Testimony of Kathryn (Kate) Piper*- January 29, 2014
Vermont House Human Services Committee

Benefits of DR as Implemented in Vermont:

1. **Expansion of safety net:** DR has had the intended effect of increasing the number of families served by CPS and receiving services as a result. According to data submitted by VT DCF to NCANDS, the number of referrals accepted for CPS intervention jumped from 2,947 in 2008 to 4,831 in 2010. The number of families receiving services went from 659 cases in 2008 to 920 cases in 2010. DCF now has the ability to open a family case without a substantiation.
2. **More Family-Friendly approach:** Almost all of the professionals I interviewed said that the less accusatory and less adversarial approach to families whose cases are assigned to the assessment track has resulted in a better working relationship between DCF workers and families. Families are much less defensive and willing to work collaboratively with DCF to address risk and safety issues.

Does this better relationship result in greater engagement in services, lasting behavioral changes and improved child safety?

What does the research tell us?

Hughes, R. C., Rycus, J. S., Saunders-Adams, S. M., Hughes, L. K., & Hughes, K. N., North American Research Center for Child Welfare (2013:500,508):

> "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."

> "In our review [of DR research] we identified significant problems in research methodology and implementation…calling into question the reliability and accuracy of many of the claims and conclusions made in these studies….Child safety is not being uniformly assessed, accurately measured or fully addressed in either DR programming or research."

Institute of Medicine & National Research Council (2013:5-26): Study findings

> based on administrative data rather than direct measures of safety... must be interpreted carefully, because 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."

Fluke, J., Merkel-Holguin, L., & Schene, P., Kempe Center for the Prevention and Treatment of Child Abuse and Neglect. Current home of the National Quality Improvement

Center-Differential Response (NQIC-DR) funded by the Children's Bureau, US DHHS (2013:547):

> "Whether the conduct of an investigative fact-finding model enhances or diminishes the likelihood of successful engagement remains an open question from a research perspective."
>
> "Among the questions that we believe require further inquiry are:
> 1. Does DR impact the level of family engagement leading to improved child safety, in what contexts and for whom?"

What does the Final Report on the NCIC Implementation Project: Evaluation of VT DCF, FSD, Practice Transformation tell us about the safety of children whose cases are assigned to the assessment track in Vermont?

Nothing. This is basically an implementation study evaluating DCF staff and community partner buy-in to the transformation plan. The study also measures family satisfaction. While the report claims on page 22-23 that "the organizational and practice shifts are being accomplished without any reduction in the state's record of safety," this conclusion is misleading in that child safety is measured by "re-reports and re-substantiations after an investigation." There is no investigation on the assessment track and no substantiation. Therefore this definition of child safety is inapplicable to children whose cases are initially assigned to the assessment track and/or whose re-report ends up on the assessment track. Under this definition there can be no maltreatment recurrence for children on the assessment track.

The report does make the observation that some external stakeholders … "believe FSD is pushing a single model of family engagement at them which does not mesh well with their views of what children and families need." It would be interesting to dig further in the data to see what these stakeholders believe children and families need that is not being provided.

My recommendation: Ask DCF, FSD to provide data on the number/rate of re-reports received on children whose cases have been assigned to the assessment track. The re-reporting rate should be lower than that for cases on the investigation track, given that these are supposed to be lower risk cases to begin with.

DR is implemented in different ways from state to state, making it impossible to generalize study findings from one state to another:

DR states differ considerably in the criteria used for, and timing of track assignment and the percentage of referrals (19-70%) and kinds of cases assigned to the assessment track. In all DR models, the assessment track is designed to handle low to moderate risk cases. The key to DR program effectiveness is the ability to sort cases by risk level (Waldfogel, 1998).

Concern: A much higher percentage of cases involving children with prior victimization are ending up on the assessment track in Vermont compared to other DR states. According to 2010 NCANDS data, 21% of children with prior victimization were placed on the assessment track. In the Minnesota and Missouri study samples none were. In Oklahoma and Kentucky only 7% and 16% respectively of children with prior victimization were placed on the assessment track. This is concerning given that a prior history of child maltreatment is the single factor most highly correlated with future maltreatment (Hughes, et al., 2013). In their 2012 follow-up on families provided poverty-related services on the assessment track in the Minnesota study, Loman and Siegel found that the provision of services on the assessment track had less effect among families with prior CPS involvement, "suggesting that the short-term assistance that generally characterizes DR family assessments is most effective among families that are being seen for the first time and might be targeted first to this group…Chronic families are likely to need more assistance…[M]ore may be needed to address deeper and more intractable problems such as mental illness, substance abuse, domestic violence, or children that are difficult to care for" (A. Loman & Siegel, 2012). English and colleagues reached a similar conclusion in their study of the Washington State DR program ("Families with chronic histories, domestic violence, substance abuse and other problems may require a more comprehensive assessment and intrusive intervention.")(English, Wingard, Marshall, Orme, & Orme, 2000).

Before the implementation of DR these cases may have ended up in court where there are far more protections to ensure the safety and well-being of children such as: 1) the appointment of a GAL and attorney for the child; 2) a court-mandated service plan; 3) requirements that parents waive confidentiality so that DCF can monitor participation and progress in services; and 4) clear timelines for achieving case plan goals and permanency for the child.

This concern is mitigated by the unusual number of cases assigned to the assessment track that end up in court in Vermont compared with other DR states. According to 2010 NCANDS data, nearly as many cases on the assessment track (110) ended up in court as substantiated cases on the investigation track (117). This also suggests, however, that many high risk cases are being assigned to the assessment track.

Changes to consider:

1. Currently there is a legislative mandate that cases involving physical abuse of children under the age of 3 must be investigated. Given that at least as many young children die from neglect as from abuse (Institute of Medicine & National Research Council, 2013), the committee might want to explore expanding this mandate to all cases involving children under the age of three. This is particularly important in light of recent research on the lasting effects of neglect on early brain development. Other states limiting

assignment to the assessment track based on the age of the child are Wyoming, West Virginia and North Carolina (Merkel-Holguin, Kaplan, & Kwak, 2006).

2. 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 parental pressure on the child to recant the allegations. Yes, 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 place pressure on the child to recant. Also, DCF needs to reconsider its practice of conducting family interviews in such cases and ought to be able to meet with the child individually. As some researchers have noted: "The family assessment process in DR generally supports meeting the entire family together. This approach is viewed as potentially dangerous for victims of interpersonal family violence" (Sawyer & Lohrbach, 2005). In their Minnesota study, Loman and Siegel found that the less investigative characteristics of the DR approach "may have inhibited family members from reporting domestic violence issues"(L. A. Loman & Siegel, 2004).

3. Develop practices that provide more effective means of handing off a case to service providers after a referral has been made. Consider legislation that requires service providers to notify DCF if families referred to services choose not to participate in services. In Missouri, if a family refuses services from an agency, the agency must notify CPS . In Hawaii, if a family chooses not to participate in services or does not complete services as recommended, the case is routed back to DCF for a possible investigation and/or court-ordered service plan (Children's Bureau, 2011). Follow-up by DCF is particularly important where referrals are made for substance abuse and mental health treatment where voluntary engagement and completion of services is frequently problematic. In their pivotal study of models of change, Prochaska and DiClemente (1982:278) noted that "between 35% and 60% of clients in community mental-health clinics terminate their treatment by the third session of therapy (Haspel, 1980)." In cases involving substance abuse, the "data show a serious falling off in numbers when comparing parents screened and referred to services and those who successfully complete treatment. ..Reasons may include client's lack of readiness, a poor 'hand-off' from child welfare to treatment services or an information deficit in child welfare agencies as to available treatment" (Young & Gardner, 2009).

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

Questions to ask:

1. What percentage of cases assigned to the assessment track are high to very high risk cases, as measured by your SDM Family Risk Assessment? How many of these cases are resulting in a) an open family case; b) the filing of a court petition; and c) the removal of the child from the home? What percentage of cases is switched from the assessment track to the investigative track? How often does that occur due to a parent's refusal to grant DCF permission to interview the child?

2. What mechanisms are in place to monitor whether families referred to services on a voluntary basis are in fact receiving those services? What practices are in place regarding the handoff by DCF workers to service providers and help for families to overcome barriers to service provision?

*Kathryn (Kate) A. Piper, J.D., M.Ed., is a Ph.D. Candidate in Social Policy at the Heller School at Brandeis University. Her dissertation topic is on differential response in child welfare policy. She has had over 20 years of experience representing children in CHINS proceedings in Vermont and is a NACC certified specialist in child welfare law. She has served on the Justice for Children Task Force (2008-2011), Chapter 55 Rewrite Committee (2007-2009), Permanency Planning Implementation Committee (PPIC)(1997-2005), Guardian ad Litem Oversight Committee (2004), Vermont State Board of Education (1990-1993) and Vermont Board of Bar Examiners (1992-1993). Last year she conducted a small qualitative study of differential response in Vermont. The study involved interviews with eight professionals- two elementary school guidance counselors, one school nurse, a community-based service provider, one DCF district director, 2 DCF case work supervisors and one DCF investigator. This was a convenience sample and not necessarily representative of the views of professionals in similar positions around the state.

If you have any questions or need further information, I can be reached at kpiper@brandeis.edu 802-793-2174. I will be returning to Vermont March 2nd.

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