Oral Testimony- VT House Human Services Committee-1/29/14

Thank you for this opportunity to speak to you from a distance. My name is Kate Piper. I am a doctoral candidate in social policy. My dissertation topic is on differential response in child welfare. Over the past 2 ½ years, I have read everything I could find on differential response. I also conducted a short study of DR in Vermont for one of my classes. In doing so, I interviewed 8 professionals including 1 DCF district director, 2 case work supervisors, 1 investigator, two elementary school guidance counselors, a service provider and a school nurse. This was not necessarily a representative sample.

Prior to my going back to school, I was the juvenile defender in Caledonia and Essex counties for 19 years. I have represented hundreds of children in child protection proceedings in Vermont. I also served on the JCTF, the Chapter 55 Rewrite Committee and PPIC.

My testimony today will raise more questions than provide answers. I have to apologize if it is not as complete as I would have liked. I am in MT taking care of my grandchildren and had only a few days notice of this hearing. I would like to have been able to talk to Cindy Walcott about the data and their current practices. I only have access at this time to the 2008 and 2010 NCANDS data.

I will begin by saying that I see definite benefits to children and their families as a consequence of DR. In VT DR has led to an expansion of the number of families served by DCF and receiving services as a result. It has allowed DCF to help families without first having to subject them to an investigation and substantiation. I believe this has allowed DCF to intervene before a family reaches a point of crisis. This has also led to a better working relationship between DCF and the families it serves. DR is a more family-friendly approach.

It remains an open question, though, as to whether this improved relationship with DCF has led to more engagement in services by families, lasting behavioral changes and better outcomes for children. Nationwide, the jury is still out on that. As one preeminent researcher in the area of child welfare put it: "The current body of research supporting claims of safety and improved outcomes for children in DR programs is, at best, inconclusive, and at worst, misleading."

The only research of DR in Vermont that I am aware of is that done by the NCIC Implementation Project. Their report is entitled "Evaluation of VT DCF, FSD, Practice Transformation". This report is essentially an implementation study. The only outcomes it looks at are "buy-in" to the practice model by DCF staff and community partners. It also looks at family satisfaction but it tells us nothing about the safety of children whose cases are assigned to the assessment track in Vermont. The only safety outcome contained in the report is data on "maltreatment recurrence" which is defined as "re-reports and re-substantiation after investigation." By definition this measure does not include children whose reports have been placed on the assessment track. There is no investigation or substantiation in cases on the assessment track. Therefore, there can be no recurrence under this definition.

What data does this committee need from DCF to begin to assess child safety? I would recommend that DCF provide data on the rate of re-reports received on children whose cases have been assigned to the assessment track. I would also be curious to know how many re-reports are being diverted to the assessment track. The re-reporting rate for cases on the assessment track should be lower than those on the investigation track given that these are supposed to be lower risk cases to begin with. Even this

measure of maltreatment recurrence doesn't get around the problem identified by the IOM and the NRC. As they point out, re-reporting might not be an accurate measure of maltreatment recurrence since "the differential response process could plausibly result in less involvement of any agency with the children who could then be less likely to be re-reported even though they were being reabused." In other words, if families referred to services on a voluntary basis choose not to participate in those services, there will be fewer mandated reporters with eyes on these kids.

DR is implemented in different ways from one state to the next. For this reason it is impossible to use study findings from one state to justify differing practices in another state. One way Vermont differs from other states with DR programs is in the percentage of children who are prior victims of abuse or neglect whose cases are being assigned to the assessment track. According to the 2010 NCANDS data, 21% of children with prior victimization were placed on the assessment track in Vermont. This is compared to none, 0 %, in the study samples in MN and MO, 7% in OK and 16% in KY. This is concerning given that a prior history of child maltreatment is the best predictor of future maltreatment. Some DR researchers have suggested that families with chronic CPS involvement may not be appropriate for the assessment track. They may need a lengthier involvement with CPS and a more authoritative approach, especially if these cases involve problems of parental substance abuse, mental health and domestic violence. Research shows that the voluntary follow-through with treatment for these intractable problems is not good in most cases.

What changes might the committee want to consider:

1. Look again at the criteria used for track assignment.

2. Expand the mandate that cases involving children under the age of 3 be investigated to include ALL allegations of maltreatment, not just physical and sexual abuse. At least as many children die from neglect as from abuse. This proposed change is particularly important in light of recent research on the lasting effects of neglect on early brain development.

3. Remove the requirement that parental permission be obtained in order for DCF to interview the child in any cases involving physical abuse, domestic violence or likely parental pressure on the child to recant the allegations. Yes, under the current protocol, DCF has the option of switching the case to the investigation track if a parent refuses permission but in the meantime, the parent has been given an opportunity to put pressure on the child to recant. Research suggests that in cases of interpersonal family violence, victims are often inhibited by their abusers from disclosing DV.

4. Mandate that if at-risk families who are referred to services by DCF do not participate in or complete the service, the service provider must notify DCF so that DCF can consider the need to switch the case to the investigation track and/ or seek a court-ordered plan of treatment. In my 19 years of working in this field, I saw too many cases where time and time again, a family had been reported, had agreed to participate in services, had failed to follow through and then was re-reported because the child had been reabused or neglected. By the time I saw these cases in court, the damage to the child was practically irreparable because the maltreatment had been going on for years.

5. Mandate a review of the availability and gaps in services. Every person I interviewed spoke about the long waiting lists to get into treatment in Vermont.