



*All children will grow up safely, in loving families and supportive communities, with everything they need to flourish—and with connections to their culture, ethnicity, race, and language.*

*- Vision, CWLA National Blueprint for Excellence in Child Welfare*

## **Quality Improvement Report**

*COMPLETED BY*

**Child Welfare League of America**

**Submitted to**

**Governor Deval Patrick  
And Secretary John Polanowicz**

**May 22, 2014**

# Table of Contents

INTRODUCTION.....	2
SCOPE OF WORK .....	3
CWLA TEAM'S MODEL .....	4
Review Process .....	4
CASE SUMMARY: Jeremiah Oliver/Oliver Family .....	7
Family Constellation .....	7
Case Chronology.....	8
Medical Examiner's Report.....	11
INTRODUCTION TO FINDINGS AND RECOMMENDATIONS .....	12
Framework for Findings and Recommendations.....	12
FINDINGS AND RECOMMENDATIONS .....	13
Rights of Children .....	13
Findings .....	13
Recommendations .....	16
Shared Responsibility and Leadership .....	20
Findings .....	21
Recommendation .....	22
Engagement/Participation .....	23
Findings .....	23
Recommendations .....	27
Supports and Services .....	29
Findings .....	29
Recommendations .....	33
Quality Improvement .....	37
Findings .....	37
Recommendations .....	39
Workforce .....	40
Findings .....	40
Recommendations .....	45
Race, Ethnicity and Culture .....	47
Findings .....	47
Funding and Resources .....	48
Findings .....	49
Recommendations .....	50
Important Themes and Critical Next Steps to Address Them .....	50
Future Steps .....	52
Appendix A - Staff Survey	
Appendix B - Consolidated List of Recommendations	
Appendix D - Excerpt, "First Do No Harm"	
Appendix E - CWLA National Blueprint Executive Summary	
Appendix F - CWLA Progress Update, March 13, 2014	

## INTRODUCTION

In January of 2014, the Massachusetts Executive Office of Health and Human Services (EOHHS) sought the assistance of the Child Welfare League of America (CWLA) in response to concerns regarding the safety of children served by the Department of Children and Families (DCF). The precipitating event for this request was the disclosure that Jeremiah Oliver, the youngest child of a family with an open DCF case, was missing from his home, and that DCF was unable to account for his whereabouts. EOHHS requested an objective third-party review of the Oliver case as a part of a larger Quality Improvement Review. CWLA was asked to examine the appropriateness, comprehensiveness, and consistency of certain agency policies and practices in the context of the Oliver case and through the lens of nationally recognized standards and best practices.

Massachusetts is no stranger to high profile cases that result in public outcry and examination of child welfare by task forces, commissions, and panels that make detailed recommendations and plans for needed change. For example, the 1978 Gallison case<sup>1 2</sup> led to the separation of child welfare from the Department of Public Welfare and to the creation of the Department of Social Services. In 1992, a Governor's Special Commission on Foster Care was convened after the sudden removal of Mikey Sanborn from the foster home where he had lived for eight years. Most recently, in 2007, Haleigh Poutre's case led to, "First, Do No Harm" - A Report of the House Committee on Child Abuse and Neglect.<sup>3</sup> Each of these cases inspired calls for reform and lists of recommendations for the practice of child welfare.

The Oliver case and other high profile cases highlighted in the media during the period of CWLA's Quality Improvement Review point to systems issues within DCF, multi-systemic issues (across EOHHS, other agencies, and systems), and societal challenges. Many of these issues have been addressed in earlier reviews, and many were identified in "First, Do No Harm" in 2007. (See Appendix D.)

Addressing issues such as child abuse and neglect, domestic violence, chronic mental health challenges, drug abuse and addiction, multi-generational challenges, poor parenting choices, homelessness, cultural differences, disproportionality, parental incarceration, and poverty require coordinated efforts on multiple fronts. To prevent the deaths of children, like Jeremiah, who come to the attention of DCF because of allegations of abuse and neglect, we must look

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<sup>1</sup> COMMONWEALTH vs. DENISE M. GALLISON. 383 Mass. 659, February 3, 1981 - June 3, 1981. Retrieved from: <http://masscases.com/cases/sjc/383/383mass659.html>

<sup>2</sup> COMMONWEALTH vs. EDWARD R. GALLISON. 384 Mass. 184, May 5, 1981 - July 31, 1981. Retrieved from: <http://masscases.com/cases/sjc/384/383mass184.html>

<sup>3</sup> "First, Do No Harm" – A Report on Child Abuse and Neglect (2007). Massachusetts <http://archives.lib.state.ma.us/bitstream/handle/2452/35635/ocn122264972.pdf?sequence=1>

beyond DCF itself; we must address the core issues that lead children and families to need DCF's intervention and services. No amount of negative media coverage, grandstanding, finger-pointing, or terminating Commissioners will change such enormous problems without concerted, coordinated efforts at local, state and national levels. For many years, Massachusetts has not been attentive enough to these issues. These are problems that can be changed only when all individuals, communities, and organizations are ready to examine their roles and take responsibility for their contributions to tragic case outcomes such as Jeremiah's death, and when they are willing to work collaboratively to make improvements. Everyone must be ready to advocate for overhaul of the parts of the system that do not protect children adequately, and for providing appropriate levels of services and funding.

## **SCOPE OF WORK**

In contracts between EOHHS and CWLA, the CWLA Team was charged with reviewing certain information and providing analysis of:

- The Oliver case;
- DCF's Critical Incident Unit (CIU) investigation regarding Jeremiah Oliver and his family;
- DCF's home visitation policies and practices;
- The assessment methodology DCF used to conduct its Tier Review Process, including a review of practices related to young parents; children of parents with a history of substance abuse, domestic violence, mental health or unresolved trauma; and, substance exposed newborns;
- DCF's practices related to 51A reports including staff training and screening criteria;
- DCF intake and case assignment practices;
- Technology Needs and Challenges;
- Staffing in the North Central DCF Area Office;
- Medical Screenings;
- Criminal Offender Record Information (CORI) and Background Checks;
- Quality Improvement Processes, including the Case Review Process;
- Caseload and Workload Ratios;
- Case Practice and Policy, including the Case Practice Model (ICPM); and
- Staff Qualifications, Training, and Supervision.

## **CWLA TEAM'S MODEL**

Between 2005 and 2009, CWLA, in partnership with another state's Department of Children and Families, developed a special model for reviewing critical cases and child fatalities. The process is a holistic quality improvement tool with the goals of learning from tragic events, and applying lessons learned to improve service delivery and enhance an agency's capacity to perform well.<sup>4</sup> At the root of the model is recognition that, for a review process to have positive and lasting results, it must be highly interactive and transparent, it must engage staff, consumers, and other stakeholders, and it must emphasize learning rather than finding fault. Participants must be made to feel safe in sharing truthful information, their insights, and opinions, and staff must feel supported and cared for during the review process.

Paramount to CWLA's Quality Improvement Review is the determination that Jeremiah Oliver's legacy should be that, in his memory, Massachusetts makes lasting improvements that increase child protection, and will give children of the Commonwealth and their families increased supports and services to help them to flourish.

### **Review Process**

The CWLA Team reviewed the Oliver family's case record and conducted interviews with individuals who have had or currently have direct involvement in the case, including the DCF Social Workers, Supervisors, Managers, and Attorneys currently employed by the Department. In addition, interviews were conducted with internal and external collateral professionals who have had or have responsibility for working with either the parents or the children in the Oliver family. Two providers declined to meet with the CWLA Team.

The CWLA Team reviewed the following documents:

- DCF Policies, Procedures and Guidelines
- 2007 Massachusetts Legislative Report issued by the House Committee on Child Abuse and Neglect
- 2012 Trends Critical Incident Report, DCF, January 2012
- Examples of monthly reports issued by DCF, including:
  - Caseloads (investigations/assessments, and home visit reports specific to the North Central Office)

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<sup>4</sup> Schultz, M. Bartolo, A., Reitz, A., & Davis, E. (2007). Child Fatality Review as a program improvement tool: toward a respectful and effective transfer of learning to practice. Common Ground.

- Statewide home visits reports
- Statewide twelve month weighted caseload summaries
- Statewide monthly caseload/weighted summaries
- Statewide monthly supervisor monitoring report
- Statewide screening, supported and closing rates report
- Statewide twelve month summary of completed investigations
- Statewide social worker workload report and number of social workers with more that 22 cases for one reporting month
- Statewide reports of child abuse and neglect - twelve month summary
- Statewide initial assessments - twelve month summary
- Statewide case management cases-twelve month summary
- Statewide twelve month weighted caseload summary
- Statewide adoption report - twelve month summary
- Statewide family resource FTE needed
- Statewide family resource total number of licensed homes summary
- Statewide summary of total number of active, licensed family resource homes
- Statewide summary of total number of ICPC homes
- DCF Organizational Charts for Central Office, Regional Offices, and Area Offices
- Memorandum of Understanding (MOU) between Service Employees International Union (SEIU) local 509 and DCF regarding caseloads and caseload weighting
- Documents and correspondence from SEIU local 509
- Job descriptions, including educational and experience requirements, for the following DCF positions:
  - Director of Areas
  - Area Clinical Manager
  - Area Program Manager
  - Social Worker C, D, and E
  - Social Worker A & B
- ICPM Training Modules
- Structured Decision Making® Instruction Manual (2011)
- Child Welfare Institute training materials for New Social Worker Professional Development, Supervisor Training, Manager Training Practice Coaching, Investigator and Hotline Training Series, and the topics for in-service training
- DCF Substance Abuse Tool Kit
- DCF Domestic Violence Unit's training materials
- Draft bills and outside budget language from the Legislature concerning background checks
- Official Audit Report - Issued March 26, 2014 Department of Children and

- Families For the period July 1, 2010 through September 30, 2012<sup>5</sup>
- EEC Public Approval Reports of DCF Area Offices.

The Review Team, with assistance from two additional facilitators, conducted a total of six focus groups across the state. Approximately 160 individuals participated in these groups, including:

- Representatives of the following state agencies, programs, and initiatives:
  - Children’s Behavioral Health Initiative
  - Department of Early Education and Care (EEC)
  - Department of Mental Health (DMH)
  - Department of Public Health (DPH)
  - DPH - Family Health and Nutrition
  - DPH - Substance Abuse Services
  - DPH - Community Health and Prevention
  - Department of Transitional Assistance
  - Department of Veterans’ Services
  - Department of Youth Services
  - Executive Office of Education
  - Interagency Council on Housing and Homelessness
  - Mass Health
- Professionals including court personnel, parent support organizations, and representatives from the provider community, including many from both the Massachusetts Provider’s Council and the Children’s League of Massachusetts;
- Birth parents and extended family members, foster families, adoptive families, kinship families;
- Former foster youth/young adults;
- Members of the DCF Parents’ Advisory Committee;
- Former/current participants in the DCF Fatherhood Initiative;
- Representatives from the Court Appointed Special Advocates (CASA).

The CWLA Team met with the Office of the Child Advocate (OCA) staff concerning the Oliver case, and reviewed two OCA Reports.<sup>6</sup>

The Review Team received more than fifty phone calls and emails from birth parents, foster parents, DCF staff, foster youth, former foster youth, and numerous “interested and concerned” professionals across Massachusetts. Team members responded to most of these calls/emails, and in some cases, met in person with groups or individuals.

In addition, a 26 question staff survey was developed by the CWLA Team. The survey was sent to all levels of DCF staff in Central Office, and all Area and

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<sup>5</sup> Retrieved from: <http://www.mass.gov/auditor/docs/audits/2014/201310583s.pdf>

<sup>6</sup> Reports on Jeremiah Oliver, and Chase Gideika

Regional Offices. A total of 1,146 DCF staff responded to the survey, which is more than one-third of the total staff. (Survey results are included in Appendix A)

The CWLA Team conducted several briefings with lawmakers, and had ongoing communication with the Governor's staff, and EOHHS staff throughout the review period. The CWLA Team also attended the public hearing conducted by the House Post Audit and Oversight Committee and Committee on Children, Families and Persons with Disabilities on January 23, 2014, and attended the Governor's press conference on January 27, 2014.

The CWLA Team submitted a Progress Update to Governor Patrick and Secretary Polanowicz on March 13, 2014. (See Appendix F.)

An Exit Meeting was held on May 16, 2014, with the DCF Commissioner, members of her leadership team, and other DCF staff who were integral to the review process.

During the approximately five weeks between issuance of this report and the conclusion of CWLA's current contract with EOHHS, the CWLA Team will continue to provide technical assistance to DCF and EOHHS, and will assist leadership and staff to address some of the findings and take initial steps toward implementation of several recommendations. (See Future Steps)

## **CASE SUMMARY: Jeremiah Oliver/Oliver Family**

Due to the sensitive nature of this case and the ongoing criminal investigation, the following case chronology contains only information that has been made public to date.

### **Family Constellation**

Jeremiah Oliver's nuclear family included the following household and non-household members:

<b>Person</b>	<b>Age (as of 12/2013)</b>	<b>Relationship to Jeremiah</b>
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#### **Residing in the household**

E.O.	28	mother
A.S.	23	mother's boyfriend
J.	7	sibling
R.	9	sibling



**Not residing in the household**

J.O.	41	father
B.O.	10	half-sibling

**Case Chronology**

The Oliver family history includes child protective involvement in another state dating back to 2005. The family received and participated in various services at different intervals until August 2007. The family moved to Massachusetts around 2011. Massachusetts DCF requested information from the other state, but received only summary information that did not provide sufficient detail about the family's history. Additional information was not provided by the other state until after Jeremiah's disappearance. A new request was initiated at the beginning of this review, and the other state supplied more detailed information.

On September 8, 2011, the Oliver family became involved with the Massachusetts Department of Children and Families (MA DCF) for the first time. The children were ages 7, 5, and 2.5 years old. A 51A report was filed alleging neglect of the Oliver children by their parents. The case was screened in for investigation and was then opened for services.

The assigned DCF Social Worker met regularly with the family over the course of the next fifteen months. Referrals were made for services for both the parents and children. Clothing, furniture, and toys were obtained for the family. During this time, the Social Worker accompanied Jeremiah's mother to school meetings and assisted her in making and attending appointments for the children.

On March 12, 2012, a 51A report was received alleging neglect of the Oliver children. This report was screened out, as the assigned Social Worker followed up on those issues identified in the report.

From April through the fall of 2012, the Social Worker continued to provide support to the Oliver family. Mother moved several times and was housed in shelters. In September 2012, Jeremiah's mother informed the Social Worker that she had found a new apartment and requested assistance in transitioning to this apartment in a different city. The move necessitated transferring the case to a different DCF Area Office. The family relocated in October, 2012. The Social Worker provided support that included assisting in stabilizing housing, helping mother attend to the children's school and day care needs, and making referrals to other appropriate community supports.

On December 15, 2012, the Social Worker completed a Case Transfer Summary, in which she identified the issues currently being addressed, the services the family was receiving, and contact information for the providers of those services.

On December 24, 2012, the Social Worker made a final home visit to the Oliver family. She addressed with mother the Service Plan tasks to which they had agreed and the Department's expectations regarding completion of those tasks. The Social Worker brought Christmas gifts for the children and encouraged mother to work with the new DCF worker.

On January 7, 2013, DCF received another 51A report alleging neglect of the Oliver children. This report was screened out. The Oliver family case was officially transferred to the North Central Area Office on January 15, 2013. A home visit to the Oliver family was not made in January 2013. The new DCF Worker had been instructed by the Supervisor to make a home visit and did not let the Supervisor know of her inability to complete this task. Two home visits were made during the month of February 2013. During the course of one of those visits, the case record indicates that mother requested that her case with DCF be closed. The DCF Worker agreed to discuss that possibility with her Supervisor. A home visit was not made during the month of March 2013.

On April 2, 2013, the DCF Worker attended a meeting at Jeremiah's pre-school. She also made a visit to the Oliver home on April 30, 2013. The DCF Worker did not speak directly with the children, but observed them while they were playing. She noted the children were clean and dressed appropriately. During this visit, mother mentioned that she was thinking about sending the children to her mother's home in Florida for the summer.

On May 14, 2013, a 51A report was filed alleging the physical abuse of the oldest child by mother. This report was screened in and was supported following the completion of the investigation. On May 20, 2013, the Investigations Social Worker visited the family's home and met with mother concerning the allegations. Mother provided information that her children were receiving services outside of the Department. During this visit, the Investigations Social Worker spoke at length with Jeremiah. This was the last time that any DCF staff saw him. The DCF Worker cancelled a scheduled May 28, 2013 visit with the family.

On June 8, 2013, a 51A report was filed alleging neglect of the Oliver children by their mother. On June 10, 2013, another 51A report was filed alleging neglect of Jeremiah by his mother. On June 17, 2013, a third 51A report was filed alleging neglect of Jeremiah by his mother. Two of the three reports were filed by mandated reporters; all three of these reports were screened out.

On June 17, 2013, mother contacted Jeremiah's school and informed them she was considering moving to Florida.

On June 26, 2013, Mother contacted her DCF Social Worker, stating that she did not want any further involvement with the Department, and she was not receiving any services or assistance from the Department. She also refused to provide her new address to DCF. Following this conversation, the Social Worker contacted the family's providers, one of whom stated that she met with mother weekly, but only outside of the home, and that she did not know where the Oliver family was living. Staff at Jeremiah's school reported that mother had informed them he would no longer be attending the program as the children were moving to Florida.

Home visits were not made in either June or July 2013. The Supervisor and Area Program Manager were aware of this situation.

On August 22, 2013, the DCF Worker learned through a community provider that the children had not moved to Florida and that the family was living at a new address. In September, the same provider stated that mother was using the services less frequently and that services were scheduled to be terminated in October 2013.

In September 2013, DCF undertook an agency-wide review of all cases involving children ages 0 – 5, who were living at home. The Oliver family's case was part of this review. False information was given concerning the status of the family/case, and eventually it became known that the DCF Worker had not made a home visit during September 2013.

On October 9, 2013, the DCF Worker contacted Jeremiah's school and learned that he had not attended the program since June 26, 2013. The DCF Worker did not make a visit to either the school or the family home during October 2013.

On November 5, 2013, the DCF Worker visited the school of the older children and interviewed both of them. The oldest child indicated that his younger sibling was living with their "other family" that he did not know. The middle sibling reported that the brother of her mother's boyfriend sometimes watched Jeremiah. Following this interview, the DCF Worker made an unannounced visit to the family's home. When no one answered the door, the Worker left a business card.

On November 15, 2013, the Guidance Counselor called the Social Worker to report that she had been unable to reach mother.

A home visit was not made during the month of November 2013.

On December 2, 2013, a 51A report was filed by a mandated reporter alleging the neglect of the three Oliver children by their mother. This report was screened in for investigation and assigned to a DCF Investigations Social Worker. On the same date, the Social Worker and Supervisor attempted to make a home visit;

however, no one answered the door. At 8:55 PM, mother left an “incoherent” voice mail message for the DCF Worker. On December 3, the DCF Worker left a message for mother to contact her. On this same day, a man described as a “friend” of mother called the DCF Worker and stated that mother was “depressed.” The DCF Worker asked that mother contact her immediately.

On December 5 & 6, 2013 the Investigations Social Worker made a total of three unannounced visits. Although noises could be heard from the apartment, no one answered the door. On December 7, 2013, Comprehensive Emergency Services (CES) was sent to the home. Voices were heard coming from within the home, but no one answered the door.

On December 9, 2013, the case Supervisor left a message for mother indicating that if mother did not contact DCF by 5 PM that day, legal intervention would occur. Mother did not respond as requested. On Tuesday, December 10, 2013, the Department requested and was granted, custody of the three children and the two older children were removed from their home on that same day.

On December 13, 2013, the ISW spoke with both the maternal grandmother and maternal aunt who reside in Florida. Both denied that Jeremiah was with either of them. The local sheriff's office dispatched an officer to the maternal grandmother's home and confirmed that Jeremiah was not there.

On December 13, 2013, mother appeared in court but did not comply with the court's order to bring Jeremiah with her. Mother refused to disclose the location of her child and was subsequently arrested. Mother's boyfriend was also arrested. Both face numerous criminal charges related to the three children.

Despite the efforts of local and state police, Jeremiah remained missing until Friday, April 18, 2014. On that day, police, searching an area suggested to them via a “tip,” located the remains of a child, later confirmed to be those of Jeremiah Oliver. Autopsies have been performed, but the results have not yet been made public.

On Saturday, May 3, 2014, a wake and funeral were held for Jeremiah.

As of this writing, the criminal investigation is continuing. Both Jeremiah's mother and her boyfriend remain in jail.

Jeremiah's siblings are in the care of DCF and are receiving supports and services appropriate to meet their needs.

## **Medical Examiner's Report**

The Medical Examiner's Report had not been released at the time of this report.

## **INTRODUCTION TO FINDINGS AND RECOMMENDATIONS**

The CWLA Team thanks all Review participants, including DCF and EOHHS staff, OCA staff, service providers, service recipients, community stakeholders, and legislators, for their investment in the process, their willingness to participate in interviews and focus groups and share their experiences, and for their commitment to identifying needed changes.

Throughout the review process, DCF staff at every level of the organization have been cooperative and responsive to the CWLA Team's requests for information.

As the findings and recommendations in this report indicate, the CWLA Team has identified a number of significant issues concerning case practice in the Oliver case. The CWLA Team did not conclude, however, that DCF was responsible for Jeremiah's death or that DCF could have prevented the tragic outcome for this little boy. While there is significant evidence that some DCF staff did not do their jobs in the Oliver case, there is not evidence that DCF's actions and failures caused Jeremiah's death. DCF and many of the adults in Jeremiah's life failed to protect him.

Since Jeremiah's siblings were removed from their home and placed in the custody of DCF, they have received excellent supports and services. There has been exceptional social work. There has been extraordinary teamwork within DCF and among DCF, schools, and community providers to ensure that the children's privacy is protected, and that they receive everything they need to overcome the trauma of their experiences and the loss of their brother.

### **Framework for Findings and Recommendations**

The CWLA Team has used the recently published CWLA National Blueprint for Excellence in Child Welfare,<sup>7</sup> as the framework for presentation of these findings and recommendations. Through its vision, principles, and standards, the National Blueprint is intended to be a catalyst for change, and to promote policies and practices that help organizations and communities more effectively ensure the safety and wellbeing of all children. The National Blueprint can also serve as a guide for DCF, EOHHS, the Massachusetts Legislature, and community partners, as they move forward to better serve the children, youth, and families of Massachusetts. (See Appendix E for Executive Summary CWLA National Blueprint.)

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<sup>7</sup>CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, April, 2013

The CWLA Team’s findings and recommendations align with the principles and standards of the CWLA National Blueprint. Presentation of findings and recommendations is not intended to represent priority. (See the Implementation Timetable attached in Appendix C for recommended timeframes for accomplishment of the CWLA Team’s recommendations.)

These findings and recommendations are based upon the CWLA Team’s synthesis of information gathered during the quality improvement review process, including: the Oliver case record; interviews; focus groups; review of reports and data; DCF policy, procedures, guidance, tools, training materials, and memoranda; other reports and correspondence; meetings with internal and external stakeholders; and consideration of current trends, research, and best practice in child welfare.

The CWLA Team found strengths and concerns that are consistent with DCF internal reviews and recent reports issued by the Office of the Child Advocate.<sup>8 9</sup>

## **FINDINGS AND RECOMMENDATIONS**

### **Rights of Children**

#### **Principle:**

*It is the responsibility of all members of society to work toward the shared goal of advancing the fundamental rights and needs of children.*

### **Findings**

It is a perennial challenge for child welfare organizations to make the right decisions when questioning whether or not a family is in need of assistance, whether a family can care for children, whether children can remain in the home safely, and whether it is necessary to remove children from their home to protect them from child abuse and neglect. A common thread in discourse about the deaths of children known to child welfare organizations is that “the pendulum has swung too far” – that there is too much emphasis on preserving families and not enough emphasis on protecting children – as if there is a choice between one or the other. CWLA believes that is a false dichotomy.

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<sup>8</sup> OCA Report on Jeremiah Oliver, 1/2014

<sup>9</sup> OCA Report on Chase Gideika, 5/2014

In fact, DCF must do both, and its regulations at once recognize the difficulty of the dual mission and require the dual mission. DCF regulations, 110 CMR, state:

*The policy of the Commonwealth of Massachusetts and therefore of the Department of Children and Families (Department) is to strengthen and encourage family life so that every family can care for and protect its children. To that end, the Department will make every reasonable effort to encourage and assist families to use all available resources to maintain the family unit intact. However, for so long as a family cannot or does not provide the necessary amount of care and protection for its children, the Department will intervene to protect the right of children to sound health and normal physical and mental development. These dual obligations - to protect children and yet simultaneously to respect the right of families to be free from unwarranted state intervention - present an inherently difficult balance to strike. Yet, this is precisely the Department's mandate. The effort to balance these two basic obligations, above all others, shall govern the Department's activities.*

Central tenets of the CWLA National Blueprint are that children's rights are human rights, that it is the right of each child to have decisions made in his/her best interests, and that it is the responsibility of all members of society to uphold the rights of children. An artificial dilemma is created by considering family preservation and child protection to be opposite sides of a pendulum swing. Both family preservation and child protection are necessary, and any decisions about either should be driven first and foremost by each child's right to have decisions made in his/her best interests.

While the CWLA National Blueprint identifies rights of children that may be broader than those identified in MA law and regulation, the Blueprint's concepts are consistent with Massachusetts' initiatives in recent years, and the CWLA Team believes that using it as a foundation for change will help DCF to better achieve its mission.

## **Upholding Rights of Children**

DCF's current mission statement, practice model, and policies state that it is DCF's responsibility to protect children from abuse and neglect. They do not specifically state that it is DCF's responsibility to uphold the rights of children or to act in their best interests.

In the survey of DCF staff conducted by the CWLA Team, only 35% (373) agreed strongly with the statement, "I am responsible for advancing the fundamental rights of children." 109 disagreed/disagreed strongly, while 87 did not respond to this statement. (See Appendix A, Question 11)

## **Right to Protection**

Jeremiah and his siblings were not protected from abuse and neglect during some of the time that they resided with their mother or during the time they

resided with their mother and her boyfriend.

In deference to Jeremiah's siblings, their right to privacy, and the ongoing litigation connected with Jeremiah's disappearance and death, details of their experiences will not be disclosed here. The CWLA Team is confident, however, that adults around the children might have done more to protect the children and defend their rights to have their needs met.

### **Corporal Punishment**

Children should be protected from corporal punishment.

Children have a right to be protected from corporal punishment in every setting in which they live, learn, and receive supports and services. Research regarding the harmful effects of physical discipline/corporal punishment on the well-being of children is extensively documented.<sup>10 11 12</sup> Parents, caregivers, and other adults do not have the right to harm children. It is a basic premise of human rights that one individual's rights may not be used to harm another or to violate another's rights. Therefore, a parent's right to raise a child according to his/her beliefs does not supersede a child's right to be protected from harm.

Jeremiah and his siblings were not protected from corporal punishment.

### **Caregiver Safety**

Children have a right to remain with their families and for their families to receive the support and services needed to preserve the family if possible.

In order to determine whether a caregiver can meet a child's needs, DCF must assess the caregiver's background and history, capacity, including availability of supports, and the caregiver's responsiveness to services. It should be assumed that all adult household members are potential caregivers and they should be included in any safety assessments and risk assessments conducted on behalf of children in the home or returning to the home. (See Engagement/Participation Findings, SDM® Safety and Risk Assessment)

The Oliver family and mother's boyfriend did not keep the children safe, and did not provide the nurturing and love that is each child's right. Mother's boyfriend was not included in any safety or risk assessments. There is not evidence that

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<sup>10</sup> Gershoff, E.T. (2008). Report on Physical Punishment in the United States: What Research Tells Us About Its Effects on Children. Columbus, OH: Center for Effective Discipline.

<sup>11</sup> American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. (1998). Guidance for Effective Discipline. *Pediatrics*, 101(4), 723–728.

<sup>12</sup> American Psychoanalytic Association. Position Statement Regarding Physical Punishment. Retrieved from: [http://apsa.org/About\\_APsaA/Position\\_Statements/Physical\\_Punishment.aspx](http://apsa.org/About_APsaA/Position_Statements/Physical_Punishment.aspx).



DCF was aware of his presence in the home until after Jeremiah's disappearance.

Background checks of foster, kinship, and/or adoptive parents were not a factor in the Oliver case until after removal of Jeremiah's siblings from their mother's home. Background checks, however, have been a focus of the media and the Legislature. The CWLA Team has completed extensive research on current best practices for consideration of background checks and is making detailed recommendations for use of background checks as one component of comprehensive assessment of caregivers and caregiver applicants. (See pages 18 – 19.)

### **Right to Education**

Children should have access to formal education. Children have a right to education with the resources, skills, and contributions necessary for the survival and full development of the child. Each child has the right to develop to his or her full potential. Early childhood education is particularly important for ensuring school readiness. Children should be given access to early childhood and school programs that respond to their social, emotional, psychological, physical, academic, and creative needs.

In addition, schools can play a critical role in child protection by providing eyes on a child and family, observing and reporting changes in family dynamics, and communicating regularly with DCF. It is imperative for children at highest risk to have educational services, including pre-school. Current practice, however, is for slots of some of the most vulnerable children to be terminated because of excessive absence.

Jeremiah was not enrolled in his Head Start school program after June 26, 2013. Until October 9, 2013, the DCF Worker was not aware that Jeremiah was not enrolled and not attending school.

### **Recommendations**

1. DCF should revise its policies, practice guidelines, website, and written materials for consumers to consistently communicate that the agency's primary responsibility is to protect children and to make decisions in their best interests. It should be reiterated to all DCF personnel that although family preservation may be in the best interests of many children, and staff should make sincere efforts to preserve families whenever possible, any decisions about a child's individual goal and plan for removal from the home, reunification with the family, or other plan for permanency should be made in that child's best interests, and not according to a prescriptive hierarchy.

2. All personnel in every organization in Massachusetts providing services to children and families should be trained in the rights of children, as defined in the *Rights of the Child* section of the *CWLA National Blueprint*.<sup>13</sup> The workforce should be charged with upholding and protecting those rights. EOHHS should develop appropriate training materials and provide them to EOHHS agencies, their respective licensees, and their contracted vendors. In addition, the materials should be provided to MA membership organizations such as the Children's League and Providers' Council, and should be circulated through the Children's Trust. (See also Workforce Findings and Recommendations.)

3. To help protect children from corporal punishment, DCF should develop a handout for parents/families concerning the negative effects of physical discipline on children.<sup>14</sup> The handout should be added to information given to each family on initial contact, along with information about positive parenting. DCF should also post the written information on its website and should make it available to community providers, schools, early education programs, and medical providers.

4. The MA legislature should consider enacting law that would make corporal punishment of children illegal in Massachusetts.

5. Massachusetts media outlets should undertake a public education campaign to raise public consciousness of each individual's responsibility to protect children from abuse and neglect and to uphold the rights of children.

### **Background Checks**

6. DCF should begin to develop and/or revise and promulgate regulations that ensure that foster and adoptive parent applicants and kinship resources are appropriately assessed and evaluated, without violating the rights of children to maintain connections with their families and communities, and to preserve their racial, ethnic, cultural and religious identities.

7. DCF and EEC should revise regulations to adapt to current best practice trends toward uniform approval processes for kinship and foster/adoptive caregivers. Requirements should be sensitive to the role of disproportionality in criminal prosecution and conviction, and the importance of placing children with relatives whenever possible. The American Bar Association's research concerning foster parent licensing standards<sup>15</sup> will serve as a helpful foundation for revision of regulations.

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<sup>13</sup> CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, April, 2013 p. 25 - 35

<sup>14</sup> CWLA National Blueprint (2013). Standard I.15

<sup>15</sup> Improving Foster Care Licensing Standards around the United States: Using Research Findings to Effect Change (2012). Retrieved from [http://www.americanbar.org/content/dam/aba/administrative/child\\_law/FC\\_Licensing\\_Standards.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/child_law/FC_Licensing_Standards.authcheckdam.pdf)

8. DCF and EEC should consistently support an approval process, rather than a waiver or variance process. Regulations and standards should identify the qualities and characteristics needed by the foster/kinship/adoptive parent, and the minimum requirements that must be evident in the home. Any waivers or variances granted by either DCF or EEC should be limited to non-safety standards.<sup>16</sup>

9. Draft standards in development by American Bar Association (ABA), National Association for Regulatory Administration (NARA), Generations United (GU), and Annie E. Casey Foundation (AECF), expected to be available in May, should be considered as a foundation for home study and approval requirements in Massachusetts.

10. DCF Area Directors and Area Clinical Managers should determine which homes with children in care, currently approved through a background check waiver process, should be subject to heightened case monitoring, home visitation, supervision, or case oversight. These existing caregivers should be subject to background checks recommended herein upon renewal. Such placements should not be disrupted unless there is evidence of recent criminal activity and there is determination that continued placement in the home is not in a child's best interests, and/or when there is evidence and determination that continued placement in the home is not in the child's best interests for reasons unrelated to the caregiver's background check.

11. MA Regulations 110 CMR 18.0 (DCF Criminal Offender Record Checks) and 102 CMR 5.0 (EEC Standards for Licensure or Approval of Agencies Offering Child Placement and Adoption Services) should be revised to require that if the results of a background check indicate that an applicant has been convicted of any of the following felonies and a court of competent jurisdiction has determined that the felony was committed, then the individual's application shall be rejected and the individual shall be excluded from eligibility as a foster parent, adoptive parent, or kinship provider. There shall be no exceptions for these crimes:

- a state or federal felony conviction for assault and battery on a child with injury (c. 265, §13J),
- assault with intent to rape (c. 265, §24),
- forcible rape of a child/assault with intent to rape a child (c. 265, § 22A, 22B, 22C, 24B),
- rape and abuse of child aggravated by age (c. 265, § 23A),
- rape and abuse of child by previous offenders (c. 265, § 23B),
- posing or exhibiting child (c. 272, §29A),

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<sup>16</sup> Report To Congress On States' Use Of Waivers Of Non-Safety Licensing Standards For Relative Foster Family Homes (2011). Children's Bureau, ACF, U.S. Department of Health and Human Services. Retrieved from [http://www.acf.hhs.gov/sites/default/files/cb/report\\_congress\\_statesuse.pdf](http://www.acf.hhs.gov/sites/default/files/cb/report_congress_statesuse.pdf)

- incest (c. 272, §17),
- indecent assault and battery (c 265, §13H, c 265, § 13B, 13B ó, 13B ., c265, §13F),
- inducing a minor to prostitution (c. 272, §4A),
- murder (c. 265, §1),
- rape (c. 265, §22(b), c 265, §22(a)),
- unnatural acts with a child under 16 (c. 272, §35A),
- enticement of child under 18 prostitution (c.265, § 26D),
- human trafficking (c. 265 §§50-).

If a record check reveals that a foster care, adoption, or kinship applicant or any potential caregiver in the home has a state or federal felony conviction for physical assault, battery, or a drug-related offense, and a court of competent jurisdiction has determined that the felony was committed in the past 5 years, the department or licensed placement agency shall reject the request for foster care placement, adoption, or kinship care.

12. DCF and EEC regulations should be revised to require that for any foster care, adoption, or kinship applicant whose background check indicates conviction for any crimes other than those listed in the previous recommendation that are currently listed on Table A of 110 CMR 18.00 (hereinafter “Table A crimes”), DCF or the licensed provider should require screening by a mental health or criminal justice professional from outside of the agency before completion of the home study, and a written opinion by the mental health or criminal justice professional that the individual does not pose an unacceptable risk of harm to the child(ren) to be placed in his or her care. Additionally, DCF and EEC regulations should require review of the outside professional’s opinion and review of the individual’s application and supporting documents by at least two licensed clinical staff. If the home study has been completed, the review must be conducted by persons who were not involved in the applicant’s home study.

13. DCF and EEC should revise regulations to require that if an applicant for foster care adoption or kinship care was convicted of any crime other than those requiring exclusion, the licensing/approval agency shall consider the following factors in making its decision whether to approve or deny the application or renewal:

- (1) the type of crime;
- (2) the number of crimes;
- (3) the nature of the offenses;
- (4) the age of the individual at the time of conviction;
- (5) the length of time that has elapsed since the last conviction;
- (6) the relationship between the crime and the individual’s capacity to care for children;
- (7) if a specific child has been identified, the current and future needs of the child to be placed and the probable effect that the crime would have

on the applicant's ability to fulfill those needs;  
(8) the relationship between the individual and the child in question, if any;  
(9) evidence of rehabilitation; and  
(10) opinions of community members concerning the individual in question.

14. DCF and licensed placement providers should ensure compliance with current policy relative to retaining all records of any criminal background checks they undertake for applicants for foster care, adoption, or kinship care.

15. The CWLA Team recommends that the executive branch and the legislature should carefully consider potential ramifications that any changes to background checks for foster and kinship resources might have on background check completion for other child caring situations, including but not limited to licensed child care centers, family child care, residential providers, and adoptive parent applicants through DCF and licensed adoption agencies.

### **In-Home Safety**

16. To uphold each child's right to be protected from abuse and neglect while also upholding the child's right to live with family unless it is not in the child's best interests, DCF should develop clear protocols for evaluating risks to children living at home, including risks from household members who are not the child's parents. Structured Decision Making tools and safety assessments should be used consistently to assist workers in making informed decisions and recommendations.

17. DCF should increase the availability of Substance Abuse, Domestic Violence and Mental Health Specialists to assist staff in evaluating the potential risk to children who remain at home, especially when there are allegations of abuse, domestic violence, mental health challenges and/or substance abuse by adults in the household. DCF staff should be provided with training concerning the increased risks associated with live-in intimate partners.

## **Shared Responsibility and Leadership**

### **Principle:**

*Families, individuals, organizations, and communities share responsibility for assuring the safety and well-being of children and youth. To help children and youth flourish, leaders at every level and in all realms ensure that individuals, families, organizations, and systems collaborate, communicate, create, and nurture meaningful partnerships.*

## Findings

### Shared Leadership

Focus group participants were quick to point to positives concerning DCF leadership, including:

- sister agencies have “constructive” relationships with the agency;
- the agency has become more open in the past two years;
- there is a growing emphasis by leadership on the importance of cross-training;
- DCF has set good examples for other agencies in engaging parents, especially through its Father Initiative;
- DCF has taken the lead in developing resources for trauma-informed approaches;
- DCF has been proactive in building relationships with educational leaders and in encouraging the use of trauma-informed approaches;
- DCF leadership has been willing to work across agencies on projects and in cases that involve multiple agencies.

The CWLA Review Team found consistent concerns regarding leadership’s abilities to:

- Create an atmosphere of trust and respect among EOHHS, DCF senior leadership, staff, and community partners;
- Facilitate communication within the agency among co-workers, units, and program areas;
- Preserve and nurture successful collaborative working relationships;
- Accept responsibility for decisions that negatively impact DCF staff, community partners, and the children and families served by DCF.

Leadership is defined by behaviors, traits, roles, relationships, interaction patterns, and influence on organizational goals and culture.<sup>17</sup>

Leadership behaviors and practices influence worker motivation, organizational commitment, productivity, and job satisfaction.<sup>18</sup>

Leaders must acknowledge the influence of their behavior on workers’ job satisfaction and productivity and must also be more aware of workers’ expectations and perceptions of leadership.<sup>19</sup>

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<sup>17</sup> Elpers, K., & Westhuis, D.J. (2008), Organizational leadership and its impact on social workers’ job satisfaction; A national study, *Administration in Social Work*, 32(3), 26-43.

<sup>18</sup> Ibid.

A recent research study found that workers in child welfare agencies with more engaged and functional climates (having a clear concept of success in the organization) and less rigid cultures have higher levels of job satisfaction and also increased organizational commitment.<sup>20</sup>

A positive organizational culture - the attitudes, behaviors, and values of an organization - can not only create a supportive work environment, increase productivity, improve self-efficacy, but can also contribute to decreasing staff turnover. The elements of constructive organizational culture include humanistic encouraging, achievement, and pathways to fulfilling professional goals.<sup>21</sup>

Many factors influence an organization's culture:<sup>22</sup>

- Use of evidence-based practice
- Job satisfaction
- Self-efficacy
- Work-life fit
- Training
- Supervisory support, flexibility & awareness
- Workload
- Salary/benefits

## Recommendation

1. EOHHS and DCF should develop a plan for ensuring that individuals at each level of leadership have the following competencies:

- Broad-based child welfare knowledge and experience;
- Strong communication and listening skills;
- Effective problem solving skills;
- Ability to provide support for staff in a respectful and professional manner;
- Cultural competence, cultural humility, and awareness of the diverse individuals and groups in their community and among the DCF and community provider workforce;

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<sup>19</sup> Ibid

<sup>20</sup> Glisson, C., Green, P., & Williams, N.J. (2012). Assessing the Organizational Social Context (OSC) of child welfare systems: Implications for research and practice. *Child Abuse & Neglect*, 36, 621-632.

<sup>21</sup> Collins-Camargo, C., (2010). A study of the relationships among effective supervision, organizational culture promoting evidence-based practice, and worker self-efficacy in public child welfare, *Journal of Public Child Welfare*, 4(1), 1-24.

<sup>22</sup> Abgenyiga, D.L.,(2009). Child welfare employee recruitment and retention: An organizational culture perspective. *Child Welfare*, 88(6), 85-108.

- Skills necessary to initiate, nurture, and sustain collaborative working relationships with all external community partners, as well as colleagues within DCF and EOHHS;
- Understand, embrace, and model a working philosophy of shared accountability and responsibility; and,
- Knowledge and understanding of the effect of secondary traumatic stress on the workforce, and appropriate interventions.

## **Engagement/Participation**

### **Principle:**

*Children, youth, and families are engaged and empowered to promote family success and build community capacity. Service providers and organizations acknowledge, appreciate, and validate the voices and experiences of those whose lives they touch, so that responsive community-based resources and services are developed, nurtured, and sustained.*

## **Findings**

### **Visitation**

The CWLA Team made the same determination that has been widely reported in the media and in previous reports: a primary concern in the Oliver case was the fact that one of the assigned workers did not visit as required by DCF policy. Between January 2013, when the case was transferred to the North Central Area Office and December 2013 when Jeremiah was reported missing, the assigned worker made only three successful visits to the home: 2/12, 2/21, and 4/30; a 5/28 visit was canceled. When the worker made an unannounced visit to the home on 11/2/2013, it appeared that nobody was at home. The worker and supervisor made a visit to the home on 12/2/2013, when, again, nobody answered the door. There was one additional visit with Jeremiah's siblings at their school on 11/2/2013.

The Tier III review information reported by the worker and supervisor included the statement that mother had "recently obtained an apartment for her family. The apartment is adequately furnished. The home has been clean without safety hazards." Once Jeremiah was reported missing and the case was reviewed by the Case Investigation Unit (CIU), it was determined that the Oliver family had moved during the summer, and the worker had not seen the family's apartment.

The current requirements for documenting visits and the available data reports



make it difficult for supervisors and managers to monitor whether or not visits to children and families have been completed. Workers are expected to enter each visit into iFamilyNet (DCF's data system) within 30 days of the visit. Since many visits have not yet been entered by the end of the calendar month, the monthly reports cannot reflect accurate information. It is anticipated that in July 2014 DCF will be implementing a real-time mechanism for reporting of visits. There is not a current mechanism for real-time reporting of visits, nor is there a mechanism for verifying information entered into the iFamilyNet system.

### **Integrated Case Practice Model (ICPM)**

Practice models that are designed to have a positive, system-wide impact, are transparent, well-articulated, and contain principles and standards of professional practice that guide the everyday interactions among employees, children, families, and community partners to achieve defined outcomes.<sup>23</sup> A case practice model should make an "explicit" link, connecting the agency's policy and practice with its mission, vision, and core values.<sup>24</sup>

Experts maintain that a case practice model should have the following elements:<sup>25</sup>

- Core principles, agency values, and standards of professional practice;
- Strategies and functions to achieve the core principles, values, and standards;
- Plan for assessing service needs and engaging families;
- Strategies to measure child/family outcomes and agency outcomes; and
- Plan for supporting organizational practice change.

DCF's Integrated Case Practice Model (ICPM), rolled out in 2009, is at a crossroads in its development and use. The CWLA Team received feedback from many sources that the ICPM has been poorly supported (staffing), and not well-integrated into practice or well-received in many DCF Area Offices across the state. The model was challenged from the start by significant cuts to the DCF budgets, variability in leadership, an organizational culture lacking in trust (limited staff buy-in), union/management differences, and ever-growing caseloads of families and children with complex and challenging needs.

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<sup>23</sup> Myslewicz, Mary, Casey Family Program Report, July 2008

<sup>24</sup> National Child Welfare Resource Center for Organizational Improvement (April 2008). Understanding and Developing Child Welfare Practice Models. Retrieved July 14, 2008 from: <http://www.hunter.cuny.edu/socwork/nrcfcpp/information.html#hottopics>

<sup>25</sup> National Child Welfare Resource Center for Organizational Improvement (April 2008). Understanding and Developing Child Welfare Practice Models. Retrieved July 14, 2008 from: <http://www.hunter.cuny.edu/socwork/nrcfcpp/information.html#hottopics>

There is a disconnect between DCF's stated Core Values<sup>26</sup> and the practice principles of ICPM. There is not an articulated set of practice principles that reflect the core values and support an integrated approach to practice. For example, the first value listed is that practice is "Child-Driven," yet there is no principle that speaks to the child's right to basic safety. In CWLA's review of nine other states' case practice models, two states in particular, Washington and Maryland, clearly stated that the protection of children/keeping children safe was their first priority. An effective practice model includes specific approaches and techniques considered imperative to supporting the agency's value system.<sup>27</sup>

Current DCF policy does not *require* staff to integrate the ICPM into daily practice, resulting in varied case practice, inconsistent guidance by supervisors, and wide interpretation of how the model should be used. Without clear linkages between practice and policy and adherence of both to a set of practice principles, further erosion of DCF's ability to develop integrated practices will continue.

The CWLA Team found that the ICPM does not integrate Substance Abuse, Domestic Violence, and/or Mental Health Specialists into case practice in a meaningful way. A truly integrated practice model would require such specialists to be embedded in a case consultation model. (See Workforce Recommendations.)

The ICPM does not include an evaluation component to measure whether or not the agency is meeting specific performance goals and defined outcomes. (See Quality Improvement, Findings.)

According to the Child Welfare Policy and Practice Group, many jurisdictions have concurred that a practice model has gone far to assist in reform efforts.<sup>28</sup> Some such benefits are:

- Provide a moral authority for practice;
- Force attention to how children and families should experience the system;
- Promote consistency in approaches within the agency;
- Guide the content of policy;
- Inform the design of training;
- Shape the design of the quality assurance process; and
- Clarify employee performance expectations.

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<sup>26</sup> ICPM Fact Sheet. Retrieved from: <http://www.mass.gov/eohhs/docs/dcf/icpm-general-fact-sheet.pdf>

<sup>27</sup> Myslewicz, Mary

<sup>28</sup> Child Welfare Policy and Practice Group. (2008). *Adopting a Child Welfare Practice Framework*. Retrieved from : <http://www.childwelfaregroup.org/resources.html>

## 51As

Multiple 51As, whether screened in or screened out, contain important, and often new, concerns regarding the circumstances of the identified child/ren. There were multiple 51As in the Oliver case that did not receive the required follow-up, allowing critical information to be unavailable to the DCF staff. Even the most seemingly unimportant details about a child or family help to “connect the dots” as to potential risk and safety concerns.

DCF has a requirement that when there are three or more 51As filed on a family within 12 months, the case must be reviewed by Area Office managers. Further, when there are three 51As on a case within 3 months, the case must be reviewed by the Regional Office. Budgets cuts reducing managerial positions at Regional and Area Offices have impacted DCF’s capacity for managerial oversight and have reduced ability to ensure that such reviews occur on a consistent basis.

## SDM® Safety and Risk Assessment

The Structured Decision Making® (SDM) Model has been used in Massachusetts since 2011. Developed by the National Council on Crime and Delinquency,<sup>29</sup> an evidence-based approach, SDM is designed to be used at key points throughout the life of a child welfare case to assist staff in assessing safety and risk, making informed decisions, and reducing subsequent harm. The CWLA Team found that until January 2014, SDM tools were used irregularly.

The CWLA Team reviewed the SDM® Manual and found that the instructions are clear and the tools are straightforward. The CWLA Team believes that full and consistent implementation of the SDM Model would assist DCF staff in making informed decisions about children’s safety and risk in any living situation or environment.

Much effort has gone into the development of training and tools relative to the use of Safety Mapping, and Signs of Safety (SoS), whose purpose is to facilitate the family engagement process. The CWLA Team found that the use of Safety Mapping, and Signs of Safety is inconsistent across the state.

The CWLA Team found that Signs of Safety and Safety Mapping are not required by DCF, which contributes significantly to inconsistent use across the state.

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<sup>29</sup> <http://nccdglobal.org/assessment/sdm-structured-decision-making-systems/child-welfare>

## **Engagement**

In spite of good intentions by many staff and the emphasis the Department has placed on family engagement for many years, there were numerous concerns expressed in focus groups about use of power by social workers and supervisors. Many staff seem to lack understanding of how to engage with families as partners. Stakeholders indicated that families frequently do not understand why DCF is involved with them, and are not given adequate explanations by workers of DCF's role and mandates.

At the same time, the CWLA Team heard extremely positive feedback about the work of the Ombudsman's Office, and the program that facilitates assignment of advocates to families who may need some assistance in dealing with workers and supervisors.

The CWLA Team referred several families to the Ombudsman's Office and advocates, and witnessed first hand positive outcomes from their involvement.

## **Recommendations**

1. Communities (via their local appointed and elected officials) should become more engaged in educating citizens of the Commonwealth on the dangers posed to children by substance abusing parents in general, and the specific high risks associated with the coincidence of substance use and unsafe sleep situations for infants.
2. DCF leadership and staff should develop a plan for increasing routine active engagement of children, youth, families, leadership, and workforce in determining and responding to needs within communities.<sup>30</sup> (See also Quality Improvement and Workforce.)

## **Visitation**

3. DCF should develop visit protocols to assist workers in engaging with children and families during visits, observing and documenting accurately, and assessing safety and risk based on observations and information gathered during every visit. Such protocols should be used during every visit to a child and/or family.
4. DCF should implement statewide a mandatory mechanism for real-time data entry for visits to children, families, and foster/adoptive/kinship homes. Real-time data should include at minimum, the date, time, and location of the

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<sup>30</sup> CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, 2013, pg 52.

visit, and the persons present.

5. DCF should enforce its expectation that documentation of visits/contacts be entered into iFamilyNet no later than 30 days after the date of the contact. (See also Supports and Services, Findings, Technology.)

### **Case Practice Model**

6. The ICPM should clearly reflect first and foremost, that it is built upon the belief that child safety must always take precedence, while at the same time case practice actively assists the preservation of family connections through the engagement of parents as partners.

7. Massachusetts should more fully develop and implement a practice model that will guide and support all child protective work and preventive work in the State, regardless of whether that work is performed by DCF, lead agencies, or community based providers. The model should address the rights of children, and should specify the responsibility of all child welfare personnel for upholding the rights of children.

8. The ICPM Statewide Implementation Committee should re-direct its focus to that of building and articulating a more cohesive case practice model by clarifying the desired elements of such a model, and stating a set of Practice Principles that are straightforward and easily understood. The Practice Principles should reflect the agency's mission/vision, and must be aligned with DCF policy requirements. CWLA recommends using the eight Core Principles of the CWLA National Blueprint as the framework for the review and revision process. Those Principles are: Rights of Children; Shared Responsibility and Leadership; Engagement/Participation; Supports and Services; Quality Improvement; Workforce; Race, Ethnicity, and Culture; and, Funding and Resources. Two states' practice models are recommended as examples that align with the Core Principles of the CWLA National Blueprint: Washington's Family-Centered Practice Model<sup>31</sup> and the Maryland's "Principles for CPS."<sup>32</sup>

9. The ICPM Statewide Implementation Committee should involve DCF staff from every level of the organization, including representatives from SEIU Local 509, as participants in the process of redefining and rebuilding the case practice model. In addition, the Committee should include people who are, or have been service recipients of DCF, at least two representatives from the Parents Advisory Committee, representatives from collaborative providers, and other members of the community. A philosophy of transparency and collaboration is a critical component to facilitating the paradigm shift necessary for successful integration into Massachusetts' child welfare infrastructure.

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<sup>31</sup> <http://www.dshs.wa.gov/pdf/ca/FCPModel.pdf>

<sup>32</sup> [http://www.dhr.state.md.us/blog/?page\\_id=3957](http://www.dhr.state.md.us/blog/?page_id=3957)

10. The Massachusetts Child Welfare Institute (MCWI) should revise its training modules for the ICPM and should incorporate into them the use of genograms,<sup>33</sup> as a technique for engaging families right from the start, as well as a tool for gathering important information. The training modules should also include assessing safety, protective factors, danger, and risk during each contact with the family.

11. DCF leadership must address the root cause of dissent among its managers and social work staff relative to the use of the ICPM. It is unreasonable to expect a practice model to be embraced and properly implemented until the concerns about this practice model are put to rest.

## **Supports and Services**

### **Principle:**

*Families, individuals, communities, organizations, and systems protect children from abuse and neglect, and provide an array of supports and services that help children, youth, and their families to accomplish developmental tasks, develop protective factors, and strengthen coping strategies.*

## **Findings**

### **Availability of Supports and Services**

Focus group participants shared grave concern about insufficient availability of supports and services. Attendees described long waiting lists, especially for early education and childcare, substance abuse assessment and treatment, and housing assistance.

Information collected during interviews confirms that services for substance abuse assessment and treatment are in short supply in many areas of the state, and that waiting lists are long.

Both service providers and service recipients consistently noted that availability (statewide) of childcare slots is inadequate to meet the demands of families served by DCF.

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<sup>33</sup> Special Review Summary Report: Symptoms to Systems (2013). State of CT Department of Children and Families.

Problems are compounded for families when participation in services is a condition of meeting service plan goals, but the service is not available.

### **Substance Abuse Services**

In 2014, the DCF Substance Abuse Unit created a *Substance Abuse Toolkit* to support the day-to-day work of DCF Social Workers as they engage with substance using/abusing families. The Toolkit is an excellent “where to,” “how to,” “when to,” “what is this,” resource for all DCF staff.

On May 8, 2014, The Massachusetts Senate introduced legislation “An Act to Increase Opportunities for Long-Term Substance Abuse Recovery,” (S1965), aimed at increasing access to substance abuse by easing insurance restrictions and requirements. If passed, the legislation will increase availability of existing substance abuse programs, but does not completely address the need for increased assessment and treatment programs needed across the state.

In Massachusetts, it is estimated that 70 to 80% of a DCF Social Worker’s caseload is comprised of children with substance using parents or caregivers.

The Legislature and the Governor have taken action that will improve access to substance abuse services and help address the drug abuse crisis in Massachusetts. Communities, lawmakers, stakeholders, and parents must make every effort to ensure that funding for substance abuse programs is made adequate to meet the increasing demands. Lessons can be learned from states such as Florida, where, over a 5-year period of time, 477 children known to FL DCF died. 323 of those deaths were directly related to substance using parents/caretakers, while funding for substance abuse services was cut year after year.<sup>34</sup>

### **Increased Risk for Children Ages 0-5**

In the fall of 2013, DCF Commissioner Olga Roche ordered Tier Reviews of all children ages 0-5 receiving DCF services. The reviews were ordered based on research citing that approximately one-third of children who die from maltreatment were known to child protection services prior to their deaths.<sup>35</sup> The Tier Review Reports were presented to Secretary John Polanowicz on September 13, 2013<sup>36</sup> and November 6, 2013<sup>37</sup> respectively. The results of DCF’s Tier Review process showed that 63.9% of all cases had been previously opened with DCF.

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<sup>34</sup> Miami Herald, ‘Innocents Lost’ series, March 16, 2014

<sup>35</sup> Putnam-Hornstein, 2001, Peddle & Wang, 2001

<sup>36</sup> Summary of Findings from Tier I Case Reviews (2013). MA DCF.

<sup>37</sup> Summary of Findings Case Reviews Tier II and Tier III (2013). MA DCF.

DCF data are consistent with concerns across the country about the role that domestic violence, substance exposure, mental health concerns, and the presence of unrelated boyfriends may play in increasing the likelihood of serious or fatal child maltreatment.

In 2011, more than four-fifths (82%) of children who died from maltreatment were under the age of 4 years; 42% were younger than 12 months.<sup>38</sup> Younger children account for the majority of children who die or are seriously injured due to maltreatment.<sup>39</sup> Studies have also found that boys are slightly more likely than girls to die from maltreatment-related incidents.<sup>40</sup>

Extensive research exists on the characteristics of families whose children are at risk of maltreatment. Risk factors for child maltreatment include substance abuse, domestic violence, poverty, and homelessness among other stressors<sup>41</sup> There are differences in the prevalence of child maltreatment deaths according to age, race, ethnicity, and gender. Although not specific to children ages 5 and under, research has also found that children residing with unrelated caregivers, particularly males, are at higher risk of maltreatment death than children who live in a home with two biological parents.<sup>42</sup>

Nationwide, almost 200,000 children under the age of three come into contact with the child welfare system every year.<sup>43</sup> Maltreatment chemically alters the brain's development and can lead to permanent damage of the brain's architecture.<sup>44</sup> Through high-quality, timely interventions focused on the unique needs of infants and toddlers, the developmental damage to very young children who have been maltreated can be significantly reduced.<sup>45</sup> It is critically important that child welfare policymakers and administrators understand the impact of maltreatment on infants and toddlers, so that they can systematically implement interventions and services that best meet the needs of these very young children.

As of December 2013, DCF Commissioner Olga Roche issued the following directives:

- Screen in for investigations any report alleging abuse or neglect of a child five years old or younger in which the parent (s) presents any, or a combination of the following risk factors:
  - Young parents;

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<sup>38</sup> DHHS, 2011.

<sup>39</sup> Hochstadt, 2006.

<sup>40</sup> *Child Welfare*, Vol. 92, No 2, Child Welfare League of America, (2013).

<sup>41</sup> Berger, 2005; Edleson, 1999; Mills et al., 2000; Sheldon-Sherman, Wilson, & Smith, 2013; Substance Abuse and Mental Health Services Administration, 1999.

<sup>42</sup> Schnitzer & Ewigman, 2008; Stiffman, Schnitzer, Adam, Kruse, & Ewigman, 2002

<sup>43</sup> Administration for Children and Families, 2012. *Child Maltreatment 2011*, Washington, DC:

U.S. Department of Health & Human Services

<sup>44</sup> Shonkoff, J.P., & Phillips, D.A.. (2000). *From neurons to neighborhoods: The science of early childhood development*. National Academic Press

<sup>45</sup> Ibid



- Parents of any age who have a history of substance abuse, domestic violence, mental health issues, or unresolved trauma.

The CWLA Team recognizes that the December 2013 directives added enormous stress to an already stressed workforce, and that more staff are needed to address the increased demand resulting from those directives. In spite of the increased demands and the difficulty in meeting them, the CWLA Team believes that it is necessary to continue screening and assessing according to the directives until such time as safety and risk assessment protocols, and a case practice model have been implemented consistently across the state, and a quality improvement plan has been developed.

### **Health services**

At the request of EOHHS, the CWLA Team made preliminary recommendations in its March Update Report concerning medical screening. Current medical personnel were interviewed as part of CWLA's Quality Improvement Review.

The recent report by the State Auditor found that DCF is not ensuring that children in care are receiving medical screenings within 7 days of being placed in its custody, and that more comprehensive medical examinations have not been consistently provided within 30 days of children's entry into care. The Auditor's concern is that DCF cannot ensure that children in DCF custody do not have undetected health issues.

### **Missing Children and Runaways**

A review of the DCF policies regarding the handling of cases involving missing children and youth who have run away from placement indicates that the policy adequately provides for basic follow-up and notification of law enforcement and agency personnel.

There is growing awareness that youth on the run and those in care may be more likely targets of pimps and traffickers. In light of increased understanding regarding the reasons young people run away and the risks they face while on runaway status, the CWLA Team believes that DCF should consider protocols and related training to equip workers with knowledge needed to effectively reduce the incidence of runaway behavior.

DCF is in the process of updating its policy.

## Technology

DCF staff typically use personal cell phones to communicate from the field and to respond to overnight and week-end emergencies while on-call.

The Massachusetts Statewide Automated Child Welfare Information System (SACWIS) does not fully accommodate real-time access from handheld devices.

Hotline staff do not have access to information contained in iFamilyNet. They need to call the on-call worker in order to gain access to needed information. Hotline workers should be included in real-time access to iFamilyNet, so that they can access and enter data as needed.

In its March 13, 2014 *Progress Update*, the CWLA Team made the following recommendations that, at minimum, any technological solutions include capacity to:

- Give workers immediate contact with supervisors and/or emergency personnel;
- Document visits in real-time; and
- Upload photos of children to the Massachusetts SACWIS system (iFamilyNet).

The CWLA Team also recommended that EOHHS consider the following technological functions:

- Ability for workers to access SACWIS (iFamilyNet) data from the field on handheld devices that provide data security;
- Ability to complete forms and obtain parent/guardian signatures in the field; and
- Ability to access teleconference/web-based conferencing from the field.

The CWLA Team has been informed of the following progress toward implementation of technology recommendations:

- 2/25/14 to 4/4/14 Pilot with the 60 On Call Supervisors was completed
  - 78% found devices easy to use
  - 74% would use the device daily
- 5/5/14 RFQ was posted
- 5/9/14 Written questions from bidders were due
- 5/15/14 Management's draft of MOU with Local 509 provided to the Union
- 5/16/14 Responses to RFQ were due
- 5/30/14 Projected bidder selection and contract award
- 6/23/14 Projected date to deploy to first area office
- 7/31/14 Projected staff deployment completion date

EOHHS has reported that DCF staff will be able to access case information and enter visit information in iFamilyNet from their handheld devices.

## **Recommendations**

### **Childcare/Early Education**

1. DCF and EEC should work together to revise current standards for discontinuing enrollment of a child in a funded slot when that child does not attend for a specific number of days. Such decisions should be made on an individual basis, with consideration of the child's needs first and foremost, and full consideration of the issues that interfere with and curtail the child's attendance.

### **Transfer of Cases**

2. DCF should finalize and implement its draft policy to require face-to-face meetings among staff for case transfers within Area Offices and between Area Offices. It should be expected that sending and receiving workers will be present, and that Supervisors will attend whenever possible. Up-to-date case notes and a transfer summary should be included in the case record before case transfer.

### **Trauma-informed Approaches**

3. DCF should require that every individual who touches cases in any capacity – from frontline workers to legal staff – should receive training in trauma-informed services, and should be competent in recognizing and responding to signs of trauma and domestic violence. DCF should also offer such training to judges, court personnel, and CASA volunteers.

4. DCF should develop and share with all contracted providers a protocol for trauma-informed engagement of children and families. The CWLA National Blueprint can serve as a guide for developing the protocol.<sup>46</sup>

### **Missing Children and Runaways**

5. DCF should expand its policies and procedures to require that official electronic files contain a photo of each child who enters the care and custody of the agency. Photos should be updated no less than every 6 months for children ages 5 and younger, and should be updated at least annually for all children older than 5.

6. DCF should revise runaway and missing child procedures to include age appropriate variables, procedures for search, procedures for notification of law

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<sup>46</sup> CWLA National Blueprint for Excellence in Child Welfare, p. 48, and p. 69-70.

enforcement, and for initiating Amber Alert protocols.

7. DCF should revise its policies and procedures to require a brief assessment for vulnerabilities that could place each child at heightened risk for running away, and that could place the child at risk in the community in case of running away. Assessment of vulnerability to physical violence, sex trafficking, and exploitation should be included. Recommended resources are from the University of Illinois, a recorded teleconference by the National Resource Center for Permanency and Family Connections,<sup>47</sup> and associated risk assessment and resource guides developed by the Institute for Juvenile Research, Department of Psychiatry, University of Illinois at Chicago.<sup>48 49 50</sup>

## Health Services

8. DCF should employ a Pediatric Nurse Practitioner (PNP) in each Area Office and a Doctor of Medicine (M.D.) as Medical Director at Central Office to direct and oversee medical policy and practices within DCF. (See Recommendations in *Workforce* section.)

9. The Area Office PNP should be responsible for obtaining and reviewing, within 24-hours of each child's entry into care, significant medical information for the child, including but not limited to:

- Acute and chronic medical problems;
- Medications;
- Allergies;
- Immunizations;
- Most recent medical provider contact information; and
- Dates of most recent health, dental, and mental health services.

10. The worker of record at the time the child enters the care of DCF should have direct contact with the PNP to report what is known about the child's current status. Sources of significant medical information should be parent/guardian, other caregiver, child, and/or current and past medical provider(s).

11. PNPs should rotate responsibility for coverage on weekends and holidays.

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<sup>47</sup> <http://www.nrcpfc.org/teleconferences/04-21-10.html>

<sup>48</sup> Running From Treatment: The Problem of Youth who Run From Residential Care. (2010)  
Retrieved from:

<http://www.nrcpfc.org/teleconferences/4-21-10/RUNNING%20AWAY%20FROM%20TREATMENT.pdf>

<sup>49</sup> Youth Missing From Care (2010). Retrieved from:

[http://www.nrcpfc.org/teleconferences/4-21-10/BEST\\_PRACTICE\\_GUIDELINES.pdf](http://www.nrcpfc.org/teleconferences/4-21-10/BEST_PRACTICE_GUIDELINES.pdf)

<sup>50</sup> Residential Runaway Risk Assessment User Guide (2010). Retrieved from:

[http://www.nrcpfc.org/teleconferences/4-21-10/Runaway\\_Risk\\_Assessment\\_User\\_Guide\\_.pdf](http://www.nrcpfc.org/teleconferences/4-21-10/Runaway_Risk_Assessment_User_Guide_.pdf)

12. DCF should undertake a statewide effort to educate staff and doctors at hospitals, medical offices, and community health centers that it is imperative to assure that requested information is made available quickly and efficiently.

13. The PNP should be responsible for determining the timeframe within which the child should be seen for medical screening. The screening should be done by the child's Medical Home or Primary Care Physician whenever possible, or may be done by the Area Office PNP. Emergency Departments should not be used for screening unless the child's condition requires emergency care.

14. DCF should establish a triage protocol for determining the urgency of screening.

The following recommendations should be considered by the DCF Medical staff:

- Level 1: Emergent (immediately)
  - Any child who appears acutely ill (e.g., fever, wheezing, pain, etc.)
  - Adolescent with altered mental status (likely due to drug or alcohol ingestion)
  - Any child entering care because of physical/sexual abuse who has not yet been seen for this (including rape). If possible, should be seen by a Child Protection Team located at nearest hospital.
  - Any child whose behavior is agitated and/or out-of-control.
- Level 2: Urgent (within 24-48 hours)
  - Any child with chronic illness who does not have his/her chronic medications
  - Any child who is clearly failure-to-thrive
  - Infants (<6 months) born prematurely (<37 weeks) and/or born to substance-abusing mothers
- Level 3: Expedited (within 7 days)
  - Child with chronic illness (e.g., asthma, diabetes, ADHD, seizure disorder, mental illness, severe developmental delay) who does have medications
  - Child with history of recent (past 30 days) illness who is now stable (e.g., strep throat, ear infection)
  - Child with significant dental issues
  - Child with known mental health issues, stable
  - All children under 5 years of age
  - Pregnant adolescents
  - Any child whose immunizations have been delayed
- Level 4: Routine (within 30 days)
  - Everyone not covered above

15. Comprehensive examinations should be provided within 45 – 60 days to all children and youth included in Levels 1 – 3 above, or sooner if indicated by initial screening. Any child included in Level 4 does not need another exam if

he/she has had a well child visit within the last 12 months, no other problems identified on initial screen, and immunizations and medications are up-to-date.

16. DCF should establish an “expert panel” of M.D.s from a variety of disciplines and areas of practice, who can provide support and consultation to DCF staff and medical personnel in difficult cases.

## **Quality Improvement**

### **Principle:**

*Supports and services are designed and implemented based on evidence and knowledge; data collection is focused on measuring outcomes and achieving success; continuous quality improvement is emphasized and supported; and innovative practices and programs are encouraged.*

## **Findings**

DCF’s Case Investigations Unit (CIU) completed an internal review of the Oliver case by the end of December 2013, within weeks of confirmation that Jeremiah was missing. The CIU report is confidential and includes many details about the Oliver case that have not been made public. The review process was a solid one that provided significant information and initial findings within a short period of time.

DCF does not currently have a formalized, agency-wide, quality improvement process. A wide variety of data-dense reports is generated monthly and/or quarterly, but these reports are not user friendly or built to measure the effectiveness of DCF’s practices.

Outcomes are based primarily on the federal Child and Family Services Review (CFSR) process, and not on DCF-established outcomes and outcome measures. Examples of elements to measure include: recidivism of families and children re-entering the system, timeliness of investigations, assessments, and service plans, frequency of contacts with children, frequency of home visits, adherence to policy requirements, numbers and outcomes of children 0-5, including type of allegations (abuse vs. neglect).

The federal CFSR process will be changing.<sup>51</sup> The comment period for public response to draft regulations is ending on 5/23/14. The CFSR indicators and measures will be finalized and Massachusetts will be among the first states to be reviewed under them. MA will be scheduled for a site visit in FY 2015. It will be important for DCF to integrate information from the CWLA Quality Improvement Review into its Self Report, which will be required prior to the CFSR site visit.

Previous attempts by DCF to have a meaningful continuous QI process were not fully implemented. The 2007 Report of the House Committee on Child Abuse and Neglect found that CQI was still in its “infancy.” More recently, a report by an outside consultant issued in January 2014, also found that DCF lacked an agency-wide approach to continuous quality improvement.

As the licensing authority for placement services in Massachusetts, the Department of Early Education and Care (EEC) sets standards for foster care and adoption placement services and issues licenses/approvals to private and public entities providing placement services. EEC regulations 102 CMR, currently in the process of revision, are standards that could be established as external benchmarks against which DCF could measure its performance for certain aspects of its work. The current EEC public approval process of DCF is not as effective as it could be. EEC licensing staff does not visit every DCF Area Office, resulting in a lack of statewide data concerning DCF compliance with foster care and adoption regulations.

Importantly, the staff survey conducted by the CWLA Team indicates that DCF personnel do not see their agency as having a meaningful and helpful quality improvement program.

- 73% disagreed with the statement, “DCF has: structures and mechanisms for gathering qualitative and quantitative information about work processes, quality, and outcomes; effective and ongoing process for examining and sharing information, evaluating it, and making decisions based upon it; multiple opportunities for reporting results, including reporting on key measures and emergent or urgent issues. (See Appendix A, Question 19.)
- 70% disagreed that “DCF values and rewards accountability, communication, responsiveness, and commitment to improvement.” (See Appendix A, Question 23.)
- 66% disagreed that “DCF develops and implements only those programs and practices that are based upon the best available evidence.” (See Appendix A, Question 24.)
- 76% disagreed “DCF and private providers share data and have consistent outcome measures.” (See Appendix A, Question 26.)

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<sup>51</sup> <https://training.cfsrportal.org/resources/3044>

## Recommendations

1. DCF should develop a plan for establishing a quality improvement program that includes each of the following components:
  - Clearly articulated vision, values, and mission that define DCF's purpose and direction and set the parameters for its accomplishments;
  - Plans for achieving DCF's purpose and direction;
  - Structure and mechanisms for gathering quantitative and qualitative information about work processes, practice quality, and case outcomes;
  - Effective and ongoing processes for examining information, sharing information with people who need it, evaluating information, and making decisions based upon it;
  - Processes for making change based on findings of the Quality Improvement process;
  - Processes for evaluating the effects of change; and
  - Multiple opportunities and mechanisms for reporting results, including regular reporting on key measures, and special reporting on emerging or urgent issues.
  
2. DCF should use the Council on Accreditation's (COA) public agency standards for Performance and Quality Improvement (PQI)<sup>52</sup> as a reference. These standards provide a clear, user-friendly template for the development of a total agency QI process.
  
3. DCF should implement mechanisms for soliciting and considering feedback from children, youth, families, partners, collaborators, other stakeholders, and community members on a regular basis.
  
4. DCF should establish outcome measures that reflect both aspirations and achievable impact on supports and services for children, youth, and families. The ultimate intent of programs, practices, and services should be to improve the safety and well-being of children, youth, and families in all life domains so that they will flourish. Therefore, there should be clearly articulated, measurable outcomes that are shared among DCF and providers supporting and serving children, youth, and families.
  
5. Outcome measures should provide clear indications of success and of the need for alternative approaches and interventions when outcomes are not achieved.

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<sup>52</sup> Council on Accreditation. Standards for Public Agencies, Performance and Quality Improvement. <http://coanet.org/standard/pa-pqi/>.



6. DCF leaders should cultivate a positive culture and climate in which accountability, communication, responsiveness, and commitment to improvement are valued and rewarded. The notion of each employee's personal responsibility for quality improvement should be integrated into DCF's strategic plan, operating policies and procedures, staff evaluation process, and customer/consumer satisfaction surveys. (See also Recommendations in Workforce section.)

7. To assure accountability, build trust in the community, and contribute to improved collaborative relationships, DCF should develop a plan for making its quality improvement process transparent to youth and families; to providers, to other stakeholders; and to the general public. Data should be shared regularly and periodic reports should be available for public consumption. (See also Recommendations in Engagement/ Participation and Shared Responsibility and Leadership sections.)

9. DCF should initiate discussions with MA institution(s) of higher learning to partner with them to evaluate the ICPM.

## **Workforce**

### **Principle:**

*The workforce consists of competent skilled people with a variety of experiences and representing varied disciplines. They are committed to high-quality service delivery and are provided with the training, tools, resources, and support necessary to perform their roles effectively.*

## **Findings**

### **Current Workforce**

DCF's current caseload demands are far greater than DCF's current workforce capacity. Critical indicators reveal an extraordinarily high level of workload stress to the organization. Since January 2014, DCF has experienced a significant increase in the rate and number of screened in reports of child abuse and neglect, completed initial investigations (72%),<sup>53</sup> and completed comprehensive assessments (28%).<sup>54</sup> At the same time, the number of initial assessments typically conducted on cases where there is a lower risk of harm has declined by

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<sup>53</sup> Department of Children and Families. (March 31, 2014). Investigations Completed – Twelve Month Summary.

<sup>54</sup> Department of Children and Families (March 31, 2014). Comprehensive Assessments Completed – Twelve Month Summary.

approximately 30%.<sup>55</sup> DCF estimates that, based on its current caseload agreement, 100 additional staff would be required to respond adequately to current intake patterns.

Several factors may be contributing to this demand, including:

- increased reporting from the community in the wake of the Oliver case and other high profile child cases;
- possible increases in family stressors including cases involving children ages 0-5 with safety concerns related to substance exposure, mental health concerns, and domestic violence;
- increased vigilance regarding these stresses as required by the Departmental directive requiring mandatory screening and response for children birth to five where there are substance exposure and domestic violence;
- increased turnover of staff;
- hiring challenges facing the department.

Marked increases in average workloads further indicate that demands on the workforce are excessive and untenable. The number of caseworkers with workloads of more than 20 cases has increased markedly, from 221 social workers over 20 cases in April 2013 to 899 in March 2014. It is likely that many more workers carry caseloads that exceed CWLA recommended caseloads of 12:1 for investigations/assessment, and 17:1 for ongoing child protective services. Until resolved, these factors give rise to significant concerns regarding the ability of the department to keep children safe.

The DCF workforce likewise identified limited time for direct contact with children and families as the most significant barrier they face. This sentiment is supported by data indicating that DCF is serving more children than at any time in the last two decades.<sup>56</sup> The caseload has grown 28.2% since March 2013, with half of that growth occurring since January 2014. At the same time, the case closing rate has declined 5.3% since January 2014, and 25% over the past year.

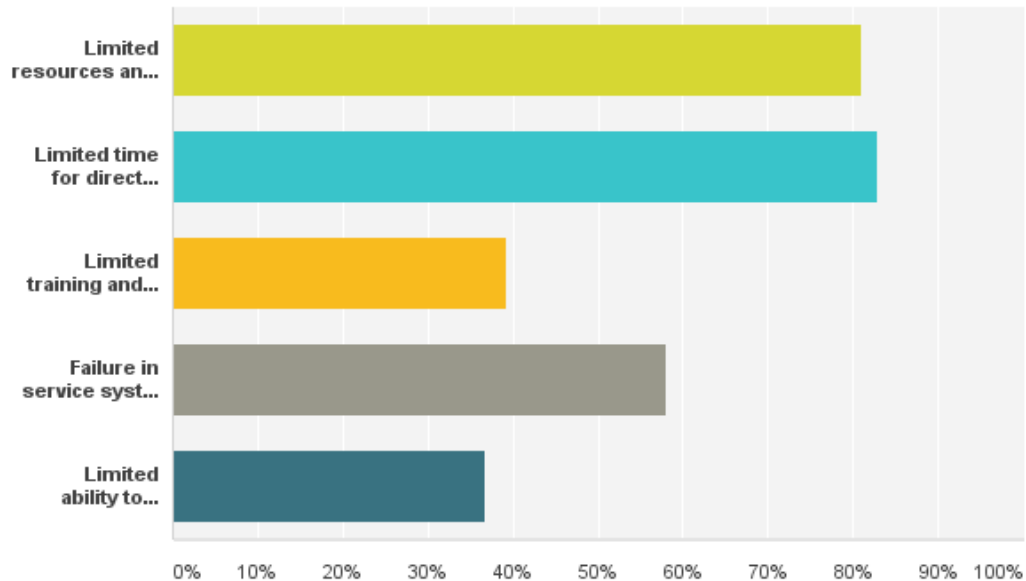
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<sup>55</sup> Department of Children and Families (March 31, 2014). Initial Assessments Completed – Twelve Month Summary.

<sup>56</sup> Department of Children and Families (May 2014). Children Served and Open Cases.

## Q6 What are the barriers to meeting the needs of children and their families? (Check all that apply)

Answered: 1,125 Skipped: 21



### Supervision

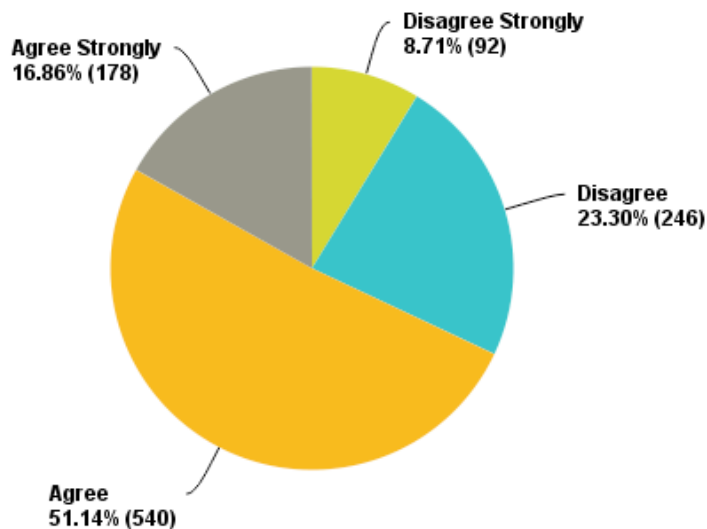
Following transfer of the Oliver case, there was little evidence in the case record that the Supervisor and DCF Worker had ongoing discussions about the stability of the Oliver family or that any attempt to engage Mother about concerns related to the multiple 51As that had been filed. While there is no direct link to the lack of supervisory oversight and social worker engagement with the family to Jeremiah's disappearance, there is evidence in the case record that had regular contacts been made, DCF would have known much sooner than December 2013, that Jeremiah was not living in the Oliver home.

The availability of time needed to manage and oversee the direct service work of the department is also of concern. It is critical that supervisors and managers have the time and resources needed to provide clinical and decision-making guidance to social work staff, and to ensure compliance with agency policies and procedures. In many instances, it appears that Directors of Areas and Area Clinical managers are often focused on administrative oversight, with insufficient time to provide clinical support for program managers, supervisors, and social workers.

The combined impact of high workloads and insufficient staff at the managerial level leave staff feeling that they do not have the support and guidance needed to perform their jobs well. While 65% of DCF staff responding to the CWLA workforce survey have 10 or more years of experience, nearly one third of staff indicated that they did not have the supervision needed to do their jobs.

### Q17 I am provided with the supervision I need to perform my job responsibilities.

Answered: 1,056 Skipped: 92



As cited in CWLA's March 2014 progress update to EOHHS, staff shortages, high caseloads, administrative burden, and poor supervision are among the critical factors that lead to the concerns regarding high turnover and organizational instability that currently exist within the Department.

Workers who receive consistent, mandatory formal and informal supervision that includes concrete guidance regarding critical casework tasks and decisions, along with strong social and emotional support are more likely to stay on the job, show higher job satisfaction,<sup>57</sup> and perform their jobs more effectively.

### Secondary Trauma

The DCF workforce is at significant risk of, and is demonstrating signs consistent with, secondary traumatic stress.

<sup>57</sup> National Child Welfare Workforce Institute. (December 2012). Workforce Resource Summary#1: Supervision.

The ability to recruit and retain high quality front line and managerial staff is currently impacted by a very stressful climate and culture within the Department. Secondary traumatic stress and compassion fatigue are concerns in all child welfare organizations that must deal with routine exposure to child abuse, family trauma, and death. This form of chronic stress is typically reflected in health problems, fatigue, sleeplessness, anxiety, irritability, hopelessness, mistrust, and cynicism.

Cultural transformation that makes an effort to reduce staff isolation, offer routine trauma-focused staff support, include critical incident debriefing, help agency staff cope with day to day stressors and deal with the impact of serious incidents of child abuse will strengthen the hardiness and resilience of the workforce.

Fortunately, most staff (70%) agree or strongly agree that they have support to deal with the impacts of secondary traumatic stress. Nonetheless, 30% of staff report that they do not have adequate supports. (See Appendix A, Question 17.)

### **Specialists**

Although the Oliver family had a history of domestic violence, mental health issues, substance abuse, and medical issues, there is not evidence that DCF specialists in any of those disciplines were consulted by DCF staff.

The agency does not currently have sufficient staff resources in substance abuse, domestic violence, mental health, or nursing to meet caseload demands and to provide the consultation staff needs to handle the complex issues presented by children and families served by DCF.

Pending Massachusetts legislation that would streamline and build stronger access to substance abuse treatment must be complemented within the DCF workforce with specialists who understand addictions and can consider the treatment and care needs of families coping with a complex array of problems.

### **Licensure and Training**

Overall DCF direct service staff have appropriate education and credentials, and have participated in mandated training provided by the Massachusetts Child Welfare Training Institute (MCWI). New worker professional development is mandatory for entering workers. The MCWI also provides DCF Supervisor Training, New Area Program Manager Training, and a list of training sessions on an impressive array of topics. Workload demands, however, have contributed to low attendance at many trainings, and inadequate response by staff to available training designed to reinforce basic knowledge and build specialized skills needed to address practice concerns.

Further, state statute exempts the workforce from state licensure requirements that apply to social workers. While these policies were understandable at the founding of the department more than 30 years ago, they are no longer adequate to meet the needs of an increasingly complex caseload.

## Recommendations

1. The following positions should be added to current DCF personnel. Their addition will require additional funding, beyond what has been recommended in budgets proposed by the Governor and Legislature.

### Central Office

- 2.0 FTEs to add support and expedite updating DCF policy, procedures, and practice guidelines that govern/guide service delivery and agency operations.
- 2.0 additional FTEs in the Massachusetts Child Welfare Institute to support additional training and education, including licensure and continuing education requirements.

### Regional Offices

- A sufficient number of FTEs to restore the number of Regional Offices to six and the additional positions necessary to rebuild the organization's capacity for oversight and integration of program specialists. At minimum, each Regional Office should have a Regional Director, Regional Program Manager, Regional Clinical Manager, and Administrative Support Staff. (See Recommendations in *Supports and Services* and *Funding and Resources* sections.)
- 6.0 FTEs (one in each Regional Office) to conduct and oversee ongoing quality improvement activities, and case reviews. (See Recommendations in *Quality Improvement* section.)

### Area Offices

- Additional Directors to restore an Area Director for each Area Office;
- An Area Clinical Manager for each Area Office.
- Additional Area Program Managers to support a ratio of one manager for each four units.
- Sufficient social worker and supervisory personnel to comply with CWLA caseload recommendations as referenced in the CWLA Progress Update.
- Each Area Office should have assigned and located in the office one licensed/credentialed specialist in each of the following areas:
  - substance abuse
  - mental health

- domestic violence.
- DCF should review and revise specialists' job descriptions and pay scales to achieve parity for individuals across these disciplines who have comparable education and hold comparable credentials.

### Medical Personnel

- FTE Pediatric Nurse Practitioner (PNP) assigned to and located in each Area Office (See Recommendation in Supports and Services section).
- A Medical Director (M.D.) in the Central Office to provide consultation to nurse practitioners, and oversee DCF's medical policy and practice, and provide consultation to contracted community providers with DCF children and youth in care.

### **Licensure and Training**

2. The Massachusetts legislature should amend M.G.L. c. 112, § 131 and 134 to eliminate DCF staff's exemption from social work licensing requirements. Entry-level DCF staff should be licensed in social work or in a related field at hire, or within 6 months of hire. All Supervisors, Area Program Managers, Area Clinical Managers, and Area Directors should hold licenses in social work or a related field (e.g. Psychology, Marriage and Family Therapy).

3. The Massachusetts legislature should amend M.G.L. c. 112, § 131 and 134 to eliminate DCF staff's exemption from continuing education and professional licensing maintenance requirements. All licensed DCF staff should be required to meet the same continuing education standards and licensing maintenance requirements that are applied to non-DCF licensees. DCF staff who hold licenses in related fields should be required to adhere to their respective licensing maintenance requirements.

4. DCF should establish standards for training and continuing education for all staff that are consistent with social work licensing requirements.

### **Secondary Trauma and Trauma-informed Approaches**

5. All staff should have competency-based training in trauma-informed approaches, and should be provided with training in secondary trauma.

6. Each Area Office should establish a peer support team that can assist colleagues in dealing with secondary trauma.

7. DCF should increase opportunities for staff to participate in cross-training with staff from sister agencies, community providers, and collaborative organizations.

8. Each DCF employee should have a meaningful plan for professional growth and development, which should be a component of an annual performance evaluation. The plan should identify continuing education goals for the coming year, including addressing any identified performance challenges, and should be responsive to the individual's preferred learning style.

## **Supervision**

9. DCF should review the status of current Supervisors and Managers to ensure that they have received supervisory training, have current performance evaluations, and demonstrate the competencies required for their respective positions. Each DCF employee should have and report to a supervisor who has the skills, knowledge, and ability to provide guidance appropriate for the individual's needs, position, and responsibilities. For any Supervisors and Managers who have not had supervisory training and/or do not demonstrate required competencies, a remediation plan should be developed with a plan for follow-up and further action, as needed.

10. Every DCF employee should have regularly scheduled supervision. DCF should establish and enforce baseline expectations for the provision of scheduled supervision to each individual. Supervision models may include group, individual, or a combination; there should be sufficient flexibility to adjust the frequency, duration, and intensity of supervision according to particular position, performance, and needs of the individual, and crisis or emergency situations.

## **Race, Ethnicity and Culture**

### **Principle:**

*Individuals, families, communities, organizations, and systems work together to understand, and promote equality, cultural humility, and strong racial, cultural, and ethnic identity, while showing consideration for individual differences and respecting the sovereign rights of tribes.*

## **Findings**

Nationwide, racial and ethnic disparities have been noted across key child welfare decision-making points including reporting, investigations, placement, and permanency planning. In 2012, Massachusetts mirrored national child maltreatment disparities with approximately 44% of victims of child abuse and



neglect that were non-white.<sup>58</sup> While African American children represent 7% of the state's child population, they comprise 23% of reported victims of abuse and neglect.<sup>59</sup> The picture appears to be more positive for Hispanic children who comprise approximately 19% of the child population and are 21% of reported victims. Issues of disproportionality are complex, and raise concerns regarding the consequences of social and economic deprivation, and the presence of systemic discriminations within agencies and in the larger society.

DCF appears to address issues of cultural diversity through its hiring practices and in its training. However, issues of cultural competence and humility do not appear to be a routine and purposeful consideration in case practice guidelines or in policy.

Participants in focus groups conducted for this review raised questions about the degree to which cultural differences and cultural strengths and concerns are well understood and reflected in case practice. However, a comprehensive analysis of this concern was outside the scope of this review.

Results of the staff survey indicate that over 57% of staff believe that DCF's provision of services is not culturally responsive and appropriate to the needs of children, youth, and families from diverse cultural, ethnic, religious, socio-economic and other backgrounds.

## **Funding and Resources**

### **Principle:**

*Funding decisions in the private sector and at federal, state, local, and tribal levels are informed by the certainty that the well-being of children, families, and communities are interconnected and that sufficient and equitable funding is essential to the well-being of all of them.*

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<sup>58</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child maltreatment 2012*. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

<sup>59</sup> Kaiser Family Foundation. (2014). Population Distribution of Children by Race/Ethnicity. Retrieved from <http://kff.org/other/state-indicator/children-by-raceethnicity/>.

## Findings

None of the budget proposals for FY 2015 include sufficient funding for DCF.

MA DCF sustained major budget cuts between FY 2009 and FY 2012. In 2009 the MA DCF budget was \$836,477,528. By FY 2012, DCF's budget had been reduced to \$737,077,781.

Data from the Massachusetts Budget and Policy Center indicates that between FY 2009 and FY 2013, the DCF allocation decreased by \$140,940,273, adjusted for inflation.<sup>60</sup> Two of six Regional Offices were eliminated and Central Office staff was reduced. Although there were efforts to maintain funding for Social Worker and Supervisor positions, reductions in line items affected direct service to children and families, including child and adolescent mental health services, services for people at risk of domestic violence, group care services, and sexual abuse intervention networks (SAIN). Funding was also reduced for the Child Welfare Institute, and for Foster Care Reviews. While the direct service staff was retained as much as possible, the infrastructure of the Department and many services were severely impacted.

The Governor's budget for FY 2015 added approximately \$9.2 M for capacity building and operational improvements at the Department of Children and Families to better serve families in need. DCF funding in the House budget is 14.2 million and the Senate Budget is 9.2 million.

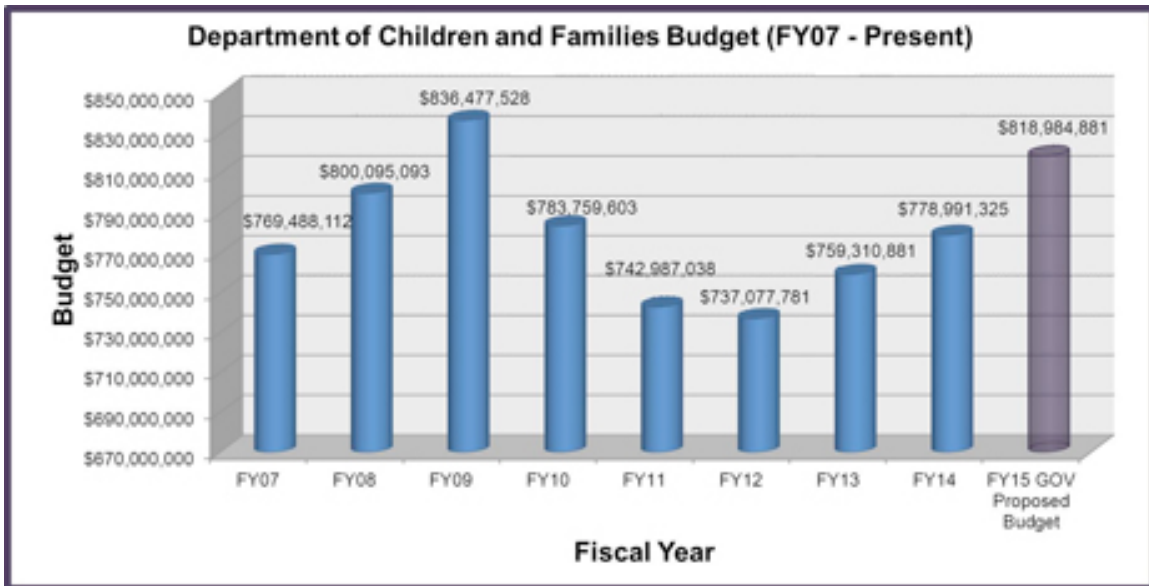
Adjusted for inflation, (\$10.1%<sup>61</sup>), DCF would require funding of \$921,303,945 in FY 2015 to match the funding of FY 2009. None of the proposed budgets for FY 2015 provide the level of funding DCF needs in order to protect children and to provide adequate supports and services to the children and families of Massachusetts.

None of the budget proposals is adequate to fund the recommendations contained in this Quality Improvement Review.

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<sup>60</sup> [http://www.massbudget.org/report\\_window.php?loc=funding\\_dcf\\_dmh.html](http://www.massbudget.org/report_window.php?loc=funding_dcf_dmh.html)

<sup>61</sup> <http://www.usinflationcalculator.com>



<http://www.mass.gov/eohhs/images/dcf/budget-chart-462x235.jpg>

## Recommendations

1. The MA legislature should approve sufficient funding for the Department of Children and Families to fund all of the positions, staff additions, and supervisory and management ratios identified in the Workforce Recommendations above.
2. DCF, DPH, lawmakers, substance abuse programs, and other community partners should work together to approve a plan to increase the funding for and availability of substance abuse programs in the Commonwealth, especially programs to provide services to parents and expectant parents.

## Important Themes and Critical Next Steps to Address Them

These important themes are highlighted here, and cross-referenced to more detailed information, as appropriate, in the sections that follow.

During the period between release of this Report and the expiration of CWLA's current contract with EOHHS, the CWLA Team will provide technical assistance to DCF leadership and staff to facilitate taking critical next steps to address these significant themes.

## **Inconsistent Case Practice From Area Office To Area Office, And Region To Region**

- The CWLA Team will work with appropriate members of Senior Staff, Regional staff, Directors of Areas and representative Workers and Supervisors to identify specific child protection practices that are inconsistent and not in alignment with DCF policy or practice guidelines. CWLA will bring to the discussion information gathered through the staff survey, focus groups, individual and group interviews with staff, providers, parents, foster parents, former foster youth, and other concerned professionals/stakeholders.
- The CWLA Team and DCF leadership will verify that certain child protection protocols including SDM and safety assessment tools are consistently in use statewide, and will monitor their use and make recommendations based on observations.

## **Refining and Implementing the Integrated Case Practice Model (ICPM) (See Engagement/Participation, Findings, ICPM.)**

- CWLA will engage the Child Welfare Training Institute and a cross section of DCF staff (including policy staff) and stakeholders to identify the strengths of the ICPM, determine what is missing or incomplete (data, forms instructions, etc.), and state desired outcomes of using the model.
- CWLA will also work with this team to:
  - Identify challenges and solutions to full adoption and implementation of the model;
  - Create a plan for seeking input from those staff not part of the cross-section group; and
  - Use current research on risk factors associated with the 0-5 age group to ensure practice protocols for this population are built into the re-tooling of the ICPM.

**Developing a Community Education and Communications Plan:** DCF and its staff have been exposed to prolonged negative media exposure. Few stories have highlighted the challenges of the work and the many committed, excellent DCF staff, or the families who have truly been strengthened by their involvement.

- CWLA will assist EOHHS and DCF leadership staff in developing a unified, year-round, formal community education and communications plan to:
  - Develop short messages for a public awareness campaign that provide solutions and tell the story of what DCF is accomplishing;

- Highlight messages regarding: community role and responsibility for children and their welfare; programs' aim to support families; child safety is a non-partisan issue; early provision of services is most effective;
  - Strengthen community understanding of the issues and concerns associated with protecting children;
  - Focus on activities that establish transparency regarding high profile cases, while respecting confidentiality;
  - Communicate regularly with the public, staff, and stakeholders;
  - Create proactive communication strategies vs. crisis management strategies.
- CWLA and DCF will reach out to various media outlets in an effort to work together in highlighting the current trends in child welfare on a national scale, not just in MA.
  - CWLA will assist DCF in convening collaborative forums with diverse stakeholders to decide on approaches to community education and communications. This will require the support of local and state decision-makers, stakeholders, including families and other public and private agencies (DPH, DMH, EEC, etc.).

## **Future Steps**

The following issues were outside of the CWLA Team's scope of work and were not addressed during this review. The CWLA Team has identified them as areas of concern that are worthy of attention, study, and further recommendation:

- Legal Unit staffing;
- Foster Care and Family Resource staffing;
- Foster care recruitment and retention;
- Training for foster, adoption, and kinship applicants and resources;
- Comprehensive Policy review;
- Educational services to children in foster care, including maintaining them in their home districts, whenever possible, and funding and providing appropriate transportation;
- Transition to independent living and continued services for youth 18 and over;
- Contracting with and funding for the full array of community-based services, including child abuse prevention, family support; trauma treatment, mental health services, family substance abuse treatment, treatment foster care and residential treatment;

- DCF's cultural competence and cultural humility; and
- Salary parity and collision between labor and management positions.

## **Appendix B**

### **Consolidated List of Recommendations**

### **RECOMMENDATIONS**

#### **I. RIGHTS OF CHILDREN**

1. DCF should revise its policies, practice guidelines, website, and written materials for consumers to consistently communicate that the agency's primary responsibility is to protect children and to make decisions in their best interests. It should be reiterated to all DCF personnel that although family preservation may be in the best interests of many children, and staff should make sincere efforts to preserve families whenever possible, any decisions about a child's individual goal and plan for removal from the home, reunification with the family, or other plan for permanency should be made in that child's best interests, and not according to a prescriptive hierarchy.

2. All personnel in every organization in Massachusetts providing services to children and families should be trained in the rights of children, as defined in the Rights of the Child section of the CWLA National Blueprint.<sup>62</sup> The workforce should be charged with upholding and protecting those rights. EOHHS should develop appropriate training materials and provide them to EOHHS agencies, their respective licensees, and their contracted vendors. In addition, the materials should be provided to MA membership organizations such as the Children's League and Providers' Council, and should be circulated through the Children's Trust Fund.

3. To help protect children from corporal punishment, DCF should develop a handout for parents/families concerning the negative effects of physical discipline on children.<sup>63</sup> The handout should be added to information given to each family on initial contact, along with information about positive parenting. DCF should also post the written information on its website and should make it available to community providers, schools, early education programs, and medical providers.

4. The MA legislature should consider enacting law that would make corporal punishment of children illegal in Massachusetts.

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<sup>62</sup> CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, April, 2013 p. 25 - 35

<sup>63</sup> CWLA National Blueprint (2013). Standard I.15

5. Massachusetts media outlets should undertake a public education campaign to raise public consciousness of each individual's responsibility to protect children from abuse and neglect and to uphold the rights of children.

### **Background Checks**

6. DCF should begin to develop and/or revise and promulgate regulations that ensure that foster and adoptive parent applicants and kinship resources are appropriately assessed and evaluated, without violating the rights of children to maintain connections with their families and communities, and to preserve their racial, ethnic, cultural and religious identities.

7. DCF and EEC should revise regulations to adapt to current best practice trends toward uniform approval processes for kinship and foster/adoptive caregivers. Requirements should be sensitive to the role of disproportionality in criminal prosecution and conviction, and the importance of placing children with relatives whenever possible. The American Bar Association's research concerning foster parent licensing standards<sup>64</sup> will serve as a helpful foundation for revision of regulations.

8. DCF and EEC should consistently support an approval process, rather than a waiver or variance process. Regulations and standards should identify the qualities and characteristics needed by the foster/kinship/adoptive parent, and the minimum requirements that must be evident in the home. Any waivers or variances granted by either DCF or EEC should be limited to non-safety standards.<sup>65</sup>

9. Draft standards in development by American Bar Association (ABA), National Association for Regulatory Administration (NARA), Generations United (GU), and Annie E. Casey Foundation (AECF), expected to be available in May, should be considered as a foundation for home study and approval requirements in Massachusetts.

10. DCF Area Directors and Area Clinical Managers should determine which homes with children in care, currently approved through a background check waiver process, should be subject to heightened case monitoring, home visitation, supervision, or case oversight. These existing caregivers should be subject to background checks recommended herein upon renewal. Such

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<sup>64</sup> Improving Foster Care Licensing Standards around the United States: Using Research Findings to Effect Change (2012). Retrieved from [http://www.americanbar.org/content/dam/aba/administrative/child\\_law/FC\\_Licensing\\_Standards.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/child_law/FC_Licensing_Standards.authcheckdam.pdf)

<sup>65</sup> Report To Congress On States' Use Of Waivers Of Non-Safety Licensing Standards For Relative Foster Family Homes (2011). Children's Bureau, ACF, U.S. Department of Health and Human Services. Retrieved from [http://www.acf.hhs.gov/sites/default/files/cb/report\\_congress\\_statesuse.pdf](http://www.acf.hhs.gov/sites/default/files/cb/report_congress_statesuse.pdf)



placements should not be disrupted unless there is evidence of recent criminal activity and there is determination that continued placement in the home is not in a child's best interests, and/or when there is evidence and determination that continued placement in the home is not in the child's best interests for reasons unrelated to the caregiver's background check.

11. MA Regulations 110 CMR 18.0 (DCF Criminal Offender Record Checks) and 102 CMR 5.0 (EEC Standards for Licensure or Approval of Agencies Offering Child Placement and Adoption Services) should be revised to require that if the results of a background check indicate that an applicant has been convicted of any of the following felonies and a court of competent jurisdiction has determined that the felony was committed, then the individual's application shall be rejected and the individual shall be excluded from eligibility as a foster parent, adoptive parent, or kinship provider. There shall be no exceptions for these crimes:

- a state or federal felony conviction for assault and battery on a child with injury (c. 265, §13J),
- assault with intent to rape (c. 265, §24),
- forcible rape of a child/assault with intent to rape a child (c. 265, § 22A, 22B, 22C, 24B),
- rape and abuse of child aggravated by age (c. 265, § 23A),
- rape and abuse of child by previous offenders (c. 265, § 23B),
- posing or exhibiting child (c. 272, §29A),
- incest (c. 272, §17),
- indecent assault and battery (c 265, §13H, c 265, § 13B, 13B ó, 13B ., c265, §13F),
- inducing a minor to prostitution (c. 272, §4A),
- murder (c. 265, §1),
- rape (c. 265, §22(b), c 265, §22(a)),
- unnatural acts with a child under 16 (c. 272, §35A),
- enticement of child under 18 prostitution (c.265, § 26D),
- human trafficking (c. 265 §§50-).

If a record check reveals that a foster care, adoption, or kinship applicant or any potential caregiver in the home has a state or federal felony conviction for physical assault, battery, or a drug-related offense, and a court of competent jurisdiction has determined that the felony was committed in the past 5 years, the department or licensed placement agency shall reject the request for foster care placement, adoption, or kinship care.

12. DCF and EEC regulations should be revised to require that for any foster care, adoption, or kinship applicant whose background check indicates conviction for any crimes other than those listed in the previous recommendation that are currently listed on Table A of 110 CMR 18.00 (hereinafter "Table A crimes"), DCF or the licensed provider should require screening by a mental health or criminal

justice professional from outside of the agency before completion of the home study, and a written opinion by the mental health or criminal justice professional that the individual does not pose an unacceptable risk of harm to the child(ren) to be placed in his or her care. Additionally, DCF and EEC regulations should require review of the outside professional's opinion and review of the individual's application and supporting documents by at least two licensed clinical staff. If the home study has been completed, the review must be conducted by person(s) who were not involved in the applicant's home study.

13. DCF and EEC should revise regulations to require that if an applicant for foster care adoption or kinship care was convicted of any crime other than those requiring exclusion, the licensing/approval agency shall consider the following factors in making its decision whether to approve or deny the application or renewal:

- (1) the type of crime;
- (2) the number of crimes;
- (3) the nature of the offenses;
- (4) the age of the individual at the time of conviction;
- (5) the length of time that has elapsed since the last conviction;
- (6) the relationship between the crime and the individual's capacity to care for children;
- (7) if a specific child has been identified, the current and future needs of the child to be placed and the probable effect that the misdemeanor would have on the applicant's ability to fulfill those needs;
- (8) the relationship between the individual and the child in question, if any;
- (9) evidence of rehabilitation; and
- (10) opinions of community members concerning the individual in question.

14. DCF and licensed placement providers should ensure compliance with current policy relative to retaining all records of any criminal background checks they undertake for applicants for foster care, adoption, or kinship care.

15. The CWLA Team recommends that the executive branch and the legislature should carefully consider potential ramifications that any changes to background checks for foster and kinship resources might have on background check completion for other child caring situations, including but not limited to licensed child care centers, family child care, residential providers, and adoptive parent applicants through DCF and licensed adoption agencies.

### **In-Home Safety**

16. To uphold each child's right to be protected from abuse and neglect while also upholding the child's right to live with family unless it is not in the child's best interests, DCF should develop clear protocols for evaluating risks to children living at home, including risks from household members who are not the child's

parents. Structured Decision Making tools and safety assessments should be used consistently to assist workers in making informed decisions and recommendations.

17. DCF should increase the availability of Substance Abuse, Domestic Violence and Mental Health Specialists to assist staff in evaluating the potential risk to children who remain at home, especially when there are allegations of abuse, domestic violence, mental health challenges and/or substance abuse by adults in the household. DCF staff should be provided with training concerning the increased risks associated with live-in intimate partners.

## **II. SHARED RESPONSIBILITY AND LEADERSHIP**

1. EOHHS and DCF should develop a plan for ensuring that individuals at each level of leadership have the following competencies:

- Broad-based child welfare knowledge and experience;
- Strong communication and listening skills;
- Effective problem solving skills;
- Ability to provide support for staff in a respectful and professional manner;
- Cultural competence, cultural humility, and awareness of the diverse individuals and groups in their community and among the DCF and community provider workforce;
- Skills necessary to initiate, nurture, and sustain collaborative working relationships with all external community partners, as well as colleagues within DCF and EOHHS;
- Understand, embrace, and model a working philosophy of shared accountability and responsibility; and,
- Knowledge and understanding of the effect of secondary traumatic stress on the workforce, and appropriate interventions.

## **III. ENGAGEMENT/PARTICIPATION**

1. Communities (via their local appointed and elected officials) should become more engaged in educating citizens of the Commonwealth on the dangers posed to children by substance abusing parents in general, and the specific high risks associated with the coincidence of substance use and unsafe sleep situations for infants.

2. DCF leadership and staff should develop a plan for increasing routine active engagement of children, youth, families, leadership, and workforce in

determining and responding to needs within communities.<sup>66</sup> (See also Quality Improvement and Workforce.)

### **Visitation**

3. DCF should develop visit protocols to assist workers in engaging with children and families during visits, observing and documenting accurately, and assessing safety and risk based on observations and information gathered during every visit. Such protocols should be used during every visit to a child and/or family.

4. DCF should implement statewide a mandatory mechanism for real-time data entry for visits to children, families, and foster/adoptive/kinship homes. Real-time data should include at minimum, the date, time, and location of the visit, and the persons present.

5. DCF should enforce its expectation that documentation of visits/contacts be entered into iFamilyNet no later than 30 days after the date of the contact. (See also Supports and Services, Technology Findings and Recommendations.)

### **Case Practice Model**

6. The ICPM should clearly reflect first and foremost, that it is built upon the belief that child safety must always take precedence, while at the same time case practice actively assists the preservation of family connections through the engagement of parents as partners.

7. Massachusetts should more fully develop and implement a practice model that will guide and support all child protective work and preventive work in the State, regardless of whether that work is performed by DCF, lead agencies, or community based providers. The model should address the rights of children, and should specify the responsibility of all child welfare personnel for upholding children's rights as discussed in Rights of Children.

8. The ICPM Statewide Implementation Committee should re-direct its focus to that of building and articulating a more cohesive case practice model by clarifying the desired elements of such a model, and stating a set of Practice Principles that are straightforward and easily understood. The Practice Principles should reflect the agency's mission/vision, and must be aligned with DCF policy requirements. CWLA recommends using the eight Core Principles of the CWLA National Blueprint as the framework for the review and revision process. Those Principles are: Rights of Children; Shared Responsibility and Leadership; Engagement/Participation; Supports and Services; Quality Improvement; Workforce; Race, Ethnicity, and Culture; and, Funding and

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<sup>66</sup> CWLA National Blueprint for Excellence in Child Welfare, CWLA Press, 2013, pg 52.

Resources. Two states' practice models are recommended as examples that align with the Core Principles of the CWLA National Blueprint: Washington's Family-Centered Practice Model<sup>67</sup> and the Maryland's "Principles for CPS."<sup>68</sup>

9. The ICPM Statewide Implementation Committee should involve DCF staff from every level of the organization, including representatives from SEIU Local 509, as participants in the process of redefining and rebuilding the case practice model. In addition, the Committee should include people who are, or have been service recipients of DCF, at least two representatives from the Parents Advisory Committee, representatives from collaborative providers, and other members of the community. A philosophy of transparency and collaboration is a critical component to facilitating the paradigm shift necessary for successful integration into Massachusetts' child welfare infrastructure.

10. The Massachusetts Child Welfare Institute (MCWI) should revise its training modules for the ICPM and should incorporate into them the use of genograms,<sup>69</sup> as a technique for engaging families right from the start, as well as a tool for gathering important information. The training modules should also include assessing safety, protective factors, danger, and risk during each contact with the family.

11. DCF leadership must address the root cause of dissent among its managers and social work staff relative to the use of the ICPM. It is unreasonable to expect a practice model to be embraced and properly implemented until the concerns about this practice model are put to rest.

#### **IV. SUPPORTS AND SERVICES**

##### **Childcare/Early Education**

1. DCF and EEC should work together to revise current standards for discontinuing enrollment of a child in a funded slot when that child does not attend for a specific number of days. Such decisions should be made on an individual basis, with consideration of the child's needs first and foremost, and full consideration of the issues that interfere with and curtail the child's attendance.

##### **Transfer of Cases**

2. DCF should finalize and implement its draft policy to require face-to-face meetings among staff for case transfers within Area Offices and between Area

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<sup>67</sup> <http://www.dshs.wa.gov/pdf/ca/FCPModel.pdf>

<sup>68</sup> [http://www.dhr.state.md.us/blog/?page\\_id=3957](http://www.dhr.state.md.us/blog/?page_id=3957)

<sup>69</sup> Special Review Summary Report: Symptoms to Systems (2013). State of CT Department of Children and Families.

Offices. It should be expected that sending and receiving workers will be present, and that Supervisors will attend whenever possible. Up-to-date case notes and a transfer summary should be included in the case record before case transfer.

### **Trauma-informed Approaches**

3. DCF should require that every individual who touches cases in any capacity – from frontline workers to legal staff – should receive training in trauma-informed services, and should be competent in recognizing and responding to signs of trauma and domestic violence. DCF should also offer such training to judges, court personnel, and CASA volunteers.

4. DCF should develop and share with all contracted providers a protocol for trauma-informed engagement of children and families. The CWLA National Blueprint can serve as a guide for developing the protocol.<sup>70</sup>

### **Missing Children and Runaways**

5. DCF should expand its policies and procedures to require that official electronic files contain a photo of each child who enters the care and custody of the agency. Photos should be updated no less than every 6 months for children ages 5 and younger, and should be updated at least annually for all children older than 5.

6. DCF should revise runaway and missing child procedures to include age appropriate variables, procedures for search, procedures for notification of law enforcement, and for initiating Amber Alert protocols.

7. DCF should revise its policies and procedures to require a brief assessment for vulnerabilities that could place each child at heightened risk for running away, and that could place the child at risk in the community in case of running away. Assessment of vulnerability to physical violence, sex trafficking, and exploitation should be included. Recommended resources are from the University of Illinois, a recorded teleconference by the National Resource Center for Permanency and Family Connections,<sup>71</sup> and associated risk assessment and resource guides developed by the Institute for Juvenile Research, Department of Psychiatry, University of Illinois at Chicago.<sup>72 73 74</sup>

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<sup>70</sup> CWLA National Blueprint for Excellence in Child Welfare, p. 48, and p. 69-70.

<sup>71</sup> <http://www.nrcpfc.org/teleconferences/04-21-10.html>

<sup>72</sup> Running From Treatment: The Problem of Youth who Run From Residential Care. (2010)  
Retrieved from:

<http://www.nrcpfc.org/teleconferences/4-21-10/RUNNING%20AWAY%20FROM%20TREATMENT.pdf>

<sup>73</sup> Youth Missing From Care (2010). Retrieved from:

[http://www.nrcpfc.org/teleconferences/4-21-10/BEST\\_PRACTICE\\_GUIDELINES.pdf](http://www.nrcpfc.org/teleconferences/4-21-10/BEST_PRACTICE_GUIDELINES.pdf)

## Health Services

8. DCF should employ a Pediatric Nurse Practitioner (PNP) in each Area Office and a Doctor of Medicine (M.D.) as Medical Director at Central Office to direct and oversee medical policy and practices within DCF. (See Recommendations in Workforce section.)

9. The Area Office PNP should be responsible for obtaining and reviewing, within 24-hours of each child's entry into care, significant medical information for the child, including but not limited to:

- Acute and chronic medical problems
- Medications,
- Allergies,
- Immunizations,
- Most recent medical provider contact information; and
- Dates of most recent health, dental, and mental health services.

10. The worker of record at the time the child enters the care of DCF should have direct contact with the PNP to report what is known about the child's current status. Sources of significant medical information should be parent/guardian, other caregiver, child, and/or current and past medical provider(s).

11. PNPs should rotate responsibility for coverage on weekends and holidays.

12. DCF should undertake a statewide effort to educate staff and doctors at hospitals, medical offices, and community health centers that it is imperative to assure that requested information is made available quickly and efficiently.

13. The PNP should be responsible for determining the timeframe within which the child should be seen for medical screening. The screening should be done by the child's Medical Home or Primary Care Physician whenever possible, or may be done by the Area Office PNP. Emergency Departments should not be used for screening unless the child's condition requires emergency care.

14. DCF should establish a triage protocol for determining the urgency of screening.

The following recommendations should be considered by the DCF Medical staff:

- Level 1: Emergent (immediately)
  - Any child who appears acutely ill (e.g., fever, wheezing, pain, etc.)
  - Adolescent with altered mental status (likely due to drug or alcohol ingestion)

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<sup>74</sup> Residential Runaway Risk Assessment User Guide (2010). Retrieved from: [http://www.nrcpfc.org/teleconferences/4-21-10/Runaway\\_Risk\\_Assessment\\_User\\_Guide\\_.pdf](http://www.nrcpfc.org/teleconferences/4-21-10/Runaway_Risk_Assessment_User_Guide_.pdf)

- Any child entering care because of physical/sexual abuse who has not yet been seen for this (including rape). If possible, should be seen by a Child Protection Team located at nearest hospital.
- Any child whose behavior is agitated and/or out-of-control.
- Level 2: Urgent (within 24-48 hours)
  - Any child with chronic illness who does not have his/her chronic medications
  - Any child who is clearly failure-to-thrive
  - Infants (<6 months) born prematurely (<37 weeks) and/or born to substance-abusing mothers
- Level 3: Expedited (within 7 days)
  - Child with chronic illness (e.g., asthma, diabetes, ADHD, seizure disorder, mental illness, severe developmental delay) who does have medications
  - Child with history of recent (past 30 days) illness who is now stable (e.g., strep throat, ear infection)
  - Child with significant dental issues
  - Child with known mental health issues, stable
  - All children under 5 years of age
  - Pregnant adolescents
  - Any child whose immunizations have been delayed
- Level 4: Routine (within 30 days)
  - Everyone not covered above

15. Comprehensive examinations should be provided within 45 – 60 days to all children and youth included in Levels 1 – 3 above, or sooner if indicated by initial screening. Any child included in Level 4 does not need another exam if he/she has had a well child visit within the last 12 months, no other problems identified on initial screen, and immunizations and medications are up-to-date.

16. DCF should establish an “expert panel” of MDs from a variety of disciplines and areas of practice, who can provide support and consultation to DCF staff and medical personnel in difficult cases.

## **V. QUALITY IMPROVEMENT**

1. DCF should develop a plan for establishing a quality improvement program that includes each of the following components:
  - Clearly articulated vision, values, and mission that define DCF’s purpose and direction and set the parameters for its accomplishments;
  - Plans for achieving DCF’s purpose and direction;
  - Structure and mechanisms for gathering quantitative and qualitative information about work processes, practice quality, and case outcomes;



- Effective and ongoing processes for examining information, sharing information with people who need it, evaluating information, and making decisions based upon it;
- Processes for making change based on findings of the Quality Improvement process;
- Processes for evaluating the effects of change; and
- Multiple opportunities and mechanisms for reporting results, including regular reporting on key measures, and special reporting on emerging or urgent issues.

2. DCF should use the Council on Accreditation's (COA) public agency standards for Performance and Quality Improvement (PQI)<sup>75</sup> as a reference. These standards provide a clear, user-friendly template for the development of a total agency QI process.

3. DCF should implement mechanisms for soliciting and considering feedback from children, youth, families, partners, collaborators, other stakeholders, and community members on a regular basis.

4. DCF should establish outcome measures that reflect both aspirations and achievable impact on supports and services for children, youth, and families. The ultimate intent of programs, practices, and services should be to improve the safety and well-being of children, youth, and families in all life domains so that they will flourish. Therefore, there should be clearly articulated, measurable outcomes that are shared among DCF and providers supporting and serving children, youth, and families.

5. Outcome measures should provide clear indications of success and of the need for alternative approaches and interventions when outcomes are not achieved. FY18

6. DCF leaders should cultivate a positive culture and climate in which accountability, communication, responsiveness, and commitment to improvement are valued and rewarded. The notion of each employee's personal responsibility for quality improvement should be integrated into DCF's strategic plan, operating policies and procedures, staff evaluation process, and customer/consumer satisfaction surveys. (See also Recommendations in Workforce section.)

7. To assure accountability, build trust in the community, and contribute to improved collaborative relationships, DCF should develop a plan for making its quality improvement process transparent to youth and families; to providers, to other stakeholders; and to the general public. Data should be shared regularly and periodic reports should be available for public consumption. (See also

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<sup>75</sup> Council on Accreditation. Standards for Public Agencies, Performance and Quality Improvement. <http://coanet.org/standard/pa-pqi/>.

Recommendations in Engagement/ Participation and Shared Responsibility and Leadership sections.)

8. DCF should initiate discussions with MA institution(s) of higher learning to partner with them to evaluate the ICPM. (See Recommendations in Engagement/Participation section.)

## **VI. WORKFORCE**

1. The following positions should be added to current DCF personnel. Their addition will require additional funding, beyond what has been recommended in budgets proposed by the Governor and Legislature.

### Central Office

- 2.0 FTEs to add support and expedite updating DCF policy, procedures, and practice guidelines that govern/guide service delivery and agency operations.
- 2.0 additional FTEs in the Massachusetts Child Welfare Institute to support additional training and education, including licensure and continuing education requirements.

### Regional Offices

- A sufficient number of FTEs to restore the number of Regional Offices to six and the additional positions necessary to rebuild the organization's capacity for oversight and integration of program specialists. At minimum, each Regional Office should have a Regional Director, Regional Program Manager, Regional Clinical Manager, and Administrative Support Staff. (See Recommendations in *Supports and Services* and *Funding and Resources* sections.)
- 6.0 FTEs (one in each Regional Office) to conduct and oversee ongoing quality improvement activities, and case reviews. (See Recommendations in *Quality Improvement* section.)

### Area Offices

- Additional Directors to restore an Area Director for each Area Office.
- An Area Clinical Manager for each Area Office
- Additional Area Program Managers to support a ratio of one manager for each four units;
- Sufficient social worker and supervisory personnel to comply with CWLA caseload recommendations as referenced in the CWLA Progress Update;
- Each Area Office should have assigned and located in the office one licensed/credentialed specialist in each of the following areas:
  - substance abuse

- mental health
  - domestic violence;
- DCF should review and revise specialists' job descriptions and pay scales to achieve parity for individuals across these disciplines who have comparable education and hold comparable credentials.

### Medical Personnel

- FTE Pediatric Nurse Practitioner (PNP) assigned to and located in each Area Office (See Recommendation in Supports and Services section);
- A Medical Director (M.D.) to provide consultation to nurse practitioners, and oversee DCF's medical policy and practice, and provide consultation to contracted community providers with DCF children and youth in care.

### **Licensure and Training**

2. The Massachusetts legislature should amend M.G.L. c. 112, § 131 and 134 to eliminate DCF staff's exemption from social work licensing requirements. Entry-level DCF staff should be licensed in social work or in a related field at hire, or within 6 months of hire. All Supervisors, Area Program Managers, Area Clinical Managers, and Area Directors hold licenses in social work or a related field (e.g. Psychology, Marriage and Family Therapy).

3. The Massachusetts legislature should amend M.G.L. c. 112, § 131 and 134 to eliminate DCF staff's exemption from continuing education and professional licensing maintenance requirements. All licensed DCF staff should be required to meet the same continuing education standards and licensing maintenance requirements that are applied to non-DCF licensees. DCF staff who hold licenses in related fields should be required to adhere to their respective licensing maintenance requirements.

4. DCF should establish standards for training and continuing education for all staff that are consistent with social work licensing requirements.

### **Secondary Trauma and Trauma-informed Approaches**

5. All staff should have competency-based training in trauma-informed approaches, and should be provided with training in secondary trauma.

6. Each Area Office should establish a peer support team that can assist colleagues in dealing with secondary trauma.

7. DCF should increase opportunities for staff to participate in cross-training with staff from sister agencies, community providers, and collaborative organizations.

8. Each DCF employee should have a meaningful plan for professional growth and development, which should be a component of an annual performance evaluation. The plan should identify continuing education goals for the coming year, including addressing any identified performance challenges, and should be responsive to the individual's preferred learning style.

### **Supervision**

9. DCF should review the status of current Supervisors and Managers to ensure that they have received supervisory training, have current performance evaluations, and demonstrate the competencies required for their respective positions. Each DCF employee should have and report to a supervisor who has the skills, knowledge, and ability to provide guidance appropriate for the individual's needs, position, and responsibilities. For any Supervisors and Managers who have not had supervisory training and/or do not demonstrate required competencies, a remediation plan should be developed with a plan for follow-up and further action, as needed.

10. Every DCF employee should have regularly scheduled supervision. DCF should establish and enforce baseline expectations for the provision of scheduled supervision to each individual. Supervision models may include group, individual, or a combination; there should be sufficient flexibility to adjust the frequency, duration, and intensity of supervision according to particular position, performance, and needs of the individual, and crisis or emergency situations.

## **VII. RACE CULTURE ETHNICITY**

The CWLA Team does not have specific recommendations concerning race, ethnicity, and culture, as the topic is beyond the scope of the current Review. There are relevant related recommendations in Rights of Children, Engagement/Participation, and Supports and Services.

## **VIII. FUNDING/RESOURCES**

1. The MA legislature should approve sufficient funding for the Department of Children and Families to fund all of the positions, staff additions, and supervisory and management ratios identified in the Workforce Recommendations above.

2. DCF, DPH, lawmakers, substance abuse programs, and other community partners should work together to approve a plan to increase the funding for and availability of substance abuse programs in the Commonwealth, especially programs to provide services to parents and expectant parents.



## QUALITY IMPROVEMENT REPORT

### RECOMMENDATIONS IMPLEMENTATION TIMETABLE

RECOMMENDATION	IMPLEMENTATION BY			PERSONS RESPONSIBLE
	60 DAYS	FY 2015	By End of FY 2018	
<b>Rights of Children</b>				
I. 1.	X			
I. 2.		X		
I. 3.		X		
I. 4.		X		
I. 5.	X			
I. 6.		X		
I. 7.			X	
I. 8.		X		
I. 9.	X			
I. 10.	X			
I. 11.		X		
I. 12.		X		
I. 13.		X		
I. 14.	X			
I. 15.	X			
I. 16.	X			
I. 17.		X		
<b>Shared Responsibility and Leadership</b>				
II. 1.	X			
<b>Engagement/ Participation</b>				
III. 1.		X		
III. 2.		X		



## QUALITY IMPROVEMENT REPORT RECOMMENDATIONS IMPLEMENTATION TIMETABLE

RECOMMENDATION	IMPLEMENTATION BY			PERSONS RESPONSIBLE
	60 DAYS	FY 2015	By End of FY 2018	
III. 3.	X			
III. 4.		X		
III. 5.	X			
III. 6.		X		
III. 7.		X		
III. 8.		X		
III. 9.		X		
III. 10.		X		
III. 11.	X			
<b>Supports and Services</b>				
IV. 1.		X		
IV. 2.	X			
IV. 3.			X	
IV. 4.		X		
IV. 5.		X		
IV. 6.		X		
IV. 7.		X		
IV. 8.		X		
IV. 9.		X		
IV. 10.		X		
IV. 11.		X		
IV. 12.		X		
IV. 13.		X		
IV. 14.		X		
IV. 15.		X		



## QUALITY IMPROVEMENT REPORT RECOMMENDATIONS IMPLEMENTATION TIMETABLE

RECOMMENDATION	IMPLEMENTATION BY			PERSONS RESPONSIBLE
	60 DAYS	FY 2015	By End of FY 2018	
IV. 16.	X			
<b>Quality Improvement</b>				
V. 1.		X		
V. 2.		X		
V. 3.		X		
V. 4.		X		
V. 5.			X	
V. 6.	X	X	X	
V. 7.		X		
V. 8.		X		
<b>Workforce</b>				
VI. 1.		X		
VI. 2.		X		
VI. 3.		X		
VI. 4.		X		
VI. 5.		X		
VI. 6.	X			
VI. 7.		X	X	
VI. 8.		X		
VI. 9.	X			
VI. 10.	X			
<b>Funding/Resources</b>				
VIII. 1.	X			
VIII. 2.		X		

## Appendix D - Excerpt from “First Do No Harm”

– A Report of the House Committee on Child Abuse and Neglect –  
March 28, 2007, Recommendations, pages 7 - 10

Retrieved from:

<http://archives.lib.state.ma.us/bitstream/handle/2452/35635/ocn122264972.pdf?sequence=1>

### READY FOR LEGISLATIVE CONSIDERATION

- **Turn control of the spotlight over to the new secretary.** Create the secretary of child welfare and the board of child abuse and neglect. To be effective immediately.
- **Mandate a 5-year comprehensive plan to coordinate child welfare efforts.** Require the secretary of child welfare to submit a rolling 5-year plan with specific benchmarks (updated annually or sooner) that coordinates and integrates child welfare efforts across state agencies. To include legislative recommendations, if appropriate. To be effective immediately. Requirements of the plan are in the following section.
- **Require improved legislative reporting from DSS.** Specify that annual and quarterly reports to the legislature be addressed to relevant committees and include results of continuous quality improvement and quality service reviews, as well as longitudinal analysis and narrative updates on reform efforts, particularly as they affect high-risk cases and children of color. Reports to include legislative recommendations, if appropriate. To be effective immediately.
- **Codify and implement Family Engagement Model.** Provide statutory exemption to allow DSS to demonstrate and evaluate differential response to allegations of child abuse and neglect using the Family Engagement Model. To be effective immediately.
- **Change screening and investigatory time limits.** Pending statewide implementation of FEM, change the time limits for completing non-emergency investigations of 51A reports from 10 calendar days to 15 working days, with a waiver provision if deemed necessary by the area director or by law enforcement. This would allow adequate time to complete necessary collateral checks and allow for proper coordination with criminal investigations if necessary. To be effective immediately.
- **Require explicit response from DSS about the plan to handle high-risk children.** Chronicle the fate of those cases involving serious harm (25% of supported 51As), and status of the risk assessment toll (SDM). Report back to the legislature within 30 days and periodically thereafter. To be effective immediately.
- **Require explicit response from DSS about its efforts to address disproportionality.** Request a detailed explanation from DSS of their current and future initiatives to reduce overrepresentation of children of color in the child welfare system. Report back to the legislature within 30 days and periodically thereafter. To be effective immediately.



- **Require annual report from DAs about criminal prosecution of serious child abuse and neglect cases.** Request analysis from local district attorneys about the types of child abuse and neglect cases referred by DSS. Include rationale for not prosecuting certain cases and submit any recommendations to improve criminal prosecutions of child abuse and neglect. To be effective immediately.
- **Maintain medical resources for area offices.** Continue funding for medical staff to assist social workers when investigating suspected child abuse or neglect cases that have medical complications.
- **Insure equitable processing of CORI waivers.** Require that CORI waivers be reviewed by two persons so that judgments made to approve or deny waivers affecting the placement of children are reached equitably.
- **Require training for certain mandated reporters.** Require those mandated reporters whose professions are licensed by the state to complete training so they are better qualified to recognize and report suspected child abuse and neglect. To be effective 1/1/2009.
- **Increase statutory penalties for willful failures to report serious child abuse and neglect.** Increase civil penalties, impose potential jail time and allow possible loss of professional license for those mandated reporters who willfully refuse to notify DSS about serious child abuse or neglect. To be effective immediately.
- **Link community policing funds to law enforcement efforts to improve child welfare.** Insert budgetary language to prioritize those community policing grants that include a focus on child abuse and neglect issues and/or coordinate domestic violence and child welfare efforts. To be effective 7/1/2008.
- **Support the Massachusetts Child Welfare Institute.** Support continued funding for the coordinated, statewide training of social workers and other DSS staff offered through CWI.
- **Monitor Family Networks and lead agencies.** Require semi-annual reporting on the status of Family Networks and the lead agency model. Focus particularly on issues of accountability, cost, quantity and quality of services provided. To be effective immediately.
- **Codify minimum educational requirements for DSS social workers and supervisors.** Following the current hiring practices of the agency, require bachelor's degrees of social workers and master's degrees in social work and related fields for supervisory staff. To be effective immediately.
- **Codify end-of-life procedures.** Place major components of the DSS policy on life-sustaining medical treatment into statute, including the commissioner's approval of the agency's recommendation and the requirement of opinions from two different medical institutions and the hospital's ethics committee. To be effective immediately.
- **Allow public end-of-life court hearings.** Following the advice of Justice Spina in a recent SJC opinion, open end-of-life hearings for children in the DSS custody to the public. To be effective immediately.

□ **Change the name.** Change the name of DSS to the Department of Children and Families to sharpen its primary focus and mission of keeping the best interests of children paramount and working to strengthen families for the sake of children at risk. To be effective immediately.

### **THE 5-YEAR COMPREHENSIVE PLAN AND PERIODIC BENCHMARKS**

Some of these matters fall solely within the purview of DSS, but many overlap with other state agencies and with non-governmental organizations. For each item, the plan should (1) estimate any new costs and identify pre-existing or potential funding sources, if needed; (2) suggest an implementation schedule with identifiable benchmarks to be reached periodically, but not less than annually; (3) establish evaluation mechanisms; and (4) identify potential roadblocks to successful implementation or evaluation. The 5-year plan shall roll from one year into the next such that there is always a view towards the future, while annual benchmarks insure that something, even if incrementally, is getting done to improve child welfare in Massachusetts.

□ **Disproportionality.** Build upon the efforts already made or recommended by DSS to address racial disproportionality. Examine how effective DSS has been and how reforms impact overrepresentation. Examine whether others (law enforcement, higher education, mandated reporters, etc.) are sensitive to making culturally competent decisions.

□ **Mandatory Reporting.** Assess the quantity and quality of training currently provided to mandated reporters. Develop standards for training that include best practices for recognizing and reporting suspected child abuse and neglect. Assess whether these trainings can be provided through preexisting mechanisms for professional training (e.g., CEUs, in-service), through online programs, or directly by DSS. Examine the value of mandating testing of mandated reporters.

□ **Screening.** Examine the efficiencies of centralizing the 51A reporting and screening process. At a minimum, consider funneling all oral 51A reports through a single 1-800 number available 24-hours a day, directing all written 51A reports to a single fax number or mailing address, and providing for online filing. Consider how effectively DSS considers multiple 51A reports filed about one family. Examine screened out 51As to determine when, and under what conditions, they were inappropriately dismissed and the impact of such inappropriate dismissals. Seek direct, online access to the National Crime Information Center for criminal history records and warrants.

□ **Child Protection Teams.** Consider statewide expansion of child protection teams at regional hospitals, at all hospitals with emergency rooms and pediatric care hospitals—based on the Children’s Hospital model.

□ **Family Engagement.** Coordinate with the Department of Social Services for the evaluation of the family engagement model (and its use of differential response and risk assessment tools) to determine how effectively findings of abuse or neglect are made and what the costs would be to implement FEM statewide. Examine the proposed combination of DSS functions such that an individual social worker would investigate, assess and provide ongoing case management. Focus on the need for specialized investigatory skills. Determine the extent of delay in the fair hearing process. Revisit the time limits.

- **Caseloads and Teaming.** *Examine the effects of teaming on caseloads and vice versa. Estimate the cost of statewide adoption of various standard caseload ratios and develop a potential multiyear plan to reduce caseloads. Examine how social workers spend their time and whether certain tasks (i.e., driving child/family to court.) could accomplished more affordably and efficiently by others.*
- **Law Enforcement Involvement.** *Investigate how effectively DSS and law enforcement collaborate, and where there is room for improvement or coordination of resources. Develop protocols for mandatory reporting of physical abuse to local law enforcement and district attorneys. Consider alignment with efforts to prevent or prosecute domestic violence and coordination with the procedures used in the investigation of sexual abuse (SAIN).*
- **Schools of Social Work.** *Examine how effectively social work and related degree programs teach child welfare practice. Examine opportunities for greater cooperation between DSS and higher education to study child welfare issues. Determine the capacity of public and private schools to meet increased demand for social work and related degrees, including concentrations in child welfare. Establish a timeline for inclusion of child welfare concentrations in bachelors' and masters' degree programs at public institutions of higher education.*
- **Social Worker Qualifications.** *Examine the infrastructure needed to support a more qualified workforce, including complete build-out of the Child Welfare Institute.*
- **Confidentiality Concerns.** *Research legal and ethical considerations to be addressed if we expand information sharing in cases of child abuse and neglect.*
- **Medical/Mental Health.** *Examine the ongoing needs for medical and mental health expertise and services. Critique proposed models for more effective client behavioral health services. Develop improved oversight of the use of psychotropic drugs on children involved with DSS or DYS.*
- **DSS critiques.** *Consider how to align a sophisticated audit unit with the proposed Continuous Quality Improvement/Quality Service Review initiatives. Provide opportunities to share findings with policy makers within and outside of DSS.*
- **CORI Reviews.** *Examine the use of CORI reviews in out-of-home (kinship or foster) placements. Determine where efficiency and equality can be improved.*
- **Aging Out.** *Monitor how effectively DSS is assisting adolescents aging out of the system with health care, housing, higher education and other needs.*
- **Rosie D. case.** *Examine the impact of the federal mandate in the Rosie D. case on child welfare efforts.*
- **MassHealth/MBHP.** *Monitor the agencies' oversight of medical and behavioral health expenditures, particularly as they relate to support services provided to DSS children and families.*
- **Federal Funds.** *Develop plan to address Massachusetts' low Title IV-E saturation rate for foster children, including a determination of AFDC status for non-TANF population and ensuring judicial determinations are made within the required timeframes.*