found that children with similar backgrounds and profiles do just as well or better in family foster care than in a residential program.[44] The number of evidence-based or evidence-informed, culturally sensitive treatments for young people who have serious emotional and behavioral problems — for example, Multisystemic Therapy, Multidimensional Treatment Foster Care and the Modular Approach to Therapy for Children With Anxiety, Depression, Trauma or Conduct Problems (MATCH-ADTC) — has grown considerably in recent years,[45] making it possible for more children to be cared for within families.

Foster parents play an integral role in providing a sense of family and belonging. A recent study found that foster parents tend to develop deeper connections with children in their care than do shift workers or live-in house parents who care for children in a group setting.[46] Yet, like kin, foster parents require proper support and coaching to help them meet the needs of young people in their care. Forty percent of the families who leave foster parenting do so primarily because of inadequate agency support.[47] Agencies can serve children well by carefully recruiting and equipping kinship and foster families to do their important job and work effectively within an expanded constellation of services. Providing peer support groups, 24/7 crisis response services, assistance working with birth parents or training to help traumatized children can make foster parents feel ngaged and supported by child welfare departments and private providers. Faith communities and private employers can assist child welfare departments in recruiting foster parents and providing support that helps foster families care for children.

The Court Appointed Special Advocates (CASA), agency attorneys and guardian ad litem programs also are key players. These judicial stakeholders can have a powerful voice in court and should urge judges to ensure that children are placed with families when it is safe to do so.

ADVANCING APPROPRIATE RESIDENTIAL TREATMENT

Private providers have an important role to play in helping children go safely home to their families, in finding and supporting available kin and in equipping foster families with the expertise required to meet the needs of traumatized young people. Expanding their approaches to offer a broader range of services, providers of customized residential treatment are critical for the small percentage of children who need such care.

Studies have found that residential treatment programs have the best chance of success if they focus on family involvement, discharge planning and reintegration into the community.[48] A strengths-based culture,[49] provided by models such as Teaching-Family and Sanctuary that treat children individually, can help kids have as normal an experience as possible. Most importantly, children should stay only as long as their treatment requires.

Putting Kin First: How One Child Welfare Agency Uses the Family Tree

In many situations when children must be removed at least temporarily from home, it can take time for the child welfare department to find relatives with whom they can stay. The family member suddenly must find room in the home, make arrangements for school and child care and meet licensing requirements, a process that can take days or months. Often, children will go to a foster family they do not know — or sometimes a group placement — while waiting for kin.

But leaders in the Washington, D.C., Child and Family Services Agency (CFSA) have made finding kin their highest priority. This has meant creating a rapid turnaround process to remove as many placement barriers as possible.

The program, called KinFirst, created an approach for frontline caseworkers to follow when working with parents they were investigating. Child protection workers began engaging parents to help identify relatives who might be available to care for a child while CFSA investigated a concern and arranged a Family Team Meeting. Under this process, a call immediately goes to the Kinship Licensing Unit to contact relatives on that list, while the Diligent Search Unit scours a series of databases to find other relatives to consider as options. All removal notices must include the list of identified relatives, with comments explaining why they could not be immediate placement resources.

When a willing relative is found, an expedited licensing process takes as little as four hours. CFSA worked with the caseworkers union to reorganize the schedules of Kinship Licensing, Family Team Meeting and Diligent Search workers. This allowed around-the-clock searches and procedures, making multiple moves of kids less likely. Because so many CFSA families span the borders between Maryland and the District of Columbia, the two jurisdictions executed an agreement for expedited kin placements. CFSA also established an emergency flexible fund to pay for furniture, clothing, food and even moving expenses to smooth the process.

In 2012, the first year of the program, kin placements upon initial removal increased from 16 percent to 24 percent. The percentage has decreased slightly since then, but only because the larger strategy behind KinFirst has been succeeding. The rapid identification of kin and quick scheduling of family team meetings have allowed children to safely return to their parents with the appropriate services in a shorter amount of time. And those who cannot return home are moving more quickly to guardianship and adoption, often with the kin who were found so quickly.

RECOMMENDATIONS

HELPING EVERY KID LIVE IN A FAMILY

While federal law provides a framework to ensure that children in the child welfare system live in families whenever possible, wide variations among and within states show a need for new state and local policies and practices to fulfill this promise to young people.

Our recommendations are aimed at equipping policymakers, child welfare agencies, judges and other decision makers with both the strategies to expand the number of families in which children can safely live and the mechanisms to ensure accountability for placement decisions.

RECOMMENDATION 1

Expand the service array to ensure that children remain in families.

Expand the service array to ensure that children remain in families. Whenever possible, children should remain at home with their parents or with a caring relative — receiving services that are designed to come to them. Communities that widen the service array have more options that allow children to remain safely in families. State and local child welfare and Medicaid agencies should work together to ensure adequate support by the behavioral health system for services that can be conveniently provided in a home setting. Attachment, Self-

Regulation and Competency (ARC),[50] which promotes resilience in children who have experienced chronic trauma such as sexual abuse, physical abuse and neglect, is an example of a promising service.

States can cover many needed child welfare services through Medicaid State Plans and waivers. In New Jersey, Medicaid's Rehabilitation Services Option provides funds for mobile crisis response teams that have been used to stabilize children to prevent out-of-home placements or moves to more restrictive placements. Arizona added a Medicaid billing code for Multisystemic Therapy, an evidence-based family- and community-based treatment program, and other evidence-based services are allowable under existing billing codes.[51]

Policymakers, public systems and the private agencies providing child welfare services can create a true partnership that reflects a vision of kids living in families. Tools, such as contracts based on child outcomes, flexible state and local funding streams and reinvestment of money saved by serving children in families, should be used to encourage private providers to shift their business models and provide more innovative services in home and community settings. For families in remote rural locations, technology can help providers reach children with more intensive service needs. KVC Health Systems, for example, employs a videoconferencing program to provide therapeutic and crisis intervention services to foster families in several states using grants from the U.S. Department of Agriculture's Rural Utilities Service Distance Learning and Telemedicine program.

Public agencies should invest in high-quality residential treatment that involves family members and has the goal of preparing a young person to live safely and thrive in a family. Systems must start by holding their caseworkers and residential providers accountable for treatment outcomes that are consistently and routinely measured across all providers. Residential providers should be required to maintain real-time data on how children in their care are progressing, and agencies should regularly monitor providers' performance over time, paying particular attention to how youth respond when they return to family settings.

RECOMMENDATION 2

Recruit, strengthen and retain more relative and foster families.

For children who must at least temporarily live outside their homes, public child welfare agencies should prioritize recruiting, supporting and retaining kinship caregivers. Child welfare agencies should exhaust all means to find available kin and provide support that allows relatives to properly care for children, removing any barriers that would keep kin from being licensed and financially supported as foster parents. (Detailed recommendations can be found in the 2012 KIDS COUNT Policy Report *Stepping Up for Kids.*)

From Orphanage to Family-Oriented Services: Changing the Provider's Business Model

Children's Village in New York and Stanford Youth Solutions in Sacramento, California, opened their doors more than a century ago looking very much alike — as orphanages that took in children when no one else would.

Today, these providers are part of a movement of changing practices in child welfare based on research showing that kids do best in families. Encouraged by public policies in their jurisdictions that made it easier to shift to services for kids in families and communities, both have de-emphasized their residential roots in favor of less expensive and more effective approaches.

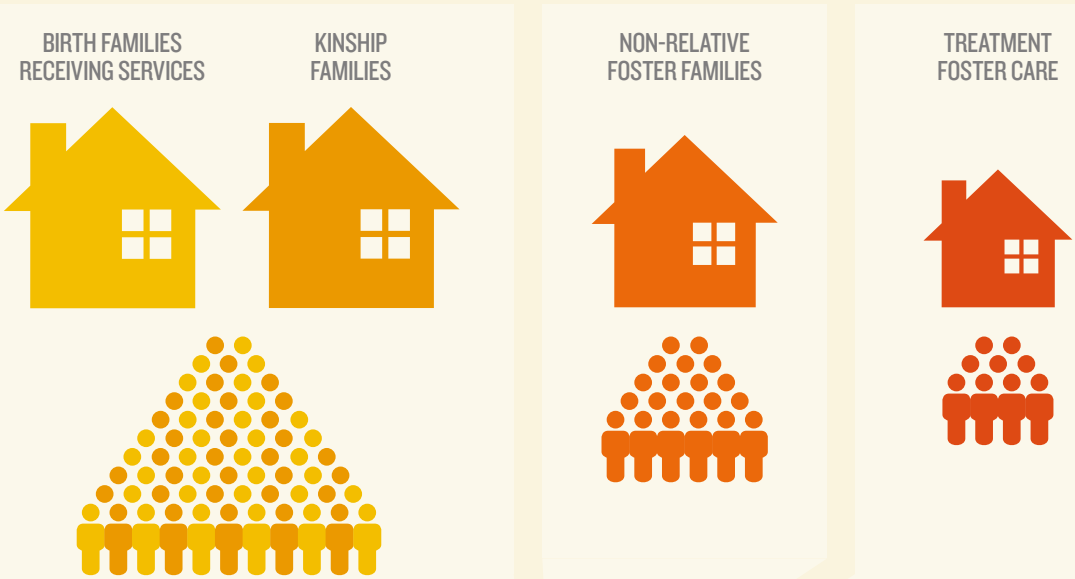
Stanford Youth Solutions, originally the Stanford Home for Children, began its transformation when board members began to realize that the children they served in residential beds weren't doing nearly as well as those receiving services with families in the community. "The big difference was the level of contact with their families," says Laura Heintz, CEO of Stanford Youth Solutions. "The kids in residential didn't feel the same level of support or contact as the kids living in the community. They were pretty much the same kids." In 2006, Stanford closed its residential beds, concentrating completely on what is now a wide range of services focused on integrating the whole family into treatment, including wraparound services, treatment foster care and family support counselors who check in with foster parents regularly and arrange for respite care when parents need a break.

New York's Children's Village, with operations in Dobbs Ferry and New York City, has shifted from a primarily residential facility to a provider of a constellation of community-based services — using evidence-based programs to support families in their homes with the goal of preventing foster care in the first place, or making family reunification work when children have been removed. During the past decade, Children's Village has increased the number of foster families it works with from 60 to 400, including foster families prepared to take on older teens receiving treatment in the facility's residential cottages. Jeremy Kohomban, CEO of Children's Village, says he sees high-quality residential treatment as a vital part of the system — but he emphasizes that residential care is an intervention, not a destination. "Our community work is all connected to this one idea that we can work together to keep kids safe and families together."

FIGURE 3

Our Vision: A Continuum of Care for Child Well-Being

All systems need to maintain continuum of care options to meet children's individual needs, while prioritizing keeping kids with families or in family-like settings. Residential treatment, when needed, should be used for only short periods of time.



Many children and youth can return home to their birth families with the right support and services. Those who cannot should live with relatives or kin if possible. If relatives are not available, systems should maintain a strong network of non-relative foster families, including treatment foster care families who are equipped to handle more severe needs.

Residential treatment is an essential option for a small percentage of young people who cannot safely live in families. Such treatment should be designed to help young people heal and return to families as soon as possible.

Likewise, recruiting, retaining, supporting and engaging foster family caregivers — the next best place when a child lacks an appropriate kin setting — should be a top priority for states and communities. Legislators should require public agencies to maintain and update a census of active foster parents, with an expectation that systems will maintain information on how the capacity of family foster homes compares with the needs of children requiring placement, including the need for emergency foster home beds. Increased investments in foster parent recruitment, licensing and support should be automatically required when the census falls below 150 percent of the projected need.[52]

Child welfare agencies should collect and analyze data to understand the population of young people entering group placement. Agencies should design recruitment and training that equip kin and foster parents to care for these youth and build the system's capacity to respond to the diverse needs of teenagers; lesbian, gay, bisexual and transgender youth; and those with disabilities. Public agencies should work with local and state associations of foster and resource parents to help enrich licensing in-service curricula and to inform resource parents about benefits, elective supplemental training and programs they can use. Jurisdictions should fund and implement evidence-informed programs that train relatives and family foster parents to meet the needs of children at greatest risk of being placed outside a family. For example, San Diego has installed Project KEEP to support foster parents and develop their skills. This program has been found to be effective at helping kin and foster parents reduce child behavioral problems.[53]

Recruitment and continuous training also should focus on emergency foster parents who can be available in a crisis to avoid the use of shelters; respite care parents who can help when foster parents need a break; and foster parents who are trained and equipped to provide treatment foster care for children suffering from severe trauma or frequent disruptions. State contracts should be designed to encourage private providers to carry out and maintain these targeted recruitment efforts. Public agencies should provide dedicated foster parent support workers who focus on both licensing and supporting foster parents, who serve as ongoing partners and coaches to kin and foster parents and who have reasonable caseloads.[54]

At the same time, agencies should strive to ease the burdens that prevent kin and foster parents from accepting the role of caregiver. Public agencies should develop a sound quality assurance system to collect feedback from foster parents. Licensing standards should be reformed in accordance with new national model standards, with enough flexibility to encourage kin to care for children while ensuring their safety.[55] Legislation and policies should provide sufficient financial support to foster parents, including liability insurance. And policymakers should require the public agency to report annually on the foster parent turnover rate and how often children in the system are moved from place to place.

Promising programs have emerged to help public agencies equip foster parents with more tools and expertise. It is smart policy to invest in these approaches and measure their effects. Counties in four states are using the Quality Parenting Initiative (QPI) to promote positive perceptions of foster parents and equip foster parents to deal with behavioral issues that can threaten family stability. QPI sites have reported reductions in unplanned placement changes, increases in the number of kids living in families, a greater likelihood of keeping siblings together and significant progress toward reunifying families.[56]

RECOMMENDATION 2

Support decision making that ensures the least restrictive placements.

Policymakers, public agency leaders and family court judges should prioritize family settings and require substantial justification for more restrictive placements.

Good decision making and accountability begin with data. Jurisdictions should gather data on the types of placements they use and the outcomes young people achieve in those placements. New proposed regulations from the Adoption and Foster Care Analysis and Reporting System address this need and would require more detailed data on the placements and experiences of children in out-of-home care over time.[57] Recently developed tools can help jurisdictions gather data. The Treatment Outcome Package,[58] a validated mental health assessment tool, has been adapted for child welfare to provide a real-time snapshot of whether children

across a system are improving. Indiana recently received approval to use federal funds for a technology system that includes Casebook. A case management tool that maps a child's family and resources, Casebook provides agencies with real-time data for decision making.

Child welfare departments should use data to design policies and practices that prioritize families and require an explanation for any child who is not placed with kin. Special attention should be given to young people for whom there is no current allegation of abuse and neglect but who are in danger of removal for behavioral problems. For these kids, interventions to improve parental supervision of teens or to resolve parent-youth conflict issues should take priority.

With all non-family placements, the public agency should review the placement at least quarterly and ensure that it lasts only as long as the child's needs require. The top executive of the state or local child welfare department should approve all group placements, as is the case in Connecticut and Philadelphia, where group placements have declined as a result. Six states prohibit group placement for children younger than a certain age, and 17 others have policies requiring special authorization or circumstances to place an infant or toddler in a group setting.[59] Prohibitions on group placements for very young children and strict authorization policies for group placement of other children should be adopted in all states. Simultaneous investments to increase the capacity and quality of family foster care are critical. Without such investments, simply changing the type of placement settings may not lead to either increased permanency or improved child well-being.

Family court judges should ensure that each non-family placement is appropriate and time limited by requiring caseworkers to provide a validated assessment of a child's documented clinical needs before making a placement decision. Agencies also should be required to provide the court with documentation that the child's needs cannot be met in a family setting and that the residential provider proposed for placement has the specific menu of appropriate therapeutic services, capacity and treatment skills to meet the child's individual needs. In Los Angeles, for example, a former presiding judge of the juvenile court required caseworkers to appear in his court every 90 days to justify a group placement.

Finally, state legislation should limit the use of shelters and assessment centers to the time between a child's removal from home and the first court review.

CONCLUSION

Kids can't wait. By definition, the young people who come into our child welfare systems already have suffered the trauma of family disruption. It is the legal and moral responsibility of our child welfare systems to provide temporary care that is safe and attentive to the well-being of the child — rather than compound the insidious harm of being separated from home. Restoring family or creating family anew means significant hope for a child's future. Without family, children are ill equipped to beat the odds stacked against them.

We can start by recognizing every kid's need for a family who can provide the normal experiences of eating at the family table and playing after-school sports. A family who can be there when a child learns to read and gets a driver's license, and who is still there — in ways we all know are important — when he graduates from college, gets his first job, marries and has children of his own.

These aspirations, which every state, every community and every policymaker should have for all children, have been recognized in recent law, including the Preventing Sex Trafficking and Strengthening Families Act of 2014.[60] High-quality residential treatment providers have increased the role of families in their programs and installed practices to prepare young people to live in families. But the residential treatment center must be designed and used for its intended purpose: as the emergency room of child welfare, not the final destination.

While the challenge is great, there are more tools than ever to help policymakers, judges and child welfare agencies make decisions and find resources that are best for kids. We can take action on solutions that produce better outcomes. Not acting would represent much more than a failure of imagination. It would be a collective failure to support generations of young people trying to find their way home.

ENDNOTES

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The Annie E. Casey Foundation is a private philanthropy that creates a brighter future for the nation's children by developing solutions to strengthen families, build paths to economic opportunity and transform struggling communities into safer and healthier places to live, work and grow. KIDS COUNT®, a project of the Annie E. Casey Foundation, is a national and state-by-state effort to track the status of children in the United States. By providing policymakers and citizens with benchmarks of child well-being, KIDS COUNT seeks to enrich local, state and national discussions concerning ways to secure better futures for all children. At the national level, the initiative develops and distributes reports on key areas of well-being, including the annual KIDS COUNT Data Book. The initiative also maintains the KIDS COUNT Data Center (datacenter.kidscount.org), which uses the best available data to measure the educational, social, economic and physical well-being of children. Additionally, the Foundation funds a nationwide network of state-level KIDS COUNT projects that provide a more detailed, community-by-community picture of the condition of children.

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