The Commonwealth of Massachusetts

ASSISTANT MAJORITY LEADER
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133

SPECIAL SUBCOMMITTEE ON FOSTER CARE
GENERAL FINDINGS AND RECOMMENDATIONS

FOSTER CARE SYSTEM

Location of Foster Children.

Findings: The Department of Social Services does not have a comprehensive statewide "master" plan to locate children in foster care, to determine their legal status, servicing needs, or to establish goals for permanency planning.

Recommendations: DSS should immediately implement a statewide inventory of all children in foster care that would include a comprehensive master plan to locate each child in foster care, state legal status, plans for continuity of placement and servicing, and permanency planning goals.

Purchase of Services.

Finding: The state's methods of purchasing services by state-funded contracts to private service providers has created a multiple-layered system of duplicative, inefficient, and ineffective administrative personnel through which large amounts of funds must pass before direct care services reach those children most in need.

The state's purchase of services focuses on buying clusters of cases, without proper emphasis on quality of care, adequate services, and cost-effective programming. This system results in reduced, inadequate, and often-inappropriate servicing for foster children, abused children, and medically and educationally needy children, and an uncoordinated, fragmented service delivery system.

The FTE model of purchasing units of cases in a ratio of 1:18 cases, purchased as 1 unit and paid by contract for $65,000 per
unit. This system has resulted in a higher concentration of duplicative administrative costs, and a dilution of services to foster families and other children in need. From a review of contracts, it would appear that some private providers are paid per unit of cases, whether or not they have the full number of cases to equal that unit. While this problem may not be widespread, the practice of rendering payment for services, that are not being provided, or cases that do not exist, warrants further investigation and a restructuring of the system to eliminate wasteful expenditures.

While the FTE model may be applicable and appropriate for certain types of cases in the DSS caseload, it does not appear to operate effectively and efficiently for foster children. The FTE model of contracting services undermines the provision of services, and strategies that have been proven effective, therefore resulting in lack of progress and movement of children effectively through the system.

**Recommendations:** There should be an immediate comprehensive, impartial and independent evaluation, audit, and reform of the state's methods of purchasing services from private providers.

Since private providers do not conform to all state regulatory provisions, and cannot receive children into care through the courts, a review of this system is necessary to determine whether private agencies are subjected to the provisions in DSS statutory mandates.

The practice of expending funds for services that are not rendered, or for cases that do not exist, must be investigated, and excessive expenditures must be eliminated. Payment should be made only for services rendered. The applicability of the FTE model to foster children should be evaluated for effectiveness and efficiency.

The members recommend a full, comprehensive evaluation of the system of purchase of services and the FTE model of buying services.
- to determine the effectiveness of this system
- to ensure that providers who service children
directly exist in adequate numbers by elimina-
ting duplications in personnel
- to determine cost-effectiveness to the state
- to encourage a review to determine whether this
problem area identified is accurate, and that
corrective measures will be implemented immedia-
ately
- to mandate that the state pay funds only for
services rendered
- to eliminate duplication of administrative efforts
and excessive emphasis on administrative in role
and function, so that services will not be dilut-
ed, and providers are paid equitably for services
provided, and to ensure that quality services are
provided to foster children and children in need

Regulations and statutes should be revised to
include by what authority and transmission of
authority a private provider may carry out
the functions and responsibilities that are
under the mandate of a public state agency.

**Licensing and Approval of Foster Homes.**

**Findings:** The foster care licensing process has been
transferred from OFC to DSS to private con-
tracted service providers without any statu-
tory or regulatory authority.

The licensing-approval process for foster care
is confusing and cumbersome; has no clear
delineation of authority, responsibility, and
channels of communication; and contains regu-
latory duplication with no defined statutory
mandate.

Children are placed in foster care at times
prior to the approval of the foster care
home, or prior to the completion of a Crimi-
nal Offender Record Information check on
prospective foster parents.

**Recommendation:** There should be an immediate comprehensive re-
view of the licensing-approval process of the
foster care system, with statutory and regula-
tory provisions implemented to redefine the
interactive roles and responsibilities between
OFC, DSS, service providers and licensing
agencies and foster homes. All costly
duplications should be eliminated, with increased emphasis on servicing to children, natural parents, and foster parents.

Statutory provisions and state mandated should be reviewed to determine legal and compliance conflicts in the transfer of the licensing process between two state agencies to private providers.

While recognizing that the need for homes is great, all foster homes should be completely and fully qualified prior to receiving any approval or placement of children. No foster home should be approved prior to CORI checks on all adult members of a household.

Information on Children in Care; Voluntary Agreements.

Findings: Foster parents often do not receive information on children placed in their care, and are therefore unaware of behavioral, medical and health needs, educational history, and other areas of need. Foster parents are often misinformed about children placed in their care, thus preventing them from providing appropriate substitute parenting.

Biological parents, especially those placing their children through voluntary agreements, are frequently excluded from participating in foster care reviews, service planning, permanency planning, and other areas of the child's placement.

Recommendations: Foster parents should receive all available information on children placed in their care. The Special Subcommittee has filed legislation requiring DSS to provide a Child Profile to all foster parents, containing relevant medical, educational, behavioral, and other information, at the time of placement.

Foster parents should be kept informed of all visits by social workers, and the visiting schedule of the biological parents. Biological parents should be included in all agreements, service plans, and case reviews, in a partnership approach.
Mass. Approach to Partnerships in Parenting (MAPP).

Findings: The MAPP training programs have not been implemented on a statewide basis, and do not include biological parents, children or teens, or social workers.

Recommendations: MAPP training programs should be implemented on a statewide, uniform basis, with periodic reviews to include meeting changing needs, and should include performance standards.

MAPP training programs should be extended to biological parents, children and teens, and social workers, and should include parenting courses and informational sessions. There should be equal participation, representation, and educational subject matter to incorporate minority, ethnic, and linguistic needs.

Foster Care Reviews.

Findings: Foster care reviews do not always allow for equal representations of members of minority communities, nor an adequate and equal opportunity to address minority issues and needs.

Foster care reviews often involve only a case summary, or a pre-determined service plan, and insufficient emphasis placed on having independent reviewers and the role of the volunteer case reviewer.

Recommendations: Information to be reviewed should be available and accessible to all members. There should be equal proportional representation of minorities and persons of varied ethnic and linguistic origins on review teams.

DSS should continue to increase the participation of foster parents, biological parents, and all reviewers in the review process. The role of the volunteer reviewer should be equal to that of all other persons on the team.

Types of Placements

Findings: Natural parents placing their children in care through voluntary agreements, or whose children are placed through court order, often are not informed of their rights.
DSS has established a policy that no child can be placed in care for more than 18 months without a final permanency plan being realized. Courts review each case every six months, but cases cannot be reviewed at intervals less than 6 months. The conditions for extension of placement are not explicit, and are not defined in mutual partnership terms.

Before placement in care, "reasonable efforts" must be made to prevent removal, or must be made for family reunification.

There are no provisions for dispositional court hearings for children voluntarily placed in care.

**Recommendations:** Regulations and statutes relating to volunteer placements should be strengthened to be more defined and specific regarding the rights and responsibilities of all parties involved.

Biological parents should be included in all aspects of agreements and placements, and should be informed of, and afforded all rights, and have access to grievance procedures.

The relationship between foster parents and biological parents should be defined and clarified in a partnership approach, when feasible.

There should be an immediate review of the need for dispositional court hearings in cases of voluntary placements.

Standards and guidelines should be developed and implemented for voluntary placements, and an operational and conditional definition of "reasonable efforts" should be developed and applied.

Permanency planning, whether adoption or reunification with families, for all children, should be an absolute priority. Without being punitive to natural parents, guidelines and possibly statutory provisions should be implemented to state conditions for extending/terminating foster care, either prior to, or subsequent to, the 18 month period.
No child should be accepted into, or placed into, foster care, except for abusive or emergency conditions, without preventive services being offered or provided to the family.

**Services and Service Plans.**

**Findings:**

Service plans are not provided for all children in foster care, nor are they always periodically reviewed for effectiveness or when conditions change.

Comprehensive needs assessments and evaluations are not always provided for foster children and children in need.

There is a lack of culture-specific programs and programs and services that address cross-cultural sensitivity for both foster parents and children.

While six is the maximum number of children that can be placed in one foster home, there are frequently multiple-status children in one home – foster, adoptive, day care, and biological children.

**Recommendations:**

As part of a comprehensive statewide "master" service and permanency plan for all children in foster care, DSS should implement a comprehensive family-based service plan for every child in the care of DSS. The plan should contain mechanisms for tracking and monitoring all children, with a philosophy of permanency planning, and a sensitivity and commitment to language, cultural, and racial concerns of minority children and families.

The needs of all children placed in any one foster home should be a strong determinant factor of how many children foster parents are able to provide for in their home. The number of children in a foster home should not outweigh the complexity of needs of the children placed.

Social workers and services should be sensitized to the needs of communities of people of color and other ethnic, cultural, and linguistic identities, and to the needs of the foster parents who provide homes.
Service plans should be reviewed and updated on a frequent basis. The timeframe for the development of service plans should be decreased from 10-55 days, to 10-30 days.

Foster parents need training and education on how to use a service plan, and how to access services required for children in their care.

Foster parents need an array of support services and training in the appropriate access and use of services.

Needs assessments and evaluations must be conducted by trained and appropriate professionals in a range of disciplines. The final outcome of the needs assessment or evaluations of the child must be coordinated and integrated into the service plan.

Foster parents, natural parents, and, when appropriate, youth, should receive copies of the service plan.

**Structure of DSS: Area Advisory Boards.**

**Findings:**

There are concerns about the centralized autonomy of DSS, and a restricted decision-making in all areas, at the local or community levels.

Community input for programming and budgetary planning is excluded or minimized at the central level.

Initiatives are needed to eliminate costly waste in duplication of planning that currently exists.

**Recommendations:**

There should be changes in the law that would create a more interdependent model of program development and implementation.

There should be improvement and strengthening in local planning, implementation, and budget proposals through enhanced functioning of Area Advisory Boards.

Citizen Boards should be strengthened by defining more clearly roles, responsibilities and authorities, and by increasing the role of the Boards in meaningful decision-making processes.
Initiatives are needed to eliminate costly waste in duplication of planning that currently exists. Built-in checks and balances are needed at the area levels for resource distribution and program planning.

Findings:

There is an emphasis on over-utilization of group homes, resulting in less resources for foster care, and less funding for needed foster care resources.

Recommendations:

As group homes are the most costly on the spectrum of services, initiatives should be made to reduce excessive use of group homes for children and youth who do not necessarily need them.

Area Boards should be involved in the decision-making needed for planning and budgeting of group homes and other resources.

Funds and resources should be re-allocated to improved utilization of foster care, and the streamlined utilization of group homes.

A reduction formula for the improved utilization of group homes, and a lessening of their use over a period of time, with an increasing move towards prevention, and increased utilization of foster homes, should be planned; monies saved through this plan should be used for resources that are needed.

Findings:

There are funding and servicing interagency disputes over responsibilities for certain children in care, resulting in delayed or reduced servicing, fragmented and uncoordinated planning, wasted funds, and children and youth falling through the "cracks".

Recommendations:

EOHS, and other state agencies, should establish a task force to study and provide specific recommendations for improving interagency coordination and cooperation to increase efficiency and effectiveness in assigning responsibility among state agencies for the provision and payment of services for children and families in need.

Findings: While DSS has made positive efforts to seek and achieve federal funds for foster children and abused children, there remain areas of non-compliance by DSS that prevent the state from receiving maximum reimbursements.

There are several areas of compliance/non-compliance by DSS: case plans for children, periodic reviews of each child in care, court reviews, statewide inventory of all children, dispositional hearings, pre-placement preventive programs, case management.

Recommendations: The members recommend that areas identified as needing continued compliance, or updated compliance, be initiated by DSS, to ensure improved foster care, and to enable the state to receive maximum federal revenues, and to ensure permanency planning for each child in foster care.

CHILD ABUSE REPORTING, SCREENING, AND INVESTIGATION.

Mandated Reporters of Child Abuse.

Findings: There are mandated reporters, in a range of professional categories, who are not reporting their suspicions, or actual indications of, abuse or neglect of children.

Mandated reporters are often unaware, or lack in education and training of their mandate to report, and to what factors and determining conditions indicate possibilities of abuse to children.

There are categories of persons who are caretakers of children, yet who are not mandated to report.

There are definitional issues relating to what constitutes abuse, or to the varying perceptions of what characteristics or conditions constitute abuse.

Recommendations: Training and re-training of mandated reporters as to their full responsibilities as mandated reporters, the specific conditions under which they must report, definitional issues, and the appropriate response to these conditions.
Training programs should be specifically tailored to certain professionals and caretaker roles, and should include the appropriate channels of communicating the reported information.

The Special Subcommittee has filed legislation to add Office for Children licensors to the categories of mandated reporters. The bill would also add school attendance officers, health practitioners, therapists and counselors, psychologists and clinical social workers, to the list of mandated reporters.

The Special Subcommittee filed a legislative proposal to require state licensing boards and departments to add a statement to applications, or renewals of applications, informing the applicant with a written statement to be signed that they are a mandated reporter of child abuse, sexual abuse, and neglect. Ch. 186 was signed into law in July, 1990.

Upon the hiring of an employee who is in a category of mandated reporters, the employer should provide that person with a standardized form outlining the employee obligations as a mandated reporter. The Special Subcommittee has filed a legislative proposal addressing this area.

Protocols should be developed for categories of professionals that would act as guidelines for social workers, nurses and health professionals, physicians and hospital workers, on the reporting process for suspected and actual abuse and neglect. Protocols should be applicable to Medical Examiners, and should be incorporated into Interagency Agreements and Interdepartmental Agreements.

**Findings:**

The role of DSS "screeners", or those who receive the report of abuse, in the reporting process, should be reviewed and revised.

Often the "screener" is the social worker that is "available" or "on call" for that particular day or period of time.

"Screeners" often lack the appropriate medical, legal and clinical training to form critical judgements or decisions about reports of child
maltreatment.

Screeners do not have specific training and education in definitional issues involving what factors constitute potential and actual abuse and neglect.

The members are concerned that Mass. has higher child removal rates, and higher substantiation of abuse rates than the national average. It is unclear what factors are contributing to these variations.

While the courts have recently enacted standards of "clear and convincing evidence" as determinants of when children are to be removed from their homes, and DSS has developed standards for placement/no placement decisions for children in care, DSS has not yet defined state standards of minimally acceptable child welfare or care, nor has DSS developed and implemented such standards, or guidelines for removal of children.

**Recommendations:** DSS should develop and implement uniform guidelines and standards of response for use by screeners, when a report of child abuse and neglect is received.

The members recommend that an interim screening/investigative stage be added to the process, or an "allegation invalid" step, to allow for more flexibility and evaluative measures to be implemented in certain cases. This step would also further protect persons who are wrongly accused, or wrongly reported as the perpetrators, yet whose names remain in the Central Registry for long periods of time, even when they are not the perpetrators, or the case has been unsupported.

Social workers who are "screeners" should receive specialized, expanded training in all legal, medical and clinical aspects of child abuse and neglect, and in definitional issues and conditions of child maltreatment.

A determination of the person to be "screener" on a particular day should not be based on which social worker is available on that day, but the role of screener should be based on a more consistent role definition. Social workers
performing the function of initial screeners should have more in-depth uniform and appropriate training and education.

Undergraduate and graduate educational and training programs for social workers should be evaluated and updated for inclusion of training in legal, medical, and clinical matters, of current social, economic and ethnic issues.

DSS should provide training to all social workers to improve abilities to understand and discern differences between family situations that are experiencing deprivation and social-economic stressors, and those that are experiencing truly abusive conditions that involve children.

**Case Investigation Process; Supported/Unsupported Decisions.**

**Findings:**

There are inadequate standards and interagency agreements between DSS, OFC, and other agencies and private contracted providers as to specific conditions under which information on reports and investigations should be communicated and shared on an interagency basis.

There is no system in place for involving multidisciplinary teams early in an investigation in certain cases of child abuse.

The timing of the entry of police officers and law enforcement personnel in certain cases of abuse remains an area of concern. The members support early entry of police officers and law enforcement personnel in certain cases, at the time of the report. In other cases, early entry at the initiation of the investigation is a recommendation.

Biological parents are often not informed of supported cases of abuse, neglect, or sexual abuse, when their children have been placed in foster care. Parents of other children in the home in which the abuse took place are also not informed.

While there are definitions of abuse, neglect, sexual abuse, and emotional abuse in the regulations of DSS, there are no statutory definitions.
DSS has recently added a "new" policy to its position and management of child abuse cases, that would automatically add a 45-day appeal process for parents and other adults who are charged with abuse and named as the alleged perpetrator. The accused is not always informed in writing or his/her rights, or rights to an appeal.

The term "reasonable cause to believe" is used throughout the reporting/investigation process in determinations of child maltreatment. However this term is not defined, nor are there applicable standards or conditions in existence.

DSS has consistently stated that its investigation involves only that abuse or neglect have taken place, and the nature of the abuse or neglect, by a caretaker only. However, the name of the alleged perpetrator is often placed in file records, the Central Registry, and other places.

The members are concerned about the role of the caretaker in the DSS screening/investigation process, in that if the abuse is committed, or suspected to have been committed by someone other than the caretaker, is this information forwarded in a timely manner to the District Attorney or the police.

**Recommendations:** Standards should be implemented as to specific conditions under which information should be communicated and shared on an interagency basis, so that a systemic response to child abuse, neglect, and sexual abuse, may be implemented.

DSS should expedite the development of standards and guidelines for use in the decision-making concerning when children are to be removed from their homes, and for when children need to be placed, or not placed, in foster care. DSS should implement training sessions for the application of the standards and guidelines.

Standards and guidelines should include specific mechanisms to prevent decisions to remove children from their homes that are based on conditions of poverty, ill-health, or are due to other social-economic conditions alone.
There should be an involvement of multi-disciplinary teams, or child protection review teams, early in an investigation in certain cases of child abuse. These teams should be uniformly utilized in a timely and coordinated manner, in both DSS and in the offices of the District Attorneys. In certain cases, including child fatalities, there should be impartial and independent review teams established to investigate.

The role of the District Attorneys should be further developed, with emphasis on early entry into a case of reported child abuse, in certain specific cases, such as a child fatality, or serious injury to a child that is due to abuse or abusive conditions. Since physical abuse cases are not being reported to the District Attorneys, and are therefore not being prosecuted, there should be dual notification simultaneously to DSS and the District Attorney, at the time of the report. The members have filed a legislative proposal with several District Attorneys, to address this area, and to further define conditions of abuse or physical injury that should be reported to D.A.'s. The use of protocols for efficient procedures for reporting and investigation are also recommended to District Attorneys.

In certain cases, social workers and other DSS workers involved in investigations of abuse, should have "back-up" systems or teams, as crucial components in the decision-making process.

There should be a definitional formula to determine what constitutes "reasonable cause to believe" and social workers should be highly skilled and trained in these determinations. In certain cases, social workers should have teams available to determine the "reasonable cause to believe" standard.

Biological parents should be informed through a notification process, when a case of maltreatment has been supported on their child while in foster care. Parents should be informed when other children in the foster home have been abused or have died. A legislative proposal has been filed to address this area.
The Special Subcommittee is reviewing definitional issues, and is examining the appropriateness and effectiveness of defining, by statute, child abuse, neglect, and sexual abuse. DSS has defined these terms, and emotional injury, in the regulations of DSS.

The members are reviewing the interactions, relationships, and relevancy of Chapter 119, sections 51A-F, which are Civil statutory sections, to certain sections of Chapters 265 and 272, which involve crimes against the person, some relative to children. Many acts of child maltreatment are, by statute, criminal offenses, yet are processed through civil statute only, in most cases, and are not reported to law enforcement personnel, or to District Attorneys.

The members recommend that there be established mechanisms to ensure that cases that are criminal by statute, be processed judicially in an expedient manner, and that law enforcement personnel and D.A.'s be involved in cases at appropriate times and in appropriate manners, even when DSS is counseling or servicing the child and families. The members have filed legislative proposals to address some of these issues, and will continue to review other areas.

The members recommend that the term "new" information be defined, and conditions under which the new information emerged, and who the parties involved with this information are, be clarified. Conditions and guidelines should be implemented that determine the format and flow of information, and how this information is to be used, and by whom. The role of the District Attorneys in this stage should be evaluated and determined — i.e., should they be involved, since the case is supported, should information gathered at this stage be shared, is this assessment period part of an investigative procedure on possible criminal acts, or part of the needs servicing assessment, and other such issues.
Responding to a Child Fatality.

Finding: DSS does not have a protocol for a multi-disciplinary systemic response plan in the event of the death or serious injury of a child. The response plan should be incorporated into current statute and regulation.

DSS, state agencies, hospitals, medical examiners, day care workers, and others do not have comprehensive protocols or procedural guidelines, when a child has died from abuse.

DSS should develop and implement a Child Fatality Policy to establish a systemic response plan that would be timely and coordinated.

DSS has a case investigation unit, or C.I.U., that is an internal investigation only, and often conducted at the discretion of the Commissioner.

The DSS Area Director is required to obtain a death certificate and autopsy report of a child who has died, and sends these to the C.I.U. This is not always complied with.

C.I.U. investigations are not always carried out within specified timeframes, and there can be delays in the filing of the 51A.

When a child dies from abuse or abusive conditions, there is no independent or impartial review.

There are untimely delays in the sharing of information on autopsy reports or other needed medical records, when a child has died, by DSS or District Attorneys.

During investigations, DSS often examines only what services were provided, and does not examine the conditions of the child fatality.

Recommendations: Statutes and regulations should be amended to state that, immediately upon the death or serious injury to a child from questionable circumstances or from abuse, a 51A report should be filed, with dual notification to the D.A.'s.
Regulations and statutes should be amended to state specifically what interagency coordination of implementing support services to others in the home or facility will take place.

There should be an immediate and impartial review of all circumstances and conditions of the child fatality.

Legal and confidential barriers should be removed, and all information, should be immediately to the teams in order for a response plan to become fully operative early in the process.

DSS should develop, in coordination with other agencies, and implement a Child Fatality Policy, that outlines specific procedures to be followed in the event of the death of a child. The Policy should contain immediate procedures to be implemented to protect other children in the home, or place where the fatality occurred.*

The Policy should include directives and procedures for investigating all circumstances surrounding the child's death, including, but not limited to, the provision of services.

D.A.'s and law enforcement personnel, should enter into the cases of child fatalities immediately upon the reporting of such cases, and should be directly involved in a cooperative manner with DSS investigators.

* As a result of the recommendations contained in Volume I, DSS has implemented policy #90-02, Child Fatality Policy.