"First, do no harm."

March 28, 2007

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There is a glossary of key terms appended to this report. Also attached are the following references:

- DSS brochure on child abuse and neglect
- DSS guide for mandated reporters
- DSS policy on LSMT
- Costs of child abuse and neglect
- House Order establishing the House Committee on Child Abuse and Neglect
- House Post Audit and Oversight Recommendations
- Requirements for Social Work Licensure in Massachusetts

March 28, 2007

Dear Honorable Members of the House:

Today we respectfully submit a report to you on our investigation and study of the manner in which the Commonwealth protects children from abuse and neglect.

Speaker Salvatore DiMasi, supported by Minority Leader Bradley Jones, asked us as a bipartisan special committee to shine a spotlight on child abuse and neglect in Massachusetts. The spotlight shows some of the glaring, ugly aspects of our society. Although the human tendency of our society may be to avert its eyes, the children of the Commonwealth need a permanent spotlight on child abuse and neglect to ensure their safety and happiness.

This work is an outgrowth of the investigation by the House Committee on Post Audit and Oversight in 2006. In early 2006, Speaker DiMasi requested a review of the circumstances surrounding a disturbing case of alleged child abuse. As a result, the Speaker decided that a comprehensive review of child abuse and neglect and the state's response was needed. That expedited review, conducted by this committee in two short months, has been wide-ranging—resulting in four lengthy, intensive public hearings, volumes of written testimony from families, government officials and other experts, extensive discussions among the committee members, and this report and its legislative recommendations.

In addition to the members appointed by the Speaker and Minority Leader, certain legislative and youth experts were asked to share their input as ex-officio members of the Committee. We are also indebted to those ex-officio members, to the House Committee on Post Audit and Oversight and its Bureau staff, to the Children's Caucus and to the Joint Committee on Children, Families and Persons with Disabilities. Their vigilance informed this report. We are grateful for the insights offered by those who shared their personal stories, those who shared their professional expertise, those who served as ex-officio members, and also for the continuing media coverage of child welfare issues.

We remind the Department of Social Services and other stakeholders that members of the legislature are their natural allies in the battle against child abuse and neglect. We must be joined for the sake of our children, for the sake of our future.

Sincerely,

For the Committee,
John Rogers, Chairman

The Committee on Child Abuse and Neglect

Established and Appointed by

The Honorable Salvatore F. DiMasi, Speaker of the House

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Executive Summary & Recommendations

"First, do no harm."

Would that it were as simple as passing a law that said "first, do no harm" to ensure that every child would be protected from abusive and neglectful caretakers.

Those few, ancient words, often attributed to Hippocrates, send a powerful message and suggest layers of meaning that can be applied to our search for solutions to improve child welfare.

Over the course of about two months, we have been educated about the persistent struggles and latest developments in the field of child welfare; we have been reminded of the difficulties families face; and we have wrestled with the limitations of limited resources.[1] In developing our recommendations, we are also cognizant of the reform efforts underway at the Department of Social Services. Our intent is to support those potentially fruitful efforts during this time of transition, to suggest additional areas for improvement, and to caution against potential pitfalls. We are wary of the pendulum swinging, as it tends to when pushed during crises. Stability is critical for safe, happy homes and so too for strong, sound government policy.

Our recommendations are many and varied. Some are symbolic. Some are affirmations of ongoing efforts. Some are overdue. Some are designed to prompt further investigation. All are intended to reaffirm a legislative commitment to keep us, as a commonwealth, focused on the troubling issue of child abuse and neglect.

In an attempt to permanently direct a spotlight on this disturbing human condition, our first and overarching recommendation is to appoint a secretary of child welfare and a board on child abuse and neglect to assess the long-term, system-wide needs and to address child abuse and neglect in an elevated, coordinated manner. Because of the ongoing reforms at DSS, understanding how Massachusetts handles child welfare issues is like trying to hit a moving target. It would be good to have one person dedicated solely to watch this all unfold, coordinate efforts at the highest levels of government, and report back to the Governor and the General Court on a regular basis so that we may be fully engaged going forward.

The problem of child abuse and neglect is not just a human services issue and neither is it simply a law enforcement concern. As such, it doesn't fit neatly in our government org chart. And to complicate matters, solutions to the problem take various public and private forms, essentially falling into three categories—prevention, intervention and, if need be, prosecution. So we're trying to be a little creative here—using what resources we do have in the most effective and efficient manner to tackle this problem and its many permutations.

The intent is to elucidate and augment, not to undercut, the reform efforts already underway in the field of child welfare. The Department of Social Services cannot tackle this alone.

We are concerned that the pressures of fulfilling the agency's primary task—which is to address society's most difficult problems—and the difficulties inherent in any reform effort of this magnitude, coupled with the difficult fiscal realities faced by the Commonwealth, may hobble this 27-year-old agency during what are still its formative years.

When we look at this from the perspective of a child, we are concerned that, while the shift to a more family-centered practice will be an improvement for most of the children involved with DSS, there are some kids whose suffering may go undetected because their abusers may manipulate the system and dupe well-intentioned social workers. We need two nets:-- A SAFETY NET for all children and for the majority of caretakers who just need some support, and A DRAGNET for those few cases where the perpetrator should be punished severely. Some further assurance that these concerns and the need for law enforcement involvement have been considered under the new model is needed.

Simply put, the secretary's job description is to keep the stoplight on and focused on the child at risk and to check regularly on the safety net and the dragnet to make sure they are both functioning properly.

The secretary, who would sit at the cabinet level, would facilitate the Commonwealth's long-term, coordinated approach to the prevention, treatment and prosecution of child abuse and neglect. The board, comprised of agency heads and other key partners, would primarily serve in an advisory capacity, giving the secretary direction and access to the resources necessary to formulate a long-range, comprehensive approach to combat child abuse and neglect. As a high-ranking, uniquely positioned government official, the secretary would be able to take a view from the top, tap into the existing resources, help translate the language of various agencies and programs, gauge structural strengths and weaknesses, recognize overlapping or conflicting efforts, and seize opportunities for coordinated response. The secretary should be able to reach into agencies and reach out to our natural allies to get the job done.

The eighteen-member board shall be well suited to advise and assist the new secretary as it shall be comprised of department heads from various executive offices and from the judicial branch:

- Criminal History Systems Board (EOPS)
- Criminal Justice, Undersecretary of… (EOPS)
- Department of Early Education & Care
- Department of Education
- Department of Mental Health (EOHHS)
- Department of Mental Retardation (EOHHS)
- Department of Public Health (EOHHS)
- Department of Social Services (EOHHS)
- Department of Transitional Assistance (EOHHS)
- DOR/Child Support Enforcement Division (EOAF)
- Department of Youth Services (EOHHS)
- District Attorneys representative
- Juvenile Court Department (Judiciary)
- Office of the Commissioner of Probation (Judiciary)
- Probate & Family Court Department (Judiciary)

Additional members include two gubernatorial appointments and the executive director of the Children's Trust Fund.

We want to be clear that we are not creating a new layer of bureaucracy, but rather creating a clearinghouse for sharing information and synchronizing policies. In a sense, the secretary will take up where this report leaves off. We've learned a great deal over the last few months about how we address child welfare—including where our weaknesses are and how much we don't yet know.

Given our experience over the last two months, we suggest that the secretary's first assignment be the development of a comprehensive plan, with periodic benchmarks and cost-estimates, for a coordinated, system-wide response to child abuse and neglect. The plan would look forward five years and be updated annually to plan for the ensuing five-year period. Then, the secretary, again working with the board, shall oversee the comprehensive plan to make sure we're not developing conflicting or inefficient solutions in our

earnest efforts to protect children. Integral to success of this proposal is "early and often" notification to the legislature so that we can take the necessary steps in an educated, timely and coherent manner. The intention here is to provide stability and make sure that "all hands are on deck" during this time of transition and in the future.

While the secretary and the board are developing the 5-year comprehensive plan, the legislature can immediately respond to certain findings of the House Committee on Child Abuse and Neglect. In addition, there are matters pending before the legislature which may address some of the child abuse and neglect issues we highlighted herein. We hope that our report will inform the work of the Committee on Children, Families and Persons with Disabilities, the Committee on Public Health, the Committee on Substance Abuse and Mental Health, as well as the Committees on Ways and Means, which will track and tackle these issues going forward.

Within the body of the report, we organized our thoughts according to the ten matters delineated in the House Order establishing the House Committee on Child Abuse and Neglect. In some cases, there is considerable overlap. For simplicity's sake, our recommendations are not organized in that fashion; instead, they are designated either for immediate consideration by the General Court or to be addressed in the secretary's 5-year comprehensive plan.

READY FOR LEGISLATIVE CONSIDERATION

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

- Require explicit response from DSS about its efforts to address disproportionality. Request a detailed explanation from DSS of their current and future initiatives to reduce overrepresentation of children of color in the child welfare system. Report back to the legislature within 30 days and periodically thereafter. *To be effective immediately.*
- Require annual report from DAs about criminal prosecution of serious child abuse and neglect cases. Request analysis from local district attorneys about the types of child abuse and neglect cases referred by DSS. Include rationale for not prosecuting certain cases and submit any recommendations to improve criminal prosecutions of child abuse and neglect. *To be effective immediately.*
- Maintain medical resources for area offices. Continue funding for medical staff to assist social workers when investigating suspected child abuse or neglect cases that have medical complications.
- Insure equitable processing of CORI waivers. Require that CORI waivers be reviewed by two persons so that judgments made to approve or deny waivers affecting the placement of children are reached equitably.
- Require training for certain mandated reporters. Require those mandated reporters whose professions are licensed by the state to complete training so they are better qualified to recognize and report suspected child abuse and neglect. *To be effective 1/1/2009.*
- Increase statutory penalties for willful failures to report serious child abuse and neglect. Increase civil penalties, impose potential jail time and allow possible loss of professional license for those mandated reporters who willfully refuse to notify DSS about serious child abuse or neglect. *To be effective immediately.*
- Link community policing funds to law enforcement efforts to improve child welfare. Insert budgetary language to prioritize those community policing grants that include a focus on child abuse and neglect issues and/or coordinate domestic violence and child welfare efforts. *To be effective 7/1/2008.*
- Support the Massachusetts Child Welfare Institute. Support continued funding for the coordinated, statewide training of social workers and other DSS staff offered through CWI.
- Monitor Family Networks and lead agencies. Require semi-annual reporting on the status of Family Networks and the lead agency model. Focus particularly on issues of accountability, cost, quantity and quality of services provided. *To be effective immediately.*
- Codify minimum educational requirements for DSS social workers and supervisors. Following the current hiring practices of the agency, require bachelor's degrees of social workers and master's degrees in social work and related fields for supervisory staff. *To be effective immediately.*
- Codify end-of-life procedures. Place major components of the DSS policy on life-sustaining medical treatment into statute, including the commissioner's approval of the agency's recommendation and the requirement of opinions from two different medical institutions and the hospital's ethics committee. *To be effective immediately.*
- Allow public end-of-life court hearings. Following the advice of Justice Spina in a recent SJC opinion, open end-of-life hearings for children in the DSS custody to the public. *To be effective immediately.*
- Change the name. Change the name of DSS to the Department of Children and Families to sharpen its primary focus and mission of keeping the best interests of children paramount and working to strengthen families for the sake of children at risk. *To be effective immediately.*

THE 5-YEAR COMPREHENSIVE PLAN AND PERIODIC BENCHMARKS

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

- ***Disproportionality.*** *Build upon the efforts already made or recommended by DSS to address racial disproportionality. Examine how effective DSS has been and how reforms impact overrepresentation. Examine whether others (law enforcement, higher education, mandated reporters, etc.) are sensitive to making culturally competent decisions.*
- ***Mandatory Reporting.*** *Assess the quantity and quality of training currently provided to mandated reporters. Develop standards for training that include best practices for recognizing and reporting suspected child abuse and neglect. Assess whether these trainings can be provided through pre-existing mechanisms for professional training (e.g., CEUs, in-service), through online programs, or directly by DSS. Examine the value of mandating testing of mandated reporters.*
- ***Screening.*** *Examine the efficiencies of centralizing the 51A reporting and screening process. At a minimum, consider funneling all oral 51A reports through a single 1-800 number available 24-hours a day, directing all written 51A reports to a single fax number or mailing address, and providing for online filing. Consider how effectively DSS considers multiple 51A reports filed about one family. Examine screened out 51As to determine when, and under what conditions, they were inappropriately dismissed and the impact of such inappropriate dismissals. Seek direct, online access to the National Crime Information Center for criminal history records and warrants.*
- ***Child Protection Teams.*** *Consider statewide expansion of child protection teams at regional hospitals, at all hospitals with emergency rooms and pediatric care hospitals—based on the Children's Hospital model.*
- ***Family Engagement.*** *Coordinate with the Department of Social Services for the evaluation of the family engagement model (and its use of differential response and risk assessment tools) to determine how effectively findings of abuse or neglect are made and what the costs would be to implement FEM statewide. Examine the proposed combination of DSS functions such that an individual social worker would investigate, assess and provide ongoing case management. Focus on the need for specialized investigatory skills. Determine the extent of delay in the fair hearing process. Revisit the time limits.*
- ***Caseloads and Teaming.*** *Examine the effects of teaming on caseloads and vice versa. Estimate the cost of statewide adoption of various standard caseload ratios and develop a potential multi-year plan to reduce caseloads. Examine how social workers spend their time and whether certain tasks (i.e., driving child/family to court.) could accomplished more affordably and efficiently by others.*
- ***Law Enforcement Involvement.*** *Investigate how effectively DSS and law enforcement collaborate, and where there is room for improvement or coordination of resources. Develop protocols for mandatory reporting of physical abuse to local law enforcement and district attorneys.*

Consider alignment with efforts to prevent or prosecute domestic violence and coordination with the procedures used in the investigation of sexual abuse (SAIN).

- ***Schools of Social Work.*** *Examine how effectively social work and related degree programs teach child welfare practice. Examine opportunities for greater cooperation between DSS and higher education to study child welfare issues. Determine the capacity of public and private schools to meet increased demand for social work and related degrees, including concentrations in child welfare. Establish a timeline for inclusion of child welfare concentrations in bachelors' and masters' degree programs at public institutions of higher education.*
- ***Social Worker Qualifications.*** *Examine the infrastructure needed to support a more qualified workforce, including complete build-out of the Child Welfare Institute.*
- ***Confidentiality Concerns.*** *Research legal and ethical considerations to be addressed if we expand information sharing in cases of child abuse and neglect.*
- ***Medical/Mental Health.*** *Examine the ongoing needs for medical and mental health expertise and services. Critique proposed models for more effective client behavioral health services. Develop improved oversight of the use of psychotropic drugs on children involved with DSS or DYS.*
- ***DSS critiques.*** *Consider how to align a sophisticated audit unit with the proposed Continuous Quality Improvement/Quality Service Review initiatives. Provide opportunities to share findings with policy makers within and outside of DSS.*
- ***CORI Reviews.*** *Examine the use of CORI reviews in out-of-home (kinship or foster) placements. Determine where efficiency and equality can be improved.*
- ***Aging Out.*** *Monitor how effectively DSS is assisting adolescents aging out of the system with health care, housing, higher education and other needs.*
- ***Rosie D. case.*** *Examine the impact of the federal mandate in the Rosie D. case on child welfare efforts.*
- ***MassHealth/MBHP.*** *Monitor the agencies' oversight of medical and behavioral health expenditures, particularly as they relate to support services provided to DSS children and families.*
- ***Federal Funds.*** *Develop plan to address Massachusetts' low Title IV-E saturation rate for foster children, including a determination of AFDC status for non-TANF population and ensuring judicial determinations are made within the required timeframes.*

Introduction

First, we must be clear about the Commonwealth's directive. It is to act in the best interests of the child. The child's welfare is preeminent—whether that means allowing children to stay at home with their families in supported environments or removing children from dangerous living situations. Either scenario may be in the best interests of the child. It depends on the facts of the case. And while judgments made by government officials should be informed by the facts and made with the wisdom of Solomon, we have found that at times those judgments were flawed because they were based on inexperience and/or on inadequate information or, more disturbingly, on out-and-out lies or deception on the part of the child's caretakers. Succinctly put, DSS needs two instruments—a safety net for the good caretakers and a dragnet for criminal caretakers. To do what is in the best interests of the child, we must have a child welfare system that has the knowledge and skills to tell these scenarios apart and to respond appropriately. A series of high profile cases in Massachusetts received national and international attention and serves as a constant reminder that the safety net has holes and the dragnet has flaws.

Secondly, we must give credit where credit is due. There are families who struggle against the odds to provide the best for their children—*and, with support, most of them succeed*. There are legions of well intentioned, hard-working, devoted public servants and private parties whose lives' work is to protect children from harm. There are untold stories of caring adults who noticed something amiss and picked up the phone to make a difficult call. There are social workers and therapists who, at times uninvited, have come into broken homes and tried to break the cycle of abuse and neglect.

Also, we must recognize that child welfare is a relatively young social science. It is a burgeoning field in which there is still so much to learn. We understand that the child welfare system in Massachusetts is in the midst of major transition, rife with the difficulties and possibilities inherent in any organizational change. The underlying theories driving the reform are (1) that there are families in the current system who feel stigmatized by charges of abuse and neglect and are resistant to government support as a result, (2) that there is a design flaw in our system so kids end up in residential care when they could be more appropriately served in their own community, and (3) that social workers tend to be inadequately supported, overworked and at times overwhelmed. As a result, we sometimes get the worst of both worlds—families that need supportive services feel stigmatized and punished by DSS investigations, while those abusers who should be stigmatized and punished sometimes go undetected by inexperienced or overworked social workers who are unable to uncover enough evidence to support removal of the child.

While the discussions have focused appropriately on the Department of Social Services, this is a governmental concern that cuts across agencies, executive offices, branches of government and across local, state and federal lines. In fact, this is a societal concern that should and does cause our partners in the educational, law enforcement, medical and social services communities to ponder anew what we all can and should be doing to help protect children. Case and point: Recent mishandling of a federal raid in New Bedford and its adverse impact on children had caused considerable public uproar and diverted scarce state resources.

We also acknowledge that others have examined the matters before us and we fully expect these matters to be re-examined by those who follow after us. Such is the nature of the problem. Still, we acknowledge the past, examine the present and have hope for the future.

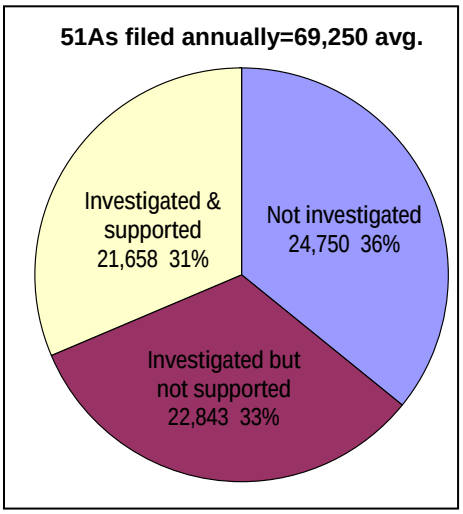
Child Abuse & Neglect Statistics

Many of our thoughts, findings and recommendations must be examined in context—in the context of the numbers of suspected and confirmed cases of abuse and neglect, in the context of the ongoing transition at DSS, in the context of the national and international efforts to improve child welfare, and in the context of the fiscal realities facing the commonwealth and the nation.

The ongoing transition at DSS and the ongoing efforts to improve child welfare are detailed in later pages. The fiscal realities we acknowledge but defer to the General Court's experts—the House and Senate Committees on Ways and Means. We start with the numbers—with the statistics on child abuse and neglect.

According to the Massachusetts Children's Trust Fund[2]:

- Massachusetts has the third highest rate of confirmed cases of child abuse and neglect in the country—twice the national average.[3]
- The incidence of children in Massachusetts suspected to be victims of abuse and neglect during 2005 reached 108,825 – nearly 300 children per day.[4]
- The number of children confirmed as abused or neglected in Massachusetts – 35,214 children – would fill Fenway Park. Half were age seven and younger.[5]
- Nationwide, child abuse and neglect is the leading cause of death for children under age four.[6]



According to the Massachusetts Department of Social Services,[7] the agency annually receives about 70,000 reports of suspected child abuse or neglect, so-called "51A reports".[8] Almost two-thirds of those 51A reports are "screened in"—prompting further investigation by DSS. After investigation, half of those screened in (or one-third of all 51A reports) remains and those families go through an extended assessment to determine what services, if any, they need. In other words, under the criteria for child abuse and neglect in Massachusetts, each year nearly 22,000 reports of suspected child abuse or neglect are found to be child abuse or neglect. Since a 51A report may represent one or many children, it is important to note that it is estimated that upwards of 100,000 children are suspected to be the victims of or at risk for child abuse or neglect each year.[9] In 25% of supported cases, a child has been seriously hurt.[10] Each year, almost 8,000 children are removed from their home after a 51A has been filed.[11] DSS asserts that its statistics indicate that less than 5% of 51A reports are for severe physical abuse or sexual abuse; while 70% are for neglect.[12]

When a child is seriously hurt as a result of abuse or neglect, there may be criminal consequences for the perpetrator. Over the last five fiscal years, 22,062 such cases were referred by DSS to the local district attorney, an average of about 4,500 each year. In 46% of the cases the referral to the DA was mandated

by state law; but the majority of cases (54%) were discretionary referrals by DSS. The vast majority of mandatory referrals were for sexual abuse (79%), followed by physical abuse (20%), and then death (1%).[13]

The numbers are subject to interpretation and at times have been hotly debated. *We have high reporting of suspected abuse and neglect in Massachusetts quite possibly because we define abuse and neglect more broadly than other states.* The numbers are nevertheless disturbing regardless of how they are interpreted.

The Cost of Child Abuse

Equally as disturbing is the cost of child abuse and neglect in Massachusetts. It is enormous—not just for the families involved, but also for the Commonwealth.

In addition to state and federal money appropriated directly to DSS, there are indirect costs associated with child abuse and neglect. Because of the complex needs of the children and families involved in child welfare, they access many state services from mental health to law enforcement. As the needs of this population become more complex, the intensity and duration of their interaction with the Commonwealth continues to grow. According to the Massachusetts Children's Trust Fund, in 2004, the total cost of treating children and families involved in the child welfare system was over one billion dollars. This amount included over $65 million for hospitalization, $8 million for the judicial system and $80 million in lost productivity and taxes to the Commonwealth. (See Appendix.)

The Cycles

> "Adult violence against children leads to childhood terror, childhood terror leads to teenage anger, and teenage anger too often leads to adult rage, both destructive towards others and self-destructive: and, therefore, an effective and adequately funded child maltreatment prevention program must be a the heart of any national, state or local crime prevention program."[14] U.S. Advisory Board on Child Abuse and Neglect, 1990.

It is commonly understood that child abuse and neglect breeds other dysfunctions and that the cyclical and generational impacts of child abuse and neglect can be the most destructive societal forces. National research shows that substance abuse and mental health issues are critical factors for families who come to the attention of child welfare agencies. In Massachusetts, most of the families (75%) whose 51A reports are supported also struggle with substance abuse, mental illness, domestic violence, unemployment or poverty.[15] Researchers continue to make scientific connections between child abuse and neglect and other of society's ills. In fact, McLean Hospital in Belmont recently found a biological link between child abuse and later substance abuse.[16]

According to the Child Welfare League of America, more than 8 million children live with parents with substance abuse problems. CWLA has found that anywhere from 40 to 80 percent of families involved with child welfare agencies live in homes where alcohol and other drugs are abused..[17]

The correlation between domestic violence and child maltreatment has also been documented. It is estimated that half of those who batter their partners also abuse their children.[18] One fourth of women who are abused by their partners abuse their own children.[19] These are unhealthy families to be sure.

This leads us to the question, "What happens to these child victims when they become parents?" In a 2002 survey:

- Of mothers known to have been abused in their own childhood:
  - 40% abused, neglected, or abandoned their children during early childhood;
  - 30% provided borderline care; and
  - 30% provided good quality care.
- Of mothers who received good care as a child, 3% maltreated their children.[20]

Knowing how interconnected these social service and economic needs are, we must be wary of "robbing Peter to pay Paul." If funds are increased in one area at the expense of another, we could just be changing the symptoms rather than fixing the underlying problem. Knowing how powerfully child abuse and neglect can affect generation after generation, it is imperative that we continue to look for and find solutions.

An Organization in Transition

The Department of Social Services (DSS), established in 1980, is the state agency assigned the tasks of combating child abuse and neglect and providing support services to children in need. At any given point, DSS serves an average of 24,000 families, including 39,000 children, across the state. DSS is organized into a central office in Boston, and 6 regions and 29 areas across the state. The agency has approximately 3,400 employees, 2,535 of whom provide direct services to children and families.

The six regional offices are matched with six regional resource centers—contracted private providers who coordinate cross-area network management and other services. The 29 area offices are matched with 29 area-based lead agencies—contracted private organizations that manage and provide access to support services for DSS families. See discussion of Private Providers, p. 35.

DSS is undergoing an ambitious reform effort, begun in 2001. After a broad-based examination by parents, community members, social workers and other DSS staff, there was a push to recast the agency's policies and procedures to reflect a more family-centered, strength-based, and culturally competent child welfare practice. To effectuate these changes, DSS is shifting away from residential placements to community-based services and enhanced permanency planning for children; has redesigned its procurement process; and is reorganizing its staffing structure to accommodate a teaming approach to the provision of critical direct services.

1. Protecting Children and Family Preservation

To provide for the safety, permanency and well-being of children—this is the mission of our child welfare system as articulated by the federal Children's Bureau and adopted by the Massachusetts Department of Social Services.

In an ideal world, all children would live safely with their own families in happy, healthy homes. Yet, that is not the world in which we live. Sometimes, there are circumstances where outside supports are needed to ensure a safe, nurturing environment for children. Sadly still, there are situations, with or without outside resources, where children are not safe with their own families.

Under Massachusetts law, the directive is to protect children and preserve families:—

> "It is hereby declared to be the policy of this commonwealth to direct its efforts, first, to the strengthening and encouragement of family life for the protection and care of children; to assist and encourage the use by any family of all available resources to this end; and to provide substitute care of children only when the family itself or the resources available to the family are unable to provide the necessary care and protection to insure the rights of any child to sound health and normal physical, mental, spiritual and moral development." [21]

In reconstructing the state's approach to child protection, we need to hold fast to the directive and to the overall mission of safety, permanency and well being for children. From the outset, those involved in revamping DSS articulated six core values around which the work of the agency is to be done. Child welfare practice in Massachusetts is to be:

- Child-driven,
- Family-centered,
- Community-focused,
- Strength-based,
- Committed to diversity and cultural competence, and
- Committed to continuous learning.

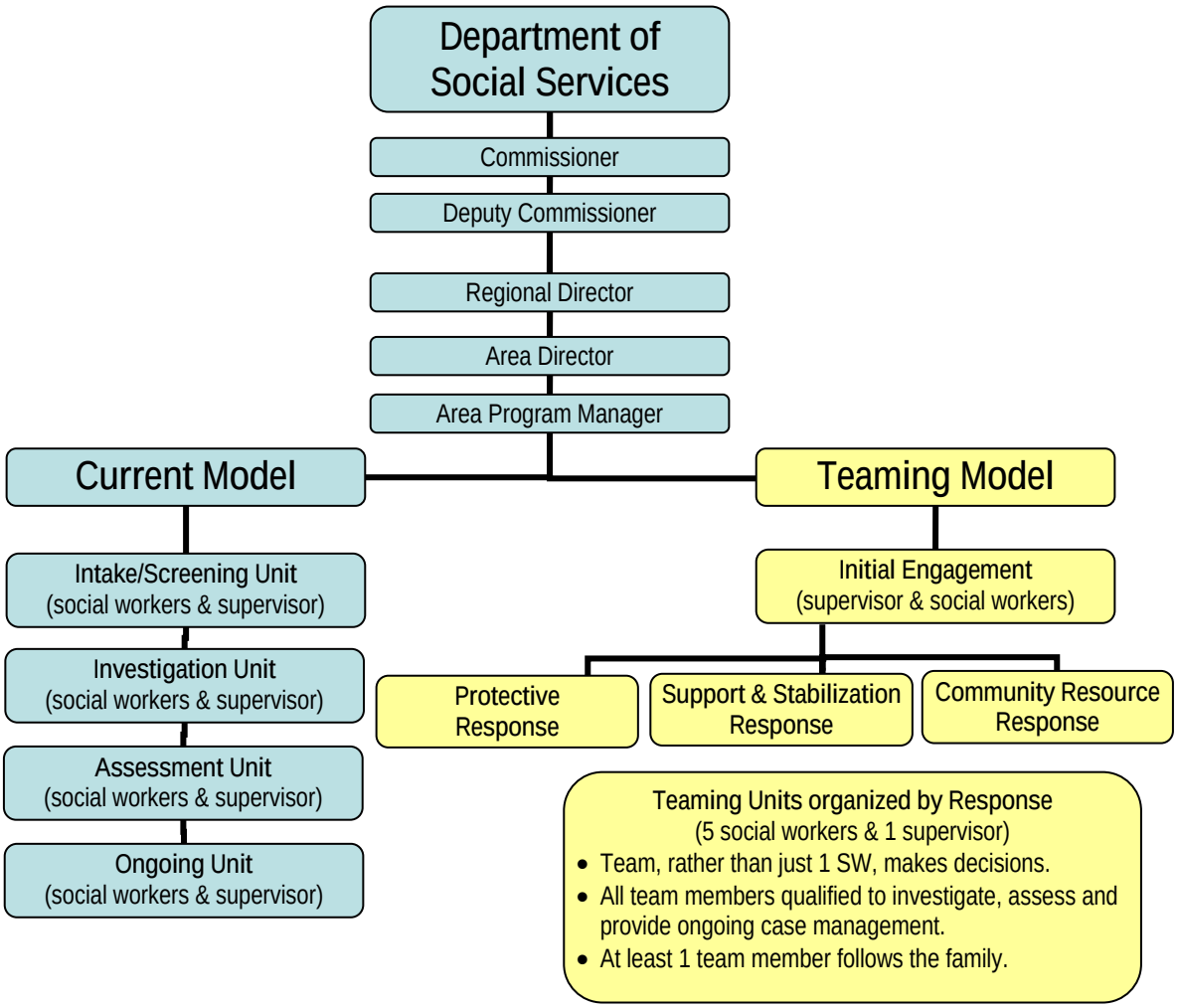
The House Committee on Child Abuse and Neglect was asked to examine the balance between protecting children and family preservation. Criticism of DSS has come when, in its efforts to protect children, families have been broken up and when, in its efforts to keep a family intact, children have been put at risk.

Each one of the core values has an impact on how well DSS balances child protection and family preservation. The child-driven core value restates the primary mission of providing for the safety, permanency and well-being of children. The family-centered and strength-based core values reaffirm that most children will be safe, have permanency and their well being can be provided for in their own families. The remaining core values—using community resources, being committed to diversity and cultural competence and being dedicated to continuous learning—provide the foundation on which the agency's practice can be both child-driven and family-centered.

The cornerstone of child welfare reform in Massachusetts—the Family Engagement Model—was conceived by a broad-based partnership of parents, community members and DSS staff who used these core values as their guiding principles. Family Networks, the redesigned service procurement for DSS families, is also based on these same core values. Central to both the Family Engagement Model and Family Networks is the belief that most children are better off staying in their own homes with the support of community-based services. Found throughout discussions about reforming DSS is the deliberate effort to improve cultural competency and to address tendencies that cause disproportionality in child welfare cases. Subsidiary issues include the fair hearing process and CORI difficulties with kinship and foster placements.

Family Engagement Model

The Family Engagement Model (FEM) developed out of an initiative called Working with Families Right from The Start (WWFRFS). It focuses on intake and assessment—quite literally, how DSS deals with families right from the start.



FEM uses family-centered practice and is designed to mitigate the perceived tension between child protection and family preservation that is built into the current screening, investigation and assessment processes.

The department has been criticized for using a confrontational process. In the department's estimation, most cases are not severe enough to warrant a child's removal from his or her home if appropriate supports are available for the family within their community. The Family Engagement Model is designed to accentuate the positive by focusing on a family's strengths, not just its weaknesses. It is supposed to differentiate between the majority of families who need a safety net—not accusations and confrontation—and those families where removal is necessary for the well being of the child.

In early 2006, implementation planning began, including union negotiations, information system redesign, field-testing, planning for and delivery of training and resource allocation. The design phase—step 2 in the process—began in January 2006 and implementation is planned for 2010—so it is still 3 years out.

Family Networks

Family Networks developed out of a need to redesign the agency's procurement process—which relied too heavily on residential placements at the expense of community-based support services. The old system, by its very design was expensive, lacked community-based programs, and unnecessarily moved kids out of their homes rather than keep families intact. Stemming from a 2002 review of purchased services, Family Networks represents "a total overhaul of how DSS purchases and manages services in the community."[22]
See discussion of Private Providers, p. 35.

Disproportionality & Cultural Competence

Cultural competence is the ability to work effectively with people from different ethnic, cultural, political, economic, and religious backgrounds. Disproportionality is the overrepresentation of children of color in child welfare compared to their presence in the general population.

In her testimony before this Committee, Sania Metzger of Casey Family Services stated that "[c]hildren from three communities of color—African American, Native American and Latino/Hispanic—have alarmingly high rates of involvement with state child protective services and disturbingly poor outcomes as they wind their way through the child welfare decision-making continuum."[23]

Poor outcomes relate to the problem of disparity within the system. Ms. Metzger explained that, "disparity refers to inequitable treatment, services and outcomes for children of color when compared to similarly-situated Caucasian children. Further compounding the issue is existing data that suggests that once involved with child protective services, these same groups of children of color receive fewer child welfare services that would allow them to remain with their families when compared to their Caucasian counterparts. As a result, too many are removed unnecessarily from their homes, left to languish in foster care and are denied the support and family connections they need to transition successfully to adulthood."[24]

Core Practice Value: Committed to Cultural Diversity/Cultural Competence

One of the six guiding principles for child welfare work in Massachusetts is a commitment to cultural diversity and cultural competence. This commitment is evident through theory and practice at DSS. It is an acknowledgement that disproportionality is present in child welfare work and deliberate efforts must be made to address the inequity of overrepresentation of children of color in child welfare systems.

Testimony before the Committee indicated that those doing child welfare work are aware of the disproportionality problem. Social work as a profession also recognizes diversity and cultural competency as an essential element of effective child welfare practice.[25] A review of agency documents and an examination of the theoretical underpinnings of its reform efforts show that DSS is attempting to resolve some of the underlying causes of disproportionality. However, this is very much a work in progress.

The Family Engagement Model is designed to keep more families intact. The use of sophisticated, actuarially based assessment tools, such as Structured Decision Making, is proven to increase equity and fairness in decisions involving families of different cultural and ethnic backgrounds.[26]

Cultural competency is an essential element of the job at DSS. It is listed front and center on DSS job descriptions and is supposed to be woven throughout the agency. Commissioner Spence testified that the agency's workforce was becoming more diverse, but state licensing requirements inhibit the growth of a even more diverse workforce. More diversity and cultural competence within the workforce should reduce the incidence of disproportionality. Any such barriers, therefore, should be identified and removed. In their place, we need mechanisms that strengthen the quality and diversity of the workforce. [Note: Accommodations are now made for ESL versions of the licensing exam.[27]]

Teaming is supposed to address disproportionality and boost cultural competency as well. If you have more people thinking about an issue, then you are more likely to reach the appropriate decision for a family and less likely to make culturally insensitive judgments. Additionally, the agency offers diversity training. Recent seminars included:

- Commitment to Cultural Diversity and Cultural Competence (265 attendees);
- Indian Child Welfare Act (65 attendees); and
- Undoing Racism (40 attendees).

Specifically in response to the problem of disproportionality, each area office has an Advisory Council on Race, Ethnicity and Language Minorities. The department is also conducting an analysis of disproportionate outcomes and expects to develop strategies to address the findings by December of 2007. Improved collection of demographic data about those who come in contact with DSS will give the agency information needs to correct biased or unequal practices.

Impact of CORIs

If it is determined that children are no longer safe with their caretakers, the Department of Social Services needs to find appropriate placements for those children, either with extended family or in foster care. Trying to balance child protection and family preservation, DSS has made a concerted effort to use kinship placements so that children, if removed from the home, are still connected with their own family.

Before placement with extended family or in foster care, a background check of the new caretakers must be completed. DSS has a 7-person unit dedicated to completing the background check. This unit has direct terminal access to the Criminal History Systems Board and, according to DSS, can access Criminal Offender Record Information (CORI)[28] usually within the hour. If, however, any criminal history appears on the CORI, a waiver must be given before the child can be placed in that home. The waiver process can be time-consuming and labor-intensive, particularly because information on the CORI report may be incorrect or indecipherable. In addition, DSS has often been criticized for denying a kinship placement based on seemingly irrelevant prior offenses.

The agency has acknowledged the need for improvement. It does provide for emergency waivers within a day on the basis of limited but critical information. The processing of waivers in non-emergency situations, however, has been problematic. The agency is looking to move the waiver approval process to regional and area offices for more cases in hopes that this will alleviate some of the delays. For the sake of children who could remain connected to their own families, the problems with CORIs and the waiver process must be resolved. The basis for denying a kinship placement should be connected to the safety of the child and not simply to the existence of some criminal record. It is essential that any discussions about CORI reforms include DSS and that any changes to the waiver process be closely monitored so that placements are swiftly and appropriately made.

Fair hearings

A fair hearing is an opportunity for a family to dispute the findings by DSS or a DSS contracted agency. Fair hearings are most often initiated after a DSS investigation supports a finding of abuse and neglect. It is, in a sense, the formal venue in which the balance between child protection and family preservation can be debated and achieved. In theory, the Family Engagement Model, with this family-centered approach, and Family Networks, with its reliance of community-based services, should mean a more cooperative relationship between DSS and families it serves. This should result in fewer children being removed from their families and less contentious removal proceedings. If so, it could be expected that the demand for fair hearings will abate and complaints about delays in the fair hearing process will abate as well.

2. 51A Reports and Mandated reporters

The Committee was asked to examine the reporting of or failure to report child abuse and neglect by mandated reporters and others (51As). Testimony submitted to the Committee, the findings of the House Post Audit case study, and subsequent research revealed the following concerns:

- Quality of judgment calls made by mandated reporters.
- Reluctance to get involved due to concerns about how DSS handles cases, fear of litigation, the impact of disclosure on therapeutic relationships.
- Failure to report rarely, if ever, punished.
- Reports get screened out, but the child is the subject of multiple reports.

About 70,000 reports of suspected abuse or neglect are filed annually with the Massachusetts Department of Social Services. These 70,000 reports represent, on average, 73,650 children who are suspected of being the victims of or at risk of abuse or neglect each year.[29] It is important to note that Massachusetts, compared to other states, is known to be a high reporting state. This fact is more reflective of our emphasis on child safety and our comparatively low threshold for abuse or neglect than on anything else.

	2002	***2003***	***2004***	***2005***	***2006***	***Average***
51A reports filed	67,366	68,404	70,417	70,812	71,900	69,780
Children harmed or at risk	73,431	73,195	74,370	73,243	74,011	73,650

About one-third of these 51A reports is screened out and not investigated by DSS. The agency screens out reports that do not meet its criteria for abuse or neglect. For example, DSS screens out reports if the abuse or neglect is not at the hands of a caretaker. DSS also screens out those reports where the alleged abuse is outdated or where the information provided is "demonstrably unreliable or counterproductive."[30] Under DSS regulations, certain incidents that fail to meet the agency's criteria (and are therefore screened out) may get referred by DSS to the local district attorney or the reporter may be referred to local police, the district attorney or the appropriate licensing authority.[31]

Yet, in some cases, hindsight makes it clear that there was a history of abuse or neglect, but, despite the warning signs, no reports were filed or, if they were, they were screened out or unsupported by DSS.

It is impossible to quantify how many reports should have been filed and were not. It has been suggested that failure to report may come from an inadequate understanding of the child protection laws; an inability to recognize signs of abuse and neglect; a hesitation to call authorities unless the evidence of abuse or neglect is clear; a desire to keep the problem within the family or within the institution and not involve authorities; a fear of how DSS will handle the problem: a "there but for the grace of God go I" attitude; a reluctance to violate the trust or confidentiality of a doctor/therapist-client relationship; and, of course, a fear of litigation. The list probably could go on.

When reports are made but then screened out (or unsupported after investigation) by DSS, there may be a chilling effect. Reporters may resist making future reports if they think they went out on a limb for no good reason. The fact that one third of the 51As is screened out (and another one third is unsupported after investigation) raises major questions about the judgment calls being made by reporters, by screeners (and

by investigators). Is the one third drop off to be expected? Is the standard for mandatory reports to DSS considerably lower than the standard set by DSS for screening in or investigating such reports? Do reporters lack understanding of basic elements of the reporting law, such as who is a caretaker? Are reporters not sophisticated enough to recognize child abuse and neglect as defined by DSS? Are reporters mistaking cultural differences in child rearing for possible abuse or neglect? How often is DSS being used as a manipulative tool in divorce cases or custody battles? Are screeners dismissing cases because the reporting is not descriptive enough? Is there just not enough time to collect good information? Or are poor clinical judgments being made during the screening or investigative processes?

It is also unclear what happens with multiple reports over time. It appears that, at times, reports have been screened out or unsupported despite multiple reports being filed and the rationale for doing so appears suspect. We wonder whether the agency has the capacity to examine reports in a collective manner where the sum is greater than its parts. Perhaps doing so would highlight a pattern that, in and of itself, would justify increased DSS involvement with or investigation of the family. Further examination of multiple 51A reports is needed.

The Committee does not have enough information to answer many of the questions posed about 51As; but does acknowledge that DSS has recognized certain weaknesses in its procedures and intends to seek statutory changes and policy shifts to address these questions. For example, the Family Engagement Model, which is the cornerstone of the ongoing reform effort, seeks to extend timeframes for most screening and investigations. Using teams, instead of isolated social workers, is intended to expand the quantity of information gathered and enhance the quality of decision-making during investigations and assessments. Expanding its staff training, through the Child Welfare Institute and planned certification of its social worker and supervisory staff, DSS expects that its greatest asset will be skilled enough to address the difficult judgment calls they are required to make. Combined, these efforts are designed to change the image of DSS from an investigatory agency to a social services agency designed to support a family during difficult times.

Still a more detailed understanding of why reports are not made and, if they are made, why they are being dismissed is needed. This is particularly true as the agency changes its processes.

Who reports?

All states permit anyone to report suspected child abuse or neglect, but they have differing rules about who must report. Approximately eighteen (18) states require all citizens to report suspected abuse or neglect.[32] Other states, like Massachusetts, require reporting only by certain people whose profession brings them into regular contact with children.

Under Section 51A of Chapter 119, Massachusetts requires certain categories of persons to report suspected child abuse or neglect to DSS. So-called mandated reporters include professionals in medical, educational, child care, law enforcement and religious settings who must contact DSS if they suspect that children have been – or are at risk of being – abused or neglected by their caretakers. Mandated reporters are also required to contact DSS, the district attorney and the medical examiner directly if they suspect a child may have died as the result of abuse or neglect.

A mandated reporter must file a report with DSS when, in his professional capacity, he or she has reasonable cause to believe that a child is suffering physical or emotional injury resulting from abuse

causing harm or substantial risk of harm to the child's health or welfare (including sexual abuse) or from neglect (including malnutrition), or who is determined to be physically dependent upon an addictive drug at birth.

Note: An oral report to DSS must be made immediately and a written report within 48 hours after the oral report. The agency has considered online reporting, as is done in other states, but decided not to pursue this option because of the intrinsic value of speaking with a trained screener who can ask relevant questions and elicit information critical to the screening decision.

Mandated reporters are not asked to decide whether or not a child is being abused or neglected. They are instead asked to judge whether reasonable cause exists to suspect such abuse or neglect. Massachusetts law provides certain protections for those who report suspected child abuse or neglect.

Changes to the list of mandated reporters have been made over time. For example, the sex abuse crisis in the Catholic Church prompted changes to section 51A to mandate that religious organizations report suspected abuse or neglect to DSS.

There is no mandatory training of mandated reporters and there is conflicting information about the capacity of mandated reporters to identify abuse or neglect. We have evidence of some mandated reporters being trained to recognize child abuse and neglect,[33] but it is unclear how widespread and effective this training is. We do know that, in addition to training its own staff, DSS teaches foster and adoptive parents and makes regular presentations to area community organizations. For example, in recent years, DSS has provided mandated reporter training to child care providers, schools, bar associations, college and graduate school students, parents' groups, medical centers, hospitals, probation officers, camps, clergy, youth organizations, early intervention programs, school nurses, counselors, police departments, domestic violence agencies, firefighters and EMTs. Private organizations also provide certain trainings for mandated reporters. Again, in response to the crisis in the church, the Archdiocese of Boston promulgated policies and procedures for the protection of children,[34] and now requires training for all volunteers about child sexual abuse.

The question still arises: How easy or difficult is it to determine child abuse or neglect? Some cases are clear cut. Many are not. There are some common signs or patterns of abuse and that information is shared during training sessions, but the more complicated cases obviously require analysis and judgment beyond a layperson's capacity.

Hospitals are uniquely positioned in children's lives. When a child is physically hurt, medical staff, as mandated reporters, must assess the situation and determine whether or not to file a 51A report. Yet, few doctors would qualify as experts in child abuse. Most primary-care physicians don't know how to diagnose child abuse.[35] Although, advances in medicine may assist in determining when a break is the result of abuse rather than an accidental fall.[36]

The child protection program at Children's Hospital in Boston serves as a model for other hospitals across the commonwealth.[37] Part of the program includes a designated child protection team (CPT) available 24-hours a day to consult on cases of suspected child abuse or neglect. The CPT is a multidisciplinary team of experts from the hospital's medicine, social work, nursing, psychology, and legal departments and its domestic violence project. This team approach is a concrete example for other hospitals to follow.

Recognized as the premier resource, the child protection team at Children's is often called upon by the Department of Social Services to consult on the more complex cases confronting the agency. In addition, the hospital has a DSS liaison to facilitate communications between the hospital and the agency.

Schools, likewise, are a constant presence in the lives of children. Once children are of school age, educators spend considerable time with them and are in a position to monitor a child's behavior and physical condition. Commissioner Spence has reached out to the educational community to let them know about the changes afoot at DSS; but, during his testimony, he acknowledged that DSS needs to do more with schools, its natural partners.

DSS provides a 31-page brochure entitled *"Child Abuse Hurts Us All: Recognizing, Reporting and Preventing Child Abuse and Neglect"* and a 3-page guide entitled *"Child Abuse and Reporting: A Guide for Mandated Reporters"* (available in English and Spanish), both of which are available on the DSS website. The Guide for Mandated Reporters identifies those professionals who must report, describes their responsibilities, defines abuse and neglect and explains how to proceed if child abuse or neglect is suspected. Both documents have been appended to this report.

Failure to report

Often, failures to report are only discovered in hindsight—when we wonder how the abuse or neglect could have gone unnoticed. We have been told that there has been a reluctance on the part of some medical and therapeutic professionals to get involved due to concerns about how DSS handles cases, fears of being dragged into litigation, and the impact on doctor-patient or therapeutic relationships. We have seen cases in institutional settings where failure to report has been attributed to the institution's decision to handle the problem internally rather than in public view. Mandated reporters have also expressed concern about confidentiality and privacy rights.

Mandated reporters' failure to report suspected child abuse or neglect is a civil infraction and punishable by a fine of up to $1,000.[38] (Civil suits may also arise out of failure to report.) We know, anecdotally, of only two instances where mandated reporters have been fined under section 51A. In 1988, Cambridge's Buckingham, Browne & Nichols School was fined $1,000 for failure to immediately report that a teacher at the school allegedly sexually abused three students; the school quietly fired the teacher in 1987, but failed to report the abuse to the proper authorities.[39] In 2005, the Groton School agreed to a $1,250 fine for its failure in 1999 to report allegations of "sexual hazing" by older students in positions of leadership.[40] Attempts to prosecute church officials under section 51A for failure to report sexual abuse failed because, at the time, they were not mandated reporters. These cases lead one to ask if institutions are reluctant to report out of a desire to protect their institutional reputation or to protect one of their own, particularly if the evidence is not clear cut or there appears to be some wiggle room under the law.

It is unclear why no other prosecutions have taken place.

The issue is back in the news again with two more high-profile cases—ones that have come to light during the short tenure of this Committee. In the Rebecca Riley case, where parents stand accused of using prescription drugs and other medications to kill their 4-year-old daughter, questions have been raised about whether the child's doctor at Tufts–New England Medical Center should have notified DSS about overmedication of the child. In the case of now deceased Joseph Magno, a longtime Maynard school

teacher, an accusation has been made that the school superintendent was told that the teacher, then still in the classroom, had abused students 30 years earlier. Both cases raise troubling and yet unanswered questions.

Some argue that increasing fines, particularly for institutions, and adding jail time are appropriate remedies for failure to report. Some suggest that such should be the case when the mandated reporter has indisputable evidence and yet fails to make the call to authorities. Still, there is the fear that mandated reporters, fearing severe criminal penalties, would overcompensate and overwhelm an already overburdened child protection system. There is a concern that, in the attempt to strengthen our abuse and neglect laws, we risk rendering the system into one of trying to find the needle of abuse and neglect in a haystack of increased reports. This is hardly the result we desire.

It has also been suggested that old allegations of child abuse, when made against persons still in a position involving children, should be forwarded to authorities.

Mandated reporters under M.G.L. c. 119, § 51A:
(Professionals licensed by the Commonwealth in bold.)

- **physicians, medical interns, hospital personnel engaged in the examination, care or treatment of persons, medical examiners,** emergency medical technicians, **dentists, nurses, chiropractors, podiatrists, optometrists, osteopaths,**
- **public or private schoolteachers, educational administrators, guidance or family counselors,** school attendance officers,
- child care licensors, **day care and child care workers, including any person paid to care for, or work with, a child in any public or private facility, or home or program funded or licensed by the state, which provides day care or residential services,** including child care resource and referral agencies, voucher management agencies, family day care and child care food programs,
- **social workers, foster parents,**
- firefighters or police officers, probation officers, clerks magistrate of the district courts, and parole officers,
- **psychologists, psychiatrists, and clinical social workers, drug and alcoholism counselors, allied mental health and licensed human services professionals,** and
- priest, rabbi, clergy member, ordained or licensed minister, leader of any church or religious body, accredited Christian Science practitioner, person performing official duties on behalf of a church or religious body that are recognized as the duties of priest, rabbi, clergy, ordained or licensed minister, leader of any church or religious body, or accredited Christian Science practitioner, or a person employed by a church or religious body to supervise, educate, coach, train or counsel a child on a regular basis.

Mandated Reporters who are staff members of medical or other public or private institutions, schools or facilities, must either notify the Department directly or notify the person in charge of the institution, school or facility, or his/her designee, who then becomes responsible for filing the report. Should the person in charge/designee advise against filing, the staff member retains the right to contact DSS directly.

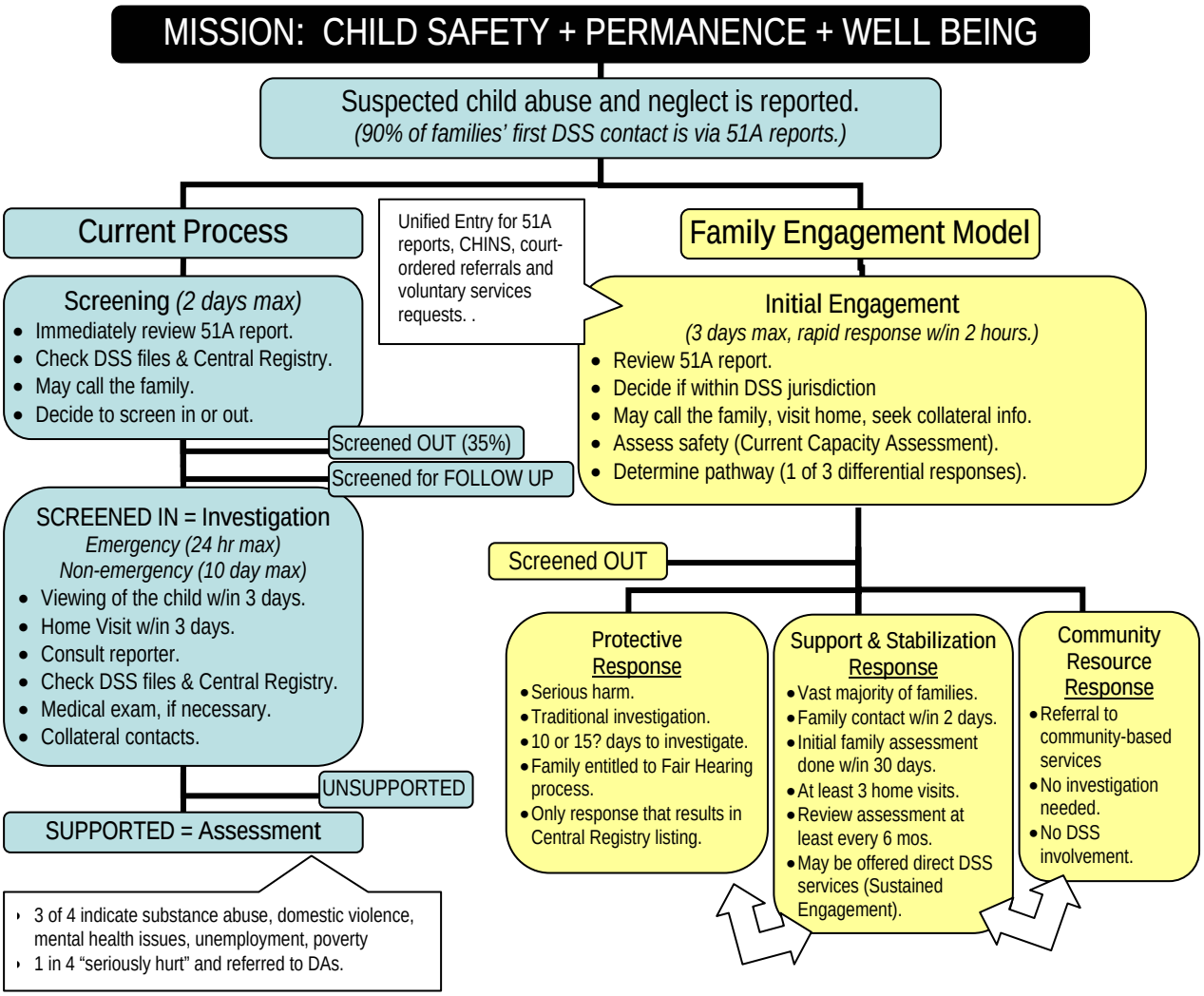
Many mandated reporters in their professional capacity are licensed by the state through their respective boards of registration or are public employees. As a licensor and/or funding source, the Commonwealth has considerable authority over these individuals.

3. DSS Investigations

The Committee was asked to examine the investigation of 51A reports by the Department of Social Services. Testimony before the Committee and the House Post Audit case study raised the following issues: the length of the statutory investigation period, the quality of collateral checks, the impact of caseloads, the need for medical expertise within DSS, and the role of law enforcement.

The investigation process is governed by statute and by DSS regulations (M.G.L. c. 119 § 51B and 110 CMR 4.26-32). If a 51A report is screened in by DSS intake workers or screeners, DSS investigators have up to 10 calendar days to make a determination about the suspected abuse or neglect. In emergencies, only 24 hours are allowed to make a determination. Investigators typically spend 2.5 days on a particular case, bumping up against the statutory 10-day deadline due to the volume of reports under investigation.

As the shift to the Family Engagement Model is just now ready to be piloted and statewide implementation is still years away, it is appropriate to note that extending the investigative time period under the current model has been universally endorsed.



The Family Engagement Model would revamp the processing of 51A reports so that the traditional DSS investigation would apply only in those circumstances in which a protective response is indicated.

On average, about half of the reports screened in and investigated are supported for abuse or neglect (about 22,000 reports annually). The Committee heard anecdotal evidence of poor collateral checks and incomplete investigations. A recent news story about the DSS response to the child abuse allegations involving a boy in West Boylston reinforces the need to examine closely the screening and investigatory processes.

The Medical Disconnect

In March 2006, the Governor's Panel stated that the Haleigh Poutre case highlighted a "frightening confluence of a health care system ignorant of abuse and a child protective system ignorant of medicine."[41]

Although DSS is not a medical agency, cases of child abuse and neglect are often medically complicated. They are often complicated by behavioral health issues as well. Physical abuse and sexual abuse have obvious medical components; and mental health and substance abuse issues have been associated with child abuse and neglect. Much attention has been given of late to lack of medical expertise within DSS. The systemic weakness had already been brought to the legislature's attention and funds had been appropriated to shore up the agency's medical team. At one point, however, Governor Mitt Romney made the decision to freeze these funds in response to a projected budget shortfall. Later in the fiscal year, Governor Deval Patrick unfroze and released the funds for the DSS Health and Medical Services Team (HMST). Once it is fully staffed, the team will have a part-time chief medical officer, a full-time social worker in the central office, six full-time regional nurses, and three acute hospital DSS nurse liaisons, in addition to the team's existing staff (a full-time director of medical services, two part-time nurses based in the central office, and an acute hospital nurse liaison at Children's Hospital). Responding to the need for increased medical and mental health expertise at DSS, Secretary Bigby of the Executive Office of Health and Human Services has directed the medical director at the Department of Mental Health to assist the Department of Social Services.

Child psychiatry, particularly the use of psychotropic drugs, has gained national attention due to the tragic case of young Rebecca Riley from Hull.

> "But the tragic case is more than a story about one child. It raises troubling, larger questions about the state of child psychiatry, namely: Can children as young as Rebecca be accurately diagnosed with mental illnesses? Are rambunctious youngsters being medicated for their parents' convenience? And should children so young be prescribed powerful psychotropic drugs meant for adults?"[42]

As legislators, we have considered what we know about the underlying facts in Rebecca's case and have determined that a medical presence within DSS is essential. Further, the development and implementation of a drug protocol is required.

4. DSS Staffing

The Committee was asked to examine the qualifications and management of social workers and other staff at DSS.

DSS Social Workers

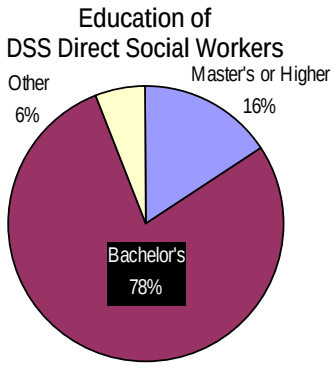
At the Department of Social Services, the lion's share of interaction with children and families is by direct service social workers. Those social workers receive case consultation from supervisors who, in turn, are overseen by area program managers. Below are sample job descriptions for these key positions based on recent postings:

Social worker	
Salary	$39,547.30 to $54,014.48
Work Experience	None.
Educational Qualifications	Required bachelor's degree or higher, preferred in social work, psychology, sociology, counseling, counseling education or human services
Duties	□ Provide professional child welfare social work services within the Department of Social Services; □ Assess, develop, evaluate, and monitor client service plans and programs; assess for risk; □ Respond to emergencies and initiate court action; □ Track and monitor individual caseloads; □ Make home and foster care visits; □ Write and review service planning goals; □ Coordinate visits between children and family members; □ Transport children; □ Provide counseling to clients and provide services for the protection of children; □ Employees may work with the schools, courts, and multiple agencies in the course of case management.

Supervisor	
Salary	$48,117.16 to $65,396.76
Educational Qualifications	A Master's or higher degree in social work, psychology, sociology, counseling, counseling education, or human services is required. *(Note: The minimum educational requirement for social worker supervisor positions at state agencies is a Bachelor's degree in social work, psychology, sociology, counseling, counseling education, or human services. For adoption, foster care, assessment, child welfare social worker, investigation, or screening supervisory assignments at DSS, a master's degree is required.)*
Duties	□ Provides case consultation and clinical supervision to direct social service employees of lower grades; performs related administrative duties; performs related work as required.

Through its hiring practices, DSS has established the following educational standards for new hires and promotions:

- Social workers are required to have a bachelor's degree, preferably in social work, psychology, sociology, counseling, counseling education or human services.
- Social work supervisors are required to have at least three years of professional experience as a licensed social worker and a master's degree in social work, psychology, sociology, counseling, counseling education or human services. Upper level supervisors must also have a year of supervisor experience.



Functional Title: Area Program Manager	
Salary	$38,067.12 to $81,723.08
Work Experience	Applicants must have at least (A) five years of full-time, or equivalent part-time, professional, administrative, supervisory or managerial experience in business administration, business management, or public administration and (B) of which at least four years must have been in a supervisory or managerial capacity, or (C) any equivalent combination of the required experience and the substitutions below. Substitutions: I. A Master's or higher degree with a major in business administration, management, public administration, industrial engineering, industrial psychology, or hospital administration may be substituted for a maximum of one year of the required (A) experience.* * Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.
Educational Qualifications	Preferred: MSW or Master's or higher degree in psychology, sociology, counseling, counseling education, or human services.
Other Qualifications	□ Demonstrated commitment to the core practice values of the agency. □ Demonstrated understanding of the theory and practice of Child Welfare. □ Demonstrated ability to collaborate effectively with community groups and organizations. □ Demonstrated ability to work with culturally or linguistically diverse populations.
Duties	The essential nature of the role is that of a member of the senior management team in the area office. The position is involved with all aspects of daily activities of the clinical staff. Under the direction of the Area Director, provides supervision to social service supervisors and any other specialty positions as assigned. Supervision would include teaching, coaching, support and evaluation of the quality and effectiveness of the work. Provides leadership and clinical consultation to all levels of area staff. Performs case management activities such as assignment of cases and approval of transfers and closings. Oversees all clinical and case management activities of assigned units which may include but not be limited to screening/investigation activities, child removal decisions and process, permanency planning, and family resource support and management. Participates in the hiring and training of new employees. Actively participates in the professional growth and development of area staff. Helps to develop comprehensive quality assurance programs within the area office including participation in centralized initiatives. Collaborates with other state agencies and community organizations in the shared provision of services to clients. Participates in the development, monitoring and evaluation of the local system of care. Interprets and trains staff on agency policy, mission, and vision.

Schools of Social Work

"Social worker" is a generic term. It is possible to find social workers in all sorts of settings, with all kinds of educational backgrounds and work experiences. People who call themselves social workers may be qualified to do so by education, examination and/or experience.

In Massachusetts, there are sixteen colleges and universities accredited by the Council on Social Work Education to offer bachelors' and masters' degrees in social work.[43] As we stated, candidates possessing degrees in social work or a related field are preferred during DSS hiring and promotional processes. Supervisors are required to possess a degree in social work or a related field.

Some who testified before our committee urged us to adopt a requirement that all DSS social workers have an undergraduate or graduate degree in social work. Earning a degree in social work sounds like it should automatically qualify someone to work in the Department of Social Services. A bachelor's degree in social work, however, provides social service training for generalists. The field of child welfare is a unique subset of social services. Professional development, in the form of pre-service and in-service training, is currently needed to complement undergraduate education even for those holding bachelor's degrees in social work. Some masters' programs do offer a concentration in child welfare, but here in Massachusetts no such programs are offered at schools of social work at public institutions of higher education.

Given that the degree programs do not necessarily address the unique dynamics of child welfare practice and given concerns about the capacity of existing programs to handle such a mandate if it were imposed, it seems more prudent at this juncture to focus on the efforts with the department to develop certificate programs through the Massachusetts Child Welfare Institute (CWI) affiliated with Salem State College. In time, we expect public higher education institutions to develop child welfare concentrations.

Social Work Programs in Massachusetts

Program Name	*BSW*	*MSW*
Anna Maria College (Paxton)	X	
Atlantic Union College (So. Lancaster)	X	
Boston College (Chestnut Hill)		X
Boston University (Boston)		X
Bridgewater State College (Bridgewater)	X	X *
Eastern Nazarene College (Quincy)	X	
Elms College (Chicopee)	X	
Gordon College (Wenham)	X	
Regis College (Weston)	X	
Salem State College (Salem)	X	X
Simmons College (Boston)		X
Smith College (Northampton)		X
Springfield College (Springfield)		X
Western New England College (Springfield)	X	
Westfield State College (Westfield)	X	
Wheelock College (Boston)	X	X

Public institutions in bold. (* = candidate for accreditation)

Yet, the schools of social work do represent untapped potential. During the hearings, it was evident that there is minimal interaction between the Department of Social Services (and even the Board of Registration in Social Work) and most area schools of social work. Social work students often complete their required field education in DSS offices. It is only logical that the department's required competencies and the curriculum of social work programs could be better aligned for the benefit of a stronger child welfare workforce. Additionally, it appears as though there are opportunities to foster mutually beneficial alliances so that the schools get better access to research information about the child welfare field and so that DSS gets the benefit of no-cost, academically rigorous analysis of their work and the needs of their clients. Issues of confidentiality may need to be addressed, but should not serve as an impediment to valuable, quality research intended to move child welfare forward.

Licensure

Most social workers in Massachusetts must be licensed by the state Board of Registration of Social Workers.[44] The Board licenses approximately 20,000 social workers throughout the Commonwealth, of which about 1,636 are DSS social workers. DSS statistics show that 34% of supervisory and non-supervisory social workers combined are unlicensed; 42% of non-supervisory DSS social workers are unlicensed[45].

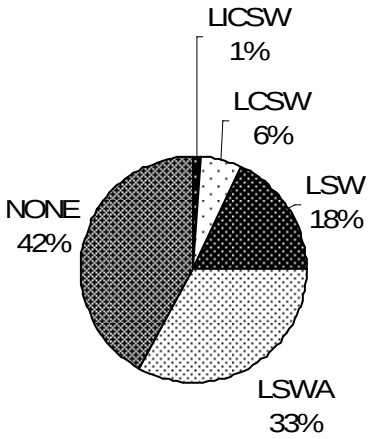
In Massachusetts, there are four levels of social work licensure (from lowest to highest):

- LSWA licensed social worker associate,
- LSW licensed social worker,
- LCSW licensed certified social worker, and
- LICSW licensed independent clinical social worker.[46]

Each level requires some combination of education, examination,[47] professional references, supervision, and experience. A social worker licensee is also required to complete continuing education before they can renew their license.[48] A license is valid for two years. See the appendix for more detailed licensure requirements.

Historically, social workers at DSS and other state agencies were exempt from licensure requirements.[49] In 1996, the law changed to require that DSS social workers be licensed and that they attend in-service training twice a year.[50] Over ten years later, it is apparent that licensure and training of DSS social workers is still quite problematic.

Licensing of DSS Direct Service Social Workers



We have been told that the failure to meet the statutory requirements reflect two weaknesses in the licensing exam: (1) that it is irrelevant and fails to adequately measure child welfare expertise needed for DSS social work and (2) that it is not culturally sensitive to the DSS workforce. As a result, a substantial portion of those who provide direct services or who supervise those providing direct services is unlicensed. The Commissioner has stated that a more appropriate examination and certification process is under development. Social workers and supervisors, in the Child Welfare Institute's certification process (described below), would need to demonstrate their skills and be evaluated based on their portfolio, an approach required in most teacher education programs. To maintain certification, social workers and supervisors would need to attend additional trainings and be reassessed every two years.

Under their contract[51], DSS social workers are entitled to a maximum of 8 days for work-related educational experiences. We do not know how often the twice-annually statutory requirement or the 8-day contractual commitment is met. We were informed that many social workers are unable to attend any of the 8 days to which they are entitled. Social workers have complained that they don't have time to attend professional development trainings given everything else they have to do. Efforts have been made to coordinate the training under the new Child Welfare Institute and in light of the ongoing family engagement reforms.

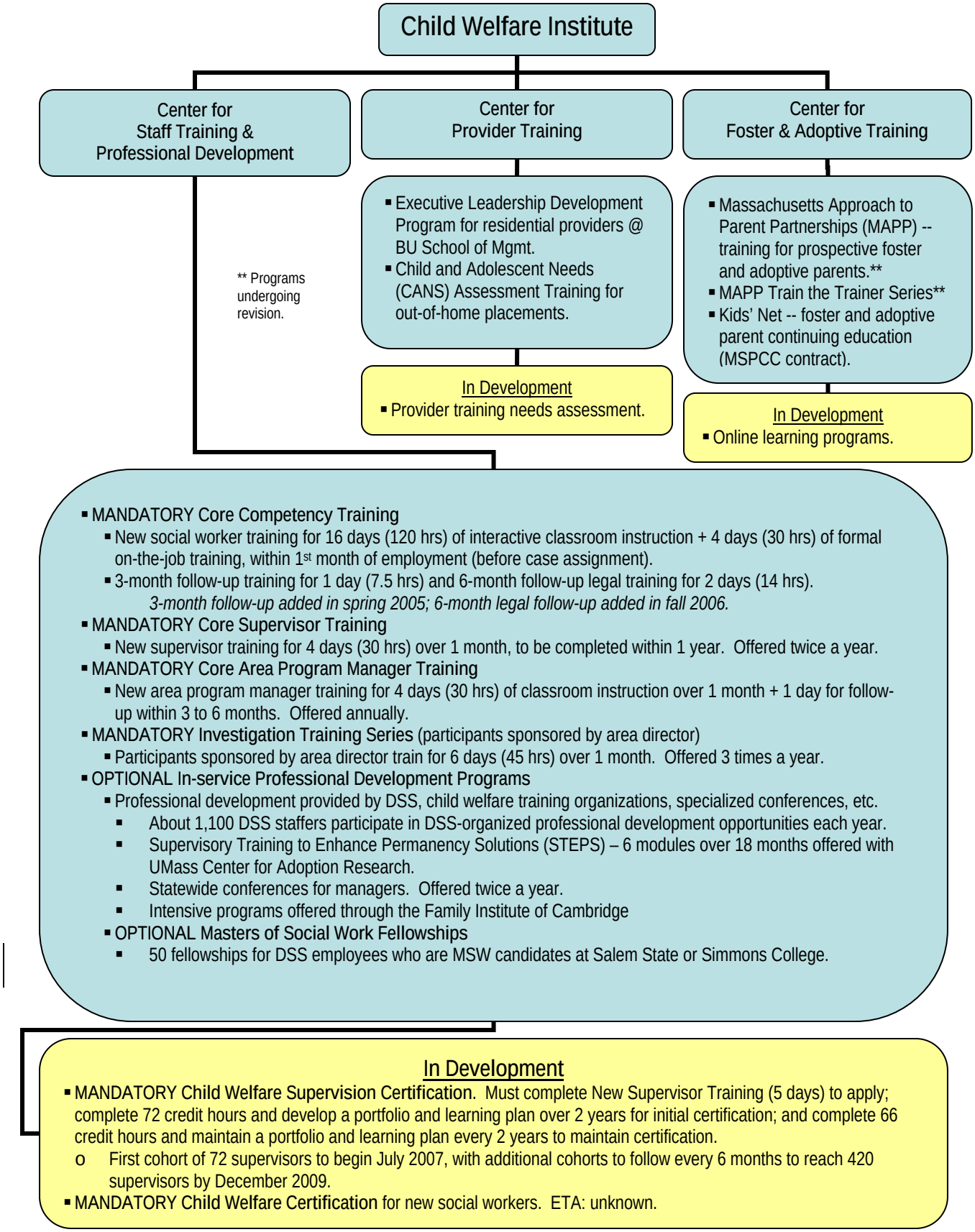
Child Welfare Institute

In November of 2004, the Massachusetts Child Welfare Institute (CWI) was officially established to promote the professional development of the child welfare workforce.[52] A partnership between the Department of Social Services, Salem State College and University of Massachusetts Medical School, CWI offers training across the state on child welfare issues for DSS staff, providers, and foster, adoptive and birth families. Many of the programs provided under the auspices of the Child Welfare Institute were in place before its establishment, but they are now more coherently administered and organized to reflect the core values and operating principles of child welfare practice in Massachusetts.

CWI provides mandatory pre-service and in-service training for new social workers, supervisors and area managers. It has been funded through a direct $3 million annual state appropriation and qualifies for federal reimbursement under Title IV-E. The institute is based at Salem State College, but its programs are offered across the state at various locations.

DSS leadership has determined that regular certification of its employees in child welfare practice is integral to the overall success of the agency, of the individual social workers and of the children and families it serves. The certificate program for supervisors is ready to go online and plans are underway to require similar intensive and continuous learning of all DSS social workers. In developing the certificate program, CWI researched many models of supervisor training, including certificate programs at BU and other academic institutions and other state training programs. These reviews strengthened the intent to insure that CWI certificate programs would engage DSS staff in a continuous, career-long learning process. The certificate program is designed to be academically rigorous with a strong emphasis on reinforcement and transfer of learning through direct practice so that content and skills learned in a formal course are brought into practical experience. CWI intends to measure the changes in supervision practice that are attributed to participation in this training program and believes that the components, the alignment of competencies and curriculum to the core practice values, and the continuous nature of the supervisor certification program is a substantial advancement over any other model of supervisor training--on a national level or within the academic world. Currently, through its fellowship program, CWI supports 45 DSS staffers attending the Salem State College MSW program and 5 DSS staff at the Simmons College MSW Urban Leadership Program. To apply, candidates must be DSS employees and already be admitted to the master's program at either school. Fellows must commit to work for the Department of Social Services for two years after they complete the program.

The Center for Adoption Research at the University of Massachusetts Medical School, through an interagency service agreement, has partnered with CWI to provide training for prospective foster and adoptive parents through the Massachusetts Approach to Parent Partnerships (MAPP). Part of their task is to revise the MAPP curriculum to insure its alignment with the DSS core practice values.


Child Welfare Institute
Center for Staff Training & Professional Development
Center for Provider Training
Center for Foster & Adoptive Training
▪ Executive Leadership Development Program for residential providers @ BU School of Mgmt.
▪ Child and Adolescent Needs (CANS) Assessment Training for out-of-home placements.
▪ Massachusetts Approach to Parent Partnerships (MAPP) -- training for prospective foster and adoptive parents.**
▪ MAPP Train the Trainer Series**
▪ Kids' Net -- foster and adoptive parent continuing education (MSPCC contract).
** Programs undergoing revision.
In Development
▪ Provider training needs assessment.
In Development
▪ Online learning programs.
▪ MANDATORY Core Competency Training
▪ New social worker training for 16 days (120 hrs) of interactive classroom instruction + 4 days (30 hrs) of formal on-the-job training, within 1st month of employment (before case assignment).
▪ 3-month follow-up training for 1 day (7.5 hrs) and 6-month follow-up legal training for 2 days (14 hrs).
3-month follow-up added in spring 2005; 6-month legal follow-up added in fall 2006.
▪ MANDATORY Core Supervisor Training
▪ New supervisor training for 4 days (30 hrs) over 1 month, to be completed within 1 year. Offered twice a year.
▪ MANDATORY Core Area Program Manager Training
▪ New area program manager training for 4 days (30 hrs) of classroom instruction over 1 month + 1 day for follow-up within 3 to 6 months. Offered annually.
▪ MANDATORY Investigation Training Series (participants sponsored by area director)
▪ Participants sponsored by area director train for 6 days (45 hrs) over 1 month. Offered 3 times a year.
▪ OPTIONAL In-service Professional Development Programs
▪ Professional development provided by DSS, child welfare training organizations, specialized conferences, etc.
▪ About 1,100 DSS staffers participate in DSS-organized professional development opportunities each year.
▪ Supervisory Training to Enhance Permanency Solutions (STEPS) – 6 modules over 18 months offered with UMass Center for Adoption Research.
▪ Statewide conferences for managers. Offered twice a year.
▪ Intensive programs offered through the Family Institute of Cambridge
▪ OPTIONAL Masters of Social Work Fellowships
▪ 50 fellowships for DSS employees who are MSW candidates at Salem State or Simmons College.
In Development
▪ MANDATORY Child Welfare Supervision Certification. Must complete New Supervisor Training (5 days) to apply; complete 72 credit hours and develop a portfolio and learning plan over 2 years for initial certification; and complete 66 credit hours and maintain a portfolio and learning plan every 2 years to maintain certification.
o First cohort of 72 supervisors to begin July 2007, with additional cohorts to follow every 6 months to reach 420 supervisors by December 2009.
▪ MANDATORY Child Welfare Certification for new social workers. ETA: unknown.

Caseloads & Teaming

Promoting child welfare is labor intensive. Everyone agrees that staffing is the "fundamental resource needed to meet the Department's primary objective."[53]

Other than staff qualifications, staffing is measured most often by how many cases a single worker is handling. The Child Welfare League of America recommends caseload standards for best practice, but acknowledges they are an inexact science.[54] In general, both the Child Welfare League and the National Association of Social Workers recommend a ratio of 15-1.

In Massachusetts, the union contract addresses caseload standards, setting a 12-1 ratio for those social workers doing assessments and investigations and an 18-1 ratio for ongoing social workers and for social workers doing screening. The contract acknowledges that these are not optimal ratios but, as is the case with all government services, there are limited resources and the contract represents the "best efforts to effectively utilize currently available resources."[55] DSS contends that the statewide average caseload is 18:1. Union officials point out that this is an average across an area and may vary from office to office. The agency has calculated the average statewide caseload as 17.11 and 17.20 for the previous two years. Union officials dispute these numbers, insisting that DSS is not counting cases or available staff properly. Some years ago, a social worker examined case files to determine how many people must be managed with a caseload of 18 to 1. Added up were children, schools, therapists, probation officers, drug and alcohol treatment counselors, parents, pediatricians, housing workers, welfare workers, DYS workers, independent living workers, health facility personnel, foster parents, lawyers, judges, grandparents. The list goes on. The result: 239 family and collateral contacts.[56]

Teaming formalizes the cooperation and collaboration normally found in the field, minimizing the risk of isolated, inexperienced social workers making judgment calls that may come back to haunt them and the children on their watch. With teaming, a small group of social workers and a supervisor organize and become "mutually responsible the team's process and tasks, and have complimentary social work skills and child welfare protective capacities expertise that they willingly share with each other to accomplish discrete work outcomes and interventions."[57]

The perennial staffing debate has been over caseloads, but the teaming initiative brings a new dimension to the discussion in Massachusetts. Given the planned statewide adoption of teaming, it is prudent to consider caseloads in the context of this shift in workloads as caseloads and teaming are mutually dependent. The union is concerned that teaming will create greater stress—as social workers are expected to do more in the same amount of time. They would argue that "a bucket can only carry so much water." The union contends this adds to an already overburdened workforce by expecting them to interact on more cases.

The teaming initiative is still in its formative stages. It was begun as a pilot in 2003; since then 8 units in 7 area offices have experimented with teaming. The initiative "restructures whole units so that workers share cases, go on home visits together, participate in group supervision sessions, and exchange information and advice on all their joint cases."[58] Lessons have been learned from these pilots and a redesign of the initiative is underway before it can be implemented statewide by 2010 as expected. The teaming initiative, only about 3% of the statewide caseload, was recognized as a 2006 winner of the Innovations in American Government Awards.[59] It is estimated that it would cost $20 to 25 million to bring the caseloads down to 15:1, the standard set by CWLA for family-centered practice.

5. DSS Records Management

The Committee was asked to examine the management of records by DSS. Concerns surfaced in the House Post Audit case study about the adequacy of FamilyNet (the agency's case management database, known on the federal level as SACWIS), confidentiality and privacy concerns serving as roadblocks to information sharing, the sophistication and quality of the data collection, and the maintenance of information about alleged perpetrators and screened out reports.

The DSS Record & FamilyNet

FamilyNet is Massachusetts' statewide automated child welfare information system (SACWIS).[60] Mandated by the federal government, FamilyNet is a comprehensive, unified, automated case management tool that supports child welfare services, including case management for social workers in foster care, adoption assistance, child protection and family preservation services. FamilyNet is considered by the federal government to be among the best SACWIS systems. (Perhaps, in part, because Massachusetts was the last state to implement it.)

FamilyNet is not to be confused with Family Networks (the procurement of services for DSS families).

All casework activity performed by DSS staff is entered into FamilyNet and available 24/7 in all DSS offices. FamilyNet went live in 1998 and includes records dating back to 1984 that were transferred from the agency's old computer system (ASSIST). The system, described by DSS IT staff as robust and stable, is constantly evolving to meet users needs; but some of its technology is becoming obsolete and there is demand for mobile communications given technological advancements and the mobile nature of the work done by child welfare workers. A comprehensive technology review is planned, including a shift to a completely web-based system. DSS has begun discussions with the federal government and intends to seek federal financial participation to subsidize future technical transitions; but it is unclear if such funds will be available.

In most cases, DSS staff has access to a complete history of an individual's involvement with DSS on FamilyNet. Documents received by DSS in hard copy are stored in a paper file in the area office. The electronic records and paper records together comprise the DSS record on a case.

Activities recorded in FamilyNet include intakes (51A reports), investigations, family assessments, permanency planning conferences, foster care reviews, case narratives (dictation), service plans, service referrals, family resource licensing evaluations, background records checks, demographic data, health/behavior information, education information, Interstate Compact for the Placement of Children requests, court case records, contractual agreements with providers, accounts payable and receivable tracking, revenue management and maximization, and more. Through FamilyNet, DSS is able to share certain information with other state and federal agencies, including the Office of Medicaid, the Department of Transitional Assistance, the Department of Revenue, the Department of Education, the Department of Early Education and Care, the Office of the State Comptroller, HR/CMS system, the court system, and the federal Children's Bureau within the US Department of Health and Human Services.

The use of Structured Decision Management (SDM), a risk management tool, is discussed in detail below in the section on Risk Assessment. This database could complement FamilyNet and provide sophisticated risk assessment and data collection tools. With its adoption of SDM, the agency will have even more data at its disposal for decision-making purposes and as well as for departmental evaluation purposes.

FamilyNet has 4 modules—2 client/server modules and 2 web-based modules. In addition to DSS staff, hospitals and organizations contracted with DSS use FamilyNet to provide case management, service coordination, service delivery and revenue management services. Lead agencies and regional resource centers have access to limited information for cases directly assigned to their organization. Hospitals and direct service providers access information about those consumers they are serving and not information about other case members or case history or activity.

Still, concerns have been raised about the amount of information to which lead agencies have access. The union has claimed that lead agency personnel have access to all DSS information. This claim runs counter to the database structure described above and counter to the promise of confidentiality made to DSS families. (Note: DSS requires anyone accessing FamilyNet to agree to confidentiality restrictions.)

There is a question about what additional information lead agencies or other private service providers are collecting about families that may not be recorded in FamilyNet and may be unavailable as DSS social workers make decisions about the children and families for which they are responsible.

Registry of Alleged Perpetrators

The Department of Social Services does maintain a registry of alleged perpetrators, pursuant to 110 CMR 4.36. The following information is included in the registry: name, date of birth, social security number, gender, address, date of listing, allegations, victims and relationship to the victims. The registry is used during screening and investigation stages to determine if there has been any earlier involvement with the Department of Social Services.

Information Sharing & Privacy Laws

In the context of child welfare, records management and information sharing is inextricably tied to confidentiality and privacy concerns. There is debate in legal and child welfare circles about the impact of privacy laws on the reporting of child maltreatment. There are concerns that certain confidentiality laws have been interpreted so broadly that they unnecessarily restrict critical information sharing.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes a privacy rule that prohibits the unauthorized disclosure of certain individually identifiable health data, referred to as protected health information. HIPAA governs the security and privacy of protected health information, giving the patient certain privacy rights and more control over how their medical information is used and disclosed. In child protection cases, personal patient health data may provide valuable insights and support quality decision making by child welfare workers. For that reason, an exemption is allowed so hospitals and other medical organizations can disclose personal patient health data in cases of suspected child maltreatment without acquiring authorization to do so.

> "HHS has provided exceptions to make clear that health care providers suspecting child maltreatment still must report it. The exceptions, however, more clearly exempt disclosure of certain child victim records than they do physical or mental health information pertaining to perpetrators of child maltreatment, parents of child maltreatment victims generally, other adults or children in the child's home, or prospective adult caretakers (e.g., foster or kinship care providers). Therefore, it is important that those seeking health information on such adults for child safety-related purposes become familiar with HIPAA privacy protections generally, as well as the scope of the exceptions."[61]

The American Bar Association's Center on Children and the Law tells us, while there are some ambiguities and conflicts, HIPAA addresses cases of abuse and neglect:

- HIPAA does not inhibit reporting of child abuse and neglect;
- HIPAA supports disclosures of health information for public health prevention, surveillance, investigation, and intervention activities;
- HIPAA provides protections for child victim health information, but disclosures can still be made with victim consent or where necessary to prevent serious harm to them or other potential child victims;
- HIPAA gives courts, law enforcement agencies, and those determining the cause of child deaths the ability to access relevant health information; and
- HIPAA protects child victim health information from being disclosed to parents or other adult representatives when disclosure would be contrary to the child's best interests.[62]

In addition to the explicit exemption, the privacy rule defers to state law on the disclosure of protected health information, which should mean that HIPAA does not impact the reporting of child maltreatment.

Trust is an important aspect of most of the professional relationships mandated reporters have with their clients. Confidentiality is a critical element in any trusting therapeutic relationship (e.g., doctor-patient or therapist-client). It has been theorized that some mandated reporters are resistant to reporting suspect child abuse or neglect because of the damage it would do to the therapeutic relationship.

Under Massachusetts law, communications between a social worker and a client are confidential.[63] Privileged communications are also allowed in doctor/patient relationships, in psychotherapist/patient relationships, and in the confessional between priest and penitent, for example. There are exceptions to these rules. In addition to exemptions to protect the safety of the client or others, there is an explicit exception to the confidentiality rule if it is to report suspected child abuse or neglect[64] or to initiate or give testimony in court proceedings related to the care and protection of children.[65] Still, Massachusetts is known for having the strongest privacy laws. The rules particularly governing information collected in reference to child abuse and neglect would be reexamined to determine whether they help or hinder in process of protecting children. DSS officials have acknowledged the state's limitations in providing protective alerts to other jurisdictions.

In 1988, legislation drafted by the Commission of Violence Against Children and filed by then Senator Peter Webber and others (S.605) addressed this limitation and other child protection needs, but the bill remained in the Senate Ways & Means Committee for the remainder of the year and was not enacted. A review of the legislation is warranted.

6. DSS Critiques

The Committee was asked to examine the capacity of DSS to critique itself and respond to criticism. The House Post Audit case study, which investigated one particular case, raised questions about the agency's capacity to uncover and deal with alleged habitual abuse and neglect over a long period of time. The case study recommended that DSS establish an audit unit that reviews processes and cases and reports directly to the DSS Commissioner. It also recommended that the agency staff this audit unit with persons qualified by education and expertise who can assess whether cases are being managed effectively and appropriately. Further examination from a global view indicates that DSS was already aware of the need for comprehensive self-examination.

Core Value: Committed to continuous learning.

One of the six core values guiding the work done by the Department of Social Services is a commitment to continuous learning. That commitment is embodied in several major DSS initiatives: Continuous Quality Improvement (CQI), Quality Service Reviews (QSR), and the Child Welfare Institute (CWI). By and large, these initiatives had their genesis in a reform effort that began over eight years ago.

Major Reform Effort

In 2002, a $1 million grant from the Marguerite Casey Foundation, working with Casey Family Programs, was awarded "[t]o support the Massachusetts DSS efforts to fundamentally revise the nature of its child welfare practice to incorporate a 'family-centered' approach at all levels of the organization."[66] The agency was to build upon a successful pilot initiative in the DSS Boston Region begun in 1999 with the Casey Family Programs.

A final report on the 3-year effort was issued in March 2006. Entitled "Gaining Momentum: Comprehensive Child Welfare Reform Takes Hold in Massachusetts", it best explains the scope of the reform undertaken and the efforts underway. Note: Working with Families Right From the Start is now known as the Family Engagement Model.

The Scope of Change

Lest one think DSS leaders, staff, and partners are only interested in surface changes, here is an overview of the new system they envision. Each of the following elements leads to new ways of working with children and families. Each aspect is intertwined with the others, so much so that alignment of policy and procedure and the pacing of change became two of the biggest dilemmas of the last two years. Elements include:

- Six core practice values against which everything is held.
- A planning and design process that includes participation by staff at all levels, as well as providers, community leaders, and families.
- Family Networks: A revised approach to DSS purchase and management of services in the community.
- Working with Families Right from the Start: A practice model that reframes the front end of the system, intake and assessment, and extends new values and practice throughout the life of a family's relationship with DSS.
- A series of teaming pilots in which social workers share caseloads and participate in group supervision.
- Family Group Conferencing in all area offices in the state.
- A system of Continuous Quality Improvement that embodies a commitment to use data as a learning tool.
- A pledge that no young people will be allowed to age out of the system without a permanent family or other long-term adult support.
- A Child Welfare Institute to develop ongoing training for staff, providers, and foster, adoptive, and birth families.

Continuous Quality Improvement & Quality Service Reviews.

Agreeing with the House Post Audit case study, DSS Commissioner Spence made the following comments: "[t]he Department does believe that there must be a profound renovation of child welfare practice. … the knowledge and experience necessary to reshape child welfare primarily lies with the child welfare community itself."[67]

In his observations on the House Post Audit case study, Commissioner Spence stated:

> "[B]ut the work of the Committee points to the need for a more concise, fine-grained assessment of the Department's child welfare practice. The investigators' detailed critique of the many micro-decisions that constitute practice in a single case yields important insights into the quality of practice. These insights could not be extracted from data alone."[68]

The Commissioner believes that, with Continuous Quality Improvement and Quality Service Reviews, these systemic weaknesses will be addressed.

Continuous Quality Improvement is the agency's overarching approach to quality assurance and systemic improvement. Each area office, each regional office and the central office have established a CQI committee, comprised of DSS staff, private providers, family members and community leaders. Initial work has been done to examine each office. More detailed reviews are underway in several pilot sites. Based on these reviews, a customized strategy will be designed to address identified strengths and weaknesses for each particular office and that strategy will be monitored for its effectiveness.

Quality Service Reviews allow for a formal review of individual cases in a systematic, independent fashion. The reviews monitor the quality of services and are intended to continually improve outcomes for children and families. Randomly selected cases are extensively examined by teams from outside the office being reviewed. These independent teams include social workers, supervisors and managers from DSS and provider agencies, as well as parents of children being served by DSS. The process follows a precise standard protocol and involves both record review and interviews with key stakeholders, including the child, family members, relatives, school officials, foster parents and service providers. The review specifically looks at the status and well-being of the child in the most recent 60 days. It results in ratings of key elements of child welfare practice, including the core functions of screening, investigation, family engagement, assessment and service planning and coordination.

Both CQI and QSR are still in their infancy. Their ability to qualitatively and quantitatively measure the effectiveness of DSS practices will need to be monitored over time.

7. Law Enforcement Involvement

The Committee was asked to examine the role of law enforcement, including local police and the district attorney. As already stated, when a child is seriously hurt as a result of abuse or neglect, there may be criminal consequences for the perpetrator.

Over the last five fiscal years, 22,062 such cases were referred by DSS to the DAs, an average of about 4,500 each year. In 46% of the cases the referral to the DA was mandated by state law; but the majority of cases (54%) were discretionary referrals by DSS. The vast majority of mandatory referrals were for sexual abuse (79%), followed by physical abuse (20%), and then death (1%).[69]

Partnering with DSS, district attorneys use child advocacy centers to minimize the trauma to children and families when allegations of abuse and neglect rise to the level of criminal investigation. These interagency, public/private partnerships coordinate investigations and assessments "with clinical and legal competence in an atmosphere that is safe and respectful of each family's culture."[70]

Commenting on his office's relationship with DSS, Essex County District Attorney Jonathan Blodgett remarked that his office has a "highly effective relationship" with the local DSS area offices. However, he does express concern about the need for early involvement of the district attorney's office and local law enforcement in those cases where serious physical or sexual abuse is alleged. In the past, delayed notification has affected criminal investigations and prosecutions because witnesses and potential suspects were not interviewed immediately after the incident. District Attorney Blodgett, who heads the Massachusetts District Attorneys Association, recommends that local DA offices be involved with DSS at the screening process so that those cases of serious physical and sexual abuse are immediately identified and appropriate steps are taken to ensure that criminal prosecutions can proceed.

In some cases, there is a tension between law enforcement and social workers about how to proceed in cases of child abuse and neglect.

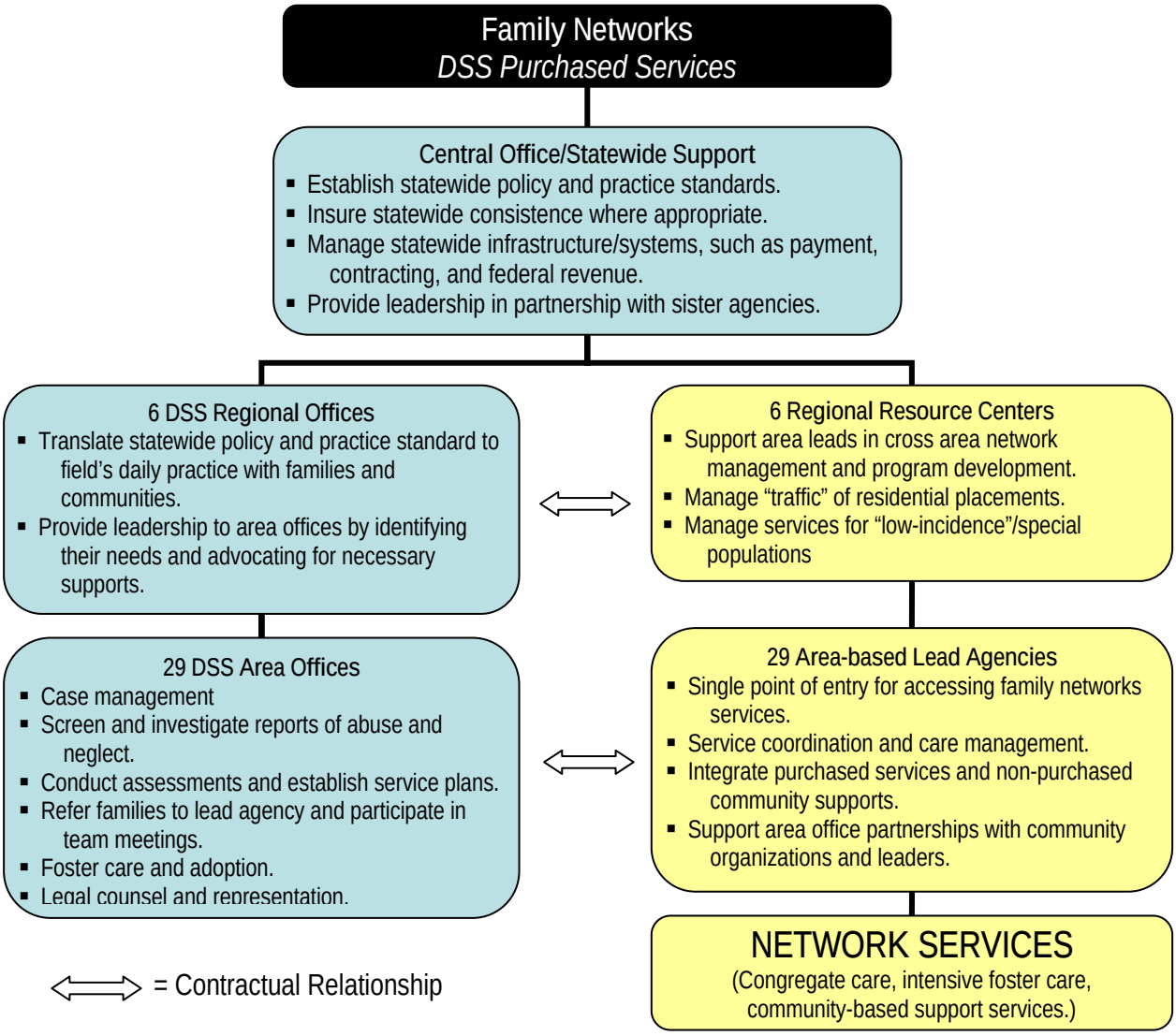
Speaking before this Committee on behalf of the Massachusetts Chiefs of Police Association, Chief Thomas O'Loughlin of the Milford Police Department seconded many of the district attorneys' concerns. He expressed an interest in revising the statutory reporting requirements so that local law enforcement is notified early on about physical harm to a child. The current standards allow for immediate law enforcement in the case of death, sexual assault or exploitation, brain damage, loss or substantial impairment of a bodily function or organ, substantial disfigurement or other serious physical injuries such as broken bones or severe burns. The chiefs of police expressed concern that this standard is too high and places the burden on the child. They suggest adapting two mechanisms already successfully used by law enforcement. The model used for cases involving sexual abuse—the Sexual Assault Intervention Network (SAIN)—could be adapted to include physical abuse as well. Chief O'Loughlin also pointed out that domestic violence protections, available under M.G.L. chapter 209A, should also be provided to child victims of abuse when the abuse is caused by a family member. In addition, the chiefs recommend that the DSS investigatory period be extended at the request of law enforcement when the alleged abuse and neglect is a criminal matter.

8. Private Providers

The Committee was asked to examine the role of private providers, including therapists and medical personnel. Discussions have centered on the move to Family Networks, with its lead agencies, and well as how well the Division of Medical Assistance (through MassHealth and the Massachusetts Behavioral Health Partnership) manages the provision of services for DSS clients.

Family Networks, Lead Agencies & Regional Resource Centers

Family Networks are managed by 29 lead agencies who work with the 29 DSS area offices to provide DSS clients with access to so-called Network Services—traditional and non-traditional support, management and resource services—for DSS clients in communities across the state. According to DSS, the cost of lead agencies is about $14.3 million and the cost of services is about $300. While DSS provides case management, lead agencies provide care management.[71]



Simply put, a lead agency is the area-based, single point-of-entry, non-profit contracts with DSS to assist the agency and its families to determine the type, intensity and duration support services needed and to recommend the program(s) the family will utilize. Through Family Team Meetings, the lead agency brings together DSS and the family to assess service needs, develop service plans and review treatment progress. Network services include congregate care, intensive foster care, and community support services. To support a diverse network, lead agencies are only allowed to provide up to 20% of these network services themselves under their DSS contract.

In the past, DSS had referred children in need of services to a limited collection of residential providers and had limited access to community-based services.[72] The move to the Family Networks model was driven, in part, by the decision to provide more services in the community rather than in costly and sometimes inappropriate residential facilities.

Building upon successes from its use of a lead agency model to purchase family-based services in 2000, a review of these old procurement processes began in September 2002; the new procurement process was first used in November of 2004; and the Family Networks model was implemented in July 2005. An initial round of negotiations is complete, new proposals are currently being evaluated by DSS, and the process will continue through the current bid cycle which ends in 2015.[73] Given its newness, it is difficult to evaluate its effectiveness.

Complementing the 29 lead agencies are 6 regional resource centers that work with DSS regional offices. These non-profits contract with DSS and provide access to residential programs, program development, cross-area coordination and management of low-incidence, special populations.

The lead agency model is supposed to be a cost-effective way of coordinating and providing services. It is intended as a means of developing and managing an integrated network of support services designed to meet individual needs in a community setting. Lead agencies have an instrumental role to play in the shift from residential to community services—they must identify gaps in service and support the development of community-based programs to fill those gaps and create a continuum of care.

Of course, questions have been raised and complaints have been made about the Family Networks model. Most questions are about lead agencies: how they work, their cost-effectiveness, and their scope and power. Legislators are concerned about adequate oversight. The union has alleged that the lack of space in DSS area offices has been given as a reason for not hiring new social workers; but instead lead agency staffers are sitting in area offices where the new DSS social workers would sit if they were hired. Lead agencies have wondered aloud how they are to provide the services asked of them under their approved budgets. Concerns have been raised anecdotal stories of the family's ongoing social worker, who is supposed to be providing case management, is being cut out of the process. Confusion has arisen about who's in charge: DSS or the lead agency? Basic questions about who is in charge and who is held accountable were met with varying answers. Questions remain about the capacity to transition from residential care to community-based services, and the overall cost of implementing the model.

MassHealth/MBHP

The Department of Social Services, the first line of defense for children at risk, is often the entry point for families who then access the services of other state agencies and programs, including the Department of Mental Health (DMH), MassHealth and the Massachusetts Behavioral Health Partnership (MBHP).

MassHealth is a program, run by the Division of Medical Assistance (DMA), that provides comprehensive health insurance—or help in paying for private health insurance—to nearly one million Massachusetts children, families, seniors, and people with disabilities. There is considerable overlap between MassHealth enrollees and DSS clients.

Similarly, the DSS and DMH clients access MassHealth services through the Massachusetts Behavioral Health Partnership. MBPH is the managed care company whose specific purpose is managing the mental health and substance abuse services for approximately 400,000 MassHealth enrollees. Many MBHP members are in the care or custody of state agencies. About 3,500 uninsured Department of Mental Health clients also receive limited services through the partnership. About 230,000 children age 18 or younger are MBPH members—half of the partnership's enrollees. Among them are children in the care and custody of DSS, children adopted through DSS, and children committed to the Department of Youth Services (DYS).

The Collaborative Assessment Program (CAP), a program jointly sponsored by DSS and DMH with the help of DMA, provides a single point of entry into DSS and/or DMH services for youth who have serious emotional disturbances and are at risk of residential placement.

The Committee found that there is a lack of oversight of authorized expenditures by MassHealth due to a lack of sufficient communication and information-sharing between other agencies and MassHealth about DSS clients.

9. Risk Assessment

The Committee was asked to examine the capacity to handle high-risk children. If DSS makes a mistake in low to moderate risk cases, the consequences are troubling to be sure; but they are not as disturbing as in high-risk cases. The child and the agency may be caused irreparable harm. Every headline-grabbing case increases the liability of the agency and interferes with its capacity to do essential day-to-day functions and its ability to reform itself from within.

DSS argues that the Family Engagement Model will be better than the current model for assigning and managing risk. Central to its risk assessment is the use of differential response. High risk cases would proceed down the protection pathway, with an expanded screening period, followed by 10 days of investigation. This new model reaffirms what is true under the current model—fully informed judgments during the screening process are essential. Risk assessment tools are designed to aid child protection workers in making critical child safety decisions and classifying children and families according to the level of risk of abuse or neglect. The use of a sophisticated risk assessment tool, combined with seasoned judgments made by qualified social workers, is essential.

DSS, like child protection agencies in many other states, has used risk assessment in one fashion or another to increase the consistency and accuracy of its decision making. Massachusetts is currently investigating Structured Decision Making (SDM), the leading risk assessment tool in the field of child welfare. Currently, at least 20 jurisdictions in the United States, including 11 states,[74] and others in Australia use SDM to inform child welfare decisions and reduce future harm to children. NOTE: DSS distinguishes between safety (current possibility of harm) and risk (future possibility of harm), but the term "risk assessment" is generally used to mean both current safety concerns and future risk.. For example, SDM is called a risk assessment program but it recognizes the aforementioned distinction between safety and risk and analyzes both current and future maltreatment.

Structured Decision Making is an integrated case management system used by child protection workers to collect relevant information in a consistent manner, to assess the child's situation more accurately and to make sound decisions about the future of the child. SDM provides tools to help determine risks, prioritize responses, target resources, monitor cases and identify long-term permanency options. It also allows for effective monitoring of compliance with an agency's policies and procedures. Its ultimate goal is to reduce subsequent harm to children. Research indicates that it is more successful than other tools in doing so. Families assessed under SDM are less likely to reappear in the child welfare system, are more likely to be treated equally due to reductions in ethic and racial bias, and those at higher risk are more likely to be properly identified and provided with effective support services.[75]

SDM, the only actuarial risk assessment tool for child welfare, has been developed by the Children's Research Center—an arm of the National Council on Crime and Delinquency. The data-driven, research-based program includes the following components for child protective services:

- Screening Criteria: to determine whether or not the report meets agency criteria for investigation.
- Response Priority: which helps determine how soon to initiate the investigation.
- Safety Assessment: for identifying immediate threatened harm to a child.
- Risk Assessment: based on research, which estimates the risk of future abuse or neglect.

- Child Strengths and Needs Assessment: for identifying each child's major needs and establishing a service plan.
- Family Strengths and Needs Assessment: to help determine a family's level of service and guide the case plan process.
- Case Planning and Service Standards: to differentiate levels of service for opened cases.
- Case Reassessment: to ensure that ongoing treatment is appropriate.

More than 20 years in development, SDM is a unique and powerful instrument with a proven track record. Every child welfare assessment under SDM becomes part of the collective knowledge and informs future decision-making. Depending on the needs of the jurisdiction, SDM can be tailored to work with its SACWIS system, known as FamilyNet in Massachusetts. The Children's Research Center claims that once implemented SDM becomes financially self-sustaining.

In his June 2006 observations of the House Post Audit case study, Commissioner Spence stated that:

> "Central to the success of differential response is the adoption by the child welfare system of reliable safety and risk assessment tools. The Department recently convened a conference on safety and risk assessment tools, involving the differential response design team, the Children's Research Bureau, sponsor of the most developed and thoroughly researched tool, Structured Decision Making, and Vermont and Ohio, states which have implemented this tool. We are discussing with the Children's Research Bureau how their tools might be customized to the needs of Massachusetts."[76]

Today, DSS has contracted with CRC to look at how its safety and risk tools can be adapted to fit the agency's core values of being family centered and strength based. SDM would be used for the Current Capacity Assessment conducted during the initial engagement phase of the Family Engagement Model. A decision on how to proceed is expected by June 30, 2007.

10. End-Of-Life Decisions

For children who may be been abused or neglected and whose lives are in the balance, there are two powerful agents of state government involved in the end-of-life decision-making process—the Department of Social Services and the judiciary.

DSS records indicate that, since October of 1993, there were 54 children in DSS custody for whom forgoing or discontinuing life-sustaining medical treatment (LSMT) was proposed. In the vast majority of cases (81%), the underlying medical condition was organic in nature (for example, birth defects or terminal illnesses). In 10 of those cases (19%), the underlying medical condition was the result of abuse or neglect. In the past three years, there have been eight children in DSS custody for whom forgoing or discontinuing life-sustaining treatment was proposed; in all but one case DSS supported the proposal in court.[77]

In terms of the more than 39,000 kids in DSS custody, the number affected by end-of-life decision-making by the state is quite small. But in the terms of the decisions being made about any one of these children, they are, without exaggeration, a matter of life and death.

State statutes, case law and DSS regulations and policies dictate the procedures that should be followed when a medical provider seeks consent to the end-of-life orders from DSS. [78]

End-of-life decisions for a child in DSS custody are ultimately made by the court.[79] DSS, however, does have an important role to play in gathering information from medical experts and interested parties and then formulating a recommendation about the child's treatment for the court.

A recent case, described in *Care and Protection of Sharlene*, 445 Mass. 756 (2006), illustrated DSS and judicial processes for end-of-life decisions and exposed some of the potential weaknesses inherent in such a difficult decision-making process.

On January 17, 2006, after hearing arguments on December 6th, the SJC reaffirmed the orders of a lower court approving both removal of life support and the issuance of a do-not-resuscitate order in the case of cardiac or respiratory failure for a child "in an irreversible vegetative state."[80] The court stated that "[t]he medical evidence is incontrovertible—the child is in a persistent vegetative state and there is no medical treatment in the foreseeable future that can restore her cognitive abilities."[81] According to news reports, the day after the SJC issued its opinion, doctors caring for the child told DSS that there were signs of improvement. Today, this child is reported to be in a rehabilitation hospital, but the details of the child's condition are under a gag order.

In the wake of this case, DSS most recently developed a LSMT protocol which the committee endorses and recommends its codification in statute.

The role of DSS

DSS does not give consent to extraordinary medical treatment—such as "no code" orders or orders giving or withholding life-prolonging treatment, but the agency has a process by which it decides what recommendation, if any, it provides to the court. (Note that the treating physician makes such decisions if emergency circumstances exist.)

The current policy[82] of DSS regarding end-of-life decisions (or life-sustaining medical treatment) is as follows:

Step 1: The treating physician makes a written recommendation to DSS.

Step 2: DSS area staff, with the support of the medical services unit at DSS, is then responsible for obtaining:

- Information from interested parties, including the child (if appropriate), the child's family, the child's caretakers, educators, therapists and health care providers;
- A second opinion from a consulting physician with appropriate expertise who is not affiliated with the hospital at which the child is being treated and does not have a direct business or financial relationship with the treating physician; and
- A recommendation from the ethics committee of the treating hospital, after the committee considered the opinion of the treating physician and the second opinion.

[Note that the attorneys for the parties involved must be informed if such a decision is being completed. A family meeting may be held to discuss the child's situation.]

Step 3: The deputy commissioner of field operations and the general counsel at DSS review the input of interested parties, the medical opinions and the ethical recommendations and then formulate a recommendation for the commissioner.

Step 4: The DSS commissioner makes the final decision whether to seek a judicial order for end-of-life decisions or how to respond to such a court request filed by another party.

Step 5: If the commissioner decides to seek a judicial order, DSS must file a motion for appointment of a guardian ad litem to investigate the request and report back to the court, and request that the court, using a substituted judgment standard, make the decision whether to approve the order.

Step 6: If the court orders end-of-life treatment, DSS area and legal staff document the existence of the court order in the child's health and legal FamilyNet (computerized) records, place the order in the child's case record and legal file and distribute the order to appropriate persons inside and outside of the agency.

Note: If a child's condition changes after the issuance of such an order, DSS policy is to contact the treating physician to discuss whether the order should be reviewed and, if so, to ask the medical services unit at DSS to initiate such a review.

The role of the court

The government—this time, the judiciary—has another important role to play in end-of-life decision making. The court applies the "substituted judgment doctrine" when making end-of-life and other medical decisions for incompetent persons. In doing so, the court attempts to determine what the incompetent person would do under the circumstances if he were competent.

Care and protection proceedings are closed under G.L. c. 119, § 38; therefore, end-of-life hearings for children in DSS custody are closed. In a 2006 decision, the Supreme Judicial Court cites § 38 in rejecting a request to open such a hearing to the public; however, in a concurring opinion, Justices Spina and Cowin recommended a legislative reexamination of the statute as it relates to end-of-life proceedings.[83] Justice Spina wrote that "[t]he need for open proceedings is particularly compelling where an agency of the executive branch of government seeks to persuade the judicial branch of government to withdraw life support. Decisions of this gravity, made with this concentration of government involvement, should be made in public."[84]

To encourage increased public awareness about the state's procedures in end-of-life matters affecting children in their custody and to encourage discourse with the legislature if the DSS decides to make significant changes to its policy, the committee recommends codifying the guiding principles of DSS policy, such as (1) the necessity of a second opinion, (2) the necessity of a hospital ethics committee recommendation and (3) the role of the commissioner as the final decision-maker for DSS recommendation to the court.

Note: There is currently no legislation before the General Court that explicitly responds to Justice Spina's call for open proceedings. One of the attorneys involved in the Sharlene case proposes other changes for end-of-life cases: (1) the burden of proof should change from a "preponderance of the evidence" to "beyond a reasonable doubt"85, (2) a mandatory stay and an automatic appellate review of a lower court's order should be imposed, (3) either counsel for the child or the GAL should argue for life, and (4) such hearings should be held in superior court or before specialized judicial panels.

Glossary of Key Terms

To talk about child abuse and neglect in Massachusetts, it is critically important to understand some of the key terms because they have specific meaning in the DSS world. It is

- 51A Report – a report of suspected abuse or neglect submitted orally or in writing by mandated reporters or others (under M.G.L. 119, § 51A).
- Assessment – If after an investigation a 51A report is supported, DSS social workers conduct an in-depth assessment over 45 days.
- Family Engagement Model (FEM) – the family-centered child welfare practice that uses differential response to handle reports concerning child abuse or neglect.
- FamilyNet – the DSS database system that includes all DSS activities with a family.
- Family Networks – the redesigned procurement of services for DSS clients.
- Lead Agency – one of 29 private providers matched with DSS area offices to manage and provide access to support services for DSS families through Family Networks.
- Investigation – If a 51A report is screened in, DSS social workers conduct an investigation, which include a home visit to determine whether the allegations should be supported. Ten days are allowed to conduct the investigation, but the actual investigation itself takes about 2.5 days. However, emergency investigations are to be completed within 24-hours.
- Regional Resource Centers - one of six regionally based private providers who coordinate cross-area management of Family Network services.
- Screening – The initial process of immediately reviewing a 51A report (oral or written) to determine whether it meets DSS criteria for child abuse and neglect.
- Social worker – in the context of DSS, social workers are the direct-service, frontline case workers. Involved in screening, investigations, assessments and ongoing case management.
- Supervisor – in the context of DSS, a supervisor is the individual who manages the direct-service, frontline social workers.

There are various charts in the body of the report compare how DSS works today and expected to work in the future.

[1] Hearings were held on January 25, 2006, January 30, 2006, February 6, 2006, and February 28, 2006. Public comment was received during the hearings and via email. These hearings were also the first attempt by the House at web casting public hearings. The web cast is available on the General Court's website at: www.mass.gov/legis.
[2] www.mctf.org
[3] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. Child Maltreatment 2004 (Washington, DC: U.S. Government Printing Office, 2006).
[4] Massachusetts Department of Social Services.
[5] Ibid.
[6] U.S. Advisory Board on Child Abuse and Neglect. (1995) A Nation's Shame: Fatal Child Abuse and Neglect in the United States: A Report of the U.S. Advisory Board on Child Abuse and Neglect. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information.
[7] www.mass.gov/dss
[8] "51A" refers to M.G.L. c. 119, § 51A, which describes the state's reporting requirements for suspected child abuse and neglect.
[9] www.mass.gov/dss. Accessed 1/18/2007.
[10] Guide to a Proposed Practice Model for WWFRFS, Fall 2005. p. 8.
[11] DSS annual reports. (Children In Placement – Initial Contact/Intake = 51A)
[12] Family Engagement Model Design Overview, December 5, 2006. p. 30.
[13] DSS Quarterly Reports,
[14] U.S. Advisory Board on Child Abuse and Neglect, 1990.
[15] Guide to a Proposed Practice Model for WWFRFS, Fall 2005. p. 8.
[16] http://cbexpress.acf.hhs.gov/nonissart.cfm?issue_id=2002-04&disp_art=450&hlt=1&terms=Massachusetts.
[17] http://www.cwla.org/articles/cv0109sacm.htm. Visited March 28, 2007.
[18] Saunders D, (1993) Husbands who assault: Multiple profiles requiring multiple responses. In N.Z. (Ed>) Legal responses to wide assault Newbury Park, CA.: Sage Straus, M. (1983) Ordinary violence, child abuse and wife-beating: What do they have in common? In D.Finkelhor, G Hotaling, and M. Straus, (Eds.) The Dark Side of Families: Current Family Violence Research (pp213-234) Beverly Hills:Sage.
[19] Ibid.
[20] 2002 study entitled "Caregiving from First to Second Generation
[21] M.G.L. c. 119, s. 1.
[22] Gaining Momentum, p. 3.
[23] Testimony of Sania Metzger of Casey Family Services. 2-6-2007.
[24] Ibid.
[25] http://www.socialworkers.org/pressroom/features/issue/diversity.asp. See also http://www.cwla.org/programs/culture/default.htm.
[26] http://www.michigan.gov/dhs/0,1607,7-124-5458_7691_7752-63242--,00.html. Visited 2-7-2007.
[27] http://www.mass.gov/?pageID=ocamodulechunk&L=4&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Social+Workers&sid=Eoca&b=terminalcontent&f=dpl_boards_sw_esl_accommodations&csid=Eoca ESL for exam.
[28] The statutory reference for CORI is G.L. c. 6, § 167-178B. Also see http://www.lawlib.state.ma.us/farqcrimrecord.html (CORI legal pathfinder).
[29] Analysis of DSS Quarterly Reports and supplementary materials.
[30] DSS regulations. 110 CMR 4.21.
[31] Ibid.
[32] www.childwelfare.gov. Accessed 1/29/2007.
[33] The Home for Little Wanderers does require mandated reporter training for new hires in their foster care programs.
[34] http://www.rcab.org/Administration/Policy/HomePage.html. Visited 3-12-07.
[35] http://magazine.uchicago.edu/0106/features/children.html. Visited 3-28-2007.
[36] Need cite.
[37] http://www.child-protection.org/ - Children's Hospital Child Protection Program. Visited 3-13-07.
[38] Frivolous reports are likewise punishable by a fine of up to $1,000.
[39] School settles in sexual-abuse negligence case. Boston Globe. 8-8-1990.
[40] Groton's Guilt. The Lowell Sun. 4-26-2005. Groton School Fined in Abuse Case, The Lowell Sun. 4-26-2005.
[41] Report to Governor Mitt Romney from the Special Panel for the Review of the Haleigh Poutre Case. 3-20-2006.

[42] AP story, Denise Lavoie, 3-23-2007.
[43] http://www.cswe.org/CSWE/. Visited 3-12-2007.
[44] The Board of Registration of Social Workers is established in M.G.L., c. 13, §§80-84. M.G.L. c. 112, §131. 258 CMR 9.02. Social work students and those with applications pending may also practice without a license. In Fiscal Year 2005, the Board received 39 complaints and resolved 27 complaints from this and previous fiscal years. The Board held one investigative conference. The Board entered into one consent agreement, revoked one license, issued one suspension, and placed two licenses on probation.
http://www.mass.gov/?pageID=ocamodulechunk&L=4&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Social+Workers&sid=Eoca&b=terminalcontent&f=dpl_consumer_press2006_sw_2006_05_25&csid=Eoca. Visited 3-12-2007.
[45] DSS: Social Work License Status, Q2SFY2007. MA DSS CQI Databook – Statewide/Quarter1, FY'07, p. 26.
[46] M.G.L. c. 112, §131, §136. 258 CMR 12.01 et seq.
[47] The Association of Social Work Boards (ASWB) is the association of boards that regulate social work. ASWB develops and maintains the social work licensing examination used across the country, and is a central resource for information on the legal regulation of social work. From http://www.aswb.org/ 2-15-2007. ASWB processes social work licensing applications on behalf of the Massachusetts Board of Registration of Social Workers.
[48] M.G.L. c. 112 § 136. 258 CMR 9.09.
[49] M.G.L. c. 112, §131. 258 CMR 9.02.
[50] St. 1996, c. 151, § 564. They remained exempt from the continuing education requirements of other licensees.
[51] SEIU contract – the majority of DSS staff belongs to Bargaining Unit 8.
[52] http://www.salemstate.edu/collegerel/CRS-041123_child_welfare.htm. Visited 3-12-2007.
[53] See Supplemental Agreement Q covering Bargaining Unit 8 Employees at the Department of Social Services in the Collective Bargaining Agreement between the Alliance, AFSCME-SEIU, AFL-CIO, Bargaining Units 8 & 10 and the Commonwealth of Massachusetts. www.seiu509.org. Union contract, p. 94-98, @ 95.
[54] http://www.cwla.org/programs/standards/caseloadstandards.htm. Visited 3-16-2007.
[55] Union contract, p. 94-94 @ p 94.
[56] SEIU Local 509 "Only 18 Cases."
[57] Family Engagement Model Design Overview, December 5, 2006, p. 46.
[58] Gaining Momentum, p. 1.
[59] Awarded by the Ash Institute for Democratic Governance and Innovation at the John F. Kennedy School of Government at Harvard University.
[60] http://www.acf.hhs.gov/programs/cb/systems/sacwis/about.htm. Visited 3-24-2007.
[61] http://www.familyrightsassociation.com/bin/white_papers-articles/impact_of_hipaa_on_child_abuse.htm. Visited March 26, 2007. Also see http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf. Visited March 26, 2007.
[62] Ibid.
[63] M.G.L. c. 112 § 135A. Also see, 258 CMR 22.00 et seq.? for Board of Registration rules and regulations on confidentiality of client communications and records.
[64] M.G.L. c. 119, § 51A.
[65] M.G.L. c. 112 § 135A.
[66] http://www.caseygrants.org/documents/reports/2002_december_grantees.pdf. This follows a pilot initiative for more foster care in the DSS Boston Region, begun in 1999 with the Casey Family Programs.
[67] Observations on the Report of the Committee on Post Audit and Oversight of the Massachusetts House of Representatives, written by DSS Commissioner Harry Spence, p. 2.
[68] Ibid, p. 14..
[69] DSS Quarterly Reports,
[70] http://www.mass.gov/dasuffolk/cac02.html. Visited 3- 27-2007.
[71] Email response from DSS. Sent 3/21/2007.
[72] Previously these services were known as: Commonworks, Residential Treatment, Group Homes, Contracted Foster Care, Family Based Services, Shelter. See p. 9. See Info for Educators p. 3.
[73] Email response from DSS. Sent 3/21/2007.
[74] SDM is used by California, Georgia, Michigan, Minnesota, Missouri, New Hampshire, New Mexico, Ohio, Rhode Island, Vermont and Wisconsin. WHAT ABOUT INDIANA and ALASKA NEW YORK???
[75] http://www.nccd-crc.org/crc/c_sdm_about.html
[76] Observations p. 11.
[77] Email response from DSS. Sent .3-20-2007.

[78] See *Superintendent of Belchertown State School v. Saikewicz* ,373 Mass. 738, 370 N.E.2d 417 (1977) (enunciated the "substituted judgments" test), *In the Matter of Earle A. Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980), and *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982) .110 CMR 11.00 governs medical authorizations, including no-code orders (11.12), life-prolonging medical treatment (11.13), and legal proceedings (11.18).

[79] For the purposes of end-of-life decision-making, a child in DSS custody excludes those involved in a voluntary placement agreement or in CHINS custody.

[80] *Sharlene*, 445 Mass. 756, 757.??

[81] Ibid, p. 770.

[82] Attached is the draft policy (dated 11-14-2006) for *Forgoing or Discontinuing Life-Sustaining Medical Treatment*. The policy was approved by EOHHS and DSS executive staff and is currently in use. As of 2-22-2007, it awaits approval by Local 509.

[83] See *Care & Protection of Sharlene*, 445 Mass. 756, 840 N.E.2d 918 (2006).

[84] *Sharlene* at 775.

[85] See *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982). See pages 711-713.

FORGOING OR DISCONTINUING LIFE-SUSTAINING MEDICAL TREATMENT

Overview

Among the most difficult situations that can occur during DSS involvement with a family are those in which a child's health is so severely compromised that a decision must be made about the appropriateness of forgoing or discontinuing life-sustaining medical treatment (LSMT). According to the American Academy of Pediatrics, LSMT encompasses all interventions that may prolong the patient's life, such as cardiopulmonary resuscitation, respiratory and circulatory support, and artificially administered nutrition, hydration and medications. The following describes the process to be followed when a medical provider or the Department believes that the medical situation of a child who is in DSS placement requires decision-making regarding such interventions, including seeking a judicial action to forgo or discontinue LSMT.

DSS regulations (110 CMR 11.12) do not permit the Department to make a decision about whether to forgo or discontinue LSMT, such as by ordering that a child in its custody not be resuscitated. A parent makes this decision when the child is in DSS placement due to a Voluntary Placement Agreement or CHINS custody, and a court makes the decision when the child is otherwise in DSS custody.

Any DSS request for a court order must begin with a written recommendation to the Department by a treating physician that outlines the specific medical interventions that she/he believes should be withheld or withdrawn and the medical rationale. To determine the action it will take, the Department supports a thorough exploration of the child's situation and best interests in several ways by:

- working with the family,
- obtaining a second opinion from a consulting physician with appropriate expertise who is not affiliated with the hospital at which the child is being treated and does not have a direct business or financial relationship with the treating physician (hereinafter referred to as the "second opinion physician"), and
- obtaining a recommendation from the Ethics Committee of the treating hospital.

When the child is in DSS non-CHINS court custody, it is the Department's responsibility to gather information from these sources as well as from the family of the affected child, the child herself/himself (when cognitively and emotionally appropriate), other health providers, therapists, educators, caretakers and others who are involved with the child, and formulate a recommendation on whether to pursue a judicial order. The Department's final decision to pursue the judicial order is made by the Commissioner, in consultation with the Deputy Commissioner of Field Operations and General Counsel. The Department may seek additional perspectives from medical, ethical and legal experts at many junctures throughout the process.

IMPORTANT: *In those rare circumstances when a child's medical situation requires immediate decision-making regarding forgoing or discontinuing LSMT, the Department recognizes that the treating physician must use her/his best medical and ethical judgments on whether ongoing resuscitative efforts are medically indicated for the child, including a child who is in DSS custody. It is not the intention of this policy to interfere with or impede a physician who faces such a medical emergency, or to replace the medical community's routine expectations regarding such judgments and how they are made and reviewed.*

Family Roles in the Process

The Department endeavors to inform **both parents** of a situation in which an order to forgo or discontinue LSMT is being considered. The child's legal status affects the parents' and Department's specific roles in decisions regarding forgoing or discontinuing LSMT as described below.

Children in Placement Due to VPA or CHINS Custody. If decisions are required regarding forgoing or discontinuing LSMT for a child who is in placement due to a Voluntary Placement Agreement or CHINS custody, *only* a parent can consent. The Department arranges for parents to be informed as soon as it learns of any situation that requires such a decision to be made, and provides support to the parents. If no parent is available or able to make decisions regarding medical treatment, the Clinical staff must contact the Legal staff to discuss how the situation will be addressed.

Children in Non-CHINS Court Custody. When the child is in DSS non-CHINS court custody, parents are informed that the Department, along with other entities (such as the physician, hospital or parents themselves), has authority to proceed with a request to obtain an order regarding forgoing or discontinuing LSMT. Most courts request information about the parent's wishes, regardless of the child's placement circumstances. Parents are encouraged to express their wishes about the request and ask questions. Efforts to inform include contacting incarcerated parents and those who are out of state when contact information is available.

If the Department determines that contacting a parent might pose a danger to the family, a safety plan is developed. The Department is not required to inform a parent that a decision regarding forgoing or discontinuing LSMT is needed if the parent's rights have been terminated. Whether or not the Department does inform the parent depends upon such issues as the child's adoption placement status and whether the parent continues to maintain positive contact with the child. *Please NOTE: A post-termination agreement may exist between the biological parents and the Department that will govern the sharing of information about forgoing or discontinuing LSMT.*

Even when parents have legal interests that directly conflict with the child's (e.g., when the child's health has been compromised by the actions or inactions of the parent), the Department may inform parents that an order to forgo or discontinue LSMT is being considered. This may occur in the context of the parents' legal case, and DSS Legal staff should advise the Department how to proceed in these situations. The opportunity for parents to express their wishes may be critical to their emotional adjustment and that of other children in their care. It is possible for many reasons that parents may hold wishes that appear to conflict with the child's best interests; however, they should still be allowed to express these wishes, even if the court may rule against them or they will be unable to participate in court.

Children are considered able to make judgments about their own orders to forgo or discontinue LSMT, unless the treating medical or mental health providers determine that they are likely to suffer physical or psychological harm as a result of discussing the issue or there is a concern that they are not cognitively competent to adequately consider what is being proposed. If the treating medical providers believe that the child is able and competent to do so without risk of harm, the Department, with the assistance of the medical providers, informs the child that such an order is being considered and allows the child to express her/his wishes. Attorneys for all parties should be notified that such a decision is being contemplated.

For every situation, including those in which parental rights have been terminated but the child has not yet been placed with her/his adoptive family, the Department considers with the parents the value of convening a **family meeting**, involving kin if the parents agree, in which the child's treating physician, medical providers, the child herself/himself and her/his caretakers can discuss the child's situation and any recommendations. Any such family meeting must be convened in accordance with the Department's confidentiality requirements.

When discussing LSMT with a family, the Department takes extra care to keep in mind the Department's Core Practice Values. The Department should remain especially sensitive to the cultural or religious background of the family, which may strongly influence their response.

Procedures: Obtaining a Judicial Order to Forgo or Discontinue LSMT for a Child in DSS Non-CHINS Court Custody

When the health of a child is so severely compromised that consideration of forgoing or discontinuing LSMT is appropriate, either the treating physician or the Department may initiate the discussion. For the ***child who is in DSS non-CHINS court custody***, DSS requires:

- a written recommendation from the treating physician, using the form DSS provides, that specifies the LSMT she/he proposes to forgo or discontinue and the rationale for the recommendation;
- a written recommendation from a second opinion physician; and

- the recommendation of the treating hospital's Ethics Committee using the form that DSS provides. The treating physician's and second opinion physician's recommendations are provided to the Ethics Committee for their consideration.

The DSS Medical Services Unit supports the Area Office staff in obtaining the required information and conveys it to the Deputy Commissioner and General Counsel who review it and develop a recommendation for decision-making by the Commissioner, including that the Department may:

- advocate in court for the recommendation(s) made by the treating and consulting physicians and hospital's Ethics Committee;
- inform the court of its disagreement(s) with the recommendation(s) made by the treating and second opinion physicians and hospital's Ethics Committee;
- develop and present in court a modification of the recommendation(s) of the treating and second opinion physicians and hospital's Ethics Committee; or
- decide not to file a recommendation in court.

*[NOTE: As indicated above, when forgoing or discontinuing LSMT is being considered for a **child who is in DSS placement voluntarily or due to CHINS custody**, the parent makes the decision. DSS's role is to support them in this process. However, if the parent is unavailable or unable to make the decision, DSS Legal staff should be consulted.]*

Area Office Staff Responsibilities

[NOTE: In the procedures below, the term "manager designee" indicates someone other than a Social Worker or Supervisor who is a member of SEIU Local 509.]

1. **Initial Discussions Regarding a Decision to Forgo or Discontinue LSMT.** At a minimum, the Area Office staff contact the treating physician or medical provider to discuss the child's current medical status. The Area Office staff may also convene a meeting with parents and/or kin (if parents agree and DSS confidentiality requirements allow), the treating physician and/or medical provider to discuss the child's current medical status, diagnoses, treatment options, prognoses and recommendations regarding the forgoing or discontinuing of LSMT.
2. **Notification of DSS Staff.** As soon as a treating physician or medical provider informs DSS Area Office staff, or the DSS Area Office staff otherwise become aware that the child's physical condition may require decision-making regarding forgoing or discontinuing LSMT, the Area Director/manager designee verbally notifies the ***RD/manager designee, Regional Counsel/designee and Medical Services Unit***.
3. **Initial Information Provided to Medical Services Unit.** The Area Director/manager designee communicates the following information to the Medical Services Unit verbally and/or in writing:
    - the child's name, date of birth and the name(s) of the parent(s);
    - the child's current location;
    - name(s) and telephone number(s) of the treating physician and any other medical provider(s);
    - the child's current legal status;
    - the child's medical circumstances and the treating physician's recommendation, including a copy of the completed and signed Physician's Recommendation Form as soon as available;
    - whether the parents have been informed and their wishes with regard to the medical provider's recommendations. If a parent cannot be located or is unable to communicate her/his wishes, this should include an explanation of these circumstances and the efforts that were made to obtain information from her/him regarding the recommendations;
    - whether the child has been informed of the request, and if so, the child's wishes with regard to the treating physician's recommendations;
    - the status of arrangements to obtain the second opinion physician's written recommendation; *[NOTE: Procedures for obtaining a second opinion are described below.]*
    - whether a hospital Ethics Committee has reviewed the recommendations from the treating and second opinion physicians regarding forgoing or discontinuing LSMT, and if so, a copy of the completed and signed Ethics Committee Recommendation Form;

- the name and contact information for any GAL appointed for the child and any report from the GAL regarding forgoing or discontinuing LSMT; and
- the child's current placement if different from the child's current location.

4. **Required Submissions to Request Judicial Orders for Child in DSS Non-CHINS Court Custody.** The Area Director/manager designee arranges for the following to be submitted to the DSS Medical Services Unit:
   - the DSS form completed and signed by the treating physician detailing the child's diagnoses, treatment options, prognoses and the physician's recommendation regarding forgoing or discontinuing LSMT for the child, with any supporting medical information;
   - the DSS form completed and signed by the second opinion physician; and
   - the DSS form completed and signed by the Ethics Committee of the hospital where the child receives treatment, detailing the Committee's recommendation regarding forgoing or discontinuing LSMT for the child.
5. **Distribution of LSMT Order to Medical and Personal Care Providers.** Upon receipt of an order consented to by either a court or a parent regarding LSMT, DSS Area Office staff arrange for copies of the order to be provided to the emergency medical response team in the area in which the child resides, the foster parent or residential program (when applicable) and to all professionals involved with the care of the child (including the school, when the child is enrolled), and for a copy to be filed in the child's DSS case record.
6. **Documentation of LSMT Orders.** Area Office staff arrange for information about the LSMT order to be documented in dictation and the child's FamilyNet health record.

Legal Staff Responsibilities

1. **Legal Filings.** DSS Legal staff will be responsible for filing the applicable motions seeking an order to forgo or discontinue LSMT, if the Commissioner, in consultation with the Deputy Commissioner and General Counsel, determines that such an order is appropriate.
2. **Appointment of GAL.** If not already appointed, DSS Legal staff seek court appointment of a GAL.
3. **Review of GAL Report.** DSS Legal staff review any available GAL report that considers a Do Not Resuscitate (DNR) or other order to forgo or discontinue LSMT. If a GAL report is not available, the Legal staff discusses recommendations with the GAL and ascertains the GAL's position.
4. **DA Notification.** DSS Legal manager/designee notifies the District Attorney if information is obtained that the child's medical situation may be related to criminal activity and there is or previously has been a DA referral made by DSS related to the child's injuries or condition.
5. **Coordination with Medical Facility Legal Staff.** DSS Legal staff coordinate communications between the legal staff of DSS and the medical facility, if indicated.
6. **Coordination with Medical Provider and Other Clinicians.** If necessary, DSS Legal staff meet with the child's treating physician and other clinicians involved with the child's care.
7. **Distribution of Judicial Orders.** DSS Legal staff coordinate with Area Office staff to arrange for copies of any judicial order to be:
   - provided to the DSS Medical Services Unit, the medical facility, the foster/pre-adoptive parent, any other medical provider, school (as needed), emergency medical response team and other caretakers, and
   - placed in the child's DSS record.
8. **Documenting Judicial Orders.** DSS Legal staff arrange for information about the order to be documented in the child's FamilyNet legal record and place a copy of the order in the legal file for the custody case.

Central Office Staff Responsibilities

1. **Review of Request for Judicial Order to Forgo or Discontinue LSMT for Child in DSS Non-CHINS Court Custody.** The Medical Services Unit:

- assists Area Office staff in obtaining the written recommendations from the treating physician, second opinion physician and treating hospital's Ethics Committee, as needed;
- reviews for completeness the signed form from the treating physician (including any supporting medical information), the signed form from the second opinion physician, the signed form from the hospital Ethics Committee, and the information from Area Office staff;
- discusses the situation directly with the treating physician and/or other provider(s) if necessary; and
- forwards the request to the Deputy Commissioner.

2. **Review by the Deputy Commissioner and General Counsel.** The Deputy Commissioner and General Counsel review the request, in consultation with the treating physician or medical provider and any medical, ethical and/or legal experts if necessary, and develop a recommendation which they communicate to the Commissioner. They may convene a meeting to discuss the information and develop the recommendation.
3. **Review by Commissioner**: The Commissioner makes the final decision regarding any recommendation to be made in court, in consultation with the Deputy Commissioner and General Counsel and/or any medical, ethical or legal experts she/he determines necessary. The Commissioner's decision is forwarded to the Medical Services Unit.
4. **Communication of Commissioner's Decision.** The Medical Services Unit communicates the decision to the Area Office Clinical staff and Legal staff verbally and in writing.

Obtaining a Second Opinion from a Physician

The Medical Services Unit will assist in identifying physicians qualified to render a second opinion when a child's treating physician recommends decision-making regarding forgoing or discontinuing LSMT. Such a physician will not be affiliated with the hospital where the child receives treatment nor will she/he have a direct business or financial relationship with the treating physician.

Requesting Orders during Non-Business Hours

Recommendations to request an order to forgo or discontinue LSMT are most often *not* emergencies. There are few circumstances in which immediate action is necessary to meet the best interests of the child involved. Most recommendations that are received during non-business hours, including evenings, weekends, and holidays, can wait to be handled by the Area Office staff on the next business day.

If it is not feasible to wait until the next business day, the Area Director/manager designee should contact the Deputy Commissioner for approval to contact Legal staff with the request to obtain an order to forgo or discontinue LSMT. Under emergency circumstances, the Deputy Commissioner may attempt to arrange for a recommendation from a second opinion physician regarding the recommendation to forgo or discontinue LSMT. However, this should occur only in rare circumstances. The Medical Services Unit should be notified on the next business day regarding the recommendation and any actions that have been taken.

Children who Enter DSS Care or Custody with LSMT Orders

When a child whose health has been severely compromised enters DSS care or custody with an order regarding forgoing or discontinuing LSMT already in place, the Area Director/manager designee:

- obtains a copy of the order from the parent or physician,
- documents this information in dictation and the child's FamilyNet health and legal records,
- forwards a copy of the order to the Medical Services Unit and
- places the copy of the order in the child's record.

When such a child enters DSS placement due to a Voluntary Placement Agreement or CHINS custody, the parent(s)/guardian(s) maintains responsibility for any medical or legal decisions concerning LSMT. When such a child enters placement due to non-CHINS court custody, the Area Director/manager designee notifies the RD/manager designee, Regional Counsel/designee and Medical Services Unit as described in "Area Office Staff Responsibilities," Procedure 2 and Procedure 3, bullets 1 through 7, above. The Medical Services Unit will assist the Area Office in determining whether it will be necessary for the treating physician or anyone else to complete a review of the existing order.

DSS Responsibilities When Someone Other than DSS or a Parent Seeks an LSMT Order

In some situations, someone other than DSS or the parent will seek an order regarding forgoing or discontinuing LSMT on behalf of a child in DSS care or custody. When this occurs, the Area Office staff document in dictation the information received regarding such actions, arrange for the Medical Services Unit to be notified, and continue to communicate with the child's medical providers as appropriate to the child's legal custody status. The Department enters into legal action as deemed appropriate to meet its responsibilities for acting on behalf of the child's best interests, utilizing the advice of medical, ethical and legal experts, as necessary, to formulate its recommendation to the court.

Implementing the Order

Each situation involving forgoing or discontinuing LSMT is unique. The Department carries out each order according to the directives of the court.

Periodic Reviews of Active LSMT Orders

The child's health status and any order to forgo or discontinue LSMT that is in place are reviewed as part of the Foster Care Review. The Department also provides for an annual review by the Medical Services Unit to determine whether there is reason to re-evaluate the existing order. The Medical Services Unit sends the Physician's Recommendation Form to the Area Director/manager designee. The Area Director/manager designee requests that the child's treating physician complete and sign the form and submit it to the Medical Services Unit with supporting documentation if she/he chooses. The Medical Services Unit may request clarification from the treating physician or consultation from other physicians if necessary to make a decision. If the Medical Services Unit determines that updated recommendations are needed, the procedures described above for review of new proposals to forgo or discontinue LSMT are followed. If no further review is necessary, the Medical Services Unit informs the Area Director/manager designee, sends a copy of the form to the Area Director and files the completed form with the copy of the existing order.

Responding to Changes in the Child's Medical Situation

If a DSS manager learns of a change in the medical condition of a child who is in DSS custody for whom an order to forgo or discontinue LSMT has been issued, she/he contacts the treating physician for a medical recommendation regarding whether the change in the child's condition warrants a review of the existing order. If the treating physician believes that a review of the existing order is warranted, the DSS manager notifies the Medical Services Unit to initiate a review that follows the procedures above for periodic reviews.

Required Reconsideration When Anesthesia or Surgery is Required for Child for Whom a DNR Order is in Place

Anesthesia and surgery introduce additional risks for any patient and often necessitate medical interventions that may be precluded by an existing DNR order (e.g., intubation, mechanical ventilation). When either is considered for a child for whom a Do Not Resuscitate (DNR) order is in place, the American Academy of Pediatrics recommends that a required reconsideration of the order occur. The Department regards these as circumstances in which the child's medical situation has changed. When the child is in DSS non-CHINS court custody, the Department follows the procedures above for Annual Reviews to determine whether to seek an amendment of any judicial order for the surgical and immediate post-operative period.

Further Reference

For information regarding the death of a child who is in DSS care or custody, including organ donation, autopsy and funeral arrangements, see *Policy #90-002*, Responding to a Child Fatality.

Cost of Child Maltreatment in Massachusetts In 2004

Prepared by the Massachusetts Children Trust Fund

DIRECT COSTS

Hospitalization

Rationale: There were 5,441 children found to be victims of physical abuse in Massachusetts in 2004.[1] One of the less severe injuries is a broken or fractured bone. Average cost of treating fracture of a child's arm in MA in 2004 $12,105.[2] Calculation: 5,441 x $12,105

$65.9 million

Chronic Health Problems

Rationale: 30% of maltreated children suffer chronic medical problems.[3] In Massachusetts in 2004, there were 36,201 substantiated incidences of child maltreatment.[4] The average cost of treating a child with asthma in a MA hospital in 2004 per incident is $5,794. Calculation: .30 x 34,201 = 10,260; 10,260 x $5,794

$59.4 million

Mental Health Care System

Rationale: There were 36,201 substantiated incidences of child maltreatment in Massachusetts in 2004.[5] To keep this a conservative estimate, the 32,762 cases of neglect are not included. Counseling is one of the costs to the mental health care system and it is estimated that one in five children receive these services $2,860 per family.[6] Calculation: 36,201-32,762 = 3439; 3439 / 5 = 688 x $2860

$2.0 million

Child Welfare System

Rationale: About $617.4 million was spent on child welfare and protective services in Massachusetts 2003-2004.[7] NOTE: Administrative costs are not included.

$617.4 million

Law Enforcement

Rationale: The National Institute of Justice estimates the following costs of police services for each of the following interventions: child sexual abuse ($56), physical abuse ($20), and emotional abuse ($20).[8] Cross-referenced against Massachusetts' statistics on substantiated cases of each kind of abuse in 2004.[9] Calculations: Child sexual abuse 1,067 x $56 = $59,752; physical abuse 5,441 x $20 = $108,820; emotional abuse 90 x $20 = $1800

$170,372

Judicial System

Rationale: The estimated cost per initiated court case of child maltreatment is $1,372.34 and about 16% of child abuse victims have court action taken on their behalf .[10] Calculations: 36,201 x .16 = 5,792; 5,792 x $1,372.34

$8.0 million

TOTAL DIRECT COSTS **$752.9 million**

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[1] U.S. Department of Health & Human Services Child Maltreatment 2004.
[2] HCUPnet (2004). Available on-line at http://hcupnet.ahrq.gov/HCUPnet.jsp.
[3] Hammerle (1992) as cited in Myles, K.T. (2001) Disabilities Caused by Child Maltreatment: Incidence, Prevalence and Financial Data.
[4] U.S. Department of Health & Human Services Child Maltreatment 2004.
[5] Ibid
[6] Daro, D. Confronting Child Abuse (New York, NY: The Free Press, 1988)
[7] The General Court of the Commonwealth of Massachusetts Chapter 26 of the Acts of 2003 (for FY 2004)
[8] Miller, T., Cohen, M. & Wiersema (1996). Victims' Cost and Consequences: A New Look. The National Institute of Justice. Available online at www.nij.com.
[9] U.S. Department of Health & Human Services Child Maltreatment 2004.
[10] Dallas Commissions on Children and Youth (1988). A Step Towards a Business Plan for Children in Dallas County: Technical Report Child Abuse and Neglect. Available on-line at www.ccgd.org

INDIRECT COSTS

Special Education

Rationale: More than 22% of abused children have a learning disorder requiring special education.[11] Average cost per pupil in special education in MA in 2004 was $11,123.[12] Calculations: 36,201 x .22 = 7964; 7964 x $11,123.

$88.6 million

Mental Health and Health Care

Rationale: The health care cost per woman related to child abuse and neglect is about $8,175,816/163,844 = $50.[13] The costs for men are likely to be different and a conservative estimate would be half that amount, or $25.[14] Calculations: 17,697 x $50 = $884,850; 17,707 x $25 = $442,675

$1.3 million

Juvenile Delinquency

Rationale: About 27% of children who are abused or neglected become delinquents, compared to 17% of children as a whole.[15] Cost per year per child for incarceration in MA is $_____. Calculations: .10 x 36,201 substantiated cases = 3,620; 3,620 x $_____.

Lost Productivity to Society

Rationale: Abused and neglected children grow up to be disproportionately affected by unemployment and underemployment. Per capita personal income in MA in 2004 was $42,176[16]. MA state income tax rate is 5.3%. Assuming that a maltreated child's impairments reduce his or her future earnings by as little as 5% to 10%,[17] lost of productivity is estimated at $76.3 million ($42,176 x .05) to $152.7 million ($42,176 x .10) and estimated loss in state income tax revenue is $4 million to $8.1 million. Conservative estimate used.

$80.3 million

Adult Criminality

Rationale: In 2003-2004, The Massachusetts Department of Corrections' budget was $791.1 million.[18] According to the National Institute of Justice, 13% of all violence can be linked to earlier child maltreatment.[19] Calculation: $791.1 million x .13

$102.8 million

TOTAL INDIRECT COSTS **$273 million**

TOTAL COST OF CHILD MALTREATMENT IN MASSACHUSETTS **$1,025.9 million**

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[11] Hammerle (1992) as cited in Daro, D., Confronting Child Abusse (New York, NY: The Free Press, 1988)
[12] MA Department of Education
[13] Walker, E., Unutzer, J., Rutter, C., Gelfand, A., Sauners, K., VonKorff, M., Koss, M. & Katon, W. (1997). Cost of Health Care Use by Women HMO Members with a History of Childhood Abuse and Neglect. Arc General Psychiatry, Vol 56, 609-613 cited in Fromm & Suzette (2001) Total Estimated Cost of Child Abuse and Neglect in the U.S.
[14] Fromm & Suzette (2001) Total Estimated Cost of Child Abuse and Neglect in the U.S.
[15] Widom, C.J., & Maxfield, M.G. (February 2001) An Update on the "Cycle of Violence" U.S Dept. of Justice, National Institute of Justice available on-line at http://www.ncjrs.gov/
[16] Bureau of Economic Analysis on-line at http://www.bea.gov
[17] Daro, D. Confronting Child Abuse (New York, NY: The Free Press, 1988)
[18] The General Court of the Commonwealth of Massachusetts Chapter 26 of the Acts of 2003 (for FY 2004)
[19] Widom, C.J., & Maxfield, M.G. (February 2001) An Update on the "Cycle of Violence" U.S Dept. of Justice, National Institute of Justice available on-line at http://www.ncjrs.gov/

The Commonwealth of Massachusetts

House of Representatives,

***Ordered**, That* **11 members of the House, 8 to be appointed by the speaker and 3 by the minority leader, be authorized to make an investigation and study of the manner in which the commonwealth protects children from abuse and neglect. In the course of its investigation, the committee shall study the following and other related matters:— the balance between protecting children and family preservation, the reporting of or failure to report child abuse and neglect by mandated reporters and others, the investigation of such reports by the department of social services, the qualifications and management of social workers and other staff at the department, the management of records by the department, the capacity of the department to critique itself and respond to criticism, the role of law enforcement, including local police and the district attorney, the role of private providers, including therapists and medical personnel, the capacity to handle high-risk children, and the commonwealth's role as a guardian in end-of-life decisions.**

The committee shall report to the general court from time to time the results of its investigation and study and its recommendations, if any, together with drafts of legislation necessary to carry its recommendation into effect by filing the same with the clerk of the House of Representatives on or before March 28, 2007.

Recommendations For
A Case Study Within The Department of Social Services

1. **Strengthen and streamline the mandated reporting system.** Require that mandated reporters receive initial and ongoing training. Consider online education and training, including the development of strategic partnerships with Massachusetts educational institutions. Increase penalties and enforcement of penalties for failure to report child abuse/neglect.
2. **Develop and implement a high-risk assessment tool.** Design an objective and effective tool or instrument to identify and monitor those children in need of increased attention and careful management.
3. **Improve educational requirements for social workers.** Institutions of higher education should require more outside-the-classroom training for students pursing a degree in social work.
4. **Establish an audit unit that reviews processes and cases and reports directly to the DSS Commissioner.** Staff audit unit with persons qualified by education and expertise who can assess whether cases are being managed effectively and appropriately.
5. **Increase law enforcement involvement in child abuse/neglect cases.** Require earlier notification of the local district attorney and police officials in additional circumstances of child abuse/neglect, such as the leg burns and the negligent care of a child with alleged homicidal tendencies and self-abuse as described in this case.
6. **Codify and make public the end-of-life decision-making process.** If decisions are to be made about withholding or withdrawing life support from children in the custody of DSS, that process should be thorough, clear and open to public scrutiny.[13]
7. **Improve DSS records management systems.** Implement changes to guard against fragmented, disjointed and poorly managed record-keeping so that a child's situation can be readily and comprehensively assessed by DSS and, if appropriate, the courts.
8. **Improve coordination with MassHealth.** Services provided to DSS-involved families through MassHealth should be monitored to ensure better management and oversight.
9. **Transmit this report to the Commonwealth's schools of social work.** Inform those who train social workers and social workers themselves about the details of this case study so it can be used as a teaching tool.
10. **Distribute this report to legislative committees handling child welfare and protection issues and related financial and budgetary matters, to the Governor, and to the State Auditor.**

[13] See Care and Protection of Sharlene, 445 Mass. 756.

Requirements for Social Work Licensure in Massachusetts

This is a summary; applicants must review the Massachusetts regulations for detailed requirements.

Education	Examination	Professional References	Supervision	Documented Experience
LICSW				
MSW, DSW or PhD in Social Work from a CSWE accredited school of social work	Clinical	Two professional references from appropriately **licensed** individuals (see instructions p. 2)	One supervisory reference from **LICSW**	Two years (3,500 hours) post-MSW documented clinical experience with 50 face-to-face supervision hours per year (100 hours total) under a LICSW; hold current LCSW or equivalent
LCSW				
MSW, DSW or PhD in Social Work from a CSWE accredited school of social work	Masters	Two professional references	One supervisory reference from **LICSW/LCSW**	None Required
LSW				
Bachelors degree in Social Work from a CSWE accredited school of social work	Bachelors	Two professional references	One supervisory reference from **LICSW/LCSW**	None required
Bachelors degree in any field	Bachelors	Two professional references *	One supervisory reference *	Two years (3,500 hours) of supervised experience from a BSW or MSW
Two and a half years (75 sem/100 qtr hours) of college	Bachelors	Two professional references *	One supervisory reference *	Five years (8,750 hours) of supervised experience from a BSW or MSW
Two years (60 sem/80 qtr hours) of college	Bachelors	Two professional references *	One supervisory reference *	Six years (10,500 hours) of supervised experience from a BSW or MSW
One year (30 sem/40 qtr hours) of college	Bachelors	Two professional references *	One supervisory reference *	Eight years (14,000 hours) of supervised experience from a BSW or MSW
High school diploma or equivalent	Bachelors	Two professional references *	One supervisory reference *	Ten years (17,500 hours) of supervised experience from a BSW or MSW
LSWA				
Associate degree (or 60 sem/80 qtr hours) in human service field	Associate	Three references *	N/A	None required
Bachelor's degree (or 120 sem/160 qtr hours) in any field	Associate	Three references *	N/A	None required
High school diploma or equivalent	Associate	Three references *	N/A	Four years documented experience

* At least one of the professional and/or supervisory references must be licensed as a LICSW or LCSW