

DRIVING CRITICAL REFORMS AT DCF IDEAS FOR A DIRECTION FORWARD IN MASSACHUSETTS' CHILD AND FAMILY SERVICES

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EXECUTIVE SUMMARY

On October 28th, the Office of the Child Advocate (OCA), an independent office that reports to the Governor on child welfare services, released its official review of DCF's involvement with Bella Bond—a two-year old girl who disappeared in May or June 2015 and whose body was later discovered on Deer Island on June 25, 2015. The review concluded that DCF had failed to take sufficient action to protect the child during a number of interactions with the agency in 2012 and 2013. Among the OCA's findings were observations that the abuse and neglect reports from 2012-2013 warranted a higher level of response, the agency underestimated the degree of risk of abuse or neglect Bella faced, caseworkers overseeing the Bond family gathered "minimal, if any" information on the current family and personal history of Bella's mother, Rachelle Bond, an inadequate amount of information was gathered from family service providers and the cases opened in 2012 and 2013 were closed prematurely.¹

The OCA's review comes on the heels of several recent highly publicized cases of child abuse and neglect under DCF's supervision, which have once again propelled the troubled agency into the spotlight. This recent series of tragedies should not be written off as anomalies in an otherwise well-functioning system. A review of federal circuit court justice William Young's findings (*Connor B. v. Patrick et al.*, No. 13-2467, 1st Cir. 2014), discussed in this paper, makes it very clear that DCF is dysfunctional.

As DCF again faces intense public scrutiny, the agency must now work more aggressively than ever to fix critical internal failures that continue to plague it in spite of a range of reforms enacted in early 2014 and expanded under the new administration.

As Governor Baker announced recently, fixing DCF will require fundamentally re-thinking the agency's mission. This entails a shift in strategy that makes children's safety and well-being the top priority in all response options dealing with alleged cases of child maltreatment.

A number of studies point to a range of areas that should be the focus of reform. This report dissects these studies and their recommendations, with additional suggestions for a direction forward for DCF in the context of a broader discussion of the agency's recent history and issues with mission ambiguity. Our first and most important recommendation is to overhaul the current two-tiered child intake system, which should be the central focus of any changes at the agency. For this, we propose several options to consider moving forward with the agency's practice model, including strengthening criteria for track assignment, modifications to the 45-day comprehensive assessment period, and requiring that Child Protective Services (CPS) review cases with families that refuse voluntary services on the assessment track.

As DCF reforms its practice model to better protect children, the agency should also focus on revamping its technological infrastructure to provide its workers the tools they need. We provide examples of states that have implemented innovative systems to improve their agencies' operations and discuss future federal regulatory reforms that will change the way state foster care agencies manage their information systems.

ONGOING ISSUES

Over the last several months, a number of high-profile cases have brought to light ongoing failures at the Department of Children & Families (DCF).

On July 14 this year, seven-year-old Jack Loiselle was found unresponsive by his father at their home. Medical examination showed Jack was in a coma and had large bruises on several parts of his body, burns on his feet, and suffered from significant malnourishment, weighing just 38 lbs. His father was soon arrested and charged with beating and starving his son.

The severe abuse and neglect had taken place on DCF's watch. The case review published by the Governor's Office on September 4th shows Jack and his father had been "receiving services through DCF" over the course of the prior five months, including 110 visits and 16 interactions between the Loiselle family and DCF caseworkers.² According to the *Boston Herald*, Hardwick School Superintendent Maureen M. Marshall released the following statement about the Loiselle case: "The school department had on a number of occasions requested the help of the Department of Children and Families."³

Only a month later, the public learned of another incident involving DCF: two children in custody of an Auburn-based foster home were found unresponsive, suffering from asphyxiation and symptoms indicating heat exhaustion. Two-year-old Avalena Conway-Coxon died upon arrival at the hospital, and a second 22-month-old girl was left in critical condition. The incident took place just three days after a routine visit by DCF and remains under State Police investigation. In response to the incident, Governor Baker vowed to conduct a comprehensive review of social services in the Worcester County area.⁴

Most recently, the death of Bella Bond has raised questions surrounding DCF's interactions with the child's family and the degree to which more preventive measures could have been taken. As reported in the most recent OCA report, DCF

conducted two investigations in 2012 and 2013 based on suspected neglect and abuse of Bella Bond, who at the time was in the custody of her biological mother, Rachele Bond, and Rachele's boyfriend, Michael McCarthy.⁵

A TROUBLED HISTORY

These more recent cases have revived a public conversation about DCF that dates back several years. Some of the most disquieting details about the agency's dysfunction were first revealed at the conclusion of a class action suit brought on by the national watchdog group Children's Rights, who filed suit in April 2010 against the Commonwealth on behalf of all children in DCF foster care custody, with a focus on alleged violations of their due process rights.⁶ U.S. District Court Judge William Young, who presided over the case, dismissed it on technical grounds. His findings and rulings, however, highlight significant issues at the agency. Included in the Judges' findings are the following observations and statistics as originally reported by the Children's Research Center (CRC), which performed a study of DCF case files on behalf of the plaintiffs in the case:

- Among 242 children in the two-year cohort⁷ 56 allegations of abuse or neglect during the DCF observation period were reported;
- Only 11.7 percent of case workers do regular home visits at federally mandated monthly rates;
- Only 12.9 percent of children in the two-year cohort were consistently contacted on a monthly basis by their caseworker throughout the two-year review period;
- Only 7.1 percent received required 30-day medical visits;
- Massachusetts' caseloads for social workers exceed recommended national standards (12 to 18 cases). Almost half of the Commonwealth's 836 caseworkers had weighted workloads greater than 18 cases. To meet national standards, however, DCF estimated that it would need nearly 200 additional caseworkers at an approximate

annual cost of \$10.1 million;

- Due to heavy workloads, existing training opportunities frequently go underutilized;
- About 35 percent of children in the two-year cohort were missing case plans in their case files;
- Only 11.6 percent of children received a required foster care review within six months of entering DCF custody;
- These results, when compared to those of other states, placed the Commonwealth fourth worst out of 46 states reporting on maltreatment in foster care in 2006, the seventh worst out of 46 reporting states in 2007, the fourth worst out of 48 states in 2008, the seventh worst out of 49 states in 2009, the eighth worst out of 47 states in 2010, and the seventh worst out of 49 states in 2011.⁸

Since the November 2013 ruling, several more high-profile incidents have fueled public debate over DCF's shortcomings and the need for reform. The most significant catalyst for new reforms was the disappearance and subsequent death of five-year-old Jeremiah Oliver, whose body was found abandoned on the side of the road in a suitcase three months after the boy went missing in September 2014. The incident sparked national outrage and resulted in the termination of a social worker and two of her supervisors.

The details that emerged over the weeks following Jeremiah Oliver's death prompted public officials from all corners of state government to call for an independent examination of the agency. The ensuing review of the case was performed by the Child Welfare League of America (CWLA), who identified a range of "significant issues concerning case practice in the Oliver case", including substantial evidence that DCF staff, who had been delivering services to the Oliver family since 2011, did not do their jobs.⁹ Though the report concluded that DCF was not directly responsible for Jeremiah Oliver's death, a subsequent lawsuit filed in Worcester Superior Court alleged managers at DCF offices in Leominster lied to

the authorities about details in the Oliver case and did not follow procedure on a number of alarming reviews of high-risk cases brought to their attention.¹⁰

On March 26 2014, approximately four months after Oliver's death, the Office of the State Auditor released a report confirming DCF's dysfunction and system failures. Among the report's conclusions were:

- DCF is not ensuring that children receive required medical screenings within seven days of being placed in its custody and more comprehensive medical examinations within 30 days of being placed in its custody. The effect of this is that DCF's management cannot effectively ensure that children in DCF custody are not continuing to suffer from undetected health issues, trauma, and injury from abuse and neglect
- DCF does not have adequate documentation to substantiate that it has conducted all required background record checks (BRCs) on individuals living in some of its foster homes. Therefore, DCF cannot substantiate that these BRCs were performed before DCF placed children in foster homes.
- Although DCF has established an internal control plan (ICP), the plan is not fully compliant with Chapter 647 of the Acts of 1989 and guidelines established by the Office of the State Comptroller. DCF's department-wide risk assessment had not been revised since 2008 and did not contain an up-to-date, high-level, department-wide summary of risks and controls for all its divisions, programs, and functions with cross-references of risks identified to internal controls (e.g., departmental policies and procedures) established to mitigate them.¹¹

PUTTING ISSUES AT DCF IN CONTEXT

The most recent instances of child neglect and abuse under DCF's watch suggest that the reforms mentioned above have not adequately mitigated some of the fundamental causes of system failures at the agency. A number of recent studies and

reports reiterate this, pointing to Massachusetts' inability to bring agency practices up to a level of quality that is acceptable by national standards.

How does Massachusetts compare to other state child and family service agencies across the country? Reports from one of the most prominent and trusted sources for federal data show Massachusetts severely struggling relative to its national peers. The Child and Family Services Review (CFSR) is one of the leading sources for performance data on child welfare services, and provides a comprehensive federal performance assessment of social service agencies in every state. CFSRs are conducted by the Children's Bureau, an office of the federal Administration for Children and Families (ACF), which lists the following three goals for the national assessments:

- Ensure conformity with federal child welfare requirements;
- Determine what is actually happening to the children and families engaged in child welfare services;
- Assist states in helping children and families achieve positive outcomes.¹²

In the heat of the 2014 campaign season, the review released alarming figures for Massachusetts, illustrating the poor performance of DCF relative to its peers in other states. The report, published in October 2014, showed that the Commonwealth's performance is nowhere near acceptable standards for child welfare services. The assessment shows Massachusetts ranked last out of 48 reporting states for 'maltreatment in foster care'—defined as the number of cases of maltreatment per 100,000 days of foster care administered by the agency—for fiscal 2013.¹³

An updated report released in May 2015 shows even more disturbing results. During fiscal 2013, there were 27 cases of maltreatment for every 100,000 days of foster care administered by the agency. This puts Massachusetts last on a list of 46 states that reported data to the feds—the next worst state over this period was Iowa, with 22.68 cases of maltreatment for every

100,000 days of foster care.¹⁴ Massachusetts' 27 cases of maltreatment per 100,000 days is also more than three times the national standard of 8.5—a disconcerting reminder of the need for improvements at the agency to align its performance with acceptable levels.¹⁵

Though foster care data is helpful in providing insight regarding this component of DCF's operation, looking at data on foster care maltreatment can only tell us so much. Another valuable metric the CFSR uses for measuring the performance of child and family service agencies is 'recurrence of maltreatment'—which shows the annual percentage of repeated cases of abuse and neglect.¹⁷ According to the May 2015 report, Massachusetts had a 14.2 percent rate of maltreatment recurrence during fiscal 2013—significantly higher than the CFSR's national standard of 9.1 percent. In this category, the Commonwealth ranked 45th out of 49 states.¹⁸

It is important to note that federal data on recurrence of maltreatment, though helpful in contextualizing how Massachusetts compares to its peers, offers a limited picture. One of the most fundamental issues with this metric is that the CFSR does not include data on recurring maltreatment that occurs on the assessment track in states that have employed a two-tiered model. This severely limits the comprehensiveness of these assessments, as we explore later in this report. In addition, reporting standards are not uniform across states—Massachusetts DCF, for instance, is among a small group of states nationwide with the lowest threshold for levels of qualifying evidence. DCF's 15-day response period is also one of the nation's shortest timeframes across state CPS agencies—something which may impact the number of days included in the CFSR's data. Nonetheless, these federal reports offer valuable estimates of performance and a more macro-level perspective in determining DCF's national standing.

Several other studies confirm what the figures above indicate. A 2012 report from the Foundation for Government Accountability, for

FIGURE 1. MALTREATMENT IN FOSTER CARE BY STATE - FEDERAL FISCAL YEAR 2013

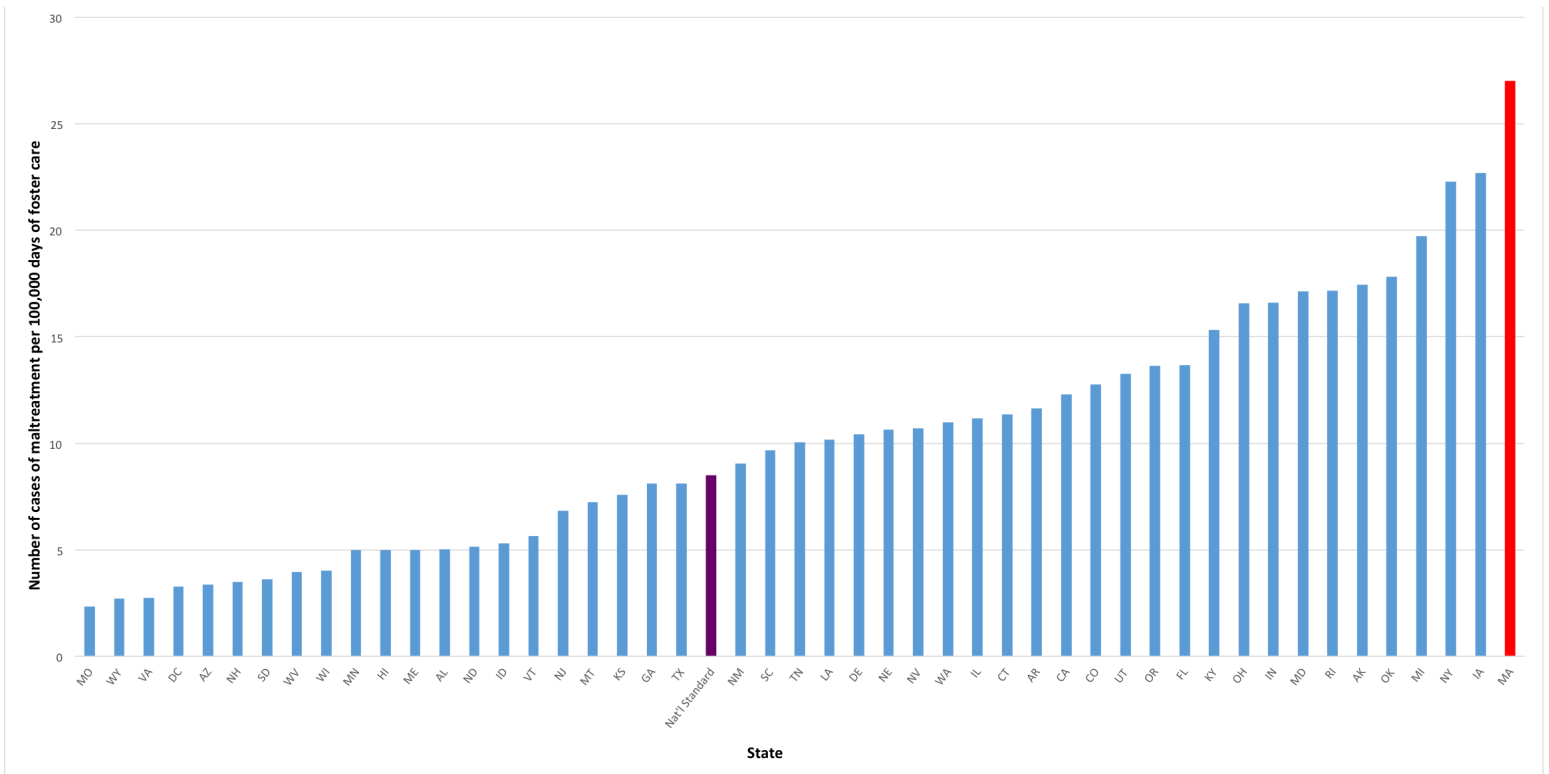
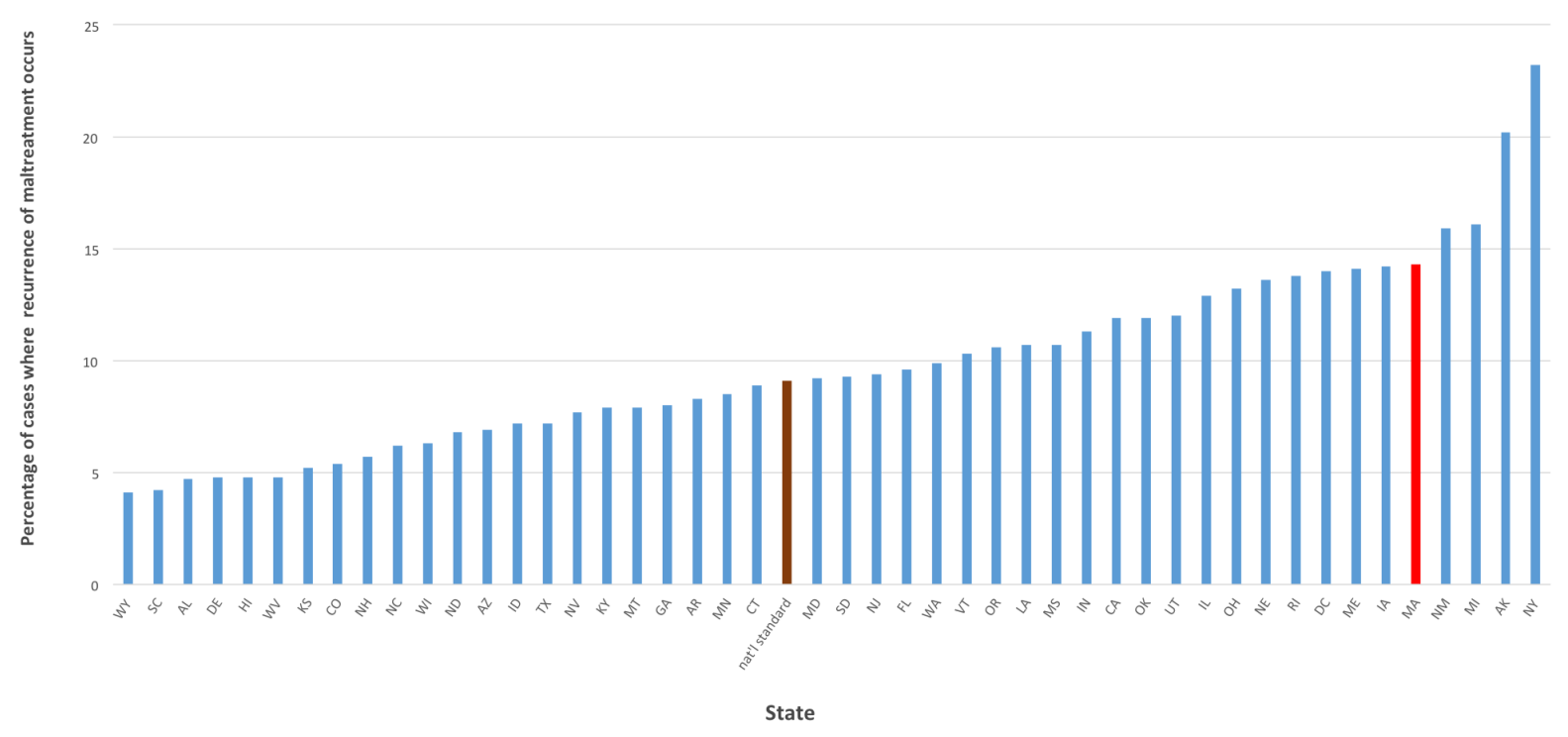


FIGURE 2. RECURRENCE OF MALTREATMENT BY STATE - FEDERAL FISCAL YEAR 2013



example, ranked Massachusetts the worst state for child services. The report, which employs a methodology that ranks all states based on scores in 11 “key outcome areas” and 41 separate data measures, shows that Massachusetts fell from 44 to 50 in the rankings between 2006 and 2012.¹⁹

Local government groups have also demonstrated the problematic state of DCF. The 2015 annual report from the OCA shows that the agency reviewed 290 reports of abuse or neglect in connection with 633 individual allegations of maltreatment in 2014. This figure is an 18 percent increase from the 241 reports of abuse or neglect in support of 538 individual children in 2013. These 290 reports focused on “supported allegations” regarding 184 children in DCF custody that year.²⁰ The increase might be reflective of a greater volume of maltreatment occurring under DCF oversight during this period. But the jump could be at least partially explained by increased vigilance in reporting galvanized by high-profile tragedies like the case of Jeremiah Oliver. As DCF shared with the Pioneer Institute, this uptick could also be partly due to increased reporting of Safe Sleep-related cases, which had previously gone unreported, and escalating numbers of opiate-related family incidents, including a growing number of reports of Substance Exposed Newborns.

One of the most recent reports on the agency comes from the Ripples Group, which is consulting with the OCA in a comprehensive evaluation of DCF. The September 9, 2015 interim report paints a bleak picture of the agency. It cites several reasons for systems failure in its preliminary findings, including excessive caseload volumes, diminishing management capacity, communications problems between supervisors and caseworkers, and a lack of a clear and shared agenda to improve the agency.²¹

Mission Confusion

The findings of the aforementioned reports point to the need for improvement in various areas of DCF’s operation. However, the top priority in any

DCF reform should be targeting and correcting specific practices that expose children to greater risk. In particular, significant revisions to the two-tiered case intake system must be implemented, with a focus on the assessment track—the track to which low- and moderate-risk cases are supposed to be assigned.

The recent tragedies have raised serious concerns regarding DCF’s assessment track and its efficacy in ensuring the safety of children who are diverted to this casework pathway. A September 2015 report from the New England Center for Investigative Reporting (NECIR) and the *Boston Globe* revealed, 10 children diverted to the assessment track died from 2009 through 2013²²—7 of these children died in 2013 alone.²³ These instances of systems failure highlight issues with the diversion process and how risk is assessed in accordance with the agency’s Integrated Casework Practice Model (ICPM). They are reminders that too often the goal of supporting and preserving families served by DCF injuriously takes priority over child safety. The 2014 CWLA report echoes this sentiment, citing a “disconnect” between DCF’s stated Core Values and the way ICPM is implemented. The report notes:

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.²⁴

Moving forward, the fundamental focus should be addressing this lack of clarity surrounding DCF’s mission and fixing it through an overhaul of the two-tiered system.

Pervasive “mission confusion” at DCF was a central concern in one of the Baker

administration's public announcements on the subject. The confusion refers to ambiguity surrounding two principal goals of agency workers that often conflict: family preservation versus child protection. As Baker proposes, DCF's future success will depend on how the agency re-prioritizes to ensure child safety is the cardinal objective in all interactions with families. To accomplish this, the agency should significantly revise its practice model, ICPM, introduced in 2009, which dictates procedures for Child Protective Services (CPS) in cases of alleged child maltreatment.

CPS systems first screen and respond to reports of child maltreatment to determine whether the alleged instances necessitate a formal CPS response. The traditional CPS approach involves an investigation that includes evidence and data collection, interviews with alleged victims and perpetrators, substance abuse assessments, domestic violence assessments and criminal background checks. The investigation concludes with a determination of whether sufficient evidence exists to confirm that maltreatment occurred.

DCF's ICPM employs a different system, separating requests for review into two tiers for CPS: investigation response and assessment response. This is a form of the "Differential Response (DR)", or "Alternative Response (AR)" model—an alternative approach to reviewing reports of child abuse and neglect that is supposed to engage low- to moderate-risk cases through family-centered support services in lieu of a traditional investigation. The DR model is the product of child welfare services reform movements that advocated for CPS strategies designed to prioritize family preservation. The model has been widely implemented across the country, with 20 existing statewide implementations last year.²⁵ DR systems typically possess the following components:

- (1) At least two pathways are available for screened-in cases;
- (2) Decisions to divert cases to alternate

pathways are determined by risk protocols and case characteristics;

- (3) A case can change pathways when risk levels increase or decrease;
- (4) Protocols for alternate responses are codified in statute or explicitly stated in policy;
- (5) Families in alternate pathways can refuse services;
- (6) Cases in alternate pathways do not result in a maltreatment disposition;
- (7) No perpetrators of maltreatment are identified for those cases receiving an alternate response.²⁶

The DR model is designed to divert cases categorized as low- or moderate-risk to a track that is both voluntary and less invasive to families with whom CPS interacts. The underlying idea is to address cases in a way that is less adversarial and more flexible and supportive of the parents under review. This goal is at the core of MA DCF's practice model: a DCF document from October 2009 lists the purpose of the ICPM assessment track as "to engage and help" families, with focus on "determining what (if any) supports and services families need."²⁷

Is there a consensus on DR?

It is important to note that much of the research produced since DR's introduction to child protection agencies concludes that outcomes from various two-tiered systems across the country are inconclusive. Findings from state-level assessments are mixed.²⁸ As a report from Child Information Welfare Gateway points out, many evaluations indicate that child safety "has not been compromised" in states that have employed a DR model.²⁹ It is also important to acknowledge that DR systems vary significantly by state and jurisdiction in terms of implementation and structure.³⁰

Nonetheless, significant research published recently suggests that DR presents grave concerns with respect to child safety. A 2013 study from a team of researchers affiliated with the North

American Research Center for Child Welfare (NARCCW) shook the social science community when it found that “child safety is not being uniformly assessed, accurately measured or fully addressed in either DR programming or research”, and that “insufficient data” exists to support the conclusion that children diverted to alternative tracks were as safe as those in investigation tracks.³¹ The study concludes that there are “many factors operating in DR programming that potentially contribute to inaccurate assessments of children’s safety,” with specific reference to issues surrounding the screening process. The study also points out that most of the research concerning DR up to this point has been published by groups with ties to a national advocacy campaign promoting the model. Citing a problematic connection between researchers who have pushed to make DR a national standard for CPS systems and the advocacy group that created and has aggressively marketed the DR model, the authors argue that the evidence-based claims of much of the existing research are at minimum very questionable. As the authors express: “many claims in this body of literature about the benefits of DR exemplify marketing and promotional strategies rather than objective science.”³²

There is an important distinction between traditional screening and screening conducted under DR systems that helps explain how screening under DR can lead to track assignment based on insufficient information. Traditional screening at child services agencies is not designed to make a decisive initial determination about child maltreatment or risk of maltreatment. When a screener recommends that a case be accepted for follow up review, he/she is confirming there is “sufficient potential that a child is at-risk” to justify further review, but also that “additional case fact-finding is necessary” to accurately determine the level of threat a child may be facing. In contrast, a screener under the DR model will typically make a recommendation for case acceptance, prioritize the case for response by the agency, and also make a recommendation for a track assignment based solely on a phone interview, which provides limited scope and potentially inaccurate information.³³

A survey of DR systems in 16 jurisdictions, including Massachusetts, found that the “majority of jurisdictions make the track assignment during the central/hotline call.”³⁴ This means they do not conduct an investigation of alleged maltreatment before track assignment, but instead use only information based on the hotline call and eligibility criteria.³⁵ This suggests significant limitations in information gathering before track assignments are made. This is especially true for Massachusetts DCF, which currently has in-place a system whereby a track assignment has to be made within 24-hours of a phone call reporting abuse for all reports that are not screened out—many states, in contrast, provide at least a 72-hour window, according to SEIU local 509A.³⁶

Another troubling feature of DR systems relates to states’ reporting of specific CPS data to the federal CFSR, as mentioned above. The information states report does not include data on recurrence of maltreatment from assessment tracks. The category ‘recurrence of maltreatment’ is defined as a substantiation of a re-report after a substantiated incident of maltreatment. Any case placed on the assessment track, however, cannot be substantiated—therefore, any instance of recurring maltreatment that occurs in cases on the assessment track are not included in this data. This leads to an incomplete picture of the volume of recurring maltreatment cases in each state and raises serious accountability concerns, as state agencies are not being held responsible for child safety outcomes for children on this track. Furthermore, the absence of a mandate for this information might incentivize states to adopt DR systems to conceal information that reveals more pervasive levels of maltreatment in their CPS systems.³⁷

Troubles with DR beyond Massachusetts

The 2013 NARCCW study opened the door to a great volume of research that illustrates troubling results states are having after implementation of a two-tiered system, and there are several notable examples of state CPS failures that support these findings. These examples demonstrate that MA DCF is not alone in experiencing child

maltreatment issues that are linked to a two-tiered case intake system.

Florida's experience is illustrative of the failures that can result from a case intake system that makes both family preservation and child safety central priorities when the two often can't be reconciled. A *Miami Herald* spotlight study revealed that more than 80 children died from 2008 to 2014 under the Florida DCF's voluntary track "safety plans" – unenforceable written agreements signed by parents who vow not to repeat offend. The safety plans were a core component of a system model designed to be more "family friendly" and less intrusive to families interacting with the agency. The report notes that parents who agreed to voluntary services were given repeated chances to improve behavior, but in at least 34 cases children died after DCF had documented 10 or more reports.³⁸ The *Miami Herald* findings were a large catalyst for reform: Florida enacted significant changes to its child welfare system shortly after the report's release.

Illinois is another state that has faced issues with DR, which it discontinued but pending legislation would reinstate. In 2012, the acting director of Illinois' Department of Children and Family Services expressed that cutting the DR program was the reasonable course of action as it had "driven up caseloads for investigative staff" and thus contributed to unsustainably high investigations caseloads that put children at risk.³⁹ An October 2013 report from the Children and Family Research Center of the University of Illinois, which performed an independent evaluation of Illinois' DR system, found that families randomly-assigned to the DR track in Illinois had "significantly higher rates of re-reports and substantiated re-reports" of maltreatment—18.8 percent of these families experienced a re-report within 18 months of initial case closure, compared to 14.7 percent of families on the investigation track.⁴⁰ The report also provided evidence showing that parents who started down the DR track and then refused services—what the report refers to as "DR withdrawers" and "DR switchers"—were the group

at highest risk for maltreatment recurrence.⁴¹

Wyoming has also had issues with its two-track system. In a 2008 report from the state's Child Protective Services (CPS), the authors note in their review of a randomly selected cross-section of family clients that the families in the assessment track, where "cooperation is optional", "rarely accepted services and their problems often worsened."⁴²

Virginia is another illustrative example. A 2008 report from the Virginia Department of Social Services concluded that 54 percent of all families in the state's assessment track were high or moderate risk.⁴³ These figures parallel the findings of a 2010 study concerning California's first Differential Response program, Another Road to Safety (ARS). In the 'Discussion' section of the report, the authors note that almost half of the DR sample group evaluated in the study was determined to be either "high risk" or "very high risk" by ARS staff.⁴⁴ The Virginia report also found that families diverted to the assessment rack were more likely to decline at least one type of service—11 percent versus 6 percent for families in the investigations track.⁴⁵ This suggests that parents diverted to assessment might present higher risk that goes undetected and are more likely to walk away from an offer of voluntary services.

Minnesota is also considering comprehensive reforms to its two-tiered system. After a high-profile incident involving a four-year old boy who died in the custody of his stepmother in 2013, Gov. Mark Dayton appointed a task force to examine the state's Child Protective Services. In March 2015, the task force released a report with a number of recommendations focused on changes to the family assessment track of the state's child protection system, with the central goal of making its CPS "child-focused". The report also recommended that long-term consideration be given to eliminating the voluntary DR track and merging into one overall CPS system. The task force's recommendations for short-term improvements list the following fundamental

items to drive immediate reform at the agency:

- All children, regardless of track, should receive a comprehensive assessment which provides the foundation for assisting children, youth and families with what they need
- Progress should be monitored to see if the child (and the family, where appropriate) is getting better because of child protection intervention
- Child Protection workers (in both tracks) should review progress with both forensic and family engagement tools close at hand.⁴⁶

The Task Force's report also makes reference to the importance of first interviewing children individually in cases of alleged maltreatment, "prior to contact with (a) parent/legal guardian."⁴⁷ This recommendation addresses one of the most problematic features of the assessment track in the DR model: the requirement that agencies first receive parental permission to interview children in cases of alleged abuse or neglect. This approach, intended to be less invasive to parents under review, increases the risk that alleged victims will be reluctant to fully disclose case details out of fear of retaliation. A 2005 study on domestic violence intervention in child welfare services reiterates this concern, stating that this approach could be "potentially dangerous for victims of interpersonal family violence as it may threaten the person responsible for the violence."⁴⁸

Massachusetts DCF should consider incorporating the items bulleted above into its practice model. The agency should consider commissioning an independent research group, analogous to the Minnesota Task Force, to examine the assessment track of the ICPM. Importantly, the agency should also put in place measures to ensure individual interviews with children that are alleged victims of abuse are not conducted in a group setting at which the entire family is together and present.

Improving Management Practices and Information/Technology Systems

Significant revisions to the two-tiered case intake

system should be the central focus of reform at DCF. However, as the agency fixes its practice model, it should also make fundamental changes to its technology infrastructure and update its data and management tools to fix ongoing issues with information-sharing; communications between supervisors, managers and caseworkers; and excessive caseloads per worker. These issues have been widely cited in a number of recent reports on DCF and present serious obstacles to efficient and effective agency operations.

A January 2015 review of DCF by the Massachusetts House of Representatives Committee on Post Audit and Oversight and the Joint Committee on Children, Families and Persons with Disabilities mentioned that the Executive Office of Health and Human Services (EOHHS) had tasked CWLA with investigating DCF's technology and that CWLA concluded in a spring 2014 report that critical technological improvements would be fundamental to reform.⁴⁹ Per CWLA's findings, DCF has since issued 3,000 iPads to its staff and has been working to implement a mobile-based version of the agency's FamilyNet software, a statewide automated child welfare information system (SACWIS) that is used for "virtually all DCF activities, including intake, investigation, assessment, clinical/case management, adoption, financial, legal and providers services."⁵⁰

FamilyNet has been DCF's software since 1998,⁵¹ and the agency rolled out a new version of the software in July 2014. In spite of the recent update, several recent reports, including the OCA's September report, point to the need for improving the program to better meet the demands of DCF's current workforce. As a representative of SEIU Local 509 shared in conversation with the Pioneer Institute, the migration from FamilyNet to iFamilyNet—a transition from the more antiquated, server-dependent database to a web and mobile-based database—has been problematically slow. A fundamental goal of the migration to the web-based solution was to establish more flexibility for DCF staff to access FamilyNet remotely—a critical capacity for

caseworkers who log significant hours in the field without desktop accessibility. Local 509 provided an estimate that roughly 20 percent of clinical functions of FamilyNet have been migrated over to the web-based platform since transition started five years ago. Though, the union representative acknowledged that some of the delay can be attributed to policy revisions that have prompted demands for new system changes during this time. This extreme delay in the migration process presents significant issues for caseworkers who require access to vital functions of iFamilyNet from the field, and suggests that DCF is in desperate need of more IT resources to speed up the transition and bring the agency's practices in alignment with 21st century demands.

Implicit in the findings of the reports cited above and evidenced by the slow migration of FamilyNet, Massachusetts DCF is at a crossroads with its technology and is largely behind the curve in this area. The agency's procurement of 3,000 iPads for staff use is an important step, but providing new hardware is just one stage in what will be a longer process of necessary updates to DCF's technology infrastructure. A particular focus should be adopting tools and practices that fix issues with information sharing and communications, and offer data-driven functions that facilitate more accurate and informed case management judgments.

The OCA/Ripples report mentions a particularly important measure that should drive these efforts: establish a management dashboard to better organize and track data like case information and input from field workers and supervisors. As the report shares, DCF has had ongoing issues with management practices resulting from absent information on outcomes and internal data. Without effective organization in the reporting and documenting of case-specific information and consistent information on outcomes, a culture of accountability is impossible to establish.⁵² A June 2014 Massachusetts Law Reform Institute study offers similar commentary, stating that "for too long DCF has neglected to maintain, use and make publicly available much of the data about its

progress in achieving the basic outcomes expected of any child welfare agency."⁵³ With improved tracking and organization and timely data reports, an effective management dashboard would help achieve these outcomes and mend the schism between managers and caseworkers that results from the absence of effective information sharing and accessible outcomes data. A September 2014 report produced by the Center for the Study of Social Policy (CSSP), a national think tank, makes the related observation that "effective use of reliable data to drive changes" will be critical to DCF's future success. The CSSP report mentions several areas in which the agency's current technology systems need to improve, such as incorporating information sharing functions and integrating into the system data from multiple public and private sources.⁵⁴

The MLRI report mentioned above also recommends incorporating statistical tools capable of predictive analytics, or "predictive risk modeling"—data functions that offer valuable tools for risk assessment and more effective prevention. As the report mentions, these functions are becoming increasingly common across child welfare systems across the country, and some states have already started partnering with universities to pilot predictive modeling tools.⁵⁵

Massachusetts should look to other states that have implemented successful data and management tools for their child and family services agencies.

New Jersey's Department of Children and Families (NJDCF) has undergone a series of systems transformations over the last several years that provide valuable lessons to improve DCF's IT resources. In 2007, NJDCF adopted a versatile reporting service called "Safe Measures", which helped to facilitate access to data from both the Statewide Automated Child Welfare Information System (SACWIS) and the state's Spirit Data System. A key element of the agency's 'Case Practice Model,' the child welfare improvement program New Jersey launched in 2007, the information tool was an important development

in giving managers, supervisors and case workers more useful, real-time data on a range of valuable measures, including current caseload levels, requirements for federal compliance, and historical logs of important case events. Safe Measures has been especially helpful in improving managers' ability to track progress in accordance with national caseload standards and distribute cases more effectively among caseworkers.⁵⁶ According to the OCA's most recent report, this is a particularly problematic area that Massachusetts DCF needs to improve.

A critical step after adoption of new data and reporting tools was establishing an effective mechanism for training staff and ensuring effective use of these instruments. To achieve this, NJDCF conducted a comprehensive assessment of best practices across five states and consulted with national child welfare experts to gain a better picture of where data programs have had success in child services. Through this process, NJDCF developed the "Manage by Data Program," which is an 18-month fellowship through which 100 carefully selected staff from various levels within the agency are trained to cultivate improved technological proficiency at the agency. Started in 2009, and now a nationally recognized initiative, the program is designed to provide supervisors with more capacity and know-how to instruct caseworkers to use the new analytic and data tools proficiently.

As a transcript from an August 2015 presentation to the Children's Bureau shows, a key goal of the program is to train staff to better identify and understand patterns across the state by county and determine differences in trends by practice area.⁵⁷ The CSSP report cited above describes the capstone projects led by teams under the oversight of program fellows which "explore pressing local practice issues," helping to generate more accurate case profiles of children and families served by the agency, improve specific areas of practice and improve uniformity in offices across the state. In one project, for example, data fellows determined that field investigations could be improved by reducing the rate of anonymous referrals during

hotline call screening. Data analysis revealed significant variation in rates of anonymous referrals among screeners—as low as 3 percent and as high as almost 50 percent. Through a thorough review of recorded calls, the fellows developed a method and script template that brought about significant reductions in anonymous referrals—a decline of more than 2,000 over 18-months.⁵⁸

The Manage by Data Program is an example of how organization and training in information and data-driven practices in child services can drive the success of continuous quality improvement (CQI) efforts. As NJDCF's story indicates, a key ingredient of success is the development of standard written guides, manuals and other resources to help staff effectively use data for performance purposes. Tennessee for example, makes regular updates to its CQI manual, making modifications to clearly delineate any changes made in the CQI process, the role of central and regional staff and information sources to use in data assessment. Kentucky has also developed an effective system with formal training for its CQI staff, dividing their system into both state-level and regional specialists who develop visualizations of trends in regional performance, examine trends by location and discuss findings in regular phone and videoconferencing meetings.⁵⁹ Written materials to guide staff will be especially critical to Massachusetts DCF in consideration of the agency's rocky rollout of the practice model launched in 2009. As a member of SEIU local 509 shared with Pioneer, no written guidebook for the practice model was ever put together and provided to agency workers—the vast majority of information and communications regarding protocol, training and implementation came through a series of memos released between 2009 and 2014.

Providing clear and defined goals in written materials will also be critical in facilitating better communications between the field and central offices. Pioneer's discussion with members of SEIU local 509A mirrored this sentiment, as the union representative shared that significant issues with the rollout of the agency's practice

model were due to lack of communication and inconsistent implementations across regional offices. As the September 9 report from the OCA and the Ripples Group mentions, a DCF employee survey in December 2014 showed that many staff feel disconnected from the central office, especially when it comes to managerial decision making. The same report shared that many of the workers surveyed expressed that their feedback regarding how to improve policy was not being received or implemented by managers. As one worker put it, “policies are done in a bubble.”⁶⁰ Establishing tools and accompanying training protocols for their use would help to eliminate these issues with information silos.

As Massachusetts DCF recruits its own CQI team, it should look to the examples of New Jersey and other states to ensure best practices during its initial phase of operation. Massachusetts DCF could benefit from a similar program to effectively train agency staff to use valuable data tools to improve agency practices, given both the disconnect across regional offices and specific issues with inaccurate assignments in the case intake system. Communications from the central office during rollout of new programs at DCF have often been inconsistent.

Considering new federal requirements

In addition to other states’ data and information management tools, DCF should consider programmatic changes to its information systems in anticipation of federal regulatory revisions being proposed by the Administration for Children and Families. ACF proposes a rule that will remove the requirement of a single comprehensive system and establish new requirements regarding design, data quality and data exchange standards for agency information systems. The revisions will also bring rules for title IV-E agencies into alignment with developments in emerging technologies to improve agency administration. Importantly, these new rules will allow state foster care agencies more flexibility to employ whatever blend of data tools and IT solutions will best meet the unique needs of their state’s young and vulnerable populations.⁶¹

The primary changes in the proposed rule are as follows:

- (1) *Providing title IV–E agencies with flexibility to determine the size, scope, and functionality of their information system;*
- (2) *Allowing the CCWIS to obtain required data from external information systems so that a copy of that data is then stored and managed in the CCWIS;*
- (3) *Emphasizing data quality and requiring a new data quality plan;*
- (4) *Requiring new bidirectional data exchanges and use of electronic data exchange standards that strengthen program integrity;*
- (5) *Promoting more efficient and less expensive development of reliable systems that follow industry design standards including development of independent, reusable modules*⁶²

There is no shortage of new technologies Massachusetts DCF could introduce to improve their services. A May 2014 report prepared by Freedman Consulting, LLC explores the enormous variety and breadth of available technology solutions that human services groups can adopt. Solutions that apply automation to frontline worker processes show particular promise. Florida’s Department of Children and Families, for example, has incorporated voice recognition software that allows caseworkers in the field to transcribe case interviews automatically. Related tools that facilitate self-service for clients, such as automated processes for checking and submitting applications, reduce workloads for staff and eliminate the need for in-person assistance. The report also mentions integration as a fundamental function for human service technologies, citing cross-agency data sharing in New York City and Boulder County Colorado’s integrated case management tool as instances of successful deployments.⁶³

RECENT CHANGES TO FIX SYSTEM FAILURES

What changes have been enacted to address the system failures that have occurred since Jeremiah

Oliver's death? Arguably the most significant is new staff recruitment: DCF now has 298 more social workers than it did in January 2014, the month following discovery of Oliver's body. In addition to this increase in hiring, as mentioned above, DCF has also issued 3,000 iPads to its social workers, supervisors and managers. Since June of this year, all newly recruited social workers receive iPads and a cell phone at orientation. Previously, DCF did not issue phones for case use and staff were required to use their personal devices.

In addition to these improvements, DCF has focused on strengthening policies in several areas, including education for children in care and case transfers. The agency has also made their employment qualifications stricter, including more stringent background checks and, as of June 1 this year, a requirement that all social workers be licensed. More than 80 percent of DCF social workers are now licensed, with the remaining 20 percent in the process of gaining licensure.

Since Governor Baker's election last year, the agency has introduced several more reforms. Following a gubernatorial race largely defined by past problems at DCF and questions about a direction forward for the agency, the Governor's first several months in office saw a range of efforts to bring Massachusetts' social services up to par with other states.

For example, since January 2015 DCF has started recruiting a CQI team to better manage the high volumes of casework across the Commonwealth. The new team, which would assist with monitoring and tracking trends, will consist of five new hires. Additional plans for recruitment include bringing on board a new medical director—the first of its kind at the agency—to improve delivery of services in difficult medical cases. As regards current staff, the Department is working closely with the social workers union to create comprehensive changes to practices and procedures, and has recently introduced more opportunities for additional staff training and professional development in implementation of the new licensing requirements.

RECOMMENDATIONS

Recommendation One: Perform a comprehensive review of ICPM and overhaul the practice model to better reflect the mission value of putting child safety and well-being first.

As lawmakers and the Governor's office determine a course forward, they should take a closer look at both instances where DR deployment has been directly linked to CPS failures and examples of where DR reforms are currently being considered and implemented. The bottom line for Massachusetts is that sufficient evidence indicates that certain features of DR can expose higher volumes of children to greater risk of harm. Making necessary changes to the intake system to prioritize child safety will be critical to avoiding future tragedies like the ones that befell Jeremiah Oliver and Bella Bond. As the CWLA report mentions, nine other states clearly express in their practice models that child safety is the top priority, Massachusetts should do the same, and establish procedures that leave no uncertainty about this priority across all the state's DCF offices.

SEIU local 509 shared that all reported allegations that are not screened out through the first 24-hour period go through a 15-day response period. If a case stays open after this period, regardless of which track, a 45-day comprehensive assessment period begins. However, the track assignment determines the level of training the case reviewer will have. While those on the traditional track are trained in forensics and other skills to identify signs of abuse and neglect, staff conducting reviews on the assessment track are social workers who do not possess those skills and are already managing significant caseloads beyond their assessment track review responsibilities. DCF staff on the assessment track are not sufficiently equipped to identify abuse or neglect within this comprehensive assessment period—something that can at least partially explain how high-risk cases like that of Jeremiah Oliver ended up on the assessment track.

To fix this, DCF should consider an option that would continue the two-tiered structure

of the ICPM model, but with modifications to ensure that cases diverted to the assessment track still include some elements of the traditional investigation track such as thorough substance use and domestic violence screening. As mentioned above, the Minnesota Governor's Task Force made the recommendation that child protection workers (in both tracks) should review progress with both forensic and family engagement tools close at hand. Massachusetts DCF should consider this recommendation and ensure that all agency staff conducting reviews during the 45-day comprehensive assessment period are trained in forensics and other areas that facilitate proper identification of maltreatment. Additionally, DCF should introduce a measure to ensure that children who are alleged victims of maltreatment are interviewed independently of their families. This should be done prior to contact with parents or legal guardians whenever possible.

Additionally, DCF should put in place measures to ensure that all family cases diverted to the assessment track continue to be monitored regularly for at least 12 months after cases are initially closed. In cases when families are assigned to the assessment track and refuse voluntary services, CPS should be notified for follow up review to assess whether families that refuse services should be moved to the CPS traditional track. As Kate Piper pointed out in her January 2014 testimony before the Human Services Committee of the Vermont House of Representatives, Hawaii has a system in place whereby cases with families that elect not to accept recommended services are "routed back to DCF for a possible investigation and/or court-ordered service plan."⁶⁴ Massachusetts DCF should adopt a similar practice.

As mentioned above, a number of studies point out that cases diverted to an alternative track often end up being moderate- to high-risk cases. To eliminate re-occurrence of this issue in Massachusetts DCF cases, the agency should strengthen its criteria for intake assignments by adding areas to check before a track assignment decision is made. The Governor's office recently

announced that DCF will start to employ criminal records checks and reviews of guardians' historical interactions with DCF in all cases. These will be critical additions, but the agency should consider mandating other measures. At minimum, DCF should also require a check of court records—documents like affidavits and Petitions for Relief from Abuse can provide extremely important information that goes overlooked in case reviews under the current system. Additionally, DCF should seek information from collateral sources before a case intake decision is made, including interviews with extended family and professionals, like caseworkers, teachers, family physicians, mental health professionals and substance abuse counselors, who have had interactions with a family under review. If sufficient information is not immediately available, track assignment should be postponed until more facts can be determined. As recommended by the Minnesota Governor's Task Force for their CPS system, which faced similar issues with its case intake system and related tragedies, track assignment should also be postponed until both the child and caregiver have been interviewed separately.

Many of the suggestions in this report involve additional measures to improve training and strengthen screening criteria. Accordingly, it's reasonable to expect that they will require more resources. However, it is important to note that a number of studies show that in some DR employments, a two-tiered case intake system can be more expensive during the first few years of use, but hold the potential for long-term savings.⁶⁵ As is the case for all existing research on DR, conclusions concerning the cost of two-tiered systems vs. the traditional model are mixed.⁶⁶ Accordingly, an accurate cost picture is hard to determine. The new CQI team should include in its preliminary plan an analysis of the projected costs that the proposals in this study would require.

Recommendation Two: Update DCF's management information systems and data tools to improve tracking and organization of case information and outcomes data. Establishing

a management dashboard should be a focus here, as suggested by the OCA/Ripples report. DCF should also look to successful deployments of systems in other states, some of which are discussed in this report, through this process. Massachusetts should look specifically to the case of New Jersey and its ‘Manage by Data Program,’ which has been a critical component of the state’s CQI process. This example should be a focus of the CQI team that Massachusetts DCF is currently recruiting. The agency should consider a best practices assessment similar to the one performed by NJDCF and authorize a study to determine the costs and benefits of employing a similar data fellowship program as a part of the new CQI team’s strategy.

The agency should also re-examine its technology resources in consideration of pending federal regulatory changes. There is a broad spectrum of data and analytics tools that DCF can employ to improve its services per the ACF’s proposed new requirements for design, data quality and data exchange standards. As recently pointed out in the *Boston Globe*, predictive analytics are one option with promising potential.⁶⁷ Predictive analytics have proved enormously helpful in criminal justice reform, as the case of Oregon’s Youth Authority illustrates. Many functions that this kind of tool offers have direct application to child and family services.⁶⁸ Beyond tools that can perform analytics risk modeling, DCF should also consider establishing automated processes for checking and submitting applications as well as tools that employ self-service for clients trying to renew benefits and perform other functions without assistance from DCF staff. The priority in adoption of new technology should be effective intake and screening tools to gather data prior to pathway assignment to improve the quality of information available to DCF staff at critical decision-making points.

CONCLUSION

As the current administration works with DCF to prepare the agency for the future, it is imperative that the focus remain on the two-tiered intake

system; DCF must change its practice model to better implement the mission value of putting child safety and well-being first. In making the necessary changes to its two-tiered system, the agency should consider employing the recommendations included in this report.

As DCF proceeds with an internal review, the agency should also follow the recommendations of other reports cited in this study that the agency adopt and incorporate new technologies to improve caseload management, outcomes data availability and information sharing between field workers, managers and supervisors. Technology is the connective tissue of today’s human services agencies, and Massachusetts can learn from the examples of others to establish better practices in this area.

The Commonwealth should also look at the coming revisions to federal requirements as an opportunity to implement a range of IT solutions that prepare DCF for the future. As mentioned above, there is a range of solutions to consider that, if integrated and employed in an effective way that matches the needs of DCF workers, could significantly reduce future system failures. Given Massachusetts state government’s record with in-house software development and IT projects, officials should be extremely cautious in considering building additional technology solutions internally. There is no need to assume this risk to re-invent the wheel, as the examples of the Massachusetts Health Connector⁶⁹ and Department of Revenue illustrate.⁷⁰

DCF social workers are given a responsibility few of us would want: assessing an abuse or neglect complaint and recommending whether to take a child away from a parent or leave the child at home under DCF oversight. Accordingly, writing off DCF’s problems by scapegoating employees is unfair because it mischaracterizes the scope and nature of those problems. The agency has more than 100 attorneys interacting with families, social workers, supervisors, and the probate court. Finding and overseeing foster care guardians willing and able to care for displaced children at

a payment rate of \$20-\$25 per day (plus clothing allowance) is a perpetual challenge. Monitoring at-risk children in all settings and assuring that proper care is being provided are not simple.

To ensure that social workers can perform their jobs given these enormous demands and challenges, the state must move quickly to enact reforms that give workers the tools they need, the right systems, and a consistent vision and clear agency priorities.

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16. Data tables showing Massachusetts child services’ performance relative to its peers in these categories is available in Appendix I.

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APPENDIX I

Maltreatment in foster care

Cohort: Children in foster care during a 12-month period

12-month period: FFY 2013

	Observed Performance			Risk Adj.	Risk Standardized Performance (RSP)			RSP Relative to National Standard (NS)			
	Served	Denom	Numer		Observed Performance	Median Age	Lower CI	RSP	Upper CI	NS	NS Met / Not Met / No Different
AK	2820	682424	89	13.04	6	14.19	17.46	21.47	8.50	Not met	PIP
AL	7083	1603022	55	3.43	7	3.88	5.02	6.48	8.50	Met	No PIP
AR	7001	1331622	111	8.34	6	9.68	11.65	14.01	8.50	Not met	PIP
AZ	22408	5006086	118	2.36	6	2.82	3.37	4.02	8.50	Met	No PIP
CA	79868	19079247	1615	8.46	7	11.71	12.30	12.91	8.50	Not met	PIP
CO	9093	1886505	160	8.48	10	10.94	12.77	14.9	8.50	Not met	PIP
CT	5151	1341255	102	7.60	9	9.38	11.37	13.78	8.50	Not met	PIP
DC	1521	403886	7	1.73	9	1.84	3.28	5.85	8.50	Met	No PIP
DE	1121	264131	19	7.19	9	6.78	10.41	15.99	8.50	No dif	No PIP
FL	32757	6722430	657	9.77	5	12.67	13.67	14.76	8.50	Not met	PIP
GA	12883	2787511	161	5.78	7	6.96	8.12	9.46	8.50	No dif	No PIP
HI	1808	399279	13	3.26	6	3.09	5.00	8.09	8.50	Met	No PIP
IA	10200	2266201	360	15.89	8	20.45	22.68	25.15	8.50	Not met	PIP
ID	2316	474795	17	3.58	6	3.43	5.30	8.17	8.50	Met	No PIP
IL	19176	5452819	435	7.98	6	10.17	11.17	12.27	8.50	Not met	PIP
IN	18193	4128470	493	11.94	6	15.19	16.59	18.12	8.50	Not met	PIP
KS	9670	2257880	122	5.40	7	6.37	7.59	9.05	8.50	No dif	No PIP
KY	11648	2493100	268	10.75	8	13.6	15.32	17.27	8.50	Not met	PIP
LA	6920	1465830	108	7.37	6	8.44	10.17	12.26	8.50	No dif	No PIP
MA	13416	3036535	569	18.74	10	24.89	27.02	29.33	8.50	Not met	PIP
MD	6681	1630878	194	11.90	9	14.88	17.12	19.71	8.50	Not met	PIP
ME	2431	596043	20	3.36	5	3.34	5.00	7.48	8.50	Met	No PIP
MI	20636	4931951	669	13.56	7	18.29	19.73	21.29	8.50	Not met	PIP
MN	9860	1968128	67	3.40	9	3.95	4.99	6.31	8.50	Met	No PIP
MO	15837	3727184	59	1.58	7	1.81	2.32	2.96	8.50	Met	No PIP
MS		Excluded due to data quality									
MT	3276	780891	41	5.25	5	5.37	7.23	9.72	8.50	No dif	No PIP
NC		Excluded due to data quality									
ND	1906	420100	14	3.33	9	3.23	5.16	8.25	8.50	Met	No PIP
NE	7294	1677088	124	7.39	9	8.94	10.65	12.69	8.50	Not met	PIP
NH	1078	249315	4	1.60	7.5	1.77	3.49	6.87	8.50	Met	No PIP
NJ	11247	2518303	121	4.80	5	5.72	6.82	8.14	8.50	Met	No PIP
NM	2999	714804	48	6.72	6	6.87	9.06	11.95	8.50	No dif	No PIP
NV	7625	1741706	134	7.69	5	9.04	10.69	12.65	8.50	Not met	PIP
NY	29315	7722797	1205	15.60	8	21.07	22.29	23.59	8.50	Not met	PIP
OH	20525	4368129	503	11.52	7	15.17	16.56	18.07	8.50	Not met	PIP
OK	14673	3574447	467	13.06	5	16.29	17.83	19.52	8.50	Not met	PIP
OR	11601	2945133	290	9.85	6	12.15	13.63	15.28	8.50	Not met	PIP
PA		Excluded due to data quality									
PR		Excluded due to data quality									
RI	2669	602210	71	11.79	9	13.63	17.18	21.65	8.50	Not met	PIP
SC	5674	1121859	77	6.86	7.5	7.76	9.67	12.06	8.50	No dif	No PIP
SD	2148	492797	11	2.23	6	2.19	3.62	5.98	8.50	Met	No PIP
TN	13731	2880400	199	6.91	9	8.74	10.04	11.53	8.50	Not met	PIP
TX	45810	10569686	619	5.86	5	7.51	8.12	8.78	8.50	No dif	No PIP
UT	4525	934655	86	9.20	9	10.76	13.27	16.37	8.50	Not met	PIP
VA	6868	1616261	28	1.73	10	1.94	2.73	3.85	8.50	Met	No PIP
VT	1508	341896	12	3.51	11	3.41	5.63	9.3	8.50	No dif	No PIP
WA	14242	3513702	275	7.83	5	9.77	10.99	12.36	8.50	Not met	PIP
WI	10384	2297347	64	2.79	7	3.17	4.02	5.1	8.50	Met	No PIP
WV	7599	1624587	43	2.65	9	2.98	3.96	5.27	8.50	Met	No PIP
WY	1809	346209	4	1.16	10	1.41	2.72	5.24	8.50	Met	No PIP

Recurrence of maltreatment

Cohort: Victims of a substantiated or indicated maltreatment report in a 12-month period
 12-month period: FFY 2012-2013

Observed Performance			Risk Adj.	Risk Standardized Performance (RSP)			RSP Relative to National Standard (NS)			
Denom	Numer	Observed Performance	Median Age	Lower CI	RSP	Upper CI	NS	NS Met / Not Met / No Different	Initial PIP Decision	
AK	2420	390	16.1%	5	18.5%	20.2%	22.1%	9.1%	Not met	PIP
AL	8821	319	3.6%	7	4.3%	4.7%	5.3%	9.1%	Met	No PIP
AR	11112	706	6.4%	7	7.7%	8.3%	8.9%	9.1%	Met	No PIP
AZ	10915	580	5.3%	5	6.4%	6.9%	7.4%	9.1%	Met	No PIP
CA	76312	7013	9.2%	6	11.7%	11.9%	12.2%	9.1%	Not met	PIP
CO	10357	438	4.2%	6	5.0%	5.4%	5.9%	9.1%	Met	No PIP
CT	7931	546	6.9%	7	8.2%	8.9%	9.6%	9.1%	No dif	No PIP
DC	2111	229	10.8%	7	12.4%	14.0%	15.8%	9.1%	Not met	PIP
DE	2249	81	3.6%	7	4.0%	4.8%	5.9%	9.1%	Met	No PIP
FL	52050	3898	7.5%	5	9.3%	9.6%	9.9%	9.1%	Not met	PIP
GA	19206	1200	6.2%	6	7.6%	8.0%	8.5%	9.1%	Met	No PIP
HI	1366	47	3.4%	6	3.7%	4.8%	6.2%	9.1%	Met	No PIP
IA	10707	1208	11.3%	5	13.5%	14.2%	15.0%	9.1%	Not met	PIP
ID	1416	78	5.5%	6	5.9%	7.2%	8.9%	9.1%	Met	No PIP
IL	27238	2759	10.1%	6	12.4%	12.9%	13.3%	9.1%	Not met	PIP
IN	21231	1874	8.8%	6	10.9%	11.3%	11.8%	9.1%	Not met	PIP
KS	1965	76	3.9%	7	4.2%	5.2%	6.4%	9.1%	Met	No PIP
KY	15957	994	6.2%	5	7.5%	7.9%	8.4%	9.1%	Met	No PIP
LA	7630	636	8.3%	5	9.9%	10.7%	11.5%	9.1%	Not met	PIP
MA	19350	2147	11.1%	6	13.7%	14.3%	14.9%	9.1%	Not met	PIP
MD	13251	943	7.1%	6	8.7%	9.2%	9.8%	9.1%	No dif	No PIP
ME	3852	432	11.2%	6	12.9%	14.1%	15.4%	9.1%	Not met	PIP
MI	33152	4116	12.4%	6	15.6%	16.1%	16.5%	9.1%	Not met	PIP
MN	4296	283	6.6%	6	7.6%	8.5%	9.5%	9.1%	No dif	No PIP
MO	Excluded due to data quality									
MS	7140	590	8.3%	7	9.9%	10.7%	11.5%	9.1%	Not met	PIP
MT	1357	84	6.2%	5	6.5%	7.9%	9.6%	9.1%	No dif	No PIP
NC	8817	426	4.8%	7	5.7%	6.2%	6.8%	9.1%	Met	No PIP
ND	1458	76	5.2%	6	5.5%	6.8%	8.4%	9.1%	Met	No PIP
NE	3709	399	10.8%	6	12.4%	13.6%	15.0%	9.1%	Not met	PIP
NH	901	37	4.1%	6	4.3%	5.7%	7.6%	9.1%	Met	No PIP
NJ	9052	660	7.3%	6	8.7%	9.4%	10.1%	9.1%	No dif	No PIP
NM	6192	772	12.5%	6	14.9%	15.9%	16.9%	9.1%	Not met	PIP
NV	5599	337	6.0%	5	6.9%	7.7%	8.5%	9.1%	Met	No PIP
NY	68293	12149	17.8%	7	22.9%	23.2%	23.6%	9.1%	Not met	PIP
OH	28974	2957	10.2%	6	12.8%	13.2%	13.7%	9.1%	Not met	PIP
OK	9941	936	9.4%	5	11.2%	11.9%	12.7%	9.1%	Not met	PIP
OR	10727	887	8.3%	6	9.9%	10.6%	11.3%	9.1%	Not met	PIP
PA	Excluded due to data quality									
PR	Excluded due to data quality									
RI	3208	350	10.9%	5	12.5%	13.8%	15.3%	9.1%	Not met	PIP
SC	11276	370	3.3%	6	3.8%	4.2%	4.7%	9.1%	Met	No PIP
SD	1215	90	7.4%	5	7.7%	9.3%	11.3%	9.1%	No dif	No PIP
TN	Excluded due to data quality									
TX	62295	3539	5.7%	5	7.0%	7.2%	7.4%	9.1%	Met	No PIP
UT	9473	873	9.2%	7	11.3%	12.0%	12.8%	9.1%	Not met	PIP
VA	Excluded due to data quality									
VT	658	52	7.9%	9	8.0%	10.3%	13.2%	9.1%	No dif	No PIP
WA	6473	504	7.8%	6	9.1%	9.9%	10.8%	9.1%	No dif	No PIP
WI	4389	211	4.8%	6	5.5%	6.3%	7.1%	9.1%	Met	No PIP
WV	4418	163	3.7%	6	4.2%	4.8%	5.6%	9.1%	Met	No PIP
WY	774	21	2.7%	6	2.9%	4.1%	5.8%	9.1%	Met	No PIP



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