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BOARD OF SUPERVISORS
CHILDREN'S SPECIAL INVESTIGATION UNIT
COUNTY OF LOS ANGELES

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 383
LOS ANGELES, CALIFORNIA 90012

CONFIDENTIAL AND PRIVILEGED REPORT

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April 16, 2012

TO: Supervisor Zev Yaroslavsky, Chair
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Amy Shek Naamani
Lead Attorney, CSIU

SUBJECT: REPORT REGARDING DCFS RECURRING SYSTEMIC ISSUES

Enclosed please find the Children's Special Investigation Unit's 2011 Recurring Systemic Issues report which undertakes an analysis of the findings from the child fatality and critical incidents that were reviewed by CSIU between October, 2010 and December, 2011. In analyzing the issues that were identified across the cases investigated, patterns of systemic weaknesses emerged. These patterns, which are referred to in this report as Recurring Systemic Issues ("RSI"), are the 'big picture' issues that are in need of immediate remedial attention.

This fact-based analysis presents a unique opportunity to examine the need and possibility for wholesale changes in the way DCFS and the County of Los Angeles carry out the charge of providing services to families and children in crises. Accordingly, in addition to identifying the RSI, this report suggests opportunities for improvement that, if capitalized upon effectively, can lead to positive changes and outcomes for the children and families DCFS serves.

CSIU has scheduled a review and debriefing of this report with Director Phillip Browning for April 17, 2012. A copy of Appendix A of the report containing CSIU's suggested improvements will be provided to Director Browning.

Should you have any questions or concerns, please contact me at [redacted]

ASN:pl
Attachment

c: Children's Deputies

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2011 RECURRING SYSTEMIC ISSUES REPORT

EXECUTIVE SUMMARY

The Children's Special Investigations Unit ("CSIU") was established by the Board of Supervisors to act as Special Counsel in order to provide independent legal review of child deaths and serious incidents of child abuse and neglect while under the care and/or supervision of County Departments. CSIU conducts detailed factual investigations into child fatalities for the purpose of identifying systemic issues/problems that may have contributed to the child's death. CSIU investigations are unique since its independent nature affords CSIU the opportunity to examine the roles and responsibilities of multiple County Departments, not just the Department of Children and Family Services ("DCFS").

CSIU utilizes a fact-based analysis of each fatality to identify systemic issues. As such, the issues that are identified in CSIU's reports relate back to a specific child who died despite intervention by DCFS and other County Departments. In this report, CSIU has undertaken an analysis of the findings from the cases it reviewed over a period of approximately 18 months. This collective review of 14 child fatalities and 1 critical incident enabled CSIU to identify patterns of systemic issues that are representative of the larger, fundamental systemic issues that has impeded DCFS' ability to carry out its mission with excellence. The following Recurring Systemic Issues were identified:

1. Front End Investigative Failures
2. The Ineffective Implementation of Policies and Decision-Making Tools/Strategies
3. The Need for Improved Communication, Integration and Coordination of Services
4. The Need for Strategic Human Resource Management

In 13 out of 15 cases investigated by CSIU, 'front-end' failures were identified as a contributing factor to a tragic ending. These failures range from poorly conducted emergency response investigations to jeopardizing the validity of risk and safety assessments by incorrectly using (or not using at all) the tools that are in place to make sure those assessments yield reliable results. As discussed in detail below, front-end failures come in many forms but all are equally dangerous because if DCFS' initial

contact with a family is flawed, the course for potential disaster is set from day one and it becomes very difficult to stop the runaway train.
In 10 out of 15 cases, CSIU found poor communication and/or coordination between

DCFS and other service providers, including other County Departments, to be a systemic issue that contributed to the death of a child. For this reason, the recommendations in this report often speak to the need for DCFS to effectively communicate with and integrate other Departments into its delivery of services. CSIU's investigations also revealed that the need for DCFS to coordinate services provided to families by outside agencies is equally important—but lacking.
DCFS does not stand alone in the mission to protect children and cannot possibly address every issue presented by the families it serves on its own. Other County Departments and community professionals must take an active role in providing the services that fall within their area of expertise. Having said this, DCFS has the critical role of coordinating and integrating all professionals that play a role in child protection. In a system comprised of countless service providers, relatives, community members, and caregivers, DCFS **must** be the nucleus for communication and information-gathering because ultimately, it is DCFS who is responsible for the children in its care, custody, and control.

Finally, DCFS must recognize that one of its greatest challenges is dealing with the 'human element' of its organization. In other words, no matter how many policies and procedures are put into place, the Department's success will always depend on its ability to identify, hire, train and supervise qualified individuals. In order to ensure children's lives are not endangered by poor performers, DCFS must establish basic performance expectations for employees at all levels and reinforce those expectations with meaningful performance assessments and guidelines for accountability.
In order to address these Recurring Systemic Issues, CSIU recommends that:

1. DCFS should consider a whole new approach to the recruitment, training, and retention of 'front end' workers.

    - DCFS should explore expanding the qualifications for social workers to include a broader range of educational backgrounds and types of experience. This may require changes to state regulations and/or the job specifications developed by the County's Civil Service Board.
    - DCFS must provide hands-on, practical training at its Core Training Academy and consider implementing tools that will help assess whether training has been effective such as situation-specific simulations, written testing, and/or the use of field officers who evaluate the performance of investigators before they are approved to work independently.

2. DCFS must undertake a comprehensive review of its policies, strategies and decision-making tools to ensure that they are necessary and that they are achieving their intended purpose. In doing so, DCFS should consider:

- Streamlining its almost 4,000 pages of policy so that they are easy to navigate, understand and apply in daily practice.
- Avoid relying upon policy to fill the void of competent supervision and management.
- Developing new criteria for the supervision/monitoring of Voluntary Family Maintenance (VFM) cases.
- Clarifying the purpose of Team Decision Making (TDM) meetings and the role of TDM Facilitators.
- Adopting Structured Decision Making as a training/validation tool as opposed to its current use as a determinative tool by line workers.

3. DCFS needs to improve communication and cooperation among all professionals whose expertise is a necessary component of child welfare and protection, including its own social workers, other County Departments, and Community Service Providers.

   - DCFS must change its messaging from "Do Not Detain/Keep the Numbers Down" to an emphasis on its six departmental goals being equally important.
   - DCFS should explore developing an Executive Steering Committee or other similar vehicle for engaging in regular contact and communication with the other County Departments it necessarily relies upon.
   - DCFS must take an active role in selecting and/or screening the Community Service Providers it relies upon when making critical decisions about the children in its care and a family's ability to ensure child safety.

4. DCFS must adopt a strategic plan for managing its human resources.

   - DCFS should evaluate the roles and responsibilities of its Supervising Continuing Services Workers (SCSW) to better leverage their utility and effectiveness.
   - SCSWs must receive timely training that is focused on the issues they will face on a day-to-day basis.
   - Performance standards must be established, maintained and uniformly enforced for employees at all levels including supervisors, Assistant Regional Administrators, Regional Administrators and Deputy Directors. These standards must be reinforced through meaningful performance evaluations.
   - In order to assist its management staffs effectively navigate through the complex arena of performance management, DCFS should consider incorporating professional human resources specialists and/or legal counsel that are available to consult with SCSWs and guide them through the complex arena of effective performance management.

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2011 RECURRING SYSTEMIC ISSUES REPORT

INTRODUCTION

According to the Department of Children and Family Services' ("DCFS") Bureau of Information Services, there were 570 child deaths reported to DCFS between June 2010 and December 2011. Of those, 268 children had prior DCFS history and 302 had no prior DCFS history. Pursuant to SB 39 guidelines, DCFS reported that 37 fatalities out of the 268 with prior DCFS history were the result of abuse or neglect. Between October 2010 and December 2011, the Children's Special Investigations Units ("CSIU") reviewed 14 child fatalities and one critical incident culminating in seven full reports[1]; one 'trend analysis' of three cases[2] and five preliminary case reviews in which full detailed reports were deemed unnecessary.[3]

This report undertakes an analysis of the findings associated with the 15 child fatality incidents reviewed by CSIU. In analyzing the issues that were identified across the cases investigated, patterns of systemic weaknesses emerged. These patterns, which are referred to in this report as Recurring Systemic Issues ("RSI"), are the 'big picture' issues that are in need of immediate remedial attention. The following four RSI were identified:

- "Front End" Investigative Failures;
- The Ineffective Implementation of Decision-Making Tools and Strategies;
- The Need for Improved Communication, Integration and Coordination of Services; and
- The Need for Strategic Human Resource Management.

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[1] Jorge T.; Deandre G.; Vyctorya S.; Zachary H.; Viola V.; Adrian G. and Abigail M.
[2] Cynthia F.; Johnny C.; and Hakeem F.
[3] Parrish G.; Christian D & Micheal N.; Erica J.; Valery O.; and Amanda C.

This fact-based analysis presents a unique opportunity to examine the need and possibility for wholesale changes in the way DCFS and the County of Los Angeles carry out the charge of providing services to families and children in crises. Accordingly, in addition to identifying the RSI, this report suggests opportunities for improvement that, if capitalized upon effectively, can lead to positive changes and outcomes for the children and families DCFS serve.

REMEMBERING THE CHILDREN

DCFS exists to protect abused and neglected children. Accordingly, when DCFS intervenes to protect a child and the child dies nonetheless, that child must become a catalyst for reflection and improvement. For this reason, we begin with a brief review of the children who were the catalysts for the changes recommended in this report.

Johnny C.

Five year old Johnny C. was detained by San Bernardino County CPS and found to be the victim of extremely violent physical, sexual and emotional abuse while residing with his mother in her boyfriend's home. At the time of DCFS' last contact with the mother in 2006, she had already lost custody of three other children due to allegations of physical abuse and drug abuse. The 2006 DCFS referral alleged that mother used methamphetamines and neglected Johnny. Mother evaded DCFS for six weeks and did not drug test. The referral was deemed "unfounded", the SDM indicated no safety risks, and the referral was closed.

Christian D. & Michael N.

Five year old Christian and one year old Michael were shot by their twenty six year old mother in a failed 'murder/suicide' attempt. The mother was a former DCFS dependent with an extensive history of mental health issues as well as a mild to moderate developmental delays. Five years prior, the mother 'aged out' of the dependency system while pregnant and had transitioned into an adult placement through Regional Center where she would receive services. After mother had Christian, DCFS received two referrals alleging neglect of Christian. The referrals were closed and no services provided despite the fact that it was ascertained that the Mother was not compliant with her entire Regional Center service plan.

Parrish R.

Parrish R died as a result of a stab wound to the chest inflicted by his sister over an altercation regarding money. There was no information in the DCFS file which would suggest that the sister had a propensity for violence to the extent that she would take the life of another. In the month preceding Parrish's death, law enforcement received calls primarily related to marijuana use, fighting, and noise or family disturbances. The

sister had no criminal history and her DCFS history was related primarily to marijuana use. While Parrish and sister seemed to argue and fight, the resulting murder was surprising and unforeseeable.

Viola V.

Two year old Viola V. had been living for sixteen months in the home of her soon-to-be adoptive mother Kiana B. when she died by her hand from severe physical abuse. Notwithstanding a criminal record and seven prior DCFS referrals related to her own biological child and other foster children placed in her home, United Care Foster Family Agency (FFA) certified her as a foster parent and DCFS continued to place children into her care. Relying primarily upon the FFA to assess Viola's wellbeing, DCFS was oblivious to the multiple red flags that existed within the home (including the foster mother's fiancé who was a convicted felon) that should have been clear indicators that the foster mother posed a danger to the children DCFS entrusted to her care.

Deandre G.

Deandre was just two years old when he died from blunt force trauma to the abdomen. Although DCFS had been investigating two open Hotline referrals that had been reported within 4 weeks of his death, DCFS had no contact with Deandre before he died. Instead, the Emergency Response worker spent nearly a month returning to the same wrong address trying to find the family despite having the correct address in the file the entire time. At the time of Deandre's death, DCFS had still not made contact with him.

Jorge T.

Jorge T., age 11, committed suicide by hanging himself with a jump rope while his family watched the LA Lakers play-off game in the next room. Earlier that day, he had disclosed suicidal ideation to his teacher due to the physical and emotional abuse he was suffering at home. When the ER worker finally arrived at Jorge's home 5-6 hours later, Jorge denied being suicidal. Despite his siblings corroborating the allegations of abuse, Jorge's history of mental health issues (for which DCFS had previously provided services) and his avoidance behavior, the ER worker determined there were no safety issues and left Jorge in the home. An hour and a half later, he hung himself in his mother's bedroom.

Adrian R.

Adrian R. died after taking 300 of his grandmother's gout pills. In the 18 months preceding his suicide, there were three allegations of physical abuse of Adrian by his father; all of which should have been substantiated but were instead closed as "unfounded". Although he had contacts with DCFS, the Department of Mental Health, and the Department of Probation, he never received the coordinated services that he so desperately needed.

Zachary H.

18 year old Zachary died of an accidental drug overdose after running away from his DCFS group home to his friend's board and care facility where they got high on methadone and marijuana. Zachary first became a dependent at age 6 and after several years, his maternal aunt assumed legal guardianship over Zachary and the Dependency case closed. However, Zachary re-entered the dependency system at age 15 as his legal guardian was no longer willing to care for him given his severe behavioral problems. Throughout his teen years Zachary had contacts with DCFS, Probation and DMH who together, worked hard to meet Zachary's special behavioral, educational, and emotional needs. In the end it was a tragic accident that took him.

Cynthia F.

Two month old Cynthia died when her parents, who were drunk at the time, left her face-down in her crib. A Hotline referral had been made at the time of Cynthia's birth because she was born while her mother was in an in-patient drug program and on methadone. Based on a completely blank SDM "Hotline tool" the referral was "evaluated out" and there was no investigation required. Cynthia was never seen despite the fact that Cynthia's mother had a prior history with DCFS having lost custody of four other children due to drug abuse; a history of which the ER worker was unaware.

Erica J.

Two year Erica she died of massive trauma Oct 7, 2010 inflicted upon her by her mother's boyfriend. At the time of Erica's birth, DCFS had received a Hotline referral from the hospital due to concerns that both parents were minors, they were both on probation, were prior DCFS dependents themselves, Mother had a propensity for violence and the plan was to live with the paternal grandmother who was a Regional Center Client. The SDM risk finding was "high" and the recommendation was to promote to a case; however, the findings were overridden because "the allegations were unfounded". There was no open DCFS case at the time of her death.

Hakeem F.

Hakeem suffered critical head injuries consistent with being thrown against a wall. This occurred just eight weeks after he was born exposed to marijuana. Mother had a lengthy drug history and had lost custody of four of Hakeem's older siblings. Despite Mother's known history with DCFS and her pattern of disappearing from DCFS, the Hotline generated a 5 day response time. DCFS permitted Hakeem to be released to his mother following one initial contact with the family while Hakeem was still in the hospital. The referral remained open for 57 days with no additional contact between DCFS and the family. The referral was still "open" at the time of Hakeem's near death.

Amanda C.

Ten year old Amanda died of natural causes associated with an enlarged heart and liver disease. Amanda's family had 10 prior referrals and three VFMs. While the family was participating in a VFM, a teacher made a Hotline referral alleging sexual abuse based upon Amanda's explicit sexual knowledge. Amanda was referred to the Hub for a sexual abuse examination but the Hub declined to examine her unless or until she made disclosures of sexual abuse during counseling. The DCFS referral was closed as "inconclusive". Two years later Amanda died with evidence of sexual trauma inflicted within 48 hours of death.

Valery D.

Nine month old Valery died of blunt force trauma inflicted by her father. At the time of her death, the family had an open DCFS referral concerning her two year old sibling Orlyn who suffered a spiral fracture of the femur. Father claimed that Orlyn accidentally slipped from his arms and fell to the sidewalk. The hospital that treated the spiral fracture indicated that the father's explanation for the injury was consistent with the injury. However the ER worker waited 7 weeks before initiating a request for a second opinion from the medical Hub. Ultimately, due to lack of coordination between DCFS and the Hubs, the exam did not occur until almost three months after the referral and less than three weeks before Valery was killed. The results of the Hub exam were not provided until two days after her death.

Vyctorya S.

25 month Vyctorya died of severe malnutrition and severe physical abuse. Vyctorya entered foster care at four days old and returned to her parents' care eighteen months later. Although court reports clearly indicated that neither parent had complied with the case plan and despite serious concerns raised by her FFA social worker, Vyctorya was returned to her parents. In the seven months she was home, Vyctorya lost almost half of her body weight and was missing clumps of hair. Additionally, obvious indications of physical abuse were either ignored or not noticed. Five months after being returned home, the Court terminated jurisdiction per DCFS' recommendation. Two months later, Vyctorya died.

Abigail M.

Thirty-month old Abigail died covered in bruises that her parents attempted to hide with blue paint. Abigail was removed from her parents due to Non-Organic Failure-to–Thrive but she was returned to them after two years in relative placement. In the months following Abigail's return, Mother expressed to her Family Preservation worker her intense dislike of Abigail. The Family Preservation worker reported this information to the DCFS worker, yet no action was taken. When the Family Preservation worker observed unexplained bruises on Abigail, he called the DCFS Hotline directly. The ER worker never spoke to Abigail's daycare provider, Abigail's sibling, or her former

caretakers (her grandparents) although each of these individuals had critical information regarding the Mother. Despite an SDM risk assessment of "Very High", the referral was closed because the family was "already receiving Family Maintenance services". One month later, Abigail died.

The following table is a summary of the Recurring Systemic Issues that were identified during CSIU's review of the above cases:

Case	Front End Investigative Failures[4]	Improper Use of Decision Making Tools and/or Strategies[5]	Failure to Integrate and/or Coordinate Services[6]	Inadequate Supervision and/or Performance Management[7]
Jorge T.	✓	✓	✓	✓
Deandre G.	✓	✓	✓	✓
Vyctorya S.	✓	✓	✓	✓
Zachary H.				
Viola V.	✓	✓	✓	✓
Adrian R.	✓	✓	✓	✓
Abigail M.	✓	✓	✓	✓
Cynthia F.	✓	✓		✓
Johnny C.	✓	✓		✓
Hakeem F.	✓	✓		✓
Parrish G.				
Christian D. & Michael N.	✓		✓	✓
Erica J.	✓	✓	✓	✓
Valery D.	✓		✓	✓
Amanda C.	✓	✓	✓	✓
TOTAL	13/15	11/15	10/15	13/15

[4] Includes Hotline assigning inappropriate response times/incorrect use of SDM "Hotline" Tool; failure to identify prior DCFS and/or criminal history; failure to interview necessary parties and/or request input from necessary professionals; incorrect referral dispositions; etc.
[5] Includes improper VFMs; incorrect and/or failure to use SDM tools; ineffective TDMs (issues missed and/or lack of presence by all necessary parties).
[6] Includes lack of protocols for joint departmental responses to crisis; miscommunications between DCFS and other Departments regarding respective roles; failure to adequately assess qualifications and/or obtain meaningful progress assessments from service providers; missed opportunities for legal guidance by County Counsel; etc.
[7] Includes all cases in which SCSWs signed off on reports, recommendations, or dispositions that ultimately proved to be problematic.

THE DCFS CONTINUUM

"The Department of Children and Family Services, with public, private and community partners, provides quality child welfare services and supports so children grow up safe, healthy, educated and with permanent families."

This is DCFS' mission statement. Given this mission, it is clear that DCFS serves society's most vulnerable population. In the nature of this work—child welfare and protection—there is 'zero tolerance' for failure. As such, the unavoidable reality is that DCFS' successes are easily over-shadowed by its failures. Despite the fact that DCFS has kept thousands of children safe and helped countless families, even one publicized child fatality can negate that success. Thus, DCFS must continually strive to improve its delivery of services to the children and families of Los Angeles County.

The primary objective of DCFS is to protect children from child abuse and neglect and to provide assistance to families to ensure that children grow up safe, healthy, educated and with permanent families. In order to fulfill this objective, DCFS must undertake a three-step process that can be characterized as the 'continuum' of DCFS' intervention for the protection of children:

1) DCFS must first identify the children who are in need of protection.
   - Conduct initial investigations regarding suspected maltreatment
   - Determine what level of intervention, if any, is required based on safety and risk assessments
2) Identify the support and treatment services necessary to address the issues/problems that resulted in the abuse/neglect.
   - Conduct assessments of family strengths, resources, and needs
   - Develop individualized case plans
3) Ensure that identified support and treatment services are provided and assess their efficacy in achieving the goals of child safety, permanency and strengthening families to care for their children.
   - Provide direct services to support families to address the problems that led to maltreatment and to reduce the risk of subsequent maltreatment
   - Coordinate services provided by other professionals
   - Complete case management functions such as maintaining case records, systematically reviewing and assessing case plans, assessing the parents' substantive progress and whether the underlying issues that brought the family into the dependency system, have been ameliorated.

Step 3 of the continuum is what most people would commonly associate with social work – providing support and assistance to help people and to make a positive difference in their lives. Steps 1 and 2, however, must be carried out effectively in order for Step 3 to be effective. In other words, in order to provide 'social work' services, the victims of maltreatment must first be identified and case plans developed based upon a sound assessment of the totality of the family's circumstances.

a. Steps 1 and 2 of the Continuum —"The Front End"

The 'front end' of DCFS is where steps 1 and 2 of the continuum are carried out. If the 'front end' does not appropriately identify those children in need of protection and the reasons wherefore, the work of the 'back end' in providing services and treatment to the family will not take place and/or not be effective.

- The Hotline

Reports of alleged child abuse and/or neglect are received and screened by DCFS' Child Protection Hotline workers to determine if intervention is necessary. A report is "screened in" when there is sufficient information to suggest an investigation is warranted. However, a report may be "evaluated out" if there is not enough information on which to follow up or if the situation reported does not meet the legal definition of abuse or neglect. If, based upon the Hotline worker's evaluation of the information provided by the caller the referral is "screened in', the worker must next determine how urgent of a response is required. Accordingly, the role of the Hotline workers is critical as they are tasked with determining whether DCFS will even make contact with the child(ren) and family and if so, how quickly. The Hotline worker is figuratively, the "gatekeeper" to DCFS.

In order to determine whether a call should be 'screened in' or 'screened out', the Hotline worker must effectively gather and evaluate information; conduct preliminary checks on CWS/CMS[8] and CACI[9] to determine if the family has a current open case or has a DCFS history; and assess the credibility of the reporter based on their knowledge of the family and circumstances.

Once the necessary and relevant information has been gathered, the decision regarding the type and urgency of the response is based on an analysis of the information to determine if the child is at imminent risk of serious harm. This decision is based upon a number of factors including: the nature of the act or omission; the severity of harm to the child; the relationship of the child to the person responsible for the maltreatment; the access of the perpetrator to the child; the child's vulnerability (e.g., due to age, illness, or disability); and the other known cases of maltreatment by the parent or caregiver. DCFS utilizes the Structured Decision Making ("SDM") Hotline Tool to assist the Hotline

[8] Child Welfare System/Case Management System
[9] Child Abuse Central Index

worker in determining the type and timing of the DCFS response (i.e., immediate, 24 hour response, or 5 day).

- The Emergency Response Worker ("ER worker")

Once the Hotline has made a determination that the allegation requires further DCFS investigation, the initial referral is assigned to an Emergency Response worker or, if the referral is received after working hours or on a weekend, an Emergency Response Command Post worker. The importance of the ER workers' role cannot be overstated. It is at this point of the DCFS continuum when, based on the investigation conducted, the most critical determinations are made: did the alleged abuse/neglect occur? If so, what is the level of risk? Is the child safe? If not, what needs to be done to ensure the child(ren)'s safety? It is at this stage of DCFS's involvement that literally, life or death decisions are made.

In order to answer the necessary threshold questions, the ER worker must undertake interviews of the parents and other people who have contact with the child, such as doctors, teachers, or child care providers. They also may speak with the child, alone or in the presence of caregivers, depending on the child's age and level of risk. Based upon the information obtained through their investigative efforts, the ER worker must undertake an evaluation of that information to come up with a FACTUAL determination as to whether or not the alleged abuse and/or neglect occurred. Once that determination has been made, an assessment based upon the information gathered, must be undertaken to determine the level of risk and safety present. That assessment process utilizes the factual information gathered and incorporates an evaluation of risk and safety factors and the family's strengths and needs regarding the care of their children, in order to come up with a determination as to 'what to do'.

b. Step 3 of the Continuum—"The Back End"

After a referral has been investigated and determination has been made that the alleged abuse/neglect occurred and that DCFS intervention is necessary to protect the child(ren) and/or prevent reoccurrence, a case plan is developed. The case plan should be tailor made to address and to facilitate the amelioration of the underlying issues that necessitated DCFS intervention (i.e., substance abuse program and drug testing, anger management classes, parenting programs, etc.). The case plan is generally designed by the front end worker after s/he has fully assessed the familial situation based upon the facts gathered.

Once the case plan is in place, DCFS must provide services to the family to carry out the case plan, monitor and evaluate parental progress in complying with the case plan activities, as well as continually evaluate the child(ren)'s wellbeing, whether they remain in the home or are in out-of-home care. The range of services provided by the "back end" includes family maintenance services (voluntary and/or court-ordered), family reunification services (voluntary and/or court-ordered) and permanent placement services. These types of services represents step 3 of the DCFS continuum and are

provided by 'FM/FR workers' (family maintenance/family reunification), 'PP workers' (permanent placement) and 'adoption workers'.

RSI #1: FRONT END INVESTIGATION FAILURES

As discussed above, the 'front end' is when Steps 1 and 2 of the DCFS continuum of services occur. The 'back end' of the continuum is largely, if not wholly, reliant upon Steps 1 and 2 being performed appropriately because unless the children and families who need DCFS to protect and assist them are properly identified and brought 'into the system', the 'back end' cannot do the work of providing the services/treatment needed to ameliorate the risk associated with the family's identified issues. An equally important part of correctly identifying the families that must be brought 'into the system' is the identification of **all** of the issues that must be addressed before DCFS can safely 'exit' from the family's life. If existing issues are not identified by the 'front end', the 'back end' receives an incomplete picture and will not know to provide the necessary services/treatment. Accordingly, those children and families who are erroneously determined not to be in need of DCFS intervention or who are not thoroughly assessed by the 'front end' are left without protection and the full benefit of child welfare services from DCFS.

In 13 out of 15 fatalities reviewed by CSIU, 'front end' failures contributed to one degree or another to the adverse outcome of the case. The failures identified ranged from basic fundamental failures (such as failing to correctly identify prior DCFS history) to more complex issues (such as giving undue weight to conclusions reached by medical personnel and/or law enforcement). Other front end investigative issues included the Hotline not assigning appropriate response types, failing to identify prior criminal history, failing to interview necessary parties, failing to use and/or incorrectly using assessment tools, and inappropriate dispositions/closures of referrals. The commonality amongst the failures was that outcomes and/or decisions were driven by the quality of factual information, or more accurately stated, the poor quality of factual information that served as the foundation for the assessments and resulting poor decisions.

The high occurrence level of 'front end' weakness found in the child fatality incidents reviewed by CSIU suggests a need to consider whether the system itself may be part of the problem. The myriad of oversights, mishandling of investigations and poor decisions identified in the CSIU case reviews as contributing to the fatalities, are symptomatic of an inherent limitation in the system itself – reliance upon human judgment which is an absolute necessity in the context of child welfare/protection work. There is no escaping the fact that an individual worker's decisions are based upon their personal judgment and evaluation of the situation they are investigating. If we recognize this 'truth' then the question raised is whether the 'mistakes' are just the personal failings on the caseworker's part or are there systemic problems that affect all the workers in the agency?' The answer is probably 'both'.

a. Poor Emergency Response Investigations—The Need to Treat ER Investigations as Fact-Finding Missions

The work of the 'front end' is heavily focused on making decisions. Front end workers must decide whether the alleged abuse/neglect occurred, then decide what, if any, intervention is appropriate. Those decisions, in turn, set the stage for what happens on the 'back end' where the services/treatment determined necessary by the front end worker are provided to the family. In order to make these decisions, the front end workers rely on a plethora of tools designed to achieve consistency in investigations and assessments – but the efficacy of the tools is wholly reliant upon the 'the facts' that are gathered and how they are utilized. In other words, good decisions cannot be made without good information.

The DCFS Emergency Response Practice Model does remind workers that "*information gathering is not limited to learning about whether or not an 'incident occurred' but a full assessment of child safety and risk that explores history, chronicity, and patterns in a variety of areas of family functioning.*" What the ER Practice Model fails to emphasize, however, is that the ability to make a "full assessment of child safety and risk" is entirely dependent upon accurate and thorough fact-gathering. Researchers agree that while it is true that the process of decision making in the child welfare context involves many layers and factors beyond the facts of the case itself, the first step in any decision is to gather the relevant information. Information is the foundation of risk and safety assessment.

In this regard, information collection is perhaps the most important aspect to both the "what happened" part of the investigation and to the safety intervention because having sufficient and relevant information is fundamental to effective decision-making. A social worker cannot possibly adequately determine what happened and assess safety and risk factors without first obtaining the right *facts* and reaching logical conclusions based on those facts. In this regard, ER investigations are currently falling short.

- Why limit the sources of information?

For example, CSIU observed repeated incidences of ER workers failing to speak with people who would obviously have important information regarding the family or the incident under investigation. While DCFS policies attempt to regulate this integral part of an investigation, no policy can accurately and fully, delineate what is necessary in individual cases themselves as each case presents unique facts and circumstances. At various times DCFS has promulgated 'collateral contact'[10] policies that have ranged

[10] A "collateral" is defined as a "person who has specific knowledge about an incident of alleged abuse...or who has relevant information about the child and/or the child's family...a collateral is someone who is not already identified as a client, reporter, service provider, substitute care provider or attorney."

from no specified number of contacts being required, to a minimum of three contacts, to requiring 'all pertinent collateral contacts"[11].

In several cases reviewed by CSIU, the failure of the emergency response investigator to interview the 'right' people resulted in missed opportunities for information to be gathered that would have been critical to the investigation and which likely could have averted the case going down the path of tragedy.

For example, in Jorge T., the teacher and therapist to whom Jorge had disclosed physical abuse and suicidal ideations were not interviewed. In the case of Deandre G., the ER worker failed to interview law enforcement officers who had already discerned that the address at which the ER worker repeatedly attempted to locate Deandre and his mother, was incorrect and they had the correct address. Because the ER worker spent days on a wild goose chase, he was never able to actually make contact with the family before Deandre was killed.

Similar lapses occurred in the investigation of the allegations that Abigail M. was the victim of physical abuse by her parents. The ER worker chose to interview personnel from Abigail's brother's school rather than interviewing her day care provider even though Abigail was the identified victim. The ER worker also failed to interview the sibling who witnessed (and reported) their mother's abuse of Abigail, or the grandparents that cared for Abigail during the entire time she was in out-of-home placement. As it turns out, if the ER worker had interviewed these parties, they would have shared valuable information and first-hand observations regarding Mother's mistreatment of Abigail.

In each of these cases, the ER worker's failure to obtain critical factual information from available sources, compromised their investigation and resulted in incomplete and faulty analyses of the safety and risk factors. The decisions made based thereon, resulted in children remaining in unsafe homes which ultimately enabled these children to suffer mortal harm.

- <u>Skill and instinct are not optional job requirements</u>

In addition to the failure to conduct quality interviews of logical parties, CSIU observed a general lack of skill on the part of ER workers. For example, in Jorge T., the Hotline referral alleged that Jorge was so distraught from the physical abuse that had been inflicted upon him by his parents, he was acutely suicidal. Despite the mother's admissions and his siblings' confirmation of Jorge being hit by his parents, the ER worker closed the referral as 'inconclusive'. Further, the ER worker failed to recognize obvious signs that Jorge's denials of his suicidal intentions were false. Sadly, Jorge killed himself within 2 hours of denying his plans to do so.

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[11] "CSWs are to contact all pertinent collateral contacts that will help in understanding the nature and extent of the alleged child abuse/neglect...the number of pertinent collateral contacts shall be based on the case circumstances and the CSW and SCSW's professional judgment..."

In the Deandre G. investigation, despite numerous failed attempts to contact the family at the same address, the ER worker did not have the skill and/or instinct after the first few times, to try something other than repeatedly knocking on a door with no answer. To the contrary, the ER worker did not seem at all concerned when even after 8 attempts over the course of 22 days, he still had not laid eyes on Deandre. The referral was still open and the ER worker was still trying to catch Mother and Deandre at home when Deandre died.

- Failure to capitalize on available resources is unacceptable

Poor investigative skills were also at issue in instances where DCFS workers failed to correctly identify prior DCFS and/or criminal histories. DCFS workers have numerous tools at their disposal—including CWS/CMS for investigations prior DCFS history; CLETS[12] for obtaining criminal background information; and FCI[13] for cross-referencing families with agencies such as Probation, District Attorney, Sheriff's Department, Public Social Services, Mental Health and Health Services. These tools, if used correctly, provide investigating social workers valuable information that can provide context for the current investigation.

These tools however, are just the *source* of information, they cannot analyze the information; that must be done by the social worker. Effective analysis of gathered information requires a degree of inquisitiveness to look at the information provided by these tools and figure out whether and how the information may be relevant to their investigation or whether something simply does not "add up". Like any technological tool, some of these resources have limitations. CSW/CMS, for example, is extremely sensitive in that any misspelling of a name can produce incorrect results and, often times, client records are duplicated so that two "hits" for the same person can come up. If the records have not been merged, each "hit" may contain different information. A skilled investigator should be aware of these quirks and know how to work around them (i.e., perform partial name searches, click on multiple hits to determine if multiple records for one person need to be merged, etc.)

Based on CSIU's observations, workers are proceeding with incomplete background information because they either do not utilize these information sources, they do not take the time to ensure that they have the right results and/or they fail to appropriately analyze the information provide. In Viola V., for example, Kiana Barker had a total of seven prior DCFS referrals yet not a single ER worker picked up all six prior referrals. Because Barker's history was unknown to the multitude of investigators, such was never incorporated into their analysis and decision to allow Barker to continue being a foster parent. Similarly, Vyctorya S. was with her parents on a 'home of parent' court order when a Hotline referral was received regarding three of Vyctorya's siblings. Relying on an outdated criminal clearance report that was two years old, the ER worker did not realize that there was an active Arrest Warrant issued for the mother. This was

[12] California Law Enforcement Telecommunication System
[13] Family and Children's Index

also the case in Abigail M. where during the investigation of the referral immediately preceding her death, the father had an active Arrest Warrant for violating the terms of his probation, ironically the one that required him to complete 52 weeks of child abuse prevention program.

The case of Johnny C. exemplifies the importance of ER workers being 'user savvy'. In that case, the ER worker spelled the mother's surname Gonzales with a 'z' instead of an 's' which returned a result of 'too many results to identify" for the CWS/CMS history search. Such a result should not have been surprising given how common the name 'Gonzalez' is and that it can often be spelled with a 's'. Accordingly, had the ER worker thought to run the search using that alternate spelling, he would have discovered not only did the mother have prior six prior DCFS referral, but in fact she had previously lost custody of three other children due to physical abuse and drug use.

b. Incorrect Dispositions of ER Referrals—Poor Investigations Yield Poor Results

At the conclusion of their investigation, the ER worker must make a determination based upon the facts gathered, of whether the alleged abuse/neglect occurred. Based upon that decision, the ER workers must then assign a 'disposition' to the referral. There are three possible dispositions that can be assigned to a Hotline referral pursuant to Penal Code Section 11165.12:

- "Unfounded report" means a report that is determined by the investigator who conducted the investigation to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse or neglect, as defined in [Penal Code] Section 11165.6[14].

- "Substantiated report" means a report that is determined by the investigator who conducted the investigation to constitute child abuse or neglect, as defined in [Penal Code] Section 11165.6 based upon evidence that makes it more likely than not that child abuse or neglect, as defined, occurred.

- "Inconclusive report" means a report that is determined by the investigator who conducted the investigation not to be unfounded, but the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect, as defined in [Penal Code] Section 11165.6 has occurred.

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[14] Penal Code Section 11165.6 defines "child abuse or neglect" to include "physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2 (negligent treatment or the maltreatment of a child...under circumstances indicating harm or threatened harm to the child's health or welfare), the willful harming or injuring of a child or the endangering of the person or health of a child, as defined in Section 11165.3 (unjustifiable physical pain or suffering), and unlawful corporal punishment or injury as defined in Section 11165.4 (cruel or inhuman corporal punishment or injury resulting in a traumatic condition)."

Naturally, when the quality of the investigation is compromised, the resulting disposition is compromised as well. CSIU found countless incidents of dispositions that were beyond compromised—they were simply wrong. For example, in the Viola V. case, out of seven referrals, at least three should have been determined to be "substantiated" or "inconclusive" but were instead deemed "unfounded" even though there were admissions and corroborating witnesses. Likewise in Adrian R., three separate allegations of physical abuse were deemed "unfounded". All three should have been substantiated based on admissions and physical marks but were instead closed as 'unfounded'. During the investigation of the last referral alleging physical abuse by Father, the referral was again deemed "unfounded" based upon the father's denials and Adrian was left at home where he killed himself hours later.

The "inconclusive" disposition has also been applied incorrectly. "Inconclusive" does not mean "It happened but we do not think services are warranted." "Inconclusive" means that after a thorough investigation, evidence is lacking such that the investigator cannot make a determinative decision one way or the other. This classification should apply, for example, when parties with essential information cannot be reached or the family cannot be located. Instead, DCFS appears to use "inconclusive" to denote referrals wherein the facts support a finding of "substantiated" but, the safety and risk assessments indicate that DCFS intervention is not warranted.

Incorrect dispositions create several problems. First and foremost, an incorrect disposition leaves children at risk of continued abuse if it results in no intervention at all by DCFS. An incorrect disposition can also leave a family without the proper *level* of DCFS intervention. For example, "unfounded" and "inconclusive" dispositions result in either NO services being provided or, if anything, a referral to community resources with no oversight by DCFS. In contrast, a "substantiated" disposition generally results in, at a minimum, voluntary services being offered to the family.

Another potential problem with incorrect dispositions is that they create a potentially skewed family history that affects future investigations. This is particularly true for the "unfounded" disposition—which accounts for approximately half of the referrals in Los Angeles County. As counter-intuitive as it may seem, it appears that the more referrals DCFS labels "unfounded", the less likely it is that subsequent referrals will be "substantiated" or even "inconclusive". It seems the effect that 'serial unfoundeds' have is the opposite of the axiom, 'where there's smoke there's fire' and instead, they are viewed as supporting the 'innocence' of the alleged perpetrator. The danger to the children is exponentially compounded when time after time, dangers are not properly identified which creates an opportunity for the dangerous situations to continue and worsen.

In fact, one of the very first risk assessment tools utilized by ER workers investigating Hotline referrals is the SDM Safety Assessment Tool. One of the categories that factors into the SDM Safety Assessment Tool is "previous maltreatment of child(ren)" by the

caretaker. According to this tool, the worker must factor in prior substantiated referrals and prior inconclusive referrals but NOT prior unfounded referrals. Accordingly, classifying a referral as "unfounded"[15] makes it essentially irrelevant to future investigations. The proper assignation of a referral's disposition is critical to facilitating an opportunity to evaluate an accumulation/pattern of incidents that together, may constitute abuse/neglect.

c. **Time for a New Approach?**

Social work is not an exact science. Carrying out the responsibility of obtaining the facts necessary to determine: 1) whether or not the allegations of abuse/neglect are true; 2) whether to remove a child from their parents; 3) what type of services may be needed and; 4) what services are available to help the family, all the while ensuring that the child(ren) are safe, is undoubtedly challenging. It is a tall order particularly when all this must usually be done in a 'crisis' situation. While it is easier to chalk up the mistakes made by workers involved in child fatalities to personal failures, we must consider whether the system itself may inadvertently be creating opportunity for poor outcomes to occur.

The current practice of DCFS is to view line social workers generically, distinguishing them only in some areas of specialty such as adoptions, medically fragile unit, Native American Indian unit, etc. Accordingly, those who are assigned to the Hotline and/or Emergency Response (the 'front end') possess the same minimum qualifications and training as those workers who are assigned to provide family maintenance, family reunification and permanent placement services (the 'back end'). However, there must be recognition that there is a very distinct difference between the work of the 'front end' and the 'back end'.

As discussed above, having quality Emergency Response investigations is critical to establishing the correct course of a case. When a referral comes into the Child Protection Hotline, it means that someone in the community has seen or heard something so compelling, it prompted them to do something about it—call DCFS. That call to DCFS may literally be a child's one and only lifeline. In essence, the front end of DCFS' intervention is like the Emergency Room of a hospital where patients in crisis must be triaged and stabilized under circumstances that are often incredibly intense and stressful. Not every doctor is equipped to be an ER physician but, the ones that do their job well can literally save lives. The same is true for front end DCFS workers. For this reason, Front end workers must possess superior investigative skills, the ability to quickly analyze complex social and psychological issues, and the wherewithal to

[15] CSIU is has heard that some workers were reluctant to close referrals as 'inconclusive' as that would trigger reporting the parent the Department of Justice's CACI (Child Abuse Central Index) which could potentially have an adverse effect on employment decisions and other procedures involving a background check. To avoid this, referrals were closed as 'unfounded" instead. However, with the recent passage of AB 717, only "substantiated" findings are reportable to CACI thus, to the extent a conservative approach was ever justified, that is no longer the case.

recognize the need to consult with other professionals, agencies, or even their own internal supervisors before making decisions.

The 'front end' workers are not only the gate keepers to DCFS, they also set the foundation for all future interactions between DCFS and the family. For example, if drug abuse is missed during an initial investigation and the family's issues are instead characterized as "anger management and domestic violence", drug abuse treatment will not be incorporated into the family's service plan. Once this happens, drug abuse is likely to forever remain "off the radar" and will remain an unaddressed, but dangerous, issue for the family. Thus, if DCFS' initial investigation is flawed, it becomes exceedingly unlikely that someone "down the line" will identify safety issues that were missed by the ER worker.

- The People, The Skills

An Emergency Response investigation is not a simple undertaking. There is simply no possible way to reduce a child abuse/neglect investigation into a set of 'how to" policies as the tasks involved require both learned and innate skills. An ER worker must be able to able to read a situation, to be perceptive and to be able to challenge effectively. The ER worker must be a skilled interviewer because it takes finesse to illicit facts from people who are faced with criticism of their parenting skills or, even worse, faced with the threat of losing their children. An ER worker must have the analytical skills and a "gut instinct" to get to the bottom of "what happened" and to understand the risk factors and to recognize triggers that might indicate a child is at risk. An ER worker must also, in a relatively short period of time, decide whether additional professional assessments or input are necessary and then analyze the information presented by such experts. Given the highly stressful environment they must function in, they also need to be resilient, tenacious, and calm at all times.

The unique demands of the position are too many to count but one thing is clear—these investigations must be entrusted to only the most qualified and skilled workers. The ER investigations should be the equivalent of the military's "special forces" or the veteran law enforcement detectives that investigate homicides and other high-profile crimes. One would therefore assume that the DCFS workers who investigate these referrals possess superior skills and are some of the Department's brightest "stars." One would also assume that because investigating referrals requires a specific skill set, DCFS seeks out individuals and hires only those who are especially qualified. Unfortunately, neither assumption is correct.

Instead, precisely because of the demanding and intense nature of being an ER worker, the assignment is often viewed as less desirable than other assignments within DCFS. Thus, workers who are skilled and experienced are the least likely to opt for an ER assignment. While this does not mean that there aren't any "stars" in ER, it does mean

that ER workers are more likely to be inexperienced, overworked, and just "doing their time" before moving on to a more desirable assignment.[16]

The problem is further compounded by state regulations that potentially preclude DCFS from recruiting individuals with the specific skill set that would be ideal for the work in ER[17]. State Regulation 31-070 requires that child welfare workers must possess a bachelor's degree in social work or its equivalent in education and/or experience as certified by the State Personnel Board or a county civil service board. In Los Angeles County, the Civil Service Board has determined that for the position of "Children's Social Worker" the equivalent of a Bachelor's degree in social work, are degrees in "psychology, sociology, child development, or a related human services field." Excluded from the list of acceptable 'equivalent' degrees are ideal areas of study such as criminal justice, public administration, and police science. The minimum qualifications also exclude individuals who have advanced degrees in field such as Education and Law, unless they happen to have an undergraduate degree in one of the accepted fields. Finally, the minimum qualifications exclude individuals with a background in law enforcement—a group that would presumably have a great deal of experience conducting factual investigations involving reluctant witnesses and complex social dynamics.

Clearly, it is time for a new approach. DCFS must recognize, as other jurisdictions seem to have done, that there is a distinction between the investigatory aspect of social work and the service provision aspect. Inherent in this distinction is the fact that workers who want to help a family and may even view themselves as the family's ally may not be as suited or equipped to conduct factual investigations that require critical assessments of credibility. Case-carrying workers who handle the service provision aspect of a case need to gain the family's trust and foster long-term relationships in order to gain the family's cooperation. The ability to achieve these objectives requires a different skill set than those needed by an ER worker and most likely, a different personality type as well. By contrast, investigative workers need to be objective and perhaps a little less empathetic because their job is to gather facts regardless of what the outcome might be.

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[16] The ER worker assigned to investigate the hotline referral in Jorge T. was just 11 weeks out of the DCFS academy.

[17] Regulation 31-070 of the Manual of Policies and Procedures, Child Welfare Services State of California (May 1999), requires that at least 50% of professional staff providing emergency response services, and at least 50% of the professional staff providing maintenance services shall possess a Master's Degree in Social Work, or its equivalent in education and/or experience as certified by the State Personnel Board or a county civil service board. The regulation further requires that 100% of the supervisors of staff providing emergency response and family maintenance services shall possess a Master's Degree in Social Work, or its equivalent in education and/or experience as certified by the State Personnel Board or a county civil service board. The remaining emergency response and family maintenance services professional staff shall possess a bachelor's degree in social work or its equivalent in education and/or experience as certified by the State Personnel Board or a county civil service board. CSIU is advised that Los Angeles County received a waiver from the State of the required staffing levels of MSWs.

DCFS should allow qualified individuals to commit to Emergency Response work and should change requirements that unnecessarily limit the applicants to the exclusion of well-qualified individuals. This would involve a wholesale change to the way DCFS recruits and hires the people who conduct these investigations. For example, CSIU found that in Florida, Texas, and Rhode Island child welfare agencies have a separate category of employees called "CPS Investigator" or "Child Protective Investigator." The investigator positions in these jurisdictions are distinct from the case-carrying workers (those are referred to in one jurisdiction as "CPS Family Based Safety Services Caseworker). Candidates are recruited for and offered a job specifically in the investigations unit. Thus, by accepting the job, the individual is making a commitment to become a skilled and experienced "investigator".

The job specifications for the investigator positions focus on the unique skills that are required for this type of work. They look for candidates with "a thorough knowledge of interviewing skills...the ability to extract and interpret highly complex information and ascertain facts by personal contacts and analyzing documents...the ability to utilize sophisticated information systems equipment in order to enhance the fact finding and analytical process..." In Texas, there is even a distinct classification called "Special Investigator" that is assigned to "consult with other CPS staff investigating cases that are high profile or high-risk nature." For the position of "Special Investigator" two years of law enforcement experience is ***required***.

CSIU found other jurisdictions, such as Arizona, that do not create a separate "investigator" category but do include disciplines such as education, criminal justice, and law enforcement in the minimum qualifications for their child protective services workers. In Arizona, a social worker is not eligible to perform investigative work until they reach the "Child Protective Service Specialist II" classification, which requires 2-3 years of experience depending on the level of education completed. Even then, the investigative work is discretionary. It is not until a social worker in Arizona reaches the level of "Child Protective Specialist III" that an emphasis is placed on investigative work.

The approach taken by these jurisdictions makes sense. Clearly, they recognize the value of having skilled and experienced "fact gatherers" in charge of figuring out what happened before anyone starts trying to figure out how to "fix it". This is not to say that ER investigators do not need to possess the ability to carry out quality assessments of safety and risk, such skills are necessary for them to determine 'what to do' after having gathered all the necessary facts. Rather, having the skills necessary to be an effective 'fact gatherer' should go hand in hand with good assessment skills. When the right facts are gathered from the start, all future interactions with the family will be supported by a fundamental understanding of the family's history and an awareness of all the issues that must be addressed in order for the children to be safe. Simply put, done right, the ER investigation establishes a strong foundation upon which the traditional social work can be done: providing the family with the support and assistance that it needs to address the underlying issues that brought the family into the child welfare system so that children can grow up in a safe and healthy environment.

➢ The Training

To compound the unique challenges faced by ER workers who may not possess the innate abilities required for conducting effective investigations, is the fact that there is insufficient training provided to these workers to carry out their responsibilities. As discussed above, the activities inherent in conducting investigations require a different skill set that include things such as interviewing skills needed to elicit information from a variety of different interviewees from young children to reluctant witnesses, having sufficient knowledge and understanding to recognize signs of abuse, having good deductive reasoning skills, knowing how to read 'rap sheets', knowing how to recognize signs of intoxication or being under influence of drugs, etc. Unfortunately, the current training curriculum at the DCFS Training Academy does not adequately address these unique needs. For example, training in interviewing consists of 3-4 hours of class room style learning while training on how to use the CWS/CMS system comprises of 4 days! The focus seems to be on 'what has to be done' (i.e. within how many days contacts must be made; documentation requirements) rather than 'how to do it'; that is, an emphasis on form over substance.

Training to conduct effective and thorough investigations is a standard component of training at law enforcement academies. In the law enforcement field, a course in basic criminal investigations can comprise of 40 hours, drug abuse recognition may be 24 hours and a course on interviewing and interrogation can be 40 hours. Even after that level of training, a new graduate does not get assigned to become a detective (those who conduct investigations into crimes) until significant experience has been gained and the officer having demonstrated that he/she possesses the type of personality and innate skills necessary to do that type of job.

DCFS needs to provide specialized training to its ER workers that prepares them to be able to effectively gather the facts and information necessary for them to discern 'what happened'. An example is training in forensic interviewing. A specialized skill like forensic interviewing takes time to teach and to learn; 3-4 hours is simply not sufficient. ER workers should also be trained on how to recognize signs of substance abuse/intoxication, mental illness, signs of failure to thrive and other indicators of child abuse/neglect and safety issues. In other words, training must be tailored to and commensurate with the essential skills needed for carrying out the responsibilities of an ER investigator and those skills need to be taught in a practical fashion rather than just 'theory'. It also should go without saying, that the trainers must be those qualified and experienced in not only the subject matter that they are teaching, but also in the process of training others.

In order to teach ER workers in a practical and effective way, competent curriculum design is essential. Problem-based learning is one means of meeting both the objectives of transformative learning and adequately testing/screening potential investigators. It employs an experiential activity-based format designed to take advantage of an adult learner's level of cognitive development. Problem-based learning

places students in the active role of problem solvers who are confronted with complex problems similar to those confronted in workplace situations. The model is learner centered and facilitates the transfer of knowledge from a classroom environment to real-life settings. Properly conducted, problem-based learning promotes collaboration, builds teamwork skills, and develops leadership abilities through cooperative work-group experiences. Students move through a series of inquiries involving the generation of ideas and discussion of known facts and learning issues. Participants then develop a plan of action to resolve problems and evaluate the learning process. Law enforcement agencies across the country are implementing problem-based learning in training programs.[18] DCFS should explore the viability and suitability of such a training approach for its 'front end' workers.

The nature of the work done by 'front line' Emergency Response workers is extremely challenging particularly given the inherent danger that volatile family situations can pose. Accordingly, DCFS must develop a robust training program that prepares its Emergency Response workers on the 'how to do' rather than the 'what to do' and equally important, prepares them for success. The training should incorporate means by which to assess the readiness/preparedness of the workers to do the job of investigating allegations of child abuse/neglect such as real-life situation specific simulations, written testing and/or use of 'field training officers' to evaluate performance of ER workers. These are the same or similar 'litmus' tests that law enforcement utilizes before putting a new cadet 'on the line' and before they get to strap on a gun belt. Such means to assess worker readiness provides a level of confidence that those being asked to carry out jobs that can have life or death consequences, are capable of doing so effectively and appropriately.

➢ <u>The Way to Improvement</u>

Recognizing and acknowledging the need to differentiate between the work performed and the skills necessary to carry out the investigative aspect of the front end work versus the 'back end', is a necessary first step to correcting the 'they are fungible' approach that contributes to poor child welfare outcomes. The latter approach has resulted in DCFS not having the most suitable and qualified people on the 'front lines' to make decisions that can have life or death implications for a child. This is borne out by the fact that 'front end' mistakes were identified as contributing factors in almost every single child fatality reviewed by CSIU.

Once the people with the aptitude, interest and commitment to perform 'front line' work are identified, providing them with specialized training to facilitate effective investigations should naturally result in a better qualified and effective 'front line'. This in turn would yield more positive outcomes, not only for children and families, but for DCFS as well if its resources on the 'back end' are being directed at those children and families who are actually in need of assistance. Continuing to entrust to those who are

[18] http://www.lapdonline.org/assets/pdf/boi_rand_03_03_31.pdf

ill equipped and/or ill prepared to carry out the responsibility of potentially making life or death decisions, is not only imprudent for child safety but it is perhaps unreasonable to the worker being asked to do that job.

RSI #2: **THE INEFFECTIVE IMPLEMENTATION OF DECISION-MAKING TOOLS AND STRATEGIES—WHAT IS THE INTENDED PURPOSE?**

Once DCFS completes its investigation into "what happened", it must decide what level of intervention is necessary (if any) and what services have to be delivered in order to address the issues that brought the family to DCFS' attention and to protect the children from future abuse. The task sounds simple enough but in reality, these decisions are not straight-forward. Complex family dynamics, distrust of the child welfare system, mental health issues, substance abuse and addiction, socioeconomic challenges, and limited resources are just a few of the factors that come into play as social workers try to meet the challenge of "fixing" families. To complicate matters further, social workers must also comply with legal timeframes and departmental and legislative mandates. No one can deny that the landscape of social work is extremely complex.

From the Department's perspective, there is a further complication in that it relies on a work force that is as diverse as the clients it serves. Social workers come from a variety of ethnic and social backgrounds that inescapably shape the biases they bring to their work. They also come from numerous educational backgrounds with varying degrees of higher education, and have different levels of clinical training and experience. And, of course, as is the case with any large organization, there are varying levels of competence.

Against the backdrop of this complex landscape, DCFS must reconcile the tension between the need to give its workers freedom to rely on their independent judgment and the need to ensure that they consistently reach sound decisions that protect children. DCFS has met this challenge by delivering a multi-layered message that is designed to align its workforce of thousands under common goals. The messaging begins with a mission statement and is supported by six departmental goals. The mission statement and goals are then communication and incorporated into the day-to-day practice of its social workers. This is achieved, in part, through the implementation of the Department's many policies and procedures and through strategies such as Point of Engagement, Team Decision Making Meetings, and the use of Standard Decision Making Tools.

The establishment of policies, tools, and strategies is a good thing. When used correctly, such strategies can offer guidance in decision making and give social workers the support they need to make sound judgment calls. And, by tying these day-to-day tools and strategies to its mission and departmental goals, DCFS can achieve a level of consistency that is essential given its sheer size and the scope of services it must deliver in order to protect children. So, the question becomes—if these tools and

strategies are supposed to guide workers to sound decisions, why are they leading some workers to tragic results?

The problem is that it is not enough to simply create policies, programs, and tools. These tools must be complimented with a clear message about their intended purpose; adequate support and resources; and practical training. The Department must therefore take an active role in communicating the purpose of these strategies to its workers on a department-wide basis in order to ensure that every office in every region is utilizing these tools and strategies correctly and consistently. The Department must also train and, when necessary, re-train its workers and administrators so that even as new line workers, supervisors, and administrators come into the picture, the strategies continue to be carried out in a manner that is consistent with the Department's intent and purpose. And, the Department must periodically assess the use of these tools and strategies in order to ensure that they are still relevant and are being implemented in a way that remains true to their intended purpose. As it currently stands, there are a number of tools and strategies that DCFS has adopted that are in need of this type of re-evaluation. It is therefore time for DCFS to re-visit its policies, procedures, tools, and strategies and to ask itself—what was the intended purpose of these tools and strategies?

a. The Role of DCFS Policy—It's Like Trying to Find a Needle in a Haystack

Companies and organizations across the country rely on policies and procedures as a means of establishing basic expectations and standards for employee conduct. Policies and procedures cannot possibly address every scenario an employee will encounter but they are ideal for establishing basic instructions and guidelines for recurring situations so that over time, employees and managers will make decisions that are consistent with the organization's large-scale goals.

In order to be effective, however, policies and procedures must be easy to understand, easy to apply, and accurate from one document to the next.[19] Stephen Page, author of four best-selling books on policies and procedures, notes several reasons users are likely to ignore or violate policies including: complex or wordy content, unclear purpose or title, weak or lacking communications and training efforts, and overly frequent revisions/issuances of policy. Unfortunately, DCFS' policies are not easy to understand and apply but instead tend to suffer from each of the pitfalls that make policies likely to be ignored or violated.

DCFS has a policy[20] for just about every action a social worker can possibly take—there is even a seven-page policy that tells workers what to do when a client speaks a language other than English.[21] CSIU found that as of March 12, 2012, DCFS has 4,364

[19] See Stephen Page, MBA, PMP, CRM, CFC, "Writing Effective Policies and Procedures" (PowerPoint, 2003)
[20] DCFS uses the terms "policy" and "procedural guide" interchangeably. Accordingly, for clarity, this report uses the word "policy" to refer to DCFS' policy/procedural guides.
[21] DCFS Policy No. 0070-501.10

total pages of policy. The policies range in length from 1 to 67 pages with the average being approximately 14 pages long. Each policy cross-references between 1 and 48 other policies with the average policy cross-referencing 7 other policies.

In addition to the sheer number of policies, CSIU has first-hand experience with the frustration that can ensue when looking for the policy that is relevant to a specific issue. The policies are not set-up in a logical format and are difficult to navigate because they do not have a search function that enables users to run keyword or subject matter searches. Thus, even when referencing a policy might be helpful, workers have to search for a needle in a haystack to find the policy and/or language within a policy that applies to a given situation.

For example, as CSIU experienced during its investigation of Abigail M., if someone needs information on the Department's collateral contacts policy, they can't simply run a search for the phrase "collateral contact". Somehow, they must determine that collateral contacts are discussed in the "Emergency Response—Assessments and In-Person Responses" section and *not* in the "Contacts: Visitation, Letters, and Telephone Calls Section" (even though there *is* a policy in that section entitled "Attempted Contacts on [Hotline] Referrals"). Assuming one knows to look for "collateral contacts" in the "Emergency Response" and not in the "Contacts" section, there are more than 50 individual policies relating to everything from search warrants to Shaken Baby Syndrome within the "Emergency Response" section. It is only by opening and reviewing each individual policy that one will discover collateral contacts are discussed in the policy entitled "Disposition of the Allegations and Closure of the Emergency Response Referral." If DCFS' policies are truly there to guide workers and to establish consistency among DCFS' work force, they must be written and organized so that it does not take years of working with the policies to understand their structure, format, and substance.

In addition, DCFS' current policies are not easy to understand nor are they easy to apply in daily practice. As noted above, the average policy is approximately 14 pages long and cross-references 7 other policies. Policy must be written to assure understanding and encourage continual use. The cardinal rules for good policy writing in the child welfare context include: clear, concise, simple language, precision, accuracy, consistency, and up to date. It is generally accepted that language consistent with a middle school level is preferable for policy in the child welfare context. Without exception, the level of language and writing should not exceed the 9th grade level.[22]

DCFS' policies, as currently written and organized, do not meet these guidelines. Procedural Guide No. 0400-504.45, for example, is the DCFS policy on "Supervised Visits". It is 20 pages long and cross-references 6 DCFS policies, 3 Welfare and

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[22] ACTION for Child Protection, Inc. for The Office of Children's Services, Alaska Department of Health and Social Services, "An Expert Review of Policy that Regulates Practice and Decision Making During Investigation." (2007)

Institutions Code sections, the California Department of Social Services Manual of Policies and Procedures, and the California Rules of Court. Within its 20 pages, the policy contains a 10-step checklist for preparing a Monitor to monitor visits and a 10-step checklist for preparing the visitor to visit. This is in addition to the two attachments that repeat much of the same information and must be signed by the monitor and the visitor respectively. The policy also lists the requirements for Volunteer Monitors in two sections without any apparent need to do so, which creates confusion and forces the reader to compare the two sections to make sure they are, indeed, duplicative. Finally, the policy lists requirements for serving as a Professional and/or Therapeutic Monitor even though such monitors are not DCFS employees and are therefore not "governed" by DCFS' policies.

Given the frenetic pace of day-to-day social work, expecting DCFS' social workers to read and assimilate such cumbersome and voluminous policies and then apply them in their day-to-day practice is simply unrealistic. Creating social work roadmaps with this level of "how-to" is like expecting a therapist to use a script that tells her what questions to ask and what responses to expect from her client in a therapy session. Likewise in the hospital emergency room, doctors are not given step by step instructions for what to do for every scenario that they may face. What happens when the therapy session or ER patient deviates from the script? Like therapy and emergency medicine, social work demands a level of skill and professional judgment, the absence of which cannot be compensated for by an over-reliance on policies. Accordingly, policies should set forth the rules of the Department, not the "how-to" for implementation of those rules.

If the ultimate goal is for these policies to offer guidance and establish "best practices" for recurring situations, DCFS needs to ensure that its policies are written in a way that makes it really easy for workers to refer to and apply policies on a day-to-day basis. Each policy should reference the departmental goal that is the target of the policy; the language must be straight-forward; and the policies should be consistent from one to the next.

Once the policies contain the right message in a reader-friendly format, DCFS must ensure that its message is communicated in a consistent manner by ensuring that all workers receive training on the content of the policies and the Department's expectations for implementation. This of course means that the policies cannot change on a daily, weekly, or even monthly basis. The reality is that amending policies should not be an everyday occurrence—it should only be done when the Department, after consulting with legal counsel, determines that a change is absolutely necessary.

DCFS expends significant time and money to draft, revise, and implement its policies. Given their sheer volume alone, it is time for DCFS to seriously re-assess the purpose that is supposed to be served by its policies and to re-vamp its current policies to achieve the right results.[23] With minimal re-organization and simplification, these

[23] The timing for such a re-evaluation may be perfect since DCFS has recently created as in the process of implementing its Core Practice Models. These Practice Models are intended to address the day-to-day

policies will be an effective means of promoting the Department's goals and incorporating those goals into day-to-day practice.

b. Point of Engagement—Every Component Matters

DCFS began developing the Point of Engagement Process ("POE") in 1999 in response to a Price Waterhouse Coopers audit recommendation that the department revise its case flow process and provide a faster response for services. POE is a service delivery model where the basic goal is to deliver services to families in crisis at the earliest possible opportunity and to ensure that the family is not "lost" as the case is transferred from the investigations worker to the continuing services worker. The basic idea behind POE is that if DCFS enters the picture prepared to immediately deliver services without interruption, children who would have ordinarily been detained will be allowed to remain at home because the services and supports that are put into place will mitigate safety factors and reduce (or eliminate) the risk of future abuse or neglect. If, for whatever reason, removal of the children cannot be avoided, the immediate and uninterrupted delivery of services will put parents on a faster track to reunification or, if the parents choose to not take advantage of the services, put the children on a faster track to permanency.

In theory and on paper, POE appears to be an ideal model for delivering services and for protecting children. For those families that are genuinely ready to accept help, services are delivered in short order, with their input, and in collaboration with support systems they already trust (like family, clergy, friends, etc.) And, for children whose parents are not committed to rehabilitation, the sooner services are offered, the sooner the path to permanency can begin. This is all true assuming that implementation of POE is in line with the departmental goals it is intended to promote and that all components of the model are implemented as intended.

With respect to ensuring that POE is implemented in line with the departmental goals, there appears to be a gap between DCFS' goals and the stated objectives of POE that are being conveyed to workers. Notably, DCFS' departmental goals are depicted on its website and elsewhere in a list format with "Improved Child Safety" at the top of the list. By contrast, "Improved Child Safety" is not even listed as a departmental goal in materials that deal exclusively with POE. Instead, POE is described as achieving the departmental goals of "Reduce the number of child detentions", "Reduce the median length of stay in placement", and "Reduce the rate of abuse in foster care". Notably, "Reduce the number of child detentions" appears first on the list which sends a message that it is the top goal in POE. As for the two other "goals", they are not even accurate re-statements of the Department's stated goals.

In addition to making sure that the message of POE's purpose is consistent with its goals, the Department must ensure that every component of the POE model is in place

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practice of DCFS social workers and may therefore present the perfect opportunity to eliminate redundancies and/or contradictions that may exist in policy.

in order for it to achieve its intended purpose. Unfortunately, the "vision" of POE is not being implemented in real-life practice and the failure to do so results in a "watered-down" version of POE that cannot possibly be as effective as the model and possibly, even contrary to its intended purposes when 'bits and pieces' are being utilized out of the context of the whole.

- The Absence of Key Personnel

The success of POE as a model for delivering services depends on the inclusion of certain key personnel. Specifically, according to DCFS, POE is supposed to utilize "well-trained emergency response child abuse investigations units to provide more thorough investigations and Intensive Services Workers to provide timely provision of services." As discussed earlier in this report, well-trained investigators are a fundamental aspect of DCFS' intervention and should be at the heart of any model that is developed for the purpose of meeting any of DCFS' departmental goals. It should therefore go without saying that in order to deliver effective services at the earliest possible opportunity, as POE is supposed to do, the issues to be addressed by such services must first be identified through thorough factual investigations.

The concept of an Intensive Services Worker ("ISW") is equally fundamental to the POE model. When POE was developed, ISWs were identified as workers who would be a continued presence for the families as their case was transferred from the investigator to the continuing services worker. Having a recognizable face follow the family through the transition would ensure that families who agreed to participate in services at a very early stage would remain motivated and engaged in the process. In addition to being a continued presence for the families, the ISW was there to support the investigations and continuing services workers. Having an ISW in place was supposed to ensure that when the case went from investigations to continuing services, the file did not simply end up at the bottom of a continuing social worker's pile where the family might languish for weeks without hearing from anyone or receiving their service referrals. Also, the ISW was to be in charge of gathering "basic identifying data such as birth records, the father of the child, and accessing eligible benefits such as social security, along with other case management protocol."[24] By taking such tasks off the investigators and continuing services workers' plate, the ISW would free those other workers up to perform more critical functions.

For a model that is supposed to be characterized by the "seamless and timely transfer of responsibility from front end investigations to actual service delivery in order to provide more thorough investigations and needed services to children and families" it seems that qualified and specially trained investigators and ISWs are a "must-have". In reality, what happened is that the ISWs were re-deployed to Emergency Response when the Department reallocated personnel to address the "ER over 60" crisis. Likewise, the "ER over 60" crisis prompted DCFS to fill needs in its investigator ranks

[24] Marts, et al. "Point of Engagement: Reducing Disproportionality and Improving Child and Family Outcomes", Child Welfare, Vol. 87 #2 (2008).

with temporary workers that had less-than sufficient experience and/or commitment to the Department (for example, part-time and temporary workers). Accordingly, one of the most essential components of POE—key personnel—has been dropped from POE in its implementation which results in compromising the integrity and effectiveness of the strategy.

- Community Collaboration...but no County Cooperation?

Another critical component of the POE model is that it seeks to build consensus by including the family and members of their support network into the decision making process. The idea is that if DCFS has full "buy-in" from the family and the family is supported by people they trust (like pastors, family, and friends), the family is more likely to engage, participate, and benefit from services. And, as a result, children can safely be left in their homes because there are supports in place to lower (or eliminate) identified risks.

To achieve this consensus, the POE model calls for DCFS to seek support from community based organizations, faith-based groups, local businesses, and community leaders who care about children.[25] POE also relies upon the active engagement of resources within DCFS and other county services such as the Departments of Mental Health, the Department of Health Services, the Department of Probation, and the Department of Public Social Services, along with the Sheriff's Office.[26]

A 2008 study that analyzed the implementation of POE in the Compton office found that the relationship between that office and its community based organizations has improved dramatically as a result of POE implementation. According to one worker, "[before] when referrals were made and there was no way to determine if [families] got the services. Now we have a relationship with the agencies we refer to and they let us know if the families come. They also help the family link to other agencies to find services. They help us."

The integration of other County Departments, on the other hand, has not been so positive. For example, one of the key components in the POE process is the use of Up-Front Assessments ("UFAs"). A UFA is requested when an emergency response worker suspects a problem connected with mental health, substance abuse or domestic violence and needs additional expertise and insight to determine the extent of the identified issues. UFAs are supposed to be conducted by experts in the designated field (mental health, substance abuse, or domestic violence) who are either licensed clinicians or have a Master's degree and work under the direct supervision of a licensed clinician. The intent is for these individuals, who have specialized knowledge in these areas, to conduct a time-sensitive assessment so that the investigating social worker can incorporate the expert's conclusions into his/her investigation and, presumably,

[25] Marts et al.
[26] Marts et al.

arrive at better informed decision regarding the possibility of mitigating safety factors and the degree of risk posed by the identified issues.

Again, this all sounds ideal on paper. According to information received by CSIU, however, when the developers of POE sought out other County agencies to assist with the mental health, drug abuse, and domestic violence screenings that are an integral component of POE, they came up empty. Accordingly, these screenings are currently conducted exclusively by Family Preservation agencies that already contract with DCFS to provide a wide range of other services. The lack of options for UFA referrals beyond Family Preservation Agencies has the potential to create a backlog, compromise the quality of UFAs, and may even make UFAs cost-prohibitive. Such results would disrupt the intended flow of the POE process. If investigators are to use UFAs as a means of assessment the most common issues DCFS sees in its families (drug use, domestic violence, and mental health), they must have ample referral options and a network of providers who understand the time-sensitive nature of UFA requests and are willing participants in this critical component of POE.

In order for DCFS to effectively implement a model that is designed to essentially overhaul its approach to delivery of services, it must obtain "buy-in" from other County agencies that are in a position to help DCFS achieve its mission. To do this, DCFS must be persuasive in convincing these other agencies that delivering services to DCFS-involved children and families is NOT just DCFS' mission, it is a county-wide mission in which numerous departments have a role to play. In other words, DCFS cannot simply create a model that contemplates county-wide cooperation without a solid commitment from the other departments and agencies that are clearly essential to the POE model.

- Region to region and office to office...it should all be the same

Finally, if POE is going to succeed as the Department's new service delivery model, it must be consistently implemented region to region and office to office. Anything short of this defeats the purpose of POE as a means of meeting the Department's goals of Improved Child Safety, Decreased Timelines to Permanence, and Reduced Reliance on Out of Home Care. CSIU was informed that since its initial implementation in 2005, POE has morphed and current office implementation varies resulting in little resemblance or fidelity to the original model. Apparently, the only offices that have remained true to the original model and intent are those in SPA 6. In fact, it even appears that some offices have not implemented POE at all. If this is indeed the case and the POE strategy is not being used as intended, being used haphazardly or only selectively, then naturally the efficacy of the strategy is seriously compromised.

c. Voluntary Family Maintenance ("VFM")

VFMs are characterized as a component of POE but it may be more accurate to characterize VFMs as an "outcome" of the POE model. Recall that POE is a service delivery model that emphasizes thorough factual investigations, immediate and uninterrupted services, early assessments, and consensus building through the incorporation of community and family support networks. The intended outcome of having all of these components in place is that fewer children will need to be detained because with a full understanding of the family's issues, a clear direction for addressing those issues, and commitment from individuals/entities who will support the family through its participation in services, children can be safe in what would otherwise be an unsafe situation.

So, with all of those components in place, the desired outcome is that if the family agrees to participate in voluntary services, court intervention is not necessary. As POE proponents would say, "Court is the last resort." The vehicles through which "court is the last resort" are carried out include VFMs and VFRs ("Voluntary Family Reunification"). In a VFR, the children are removed from the home without court supervision but, with consent from the parents. The children are then placed with relatives or in a foster home while the family participates in services. When DCFS determines that the parents have rehabilitated, the children are returned. Since none of the fatalities investigated by CSIU involved children on VFRs, this report will not address the viability or effectiveness of VFRs. It will instead focus on VMFs because that is where CSIU has seen examples of the clear disconnect between the model's intended purpose and its implementation.

Under a VFM, the children remain in the home and the family voluntarily participates in services such as counseling, substance abuse testing, and parent education. VFMs are utilized under the following circumstances:

- Substantiated Abuse/Neglect Allegation + Moderate/High Risk on the SDM Risk Assessment Tool
- Substantiated Abuse/Neglect Allegation + High/Very High Risk on the SDM Risk Assessment Tool + Mitigation of Safety Factors Identified on the SDM Safety Assessment Tool

Accordingly, the only instance in which detention and court intervention are warranted is as follows:

- Substantiated Abuse/Neglect Allegation + Unmitigated Safety Factors Identified on the SDM Assessment Tool

The intent and purpose of VFMs, then, is to meet DCFS' departmental goal of "Reduced Reliance on Out-of-Home Care" and the legislative mandate to reduce the necessity for removing children from their home. The distinction between a VFM case and one that would have otherwise required removal of the children from the home under court

supervision, then, is the family's willingness/ability to mitigate safety factors. With this in mind, it is clear that VFM cases are not any less serious and do not pose less danger to children than detention/court cases—rather, they are detention/court cases that were "saved" from court intervention because DCFS gained the family's cooperation and put safety measures into place to protect the children while services are provided to the family.

➢ The Need for Intensive Supervision and Services

VFM cases must therefore be approached with a recognition that but-for the mitigation of safety factors, these children would have been removed from the home and court supervision would have been in place to monitor the parents' progress and to sanction return of the children to the home. As such, DCFS has a great responsibility to these children and must, at all costs, ensure that the decision to leave these children in what would have otherwise been an unsafe situation does not backfire. To that end, DCFS must employ **intensive supervision** to confirm that the mitigated safety factors remain mitigated and **intensive services** to ensure that the departmental goal of "Reduced Reliance on Out-of-Home Care" does not inadvertently take priority over the equally important goal of "Improved Child Safety".

The POE model appears to contemplate intensive services and supervision for VFM cases by incorporating elements such as an Intensive Services Worker, Family Preservation involvement for "high risk" and "very high risk" cases, and the use of an MCPC or designated family preservation staff to help develop specialized case plans for "high risk" families.[27] As implemented, however, VFMs do not receive the intensive services and supervision that are warranted in the recognized precarious circumstances under which they are utilized.

First and foremost, as discussed above, the ISW component has been eliminated and so, the worker who was supposed to provide immediate linkages to services and remain a continued presence for the family as the case is transferred to the continuing services worker is no longer part of the VFM team.

Second, despite the recognition that most VFMs would have been a court case but-for the mitigation of safety factors, there is nothing in DCFS policy or in the way that VFMs are monitored that takes into account the need for heightened vigilance and intensive supervision of these cases. For example, whereas VMFs warrant additional contacts with the children and the family to make sure mitigated safety factors remain mitigated, in practice VFMs do not require any contacts beyond those that are required for ordinary court-ordered in-home placements (i.e., twice a month for the first three months and once a month thereafter). Likewise, there is no specific requirement for

[27] MCPC stands for Multi-Disciplinary Case Plan Committee and is a case-planning committee comprised of the network service providers and staff from DCFS, Probation, Health Services, Mental Health, Education and other agencies. The MCPC meetings are face-to-face and or convened telephonically, in emergency situations.

unannounced home visits, which would be an ideal way to confirm that the family is complying with the conditions of the VMF agreement that they are required to sign, particularly given the voluntary nature of the family's commitment to cooperate with DCFS. Likewise, DCFS policy and practice do not require intensive supervision of the parents' compliance with the service-component of their VFM contract. CSWs are only required to obtain written progress reports from service providers every three months. Given that VFMs are in place for only six months, obtaining written reports from service providers every three months is simply inadequate and clearly, ineffective to 'catch' non-compliance early in the life of the VFM case.

Finally, and perhaps most concerning, is the fact that once a VFM is put into place, there isn't any sort of formal review process until the six-month mark where DCFS must decide whether the VFM has been successful. Even then, the case-carrying worker is not required to complete a formal report, as would be required if the court was monitoring the case. This lack of reporting is especially concerning given the fact that most DCFS offices do not have a VFM unit. Instead, CSWs carry a mixed caseload comprised of VFMs and court-ordered FR/FM cases. With such a structure in place, it becomes really easy for workers to place focus on the court-supervised cases that require reports and possible testimony while treating VFMs as "less important" because they are "voluntary".

At the end of the six-month VFM period, at which point the worker has had only nine contacts with the family and two written reports from services providers, the options are: (1) continue for three more months **with ARA approval**; (2) initiate a VFR (which, why would the family agree to voluntary removal of their children at this point?; (3) remove the children and file a petition in court; or (4) terminate services all together. Given the precarious nature of the cases in which VFMs are initiated, DCFS must do more in the six months that precede the decision to take one of these four steps.

This framework of VFM implementation makes it a little less surprising, though not less disconcerting, that CSIU observed serious lapses in VMFs such as:

- A CSW did not independently corroborate Mother's compliance with the VFM agreement requirement that she participate in therapy and take her prescribed medication until ten months after the VFM was initiated. Even then, the CSW relied on Mother's self-reporting to corroborate compliance, rather than speaking directly with mother's services providers.
- A VFM in which Mother was living in a board and care facility yet all but one of the CSW's visits were announced thereby giving Mother ample notice of the CSW's presence.
- A VFM in which a baby was placed with parents while they were residing in a homeless shelter without assessing other residents who would have

significant contact with the baby nor follow up with the service providers from whom the parents were allegedly receiving services.

- A VFM that was approved with moderate/high SDM risk assessment even though Mother had documented history of drug use and the family had disappeared from DCFS when a prior VFM was offered **just two months prior.**
- A hotline referral that was closed despite a "very high" risk level and recommended decision to "promote" the case because a VFM had been closed just three weeks prior and the family was not eligible for further VFM services because of time restrictions in DCFS policy.

With such lapses in mind, DCFS should re-assess VFMs for the purpose of ensuring that VFMs, as they are being implemented, are consistent with VFMs, as they were intended. In doing so, special attention must be paid to the fact that the families being placed into VFMs are families that were on the "brink" of court intervention and, as such, require a heightened level of services and supervision. To do otherwise is setting the children in these families up for disaster. Accordingly, there should be strict criteria that governs the level of services and supervision that will be employed by DCFS in VFM cases.

- <u>The New Criteria for VFM Implementation</u>

In particular, DCFS should explore implementing VFM-only units in which CSWs have lower caseloads such that they are available to make more frequent contacts with the children, parents, and service providers. To the extent possible, DCFS should re-introduce the concept of an ISW who is involved from the time of the hotline referral investigation until the family is in touch with their continuing services worker. As the ISW will be the "constant" during this critical stage, that worker, in conjunction with other professionals, family members, and community supporters should take an active role in developing the VFM agreements and service plans. The VFM agreement should be tailored to the family's specific needs and strengths, as should the case plan. Along the same lines, the service providers who are on the referral list for VFMs should be deliberately chosen to serve VFM families because they understand and are prepared to deliver the level of services these families need. With these qualified professionals in place, the family's progress should be assessed in a formal setting (either a sit-down meeting or a written report) at regular intervals by, at a minimum, the case-carrying worker and the supervising social worker.

Implementing such criteria for the services and supervision of VFMs will better position DCFS to meet its goals of "Improved Child Safety" and "Reduced Reliance on Out-of-Home Care" in a manner that does not compromise one for the sake of the other.

d. Team Decision Making ("TDM") Meetings

TDMs are a component of POE but they are also used at other stages of DCFS' intervention. At a TDM meeting the family, their relatives, friends, community members, caregivers, service providers, and DCFS staff collaborate in the decision making process with the goal of reaching consensus on a decision regarding placement of the children and/or the design of a Safety/Action Plan, which protects the children and preserves or reunifies the family.

According to DCFS Policy No. 0070-548.03, TDMs are held when: (1) a child is being considered for removal from his/her home; (2) a child is being considered for placement/replacement; and (3) a child is being considered for reunification. TDMs are ideal because they provide an opportunity for all parties involved in the family's rehabilitation to "come to the table" and participate in critical decisions. TDMs are, quite possibly, one of the most concrete ways for DCFS, service providers, relatives, and others to show their commitment to a family in crises. TDMs can also serve as an excellent reminder to all involved that the children are at the heart of it all because TDMs are convened to make decisions about the *children*.

In speaking with DCFS, CSIU learned that TDMs can be extremely effective, if done correctly. Like other tools and strategies discussed in this report, the key to ensuring that TDMs remain an effective means of promoting consistency in decision-making lies in implementation that maintains fidelity to their intended purpose. In this regard, it is critical for DCFS to clarify its "message" on TDMs because what is currently missing in application is the recognition that TDM facilitators are key players in TDMs and that in order for TDMs to be useful and effective, the right participants must be present.

- Lack of Clarity Regarding the Role of TDM Facilitators

TDMs are presided over by TDM Facilitators. DCFS Policy No. 0070-548.03 sets forth DCFS' expectations for TDM Facilitators and states that TDM Facilitators "have a complex and vital role throughout the TDM process...[they] are SCSW's who have broad knowledge of DCFS policies, procedures, and available resources while demonstrating adherence to the guiding principles." The Policy also identifies the TDM Facilitators' responsibilities to include, among other things, the following:

- Reviews the DCFS 174[28] prior to the TDM, and invites appropriate Community Partners.
- Manages the TDM meeting, and supports DCFS' best practices and procedures such as ensuring that: adequate translation services are provided to all participants; youth and family have a clear understanding of the services being offered and choices being made prior to agreeing to and signing the safety plan; family history is presented in a manner that is

[28] The DCFS 174 is the form that the case-carrying social worker completes in order to request that a TDM be scheduled and a facilitator assigned.

sensitive to the feeling and potential reactions of participants…conversation is focused on issues relevant to the meeting and in keeping with the strength-based framework; and all options available to the youth and/or family with regard to placement are presented in a non-biased manner.

- Develops a consensus among the participants by finding common ground amid diverse interests and opinions, focusing on family strengths, negotiating services, and developing Safety/Action Plans to **ensure child safety.**

Based on the above, it is clear that in order to effectively carry out their role in a TDM, TDM Facilitators should be intimately familiar with the family's DCFS and/or criminal histories, the circumstances that brought the family to the attention of DCFS, the nature of any services completed, and any other factors that might be necessary for developing a Safety/Action plan that ensures child safety.

Yet, the message that is apparently being received by the workers is that TDM Facilitators are not expected to review even CWS/CMS prior to the TDM. Their review of the case prior to the TDM, at which they are expected to play the critical role outlined above, is limited to the information presented by the case-carrying worker on the DCFS 174. The DCFS 174 is essentially a one-page form with boxes for basic identifying information such as the participants' names and checkboxes for identifying "concerns of family/child." The form does not contain so much as a blank box so that the case-carrying social worker can provide a detailed narrative to the TDM Facilitator.

Thus, even though the TDM Facilitators are supposed to help develop Action/Safety plans that ensure child safety and confirm that the decision reached at the TDM complies with applicable legal and DCFS guidelines, the TDM Facilitator must rely on the parties present at the TDM to give him/her all of the information that is necessary for these purposes. The danger of this process was observed by CSIU in a case where children were left in the home of a maternal grandmother despite her extensive criminal history, which included a release from prison just one month prior to the Hotline referral.[29] When questioned about whether the TDM Facilitator considered such factors in approving the Safety Plan, DCFS advised that "the issues were not brought to the attention of the TDM Facilitator."

The same issue came to light in CSIU's investigation of Abigail M. where the DCFS 174 form was essentially blank except for the family's identifying information. The TDM held in Abigail M. resulted in the return of Abigail and her 2 siblings (all under the age of 5) to the parents' home even though (1) visits had been liberalized to unmonitored just 10 days prior; (2) the children were all under the age of 5 and had been out of the parents' care for 18 months; and (3) the parents had ongoing criminal proceedings that would require them to be in jail on the weekends for the next 11 months. None of these issues

[29] The case was not referred to CSIU for a formal investigation but was discussed at a Child Fatality Roundtable in which CSIU participated.

was addressed in the Action Plan that was supposed to ensure the children's safety as they made the transition back to their parents' home. Thus, although developing an Action Plan the ensures child safety is identified by DCFS as one of the TDM Facilitator's most fundamental responsibilities, the TDM Facilitator in Abigail's case failed to recognize these glaring red flags that should have been addressed in the Action Plan. Clearly, more must be done to ensure that TDM Facilitators have all of the relevant information about the case and then use that information to develop meaningful Safety/Action Plans.

- Who should be part of the "Team"?

The Abigail M. case also brought to light another critical component of TDMs—that in order for TDMs to be useful and effective, the right participants must be present. Missing from the TDM was a therapist who had been providing both parents' "Child Endangerment Prevention" classes and a counselor or representative from Father's domestic violence program. Also missing were the paternal grandparents who had been the children's caretakers for 18 months since the children were removed from their parents and who had provided valuable information to the social worker on more than one occasion. If the goal of TDMs, as stated in policy, is to "create a collaborative effort between DCFS staff, family, youth, community members, caregivers, and service providers...to make the best possible placement decision for a child(ren)..." then, does it not follow that all necessary participants must be present in order for this process to be effective?

This, of course, means that TDMs cannot be scheduled with 24-hours' notice, as was done in the Abigail M. case. CSIU understands and appreciates that detention TDMs, because of their time-sensitive nature, will inherently be scheduled with last-minute notice to the parties. This is not as concerning because the parties involved at the detention phase are not likely to be as numerous as those involved at reunification TDMs. For reunification TDMs, at least, the TDMs must be scheduled with enough notice to maximize the likelihood that service providers, counselors, family members, caretakers, and others will be available to attend. Since DCFS policy already provides for a "TDM Scheduler" whose sole purpose is to schedule the TDM, it seems that putting criteria in place for appropriate scheduling of TDMs should be relatively straightforward.

Currently, there are approximately 47 TDM Facilitators employed by DCFS and CSIU has been informed that TDM Facilitators participate in a 5-day training program. Since DCFS has already identified the group of individuals who serve in the TDM Facilitator position and a training program is in place to ensure that the TDM Facilitator role is carried out in line with the Department's intended purpose, it seems that the framework is in place for DCFS to address the apparent disconnect between its policy and intended purpose of TDMs and the manner in which TDMs are being implemented in practice.

e. Structured Decision Making

The Structured Decision Making ("SDM") model was developed by the Children's Research Center (CRC), a division of a private research organization called the National Council on Crime and Delinquency (NCCD). SDM is an actuarial-based model for making structured decisions to assist social workers in making accurate and consistent decisions about the levels of risk for maltreatment found in families, to provide guidance about service provision, and to assist with reunification and permanency planning.

In California, the Department of Social Services (CDSS) initiated the SDM project in 1998. Los Angeles County was one of the seven counties that initially volunteered to participate, largely because a Child and Family Services Review (CFSR) conducted by the U.S. Department of Health and Human Services (DHHS) found that the State of California did not achieve substantial conformity with any of DHHS' primary objectives—safety, permanence, and well-being. County representatives worked with CDSS and CFS to develop the SDM tools for Los Angeles County (Hotline tool, safety assessments, risk assessments, etc.) and protocols. SDM became fully operational in Los Angeles County in approximately 2004 and was intended to enable DCFS to achieve conformity with DHHS' primary objectives and its own departmental goals of improved safety, improved permanence, and reduced reliance on detention.

The SDM model provides instruments/tools designed to simplify and standardize decision making for social workers and supervisors. Each of the SDM instruments is comprised of a standardized list of questions/items that are intended to guide the social worker to a conclusion. For example, the Safety Assessment Tool helps the social worker identify potential safety factors, steps that might be taken to mitigate those safety factors, and ultimately whether removal of a child from his/her home is necessary as a result of the identified safety factors. Likewise, the Risk Assessment Tool contains a list of items that are considered to pose risk to children, such as the number of prior DCFS investigations, number of children in the home, age of the children in the home, mental health and/or drug abuse by the caretaker, etc. Each item on the list is assigned a numerical value and once the tool is completed, all values are totaled and becomes the basis for the SDM's assignation of the level of neglect and/or abuse risk present.

Naturally, as is the case with any process and/or tool that strives to standardize the human thought process, the validity of the result is entirely dependent on the information that is "fed" to the tool. In addition, the "user" (i.e., the social worker) must respect the result in order for the tool to achieve its intended purpose. While the need to "override" the tool based on the social worker's clinical training and judgment may arise from time to time, such an action should be the exception, not the rule, if the tool is serving its intended purpose. Having said this, as long as accurate and thorough information is being inputted into the tool and as long as the tool's result is not routinely disregarded, the concept of SDM seems like an ideal way to balance the need for consistent decisions with the need to allow social workers to exercise independent judgment and utilize their own clinical training skills.

In practice, however, the use of SDM has been haphazard at best. Instead of clarifying the decision-making process and achieving consistency, workers are able to apply these tools at two extremes—either they ignore and/or manipulate them to justify a pre-determined course of action or they rely on them to such a degree that their own judgment and clinical training become irrelevant. Either way, it's not the result DCFS wants and these tools and strategies are not achieving their intended purpose.

In at least nine of the cases investigated by CSIU, the SDM tool was identified as a contributing factor to the adverse outcome in the case. In Jorge T., for example, there was no documentation whatsoever of the ERCSW performing an SDM Risk Assessment when she went to investigate the hotline referral. It wasn't until 18 days after Jorge's death that the ERCSW documented an SDM Risk Assessment that yielded findings of "high" risk. In Deandre G., **two** hotline workers each used the SDM screening tool incorrectly which resulted in the referral not being assigned as an immediate response. Both referrals remained open at the time of Deandre's death.

Other cases showed that even when the SDM tool comes up with the right "result", there are ways to manipulate SDM to reach a desired result. In Adrian R., for example, three weeks after a VFM was closed, a new hotline referral was investigated which yielded a "very high" risk result on the SDM Risk Assessment Tool and the "recommended decision" was to "promote" to a case. Inexplicably, the SDM Safety Assessment Tool was filled out by checking every box that indicated a safety threat with a "no", which justified closing the referral with no further action. Similarly, in Abigail M., the final lifeline for Abigail was a hotline referral that came into DCFS while Abigail was home on a Family Maintenance court order. Even though the worker gave several incorrect answers on the SDM Risk Assessment Tool, the tool yielded a "very high" risk result and recommended promoting the referral to a case. Instead, the ERCSW ignored the SDM, closed the referral, and put Abigail's life back into the hands of the case-carrying worker who had already ignored a multitude of glaring alarms.

The manipulation and/or disregard of the SDM tools by social workers was documented in a study performed at USC by the California Social Work Education Center. The study found that the data collected suggested that "...not all of the caseworker assessment tools are being used [as intended] and that they may not be used consistently by social workers across situations. For instance, participants in both the key informant and social worker sub-studies acknowledged that, with respect to a single case, tools are often completed by different social workers, depending on where in the system the case is at a given time." Even the **same** worker can reach different results in a single case. In the Adrian R. case, the **same** worker completed two assessments within four weeks of each other with **opposite** outcomes despite there being no change in the family's situation.

During the course of interviewing DCFS workers, the Social Work Education Center researchers received comments that included "if anyone thinks that the tools cannot be manipulated by burnt-out staff or less committed staff, [they] are gravely mistaken. There are folks out there who are manipulating it grossly because it really demands that

the information going in is accurate and will be used to provide the best service delivery. It isn't a magic pill."

Clearly, there is an outward awareness that the validity of the SDM tools are questionable, at best, as the tools are currently being used. Given that social workers are already inundated with paperwork, DCFS needs to consider whether there is a point to 'adding more paper to the pile' if the tool is not achieving its intended purpose. For this reason, it may be time for DCFS to re-evaluate the purpose of the tool and whether the tool is achieving its intended purpose. In this regard, DCFS should consider whether the SDM tools might serve a better purpose as a validation tool to be used by Supervising CSW's in their review of the CSW's work rather than a 'determinative' tool used by the CSW's.

- The Need to Assess the Tools/Strategies

The "alphabet soup" of tools and strategies currently utilized by DCFS to assist workers achieve improved outcomes for children and families, are all founded in good intentions. Conceptually, all seem to be well reasoned and should achieve their intended results. However, because the plethora of these tools/strategies have not been supported by establishing clear understandings of their purposes and a lack of user competence due to inadequate/ineffective training, they have become potentially dangerous rather than protective. The nature of these tools is such that they are vulnerable to 'garbage in/garbage out', manipulation and misinterpretation that can lead to disastrous results.

It is critical that DCFS undertake a comprehensive and cohesive review of these tools and strategies to ensure that they are appropriate and effective for achieving their intended purposes. Not only are these tools and strategies incredibly time consuming, the costs associated with utilizing and maintaining them, are significant. DCFS needs to undertake an evaluation of which of the existing tools/strategies are truly necessary and effective. Lastly, to achieve maximum advantage of these tools/strategies, DCFS should ensure that they are recalibrated as needed in conjunction with intensive training and ongoing monitoring of their use.

RSI #3: COMMUNICATION, INTEGRATION AND COORDINATION OF SERVICES —"IT TAKES A VILLAGE"

Every time a call is received by the DCFS Child Protection Hotline, it puts into motion a network of individuals and agencies that must be mobilized in order to protect children and support families in crises. This mobilization begins with a series of actions taken by numerous workers within DCFS. As previously discussed in this report, a Hotline referral is first investigated to determine whether the allegation of child abuse will be deemed "substantiated", "unfounded", or "inconclusive". Once DCFS completes its initial investigation, it must determine what level of intervention is warranted (if any) and what services and/or treatment must be put in place in order to address the issues that

brought the family into the system. These have been described in this report as steps 1 and 2 on the DCFS "continuum" of services. Step 3 on the "continuum" involves making sure that the services identified are, in fact, provided to the families and that the issues that warranted intervention by DCFS in the first place are ameliorated so that DCFS leaves the children in a safe and healthy environment.

As a family moves through the DCFS continuum, the family also moves through a series of social workers and other DCFS professionals. In addition to its own professionals, DCFS relies on countless other professionals within the County's existing infrastructure to assist in its mission of keeping children safe. Most often, the County departments that directly impact DCFS' ability to service children and families are the Department of Mental Health, the Department of Health Services, Probation, and County Counsel. In addition to the many agencies and departments that are internal to the County, DCFS relies on third-party service providers located throughout the County to provide treatment and/or educational services to the families it serves.

With such an extensive number of participants in the child welfare system the questions raised are:

- Does each participant recognize that they play a role in the child welfare system?
- Do they share the same goals and objective of protecting, supporting and treating children and families?
- Do they accept the responsibility?
- Are those responsibilities being carried out effectively?

Unfortunately, based upon the fatality cases reviewed by CSIU, it appears that the answer to these questions is "no" either singularly or collectively. Rather, it appears that it is quite the opposite where other parties, both inside and outside of the County, are not working cohesively with a joint understanding and commitment toward uniform goals and objectives.

Ultimately, all County Departments and Third Party providers must be unified through a common understanding and acceptance of their respective responsibilities as part of the County's continuum of care to children and families. In this regard, DCFS must be the leader in ensuring that its departmental goals, priorities, and needs are clearly communicated to each key player so that everyone is "on the same page" when it comes time to carry out their respective roles. It is only with this level of communication, integration, and coordination that DCFS will be able to effectively intervene on behalf of families in crises and meet its mission of providing quality child welfare services and supports so that children grow up safe, healthy, educated and with permanent families.

It is incumbent upon social workers, County departments, and community service providers to work together for the benefit of the children and families that are served by DCFS. Each brings a unique skill set and expertise to the process and each should approach their role in child welfare in an active, engaged manner. Thus the challenge

that must be overcome is bringing all the necessary players to the table, getting them onto the same page and having them work effectively together to achieve the common mission of providing support and assistance to the children and families of Los Angeles County.

a. **DCFS Intra-Departmental Communication and Coordination—Fortify your Army**

Once a family becomes known to DCFS, numerous DCFS staff have contact with the child(ren) and family as they progress through the DCFS and/or Dependency Court system. At a minimum, there is one social worker who takes the hotline call; one who investigates the referral; and one who provides continuing services to the family (i.e., VFM, Family Reunification, Family Maintenance, etc.). Each of these case-carrying workers has an immediate supervisor (the SCSW) and a corresponding chain of command (the Assistant Regional Administrator, Regional Administrator, Deputy Director, and the Director). Thus, without taking into consideration support staff and other administrative professionals, there are at an absolute minimum ten DCFS professionals who are responsible for each and every family that is "screened in" by DCFS.

This strength in numbers should mean that there is a built-in safety net in place to ensure that individual decisions are always "checked" by the chain of command. Thus, DCFS is set up to ensure that the missteps/failures of any one individual do not result in tragedy for the children and families who depend on the Department. In order for this built-in safety net to function as it should, however, DCFS must ensure that its departmental goals, priorities, and needs are communicated through its chain of command to each and every single worker.

As described above, each and every family that comes to DCFS' attention and is "screened in" by the Child Protection Hotline has a team of at least 10 DCFS professionals who are, in one way or another, responsible for the Department's success in intervention. For families that have multiple hotline referrals or prolonged involvement with DCFS (for example, court cases) the DCFS team grows exponentially with each contact.

It would be reasonable to expect, then, that with this many hands on each family, the decisions that are made over time are supported by institutional knowledge and expertise. Unfortunately, despite having a built-in system of "safety in numbers", there appears to be a department-wide failure to recognize the value of a cohesive, team approach to everything from investigations to the implementation of new strategies and/or programs that are supposed to further the Department's goals and priorities. Accordingly, to ensure that no individual social worker, supervisor, regional office, or executive is ever left to operate as an island, the Department must align its workforce through improved communication and consistent messaging about its overall goals and priorities.

The challenge for DCFS lies in the sheer number of people it employees and the fact that those thousands of employees are stationed in a hugely expansive geographical region. DCFS is divided up into 8 Service Provider Areas (SPAs) which consist of 18 field offices that are located throughout the County's 4,083 square miles. In addition to these 18 field offices, DCFS has a corporate headquarters, several specialized units, a team of executive directors, and countless other staff and support professionals. In this sense, DCFS is like an army at war in which the Commander-in-Chief, along with the Generals, develops an overall strategy and identifies the "missions" that must be carried out in order for the strategy to succeed. As the rank and file carry out those missions, it must always be with the clear purpose of furthering the strategy developed by the Commander and his Generals.

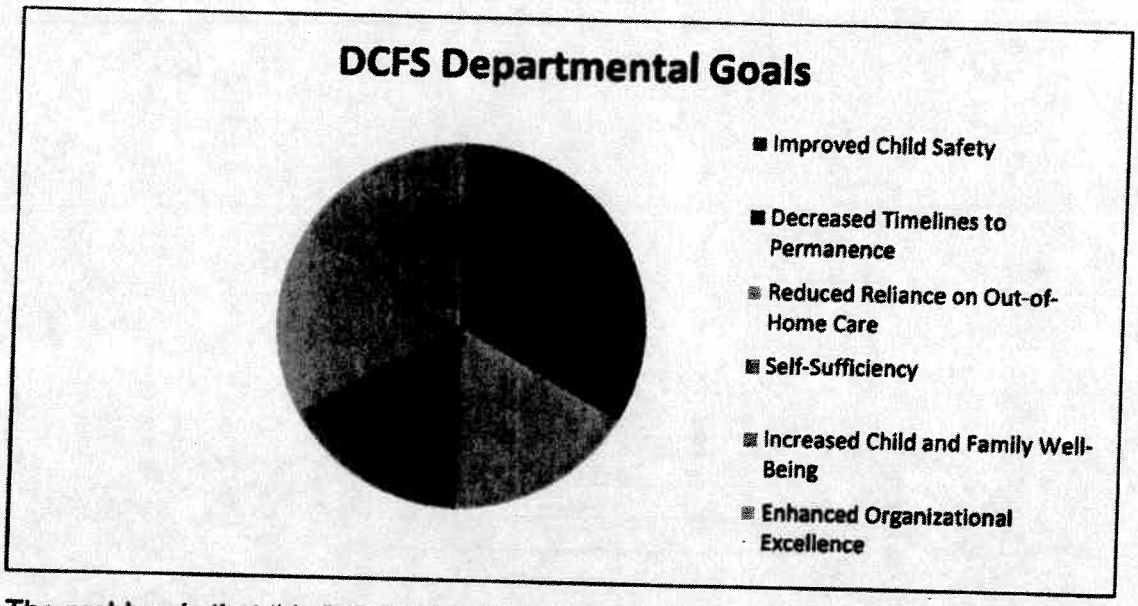
- ➢ <u>It Begins with the Commander-in-Chief...</u>

Similarly, DCFS must develop a strategy that supports its stated goals and priorities and it must ensure that the day-to-day work of its social workers is performed with the clear purpose of furthering the Department's strategy. To accomplish this, DCFS must ensure that its goals and priorities are consistently communicated and implemented across the board.

Currently, DCFS has identified six departmental goals:

- Improved Child Safety
- Decreased Timelines to Permanence
- Reduced Reliance on Out-of-Home Care
- Self-Sufficiency
- Increased Child and Family Well-Being
- Enhanced Organizational Excellence

All six goals should be and presumably, of equal in importance as all six are integral components of the Department's overall mission—to "provide quality child welfare services and supports so children grow up safe, healthy, educated and with permanent families." As such, from a visual perspective, these goals are not a "list," rather they are a pie that is cut into six equal slices:



The problem is that this "vision" is not trickling down through the chain of command and to individual social workers. Instead, depending on what tool is being implemented; what strategy is being promoted; or what statistic is being measured, individual slices of this pie are viewed as more important than others, or worse, some pieces of the pie are completely forgotten.

For example, in recent years, the focus on utilizing voluntary services and safety plans as a means of keeping children at home has clearly conveyed the message that DCFS wants to "reduce reliance on out-of-home care". Like the classic 'game of telephone', overtime, the message 'morphed' and was understood by the workers and managers as simply ' do not remove/keep the numbers down' and the other, equally important goals—decreased timelines to permanence and improved child safety in particular—were lost in the message. Individual offices and leadership celebrated as their number of detentions decreased and individual social workers were praised for low detention numbers; all while more children were dying while left in their parent(s) care.

CSIU found numerous instances in which the "push" to provide voluntary services as a means of avoiding detention yielded tragic results for Improved Child Safety. Likewise, several trends, such as VFMs being offered to parents who had previously failed to reunify and/or had their parental rights terminated and VFMs being offered time and time again despite non-compliance with previous VFMs, impeded the "Decreased Timelines to Permanence" goal because whereas children could have been "fast-tracked" through the Court system, DCFS elected to provided additional (and ultimately ineffective) voluntary services.

Accordingly, the Department must engage in an active campaign to "brand" its message that there are six departmental goals, all of which are equally important and integral components of the Department's stated mission. This means that anytime the

Department issues a new policy or implements a new program, it must be introduced with a reminder that there are six departmental goals and that while the particular policy or program at issue may be geared towards achieving a particular goal(s), all six remain a part of the Department's mission and should remain a part of each worker's day-to-day practice. At every opportunity available and in each written communication it has with its workforce, the Department must remind its workers of the six goals that unify their practice and must guide the decisions they make on a daily basis.

With a strong commitment to consistently and repeatedly communicating its goals to its workforce, DCFS can ensure that as workers go about making critical decisions on a day-to-day basis, they do so with the understanding that all six goals are equally important and one should not be achieved at the expense of another. Accordingly, in a situation where the decision to implement a VFM advances the goal of "Reduced Reliance on Out-of-Home Care" but does so at the expense of "Improved Child Safety" or "Decreased Timelines to Permanence", the social worker will not feel pressured to give more weight to one goal over the other and will do a better job of balancing these goals which should be complementary rather than competing goals.

- Generals, Colonels and Captains Must Implement with Fidelity...

On a more complex level, the Department must ensure that it adopts and endorses only those policies, programs, tools, and strategies that further its Departmental goals and once it does decide to implement a given policy, program, tool, or strategy, it must ensure that those who are charged with the implementation do so in a manner that maintains fidelity to the Department's objectives.

In other words, if something is worth implementing, it is worth implementing correctly. As previously discussed, the Point of Engagement strategy has been implemented in parts, thereby diluting its effectiveness. CSIU is aware that not all offices use the Point of Engagement model and, even where it is used, the manner in which it is used varies from office to office. Similarly, CSIU has seen numerous instances in which the SDM tools are manipulated to justify a pre-determined outcome or not used at all. With respect to policy, CSIU has heard anecdotal stories about offices where policies are routinely ignored or violated because individuals chose to do things a certain way in "their" office.

The most concerning part of all of this is that supervisors and other high-level DCFS professionals are sanctioning and sometimes even directing the misuse and/or flawed implementation of these tools and strategies. Thus, instead of ensuring that the "boots on the ground" hear the right message, the Generals, Colonels, and Captains are taking part in diluting the Department's message. As a result, the Department's efforts to meet its goals and achieve consistency become fragmented and haphazard and ultimately, unattainable.

The Department must curtail this mismanagement of its policies, tools, and strategies by ensuring that programs are implemented consistently from region to region and office to

office. The institutional perception that each region and/or office is free to make its own rules must be recalibrated through clear reminders that DCFS operates as a cohesive department—not as a set of islands. Along those lines, the Department cannot encourage fragmentation. Whenever a decision is made to implement a given program tool, or policy, the Department must go "all in" and make sure that adequate training, personnel, and resources are in place to support full implementation of the given policy, tool, or strategy. In addition, the Department should consider putting into place a review process in which all high-level managers come together on a regular basis to discuss cases in which the Department has failed in meeting its goals (such as fatalities, critical incidents, or adverse court rulings). Such meetings would serve as a constant reminder that when failures occur, they are "owned" by the entire Department and not just by the unit, office, or region in which they occurred.

- And the Soldiers Carry Out the Mission

Armed with clearly articulated goals and objectives and supported by tools and strategies that are implemented with fidelity to those goals, the soldiers will be better prepared to carry out the mission of DCFS. What must never be lost, however, is the constant reminder that there is strength in numbers. DCFS must therefore work to improve communication among its workers and to provide workers with tools that facilitate such communication.

Every single case CSIU investigated had a history of prior referrals—either because the parents were involved with DCFS as minors, the same parent had prior referrals, or both. In five of the cases, the children had, at one point or another, been declared dependents of the Court. And, in at least six cases, the parents had previously failed to reunify and/or had their parental rights terminated as to siblings. As such, in every case CSIU reviewed, there was a wealth of institutional knowledge that should have given the involved social workers valuable insight and perspective into the children and their families.

Unfortunately, there does not appear to have been a true appreciation for the value of such institutional knowledge nor the ability to synthesize and incorporate that information into its investigations. Although CWS/CMS is always checked to determine whether the family has prior DCFS history, very little seems to be done in terms of scratching beneath the surface to give context and meaning to the information obtained from CWS/CMS. The ER/CSW in Jorge T., for example, undoubtedly knew that Jorge had previously been declared a dependent of the Court. Yet, despite the fact that Court jurisdiction had been terminated just six months prior to her investigation, she did not consult with the social workers that most recently worked with the family. Had the prior dependency case involving domestic violence and physical abuse of Jorge been given the analysis it deserved, the ER/CSW would hopefully have linked the sustained allegations of domestic violence in that case and the step-father's failure to comply with the Court's orders to Jorge's statement that physical abuse at the hands of his mother and step-father was what caused his emotional meltdown. With this context, the mother

and step-father's denials regarding the physical abuse would have undoubtedly been questioned and maybe even disbelieved.

In Viola V., despite seven prior DCFS referrals, five of which concerned Viola's prospective adoptive mother as a foster mother, DCFS' Out of Home Care Division was unaware of these referrals and continued to entrust to her, the care of very young children. Viola was placed into her killers care WHILE there was an open DCFS investigation of the sixth Hotline referral involving the foster mother. In fact, not one of the six ER workers was aware of the referrals that preceded their respective investigation.

The sharing of information is critical for a department of DCFS' size and scope. When information is not sought out and/or shared, decisions are made based on incomplete and faulty assessments. As mentioned throughout this report, there are systems in place to make sure information is stored for future use. CWS/CMS and Case Files exist, in part, as a means of ensuring that information is passed on from worker to worker. Accordingly, the issue is not about DCFS' failure to recognize the need for communication. Rather, DCFS must work within its existing framework to better facilitate communication.

Along these lines, DCFS should work with the State to potentially facilitate streamlining CWS/CMS with two purposes in mind: (1) to make it user-friendly for the person entering information and (2) to make it easier to navigate so that future users, who stand to benefit most from the information that is entered about a case, will have easy access to critical information.

In addition, DCFS should implement and strictly enforce a uniform file maintenance system/policy so that as a child makes his/her way through the DCFS continuum (i.e, from the Front End to the Back End), his/her file will become a complete chronological record of everything that has resulted from DCFS' involvement in his/her life. This will ensure that any time a worker reviews a child's history it will be organized and will contain relevant information that is easy to incorporate into the current investigation.

Lastly, in order to ensure that the information in CWS/CMS and the Case Files is as complete and thorough as possible, DCFS should consider utilizing voice-recognition software or other dictation tools that can be used by workers to create the records that are inputted into CWS/CMS, Court reports, and/or stored within the Case Files. The use of such tools will enable workers to record events, interviews, notes and impressions as soon as they happen, which will result in greater detail, timeliness, and utility for future investigations. With this level of documentation, the institutional knowledge that is gleamed from each prior contact with the family will be given the context and significance that is currently lacking when such information is reviewed. There should also be the added benefit of reducing the amount of time that workers spend to manually type information

b. Inter-Agency Relationships—Integrate and Communicate with Those Who Must Share In Your Mission

In addition to its own professionals, DCFS relies on countless other professionals within the County's existing infrastructure to assist in its mission of keeping children safe. The County's existing infrastructure, if utilized effectively, can be of immense value to DCFS since it consists of many departments, each of which is enormous in comparison to equivalent county-level (or even state-level) departments elsewhere in the United States. Most often, the County departments that directly impact DCFS' ability to service children and families are the Department of Mental Health, the Department of Health Services, Probation, and County Counsel. These inter-county Agencies are an integral part of what should be, a comprehensive child welfare 'system' because each Department has a unique skill set and/or expertise that could play a critical role in DCFS' risk and safety assessments, the identification of what services are needed, and the provision of the identified services.

Given the sheer size and breadth of services that are available through the County's existing infrastructure, DCFS has an advantage over just about every other child welfare agency in the country—the key is for DCFS to use the County's infrastructure to its advantage by finding a way to effectively integrate these other departments into its day-to-day practices.

Although DCFS is the central agency responsible for protecting children and families in crises, DCFS cannot stand alone in this mission. While DCFS must take the lead in integrating and coordinating the services it provides, law enforcement, medical providers, mental health agencies, legal professionals, and educators all have a role to play in keeping children safe. When such entities are part of the County's infrastructure, they have an obligation to "own" their role in child protection. In other words, DCFS may be the central agency, but all who have a role in the system must "step up" when DCFS needs the services they provide and the resources they control in order to carry out its legal mandates.

The story of Zachary H. exemplifies the effect that inter-agency collaboration can have in the aftermath of a tragedy. Zachary died of an apparently accidental Methadone overdose while he was AWOL from his group home placement. When CSIU investigated Zachary's death, it found that Zachary had been fortunate enough to have one CSW the entire time he was in the system. His CSW ensured that he received appropriate contacts, Individualized Education Plans, and mental health assessments from the Department of Mental Health. The CSW also coordinated efforts among the key players in Zachary's life—for example, each time a placement issue arose (Zachary had more than 8 placements), a TDM was held to facilitate a team decision regarding the next best move for Zachary. In each placement, his CSW coordinated service providers to ensure Zachary's services continued (including special education and intensive mental health and behavioral services). The consistent, active involvement of his CSW was one key to the level of service Zachary received.

In addition, because Zachary was a "cross-over" youth (meaning he had Dependency and Delinquency Court involvement), he had, at one point, been detained at Los Padrinos Juvenile Hall. While in custody, he was assigned to the Elite Family Unit ("EFU")—a specialized housing unit dedicated to cross-over youth. The EFU is based on the recognition that cross-over youth have special service needs. It provides additional programs and services to the youth while they await the outcome of the Courts' placement decision. As a member of the EFU, Zachary received special education and mental health services on a daily basis and was supported by a team of advocates that included his CSW, a Probation Officer, a Public Defender, a Dependency Attorney, a court-appointed Special Education Attorney and an Educational Surrogate from the Department of Mental Health.

Sadly, despite all interventions, Zachary died. However, instead of looking back at this tragedy and finding systemic failures that could have saved Zachary, CSIU looked at this tragedy and found that the County's collective system of service providers, led by DCFS, had done all that could possibly be done for Zachary. Thus, although the objective is always to avoid tragedy, there is some level of peace that comes from knowing that the system worked hard for this child.

Tragedy is not 100% avoidable. At a minimum, however, every County Department must strive to achieve what occurred in Zachary's case. In order for this to become a reality, however, every County Department must come to the table prepared to recognize its role in child protection and to offer the services and expertise that fall within its purview. More importantly, there must be a County-wide recognition of the fact that while DCFS is charged with protecting children, it does not control all of the resources or personnel that are required to meet this objective. Accordingly, the County's success in child protection is entirely dependent upon the active participation of every Department whose responsibilities intersect with those of DCFS.

While Zachary is an excellent example of how this can be achieved, other cases investigated by CSIU exemplify the degree to which DCFS is hamstrung if other County Departments are not effectively integrated into child protection:

- The lack of a joint DMH and DCFS response to a child's "emotional melt-down" resulted in an incomplete assessment of his mental health status which should have, but did not, include an assessment of his DCFS history—particularly since DCFS had extensive documentation regarding past allegations of physical abuse in the home and the child cited physical abuse at home as a cause of his "emotional melt-down". (Jorge T.)
- The lack of coordination between a DMH school therapist and a DCFS ER worker resulted in a poor investigation of emotional and physical abuse allegations, including the failure to detect conflicting statements by the child regarding his suicidal ideations. (Jorge T.)
- The failure by DCFS and Probation to conduct a proper assessment to determine if the W&I Code 241.1 protocol had been triggered resulted in a child remaining in limbo between Dependency and Delinquency where being declared a

Dependent would have qualified him for medical insurance benefits to cover mental health services that were identified as being desperately needed. (Adrian R.)

- The reluctance by law enforcement to take an active role in investigating physical abuse allegations while the DCFS ER worker took a "back seat" to law enforcement resulted in neither agency conducting a proper investigation and evidence of physical abuse likely going undetected. (Abigail M.)
- The lack of coordination between a police department and an ER worker resulted in the ER worker spending two weeks searching for a family at an incorrect address where the police department had already ascertained the correct address (Deandre G.)
- The legal findings made at a critical court hearing sent a child back to her parents despite the parents' failure to make substantive progress in their court-ordered case plans and County Counsel failed to advise DCFS that the very reports submitted to the Court in support of the recommendation confirmed that parents' lack of compliance. (Abigail M.)
- The lack of communication between DCFS and the Medical Hub resulted in an incomplete assessment by the Hub's nurse practitioner upon which the ER worker ended up placing entirely too much weight. (Abigail M., Johnny C.)
- The failure of Probation to communicate with DCFS where they knew the whereabouts of a pregnant AWOL youth resulted in DCFS being unable to locate and protect the child. (Erica J.)

I. The Disconnect between DCFS and the Medical Hubs

The Department of Health Services' ("DHS") Medical Hubs serve two purposes within the DCFS context: they complete routine examinations of children in DCFS' care and they conduct forensic interviews and medical exams as part of DCFS' investigation process. The mere fact that the Medical Hubs exist to perform these essential functions is a credit to DCFS and DHS in that the two departments clearly recognize the value of working with one another for the protection of children.

Naturally, anytime two sizable County Departments come together, there are going to be some 'growing pains' that must be worked out in order for their integration to reach its full potential. In the case of DHS and DCFS, the impediment to realizing the full benefits of this relationship has been rooted in poor communications.

- Lack of clarity regarding their respective roles and responsibilities.

In order for these two Departments to complement one another as they should, a common understanding regarding their respective roles and responsibilities must be memorialized and then communicated to their personnel.

For example, based on CSIU's review of several cases that in which children were assessed by the Medical Hubs, it is clear that DCFS' social workers rely ***extensively*** (almost to the exclusion of other factors) on the Medical Hubs' conclusions/statements.

For example, in the Johnny C. case, despite having many pieces of information that could have all been compiled to substantiate a Hotline referral, the Hubs' conclusion that its "evaluation indicates non-abusive cause of medical findings" led to the referral being closed as "unfounded." Likewise, in Abigail M., the Nurse Practitioner's statement that injuries ***could*** be consistent with Mother's story of 'rough play' led the ER/CSW to conclude that the injuries ***were*** consistent with rough play (even though the Nurse Practitioner actually concluded that the cause of the injuries was "indeterminate").

What is unclear from the cases is whether personnel at the Medical Hubs understand the significant weight that is given to their conclusions? Do they understand that social workers defer to their medical expertise? Is it understood that the exams and accompanying conclusions may end up being used in court by any of the involved parties (DCFS, parents, and/or minors)? Of course, these questions raise another fundamental question—should social workers be deferring to the medical personnel to such a degree? Or, are the exams and interviews conducted by the Medical Hubs merely another piece of information that social workers must assimilate into their investigations?

Strides are currently underway to solidify the integration of these two Departments in that DCFS is in the process of out-stationing social workers in each of the Medical Hubs. As this process takes place, DHS and DCFS are presently working together to define the roles and duties that will be assigned to the out-stationed social workers. As a follow-up to this process, the two Departments should consider entering into a formal Memorandum of Understanding in which the fundamental questions raised above and other similar issues are addressed so that a consensus may be reached regarding the exact nature of the relationship between the medical personnel who are experts at examining children and the social workers who are experts at assessing risk and safety.

- <u>Insufficient information provided to Medical Hubs</u>

Another area of disconnect that has led to significant adverse impacts has been the failure of DCFS to provide necessary information to the Medical Hub examiners. In the cases of Amanda C., Abigail M. and Johnny C., there was little to no information about the history of the family and why the children were being referred for forensic medical examinations included in DCFS' referral to the Hub. Without this critical information, Hub examiners are left to proceed in a vacuum without information that can greatly help to put the circumstances into context. Additionally, the lack of information deprives the examiner the opportunity to assess a caretaker's truthfulness about prior history and/or conflicting explanations for the child's injuries. DCFS must provide a detailed factual account of the family's prior DCFS history (if any), what the underlying allegations are, the 'story' the parent(s) have provided, any prior statements made by the child, statements made by witnesses and any other pertinent information that the examiner can take into consideration when forming their conclusions.

Further, there have been ongoing concerns raised by the medical Hubs regarding their inability to communicate with assigned CSWs. Apparently, the Hubs are often not

provided contact information for the CURRENT CSW leaving them to try to track down the right person. Further there is no 'quick' means to advise the referring CSW if a caretaker fails to show up for a scheduled exam. Both these issues should be fairly easy to address simply by enhancing the e-mHUB[30] referral form and system, to include a field for listing CSW and SCSW name, office and telephone numbers. The 'no show' issue can be resolved by providing an option for the Hub to select which instantaneously advises the CSW that their client did not show up for an appointment which is important information for the investigating CSW to have.

- Medical Hub Examination Reports to DCFS

There is also a failure of communication due to the limited information that is usually included in the Forensic Examination reports the Medical Hubs provide to DCFS. Examination reports that lack essential information can have devastating results. The case of Abigail M. is a perfect example of how the failure to include a more detailed explanation/qualification and the basis for the medical conclusion can lead to a misunderstanding and misapplication by the CSW of the results. This problem though, is closely linked to the need for DCFS to provide the Medical Hubs with necessary contextual information. It is often the 'totality of the circumstances' that create the need for the qualification of a medical opinion. For example, while a current injury *could* possibly be consistent with the caretaker's explanation as to how it occurred, there may be a need to qualify the conclusion that ultimately, the injury was due to an 'indeterminate cause' based upon the family's past history of, for instance, neglect due to drug use. The CalEma900 form[31] which is the state promulgated suspected child abuse medical reporting form is primarily a 'check off the box' form and does not encourage or allow for a meaningful narrative. However, this problem is easily resolved by simply attaching a detailed narrative to the form report.

The above identified communication challenges should not be difficult to overcome; it merely takes the two Departments coming together to establish a clear understanding of each other's roles, responsibilities and expectations.

ii. The Special Role of County Counsel

County Counsel is similar to the other County Departments in that it, too, must be effectively integrated into DCFS' provision of services in order for DCFS to function properly. This has already been recognized as evidenced by the fact that County Counsel's services are accounted for in DCFS' annual budget, the two Departments have an ongoing relationship with one another, and County Counsel designates a sizable team of attorneys who focus solely on representing DCFS in court proceedings and providing counsel to DCFS on a myriad of legal issues.

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[30] E-mHub System is a web-based patient information tracking system of DCFS children served by the Medical Hubs

[31] The State Office of Emergency Services promulgates this form that must be used by medical practitioners for medical reports for suspected child abuse and neglect examinations.

The challenging aspect of the DCFS/County Counsel relationship is that the lines between their respective areas of expertise are not black and white. DCFS professionals are the experts in the issues that guide daily decisions about safety, risk, treatment, and rehabilitation. Clearly however, County Counsel attorneys are not social workers and have no obligation to assess the issues that are better left to social workers.

Having said this, however, the DCFS/County Counsel relationship must be rooted in a common understanding that literally everything that takes place in the child welfare arena is based upon the legal framework of the Welfare & Institutions Code and has legal implications attached to it. This can be as obvious as the legal findings that are made in Dependency Court every day or the fact that there are legal guidelines that govern DCFS' ability to gain access to children. The legal nature of DCFS' work is also apparent in more subtle circumstances. For example, designating a hotline referral as "unfounded", "inconclusive" or "substantiated" is a legal determination based on Penal Code definitions of child abuse. Thus, lines can become blurred when social workers mix the concepts of safety and risk with the factual determination of whether or not child abuse occurred, as defined by the Penal Code. Another example of the legal subtleties that exist in DCFS' daily practice arose in the recent death of Emmanuel O., where DCFS' infusion of up-front services for a family with a lengthy history of DCFS involvement may have been well-intentioned but ended up having a negative impact on DCFS' legal ability to secure a Detention Warrant.

Given the complex nature of this overlapping relationship, DCFS must rely on County Counsel to be its **active** partner in child protection. The role of County Counsel must be proactive, not reactionary in nature. As referenced above, in the case of Vyctorya S., the documentation reviewed by CSIU did not reflect that any efforts were made by County Counsel to follow-up on the inconsistencies that appeared on the face of the reports submitted to the Court (i.e., a recommendation to return the children even though the parents had not made substantive progress in their case plans). Similarly, in the recent death of Arianna P., a non-detained petition made its way to Court despite obvious indications that the children were not safe at home.

Again, social work decisions are better left to the social workers. But, when a recommendation and/or action is not supported by the factual circumstances of the case, it is the attorney's responsibility to raise these discrepancies to the Department. Social workers assess family dynamics, treatment, risk, safety, etc. But attorneys assess evidence and facts; as such, DCFS' attorneys must actively review the evidence and facts presented to them by DCFS to ensure that the facts are legally sufficient to support DCFS' conclusions and associated legal findings that must be made by the court.

An attorney's effectiveness can often be measured by his/her ability to prevent a client from making legal errors rather than dealing with the aftermath of an error. This is why most large corporations have learned to consult with their attorneys before they fire a high-level employee or before they invest in a new venture. This is the type of

relationship that DCFS and County Counsel must maintain—one in which the attorney is viewed as a proactive counselor who knows the clients business so that they can effectively position their client into a strong legal position.

- A Step in the Right Direction

The Katie A. litigation and the resulting Katie A. Strategic Plan compelled the Department of Mental Health, Probation, and DCFS to initiate a dialogue and implement a plan for coordinating their respective roles in child protection. While it is unfortunate that costly litigation had to be initiated to bring about this change, it is nevertheless a step in the right direction. In late 2011, these three Departments formalized their "Shared Core Practice Model" which acknowledges that they all need to work together to ensure that children are safe, free from abuse and neglect and are affording nurturing and permanent living environments. As CSIU discussed in the Adrian R. case, the Katie A. Strategic Plan also brought about the advent of the Coordinated Service Action Team ("CSAT"); improvements to the Mental Health Screening Tool ("MHST"); and a new protocol for ensuring that children identified as having "acute" mental health needs are immediately assessed by the PMRT.

In other positive strides, in response to the case of Jorge T., the Department of Mental Health and DCFS put into place a Countywide Expedited Response. This protocol promotes information sharing by requiring a joint field response between the existing CSW and DMH's Psychiatric Mobile Response Team ("PMRT") for children with acute mental health needs.

Yet another step in the right direction is the Project SAFE Pilot Program which was initiated on April 2, 2012. Project SAFE is an interdepartmental project between DCFS and the Department of Public Health ("DPH") in which DPH will be conducting assessments to help CSWs determine the existence or nonexistence of a parent or caregiver's Substance Abuse Disorder. The Project SAFE Pilot is currently in effect in the DCFS El Monte and Metro North Offices and will be used in those offices to supplement UFAs. While it is unclear why DPH did not simply provide such assessments under the already-existing UFA protocol, the key is that DPH is engaged in the assessment process, a step which will undoubtedly add great value to investigations and assessments in the El Monte and Metro North Offices.

- The Missing Framework for Integration

While it seems clear that some County Departments are prepared to engage when called to action, there does not appear to be a proactive approach to integrating County services. What is missing is a structure or framework that will align these various County Departments under a common mission. It simply cannot be that record deaths or costly lawsuits must occur in order for a full County mobilization to take place.

Instead, a framework for integration must be developed in which every relevant County Department accepts responsibility for its role in child protection and makes necessary

contributions to the DCFS mission. Within this framework, each Department's role must be clearly identified so that there is a common understanding among the Departments as to their respective roles. Each Department must then commit to developing programs and services to fulfill its responsibilities and dedicate the personnel and resources that are necessary to put plans into action.

In an ideal world, the framework would be an entirely new agency in which the relevant segments of each County Department are pulled together under one umbrella. For example, mental health professionals that specialize in assessing juvenile mental health issues, probation offices that focus on cross-over youth, Substance Abuse Assessment Teams, Public Health Nurses, and other such professionals from the relevant Departments would come together under an entirely new agency—a "Mother Ship" for Dependency-related services.

Of course, the reality is that from an organizational/resource perspective, the "Mother Ship" is probably not a solution that can be implemented in the immediate future. However, a feasible solution might be the concept of an Executive Steering Committee in which the Department Heads come together on a regular basis to discuss the status of ongoing programs, newly identified needs, the allocation of resources (such as Title IV-E federal funding), and other issues that must be coordinated in order to carry out their common goals.

With the groundwork that has been laid by the Katie A. Strategic Plan and other blooming alliances, County Departments are beginning to play a more active role in recognizing the need for integration. A formal structure—whether it's a "Mother Ship", an Executive Steering Committee, or something else—is the next step to bringing in those Departments that have not yet come to the table and solidifying commitments from those who at least expressed a willingness to take part in DCFS' mission.

c. Service Providers—Coordinate the Community

Providing services to children and families is one of DCFS' most fundamental obligations. In fact, DCFS would be unable to meet any of its Departmental Goals if not for the service provision aspect of its work. For this reason, DCFS must assess the quality and effectiveness of the services it provides on an ongoing basis and immediately address any deficiencies that are identified.

In addition to the many agencies and Departments that are internal to the County, DCFS relies on service providers located throughout the County to provide treatment and/or educational services to the families it serves. Aside from a handful of exceptions, DCFS does not directly contract with such service providers. Instead, DCFS takes the lead in developing case plans that are individually tailored to address the issues that brought the family to its attention and then turns the families over to the services providers who engage the family, provide the services, monitor progress, and report back to DCFS. Accordingly, once connected, it is the service providers that often have the most frequent contact and direct relationships with the children and families

served by DCFS. It is therefore critical for DCFS to in turn, have frequent contact and direct relationships with the service providers it depends upon, when making decisions about the family's progress and their ability to safely care for their children.

DCFS is responsible for providing a wide range of services in a variety of contexts. Domestic violence, physical abuse, mental health, and drug abuse are some of the most predominant issues DCFS must address in the services it provides. Accordingly, some of the most common services offered to children and families include mental health assessments, therapy, parenting education, drug treatment and drug testing, child abuse prevention programs, and domestic violence programs for abusers and victims.

The context in which these services are provided varies as well. For very low risk families, referrals are made without any DCFS supervision or follow-up to ensure participation. Voluntary services under DCFS supervision are utilized for families that present varying degrees of risk but no safety factors (either because they do not exist or because they have been mitigated). Finally, where high risk and safety factors are present, children are detained and services are provided under Court supervision. In these cases, legal findings must be made regarding the sufficiency of the services and the parents' compliance/progress in those services.

Regardless of the context in which services are offered, the family's ability to safely parent their children without governmental intervention is judged by their compliance and progress in the services offered by DCFS. However, since DCFS does not directly provide services to these families, it must rely on third party service providers to do so. Moreover, in part because there has not been a truly effective integration of other County Departments into DCFS' delivery of services, most of the service providers that DCFS relies upon are community based organizations that have no contractual obligation to DCFS or any other basis for responding to DCFS' needs. Accordingly, while DCFS must rely on these services providers to make critical risk and safety decisions, there is nothing in place to ensure that these professionals: (1) are qualified and can safely be relied upon by DCFS and/or (2) understand the dependency context and provide meaningful services to the parents.

The current reality is that DCFS' role in "providing services" is to hand parents a list of various services providers in the community. This list is not vetted by DCFS, nor are there any stated qualifications/requirements that service providers must fulfill in order to be added to the list. Despite its best efforts, CSIU was unable to obtain solid information regarding how the list is compiled and what DCFS does to ensure that the providers on the list are qualified.

With a list in hand, it is then up to the parent to contact the providers on the list, explain why they are being referred, and engage in services. Though some providers will initiate contact with DCFS if they know the family is DCFS-involved, it is not a 100% guarantee that such contact will be initiated nor is it a 100% guarantee that the service

provider will ever understand from anyone other than the parent, what circumstances led to DCFS' involvement with the family.

Once the family is engaged in their service plan, DCFS policy requires workers to "maintain regular telephone contact with the service providers and request written progress reports and assess the information provided and incorporate it into the case plan and court reports." However, very little is said about what information should be required from the service providers. And so, if one was to pull a sampling of progress reports from service providers, they would likely find general information about the parents' attendance (i.e., has attended 5 out of 10 classes), demeanor in class (i.e., pleasant, engaged, "well-mannered"), and a conclusory remark such as "making progress".

Given the weight that the parents' participation and progress in services carries on the decisions that are made about their children, this is simply inadequate. By the time a parent is done with their services, the social worker and every treatment provider should literally be on a first-name basis. Not only should the contact be regular, it should be meaningful. Keeping in mind that the parents see their service providers with more regularity than their social worker, the social worker should strive to gain insight from the service provider's regular contact with the family.

The institutional relationships between DCFS and its service providers must be improved. As a first step in this process, DCFS must establish criteria for the service providers that are placed on its referral list. If a parent introduces a "new" provider to DCFS (as often happens with faith-based programs), DCFS must still verify that the program is qualified to address the issues that brought the family to DCFS' attention and then establish and maintain a relationships with the provider. DCFS must also clarify the purpose of maintaining regular contact with providers—it is not simply for the sake of completing court reports. The purpose is to elicit meaningful information regarding the services that are being provided and the progress that is being made by the parents.

DCFS must invest time and resources and take an active role in identifying, vetting, and coordinating service providers. In doing so, it might be worthwhile to investigate the possibility of a system in which provider programs are "audited" by DCFS personnel so that DCFS has first-hand knowledge regarding the program's format and content. DCFS may even consider establishing a service provider database in which workers can share good and/or bad experiences with certain programs or even share comments regarding what types of families are well-served by a given provider. This is an area where DCFS' departmental partners such as DMH and DPH can 'step up' by possibly being direct providers of mental health, alcohol and substance abuse treatment and/or assisting DCFS to identify qualified third party providers based upon their expertise.

Currently, there is not enough of a focus on the area of service providers. So much attention is paid to identifying the families that need DCFS intervention; yet, very little thought seems to be given to, "Now that we are involved, how do we 'fix' this family?"

Unfortunately, the "fixing" part seems to be left up to third parties who have no accountability when failed intervention results in tragedy. Given the responsibility that DCFS has to the children and families it serves and the level of accountability that is placed with DCFS, it must take a more active approach to coordinating and communicating with its service providers.

RSI # 4: THE NEED FOR STRATEGIC HUMAN RESOURCE MANAGEMENT

Child welfare is a tough business. It is an area focused on children's safety and well-being, thus decisions made can literally mean the difference between life and death. Accordingly, it is an area in which there can be little tolerance for mistakes, whether caused by lack of experience, a poor judgment call or plain incompetence.

DCFS, or any organization for that matter, can promulgate many strategies and load its workers up with 'tools' intended to help them carry out their job duties but, at the end of the day, the only commodity the organization has to actually DO the job, is its people. Nothing can substitute for the human element of social work—its intellectual capacity, its judgment and its compassion. However, with these attributes comes the potential for the human failings that can result in tragic consequences. Thus, while DCFS' greatest assets are its people; its greatest potential weakness is also its people.

The fundamental challenge for DCFS is to figure out how to carry out its charge within the reality of having to relying on human judgment in an environment that has no tolerance for mistakes and/or poor performance. It is the quality and management of the 'human capital' that makes the biggest difference to strategic success. Thus, "strategic" human resource management means making investments in the people who do the job so that they can succeed. This entails a combination of effective recruitment, proper training, adequate supervision, and meaningful performance assessments and accountability. As effective recruitment and proper training have been addressed in previous sections of this report, this section will focus on supervision and performance assessments as a means of empowering people to succeed.

a. What is Social Work Supervision?

Generally, *"Supervision" has been defined as "the primary means by which an agency-designated supervisor enables staff, individually, and collectively; and ensures standards of practice. The aim is to enable the supervisee(s) to carry out their work, as stated in their job specification, as effectively as possible. Regular arranged meetings between supervisor and supervisee(s) form the core of the process by which the supervisory task is carried out. The supervisee is an active participant in this interactional process."*[32]

[32] http://www.cyc-net.org/quote4/quote-1854.html

However, there have been countless articles and books written on the subject of 'supervision' which evidence that the subject is one that eludes easy definitions and explanations and is very open to interpretation depending on the context. In the social work context, Alfred Kudushin's 1976 discussion of 'supervision' is most often cited. Kudushin breaks 'supervision' in the social work context down into three essential elements:

- ***Administrative*** – the promotion and maintenance of good standards of work, co-ordination of practice with policies of administration. Its goal is to ensure adherence to agency policy and procedure by attending to their correct and appropriate implementation. By integrating and coordinating supervisees' work with others in the agency, supervisors provide a work context that permits supervisees to do their jobs effectively.

- ***Educational*** – the educational development of each individual worker on the staff in a manner to enhance their full potential. Its goal is to address the knowledge, attitude, and skills required to do the job effectively.

- ***Supportive*** – the maintenance of harmonious working relationships. Focus is worker morale and job satisfaction.

Kadushin based his model on the concept of a three-legged stool where all three legs, or functions—administrative, educational, and supportive supervision—are equally important. In the most recent edition of *Supervision in Social Work* (2002), Kadushin and Harkness point out the "complementary nature" and "overlap" of these three functions: "*All are necessary if the ultimate objective of supervision is to be achieved*". They further note that specific supervisory responsibilities frequently fulfill more than one function. For example, when supervisors facilitate a group case review or peer group supervision, they are typically fulfilling all three supervisory functions.[33]

The Social Work Policy Institute conducted a study on Child Welfare Supervision and concluded that with respect to social work supervisors, the expectation seems to be that they are "*...skilled practitioners who can implement competent practices that result in improved outcomes for children and families; who can serve as mentors to front-line workers to help guide clinical practices; who engage with the community; who act as managers in transmitting agency policies and in evaluating performance; who demonstrate leadership qualities and who provide support to workers to help them deal with the stress and trauma of their work.*"

The conclusion that can safely be drawn from both Kadushin's principle and the Social Work Policy Institute's analysis is that the demands of social work supervision are extensive. Perhaps this is why the Social Work Policy Institute concluded that the "*real*

[33] http://muskie.usm.maine.edu/helpkids/rcpdfs/BuildingAModelandFrameworkforCWSupervision.pdf

*world service delivery suggests that it is difficult to actualize all of these roles simultaneously, and it **may not be feasible to expect to find all of these attributes in one individual.**"*

The question then becomes—is DCFS' Supervising Children Social Worker ("SCSW") classification in line with prevailing notions of what it means to be a supervisory? If so, do SCSWs understand these principles and the role that they play in the Department's expectations? Further, have they been trained and provided with the tools that are necessary to fulfill their responsibilities?

- The Role of the SCSW within DCFS

DCFS' most recent management directive (September, 2010) delineating the responsibilities of the Supervising Children's Social Worker ("SCSW"), is nine pages long. It states, in part, that:

"SCSWs are responsible for overseeing each of their CSW's casework. SCSWs must ensure that the CSWs in their unit use appropriate assessment, investigation, intervention and case planning... SCSW's are expected to create an inviting learning environment characterized by support and mutual trust between CSW and SCSWand SCSWs are responsible for the quality, quantity and timeliness of work performance and product of all employees in their unit."

The directive goes on to provide **thirty** specific activities that the SCSW must perform in order to carry out these responsibilities. These articulated responsibilities can be grouped into the same three functional areas identified by Kudushin: educational, supportive and administrative. Thus the DCFS policy appears to conform to Kudushin's principles of supervision and seems to set forth the same demands described by the Social Work Policy Institute.

Accordingly, within DCFS, the SCSW plays a critical role in the Department's ability and effectiveness in carrying out its mission of providing quality child welfare services and supports so children grow up safe, healthy, educated and with permanent families. Organizationally, the SCSWs are the 'bridge' between management and the line workers and, they are the 'translators' of the organizational mission, vision, values and practice. The supervisors are the 'mediators' of the organizational climate in that they serve as a buffer between frontline staff and administration. Substantively, they are the ones responsible for evaluating case work performance and ensuring that in carrying out their job duties, the line workers adhere to the established policies and procedures of the agency.

Supervisors are also the glue that binds the organization together – the everyday line worker with the management. They are the ones that will know when there are performance issues but they are also the ones to encourage and support their line workers. The supervisor's role is critical because they influence their workers, positively and negatively. Within DCFS, the supervisor in the best position to combat the high

rate of burnout experienced by workers who deal with intense stress and the emotionally draining nature of the events and traumas experienced in the lives of their clients.

- SCSWs as Retention Agents

According to testimony at the February 19, 2001 California State Assembly Human Services Committee Hearing, the top two obstacles to recruiting and retaining social workers were: 1) stressful and non-supportive working environments and 2) poor supervision.

Thus, SCSWs can also play a critical role in helping DCFS address the issue of retention. As noted above, poor and/or non-supportive supervision significantly contributes to the loss of quality CSWs. There is a documented statewide shortage of social workers, which is expected worsen[34]. While the U.S. Government Accountability Office estimates the annual turnover rate of public child welfare workers to be as high as 30-40%, more rigorous measures are in the 10-20% range (though with considerable geographical differences).[35] Other studies have found that excessive policy changes and paperwork, stressful conditions (e.g., high workload, low agency morale) were found to be sources of job dissatisfaction leading to departures.

Conversely, quality of supervision was found to be a key element in the success of child welfare workers and improved retention.[36] A positive organizational culture has also been found to increase the likelihood of retaining skilled child welfare workers[37] and the American Human Services Association estimates that preventable departures comprise up to 60% of the turnover rate of public child welfare workers.[38]

High turn-over rates in personnel have direct negative impacts upon DCFS' ability to deliver quality services. Those workers who stay are asked to 'pick up the slack' left behind by those who leave the agency creating additional work that muse be borne by those who already have a full plate. It also has the effect of diverting supervisory time to administrative tasks such as trying to manage the case load distribution amongst the remaining workers and concurrently having to monitor its impact upon staff. The 'revolving door' of social workers also becomes a major obstacle to timely investigations which results in potentially leaving vulnerable children at risk of harm.

Further, the ability to 'get to know the family' and foster relationships with the family that are necessary to effectively assist them cannot be achieved if the continuity of that relationship is constantly interrupted. As DCFS' own Pomona Families First Project

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[34] http://www.csus.edu/calst/government_affairs/reports/Demand_for_Social_Workers.pdf
[35] APHSA, 2001; Daly et al., 2000; National Survey of Child and Adolescent Well-Being Research Group, 2001
[36] Pecora, Whittaker, & Maluccio, 1992; Reagh, 1994; Rycraft, 1994; Samantrai, 1992
[37] http://www.csulb.edu/projects/ccwrl/Weaver_PowerPoint.pdf
[38] Daly et al.

demonstrated, there is a direct correlation between improved outcomes and a stable social worker/family relationship thus indicating that the retention of public child welfare workers is a real professional and practical concern.[39] There is also a fiscal concern associated with high turnover since DCFS has to constantly invest in recruiting and training new workers and pay overtime to those cover the caseloads 'left behind'.

- The Supervisor and Supervisee Relationship

Los Angeles County has one of the lowest social worker to supervisor ratios in California—one supervisor to every 5.5 workers.[40] This means that DCFS supervisors should ostensibly be in the position to foster meaningful relationships with their supervisees. This expectation is emphasized in the DCFS ER Core Practice Model, which states that, "*Supervisors play a critical role in ensuring that workers do not come to premature conclusions by exploring the decision making process with social workers*".

The literature also emphasizes the importance of relationships in supervision:

- "*The supervisory relationship is the core of social work supervision.*" Tsui citing Fox (1983, 1989) and Kaiser (1997).
- Tsui goes on to recommend the reconceptualization of the supervisory relationship "*as a multifaceted relationship involving the agency, the supervisor, the supervisee, and the client, within a cultural context.*"
- In discussing his Interactional Supervision model, Shulman (1993) articulates an assumption underlying his model as "*. . . there are parallels between the dynamics of supervision and any other helping relationship...the way the supervisor demonstrates the helping relationship with workers will influence the manner in which staff members relate to clients...more is 'caught' by staff than taught by the supervisor...a supervisor models a view of helping relationships through his or her interaction with staff.*" (pp. 6-7)
- Kadushin and Harkness emphasize that the supervisor's relationship with the supervisee has been found to predict practice outcomes and affect the development of counseling skills (p. 195) and has "*crucial significance for learning in supervision.*" (2002:193).

The common conclusion among all of these experts is that if a quality supervisor-supervisee relationship is achieved, the necessary learning, building of client relationships, and building of clinical skills will occur almost without effort—skills become a natural consequence of good supervision.

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[39] It should be noted that the March 29, 2012 Bureau of State Audit report of DCFS indicated a turnover rate of roughly 6 percent overall for staff social workers for 2011-12 but notes that high turnover rates are of concern in certain regions/work units, particularly the inner city offices.
[40] http://www.csus.edu/calst/government_affairs/reports/Demand_for_Social_Workers.pdf

Based upon anecdotal and case-based information, CSIU's understanding is that there is significant instability in the CSW/SCSW relationships within DCFS caused by workers transferring in and out of offices. Frequent transfers and high turn-over do not allow time for CSWs and SCSWs to build the relationship that is so crucial for supervision. For example in the case of Abigail M., the SCSW who supervised the case-carrying CSW lamented the fact that the worker had just been assigned to her and she really didn't know much about the worker and her past performance.

Just as it is important for social workers to foster and develop stable relationships with the families they serve, so must the SCSW with their supervisees. There needs to be a level of trust, respect and confidence established between the SCSW and CSWs that takes time to develop. When the relationship does not develop, the SCSW does not get to know his/her supervisee's strengths and weakness thus hampering effective performance evaluation and educational efforts. The CSW, in turn, is left feeling alone and unsupported. Without such a foundation, there is reciprocal lack of all the things that are necessary to forge a path to joint success.

- Qualifications and Training

Given the many demands and expectations placed upon SCSWs, the qualifications of these individuals and the training they receive to perform the role of supervisor become critically important. The errors made by CSWs do not occur in isolation. Each and every poor or erroneous decision that was made, every missed visit, and every substandard court report that was identified by CSIU's child fatality review as contributing to the fatality was approved by an SCSW (and in several cases, the Assistant Regional Administrator). This is extremely alarming as it is the SCSWs who are supposed to be part of the 'checks and balances' system to ensure that their CSWs are making sound assessments and decisions. That is not to say that SCSWs are expected to be omnipotent, but the errors that were identified in the child fatality cases, were usually fairly egregious and not 'close calls'. Presumably, SCSWs are those who possess sufficient knowledge, skill, finesse and demonstrated superior performance as CSWs thereby warranting their promotion to being Supervisors. These are the people who DCFS trusts to be the 'safety net' for the CSWs. So the question becomes, why and/or how did the SCSW not 'catch' those errors?

Anecdotally, it has been heard many times that the only thing that separates a SCSW from a CSW, is 'three years'. Even assuming that 'three years on the line' is sufficient experience, by itself, experience in the field does not ensure that an individual will be a good supervisor.

Pursuant to State Regulations, all Supervising CSWs are required to have a Masters of Social Work degree. However, Los Angeles County was granted a waiver of this requirement by the State Department of Social Services many years ago. Currently, of the 633 SCSWs, only 115 have a MSW degree.

Many MSW programs emphasize a Direct Practice method concentration. This methodological approach is designed to prepare students for advanced practice and leadership roles. These programs also focus upon how to function within the structure of organizations and service delivery systems and seek necessary organizational change.

As discussed above, a bachelor's degree in social work is not mandatory to become a CSW thus many CSWs have not received the educational courses that provide students with knowledge of critical thinking within the social work context, and an understanding of the values of the profession and its ethical standards and principles. It is therefore incumbent upon the SCSWs to foster these important attributes in the CSWs they supervise. However, if the SCSW themselves have not had such training, it becomes a bit of the 'blind leading the blind'. Most MSW curriculum includes courses in supervision and organizational psychology designed to give students a working knowledge and skill set that will enable them to provide supervision, resource development, and financial leadership in the modern human services organization. Additionally, MSWs have graduate field requirements that include a focus on administration/ management activities in a macro environment (working in an organization, agency, large group of people)[41].

This is not to say that a degree alone is all that is needed to prepare one to become an effective supervisor; it merely provides the foundation upon which to develop strong organizational supervisorial skills. It is incumbent upon DCFS to ensure that its SCSWs are provided with ongoing training and education to enable its SCSWs to fulfill the important role that they play in the organization.

Training is essential and a documented retention tool yet DCFS does not have an effective training program that prepares and teaches SCSWs to do the job of supervising. Supervision of others, whether in the context of social work or otherwise, requires specific skills and understanding of the role, tasks and competencies for being a supervisor that need to be acquired through training.

Of the five SCSWs interviewed by CSIU, all unequivocally stated that they felt they were inadequately trained and prepared to perform the job of Supervisor. None had been provided with any type of supervisory training prior to assuming the responsibilities of a Supervisor. Instead, they relied upon their recall of 'how their supes did it', asking their former supervisor for advice and simply 'learning as you go'. The problem with these 'training' methods is that it fosters a lack of consistency across the Department and it is vulnerable to perpetuating poor supervision if the 'student' is learning from a 'teacher' who either never themselves learned to supervise correctly, or is simply not an effective supervisor.

[41] DCFS is actually one of the main placements for MSW interns but anecdotal information seem to indicate that an intern's learning and experience (good or bad) is wholly dependent upon who their assigned 'supervisor' as there is not a set curriculum/program.

The only formal training that DCFS provides to SCSWs, is the 15 day "SCSW Core Training program". What is shocking though is that SCSWs are usually not provided with this training until several years after they have already been supervisors! In the meantime, the SCSWs are apparently expected to figure it out on their own. However, it should be noted that the SCSWs interviewed felt that even when they finally did attend the Core Training, it was less than helpful substantively and really, 'a waste of time'. They indicated that the training was of little practical value; there was no training in areas that they felt would have been most helpful to them as Supervisors such as: how to conduct and write performance evaluations, how to transition from just managing one's own work to effectively managing that of several other people's, how to deal with problematic employees, how to motivate their supervisees and keep them accountable, how to create and manage the numerous logs kept by SCSWs, etc. However, it should be noted that they felt that it was a fantastic opportunity to network with other SCSWs with whom they can form working relationships and support system.

- Active vs Passive Supervising

There is a delicate balance in the role of a supervisor. A supervisor must empower the case-carrying social worker to arrive at sound decisions. The supervisor must, however, refrain from over-powering the worker, unless absolutely necessary. The role of supervisor probably requires the highest level of sound judgment in the entire dependency process. CSIU has received anecdotal evidence of supervisors at both ends of this spectrum. There appear to be those who supervise "by the numbers" by unduly influencing workers to change recommendations in order to keep the Department's statistics in line with its objectives and goals (particularly reduced reliance on out-of-home care and shorter timelines to permanency). We also hear of those who "sign off" on court reports without any apparent concern for what is contained within those pages. Obviously, neither of these approaches are acceptable forms of supervision.

Taking an active approach is not the same as micro-managing. Rather, it reflects an understanding that a supervisor has engaged in a process with the supervisee that has guided and engendered the CSW to make a sound assessment and decision. Thus when a supervisor signs off on a CSW's recommendation or supports a CSW's decision, that should represent a process in which the Supervisor has imparted his or her own experience and judgment to assess the recommendation and that he/she *agrees* with the conclusion reached by the CSW. Accordingly, if called upon to explain or defend a decision, the Supervisor should be just as capable and articulate in doing so as the CSW. This is consistent with what SCSWs generally understand their responsibility to be: quality assurance/quality control of field work.

One way to achieve this level of familiarity with a supervisee's work is through regularly scheduled supervision which facilitates a focus on interactive, educational and supportive supervision rather than a strictly compliance based or crisis management

based supervision. Additionally, occasionally accompanying the worker on home calls and interviews could provide the SCSW with an opportunity to observe the CSWs in the field through which areas of improvement can be identified. Active supervision is the only way a supervisor can ensure that workers are receiving the mentoring and support that is absolutely critical given the serious and intense nature of their work.

- The Administrative/Clerical Tasks

The SCSWs interviewed by CSIU estimates that they spend 50% of their time on Administrative/Clerical tasks such as reviewing and compiling data lists/logs; attending meetings, responding to emails and returning phone calls. That leaves only the other 50% of their time available to provide hands on supervision of field work.

Active supervision requires utilizing information that becomes available through compliance monitoring responsibilities as a means of identifying opportunities for teaching, guiding, and directing. By utilizing data/information such as caseloads, timeliness of investigation and visits, submission of court reports, absenteeism and other metrics easily measured through information technology systems, the supervisor becomes aware of performance issues (before they result in tragedy or costly mistakes) and caseload issues. However, the SCSWs estimate that they spend about three hours a day just entering data into systems (logs) and obtaining data/information from information systems solely for compliance monitoring purposes. There are apparently logs that must be created, maintained and reviewed for just about everything: contact logs, closure logs, referral logs, ethnicity logs, detention logs, overtime logs, etc. Thus the challenge becomes balancing the time demands associated with using information systems versus their utility.

Currently DCFS utilizes a variety of data management tools that have been developed over time in response to specific needs and utilities. There are different systems for departmental statistics, timely task performance, performance management, and the list goes on. There is 'the Site', Data Dashboard, IaKids, Cognose system, mySCSW, eCaps, etc. In fact, there are 63 different information systems currently in use with an additional 17 systems that are currently in development[42]. As the number of these systems has grown over time, so does the potential for 'systems overload' as the SCSWs must therefore become familiar with and proficient at utilizing some or all of these separate systems. The interviewed SCSWs expressed frustration at having to spend significant time just trying to figure out which system to use and then how to use them depending on the data they were attempting to obtain. They were just plain confused with all of the different information systems. Additionally, given the 'choice' of systems that SCSWs have to obtain the information they need, there results an inconsistency in the use of these various systems across the agency as a whole.

[42] Not all these systems may contain the type of data that is used or necessary to SCSWs thus CSIU does not know out of the universe of 60-70 IT systems, which are relevant to SCSW work/responsibilities.

One of the modules included in the Structured Decision Making system currently used by DCFS, is 'Safe Measures'. CSIU was provided with a demonstration of the Safe Measure tool, its utilities and flexibility. It appeared that Safe Measure already incorporates many of the necessary data points that would be helpful to SCSWs (and all other managers) in managing their supervisees and is scalable to include more. The most impressive aspect of the system was its ability to almost instantaneously, provide *information/data* whether broad based or down to the individual worker level.

- The "Paper"

Active supervision is very time intensive as it requires quality interaction between the SCSW and the individual workers as well as with the SCSW's unit as a whole. On top of that, social workers are buried in paper: State reforms and federal legislation continuously require more accountability and documentation, the agency's own mandated tools like SDMs, TDMs, UFAs etc. while sound in theory and no doubt intended to help social workers, all require documentation that must be completed by CSWs which in turn, must be reviewed by the SCSWs. This creates a vicious cycle wherein the more time the SCSW spends on reviewing paperwork, the less time they have to engage in 'hands on' supervision, which in turn leaves the workers to rely more on the 'tools' that generate the paper that must be reviewed by the SCSW.

It would behoove DCFS to undertake a comprehensive evaluation of its various information technology systems and documentation procedures, their utilities and redundancies and determine whether opportunities exist for consolidating systems and/or streamlining the reporting and management process. In other words, DCFS needs to examine ways by which it can better leverage information systems and documentation to *help* the SCSWs work more effectively rather than burden them with time consuming clerical tasks. Additionally, DCFS should evaluate whether support staff can be utilized to input and gather the data for the SCSWs for the SCSWs' use thereby freeing them up to provide more hands on quality control and field supervision to their workers[43].

- The Direction of Supervision in Child Welfare

In a recent symposium sponsored by the Social Work Policy Institute (SWPI) of the National Association of Social Workers (NASW) examining the role of the child welfare supervisor, many suggestions based upon numerous studies as to how to improve supervision were identified. They included:

- Greater attention to the selection of supervisors.
- Minimum qualifications and competencies should be established for child welfare supervisors
- Recruitment of supervisors should include a combination of educational

[43] The interviewed SCSWs believed that having the necessary reports printed and provided to them, would save them half the time the currently spend on these administrative tasks.

requirements and performance expectations
- Supervisory training should be a prerequisite to transitioning into supervisory position
- Creating quality improvement debriefing processes in agencies, like those used in medical settings, to review case outcomes and support learning for supervisors and their staff, including the identification of trends and gaps in performance
- Optimize the supervisor's quality assurance role by using data and records to review performance
- Minimize the number of required forms and paperwork
- Develop agency processes to provide support for middle managers to mentor and supervise the front-line supervisors

DCFS is in desperate need of evaluating and modifying its current practices in its selection of SCSWs, the training provided (or lack thereof), the roles and responsibilities of SCSW and its performance expectations of the SCSW. DCFS must strive to develop an organizational framework to support effective child welfare supervision. DCFS would be well served to look to the extensive body of research and study that has already been undertaken in examining the challenges that are faced by the child welfare supervisor and potential solutions to overcoming those challenges. Improving the quality of supervision should improve both the performance and morale of CSWs which should ultimately, help DCFS achieve its goals of providing effective intervention and assistance to children and families.

b. <u>Meaningful Performance Assessments and Accountability</u>

In a 1993 study of interactional supervision, L. Shulman emphasizes that a supervisor's evaluation of a worker's performance *"is one of the most important elements of the supervisor's role, and when handled well, it makes a major contribution to the worker's development and to client services". However, when formal evaluations are handled inconsistently throughout an organization with regard to frequency, format, supportive atmosphere, and substantive focus, child welfare supervisors' efforts to shape supervisees' job performance and address performance problems are seriously undermined"*[44]. Additionally, efforts to impose appropriate disciplinary action are seriously undermined by ineffective and/or inappropriate performance evaluations.

This issue was discussed in great detail in the case of Viola V. CSIU's review of the performance evaluations of five social workers identified to have made serious investigative and assessment errors that collectively resulted in placing Viola in mortal danger yielded the result that 'everyone was a star'. DCFS Internal Affairs found that all five of these same workers committed policy violations. However, given the requirement under Civil Service rules for progressive discipline, the Department was hamstrung to impose discipline; out of twenty six workers and supervisors involved in

[44] http://muskie.usm.maine.edu/helpkids/rcpdfs/BuildingAModelandFrameworkforCWSupervision.pdf

Viola's case determined to have committed policy violations, only one worker received a 30 day suspension and a second received a 5 day suspension. The rest of the workers received no discipline, likely because they were consistently characterized in their performance evaluation as good or better, thereby limiting the options for discipline under progressive discipline requirements.

Viola V's case is evidence of how poorly conducted and 'overly generous' performance evaluations over time, becomes a barrier to DCFS imposing appropriate disciplinary measures and the organization becomes more and more burdened with low performers it cannot shed. The inability to discipline employees has a direct impact upon the safety of children that DCFS is entrusted to protect. There are child fatality incidents in which the same social worker and/or supervisors have been involved in more than one case. There has only been one termination associated with a child fatality and that was primarily based upon the worker's falsification of DCFS records. Other than that, despite the egregious nature of many of the mistakes made by workers, the most serious discipline has been one 30 day suspension.

Inaccurate performance assessments will without question, impede management's ability to impose discipline later on down the line, especially where there is an established performance evaluation history wherein the employee is rated as "very good" or better. It would be difficult to demote or terminate an employee absent a showing of a pattern of poor performance or other problematic issues.

- <u>The Discipline Process</u>

Assuming that a pattern of 'overgenerous evaluations' is not a potential impediment to taking disciplinary action, there are still necessary steps that must be taken in order to be able to move forward with imposing discipline. As mentioned above, the interviewed SCSWs were particularly frustrated with the fact that they have never received sufficient training on the 'what, when, why and how' of the discipline process. They have no guidance as to when or how to put a worker on an action plan, the what and how of maintaining necessary documentation or even simply, when to call HR.

When the discipline process is not handled properly, the agency's ability to actually enforce discipline is seriously compromised and likely precluded. It is therefore critical that supervisory staff is provided with adequate training and guidance to successfully 'manage out' problem workers.

- <u>Inconsistent Standards</u>

Another sure way to undermine the agency's ability to successfully impose discipline is to have inconsistent standards of performance and expectations. Anecdotal information indicates that there is a wide variation amongst SCSWs, ARAs, RAs and Deputy Directors in terms of their expectations and 'philosophy' towards discipline. There does not appear to be uniform standards of supervision and accountability across the

eighteen regional offices of DCFS; instead each office seems to have their own set of standards.

Some regional offices hold their workers to higher standards of performance than others. It is apparently common knowledge amongst workers, which SCSW and offices are more lenient than others. After transferring from one regional office to another, when one SCSW raised concerns about the refusal of support staff to perform what in her prior office were routine tasks, she was told by her ARA, "We don't do that here". CSIU has heard of instances where CSWs were elated when their court reports were rejected by their new SCSW and sent back for more information. They were pleased that finally, they were receiving guidance rather than a 'rubber stamp' from their Supervisor.

Additionally, there must be consistent enforcement of standards. Apparently, selective enforcement of standards by different regional offices is also well known. The type of discipline imposed for the same or similar performance issue varies from office to office; some are more stringent, while others are avoidant of discipline whether it be based upon fear of litigation, a belief that it discipline is not warranted because 'he/she is a really nice person' or simply, they cannot be bothered by the degree of time and effort that initiating and following through with disciplinary action takes.

SCSWs are in the best position to be the 'enforcers of standards' because they have the opportunity to observe their worker's performance and whether they conform to established standards. Thus, when a SCSW seeks support from their ARA to impose discipline, the SCSW's input should be given great consideration. Several of the SCSWs interviewed by CSIU have had experiences wherein they felt pressured by their ARA not to pursue disciplinary action even when they felt it was warranted.[45] Conversely, when SCSWs fail to enforce performance standards upon their workers, the ARAs need to hold the SCSW accountable. In either case, when ARAs demonstrate a lesser standard, it can become the 'new' standard for their SCSWs who in turn, stop enforcing fundamental standards and thereby set a lower standard for their workers. The 'trickle down' effect is obvious when management fails to 'lead by example'; this holds true from the very top of the organization all the way down.

Having consistent standards of performance and enforcement of those standards is critical to the performance of DCFS as a whole. There cannot be 18 different set of standards for each of the 18 different offices; they are all part of DCFS, thus all should be operating with the same understanding of the same standards of performance and those standards must be consistently enforced regardless of which office. Simply stated, standards must be uniformly known, consistently applied and non-selectively enforced. Management within each of the regional offices must understand and accept that their actions should not represent an action against an individual but rather,

[45] It should be noted, that there could also be liability issues associated with the failure to take appropriate disciplinary action when an employer knows, or should have known, of an employee's substandard performance.

represents the Department's response to their misconduct or failure to meet standards. Their loyalty and commitment must be to the larger organization and the children and families that DCFS serves.

While allowing under-performers to remain on the job may be tolerable in some professions or workplaces, it most certainly cannot be the case when it comes to child protection workers. There is no room for avoidable mistakes in this arena as they can, and unfortunately do, result in serious harm or death to a child. DCFS cannot afford to keep employees it knows, or has reason to know, are problematic as the stakes are too high. However, DCFS cannot take appropriate disciplinary measures if it has boxed itself in by artificially inflating such employees' performance evaluations or simply not taken appropriate disciplinary action when it could have.

Strong human resources management must be a top priority for DCFS to ensure that it has a workforce comprised of those who can and do carryout the mission of the Department. To that end, it may be beneficial for DCFS to consider utilizing human resource specialists and County Counsel with whom its management staff can consult, receive advice and guidance, and who participate with the DCFS manager in navigating through the admittedly cumbersome and complicated process of discipline within the civil service system.

CONCLUSION

This report began with the premise that the failures identified as contributing to the child fatality incidents reviewed by CSIU, were likely caused by not just the personal failures of the individual workers who made mistakes, but also possibly engendered by the system itself. The areas of major concern identified in this report bear out two complex realities: (1) that the framework devised by DCFS may have created the opportunity for failure to flourish and (2) that DCFS must be supported by other County Departments if it is to succeed in the mission of providing quality child welfare services and supports so children grow up safe, healthy, educated and with permanent families.

DCFS' ability to meet established departmental goals is wholly dependent upon the people it recruits, hires, trains, and promotes through its leadership ranks. Without properly qualified, skilled professionals who are committed to doing good work, DCFS does not stand a chance of functioning at the level required for a business with 'zero tolerance' for failure. Thus, at all levels within DCFS, attention must be paid to the qualifications of those who are hired; the training and supervision they receive once hired; their ability to meet performance expectations; and their suitability for promotion and increasing levels of responsibility.

Yet, even in the critical areas of the 'front end' and in its supervisory workforce, DCFS may have set itself up by failing to recognize the need to have the right people for the job. Social workers are not generic—the skills and personalities they possess are as

varied as the functions within the Department. Thus, rather than treating them as if they are all cut from the same cloth, DCFS must strategically recruit and staff social workers in the positions where they are most likely to excel.

With respect to the 'front end', DCFS must take several factors into consideration when recruiting and hiring, including the unique skills that are required for the job of conducting investigations, the demanding nature of 'front end' work, and the need for specialized training. With regard to the supervisory workforce, Los Angeles County obtained a waiver of the State Regulation that requires all supervisors to have a Master's Degree in Social Work ("MSW") because there simply weren't enough candidates with MSW degrees to fill vacancies. In light of this reality, it is incumbent upon DCFS to facilitate continuing education for its SCSWs—especially those that do not have an MSW—and to develop strict criteria for the qualifications that must be possessed by those who do not have an MSW before they can be elevated to the demanding role of being a supervisor.

This personnel problem is compounded by the lack of effective training programs. While training does not, by itself, guarantee that performance issues will cease to exist, it is a means by which DCFS can ensure that all social workers and/or supervisors begin their duties with a common understanding of what is it they are supposed to do on a daily basis and practical guidelines for how to do those things. Considering that DCFS already invests significant time and resources into training, it seems logical to that the Department would aim to maximize the usefulness of its existing training programs. Yet, its existing programs are largely theory-based and lack the type of practical interactive learning experiences that are essential in a field like social work where words on a page simply do not have the same impact as walking people through scenarios they are likely to encounter.

Rather than developing robust training and continuing education for its workforce, DCFS seemed to respond to the lack of qualified and experienced social workers and supervisors and performance management issues with a plethora of policies, tools, and strategies designed to achieve consistency in decision-making. The more than 4,000 pages of policy are written to give workers step-by-step guides for just about every action they take. The Point of Engagement Model is supposed to point workers in the directions of tools they can use (UFAs, VFMs, TDMs) to avoid detaining children. And, the SDM tools are supposed to ensure that workers base decisions on indicators that have been established as "legitimate" by researchers. All of these policies, tools, and strategies were supposed to regulate decision making and "make up" for the varying levels of experience and education possessed by line workers.

Instead, the result has been a dilution of the need for critical thinking, clinical analysis, and sound professional judgment. In addition, although these policies, tools and strategies are supposed to facilitate the **six** DCFS departmental goals, the way they are being interpreted and implemented seems to be conveying only one message—"No more detentions!" DCFS must therefore undertake a comprehensive review and evaluation of its organizational structure, the essential functions of its personnel and the

implementation of the strategies that are supposed to facilitate its mission of protecting children and restoring families.

Of course, it must be borne in mind that no matter how much DCFS does to improve its organizational structure; it can all be rendered meaningless without accountability. DCFS must ensure that it establishes clear and consistent standards of performance that are *uniformly enforced throughout* the department in order to avoid creating an environment in which some people seem to be going through the motions without realizing the importance of what they do on a day-to-day basis. Changing such institutional philosophies requires accountability at all levels—from the unit clerk to the Executive Management Team. Everyone must have a clear understanding of the fact that once DCFS intervenes on behalf of a child, that child is the Department's responsibility and every single person involved shares in that responsibility.

While there is no doubt that the area of child welfare is primarily the responsibility of DCFS, there is no arena in which the axiom "It Takes a Village" it more accurate than in child welfare and protection. DCFS is simply not equipped to battle mental health, substance abuse, domestic violence, a myriad of medical needs, and legal issues without the support, active participation, and available resources of other County Departments. As it exists today, some of the other County Departments who need to be partners with DCFS in addressing the complicated issues that are implicated in child welfare have not fully 'bought in' to the concept that they are part of the County's continuum of care for children and families. In order to achieve this critical "buy-in", DCFS must find a way to integrate these Departments into its delivery of services. There must also be a means by which the leaders of these Departments communicate on a regular basis so that there is always an opportunity to them to discuss what they need from one another in order to meet the needs of the children they must protect.

All this calls for a paradigm shift in the way DCFS does business because 'business as usual' will not facilitate the path to improved performance and better outcomes for children and families. Some of the changes that are necessary to effectuate such a paradigm shift have already been initiated. No longer will every warm body that enters the training academy be 'passed through' and greater emphasis will be placed on the qualifications of those who can even enter the academy. CSIU is informed that there will be much more emphasis placed on accountability at all levels within DCFS. In response to Jorge T. and the Katie A. Strategic Plan, integration of County services has improved. These steps are a solid beginning but they must be followed by many more.

Though some of the changes suggested in this report involve large-scale planning and may take time to explore, others are easier to implement and have the potential to make an immediate impact. What is imperative is for DCFS to consider the four recurring systemic issues identified in this report as it moves forward with improving its organization, its services, its collaboration with other Departments, and fulfilling its mission of providing quality child welfare services. CSIU's detailed suggestions as to how DCFS may address these challenges are attached hereto as Appendix A.

APPENDIX A

SUGGESTED IMPROVEMENTS

RSI # 1: Front End Investigation Failures

- Consider expanding the qualifications for social workers to include a broader range of educational backgrounds and types of experience such as law enforcement/criminal justice and candidates with advanced degrees in fields such as law and education.
- DCFS must take into account that different skill sets/personality types are required for Front End work. Consider direct hiring for the Front End as a way of recruiting qualified people who will commit to becoming experienced investigators. Alternatively, consider requiring workers to have 2-3 years of experience before they can be assigned to the Front End.
- Front End workers need specialized training that should be comprised of classroom training that is reinforced through field training. Consider exploring training models similar to those used by law enforcement. Consider methods that will help assess whether training has been effective: situation-specific simulations, written testing, and/or the use of field officers who evaluate the performance of investigators before they are approved to work independently.
- DCFS must undertake an evaluation of the apparent misunderstanding of the definitions of "unfounded", "inconclusive" and "substantiated". DCFS, in conjunction with County Counsel, should consider whether legislative action is required to clarify the confusion caused by using Penal Code definitions in the child welfare context.

RSI #2: The Ineffective Implementation of Decision Making Tools and Strategies

- Consider revising DCFS policies so that they are clear, consistent, easy to understand and to apply; consider building them into a database that has a user-friendly search function.
- Critically assess Point of Engagement to determine whether the process is effective without its critical components (such as ISWs and ample options for UFAs). If not, consider whether resources can be re-allocated to provide the critical components.
- Assuming POE is kept in-tact, analyze whether the offices where it is being used have implemented with fidelity and for those offices where it is not being used at all, determine whether there they should be required to implement POE.

- VFMs are implemented in some of the most volatile/vulnerable circumstances. Develop new implementation criteria for VFMs to ensure that those cases receive the necessary supervision and services. Consider options such as the establishment of VFM-only units, requiring more contacts with the children and the family than are required in non-VFM cases, unannounced visits to ensure that mitigated safety factors remain mitigated, regular contact with service providers, and internal case conferences to compensate for the lack of court supervision.
- Clarify the role of TDM Facilitators. According to policy, TDM facilitators are active participants who are ultimately responsible for ensuring that Safety/Action plans ensure child safety. But they cannot do this if referral forms are left blank and they are not required to review CWS/CMS and/or other background information. If their critical function is emphasized, TDM Facilitators AND case-carrying social workers will understand the importance of giving them enough information to be effective in their roles.
- There is awareness at all levels of DCFS that SDMs are not being utilized correctly and can be (and are) manipulated to justify pre-determined outcomes and/or avoid higher levels of review. DCFS must re-assess the intended purpose of SDM and determine whether that purpose is being met. Consider using SDMs as a validation tool to be used by supervisors to ensure that their CSWs have considered all relevant factors and reached sounds conclusions.

RSI #3: **<u>The Need for Improved Communication, Integration and Coordination of Services</u>**

- The Department has six goals—all designed to be equal and important components of its child protection mission. Yet, "Reduced Reliance on Out-of-Home Care" appears to be drowning out the other goals, including "Improved Child Safety". DCFS must ensure that all goals are being "heard" equally by engaging in an active campaign to "brand" its message (all goals are created equal) and making sure management is implementing tools and policies in manner consistent with Department's objectives.
- Information sharing among workers must be improved—give them tools that will help them create better records for future investigations so that institutional knowledge achieves its full utility and family histories are given proper context and meaning. Consider using voice recognition software or other technological tools to ensure records are accurate, detailed, and based on recent impressions. Consider a uniform file maintenance protocol so that each file is a complete chronological history and everyone's file "looks the same" so that as file moves through the continuum, every worker knows where to find critical information.

- It Takes a Village. DCFS cannot (and should not) stand alone in its mission. Consider an Executive Steering Committee and/or Inter-Departmental MOUs as a means of aligning all Departments that should play a role.
- Clear definition of roles and responsibilities must be established as DCFS moves to out-station CSWs into Medical Hubs. Beyond outlining duties of out-stationed CSW, the two Departments must reach a common understanding regarding how and what information must be shared, what type of conclusion will be reached by Hub personnel, and what the CSW will do with that conclusion (i.e., use it as part of his/her analysis, view it as a determinative factor in certain types of cases, etc.)
- DCFS and County Counsel need to work together to strengthen their attorney-client relationship. County Counsel must be active in advising, guiding, and counseling. County Counsel must proactively alert DCFS if recommendations do not appear to be supported by facts provided particularly in the court context where doing so can result in stronger reports, fewer adverse rulings, and lessened need for social workers to testify. DCFS must be active in seeking counsel and incorporating legal guidance into day-to-day decisions.
- Community Service Providers must be viewed as an extension of DCFS, not as distinct entities selected by the parents. There must be a process for screening the providers placed onto DCFS' referral list that includes an ongoing assessment of their appropriateness and efficacy. Workers must maintain regular contact with services providers, beginning with an initial dialogue in which the service providers are advised of the reasons for intervention and the expectations DCFS and/or the Court has placed upon the family. Service Providers must be advised of the need for substantive progress reports that are sufficiently detailed to enable workers to make the decisions that are based on parents' progress and rehabilitation.

RSI #4: <u>Strategic Human Resources Management</u>

- Revise the curriculum of the SCSW Core Training to include practical, relevant topics such as how to complete a performance evaluation, how to deal with problematic employees, how to motivate supervisees, how to use the numerous information systems, etc.
- Encourage SCSWs to use regularly scheduled meetings with their supervisees as a means of facilitating interactive, educational and supportive supervision.
- DCFS should undertake a comprehensive evaluation of its various information systems and documenting procedures to determine whether opportunities exist for consolidating systems and/or streamlining the reporting and management process.

- DCFS should evaluate whether support staff can be utilized to input and gather data for the SCSWs thereby freeing them up to provide more hands on quality control and field supervision to their workers.
- DCFS should consider utilizing human resources specialists and County Counsel with whom its management staff can consult, receive advice and guidance, and who participate with the DCFS manager in navigating through the admittedly cumbersome process of discipline within the civil service system.
- DCFS must ensure that SCSWs are supported by upper management in instances where they identify performance issues since they have the most direct contact and experience with line workers.
- DCFS must ensure that it establishes uniform standards of performance, enforcement and discipline.