Drivers of Custody Rates in Vermont

Policy Brief for DCF-FSD & community partners

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THE UNIVERSITY OF VERMONT
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Policy Brief for Family Services Division & Community Partners

The Vermont State General Assembly contracted with the University of Vermont (UVM) to investigate and report on the factors that have contributed to the number of children in state custody for their protection and safety. Specifically, UVM was asked to consider the influence of state policies, programs and practices, and resources that may contribute to, or conversely prevent, Vermont children being placed in foster care.

Vermont's Department of Children and Families (DCF), Family Services Division (FSD) and its community partners play important roles in the process of determining whether a child is placed in foster care as well as the terms of a child's placement. The purpose of this policy brief is to summarize the study's findings and implications as considerations for DCF and its community partners.[1]

Systems-level Factors Contributing to Foster Care Placement Rates in Vermont

The decision to place a child in foster care is influenced by factors that are and are not policy malleable.

Consistent with existing research and evidence in other states, our findings demonstrate that **contextual factors outside of policymakers control** are the strongest indicators of whether a child is placed in foster care, including: (a) **child age; (b) household economic circumstances;** and **(c) likelihood of immediate threat or danger to a child.**

We also identified malleable **aspects of state policy, programs and practices**, and resources that impact decisions to place a child in foster care. Specifically:

- **Data systems that support field personnel's decision making are inadequate.** Vermont's child welfare data systems do not allow court and child welfare professionals to meaningfully measure and track child safety, permanency, or well-being. Data are inadequate to support data-informed practices recognized as effective in the field and create opportunities for individual bias in decisions to place a child.

- **Field personnel do not uniformly apply protocols for safety and risk assessment.** Vermont, like many other states, requires child welfare professionals to systematically assess child safety and risk using the *Structured Decision Making (SDM)* tool. This tool is designed to guide decision making related to child welfare practice. The study found that child welfare personnel do not uniformly or consistently apply this tool in their practice, especially when making decisions related to child custody. Additionally, the study finds that child welfare caseworkers' background, training, and potential bias can influence removal decisions.

Strolin-Goltzman, J., Holbrook, H., & Kolbe, T. (2021). Drivers of Custody Rates in Vermont Final Report. Burlington, VT: *University of Vermont.*

- **Access to evidence-informed, community-based services is uneven across the state.** Not all Vermont families with children have similar access to evidence-informed and community-based services that provide the types of supports and services struggling families need to stay intact. Such services include evidence-based mental health treatment, family counseling, childcare, parenting supports, and legal representation and advocacy that assist families both before and during times of crisis. Access to these supports and services varies considerably among Vermont communities, placing those regions with low-population density and higher proportions of economically disadvantaged households at particular risk of not having access to these essential services. The study also showed that child welfare workers identified specific services that would have made a difference in their recommendation if they had been available for a family.

- **Vermont has not yet maximized federal dollars to improve statewide practice.** The Federal Families First Prevention Act (FFPSA; 2018) intends for Title IV-E dollars to be invested in programs that support families *before* children are removed from their home. However, this funding can only be used to pay for evidence-based practices (EBPs) identified on a US Department of Health and Human Services' registry. Currently, it is unclear the extent to which EBPs are being employed by community partners, and there lacks consistent evidence that the opportunity to use federal funding to transition to using EBPs is being maximized.

Implications & Considerations for Vermont's DCF-FSD and Community Partners[2]

The study's findings have several identifiable implications for Vermont's FSD and community partners, as well as offer opportunities for future consideration and policy development. DCF-FSD should consider actions in two areas: (1) policy and practice; and (2) infrastructure and funding – including:

Infrastructure & Funding

- **Upgrade the data systems used by caseworkers and field personnel in their work with children and families.** Existing data systems are insufficient to support effective decision making, continuous quality improvement, and service array re-alignment. Investments in a statewide child welfare information system (CWIS) with a user-friendly reporting interface – such as Casebook – is an immediate priority. Such systems can link administrative data with assessment tools that measure and report child safety and well-being (e.g., SDM and CANS). Child welfare information systems also can: (a) aid intra- and cross-agency coordination, including referrals and service provision; (b) enable more efficient progress monitoring; and (c) facilitate collaboration with outside experts in CQI and data-driven practice. Alongside investing in a new data system, additional personnel with expertise in

[2] Since the drafting of this report, FSD has already taken action on several of these recommendations and considerations.

data-driven practice are needed to set up the system and provide the support necessary for continuous quality improvement.

- **Utilize federal funding to expand the number and reach of practitioners trained in evidence-based prevention and intervention practices.**
  There is a critical need to invest in efforts to expand the number of trained practitioners, and continue to train additional practitioners working in community mental health, parent child centers, and early childhood education. Specifically, Vermont needs quality practitioners trained in evidence-based services identified by the FFPSA's Prevention Services Clearinghouse, and other trauma informed approaches. Three years ago, UVM worked with DCF/FSD and a Title IV-E funding consultant to expand the definition of the child welfare workforce with the aim of increasing the types of personnel who are eligible for federally-funded professional development, education, and training under section 8.1H of Title IV-E. The expanded definition included childcare providers, mental health clinicians, mentors, birth parents, foster/kin caregivers, healthcare, and school personnel. DCF should build on that change and invest federal funding in additional training and education for prevention focused professionals and para-professionals from multiple sectors, with targeted prioritization in areas of the state where there are no or limited services available to families (as identified by current waiting lists or geographically-based service gaps). Additionally, FSD could explore using federal funding for upstream strategies such as: (a) college tuition for birth parents and foster parents to enter Title-IV-E training degree program; (b) certificates and training opportunities for paraprofessionals and teachers in trauma-informed instruction; (c) legal advocates to work in collaboration with FSD workers and parents; and (d) foster parent/ birth parent mentoring programs.

- **Increase funding, workforce professionalization, and family-based services provided by the state's Parent-Child Centers.**
  Vermont's Parent-Child Centers provide an existing infrastructure for expanding the range of family support and mental health services available to families with young children. Evidence suggests that there is greater family engagement when services are accessed through family resource centers housed within communities, as often community-based mental health agencies carry stigma. FSD might consider diverting funding for prevention services toward family resource centers while enhancing funding for evidence based treatment interventions toward community-based mental health centers.
  Investing in Parent-Child Centers is well-aligned with this preferred service delivery model. Specifically, Parent Child Centers can provide functional family-centered, community-based practices that go beyond face-to-face contacts and family time visitation to focus on primary prevention of child maltreatment. Instead, they provide concrete supports that can enable families to maintain crucial connections and meet identified needs in their home communities (e.g., childcare respite to birth parents struggling with domestic violence or substance use; violence prevention hotline for perpetrators such as *respectphoneline.org)*.

- **Equitably allocate available state and federal funding among service districts and communities.**
  Families' abilities to access support services varies greatly among Vermont districts and communities, and according to community need. Future funding should be allocated differentially to reflect community-based need. The Community Opportunity Map[3] (Casey Family Services) can be used to identify communities where there is more or less need for family services and supports. State funding should be distributed (weighted) in a way that reflects such differences in need, and likely demand for family preservation services.

- **Support caseworkers and other child welfare personnel who experience secondary traumatic stress (STS) as a result of their work.**
  Secondary traumatic stress (STS) (i.e., compassion fatigue) is common among child welfare, mental health professionals, and school-based personnel who are regularly exposed to the stories of traumatic experiences faced by their students and clients. Findings from this study suggests that more than half of Vermont's child welfare professionals may experience moderate-to-high/severe levels of STS. Other studies also show moderate to high STS experienced by teachers and mental health clinicians. DCF should regularly assess all child welfare professionals for STS and provide formal education about STS and trauma-informed resources/referrals. Additionally, personnel would benefit from organizational structures that address STS, like reflective supervisions and transformational leadership approaches that move beyond self-care.

Policy & Practice

- **Take steps to minimize decision-making bias.**
  Individual bias plays a significant role in child welfare caseworkers' decisions to place a child in foster care. Specifically, study findings show that a caseworkers' different orientations toward risk play an oversized role in decision making, while objective assessments of current and immediate danger are inconsistently applied. Consistent application of practice strategies may minimize these types of bias, including:

    1. Embedding training on decision making bias in new employee onboarding.
    2. Implementing *Blind Team Decision Making*, a teaming model where prior to any custody recommendation caseworkers utilize team decision making without any demographic or socioeconomic information in case presentation.
    3. Promoting a culture of data-informed practice by FSD and the courts.
    4. Engaging with the media to explain the impact of the sensationalized high-profile cases on future outcomes for children, families, and caseworkers.

- **Develop expanded practice guidance for caseworkers to use when applying the SDM safety assessment to decision making.**

[3] The Community Opportunity Map uses US Census Bureau data to describe differences across regions in the likely need for family support and other social and mental health services.

The SDM safety assessment is inconsistently applied in decision making. FSD should develop new, explicit practice guidance that establishes guidelines for what circumstances do and do not apply to each specific danger item identified on the tool. This may be undertaken in partnership with Evidence Change (formerly the National Council on Crime and Delinquency and Children's Research Center, CRC). Additionally, DCF should establish policies that promote regular aggregated reviews of the safety assessment data for the specific purpose of reviewing how these data are influencing decision making at the system level.

- **Expand the service array of EBPs available to Vermont families in addition to shoring up the EBPs that are already available in VT.**
  The system would benefit from focusing prevention funding on specific opportunities for high-impact, evidence-based, professional development such as *Parent-Child Interaction Therapy*, *Child-Parent Psychotherapy*, and *Motivational Interviewing*, *Strengthening Families*, *LifeSet*, and *Families and Schools Together* (native American adaptation).