Memo

Date December 15, 2014

To Ken Schatz, Commissioner, Vermont Department for Children and Families

cc: Cindy Walcott, Deputy Commissioner, Family Services Division

From Alan Puckett for Casey Family Programs

Subject Report of Casey Family Programs Assessment of Safety Decision Making

It is our pleasure to present the Executive Summary and full Report of Casey's assessment of safety decision making in Vermont's child welfare system. We hope that the report will be helpful in your efforts to strengthen your state's service system, and we look forward to working with you in the months and years ahead. Please contact us with any questions about the report or its recommendations.

Thank you,

Alan Puckett for Casey Family Programs

Casey Family Programs

Assessment of Family Services Division Safety Decision Making

Final Report to the Vermont Department for Children and Families

December, 2014

INTRODUCTION AND PRIORITY RECOMMENDATIONS

This report outlines the findings and recommendations of an assessment conducted by Casey Family Programs at the request of former Commissioner of the Vermont Department for Families and Children (DCF) Dave Yacovone. The primary purpose of the assessment project has been to evaluate safety decision making within the Vermont child welfare system and to make recommendations for actions which can help improve child safety outcomes in abuse and neglect cases.

We want to express our gratitude and appreciation to the DCF personnel who have helped us organize and conduct this assessment, and to the more than 220 Vermont stakeholders including Family Services Division (FSD) social workers, supervisors and managers; judges, attorneys and advocates; parents, foster parents and other caregivers; young adults formerly in out-of-home care; and representatives of various service provider agencies, who have shared their knowledge, views and ideas for improvements to Vermont's child welfare system. It is clear that Vermont is blessed with many committed and knowledgeable individuals who care deeply about the state's children and families.

While this report describes a number of concerns and makes recommendations for improving child safety and the performance of Vermont's child protection system, it is important to note that the state's numbers of child maltreatment fatalities have been among the lowest in the nation—1 in 2008, 3 in 2009, 4 in 2010, 2 in 2011 and 0 in 2012—and that Vermont's rate of child maltreatment fatalities per 100,000 children in population was the lowest among all reporting states for 2012.[1] These figures align with other data from the National Center for Child Death Review which indicate that Vermont had an infant mortality rate of 4.4 deaths per 1,000 live births in 2010, compared with a national rate of 6.2 per 1,000; and that the state's child mortality rate (from all causes) of 34.6 per 100,000 in population was 36% below the national average of 54.1 per 100,000.[2] The Annie E. Casey Foundation Kids Count Databook ranks Vermont second among all US states in overall child well-being.[3] The Kids Count ranking is based on a composite of factors including measures of physical health and the economic well-being of families—major correlates of risk for child maltreatment.

Despite Vermont's overall performance in maintaining child safety, steps are urgently needed to keep vulnerable children from harm and to protect the state's status as a safe place for young people. The deaths during 2014 of two children previously in FSD custody have shaken public trust and led to legislative scrutiny of the department. A report released in November, 2014 by Vermont's Citizens Advisory Board[4] in response to a request from the state's Governor to review the two child deaths was based on different methods and source materials than the current assessment project, but produced a number of very similar findings. The degree of overlap and convergence between these two independent reviews suggests that the issues and concerns identified in these reports are valid and merit attention and action by policymakers and agency managers.

A later section of this report offers detailed recommendations for improving child safety and strengthening Vermont's child welfare system. We are aware that Vermont faces fiscal challenges and that it will not be easy to fund improvements to the state's child protection system during 2015 as recommended in this report. It is the view of this assessment team, however, that failing to provide needed resources now will leave vulnerable Vermont children at risk and may ultimately prove more costly to the state in both human and fiscal terms than implementing needed steps in a timely way. Policymakers should also be aware that enactment of any new requirements which increase the numbers of child protection referrals accepted or investigated by FSD will add to the workload for line staff and so will likely require additional new fiscal and human resources.

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[1] US DHHS Children's Administration report "Child Maltreatment 2012". Accessed 11-06-2014. Available: http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf

[2] "Child Mortality Data". Accessed 11-13-2014. Available: http://www.childdeathreview.org/statistics.htm

[3] Accessed 11-13-2014. Available: http://www.aecf.org/m/resourcedoc/aecf-2014kidscountdatabook-2014.pdf

[4] Accessed 11-25-2014. Available: http://mediad.publicbroadcasting.net/p/vpr/files/201411/VCAB-DCF-Report-2014-vpr.pdf

Five priority recommendations are highlighted in this report because the Casey assessment team believes that these items are of critical importance and can be implemented quickly without waiting for legislative action or significant additional resources. These five items are viewed by the assessment team as essential first steps for FSD to take in order to improve child safety and gain the confidence of policymakers and the public. While these priority recommendations are seen as necessary to improve child safety, enhance system effectiveness and increase public confidence in Vermont's child welfare system, managers and policymakers are advised that these items will constitute a good beginning rather than the fulfillment of needed changes. Further important policy and practice changes—some requiring additional resources—are outlined in the full Recommendations section of this report.

Priority Recommendation 1: Strengthening the Child Protection Workforce

In order to improve child safety and services to families, FSD must take immediate steps to resolve a workforce crisis and improve working conditions among critical front-line staff including child safety investigators and case-carrying social workers. Research indicates that excessive caseloads and high rates of turnover in these positions can negatively affect safety and permanency outcomes for children referred for child protection.[5,6,7] Several other steps and recommendations in this report can be effective only if Vermont addresses its child welfare workforce issues. While FSD will need to hire and train significant numbers of additional staff in order to reduce caseloads and workloads to safe and manageable levels over the long term, several interim steps can be taken immediately. These include:

- **A)** Transfer of some secondary and time-consuming duties such as transporting clients and supervising family visits from line social workers to paraprofessional staff in order to alleviate excessive workloads and allow social workers to concentrate on key casework functions which require their professional training and expertise.
- **B)** Developing a workforce council composed of line staff representing the FSD centralized intake hotline, child protection investigators, and case-carrying social workers from each DCF District to act as management-workforce liaisons, to provide DCF and FSD managers with meaningful input on key agency decisions such as determining appropriate caseload and workload levels and working conditions for line staff, and to help restore workforce morale.
- **C)** Consider use of Business Process Mapping or a similar approach to identify and introduce efficiencies which can reduce redundant and burdensome administrative requirements for social workers.

Priority Recommendation 2: Improving Safety and Risk Assessments and Safety Planning Practices

Training and guidance for social workers in use of safety and risk assessment tools, and in use of safety plans in cases where children live with families having significant identified safety or risk concerns, require immediate attention. These tools are used to inform and structure critical case decisions and to monitor the safety of children, but add value only when used by trained staff with clear and appropriate guidance from the agency. Social workers must be given sufficient work time to conduct thorough assessments, and must have the skill to "go beyond the tools" to apply critical thinking in assessment and decision making.

We understand that FSD is already working with the Children's Research Center to improve safety and risk assessment procedures and to provide updated training for social workers in use of these assessment tools; follow-through and completion of this initiative merits priority attention.

More detailed suggestions regarding use of safety plans are provided in the Recommendations section of this report and will require careful attention. Casey Family Programs can recommend an expert to provide

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[5] United States General Accounting Office (2003). "HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff". Accessed 12-03-2014. Available: http://www.gao.gov/assets/240/237373.pdf

[6] National Council on Crime and Delinquency and Cornerstones for Kids (2006). "Relationship Between Staff Turnover, Child Welfare System Functioning and Recurrent Child Abuse". Accessed 12-03-2014. Available: http://www.cpshr.us/workforceplanning/documents/06.02_Relation_Staff.pdf

[7] Wagner, D. Johnson, K. & Healy, T. (2009). "Agency Workforce Estimation: Simple Steps for Improving Child Safety and Permanency". Accessed 12-03-2014. Available: http://ncwwi.org/files/Job_Analysis__Position_Requirements/Agency_workforce_estimation.pdf

consultation and training in this area if needed. It is also recommended that FSD continue working with the National Center for Substance Abuse and Child Welfare around use of safety plans with families in which substance abuse significantly threatens child safety.

Priority Recommendation 3: Strengthening the Alternative / Differential Response Track

Vermont's adoption of a non-investigative child abuse assessment track (Differential Response, or DR) for responding to some low- and moderate-risk referrals is well-supported by precedent and research from other states, and holds potential to connect more families with services sooner and to reduce investigative burden on social workers without compromising child safety. The state's implementation of the assessment track must be given priority attention, however, in order to fulfill its potential as a safe and effective alternative to investigating all accepted referrals. The following immediate steps are recommended:

- **A)** A clear decision process must be consistently followed in making track assignments so that the assessment track is utilized only with appropriate cases.
- **B)** Child safety and risk must be assessed initially and on an ongoing basis in assessment track cases, and a clear protocol consistently followed in re-assigning assessment cases to receive a full investigation if needed.
- **C)** Families assigned to the assessment track must have timely access to evidence-based treatment services as needed, and to concrete and supportive services such as housing assistance, transportation assistance and respite care when required.
- **D)** Assessment cases need ongoing case management and monitoring in order to verify that children are safe and that families receive needed supports and services. If FSD social workers are responsible for ongoing case management and monitoring of cases assigned to the assessment track, they must be given adequate work time to fulfill these functions.

Priority Recommendation 4: Working More Effectively With Substance Abusing Families

This assessment has found that many professionals in various roles and across agencies within Vermont's child welfare system lack knowledge and understanding about how to work most effectively with families affected by substance abuse. Due to the number of such cases currently being referred for child protection services and their disproportionate impact on the state's service system, it is critically important that professionals within FSD, the court system, and in service provider agencies receive training and ongoing technical assistance to help them respond effectively to the needs of children with substance abusing parents.

- **A)** Vermont has already reached out to the National Center for Substance Abuse and Child Welfare for consultation regarding the state's opioid crisis. It is recommended that the state broaden its request to include in-depth technical assistance and training from the NCSACW for FSD staff, courts personnel and staff members of service provider agencies.
- **B)** There is an urgent need for FSD social workers in each District to have access to substance abuse content expertise to help assess child safety and risk and in order to tailor safety plans to the strengths and challenges of families with substance abuse issues. It is recommended that the agency contract for expert consultation from the NCSACW or other qualified entities where needed until enough social workers in each District have received content expert training and certification in this subject area.

Priority Recommendation 5: Improving Outcomes Measurement And Reporting

Gaining the confidence of policymakers and the public will require both action and results. Vermont and other states are currently assessed by federal regulators on a number of Child and Family Services Review (CFSR) measures intended to gauge the safety of children referred for child protection, and system performance in other key areas. Making reports of the state's progress toward CFSR goals available online with frequent updates would move FSD toward greater transparency, accountability and public trust. Publishing regular summaries of additional Vermont-specific data—for example, average social worker caseloads by District—together with CFSR measures would allow FSD managers, policymakers and the public to track other key indicators as well. Timely completion of work already begun in implementing a Results Oriented Management (ROM) data system for FSD (see full Recommendations section for more detail) would be a logical step toward providing the agency with the capability to meet this recommendation.

CONTEXT AND OVERVIEW OF THIS ASSESSMENT

Figures from the National Child Abuse and Neglect Data System (NCANDS) indicate that Vermont had the highest per capita rate of child maltreatment reporting[8] in the nation during 2012 at 117.9 referrals per 1,000 children in the state's population, compared with the national average of 46.1 referrals per 1,000 children.[9] FSD managers suggest that Vermont's referral numbers are explained in part by the fact that the agency encourages anyone with concerns about a child's safety to call the hotline and counts all calls received, including duplicate reports about the same incident. Vermont's referral numbers are also affected by the fact that state law requires FSD to respond to reports of sexual abuse alleged to have been committed by perpetrators other than a parent or caregiver—reports which are investigated by law enforcement agencies in most other states.

Data provided by FSD indicate that Vermont has had a significant increase in child protection referrals since FY2011 and experienced a sharp increase in the number of children in out-of-home care during FY2014. The number of children entering care has grown faster than the number leaving care since 2011. Vermont had 7.5 children in out-of-home care per 1,000 children in population in FY 2013 compared to a national average rate of 4.9 placements per 1,000 children. The state's placement rate increased to 9.1 per 1,000 in FY 2014[10] (national data for FY 2014 were not available at the time this report was written). Vermont's child protective services (CPS) response rate—the per capita rate at which children in the state received either a child maltreatment assessment or an investigation—was 34.8 per 1,000 children for 2013[11], below the 2012 national average of 42.7 per 1,000 but well within the range of response rates for a number of other states.[12]

Two significant issues have framed the context for this assessment. The first involves the deaths during 2014 of two children known to FSD, and extensive media coverage and legislative attention directed toward the agency in the wake of these child fatalities. These tragedies have shocked Vermonters, and rightly so; any child death from abuse or neglect is one too many. We know that the state's citizens, its legislators, and all who work in Vermont's child protection system feel the loss of these children on a personal level. It is our hope and intent that this report's findings and recommendations will help FSD do the best possible job of protecting the state's vulnerable children. To this end, it is incumbent on policymakers, agency managers and practitioners to engage in a candid discussion regarding how best to strengthen the state's child protection system. It is also important, however, to understand that no single agency or system can keep all children safe from harm. Child safety is best understood as a community responsibility requiring collaboration among FSD, families, the courts, other stakeholders and the public.

A second issue currently affecting Vermont's child welfare system is the state's struggle with a large increase in opioid abuse cases. Opioid-related admissions to state funded substance abuse treatment programs more than tripled between 2004 and 2013,[13] while the rate of infants exposed to opioids per 1,000 Vermont resident hospital deliveries more than doubled between 2008 and 2012.[14] The proportion of new FSD out-of-home care placements related to parental substance abuse more than doubled from FY2011 through FY2014,[15] contributing to an overall increase in the state's number of Vermont children in out-of-home care, which grew

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[8] Official reports by mandated and non-mandated reporters concerning suspected child abuse or neglect.
[9] US DHHS Children's Administration report "Child Maltreatment 2012". Accessed 11-06-2014. Available: http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf
[10] Based on AFCARS and NCANDS data from Casey Family Programs Data Advocacy Unit, 11-04-2014.
[11] Ibid.
[12] US DHHS Children's Administration report "Child Maltreatment 2012". Accessed 11-06-2014. Available: http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf
[13] Vermont Department of Health (2014). "Treating Opioid Addiction". Accessed 10-30-2014. Available: http://www.healthvermont.gov/adap/treatment/opioids/documents/TreatOpioidsBrief_June2014.pdf
[14] Vermont Department of Health (not dated). "Neonates Exposed to Opioids in Vermont". Accessed 10-30-2014. Available: http://healthvermont.gov/research/documents/opioid_expos_infants_4.18.14.pdf The number of 2012 cases may reflect increased outreach and identification, as well as increased incidence of infants being exposed to opioids.
[15] Based on AFCARS and NCANDS data from Casey Family Programs Data Advocacy Unit, 11-04-2014.

from 897 in FY 2010 to 1103 in FY 2014.[16] The share of the state's out-of-home care population accounted for by children in care due to a parent's substance abuse has grown by nearly 20 percentage points over the past three years. The increase in reports of serious child maltreatment associated with substance abuse is challenging the service capacity of FSD and other agencies in Vermont and contributes to ongoing public debate about how the state will respond to substance abuse problems among families referred for child protection services.

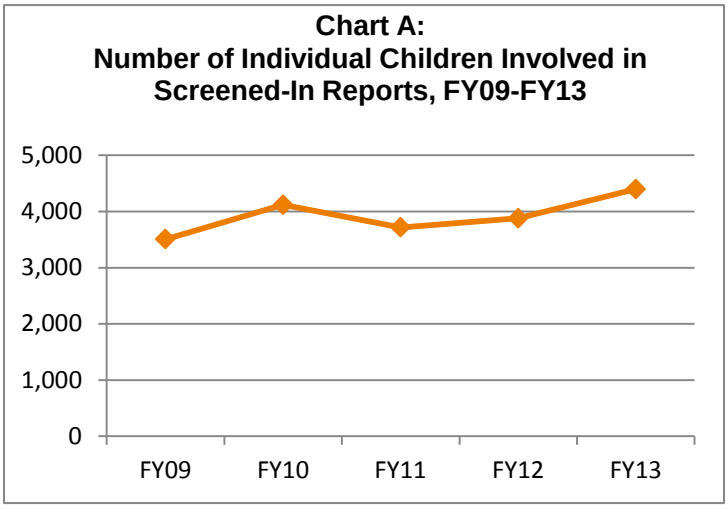
Initial planning and contacts for the assessment project began in early July, 2014. Casey teams conducted focus groups with FSD staff and other stakeholders and reviewed a sample of FSD case records during September; Web surveys and telephone interviews with key stakeholders continued through mid-October. Approximately 15 Casey staff worked on the assessment project and contributed to this report.

The following section of this report describes key Vermont child welfare system data points in greater detail and offers a brief summary analysis of reported measures.

SUMMARY OF VERMONT DATA

This section of the report summarizes Vermont AFCARS and NCANDS data provided by FSD to Casey Family Programs. Summaries include the most recent year available at the time the report was written, which varies depending on the measure.

A number of "front end" system measures indicate that FSD is encountering significantly more children now than was the case a few years ago. The number of individual children involved in screened-in (accepted) reports has increased by more than 25%, from 3506 in Fiscal Year 2009 to 4396 in Fiscal Year 2013 (Chart A)[17].



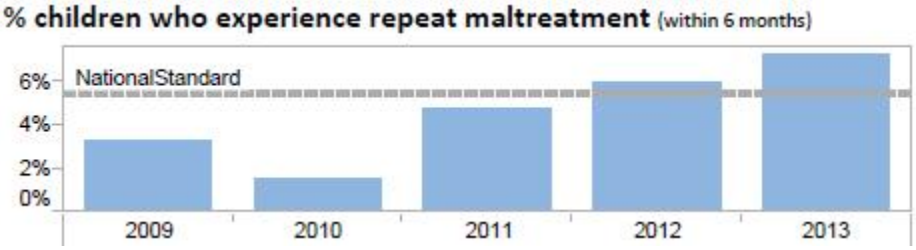
Vermont's rate of screened-in reports has increased from 26.9 per 1,000 children in population in 2009 to 34.8 per 1,000 in 2014; the state's rate of substantiated screened-in reports increased from 5.3 per 1,000 to 5.9 per 1,000 during the same period.

Vermont's performance on a federal Child and Family Services Review (CFSR) measure intended to gauge child safety and the effectiveness of child protection interventions exceeded the national standard of 5.4% of child maltreatment victims experiencing repeat maltreatment within a 6 month followup time period (lower numbers indicate better outcomes) during two recent years, reaching 5.9% in FY12 and 7.2% in FY13 (Exhibit 1). The federal measure was changed in 2014 to a national standard of 9% repeat maltreatment within a 12-

[16] Based on AFCARS and NCANDS data from Casey Family Programs Data Advocacy Unit, 11-04-2014.
[17] Chart A is based on unique counts of children in each Federal Fiscal Year, so numbers may differ from other reports using duplicate counts of children or other time periods (e.g.: state fiscal year, etc.).

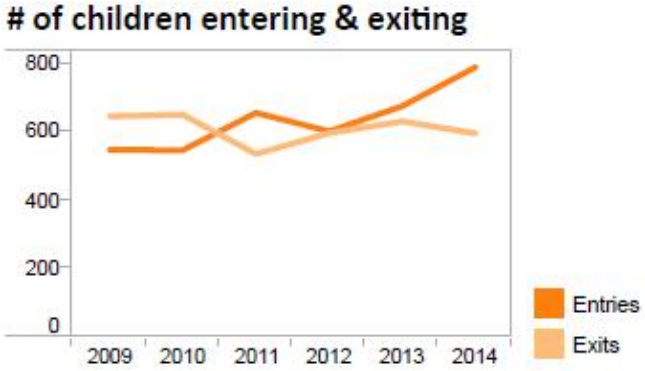
month period (not shown in Exhibit 1). The Casey assessment team did not have 2014 data on this measure at the time this report was written.

Exhibit 1: Percent of Children Experiencing Repeat Maltreatment, 2009-2013



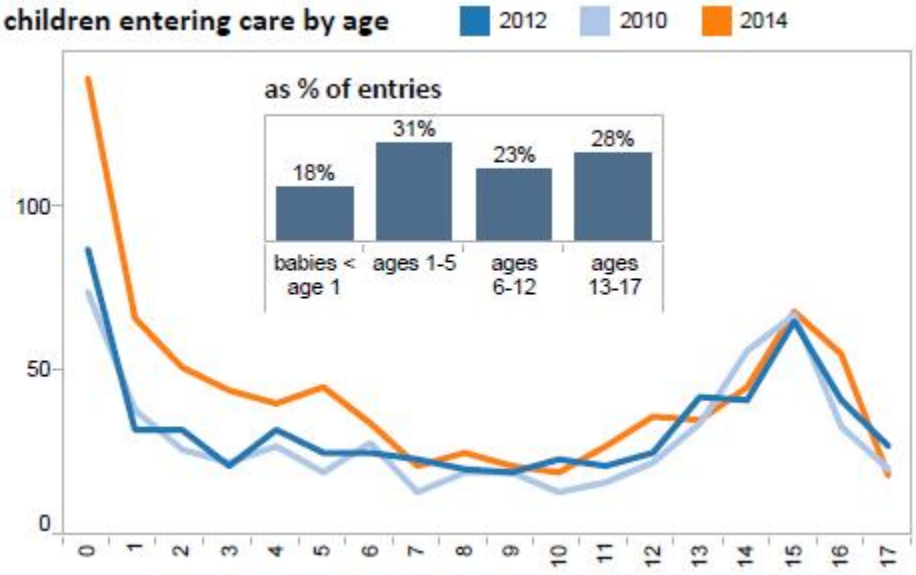
The number of children entering out-of-home care in Vermont has outpaced exits from care since 2011 (Exhibit 2). Entries have risen from 547 in FY09 to 789 in FY14, while exits have fallen from 645 in FY09 to 595 in FY14.

Exhibit 2: Number of Children Entering and Exiting Out-of-Home Care, 2009-2014



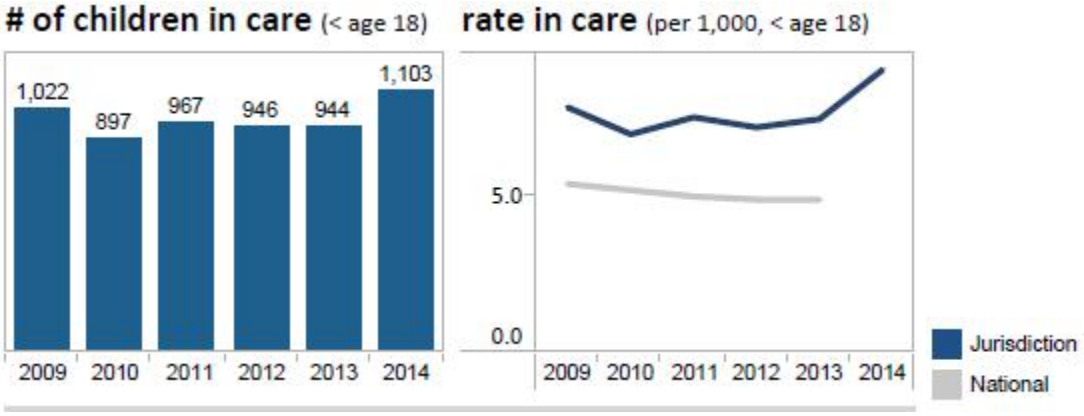
The profile of children entering out-of-home care in Vermont has changed as the number of entries has increased, with the proportion of all entries accounted for by infants and toddlers increasing sharply from 2010 to 2014 (Exhibit 3):

Exhibit 3: Ages of Children Entering Out-of-Home Care, 2010-2014



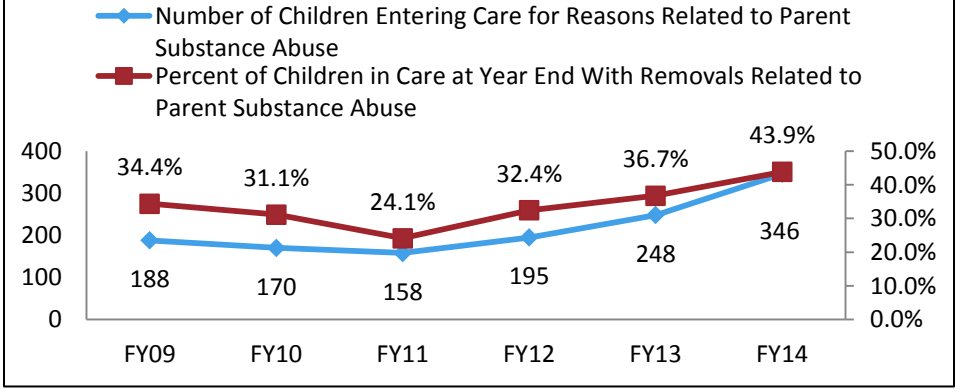
Increasing reports and entries to out-of-home care, together with decreased exits from care, have swelled Vermont's overall out-of-home care population by about 23% since 2009. The in-care rate—the number of children in out-of-home care per 1,000 children in population—has grown concurrently, from 7.9 per 1,000 in 2009 to 9.1 per 1,000 in 2014, well above the national average (Exhibit 4):

Exhibit 4: Number and Rate of Children in Out-of-Home Care, 2009-2014



The impact of cases involving parental substance abuse on Vermont's child welfare system is reflected in the state's out-of-home placement numbers (Chart B). The number of children entering out-of-home care for reasons related to a parent's substance abuse has increased each year since FY2011, and the rate of increase accelerated during FY2014. The percentage of all Vermont children in out-of-home care at year's end with parental substance abuse identified as a reason for removal from the home increased nearly 20 percentage points from FY2011 through FY2014.

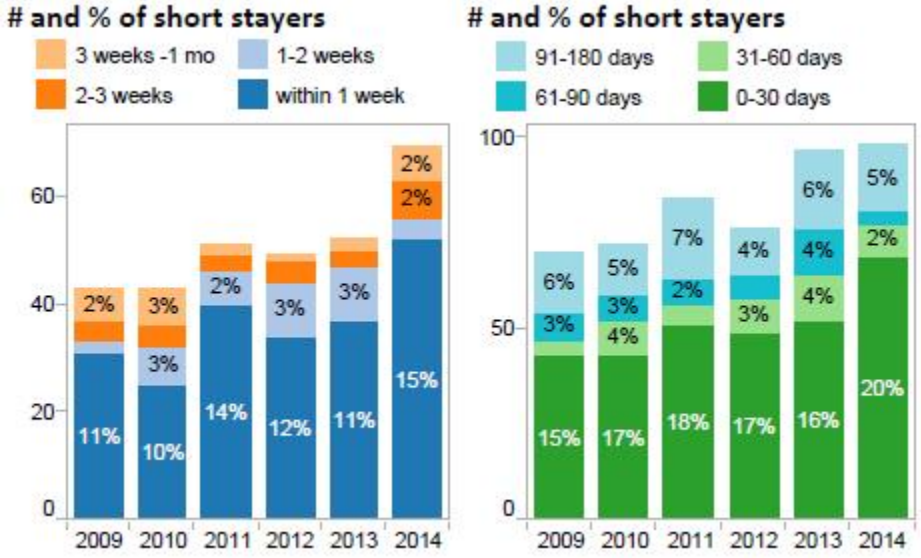
Chart B: Number of Children Entering Care and Percent of Children in Care at Year End for Reasons Related to Parental Substance Abuse



The number and percent of Vermont children who enter out-of-home care for relatively short periods were relatively steady from FY2009 through FY2013, but increased during FY2014, based on an entry cohort analysis[18] (Exhibit 5):

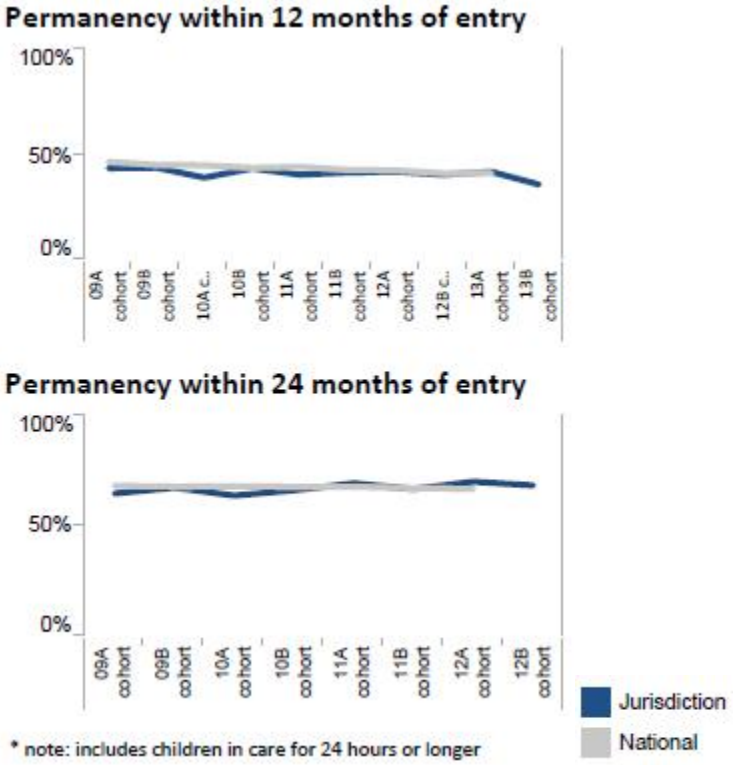
[18] An entry cohort analysis follows all children who enter care during a given period of time and provides a more accurate picture of average lengths of stay than an "exit cohort" approach, which measures average lengths of stay for a group of children exiting care during a given period. Exhibits 6 and 7 are based on entry cohort analyses.

Exhibit 5: Number and Percent of Vermont Children with Short Stays in Out-of-Home Care, 2009-2014



At the same time, the percentage of children who exited to permanent homes within 12 months after entering out-of-home care has declined and will likely be below the national average for 2014 (national data not yet available at time of report). Vermont continues to transition more children to permanency within 24 months following entry to out-of-home care than the national average (Exhibit 6).

Exhibit 6: Percent of Entries to Care Reaching Permanence Within 12 Months and Within 24 Months



Interpretation of Vermont Data:

Data provided by FSD document that the state has experienced a significant increase in child protection referrals since FY2011 and had a sharp increase in the number of children in out-of-home care during FY2014. The number of children entering care has grown faster than the number leaving care since 2011. The number of new out-of-home placements related to parental substance abuse has more than doubled, and the

percentage of Vermont's out-of-home care population accounted for by children in care due to a parent's substance abuse has grown by nearly 20 percentage points, over the past three years.

The number and percentage of children entering out-of-home care for short periods increased substantially from FY2013 to FY2014. It is likely that alternatives to out-of-home placement could be identified for some of these short-stayers through increased use of early screening and assessment, early and consistent use of family team meetings whenever out-of-home placement is imminent or has recently occurred, and strengthened safety planning practices combined with respite and other support services.

Some children who enter care due to parental substance abuse problems may tend to remain in care for longer periods at least in part because recovery from substance abuse is a long-term process and parents may be

unable to complete treatment and other requirements within the relatively short timeframes imposed by the federal Adoption and Safe Families Act of 1997 (ASFA). Some children who enter care due to parental substance abuse may be placed with members of their extended families; however, children in such "kinship care" placements often tend to remain in care longer than children in non-kin foster placements.

While there are no easy solutions to the challenges facing FSD and its partner agencies within Vermont's welfare system, the data summarized above underscore recommendations detailed elsewhere in this report including the urgent need to increase the state's ability to provide early assessment and referral to services for families reported to FSD; the critical importance of timely access to effective substance abuse and mental health treatment for parents of referred children; the need for training and guidance to social workers in conducting safety and risk assessments and in developing, implementing and monitoring safety plans for children not in out-of-home care; and the need for followup case management and after-care services for reunified families.

The increased number of families currently coming to Vermont's child protection system also underscores the importance of addressing workforce issues detailed elsewhere in this report in order to ensure that FSD has the capacity to conduct timely and accurate assessments of child safety and risk, and that social workers have the skills needed to develop, implement and monitor effective safety plans for children who remain with or are reunified with their families. FSD social workers and supervisors especially need training in how to recognize and work effectively with families in which one or more parents have substance abuse problems.

DESCRIPTION OF PROJECT METHODS

The overall assessment plan and procedures and content items for focus groups, interviews and online surveys, together with consent forms for each mode of participation, were reviewed and approved by the Casey Family Programs Human Subjects Review Committee. Participants and respondents were assured that their identities would not be disclosed and that they would not be named in this report. Online survey respondents were required to select a button agreeing that they had read the informed consent statement and wished to participate in order to access the survey, but did not provide their names, and their Web addresses were not recorded. Subject recruitment for the focus groups, interviews and online surveys was conducted by DCF, which also secured venues for the focus groups.

The methods employed in carrying out the focus groups, interviews and surveys for this assessment confer both strengths and limitations. The assessment team was able to gather input from over 220 individual stakeholders having various roles in the Vermont child welfare system within a short timeframe. The inclusion of several youth formerly in care and a number of family members together with professionals ensured that a range of voices and perspectives were heard.

One limitation of this assessment results from the process of identifying and recruiting participants and respondents for focus groups, interviews and online surveys. Partly because the time available for identifying and contacting professionals and stakeholders was quite short, this is in effect an "availability sample" with no assurance that various stakeholder groups were proportionately represented. For example, professionals and

court personnel were over-represented relative to youth formerly in care and parents / caregivers. Another factor which may have affected assessment findings was the poor turnout for some focus groups, several of which had only a small number of participants. For example, scheduled youth / alumni focus groups were cancelled due to poor turnout.

Finally, while anonymous online surveys were a practical approach intended to reach as many respondents as possible without incurring the added challenges and possible off-putting effects of a process to verify respondents' identities, the survey process also involved a trade-off due to the anonymous and confidential nature of survey administration. Because survey respondents were not required to log in or identify themselves, and since survey respondents' Web addresses were not recorded, it is uncertain that only members of the intended group completed each survey or that respondents completed a survey only once. The surveys were posted online in September, 2014 and were available to respondents for about 2 weeks.

Despite the limitations described above, the project team has found that most responses from focus group and interview participants and online survey respondents have "face validity" as good-faith efforts to provide constructive feedback, and that the responses collectively show convergence in identifying many of the same key points. A summary of views and perspectives voiced by respondents contacted in the course of the assessment are presented in the following section of this report.

Additional components of this assessment project included an analysis of key laws and policies governing child protection practice in Vermont, and the review of a sample of FSD case records. Members of the assessment team also spoke with a representative from the National Center for Substance Abuse and Child Welfare, which is providing consultation and technical assistance to the state.

The case record review covered a purposive (not randomly selected) sample of 33 case files which were examined by a team of Casey staff on site at the FSD central office in Essex Junction during the week of September 15, 2014. Cases were chosen by FSD to represent three District service areas experiencing significant numbers of substance abuse-related referrals, and focused primarily on cases involving younger children. Case files were reviewed using a template and recording form developed by Casey in consultation with FSD. While the reviewed case files contained client-identifying information such as names, dates of birth, addresses, etc., the case record review was designed to protect client confidentiality and no identifying information was recorded by the review team. Cases reviewed for this assessment did not include the two child death cases reviewed by the Vermont Citizens Advisory Board.

FINDINGS AND RECOMMENDATIONS FOR IMPROVING CHILD AND FAMILY OUTCOMES

The findings and recommendations outlined below are based on analysis of FSD data and the findings from this assessment project, and reflect the assessment team's knowledge of approaches shown to be effective in other jurisdictions. These detailed recommendations overlap in some cases with the five priority recommendations highlighted earlier in this report. We are aware that FSD is already taking action in some of these areas, for example, working with the Children's Research Center to provide additional social worker training and strengthen the agency's safety and risk assessment practices.

Workforce

<u>Workforce Findings:</u>

- Many FSD social workers have caseloads and workloads which make it difficult or impossible to complete job tasks on time while doing good quality casework;
- There is significant turnover among social worker positions in some Districts. Time required to hire and train qualified staff leaves many positions vacant for extended periods of time, requiring other staff to absorb additional cases;
- The agency's caseload counting approach makes it impossible to ascertain what true average caseloads are within work units and across Districts, but it is clear that many FSD work units are understaffed;

- Many FSD social workers feel isolated and unsupported by agency management. A number of line workers expressed having little trust or confidence in agency leaders.

Workforce Recommendations:

- Take immediate steps to ensure that FSD Districts throughout the state are fully staffed with qualified social workers and supervisors. It may be necessary to hire on a continuous basis as some jurisdictions have done in order to bring the number of line social workers up to needed levels.

  In lieu of a formal workload study, caseload levels of no more than 12 open cases (families) at any one time are recommended for investigation and assessment units, and caseloads of no more than 12-15 cases (children) are recommended for ongoing cases which include children in out-of-home care. Social workers must be allowed adequate time to complete required work for each assessment case. Depending on overall workload including administrative tasks, assign child protection investigators no more than 8 to 10 new investigations per month. Caseload counts should exclude vacant positions and newly hired staff who have not completed basic training.

  The assessment team understands that DCF cannot create new staff positions without Legislative authorization. It is clear, however, that Vermont urgently needs additional line social workers in order to effectively serve children referred for child protection services;
- Consider developing case aide positions or contracting with service provider agencies for staffing to relieve the time demands on social workers from tasks such as client transportation and supervision of family visits, which could be performed by paraprofessional staff;
- Create a workforce council composed of line social workers in order to establish more effective communication and collaboration between agency managers and line staff and to improve workforce morale;
- Provide opportunities for social workers to obtain content expert certification and other work-related training linked to salary increases;
- Remove "stand by" responsibilities from line staff. Some jurisdictions have given after-hours standby duties to contract employees who are paid a base rate or retainer fee plus an hourly rate when responding to a call;
- Invest in content expert certification for social workers in the areas of substance abuse, mental health and domestic violence; provide employees with modest pay increases for job relevant certifications;
- A workforce retention initiative is needed to reduce annual turnover in line staff positions;
- Consider use of Business Process Mapping or a similar approach to identify and introduce efficiencies which can reduce redundant and burdensome administrative requirements for social workers;

Policy

Policy Findings:

- Conditional Custody Orders: Vermont law authorizes courts to place custody of children removed from home directly with custodial parents, non-custodial parents, relatives and others through the use of conditional custody orders (CCOs). FSD is responsible for ensuring the safety of children in these arrangements but does not have decision-making authority over them. Courts often approve relatives for placement before FSD can conduct criminal history checks on them;
- Reunification: Once the court has approved reunification as the permanency goal for a child in FSD custody, FSD is not required to obtain court approval prior to returning physical custody of the child to a parent. FSD conducts a risk assessment prior to physical reunification, but does not currently use the SDM Reunification Risk Assessment intended for this purpose. In addition, FSD social workers sometimes terminate contact with and support of families affected by substance abuse or mental health problems before parents are stabilized in recovery. FSD does not receive

representation by agency attorneys until cases reach the Termination of Parental Rights (TPR) stage;

- Termination Of Parental Rights: Vermont is experiencing a substantial increase in the number of contested termination of parental rights (TPR) proceedings, straining the resources of courts, the Attorney General's office and FSD. A state policy review found no permanency mediation process, and Vermont statute does not provide for enforceable post-adoption contact agreements except in cases of step-parent adoptions.

Policy Recommendations:

- Conditional Custody Orders
  Vermont should clarify the role of the courts and FSD social workers in CCO cases to ensure children's safety and well-being. Allow FSD sufficient time to vet any prospective caregiver before a child is placed with that person. Some states, including Texas, have enacted statutes and promulgated rules that detail the role and responsibilities of the child welfare agency when children are placed with relatives as an alternative to formal foster care;[19]
- Reunification
  The requirement for an evidentiary hearing accompanied by specific findings of fact would provide an additional measure of accountability and assurance that it is safe for a child to be returned to his or her parent. Statutes in a number of states make clear that it is the court that determines when and whether a child shall be returned to the child's parent.[20] Authorizing FSD to retain legal custody and provide post-reunification support and monitoring for six months or longer, depending on the facts and circumstances of each case, could improve child safety outcomes and help more families reunify successfully. Having FSD attorneys provide legal representation before cases reach the TPR stage could help more children find permanent homes sooner;
- Termination of Parental Rights
  Birth parents may be more likely to voluntarily relinquish parental rights, avoiding protracted and costly litigation, if they know that any arrangement for post-adoption contact they may reach with adoptive parents would be legally enforceable. Over half of states have statutes that allow for enforceable post-adoption contact agreements.[21] Implementation of a permanency mediation process could also help to alleviate crowding in the court system and allow more children to attain timely permanency.

Practice

Practice Findings:

- FSD has co-located clinicians and case managers together with FSD casework staff in one District office in order to provide early assessments, service referrals and case management for families with mental health and substance abuse problems, but has not adopted this approach statewide;[22]
- Assessment Track (Differential Response): Vermont's adoption of a non-investigative child abuse assessment track (Differential Response, or DR) for responding to some low- and moderate-risk referrals is well-supported by precedent and research from other states, and holds potential to connect more families with services sooner and to reduce investigative burden on social workers without compromising child safety. The state's Differential Response initiative appears to be under-resourced, however, and lacks the support of many key stakeholders. Many social workers are unclear on their roles in assessment cases, and these cases are often placed "on the back burner". Families in the assessment track are often given little monitoring and may not receive needed basic supports or therapeutic services;

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[19] http://www.dfps.state.tx.us/handbooks/cps/files/CPS_pg_2430.asp
[20] See, e.g., Colo. Rev. Stat. § 19-3-702(3); Kan. Stat. Ann. § 38-2264(f); Mich. Comp. Laws § 712A.19a(5); N.H. Rev. Stat. § 169-C:24-b II; Tex. Fam. Code § 263.306(a)(4).
[21] https://www.childwelfare.gov/systemwide/laws_policies/statutes/cooperative.pdf#Page=2&view=XYZ
[22] The assessment team was told that co-location has been effective in the Chittenden County FSD office, and that the agency plans to implement this strategy in one additional District office.

- Safety and Risk Assessment: Safety and risk assessments are not always used as directed in policy, and safety and risk scores may not reflect danger and risk concerns noted elsewhere in the case file. Response to child protection referrals often follows an "incident focus" on the current referral without taking into account contextual safety- and risk-related information such as a family's history with the agency, a parent's criminal history, etc. Many social workers have received inadequate training in use of the SDM safety and risk assessment tools.
- Safety Planning: Social workers receive little guidance in use of safety plans to protect children not in out-of-home care. Safety plans are often inadequate, sometimes relying primarily on parental promises to do or not do something differently in the future, and seldom include steps to protect children in the event of relapse by a substance abusing parent;
- Working with Substance Abusing Families: From a system perspective, the state has been unprepared for the number and severity of referred cases involving parental substance abuse. Professionals at all levels of Vermont's child welfare system, including FSD, service providers and the courts, lack in-depth knowledge and preparation for working with families affected by substance abuse.

Practice Recommendations:

- Assessment Track (Differential Response):
  Provide clear guidance to social workers regarding their role in cases assigned to the assessment track. Allow sufficient casework time for thorough assessment, service referral, and ongoing case monitoring in assessment cases. Families in the assessment track must have timely access to appropriate services if Vermont's Differential Response initiative is to serve the needs of referred children, their families, and the state's child welfare system. An example of detailed practice guidance for caseworkers is found in Ohio's Differential Response and Child Welfare Practice Model, which covers the various tasks expected of caseworkers in order to support families and reduce risks to child safety, including engaging, partnering, monitoring and communicating with families;[23]
- Safety And Risk Assessment:
  Provide social workers with initial and ongoing training as well as coaching in use of safety and risk assessment tools. Focus training and coaching on strengthening general assessment skills as well as on specific tools used by FSD. Assessment should be comprehensive rather than narrowly focused on the allegations in a report. Assess or re-assess risk of future harm at critical points in the life of a case, including reunification following out-of-home placement;
- Safety Planning:
  Provide social workers with training and coaching in use of safety plans for cases in which significant safety threats or risks of future harm are identified and children remain in the home or are reunified following out-of-home placement, especially in families with issues of parental substance abuse, mental illness or domestic violence. Safety plans should follow a consistent format and social workers should have clear guidance on the circumstances under which their use is appropriate, assessment of parental protective capacities and engagement of parents in development of safety plans, the need to tailor plans to the facts and circumstances of cases, the length of time safety plans may remain in effect, creation of safety networks including relatives and community supports, inclusion of relapse plans in cases involving parental substance abuse or mental health problems, and monitoring and follow-up of plans once they are in place. Other practices that might be considered include employment of a full-time safety planning specialist to consult with investigators and families in the development and implementation of safety plans.
- Working With Substance Abusing Families:
  It is recommended that FSD invest in additional capacity for early assessment of families involved in child protection cases through expanded co-location of clinicians and case managers or by other means. A standard screening tool such as the Gain-SS or UNCOPE should be used in all cases with allegations or concerns of parental substance abuse;

[23] http://jfs.ohio.gov/PFOF/PDF/Differential-Response-Practice-Profiles.stm

- Each FSD District office needs access to expert consultation to help caseworkers assess substance abuse, mental health and domestic violence in referred families and to provide case-specific concrete and practical recommendations during investigations and assessments. These positions might be filled by social workers who have earned content expert certification in one of these areas;
- Vermont has already requested support from the National Center for Substance Abuse and Child Welfare; given the impact of substance abuse on the state's child welfare system, securing ongoing technical assistance from NCSACW would be a wise investment;
- Consider referring reports involving parental substance abuse, chronic mental health conditions or a pattern of domestic violence, which are screened out or assigned to the Differential Response track, to a community based service provider that can conduct outreach to these families and is able to provide an array of family support services;[24]
- The number and percentage of children entering out-of-home care for short periods increased substantially from FY2013 to FY2014. It is likely that alternatives to out-of-home placement could be identified for some of these short-stayers through increased use of early screening and assessment, early and consistent use of family team meetings whenever out-of-home placement is imminent, and strengthened safety planning practices combined with respite and other support services.

Service Array

Service Array Findings:

- Many parents with mental health or substance abuse problems do not receive needed services, and/or face lengthy wait lists when referred for treatment;
- Families also struggle due to lack of concrete services including housing supports and transportation assistance; these issues often exacerbate parents' difficulties accessing treatment services and successfully following case plans;
- Because very young children are at greatest risk of harm from abuse and neglect, and because this risk may be significantly increased in families where a caregiver has mental health or substance abuse problems, or where domestic violence is present, steps to reduce and prevent maltreatment of Vermont's infants and toddlers are critically important.

Service Array Recommendations:

- The capacity of the state's substance abuse treatment system to serve child welfare-referred parents with co-occurring substance abuse and mental health disorders requires careful evaluation;
- DCF should partner with service provider organizations and community mental health centers to increase treatment slots if necessary, and to prioritize access to mental health and substance abuse assessment and treatment for parents referred for child protection;
- Development of an array of child safety oriented services such as respite care, child care, safety network facilitators and safety monitors to assist social workers with safety plans is urgently needed. Safety monitoring has been performed in many states by public health nurses or family preservation specialists who can assist caseworkers with making frequent home visits. Safety network facilitators have been among steps proposed to strengthen safety planning practice in Florida. Family Team Meeting coordinators fulfill aspects of this role in other states;
- Expansion and replication of prevention / early intervention services such as Vermont's innovative CHARM collaborative for pregnant women with opiate addictions is strongly recommended. Washington State's PCAP program[25] and Kentucky's START program[26] provide other examples of model initiatives for serving this and similar populations;

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[24] While many systems offer no services in screened-out cases, Minnesota tribes and counties use limited funding to offer preventive supports and services on a voluntary basis to families with a child under age 10 who are subjects of screened-out child maltreatment reports. For more information see: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147684

[25] http://depts.washington.edu/pcapuw/

- Significant numbers of families served by FSD live in rural areas distant from needed services, or experience transportation challenges for other reasons. Mobile, rapid-response units and in-home services may be options for reaching and helping these families. FSD could partner with existing home visiting programs and community mental health centers to offer evidence-based treatment services with potential to benefit families and improve child outcomes. One example of an in-home program delivering mental health treatment to mothers and supporting healthy development for their young (ages 0-3) children is the Moving Beyond Depression program,[27] which provides In-Home Cognitive-Behavioral Therapy to first-time mothers under a home visiting model in several states;
- A number of Family Drug Treatment Court programs—a specific type of drug treatment court aimed at improving both substance abuse treatment and child welfare outcomes—have shown promise in other states in increasing parents' completion of substance abuse treatment and in decreasing children's time in out-of-home care, increasing family reunifications, and offering potential to reduce overall costs to taxpayers.[28] Vermont has piloted drug court programs in Chittenden and Rutland Counties with mixed results. Given the ongoing impact of families with parental substance abuse problems on the state's child welfare system, a broader Family Drug Treatment Court initiative merits consideration.

Organizational Infrastructure, Communication and Community Relations

Organizational Infrastructure, Communication and Community Relations Findings:

- Unlike most states, Vermont does not have a Statewide Automated Child Welfare Information System (SACWIS) data system, and is often unable to track system performance or child and family outcomes in a timely way;
- FSD's capacity to conduct Quality Assurance activities has been significantly affected by data system limitations and staffing cuts;
- Many stakeholders, including some mandated reporters, service providers, parents and foster parents, stated that reports of abuse and neglect or service inquiries often receive no response from FSD;
- The public has little awareness of FSD's role and mandate in protecting children, the good work social workers and the agency do on a regular basis, or the need for child safety to be understood as a community responsibility.

Organizational Infrastructure, Communication and Community Relations Recommendations:

- With assistance from Casey Family Programs, FSD has taken steps to adopt Results-Oriented Management (ROM), a set of data management tools which can help bring the agency closer to meeting state needs and federal requirements for child welfare system analysis and reporting. At the time this report was written, FSD managers stated that initial work for the ROM system had been completed and that the agency was awaiting authorization to contract for system testing and finalization. Assuring that the ROM system is fully implemented and becomes operational must be a priority for the state. In addition, training on ROM and the use of data for effective decision making is a critical piece of the overall implementation, as acknowledged by the agency;
- Additional skilled Quality Assurance staff are needed at FSD in order to strengthen the agency's ability to evaluate program effectiveness, system functioning and client outcomes;

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[26] http://policy.db.zerotothree.org/policyp/view.aspx?InitiativeID=856&origin=results&QS=%27&union=AND&viewby=50&startrec=1&tbl_Public_InitiativeYMGHFRECategory=Child+Welfare&top_parent=164

[27] http://origin.library.constantcontact.com/download/get/file/1102467033406-144/ecs_mbd_report_072414_final_distribution.pdf

[28] See Green et al 2009 "Building the Evidence Base for Family Drug Treatment Courts: Results From Recent Outcome Studies". Accessed 11-05-2014. Available: http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1002&context=sysc_fac&sei-redir=1&referer=http%3A%2F%2Fscholar.google.com%2Fscholar%3Fstart%3D20%26q%3Dfamily%2Btreatment%2Bdrug%2Bcourt%2Bevaluation%2B%26hl%3Den%26as_sdt%3D1%2C48#search=%22family%20treatment%20drug%20court%20evaluation%22

- DCF should assess whether conducting operations through 12 District offices around the state is an optimal organizational configuration in terms of efficiency and achieving consistent practice and desired outcomes for children and families;
- Addressing workload issues described above is likely one element of improving agency responsiveness to reports, inquiries and requests for assistance. With that said, case-related communication to social workers should receive a response within 48 hours. Other inquiries from stakeholders or the public should also receive a timely response from an administrative staff member or other identified representative of the agency;
- FSD must communicate more effectively with the public. It is critically important that FSD develop systematic and effective approaches to informing Vermonters about the good work the agency and its staff do every day in protecting vulnerable children and helping parents strengthen their caregiving capacities. In the same vein, obtaining stakeholder buy-in and building public support is essential to the ultimate success of practice initiatives such as Differential Response;
- A comprehensive initiative is needed to improve relationships between FSD and families who provide homes for children in foster care.

NEXT STEPS

This assessment has revealed both strengths and areas of concern in Vermont's child welfare system. The state benefits from the contributions of many experienced and committed professionals within FSD, in the courts, and in service provider agencies. Vermont has also tested and implemented innovative practices which could improve service delivery if more widely adopted, such as co-location of clinicians and case managers in FSD Districts, and the state's CHARM program for opioid abusing mothers.

However, many FSD social workers struggle under excessive workloads which hinder their ability to do their jobs, and many need additional training and guidance in core job functions including safety and risk assessment and safety planning. Improved early assessment and better access to prevention and treatment services are needed for families with substance abuse and mental health problems, and increased child safety monitoring and case followup are needed for non-custodial cases, including those in the assessment track. Professionals at all levels of Vermont's child welfare system need more training and coaching in working with families with substance abuse problems.

This report has offered a number of recommendations for improving outcomes for children and families referred to FSD. Organizational studies have shown that agencies and organizations can successfully implement only a limited number of change initiatives concurrently. Some recommendations proposed in this report may require more time and resources to implement than others.

There are, however, a number of steps outlined as priority recommendations in this report that FSD and the state of Vermont could implement quickly to improve child safety. Most immediately, steps must be taken to reduce the burden of administrative tasks on social workers and to move some work duties such as transporting clients and supervising family visits to paraprofessional staff.

Casey Family Programs offers our continued support to act on these and other opportunities to improve outcomes for Vermont's children and families during 2015 and further into the future.