Pioneer Institute: To Ensure Child Safety in Massachusetts, Most Critical Reforms Are to DR Program

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The Pioneer Institute released a report in November 2015 titled "Driving Critical Reforms at DCF: Ideas for a Direction Forward in Massachusetts Child and Family Services." The document was aimed at understanding and correcting system failures at the Massachusetts Department of Children and Families (DCF) (Blackburn & Sullivan, 2015).

This policy white paper was prompted by a series of high profile cases of serious abuse, neglect and child deaths that occurred in Massachusetts, despite a range of DCF reforms enacted by the state's administration just the previous year. Bella Bond, a 2-year-old girl who went missing in May or June of 2014, was found dead on June 25, 2014, after caseworkers had failed to gather enough information to accurately identify her level of maltreatment risk. Then, in July, 7-year-old Jack Loiselle was reportedly found unresponsive by his father. Upon examination, health care professionals determined Jack was in a coma, his body was covered with bruises and burns, and he was severely malnourished, weighing only 38 lbs. Records showed, however, that Jack had received CPS services in the 5 months prior to this incident, including 110 visits and 16 interactions with caseworkers. One month later, two foster children, both female, were found unresponsive in their caregiver's home. The 2-year-old died upon arrival at the hospital, and the 22-month-old was in critical condition. They were both suffering from symptoms of asphyxiation and heat exhaustion. This incident happened three days after a routine visit by DCF. To help Massachusetts' DCF prevent cases such as these, the Pioneer Institute's articulated goal was to inform future reform efforts so that children's safety and well-being are the top priority in all case response options (Blackburn & Sullivan, 2015).

The "first and most important recommendation" made in this report, which the authors state "should be the central focus of any changes at the agency," was to overhaul Massachusetts' version of Differential Response (DR), a two-tiered child intake system that they call the Integrated Casework Practice Model (ICPM) (Blackburn & Sullivan, 2015, p. 5).

The authors cited pervasive "mission confusion" at the Massachusetts DCF (Blackburn & Sullivan, 2015, p. 10). The agency reportedly identifies as its principal value that all practice is "child-driven," but that isn't reflected in programming. This is particularly true of its DR model (Blackburn & Sullivan, 2015, p. 10). The authors note that the DR model is the product of a child welfare service reform movement that advocates for CPS strategies designed to prioritize family preservation. They also assert that the combined CPS goals of family preservation and child protection often conflict in direct practice. They note that DR systems exist in states all across the country, and that there is no standard model, but that some DR systems typically have at least two pathways for screened in cases, and the decision to divert a case to either pathway is purportedly determined by assessment of risk. Cases can change pathways in response to changes in risk. Families on the alternative path may refuse services, and no substantiation occurs, so there is no formal disposition of maltreatment and no victim or perpetrator identified.

The authors performed a literature review looking for research on the effectiveness and outcomes achieved in states with DR programs to determine whether a consensus existed in the research community about DR's efficacy. They determined that much of the DR research evaluating outcomes from various two-tiered systems across the county was "inconclusive," and, even though some DR publications have claimed that "child safety has not been compromised" in states with DR programs. The most significant research findings contend that DR presents grave concerns with respect to child safety. The authors also concluded that the research determining that children in AR tracks are safe were based on insufficient data. Other concerns included inappropriate research methodology, inaccurate conclusions drawn from data, and potential conflicts of interests, as the researchers were noted to be connected with the advocacy groups that had created and aggressively marketed the DR model. (Blackburn & Sullivan, 2015, p. 11).

The authors also cite concerns with the intake screening process. In DR programs, screeners typically make recommendations to accept or reject cases, prioritize the cases for agency response, and make recommendations on track assignment (ostensibly based on level of risk,) all from a single phone call from a referral source. Without any extra fact-finding, these decisions appear to be made using limited and potentially inaccurate information.

The authors also highlight problems related to reporting CPS data to the federal Child and Family Services Review (CFSR). States must report data regarding maltreatment recurrences to the CFSR. Maltreatment recurrence is defined as the substantiation of a re-report after a substantiated incident of maltreatment. One of the key features of DR programs is that there is often no substantiation and therefore, many

instances of recurring maltreatment from cases that are in multi-track programs are not recorded in this data. This presents an incomplete picture of recurring maltreatment cases, and raises concerns about state accountability for child safety in the alternative track. The authors suggest that, without a mandate for this information, it may even incentivize states to adopt DR programs so they can conceal information that reveals more pervasive levels of child maltreatment on their watch.

The authors go on to discuss some of the more specific issues that states have had in their DR program implementation. They report that Massachusetts is not alone in experiencing child maltreatment issues linked to DR two-tiered intake systems. They note that the Florida DCF experienced similar mission confusion stemming from unenforceable safety plans. They report the voluntary track of Florida's DR program saw 80 child deaths from 2008 to 2014. Of those 80 children, 34 died after Florida DCF had documented at least 10 reports on the child. Illinois discontinued its DR program in 2012 because they found it encouraged case overload. Studies found there were higher rates of re-reports and substantiated reports in the alternative tracks than in the traditional response tracks. Virginia modified its DR system when a study showed that 54% of the cases in the assessment track were moderate to high risk instead of lower risk as intended. A Minnesota review initiative suggested the state reform its assessment track to be child-focused, with the long-term consensus that the two-tiered intake system in that state should be abandoned completely.

Based on their research review and on the experiences of other states with DR programs, the authors made the following recommendations in their report to guide future reform efforts in the Massachusetts:

- Engage an independent research group to conduct a comprehensive review of the ICPM assessment track, including a close look at instances where DR deployment was linked directly to CPS failures.
- Make necessary changes to their DR programming so that it always and clearly prioritizes children's safety.
- Provide better training for assessment track case reviewers, and ensure that training is standardized across all tracks so that accurate risk assessments are completed for all families. Both traditional investigation and assessment track case reviewers should be trained in both family engagement and investigation techniques.
- Correct the endemic DR practice of asking parents' permission before conducting interviews with children who are possible victims of maltreatment. Interviews should be conducted prior to a family's knowledge of the interview, if at all possible, and children should be interviewed alone, without another family member or guardian in the room.
- Ensure that cases diverted to the DR assessment track still include some essential elements of traditional investigation, such as in domestic violence and substance abuse screening.
- Monitor all cases diverted to the assessment track for 12 months after they have been closed.
- Consider re-examining cases in which families have refused voluntary services to see if those families should be re-routed into the traditional track response.
- Strengthen the criteria for intake decisions, including checking out additional information sources before a track assignment is made, including, at minimum, a required check of court records and information from collateral sources such as teachers, physicians, mental health professionals, and substance abuse counselors. If sufficient information is not available, track assignment should be postponed until it is available.

To read the entire Pioneer Institute white paper, access it online at http://pioneerinstitute.org/download/driving-critical-reforms-at-dcf-ideas-for-a-direction-forward-in-massachusetts-child-and-family-services/

Reference

Blackburn, M., & Sullivan, G. (2015). Driving critical reforms at DCF: Ideas for a direction forward in Massachusetts' child and family services. The Pioneer Institute (Issue Brief No. 137). Retrieved July 21, 2016, from http://pioneerinstitute.org/download/driving-critical-reforms-at-dcf-ideas-for-a-direction-forward-in-massachusetts-child-and-family-services

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