

Can CPS Agencies Be Reformed?

By Dee Wilson

The December 26, 2004 Portland Oregonian has as its front page headline "Child Welfare Crisis Only Worsening." The Oregonian's story proceeds to describe a recent increase in the number of Oregon children in foster care, the state's acute shortage of foster homes and comments on troubled families "collapsing under the pressures of unemployment, domestic violence, crime and addiction to alcohol or drugs." The Oregonian's story is unusual in that it contrasts the case of a 5-year-old child found to be severely malnourished in foster care with the death of a 15-month-old baby from head injuries following reunification of the child with his substance abusing mother and assaultive father. According to the Oregonian, police investigators are treating the 15-month-old child's death as a homicide.

The Oregonian's reporters also consider the perspective of Richard Wexler, Executive Director of the National Coalition for Child Protection Reform, an organization that advocates for in-home services rather than out-of-home placement of children. The Oregonian points out the inexperience of many child welfare caseworkers in Oregon and the temptation of child welfare agencies to overload foster homes when faced with acute shortages of placement resources.

The Oregonian's story describes the decisions of state officials to form a critical incident response team made up of child welfare staff and "other government officials" to study "how the Oregon Department of Human Services supervised Jordan and Ashton" (the children mentioned above). "In addition, (Governor) Kulongoski ... ordered an independent review of the state's child welfare programs, focusing on decisions made in the Portland area." Gary Weeks, Director of the Department of Human Services, described Governor Kulongoski as "deeply concerned ... about the succession of cases and wondered whether the state was doing everything in its power to protect the children in its care."

The Oregonian's story is noteworthy for paying attention to child welfare trends, as well as child abuse / neglect related child deaths and other shocking cases of child maltreatment possibly mishandled by child welfare authorities, and in acknowledging the complexity of problems facing child welfare policymakers and managers. Nevertheless, the Oregonian has played its role in a process which is typical of child welfare reform efforts around the country: a media blitz regarding a horrific case of child maltreatment galvanizes elected officials into forming a review panel to carefully study the case and to commission an external review of the state's child welfare system

as a whole. These review panels serve the political purpose of allaying public outrage by demonstrating a determination to figure out what went wrong in specific cases and to portray state officials as pro-actively involved in coming to grips with the deficiencies and needs of the state's child welfare system.

Sometimes (as in Oregon) the announcement of these reviews suggests a public crisis of confidence in a child welfare system, a questioning of an agency's competence shared by top officials. One can almost hear the Governor of Oregon exclaiming in anguished puzzlement, "Why do these (high profile) abuse cases continue to occur? What's wrong with our child welfare system?"

Parallel Developments in Washington State

Similar events have occurred at regular intervals for almost two decades in Washington State. The list of children whose abuse related deaths have driven child welfare reform includes Eli Creekmore (1986), Lauria Grace (1995), Zy'Nyia Nobles (2000), and most recently Rafael Gomez (2003) and Emerald Champagne -Loop (2003). In addition, the recent starvation deaths of Justin and Raiden Robinson (2004) after several CPS referrals alleging neglect of these children by their substance abusing mother has led to an angry media outcry and renewed discussion on editorial pages of what should be done to reform the state's child welfare system.

Each of these child deaths has been reviewed by the Ombudsman's Office or prestigious panels consisting of child advocates, community professionals and child welfare staff. Legislators have occasionally served on these review teams. These panels have made a number of recommendations for improving the state's response to child abuse and neglect, and many of these recommendations have been implemented.

In addition, the Department of Social and Health Services has periodically commissioned external reviews of the state's child welfare system by citizen panels, consulting firms with experience in reviewing government programs or highly regarded former administrators of other state agencies. There have been at least four such external reviews since 1986 (Citizen Review Panel, 1986; Hunner Report, early 1990s; Deloit and Touche, late 1990s; Riveland Report, 2000) as well as other in-depth reviews of various parts of the public child welfare system. These external reviews have provided thorough and insightful analyses of the child welfare system and have made a number of sensible recommendations for improving the state's child welfare system, many of which have been adopted.

Not to be outdone, the Children's Administration (CA, formerly DCFS) has also initiated several internal reviews of its CPS system, e.g., prior to and following the death of Eli Creekmore (1986-87), following Zy'Nyia Nobles' death (2000 - 2001). These reviews have had a major influence on agency practice. Some of the reforms resulting from these internal and external reviews have been the adoption of a risk assessment model, and more recently, specialized safety/ risk assessment tools for use in the initial stages of CPS contact with children and families or prior to reunification of children with birth parents, the statewide utilization of multi-disciplinary child protection teams, staff enhancements intended to reduce social workers' caseloads, increased capacity for gathering and disseminating critical program data, a clarification of the agency's mission and an emphasis on shared decision making in case planning within CA.

This is only a small sample of the many reforms arising out of the several excellent studies of Washington State's child welfare system. In the late 1990s, a top manager in CA Headquarters created a chart to track agency responses to the many recommendations arising from various reviews; merely keeping track of the agency's response to these recommendations had become a difficult and laborious chore.

One reason given to me by top CA managers during this period of time for not instituting a yearly systematic review of all abuse / neglect related fatalities on open or recently open cases was that a system of this type would inevitably generate large numbers of additional recommendations for practice changes, recommendations to which CA would be held accountable. Too many agency initiatives had already (by the late 1990s) made CA managers wary of further structural innovations that might result in an unmanageable reform agenda. These attitudes were widespread within CA before accreditation, Kids Come First - II (the agency's reform initiative) and the Braam Settlement Agreement.

Questions regarding Outcomes of Child Welfare Reform

Before proceeding to consider the current prospects for reforming child welfare, it is useful to step back and ask some hard questions about two decades of reform efforts in Washington State and nationally. Have these reform efforts produced results? Why is there a seemingly never-ending stream of child abuse / neglect related deaths and other serious maltreatment of children referred to CPS or actually returned (after out-of-home placement) to maltreating parents? Have the many child welfare reforms mentioned in preceding paragraphs reduced child deaths or serious inflicted injuries to children? Are public child welfare agencies on the right track in their approaches to reform of their agencies and programs? These are hard questions to answer for reasons that will become clear, but merely to pose them suggests that unless reform efforts have clear

explicit goals, along with ways of measuring their achievement, an unambiguous answer to such questions will be impossible.

The media focus on stories of abuse / neglect related child deaths has shaped child welfare reform around the country by giving precedence to initiatives which might reasonably be expected to prevent child deaths similar to or in circumstances like the most recent high profile case. It has also given reform efforts an aura of futility. Child welfare staff, child advocates and reporters understand that there will be more abuse / neglect related child deaths; and that, in some instances, social workers and supervisors will have engaged in questionable practice or decision making.

Eileen Munro, the English philosopher of science who has written widely on child welfare issues, has commented that reform agendas developed in response to child abuse deaths typically utilize three main strategies: “psychological pressure (on practitioners) to work more diligently, increased automation or formalization of the tasks to reduce or remove the scope for human (fallible) judgment, and, thirdly, closer monitoring of the front line operators to insure that instructions were followed.” However, Munro asserts that the “solutions are not working as expected but appear to be creating new problems.”

Child welfare agencies lack well-tested strategies for reducing (much less eliminating) abuse / neglect related child deaths. Lacking such strategies, child welfare managers are nevertheless compelled to act in the midst of crises resulting from high profile deaths. In these crises, they tend to adopt strategies described by Munro because they seem reasonable and are congruent with a bureaucratic ethos. It is well understood within child welfare agencies that an additional high profile death or two may discredit the current reform initiative and lead to calls for “accountability” (i.e., blame laying) and changes in top management.

One might expect that given this level of political vulnerability, public child welfare agencies would be producing in - depth studies of abuse / neglect related child deaths intended to help in the development of new intervention strategies. However, since the early 1990s in Washington State, the usual practice has been to review abuse / neglect related deaths one by one, an approach which makes it difficult to identify patterns and trends. To the credit of the Children’s Administration, this approach is gradually being supplemented by comparisons of high profile deaths and by a search for patterns among child deaths, the only way likely to produce new knowledge of practical use.

Nationally, child abuse / neglect related fatalities have increased from 1100 to 1500 in recent years (Child Maltreatment, 1997 - 2003, U.S. Department of Health and Human Services). There has been a steady upward trend in fatalities since 1999. It is possible to view these statistics as encouraging because a number of states made efforts in the 1990s to more accurately identify and review child deaths, efforts that might have increased child death statistics.

A more likely explanation is that public agencies are not sure how to reduce a low base rate phenomenon like abuse / neglect related child deaths, especially as child deaths have much the same features (with the exception of occurring mostly with infants and toddlers) as other high risk cases, i.e., substance abuse, domestic violence, poverty, mental health problems such as depression. Even in states in which child abuse / neglect related deaths have declined such as (allegedly) Oregon (from 30 per year in the mid - 1990s to 21 per year according to the *Oregonian*), researchers and policymakers are likely to be uncertain regarding the causes of the decline.

Child welfare authorities in Washington State are in the peculiar position of not knowing whether child abuse/ neglect related fatalities have increased, decreased or remained the same in recent years compared to the mid - 90s because of an administrative reluctance to categorize child deaths as abuse / neglect related without CPS findings to this effect, and a resistance to making such findings without an official determination by a medical examiner, law enforcement agency or prosecutor's office that a parent's neglect contributed to a child's death. A CPS finding that neglect contributed to a child's death can be challenged in a hearing before an administrative law judge, a reality that inspires caution in making a finding of "founded" within CA. In practice, this approach to compiling child death statistics has led to a gross undercounting of deaths related to parental negligence because criminal justice agencies and medical examiners rarely make this determination.

Prior to the adoption of these unwritten policies regarding the classification of child deaths, neglect related deaths constituted 40 -50% of fatalities on open or recently open cases in Washington State. Nationally, "neglect only" related deaths accounted for 35.6% of abuse/ neglect related fatalities in 2003 (Child Maltreatment 2003). The effect of these classification practices is to prevent meaningful comparison of Washington State's abuse / neglect child death statistics with other states, and to leave everyone in the dark regarding state trends regarding abuse/ neglect related fatalities on open or recently open cases.

There have been an average of 6 homicides per year on open / recently open cases for the past 7 years (1997 -2004; 2004 CA Performance Report), i.e., a stable pattern in abuse

related fatalities. However, reports of child neglect have steadily increased during this time period, a reporting trend suggesting the possibility of increased neglect related fatalities. It would be a welcome surprise to discover that neglect related fatalities in Washington have not increased in recent years despite a significant increase in CPS investigations of alleged neglect; but it is impossible to know what has happened in this regard due to the CA approach to counting and reporting child deaths. The Children's Administration 2004 Performance Report does not even have a category for "neglect related child death", an omission that makes CA's aggregate statistics regarding deaths related to child maltreatment meaningless.

High Profile Child Deaths

One might argue that the public outrage in high profile child abuse / neglect related deaths is fueled by the perception that these deaths were preventable; indeed, this may be the reason that some deaths, but not others, are picked up by the media for lengthy stories. It is true that several of the best known child abuse deaths in Washington State appear to have involved a biased refusal of child welfare staff to reconsider their views and support of in - home placements in the light of new information regarding injuries to child victims. It is also troubling that Eli Creekmore, Lauria Grace, Zy'Nyia Nobles, Rafael Gomez and the Robinson children were children of color, and that in some of these cases, child welfare staff were unable to combine advocacy for parents with objectivity regarding the quality of parental care.

CA managers and staff have begun to openly discuss the nature of bias and its influence on decision making, though CA has yet to develop a systematic response to this issue, e.g., assigning a person to be a devil's advocate in case staffings or helping supervisors to recognize bias in case conferences. There has been to date no more than a faint recognition that a common source of bias in a social work agency is the emotional investment of caseworkers in the therapeutic process. Even the concept of counter transference has vanished from discussions of parental engagement, an important and "hot" social work topic that is a key feature of many states' reform plans. Until child welfare caseworkers, supervisors and managers come to grips with these issues, there is every reason to believe these kinds of high profile fatalities will continue to occur.

Serious Abuse / Neglect Related Injuries as a CPS Performance Indicator

Of course, Child Protective Service systems are intended to do more than prevent child deaths due to abuse or neglect. Many children who do not die are seriously injured as a direct result of abusive or neglectful incidents. It is reasonable therefore to consider the success of public child welfare agencies in preventing serious injury to children on open

or recently open cases as a performance indicator. Unfortunately, neither the federal government nor Washington State's Children's Administration collects data on serious abuse/ neglect related injuries on open or recently open CPS cases, a glaring omission in performance data that is difficult to understand.

In discussing this subject over several years as a member of the CA management team, I often heard the argument that there is no operational definition of "serious injury" or that to count injuries on open cases would minimize the importance of the neglect of children that does not result in physical injuries. Since neither of these arguments are particularly cogent (i.e., an operational definition could be developed, counting injuries does not minimize the risks of neglect anymore than it does sexual abuse -- injuries are just one dimension of abuse/ neglect related harms to children), I have been left to speculate about the reasons public child welfare agencies are unwilling to carefully track serious injuries to children on open or recently open cases. In Washington State, the reasons appear to be that (a) the federal government doesn't require this information and (b) the CA computer system (CAMIS) was not set up to capture this data and other proposed changes to the CAMIS system have always been considered more pressing. However, these explanations beg the question of why data on serious injuries resulting from abuse or neglect has never been of enough interest to federal officials or CA managers to develop a way of collecting this information.

What does interest the federal government is the reoccurrence of child abuse or neglect as measured by the percentage of "substantiated" (through CPS investigation) cases that are "substantiated" a second time within 6 months of the initial abusive/ neglectful incident. CA uses the word "founded" instead of "substantiated". This is the federal government's only measure of CPS programs; it is, unfortunately, a highly flawed measure.

Decisions to make official findings that allegations of child abuse and neglect are valid is an administrative procedure which is independent of a decision to take legal action, place a child out of the home or require in-home services. There is no practical consequence for a CPS social worker if she does not substantiate a CPS report following an investigation, whereas a finding of "founded" may result (if parents appeal) in a hearing with an administrative law judge appointed by DSHS. Administrative law judges in Washington State frequently reverse CPS findings of child abuse or neglect, often after lengthy administrative hearings. The installation of this system in the late 1990s quickly led to a dramatic reduction in the state's substantiation rate, from about a third of CPS investigations to 15-20% of investigations. As a rule, only serious clear-cut cases are "founded" by CPS staff in Washington State; and it is these families who are more likely to be involved in recurrent child maltreatment. In other words, a low

substantiation rate is likely to lead to a high reoccurrence rate; both of these rates have been influenced by CA social workers' experiences with administrative law judges.

Because CA's "founded" rate has been so influenced by the DSHS appeals process, and because the rate is so much lower than the national average, CA's Office of Children's Research (OCR) has usually avoided utilizing it as an outcome measure, preferring instead to count total "accepted" CPS referrals on families. In addition, OCR studies of CPS decision making have found a number of additional factors other than the history of abuse/ neglect which influence CPS investigative findings, e.g., a parent's willingness to seek help, the availability or lack of physical evidence of abuse (English, et al, 2002).

Furthermore, the CPS reoccurrence rate is a dichotomous, i.e., either-or, measure; a child either experiences recurrent maltreatment or not following an initial substantiation of a CPS report. However, recurrent maltreatment is known to occur in 30-67% of families receiving therapeutic help for abuse or neglect. Families receiving in-home services have higher rates of reoccurrence than families not receiving services (Fluke, Yuan and Edwards, 1999). One plausible explanation of this research finding is that service providers are mandated reporters who act as effective monitors of child safety. Families not receiving services can more easily engage in child abuse and neglect without being reported to CPS. For this reason, CPS units that provide little or no voluntary services are likely to have lower reoccurrence rates than units that engage families in helping efforts.

A recent randomized trial of the Hawaii home visitation program (Duggan, et al, 2004) found that official rates of abuse and neglect based on CPS investigative findings were one third to one sixth of rates gathered from parents' self reports. In fact, the federal government's reoccurrence standard of 6.1% is one fifth of the minimum reoccurrence rate found in most independent studies.

It is a conceptual error to conclude that CPS interventions that do not completely eliminate abuse or neglect following initial CPS contact are failures. Most families referred to CPS are allegedly neglecting their children, and a significant percentage of these families are chronically neglectful. These families require long-term interventions; it is not realistic to expect that chronic patterns of child maltreatment will be changed overnight. CPS social workers should be connecting these parents to service programs, both for therapeutic reasons and to enlist the help of other professionals in monitoring child safety. A measure of child safety that creates a perverse incentive to close cases without providing voluntary services is not a good idea, especially when it is the only measure of child safety.

In a recent letter to the March 2005 issue of Child Abuse and Neglect, David Olds, John Eckenrode and Harriet Kitzman assert that “Policy makers and service providers should not be led to believe that the impact of prevention interventions on child abuse and neglect can be ascertained simply with founded reports of maltreatment, although this measure should not be abandoned, as it does reflect part of the truth... Investigators have a responsibility to help interested parties know that there are no single, simple measures to determine intervention impact when examining child maltreatment as an outcome.” This is a message that the federal government and state governments should take to heart.

CA utilizes two other measures of CPS performance not required by the federal government: (1) the percentage of children in out-of-home placement due to child abuse or neglect who were previously in placement due to child maltreatment and (2) the percentage of open CPS cases with 3 accepted referrals within one year, or 4 accepted referrals within two years, or 5 accepted referrals within three years. These are measures of reoccurrence superior to the federal measure (in my view) because the placement measure is a proxy for serious maltreatment and is accompanied in most cases by dependency actions; and because an intake decision to accept referrals is arguably less influenced by the administrative context than decisions regarding CPS “findings”.

The percentage of abused or neglected children in placement who have been in prior CPS related placements has been in the 6-8% range for several years and is at the top of this range in the 2004 CA Performance Report. On the other hand, the percentage of CPS cases with chronic referral histories was quickly reduced from about 25% to 15-20% within a couple of years of the adoption of this measure and has since remained fairly stable, though in the monthly performance reports this rate is currently close to 20%.

Measures of CPS Performance

	<u>National Trend</u>	<u>State Trend</u>
Child Abuse/ Neglect Related Deaths	Increase	Unknown
Serious Injuries on Open/Recently Open Cases	Unknown	Unknown
Reoccurrence/ Substantiation	Trend not established; national standard set at 6.1%	Trend not established; baseline of 10.6% exceeds national standard
Reoccurrence/placement	Unknown	Stable at 6-8%
Chronically referring families	Unknown	Initial reduction; currently stable at 15-20% of open CPS cases

Several themes emerge from this discussion: (a) the lack of information, indeed the lack of interest within public child welfare agencies, regarding serious abuse/ neglect related injuries on open or recently open cases (b) the lack of reliable child fatality statistics in Washington State combined with the national increase in abuse / neglect related child fatalities (c) the inadequacy of the single federal measure of CPS performance. Taken together, it must be obvious that the ability of public child welfare agencies to measure CPS performance is extremely limited; and, consequently, there is no basis for confidence that common approaches to child welfare reform are leading to gradual improvements in the quality of CPS performance.

The inability of public child welfare agencies to adequately measure outcomes in their largest and (arguably) most important program is a major barrier to CPS reform. How can agencies know if they are on the right track in reform initiatives if they lack adequate measures of performance? The usual answer of public child welfare agencies to this question is to measure compliance with practice standards, and to give great emphasis to these measures while paying minimal attention to outcomes related to child safety. The inadequacy of this approach to evaluating CPS programs is obvious: how do managers know that CPS “best practices” are leading to hoped for outcomes when outcomes cannot be adequately measured?

Child welfare systems have more conceptual work to do in defining and measuring child safety, but managers under pressure from the federal government and the legislature to make improvements in their child welfare practice have little or no tolerance for such discussions once expectations are clearly defined by legislatures and the (federal) Children’s Bureau. Impatience with conceptual uncertainty around program goals and with technical arguments about performance indicators is the usual state of affairs within busy child welfare agencies. However, unless child welfare agencies develop better CPS outcome measures than they currently have, they will remain dependent on media coverage of child deaths, fatality reviews, anecdotes and internal reviews of compliance with practice standards to evaluate CPS programs.

Chronic Neglect: The Elephant in the Living Room

There is one additional subject that must be addressed in any evaluation of CPS practice, i.e., the high percentage of families who repeatedly cycle through the CPS investigative process. Jean Waldfogel’s examination of repeat CPS reports and multiple substantiations in England, Canada, Australia and the United States concludes that the United States has higher rates of CPS recidivism than these other English speaking countries. Waldfogel writes, “My own estimates for the United States, Canada and England ... confirm that neglect almost entirely explains the higher rates of reporting

and substantiation (The Future of Child Protection, p.60).” Waldfogel goes on to state that “ the frequency of each specific category of reported maltreatment does not vary a great deal by country, with the exception of neglect, which is reported two to three times more frequently in the United States than in Canada or England.”

I have already mentioned that CA utilizes a measure of chronically referring families over a three-year period of time, and that close to one fifth of open cases on CPS caseloads at a point in time fall into this category. The Office of Children’s Research (OCR) longitudinal study of 261 Seattle children referred to CPS in the mid – 1990s has found that over a third of these families had 6 or more CPS referrals during the first eight years of the children’s lives.

The Washington State Ombudsman’s Office recently counted total CPS referrals on a random sample of 52 families referred to CPS on two single days; 40% of these families had a CPS history of 10 or more referrals and one quarter of the families had been referred to CPS 20 or more times (personal communication with Mary Meinig, June, 2005). In discussions with CA staff, it is common to hear about cases with 30, 40 or even 50 referrals over a period of several years.

The percentage of CPS referrals classified as neglect by CA intake staff has steadily increased in recent years; currently, 70-75% of CPS reports accepted for investigation in Washington State allege one or more forms of neglect. Nationally, this percentage is in the 60-65% range. Neglect is the most recurrent form of child maltreatment as measured by the likelihood of re-referral, multiple substantiations or increased rates of re-entry into care following a child’s reunification with birth parents. However, it is also true that a large percentage of chronically referring families are engaged in more than one form of maltreatment, e.g., neglect and physical abuse or sexual abuse (LONGSCAN, personal communication with Diana English).

CPS agencies in the United States are tolerating extreme forms of chronic neglect, and sometimes multiple forms of chronic maltreatment. This tolerance is in distinct contrast to the CPS / law enforcement response to sexual abuse or serious physical abuse, forms of child maltreatment for which there are legal sanctions. CPS agencies have yet to find effective treatments for chronically neglecting families and lack the foster homes to greatly increase the number of children in out-of-home placement, even if they had a desire to place more neglected children.

CPS systems have been highly resistant to coming to grips with a steadily increasing number of families referred for neglect, in part because any new approach with a chance of success is likely to require more resources (already in short supply) and make

new demands on an already overworked staff. In addition, public agencies are highly sensitive to external pressure or its lack; to date, there has not been strong external pressure on child welfare agencies to improve neglect interventions. This situation is beginning to change in Washington State where new legislation expanding the definition of neglect to include patterns of parental care has recently passed following the starvation deaths of the Robinson children. Again, it has taken shocking child deaths to mobilize support for legislative action.

The most positive and surprising development in the profile of child abuse / neglect during the past fifteen years has been the reduction in sexual abuse reports and substantiated sexual abuse cases. This is a national trend as indicated by a decline in substantiated sex abuse cases of more than 30 percent in 36 out of 47 states in the late 1990s (Jones and Finkelhor, 2001). In Washington State, reports of sexual abuse have declined from 15 -20% of accepted CPS referrals in the early 1990s to 6-7% in 2005.

Scholars are not in agreement regarding the causes of this dramatic decline in reported and substantiated sex abuse; but, in my opinion, it is far more likely than not that public policy regarding the investigation and prosecution of child sexual abuse, CPS / law enforcement collaborations and a social ethos encouraging the reporting and acknowledgement of sexual abuse wherever it occurs has greatly reduced the incidence of sexual abuse committed by fathers and step-fathers.

One might expect child welfare systems under attack for alleged failures of child protection to claim some credit for a major reduction in one form of child maltreatment, and to reflect on lessons that can be learned from this propitious trend of several years. Instead, the decline in sexual abuse is hardly mentioned in child welfare circles. I have found CA social workers, supervisors and managers to be skeptical of claims that sexual abuse has declined, though I have yet to hear a cogent explanation of why mandated reporters, relatives, neighbors and friends would be far less willing to report intra-family sexual abuse to CPS agencies than they used to be.

This is an opportunity for an important public policy discussion among child welfare staff, child advocates and community professionals who work with abusing and neglecting families regarding the causes of the decline in reported and substantiated sexual abuse. For several years, I naively expected that child advocates with an interest in sexual abuse would strongly urge that legal sanctions be applied more frequently in physical abuse and neglect cases. This is not the lesson I would take from the decline in sexual abuse, but at this point I am less concerned about proposals to criminalize neglect (not a practical idea except in a small fraction of cases) than I am about the lack of lively discussion regarding ways of improving child welfare outcomes in neglecting

families. In the realm of public policy, silence and denial are deadly, just as they are in abusive and neglectful families.

Improving Assessment Skills in Child Protection

One strength of Eileen Munro's work on child welfare decision-making is her insistence on the necessity of combining intuition and analytical skills. The notion that highly structured risk assessment tools, decision trees or logic models which describe rational thought processes can totally replace intuition in high stakes time pressured decision making is a misunderstanding of the nature of expertise in child welfare and in many other professions as well.

Expertise in CPS investigation and assessment involves pattern recognition; intuition works for experts because it quickly attunes CPS investigators to the presence of typical patterns of child maltreatment. Empirical studies of decision-making have established that expert decision makers under time pressures are quick to recognize standard patterns pertinent to the decision at hand, and, just as importantly, notice anomalies that indicate that something unusual has occurred or is occurring. Gary Klein's book Sources of Power is a fascinating elaboration of these ideas as applied to firefighters, submarine commanders and chess masters.

CPS training programs have been slow to appreciate the importance of pattern recognition, partly because CPS investigations are organized around allegations of specific incidents of child maltreatment and, in part, because risk assessments are mainly concerned with the number and severity of risk factors, along with the history of child maltreatment. Incident oriented investigations have led to a minimization of chronic histories of child maltreatment and a surprising tolerance for egregious cases with dozens of referrals, multiple substantiations and failed service plans.

The failure to pay careful attention to important distinctions between types of physical abuse has been an obstacle to creating thoughtful public policy, as well as to effective case planning in specific cases. Carole Bowdry (Child Welfare, 1990) has pointed out the differences in dynamics and in prognosis between battered child syndrome and excessive discipline of school-aged children and between the torture of children and misguided attempts to educate a child.

Even when chronic neglect is combined with substance abuse (as is often the case), there are important differences in co-occurring mental health disorders, e.g., depression, anti-social personality, post traumatic stress disorder which call for different CPS approaches.

A common pattern in high profile abuse / neglect related deaths in Washington State has been the failure of CPS or CWS social workers who have become advocates of parents to respond to the injuries of children, even serious re-injuries. In addition, several of the children in these cases were removed from parents in early infancy and had formed primary attachments with other caregivers. CA, to its credit, has identified this pattern in abuse/ neglect related deaths and widely disseminated information regarding its characteristics and the signs of social worker bias.

A few other jurisdictions (Texas, New York City) have done valuable studies of abuse/ neglect related deaths that go well beyond a summary of aggregate statistics. Again, what is needed is to describe patterns in child deaths, and in social workers' involvement with these cases, not just identify percentages of families with domestic violence, substance abuse and histories of prior CPS activity. Pattern recognition is the key to better practice in child protection, both in regards to reducing abuse / neglect related child deaths and in developing more effective interventions in cases of chronic maltreatment.

Resource Issues

The systems perspective that has always resonated most fully with child welfare staff is the gap between expectations and resources. It is impossible to understand policy and practice in public child welfare agencies without reference to longstanding workload problems on the one hand and inadequate services on the other.

Workload problems have been endemic in child welfare because of the steady growth in CPS reports over three decades and, more recently, because of the large growth in the numbers of children in out-of-home care between 1986 and 2000. State governments were understandably slow to fully match these increases in CPS reports and foster care populations, leaving child welfare managers with a stark choice: settle for reduced practice standards or limit services. Actually, before achieving this level of clarity, many managers of public child welfare systems and their umbrella agencies attempted to ignore or deny workload problems. I remember sitting in a meeting with a former Secretary of DSHS (the umbrella agency) in Washington State and listening to this person state that he would never allow DSHS to deny services to persons in need due to resource limitations, an attitude which was pervasive in government at that time.

The unwillingness of top managers to adjust expectations of line staff to resource limitations and clearly define workload standards has been a constant source of tension between managers and caseworkers in Washington State, with unit supervisors caught

in the middle. In Washington, union - management discussions have been an extended repetitive discussion of one subject, i.e., the determination of child welfare managers to raise practice standards up against caseworkers' (and some supervisors') insistence that current caseloads are too high to tolerate increased demands.

In recent years, the relentless growth in CPS reports and the numbers of children in foster care have declined to some extent. At the same time, a number of states (including Washington) have dramatically reduced child welfare caseloads, sometimes because of class action lawsuits or as a result of reform initiatives.

Nevertheless, there continues to be a gap between the reality of child welfare practice on the ground and policy expectations and between the expectations of legislators, Governors and child advocates and the resources (FTEs and funded services) required to meet these expectations. Currently, it is not caseload increases that are placing extreme pressures on child welfare systems; rather, it is the increase in the expectations of governments and child advocates for comprehensive reforms that are creating untenable workload demands. The extent and intensity of external pressures to reform the child welfare system in Washington State recently resulted in an ambitious reform plan (Kids Come First - II) that threatens to overwhelm managers, supervisors and line staff. It is the intensity of these pressures that lead managers to insist on higher practice standards even when new resources are not available and to refuse to acknowledge to their staff what seem like obvious resource limitations.

Rising expectations of public child welfare agencies are being fueled by the federal Child and Family Service Reviews (CFSRs), class action lawsuits and the insistence of child advocates that child welfare managers be held accountable for achieving better outcomes. Increased expectations take three forms: (a) raising practice standards (b) improving services and (c) expanding the mission of child welfare.

Washington State is one of several states pursuing accreditation, which requires a massive effort in offices to come into compliance with over 700 standards ranging from confidentiality requirements to comprehensive family assessments. CA has been given a Governor's directive to reduce CPS response time, a directive involving major new workload demands at the front end of the child welfare system; and CA plans to increase expectations for caseworkers' contact with foster parents and children in out-of-home care in the near future.

Public child welfare systems are being pushed hard to raise standards and improve services, pressures arising out of the CFSRs but also influenced in many states by class action lawsuits and by the desire of child advocates for improved educational and

mental health outcomes for children in foster care. In effect, child welfare systems are being expected to place child well being outcomes on an equal par with child safety and permanency.

The idea that child welfare organizations which are widely perceived (Cohen, 2005) as having repeatedly failed to successfully reform their systems can be motivated to deliver higher practice standards and better services while expanding their mission (without substantial new resources) is partly a reflection of a management philosophy also evident in education and juvenile justice. This is a management philosophy which challenges managers' leadership capacities, and which assumes that managers and line staff can transcend resource limitations if they are sufficiently determined. This approach to achieving improved outcomes is creating tremendous psychological pressure on the managers of public child welfare systems. Managers, in turn, are passing along these pressures down the chain of command through ambitious performance targets and new policies embodying increased demands on caseworkers and supervisors. The notion that resource limitations can be transcended (this time through managerial will and resourcefulness) is an old idea in child welfare. It is not, in my view, a sustainable approach to successful reform.

However, there is more than a management philosophy at work. The child welfare mission is expanding without open debate because of an evolving child welfare understanding of children's needs, and because American citizens of both parties refuse to lower expectations of government because of fiscal limitations.

The recent history of child welfare in the United States has been of a steadily expanding mission: first, child safety for abused and neglected children, then, in 1980, permanency added to child safety through changes in federal law and now, in the new century, child well being added to safety and permanency. This is a process that, absent cataclysmic social changes, cannot be stopped because it reflects both the best thinking of child welfare researchers and theorists and the most passionate concerns of advocates and practitioners.

Nevertheless, for reform to be successful, child welfare expectations must be brought into line with resources. Concretely, this means that caseloads in public child welfare agencies must not exceed 12 -18 cases per person depending on the program, not 24 -25 cases per person as CA is currently funded in Washington State.

Point in time descriptions of caseload numbers in public child welfare agencies do not capture the long-term effects of extreme workload problems. In this regard, workload problems resemble poverty, i.e., it is one thing for units and offices to have high

caseloads for a few months or even 1-2 years; it is far different to experience long standing workload problems; just as long term poverty has far greater effects on family functioning than temporary poverty.

Long term and severe workload problems inevitably reduce practice standards; in extreme cases practice standards may collapse. Furthermore, after some period of time, social workers and supervisors forget that they are engaging in short cuts and poor social work practices (by necessity). At this point, it is difficult to restore high practice standards even when caseloads are reduced to reasonable levels. Supervisors and staff often have to be replaced to markedly improved practice standards.

Many legislators and child advocates in Washington State are tired of hearing CA managers and caseworkers complain about inadequate staffing; these complaints are often viewed as a chronic excuse for poor performance. Unfortunately, it is true that increases in staff do not always translate into improved performance in child welfare. New caseworkers must be adequately trained and supervised, and leadership is an important factor in any successful reform effort. However, steadily increasing expectations without reducing caseloads guarantees that reform efforts will fail; no amount of talk about accountability and leadership can gainsay this reality.

Funded Services

It is a peculiar feature of child welfare in the United States that the services most needed by children and parents on open cases are not administered by public child welfare agencies. Substance abuse assessment and treatment, mental health services and domestic violence programs are administered by other public and private agencies that may or may not have an interest in child welfare.

Family support programs funded by the Children's Administration are crisis oriented, short-term programs whose main purpose is to prevent out-of-home placement. Experimental studies in other states have demonstrated that these programs are not effective at placement prevention; furthermore, these programs are not designed for chronically neglecting families, the 15-20% of families on open child welfare caseloads with the highest rates of recurrent maltreatment and the most challenging service needs.

Meanwhile, the few evidence based programs in child welfare are either unfunded or exist as small parts of funded programs, e.g., Parent-Child Interaction Therapy (PCIT), an effective treatment for physical abuse. Mark Chaffin ([Children and Youth Services Review](#), 2004) recently commented in an article on evidence based practice that not only

do most social workers in child welfare not utilize evidence based programs, they have never heard of them.

This is a child welfare mess consisting of one-third politics, one-third inertia, and one-third administrative arrangements of a long-standing nature. None of these components will be easy to change, but at least there is already a lively statewide and national discussion regarding evidence-based practice.

Since neglect cases constitute the largest fraction of new CPS referrals, it is the needs of neglecting parents and their children that should guide the reshaping of child welfare services. Unfortunately, these needs are both complex and expensive. Integrated treatment programs for substance abusing parents with co-occurring mental health disorders are badly needed. Long term case management on the model developed in mental health for chronically mentally ill adults should be provided for parents with co – occurring disorders. Less troubled families can be referred to skills development programs modeled on Project SAFECARE (Lutzker and Bigelow, 2002) or extended family support programs.

The most expensive new investment urgently needed for children in chronically maltreating families is high quality childcare programs. Fortunately, Washington State has an outstanding therapeutic child care model in ChildHaven; this type of program used to exist all over the state before they were undermined by federal funding requirements and by a CA decision to maximize federal funding even at the cost of demolishing therapeutic child care programs.

Every effort should be made to re-create therapeutic childcare programs around the state to reduce the cumulative emotional and developmental harms to children resulting from chronic maltreatment and to foster positive social development. There is already a strong evidence base for the value of early childhood education and a wealth of information regarding essential program components (Barnett and Boocock, 1998).

Work Force Improvements

An important subject often neglected in discussion of child welfare reform is the need for workforce improvements. I have occasionally heard discussions of ambitious and laudable reform initiatives at national conferences during which a presenter casually remarks that the average salary of child welfare caseworkers in the state system is \$25 – 30,000 per year! It is impossible to credit the serious intention of policymakers to improve public child welfare systems when they do not support decent salaries for staff at all levels of the organizations. The salary level of caseworkers and casework

supervisors at “top-out” is especially important, because low maximum salaries create an incentive for experienced staff to look for better paying jobs.

During recent years, CPS social worker has become an entry-level position in most urban offices in Washington State. I have been informed by CA training staff that the majority of new caseworkers in the CA Academy (basic training) are new CPS staff hired in offices on the west side of the state. New CA case workers enter CPS and often remain for no more than a couple of years before moving to a position perceived to be less demanding in another program area. As a result, career paths in child welfare in Washington State usually begin in CPS and then proceed to Child Welfare Services (CWS), Family Reconciliation Services (FRS), Foster Home Licensing (OFCL), Adoption Services, or to regional office positions.

This pattern is more evident in offices in communities that have a large variety of other employment opportunities, e.g., Olympia, Seattle, than in smaller communities where the few private agency jobs available to social workers pay far less than jobs in state agencies. It is not unusual in high turnover offices to find CPS units in which only one or two social workers have at least 18 months experience in CPS. However, there is a steep learning curve in CPS; two years is barely enough time to reach a level of competence sufficient to allow highly independent work. CPS units in which most line staff have a year or less experience in their current jobs must depend to an extraordinary degree on supervisory direction and decision making in matters large and small. I have seen CPS units in which the combination of inexperienced social workers, vacancies and heavy workload has broken the confidence of supervisors and led to a meltdown in practice standards.

To a remarkable extent, CPS programs in Washington State and around the country are organized around the reality that a large fraction of CPS staff are not professionals in child protection and, furthermore, have no desire to become so. One of the reasons CPS reform often involves the development and implementation of safety assessment and risk assessment tools is to assist staff with limited knowledge of child abuse and neglect conduct adequate safety/ risk assessments. New CPS social workers usually appreciate a well-defined assessment structure while experienced staff tend to regard the completion of assessment tools as a paperwork nuisance.

There has been little or no discussion in Washington State of how to develop a more experienced and professional work force in child protection. Discussions of professionalism usually involve statistics describing percentages of staff with Masters degrees; but even new staff with Masters of Social Work degrees are unlikely to have had graduate courses in child protection or working with involuntary clients. Even if

such graduate courses existed, they would not be a substitute for CPS experience and outstanding supervision.

Some states have attempted to deal with this problem by paying CPS investigators more than caseworkers in other programs, or by guaranteeing reasonably sized caseloads for CPS caseworkers. Both of these ideas are worth considering, but they do not adequately address the need for a professional work force in CPS, as well as a highly experienced one.

Another promising idea is for child welfare agencies to fund certification programs in substance abuse, mental health, domestic violence, child development, cultural competence, Indian child welfare, etc.; and then to increase the salary of social workers and supervisors with these certifications when they are utilizing their specialized skills and knowledge in positions designated by the agency. This idea has the merit of creating incentives for acquiring specialized skills and knowledge while allowing managers to decide which positions are critical enough to increase the salaries of certified staff filling those jobs.

Any well thought out strategy for keeping experienced staff working in CPS must find ways of reducing the relentless overwhelming emotional pressures which take a toll on staffs' physical and emotional health and well being. To this end, public child welfare agencies should guarantee CPS social workers one month per year (in addition to annual leave) when they will not be assigned new cases. Obviously, units must be adequately staffed to allow each social worker one month of freedom from case assignment without overloading other staff in the unit. Temporary relief from case assignment can do wonders for the morale of CPS social workers.

In addition, all line staff in public child welfare agencies should receive a 4-month sabbatical from case carrying duties every 3-4 years in the same way that university faculty are given teaching sabbaticals to pursue projects that can facilitate personal growth.

Some readers may believe that ideas of this sort, e.g., sabbaticals for social workers, guarantees of one month per year without new assignments, are fanciful and unrealistic. However, the fantasies of one era, for example maternity and paternity leave, are the common sense of later generations. When child welfare organizations cease to treat staff like tools or interchangeable parts, and begin to carefully attend to the needs of practitioners, these ideas will become commonplace. When this happens, the experience level of child welfare staff will greatly increase, morale will improve and improvements in practice will quickly follow.

Conclusion

It has become common to encounter pessimistic attitudes regarding the prospects for child welfare reform, due, in part, to repeated failures of reform efforts in many states. In addition, a large amount of increased funding has been invested in these reform efforts, seemingly without much effect. However, it is a big overstatement to claim that reform efforts always fail. What has occurred in recent years in Illinois and New York City indicate that even large troubled child welfare systems can be dramatically improved with the combination of new resources, dynamic leadership and a willingness to try new approaches.

It is also true that it is possible to spend extraordinary amounts of scarce resources doing the wrong things, or initiate ambitious reforms without first taking care of basics. First and foremost:

- Public child welfare agencies must be adequately staffed; caseloads should not exceed 12 -18 cases in any program. There should be equally careful attention devoted to the average number of new referrals assigned per month in CPS and FRS.
- Therapeutic resources funded by states must match the presenting problems and needs of children and families served by child welfare agencies. Concretely, this means that new service programs must be developed to serve neglecting families. Current substance abuse treatment programs must be altered to provide integrated treatment for parents with co- occurring substance abuse and mental health disorders.
- Public child welfare agencies need to develop far better measures of their CPS programs; these measures should include counts of serious inflicted injuries or neglect related injuries on open or recently open cases and accurate counts of abuse / neglect related child deaths on cases referred to CPS.
- CPS units must be able to develop and retain a large cadre of experienced and professional staff with specialized expertise in substance abuse, mental health, domestic violence, child development (including infant mental health), cultural competence and Indian child welfare. "Top out" salaries for social workers and supervisors should be increased.
- Every effort should be made to reduce the pressure on CPS caseworkers by guaranteeing one month per year of freedom from new assignments. Four-month sabbaticals from case carrying duties should be provided to caseworkers in all programs every 3 -4 years for retention purposes and to facilitate professional development.

- Public child welfare agencies should slow the pace of reform and abandon the idea that child welfare systems can be regulated into good practice. A regulatory paradigm is strangling child welfare systems in the United States; a large increase in policy requirements is not the way to reform overburdened agencies. Current practice requirements should be re-evaluated with an emphasis on listening to feedback from practitioners regarding the value of current assessment tools and procedural requirements.
- CPS training programs should teach pattern recognition, in addition to investigative skills and risk assessment. State systems should carefully study collections of abuse/ neglect related child deaths on a yearly or bi –yearly basis to identify characteristics of these cases and patterns in social workers’ approach to these children and their parents.

Until public child welfare agencies pay reasonable salaries, staff units and offices with enough qualified experienced staff to maintain high practice standards, go out of their way to reduce the stress of jobs in which high stakes decision making is an every day occurrence, learn how to better measure performance and the results of program improvements and train CPS staff in pattern focused assessments of child maltreatment, it is premature to give up on the potential of reform efforts. “Back to Basics” is a misnomer for this reform initiative since these are recommendations that have never been fully implemented, or, in some instances, even attempted. Perhaps “Basics First” is a better rallying cry for this program.

In my view, child welfare reform is like a lock and key; until one uses the right key, the lock doesn’t open. A dozen efforts to open a lock with the wrong key are no better than one effort. Finding or shaping the right “key” is the path to successful reform.

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