Sally Borden
KidSafe Collaborative
(802) 863-9626 sallyb@kidsafevt.org

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My name is Sally Borden, I am the Executive Director of KidSafe Collaborative, a small non-profit organization based in Burlington, and I serve as the Co-Chair of the Vermont Citizens Advisory Board to DCF Family Services. I have worked at KidSafe for about 16 years, and in the fields of domestic violence and victim services before that; I have Co-Chaired VCAB for the past 10 months, along with Dr. Joe Hagan.

VCAB was established in 1989 (not 1995 as our report states) by Secretary Hogan. It meets the federal requirement under CAPTA, the Child Abuse Protection and Treatment Act, that each state have a citizen review panel to: (1) Examine policies, practices and procedures of the state's child protection agency, and (2) To review specific cases to evaluate the extent to which the agency is discharging its responsibilities. VCAB is also an empanelled Multi-Disciplinary (Child Protection) Team under the provisions of 33VSA4917.

Following the tragic deaths last year of two toddlers, Dezirae Sheldon and Peighton Geraw, VCAB was asked by Governor Shumlin to conduct a thorough review of these cases. We were directed to look at:

- Did DCF and other involved agencies follow existing policies and procedures?
- Are existing policies and procedures adequate to ensure the safety of Vermont's children?
- What changes, if any, are needed to prevent similar tragedies from occurring in the future?

In order to ensure that the VCAB review panel was fair and impartial, current members who are state employees did not participate in the case review, and at the same additional members were added to provide the necessary expertise and perspective. VCAB conducted a thorough review of documentation from both cases -- not just of DCF Family

Services but also of the Family Court records, the law enforcement investigation records, and the records of private agencies contracted by DCF to provide services to these families.

Our panel found a number of areas of concern, as you know, and developed a lengthy set of recommendations. First, however, let me step back and note the following:

Vermont has one of the lowest rates of child maltreatment-related fatalities in the nation. As a state we have invested in important prevention initiatives for many years, which have strengthened families and resulted in positive health and welfare outcomes for children in our state.

We need to recognize that excellent work is performed each and every day by dedicated, professional, and competent individuals, people who are doing their very best, with the resources they have, to assure that Vermont's children are safe and protected. These individuals are charged with a huge responsibility, making decisions which profoundly affect the lives of children and families – all within a system which is under-resourced and in a society which undervalues their work.

Further, we have a child welfare system which has strived to base their work on best-practice standards, has implemented a number of innovative measures to continuously improve policy and practice, and which has benefitted from strong leadership to effectively implement improvements. We have much to be proud of, including our collective commitment to learn from these cases.

Our report, as with your work as legislative committees, is not intended as an indictment of the current system or those working in it so much as it is a set of recommendations to improve the safety and well-being of Vermont's children. VCAB's findings concur with Senate Bill 9 in that our child protection system must be comprehensive, focused first and foremost on the safety and best interests of children, and – last but certainly not least - properly funded.

From our case review, we concluded that significant work is needed in the following areas:

- Training and evaluation
- Policies and practices
- Communication and information sharing
- Courts and statutes
- Staffing and contracting

I will summarize some of the key findings:

First, the area of training and evaluation. It was difficult for us to get a handle on the staff evaluation process, but I will come back to this when we address staffing. Regarding training, the most obvious issue was in the area of training on policy and practice issues, specifically around reunification of children who have been removed from the care of their parent or parents, back with those parents. It is incumbent upon DCF-Family Services to ensure that all of their staff and the contracted agencies they are working with truly understand DCF's policy, which does in fact state that "Children in custody will be reunified with their parents *whenever it is in their best interest.*" We understand the challenges of training a large and geographically spread-out staff in a thorough and consistent way, but it is imperative to make sure that everyone doing this work for the division is on the same page.

This is especially important, given the DCF-Family Services staff turnover rate of approximately 20%. There are continually many newly hired workers who require training, as well as quality supervision and regular evaluation--all of which are predicated on the availability of adequate staff resources to carry out these activities.

The issue of training also came up most markedly around the intersection of substance abuse and child maltreatment. How and when does substance use affect a parent's ability to safely care for their child? We at VCAB didn't pretend to have the answers, but we applaud DCF-Family Services for working with the National Center on Substance Abuse and Child Welfare on this. At the very least, additional training on substance abuse issues,

particularly in light of the surge of opiate abuse in our state is needed, and we strongly support the addition of specialized staffing with substance abuse expertise, co-located in each of the DCF-Family Services District offices (based on the successful model implemented by Lund and DCF).

I'd like to note here – and full disclosure – KidSafe has the privilege of having a contract to work with the National Center on Substance Abuse and Child Welfare, as they have selected our local CHARM Team – Children and Recovering Mothers – as a model collaborative approach to working with pregnant women with a history of opiate addition and their infants. CHARM, which I facilitate, brings together medical and social services providers – including DCF – to coordinate services for these women and children. I know many of you have heard from Dr. Anne Johnston and others about this. The National Center on Substance Abuse and Child Welfare has written CHARM up as a case study, and they have contracted with me to present to various groups and conferences about our multi-disciplinary collaborative approach.

Our finding regarding the need for training, as with other issues, was not limited to DCF; in fact, there is a need across the board for training, including the court system and my fellow non-profit organizations, on issues such as supervised visitation and family reunification, and of course on substance abuse and child safety.

In addition to training, staffing -- making sure we devoting adequate resources to our child welfare system -- was a significant area of focus for VCAB. I'm sure I can speak for the Board when I applaud the Legislative Finding in S-9, calling on the House and Senate Appropriations Committees on to "ensure that adequate resources are allocated to improve Vermont's ability to prevent and address child abuse and neglect."

We found that on average across the state we are nowhere near the goal – legislated in 2009 – of 12 cases per caseworker. We were encouraged by the addition, in response to the tragedy of these child deaths, of 18 new social workers in DCF-Family Services. Yet since

that time, the number of cases has increased so the caseload average is about where it was a year ago. Equally importantly, when positions were eliminated a few years ago, DCF-Family Services appropriately maintained as many front-line staff as possible, and eliminated many "Central Office" staff – managers, quality assurance and oversight folks. While the impact of these types of cuts is not immediate, last year we saw, all too harshly, the ramifications of eliminating these functions: inadequate oversight, training, evaluation or accountability of front-line workers.

This finding is in regard not just to DCF-Family Services, but to the courts as well. We found that "An under-funded, under-resourced system has created a culture within the court, the State's Attorney's offices and DCF that puts an emphasis on bringing resolution to and closing cases as quickly as possible, sometimes without adequate attention or review." So our recommendation: we have no choice but to fully invest in the safety of our children – and that will require resources. Adding more social workers isn't the *only* answer, but surely we can't keep expecting these folks to do more with less.

The most significant area of concern noted by VCAB is policy and practice. We found that "the child welfare and Family Court systems in Vermont reflect a culture which excessively prioritizes reunification as the outcome to pursue, thus influencing practices and decisions." We recommend a thorough review by DCF-Family Services of their policies to ensure that child safety is not overshadowed by an emphasis on reunification – a review which, I understand, has already been undertaken and changes made.

At the same time, we found that the processes and tools for determining what is required for reunification to take place are not adequately specified. In both of these cases, a parent's compliance with the services to which DCF referred them appeared to be the marker by which reunification decisions were made; there was no qualitative assessment of the child's safety, or what would constitute a safe reunification.

Our recommendations – many of which I am pleased to see included in S.9 - include more frequent risk re-assessment by DCF-Family Services caseworkers using the Structured Decision Making reassessment checklist or other evidence-based tools, thorough background checks on all household members and ongoing monitoring and review of child safety concerns when household composition changes, and more and unannounced home visits.

VCAB also recommends the Family Court adopt clear standards and guidelines so judges have the information and the tools needed to make custody and reunification decisions with the child's safety interest first and foremost.

Notably, we did not reach consensus as a group on the issue you have tackled in S.9 under the heading of "Failure to Protect," establishing a new criminal statute. We agreed, in part, on a proposed evidentiary presumption which finds that where the court has found serious bodily injury to a child but medical evidence cannot corroborate the custodial parent's description of the injury, reunification is presumed to be against the child's best interest. (R-4.3, p 20). Members weighed in both pro and con, as you can see in our report addendum. Our group members, with widely diverging opinions, were not in agreement about establishing a presumption that the supervising caretaker or parent either caused the injury or is shielding the person who caused the injury. (Addendum, page 23)

We also didn't weigh in one way or the other on whether DCF-Family Services social workers should have the authority to remove children from their home – as is included in S.9 – but rather that this option be studied. I'd only suggest that if this provision of S.9 is enacted, adequate resources be allocated to fully train, supervise and support the staff to will now shoulder this responsibility alone without the benefit of support from law enforcement.

We did make a recommendation about referring cases of serious injury to SIU's (Special Investigation Units), as the lack of such referral was a significant concern in Dezirae

Sheldon's case, and I am pleased to see this in S.9 as well as provisions for funding and oversight.

Communication – or lack thereof – is a significant issue we identified throughout both cases. Communication involving DCF staff, supervisor(s), law enforcement, court parties, contracted agencies, was either lacking, insufficient, or simply not documented. Improving the provisions for DCF to communicate with those who report suspected child abuse or neglect, as well as with schools, mental health workers, and others is needed, although must be balanced with children/youth's and family's need for and right to privacy. A perhaps even greater barrier is the lack of IT capability, particularly within DCF, to share information effectively and efficiently with other offices, departments and divisions. It appears that significant efficiencies could be realized, at least within DCF, if caseworkers did not have to enter and re-enter redundant information on hard –to-navigate, time consuming forms.

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Finally, two additional, important areas VCAB addressed: 1) the importance of investing in prevention efforts, such as proven-effective Abusive Head Trauma outreach and education currently conducted by Prevent Child Abuse Vermont, and training mandated reporters, which my organization, KidSafe, conducts. And 2) establishing ongoing oversight through an Office of Child Protection Advocate, as enumerated in S.9. VCAB recommends that this office be independent, and have authority to address the best interests of children not only with DCF-Family Services, but with the entire child welfare/child protection system including Family Court, GAL's, etc. I would like to see the Child Protection Advocate work closely with VCAB; while our Board is not legislatively mandated, it would make sense for VCAB's role to support that of the Child Advocate and vice versa.

In conclusion, I have to reiterate my most difficult recommendation in this challenging economic climate: we will be remiss in our duty to look out for the safety of Vermont's children if we do not adequately fund our child welfare system.

We would not allow airplanes to fly without investing in the equipment needed to meet safety standards – because that would be saying we accepted the risk that some percentage of them would crash. We don't accept that, of course; all planes have to meet safety standards. Likewise we cannot accept the risk that some children will die because we've failed to invest in the equipment needed to make sure they are safe: the staff, training, implementing best practices, evaluation, communication tools, and oversight and accountability.

I recognize that Vermont is facing a significant deficit, and hard hard choices need to be made. If we've learned anything from these children's deaths, it's that we can't cut corners when it comes to child safety. This is tremendously difficult work, and we need to make sure we do our best to get it right.