Testimony of Kathryn (Kate) Piper*
Senate Committee on Health and Welfare
February 4, 2015

Thank you for this opportunity to speak to you. My name is Kate Piper. I am a doctoral candidate in social policy at Brandeis University. My dissertation topic is on differential response in child welfare. Prior to my enrollment at Brandeis, I represented children in child protection proceedings in Caledonia and Essex counties for 19 years. I also served on the Justice for Children Task Force, the Chapter 55 Rewrite Committee and the Permanency Planning Implementation Committee. I was certified by the NACC as a child welfare law specialist in 2012.

Differential Response

As part of my doctoral program, I have been studying the research that has been done on differential response (DR) systems in child welfare and the different ways that states have implemented DR. While I support the many of laudable goals of DR, I don't think anyone can state unequivocally that children assigned to the assessment track in DR states are kept just as safe as similar children assigned to the traditional investigation response. It really depends on how DR is being implemented.

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 more willing to work collaboratively with DCF to address risk and safety issues.

The question remains as to whether this better relationship between families and DCF results in greater engagement in services, lasting behavioral changes and improved child safety.

The theory behind DR is based on **four underlying assumptions**:

1. **Sorting cases by risk level:** Only low to moderate risk cases will be assigned to the assessment track and DCF has the tools to accurately sort cases by level of risk of future maltreatment. It is assumed that cases assigned to the assessment track will be switched to the investigation track if it is determined that the risk level to the child makes the case inappropriate for the assessment track.
2. **Family engagement:** As a result of the more family-friendly approach of DR, families will be more likely to engage in and follow through on services on a voluntary basis.

3. **Services are available and accessible:** The theory of DR is that preventive services will be offered to low risk families before they reach a point of crisis requiring a more heavy-handed and costly intervention by CPS.
4. **Services are effective:** Under most DR systems, DCF typically does not provide continued monitoring of a family's participation and progress in treatment. Thus, unless a new referral is made, DCF is unavailable to intervene when treatment is ineffective or nonexistent and the child is at continued risk of maltreatment.

How DR is implemented and resourced in a state will determine how valid these underlying assumptions are and how effective DR will be in ensuring child safety and well-being.

What do the data and recent evaluations of VT DCF-FSD tell us?

1. **Sorting cases by risk levels: Track assignment and risk assessments:**

Under Vermont's DR system, a case is assigned to the assessment or investigation track by central intake with the opportunity for input from the district offices. However, track assignment takes place before formal family risk and safety assessments are conducted. If those assessments reveal that there is a high or very high risk to the child, DCF policy requires that the district open a family services case. How many of the cases that are assigned to the assessment track score at the high or very high risk levels? How many result in open family service cases? What percentage of assessment cases are being switched to the investigation track? The statutory language is clear: Section 4915 states that the department "shall begin an immediate investigation if, at any time during an assessment, it appears an investigation is appropriate."

According to 2010 NCANDS data, nearly as many cases on the assessment track (110) ended up in court compared to substantiated cases on the investigation track (117). This suggests that many high risk cases are being assigned to the assessment track. This is somewhat reassuring in that once a juvenile petition is filed, 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. But what is happening in the high risk cases on the assessment track which don't end up in court?

Casey Family Programs Assessment of FSD Safety Decision Making-December 2014: The CFP evaluation raises many valid concerns about the safety and risk assessments that are being conducted by DCF workers. Specifically, this evaluation recommends frontline workers need more training in the use of safety and risk assessment tools. Assessment should be "comprehensive rather than narrowly focused on the allegations in a report." "Safety and risk scores may not reflect the danger and risk concerns noted elsewhere in the case file." FSD social workers need training on how to recognize parental substance abuse problems. In its report CFP recommended that the track assignment process must ensure that "the assessment track is utilized only with appropriate cases" and that "a clear protocol be consistently followed in re-assigning cases to receive a full investigation if needed."

Other data: It is possible that too many high risk cases are ending up on the assessment track. A much higher percentage of cases involving children with prior victimization are ending up on the assessment track in Vermont compared to that in the DR states that had been studied by the time DR was implemented in Vermont. According to 2010 NCANDS data, 21% of children with prior victimization were placed on the assessment track in Vermont. 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, Rycus, Saunders-Adams, Hughes, & Hughes, 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" (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).

2. Family engagement:

Does the family-friendly approach of DR result in long-lasting engagement in services or do families on the assessment track fail to follow through or drop out of services once DCF closes the case?

As two DCF staff members in Vermont describe the dilemma for me:

> I just don't know that they have the wherewithal once the social worker is out of the picture to really stay connected to a service provider…[When they don't stay connected, this may be due to the fact that] the provider didn't connect, the provider didn't push it or the parent is invested when we're there because we represent something but when we're not there, the motivation wanes.
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> Lip service…Everybody has the opportunity to say "yes" to us and say, "Yah, I'll do it. I'll do it." But it's always things get in the way…[T]here are people that just want us out and agree to do something. Maybe they'll do it while we're involved and then it drops off once we're out.

Casey Family Programs Assessment of FSD Safety Decision Making-December 2014: This evaluation recommends that DCF social workers be allowed sufficient time for service referral and ongoing case monitoring in assessment cases. "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 a relapse" by a substance abusing parent. "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."

The report goes on to recommend that assessment cases need ongoing case management and monitoring in order to verify that children are safe and families are receiving needed supports and services." To do this, however, DCF-FSD needs adequate funding. As the report states: "Vermont urgently needs additional line social workers." Vermont's rate of screened-in reports has increased by 25% from 2009 to 2013.

3. **Services are available and accessible:**

Casey Family Programs Assessment of FSD Safety Decision Making-December 2014: "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" and such parents need prioritized access to these services. "Families on the assessment track must have timely access to services if [DR] is to serve the needs of children and families." "The state's DR initiative appears to be under-resourced." Families in the assessment track "may not receive needed basic supports or therapeutic services."

What does the research tell us about child safety?

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."
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> "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."

National Quality Improvement Center on Differential Response in Child Protective Services (NQIC-DR). (2014). Final report: QIC-DR cross-site evaluation. Aurora, CO: The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, The University of Colorado School of Medicine, Department of Pediatrics, Anschutz Medical Campus

> Since the Hughes article came out, there have been three random control trial studies of DR- in OH, CO & IL. In the CO and OH study findings, families assigned to the assessment track were less likely to be re-referred than those assigned to the investigation track. In the IL study findings, families assigned to the assessment track were more likely to be re-referred than those on the investigation track. In all three site, implementation of DR did not appear to impact-positively or negatively- the entry of children into foster care. In all three sites, families assigned to the assessment track were more likely than those assigned to the investigation track to receive services to meet their material needs.

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?"

Commonwealth of Virginia, Office of Social Services,. (2008). *Evaluation of the differential response system*. Richmond, VA: Retrieved from http://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2008/differentialresponsesystem_evaluation_annualreport_2008_12-08.pdf http://www.dss.virginia.gov/geninfo/reports/children/cps/all_other.cgi.

In Virginia, parents' refusal to accept services was the reason for the lack of services in 87% of cases involving recommended counseling, and substance abuse treatment and evaluation. Overall, families assigned to the AR were "somewhat more likely to decline at least one service, 11%, than were families in either founded or unfounded investigations, 6.0% and 8.0%, respectively." The study concludes: "The hypothesis that [AR] would encourage greater receptivity to services is not supported by these data" (Commonwealth of Virginia, 2008, p. 24).

Wyoming Legislative Service Office, Program Evaluation Section. (2008). *Wyoming child protective services*. Retrieved from http://legisweb.state.wy.us/progeval/reports/2008/CPS/CPSfullreport.pdf.

[T]he track system does not appear to help families avoid subsequent or more intense DFS contacts. In our review of randomly selected DFS client families' files, we saw that many families have multiple incidents spread among the tracks; despite repeated DFS contacts, there was little indication that their CPS issues improved. In assessment and prevention track incidents, where cooperation is optional, families rarely accepted services and their problems often worsened. We recommend that DFS heighten its scrutiny of families with chronic CPS issues, and that DFS evaluate how to make the track system effective or seek its repeal.

Northeast and Caribbean Child Welfare Implementation Center (NCIC). (2013). Final Report on the NCIC Implementation Project: Evaluation of VT DCF, FSD, Practice Transformation Burlington, VT: University of Vermont.

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.

Questions to ask

1. 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. 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. 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 re-abused." 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 families.

   According to DCF data for 2012 on re-involvement within 12 months, 167 of the cases placed on the assessment track were re-reported compared to 291 on the investigation track. According to the Child Protection Report for 2012, there were 2,536 reports that were investigated and 1,119 cases placed on the assessment track. That means that 11% of cases assigned to investigations had re-involvement with DCF compared to 15% of cases on the assessment track. (See: http://dcf.vermont.gov/sites/dcf/files/pdf/fsd/2012_Child_Protection_Report.pdf, page 13.)There is obviously something wrong with this picture. The re-reporting rate for cases on the assessment track should be lower than that for cases on the investigation track given that these cases are supposed to be lower risk cases to begin with.

2. The committee might also want to look at how many re-reports are being diverted to the assessment track. The 2012 data indicate that 45% of the re-reports on cases assigned to the assessment track were assigned to that track again when re-reported. If the referral to services on a voluntary basis did not work on the first go round, why try again and subject these children to the risk of further maltreatment?

3. What percentage of cases assigned to the assessment track are high to very high risk cases, as measured by DCF's 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 are 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?

4. 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?

Changes to consider

1. Remove the requirement that DCF obtain parental permission in order to interview the child in any cases involving physical abuse, domestic violence or likely 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"(Loman & Siegel, 2004).

2. 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 or complete 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 (National Quality Improvement Center on Differential Response in Child Protective Services (NQIC-DR), 2011). Follow-up by DCF is particularly important where referrals are made for substance abuse and mental health treatment. In such cases 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). Studies of DR have found that parents whose cases have been assigned to the investigation track are more likely

to receive substance abuse treatment than those on the assessment track (Fuller, Kearney, & Lyons, 2012)

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

4. Review the criteria for track assignment.

In closing I want to add one more thing: 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 abused or neglected again. 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. Let us find a way of implementing DR that does not replicate this harmful practice.

*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 February 20th.

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