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Office of the Child Advocate

2019 System Learning Review Summary Report

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ACKNOWLEDGEMENTS

The Office of the Child Advocate (OCA) wishes to acknowledge the many partners whose commitment and support to the OCA System Learning Reviews (SLR) has made this process possible.

Division for Children, Youth and Families (DCYF) personnel have generously assisted in coordinating and giving their time to thoughtful participation in SLRs. Together, we have identified opportunities for learning and system improvements.

We also acknowledge and thank Casey Family Programs for supporting the development of the SLR process pioneered by the partnership between Collaborative Safety, LLC and the New Hampshire Office of the Child Advocate.

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FOREWORD

It is a sad fact that children, like adults, may experience serious injury and unexpected deaths. Unexplained deaths in otherwise healthy infants and toddlers are particularly troubling so early in young lives. Unfortunate circumstances may lead to child deaths caused by abuse or neglect in which parents or caregivers are criminally responsible. Accidental deaths sometimes represent caregiving practices we know increase risk, or opportunities to recognize risks, going forward. A comprehensive and thorough review of child deaths and other critical incidents is an essential component of public health. It is also essential to quality improvement of the child welfare system, as a means to ensure the effectiveness of protection and prevention initiatives. In tragedy, there must be learning.

This summary report represents a shift in approach to child death and critical incident review in child welfare. We now understand the approach to tragedy that calls out and fires employees leaves behind an imperfect system in which tragedy will re-occur until the system itself improves. We learned this in 2000 when the Institute of Medicine (IOM) published a pivotal report on human error implicated in up to 98,000 deaths per year in health care. The primary conclusion of the IOM report was that the majority of medical errors in health care were not caused by “individual recklessness.” More commonly, they found, “errors are caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them ... blaming an individual does little to make the system safer and prevent someone else from committing the same error.”¹ The IOM called for what we now understand to be a “culture of safety” in health care, and indeed in all human services.

Recent public accusations against a New Hampshire city’s police department for failure to protect a child from an untimely death reflect the logic that demands a culprit to make everything better². Yes, police should call the Division for Children, Youth and Families (DCYF) when children are in harm’s way. However, DCYF should call police too, and neighbors should call them both. By law, we are *all* mandated reporters in New Hampshire. As a community, we all carry responsibility for the safety and wellbeing of children. That includes ensuring well-resourced and effective prevention programs are available to families; and for when families struggle, child protective services that are equipped to intervene and ensure children are safe. In 2016, the federal Commission to Eliminate Child Abuse and Neglect Fatalities claimed child safety and wellbeing is *Within Our Reach*.³ Reiterating the message from the IOM in 2000, the Commission recommended grounding child death review in safety science, the science employed in safety-critical industries such as nuclear power, aviation, and health care.⁴ At the Office of the Child Advocate, we believe the lives and healthy development of children are equally as

¹ Institute of Medicine. 2000. Briefing. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press. <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf>.

² Hayward, M. (September 6, 2019). Mom reported drug use 6 months before toddler Tayden Garvey died. *New Hampshire Union Leader*. https://www.unionleader.com/news/courts/mom-reported-drug-use-months-before-toddler-tayden-garvey-died/article_fca670d6-c1c5-5cac-8cab-9ae0f5efeb84.html

³ Commission to Eliminate Child Abuse and Neglect Fatalities, (2016). *Within Our Reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, D.C.: Government Printing Office.

⁴ Ibid at 78.

important as those of power plant employees or airplane passengers. We present in this inaugural *Systems Learning Review Summary Report* the findings of critical incident review through the application of safety science.

Authority of the Office of the Child Advocate

The Office of the Child Advocate is an independent agency established to provide oversight of DCYF and assure children's best interests are protected.⁵ Pursuant to RSA 170-G:18, IV(a) the Department of Health and Human Services (DHHS) must report to the OCA all incidents affecting children involved with DCYF who experience physical injury or significant risk of harm, as well as other incidents that may affect their safety and wellbeing, including deaths to the OCA. The OCA may, upon its own initiative or upon receipt of a complaint, review and investigate the incidents.⁶

A New Approach: Safety Science

From the beginning, the OCA sought to understand the meaning of child deaths and other incidents in the context of complex multi-system interactions. Typically, the blame for child deaths and other critical incidents falls on isolated failures by individual people or agencies. Ecological systems theory⁷ tells us that is rarely the case. Rather, tragic and usually unforeseeable events emerge from a complex social system comprised of influences from relationships, roles, and interactions within environments, communities, cultures, health services, public agencies and families. The goal is to thoroughly investigate child deaths and other critical incidents to learn and ultimately improve the system's ability to support safe outcomes for children. With support from Casey Family Programs, the OCA engaged in consultation with Collaborative Safety, LLC who developed a Systems Learning Review (SLR) process and accompanying instrument. The SLR is a process to review critical incidents in a way that appreciates the complexity of multi-system influences on child welfare decision making. The SLR is a collaborative evidence-based review process grounded in safety science. Safety Science is an integrated science of evaluation that cultivates a safe environment for honest, open problem solving.

Summary Findings

This is the first *Summary Findings Report* from the OCA SLR process. As the first report, it includes consideration of all child deaths reported to the OCA since the Office came into being and began receiving notices from DCYF: February 2018 through September 2019. In that period, the OCA received notice of 26 child deaths. Of those 26, 15 children or their families had contact with DCYF prior to or at the time of death and five were examined with the SLR. The death of a parent was also examined with the SLR to test the flexibility of the process. DCYF frontline child protective workers, juvenile probation and parole officers, supervisors, field administrators, and other administrators participated in the six SLRs. Through deep case examination, common features and pressure points that impact case work decision making were identified and analyzed for themes of impact on outcomes for children. Explanation of the process and findings are presented here.

⁵ RSA 170-G:18, III. (a).

⁶ RSA 170-G:18, III. (i).

⁷ Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

CHILD DEATH REVIEW

Pursuant to RSA 170-G:18, one of the essential responsibilities of the OCA is to monitor, track and review deaths and other critical incidents involving children with DCYF's involvement. The OCA strives to learn from the tragedy of critical incidents to improve the safety of all children in New Hampshire with system strengthening.

New Hampshire has several layers of surveillance of child deaths and other critical incidents.

- Quality Assurance Specific Case Review. Internally, DCYF Policy 2850 *Quality Assurance Specific Case Review*, in accordance with RSA 126-A:4, IV(a), requires DCYF conduct Specific Case Reviews (SCRs).⁸ In SCRs, quality assurance, legal counsel, administrators, directly involved DCYF staff, an attorney from the Attorney General's Office, and certain other relevant staff as applicable, review a case.⁹ Proceedings are confidential as required under RSA 126-A:4, IV.¹⁰ Any notes or materials are destroyed. Each review is summarized on a confidential Form 2851 Quality Assurance Specific Review Summary and shared with the associate commissioner, director, legal services and general counsel, the Bureau of Organizational Learning and Quality Assurance, the safety specialist, and the Bureau Chief of Field Services to be integrated in the continuous quality improvement system of monitoring and planning.¹¹ The Form 2851 includes a summary of the case, experience and training of involved staff, available resources and services accessed or used to make informed decisions, strengths and challenges of DCYF's involvement, systemic questions identified, and practices that should have been done differently. SCRs are not required if DHHS has conducted a Sentinel Event Review on the incident.¹²
- Sentinel Event¹³ Review (SER). DHHS Policy: PR 10-01 requires reviews of sentinel events involving individuals served by DHHS (which includes DCYF). SERs are convened at the request of administrators or when events are identified with more than one agency/system involved and in which there is preliminary evidence of potentially one or more problematic systemic issue. The SERs are confidential.¹⁴ No minutes are taken or distributed.¹⁵ The Sentinel Event Reporting and Review teams identify systemic factors, opportunities for improvement, and recommendations for distribution among the review team and the DHHS Office of Quality Assurance and Improvement to be monitored at monthly meetings.¹⁶ There was only one SER in the reporting period of this report. It occurred in March 2018.
- The Child Fatality Review Committee (CFRC) is a multidisciplinary committee of experts who have historically reviewed unexpected deaths of children. Established by executive order in

⁸ DCYF Policy 2850 *Quality Assurance Specific Case Review*

⁹ *Ibid.* at 2-3

¹⁰ *Ibid.* at 2.

¹¹ *Ibid.* at 5-6.

¹² *Ibid.* at 2.

¹³ A "sentinel event" is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant change of a serious adverse outcome." DHHS Policy: PR 10-01 at 2.

¹⁴ *Ibid.* at 5, 7.

¹⁵ *Ibid.* at 7.

¹⁶ *Ibid.*

1995, the Committee was inactive since their last report issued in October 2017¹⁷. In 2019, Senate Bill 118 *Establishing a Child Fatality Review Committee* became law, codifying a new iteration of the CFRC. The CFRC will conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths for the purpose of identifying factors associated with the deaths and make recommendations to promote public health and system changes to improve services for infants, children and youth. The CFRC is mandated to complete an annual statistical report on the incidence and causes of child fatalities.

- Suicide Fatality Review Committee (SFRC) Pursuant to RSA 126-R:4 the SFRC is mandated to review and report on identified trends in patterns of suicide deaths, associated risk factors and gaps in systemic response to ensuring safety and wellbeing of individuals at risk. The SFRC reports informally to the Suicide Prevention Council (SPC). Trends and recommendations have historically been incorporated with an annual suicide prevention data report. The most recent report, 2018, includes incidences by age but does not review details of youth suicide.¹⁸
- Domestic Violence Fatality Review Committee (DVFC) Executive Order 99-5, established the DVFC to describe trends and patterns in domestic violence-related fatalities, identify risk factors and gaps in the response system, educate the public and recommend policies to reduce domestic violence-related deaths. Review of child deaths for which domestic violence was implicated has historically been conducted in conjunction with the Child Fatality Review Committee.¹⁹
- The Office of the Child Advocate has a narrow jurisdiction limited to reviewing deaths and incidents involving children who are or have been in the custody and control of the Department of Health and Human Services (Department). Pursuant to RSA 170-G:18, IV(a), the Department shall provide the OCA with a copy of all incident or other reports related to actual physical injury to children or a significant risk of such harm, as well as other incidents which may affect the safety and well-being of children in the custody or control of the department within 48 hours of the occurrence. The statute further mandates that the Department report immediately any child fatality or serious injury by telephone.

The OCA enters and tracks all received incident reports, including those of deaths, in the OCA case management system. Review and analysis unearths trends in practice, reporting, response, and follow-up services available to children and families. Those cases that warrant deeper review for systemic implications are examined in SLRs.

The OCA is the first independent oversight agency that Casey Family Programs has supported in its work to assist reform in child welfare and juvenile justice systems across the country. Casey Family Programs contracted with Collaborative Safety, LLC to create a review instrument and process specific to the OCA's oversight needs in conducting incident reviews. Collaborative Safety LLC is a consulting agency that works with numerous public and private human services organizations throughout the country. A primary focus of their work is with child welfare organizations developing systemic child fatality review processes and aligning organizational culture change to that process.

¹⁷ New Hampshire Child Fatality Review Committee, (2017). *2015-2016 Biennial Report*.

¹⁸ Annual Suicide Report, 2018 https://theconnectprogram.org/wp-content/uploads/2018/11/2017_annual_suicide_report_-_10-30-2018.pdf

¹⁹ Personal communication with a DCFRC executive committee member

SYSTEM LEARNING REVIEW PURPOSE & FUNCTION

The purpose of the SLR is to understand the case-specific and underlying systemic issues that, when addressed, will improve practice and service delivery to prevent injury or death.

The primary scientific basis for the SLR, Safety Science, engages disciplines including human factors engineering, systems engineering, organizational management, psychology, sociology and anthropology. Furthering this unique blend of sciences is the integration of behavior analysis, forensic interviewing and trauma informed care. Applied safety science reduces human error through system learning rather than focusing blame on individuals without strengthening the system.²⁰ By employing safety science, the OCA seeks to contribute to a “safety culture” conducive to active reflection, problem solving and learning, all necessary for improving practice and better outcomes for children.^{21,22}

This model has three approaches to system improvement:

1. Shift from a culture of blame to a culture of accountability
2. Focus on systemic methods of learning and investigation
3. Address underlying systemic issues with sustainable solutions rather than superficial issues with quick fixes.

While the model minimizes reliance on blame, it is not an excuse making process; there is a strong focus on accountability but the accountability is viewed as being owned by the broader, complex system rather than individuals within. It recognizes that the entire agency is responsible for addressing concerns. Furthermore, this means that as an organization and extension of state government, the agency has the responsibility to adequately learn about and improve the whole system following a critical incident as part of its accountability to children and families. If, in fact, individual malfeasance does occur, the SLR will unearth system characteristics that leave the malfeasance undetected and children at risk. Creating a safe space for frontline workers to contribute observations and experience with the demands and pressures of a system facilitates their accountability to maintain the effectiveness of the system in which they operate.

The SLR has two specific functions:

1. It surfaces systemic challenges that make it more difficult to protect children
2. It generates recommendations to address those challenges

The SLR is a new process to both the OCA and in general. It is expected technique will evolve to ensure both fidelity and meaningful use. The description of process that follows memorializes the approach used in its first application to review five incidents of child deaths and one incident of a parent death.

²⁰ Decker, SWA, (2002). Reconstructing human contributions to accidents: The new view on error and performance. *Journal of Safety Research*, 33: 371-385.

²¹ Vogus, TJ, Cull, MJ, Hengelbrok, NE, Modell, SJ & Epstein, RA, (2016). Assessing safety culture in child welfare: Evidence from Tennessee. *Children and Youth Services Review*, 65: 94-103.

²² Cull, MJ, Rzepnicki, TL, O’Day, K, & Epstein, RA, (2013). Applying principles from safety science to improve child protection. *Child Welfare*, 92(2): 179-195.

CASES REVIEWED

Child Death Review Criteria

DCYF reports to the OCA critical incidents of child deaths in two categories:

- Deaths of children who are or have been involved with DCYF (in custody or under supervision, open assessment to determine abuse or neglect, recently closed cases, open cases on other family members)
- Deaths of children with no history of DCYF involvement but the circumstances of the death are unexpected or unexplained, warranting a DCYF assessment for abuse or neglect.

Factors determining the decision to conduct an SLR of a child death or incident include:

- Current involvement with DCYF
- History of involvement with DCYF within the past three years
- Concerns about related DCYF practice or policy in a case with DCYF history
- Number and significance of concerns and complaints brought to the OCA regarding the circumstances of a child's death or incident.

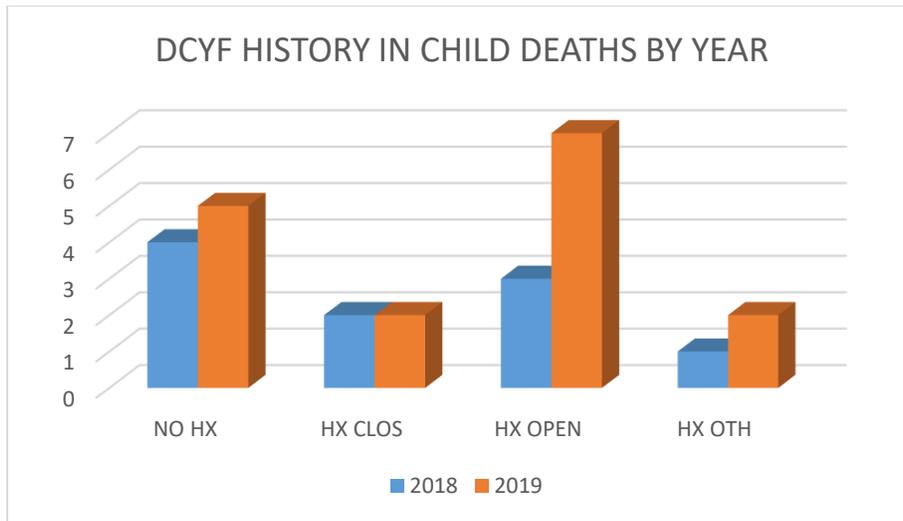
Child Deaths Reported and Reviewed

The Office of the Child Advocate delayed intensive reviews of child deaths in the first year of the Office's existence while establishing a system and engaging in training. Therefore, this report includes a summary of all deaths reported to the OCA since its establishment in February 2018 through September 2019.

Between February 2018 and September 2019, the OCA received notice of 26 child deaths. Of the 26 deaths reported to the OCA, 15 of the children or their families had contact with DCYF prior to or at the time of death. Three children had "other" history of child protection involvement including, one with recent history in another state's child protection services and two with extended family history to which they may have been exposed. Nine children had no history of any DCYF contact. (See Figure 1.) Of those children with open DCYF cases at the time of death, six were open for exposure to substances at birth. Two more had been exposed to substances and those assessments were closed. At the time of this report, one child's death assessment was still open and, as all unexpected deaths may be, subject to examination by law enforcement or prosecution. The OCA is restricted from releasing investigation findings pending that activity²³. Findings for that case will be post scripted when allowable. The child's death is reported here in aggregate only. Any identifying characteristics of the case are withheld from reporting.

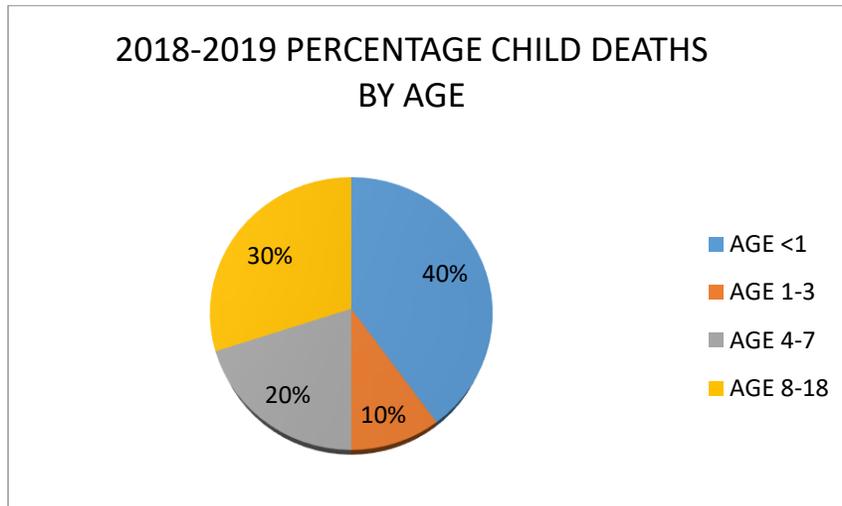
²³ RSA 170-G:18 III-a.(d) (2)

Figure 1. DCYF History in Child Deaths by Year



Of the 26 children whose deaths were reported to the OCA in the reporting period, 40 percent were less than 1 year old. Children ages 1 to 3 made up 10 percent of the deaths, meaning 50 percent of child deaths were of ages 3 years and under. (See Figures 2., 3.)

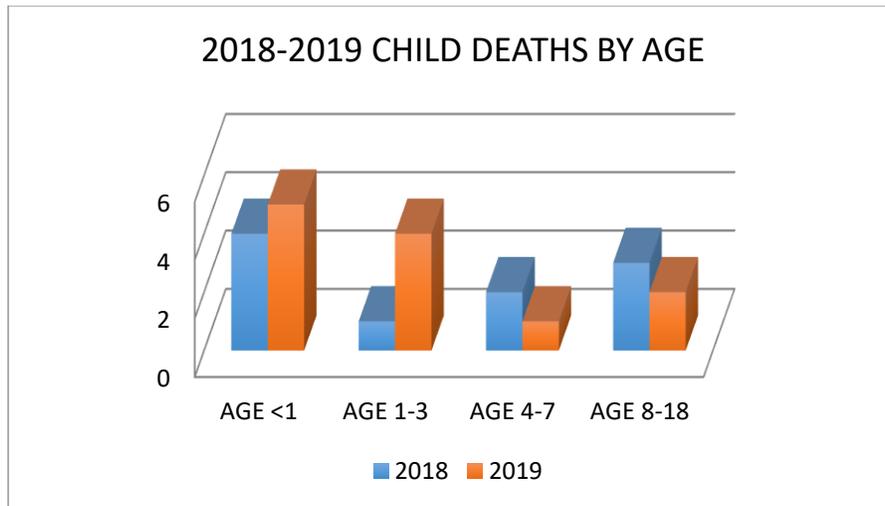
Figure 2. Percent Child Deaths by Age and Year



The trend in deaths of the youngest children aligns with national statistics that show high rates of child deaths among children occur under age one.²⁴

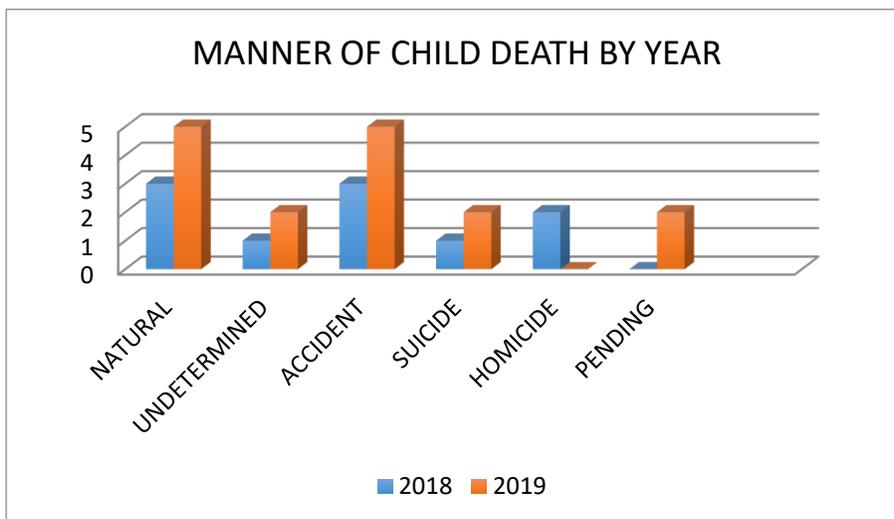
²⁴ Child Trends, (2019). Infant, Child, and Teen Mortality. <https://www.childtrends.org/indicators/infant-child-and-teen-mortality>

Figure 3. Child Deaths by Age and Year



The most common manner in which children died in New Hampshire, which also aligns with national statistics, was by natural causes (N=8) and accidents (N=8).²⁵ The most common cause of accidental death was asphyxiation, related to safe sleep practices (positioning and co-sleeping). Natural deaths reflect sudden infant death syndrome, conditions of birth including complications of prematurity, infections and other pathology. Three children committed suicide, also reflecting national trends among adolescents.²⁶

Figure 4. Manner of Child Death by Year



²⁵ Centers for Disease Control and Prevention, National Center for Health Statistics (2019). Child health: Mortality. Accessed at <https://www.cdc.gov/nchs/fastats/child-health.htm>

²⁶ National Institute of Mental Health (2019). Mental Health Information: Suicide. Accessed at: <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

Two deaths were classified as homicides: one from asphyxiation with carbon monoxide poisoning in which the perpetrator also died; and one from an overdose of fentanyl and cocaine for which both parents were founded for neglect and prosecuted on related charges.

Due to limits of jurisdiction, the OCA does not extensively review deaths of children for which there was no history of DCYF contact or potential of abuse or neglect. Instead, those cases are only examined for public health concerns and findings in DCYF assessments. In the future, the OCA will refer those deaths to the Child Fatality Review Committee.

Of the other 14 child deaths with DCYF history reported on in this summary, causes of death included:

- Asphyxiation, carbon monoxide poisoning
- Asphyxiation, hanging
- Congenital condition
- Hyaline membrane disease
- Hypothermia
- Motor vehicle accident
- Prematurity
- Overdose
- Sudden unexpected death epilepsy (SUDEP)
- Undetermined
- Viral Infections

Table 1. Findings for Abuse or Neglect

Deaths	Abuse / Neglect Finding
3	Founded for Abuse or Neglect <ul style="list-style-type: none"> • 1 Abuse, Founded, Problem Resolved²⁷ (Offender parent deceased) • 1 Neglect, Lack of Supervision, Founded, Problem Resolved (Offender parents prosecuted) • 1 Neglect, Condition of Home, Founded, Problem Resolved (Correction Plan completed)
14	Unfounded for Abuse or Neglect (1 with Reasonable Concerns)
5	Incomplete (4 Unable to Locate, 1 No Police Report)
2	Pending
2	No safety assessment conducted (Accidents)

²⁷ “Founded Problem Resolved,” means a determination by DCYF that there is a preponderance of evidence to believe that the child/youth has been abused and/or neglected and that the presenting danger has been resolved through the provision of services, supports, or other interventions to protect the child/youth and there are no ongoing safety concerns for the child/youth. DCYF Policy 1213 Final Determinations and Closing of the Assessment. <https://www.dhhs.nh.gov/dcyf/documents/dcyf-policy-1213.pdf> In the case of a child death, the problem resolved may address conditions affecting surviving siblings.

DCYF findings for abuse or neglect in the safety assessments conducted on the 26 child deaths are listed in Table 1.

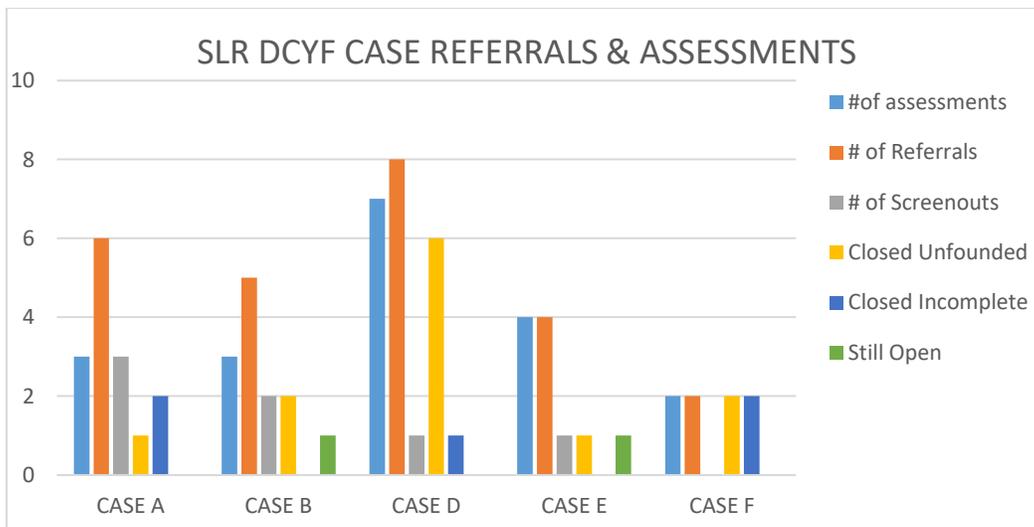
The majority of cases (14) were unfounded for abuse or neglect. Five assessments of child deaths were closed incomplete: one for “No Police Report” and four for “Unable to Locate.” Classification of incomplete assessments are limited in the DCYF computer system to a drop down list of generic labels:

- Interstate or Intrastate Referral
- Unable to Locate
- No Police Report²⁸

Without more descriptive labels, child protection social workers (CPSW) have limited options describing case closure. Of the four cases closed Incomplete due to “Unable to Locate” the CPSW knew where a deceased child’s parents were located but were unable to interview them, generally due to them declining to participate in an interview.

Only one family had an open DCYF case for ongoing services. It involved the care of siblings prior to the child’s birth. Of the six cases reviewed in SLR, none had assessments that opened for ongoing family services cases, and thus no child removals for protective purposes. One had a history of placement out of home in a delinquency case. Among the 5 cases reviewed by SLR that this summary is reporting on, there were 24 referrals to DCYF Central Intake with allegations of abuse or neglect (range 2-8 per family), 7 screened out referrals (range 0-3 per family), and 19 assessments accepted for investigating the allegations of abuse or neglect (range 2-7 per family). Of the 19 assessments conducted, 12 were unfounded for abuse or neglect and 6 were incomplete. One was still open at the time of this summary (See Figure 5.) Seven of the assessments reported here involved infants born exposed to illicit substances, a population under examination by the OCA in a separate system review.

Figure 5. DCYF Referrals and Assessments



²⁸ DCYF 1213 *Final Determinations and Closing of the Assessment*, Practice Guidance

SYSTEM LEARNING REVIEWS

Methods

The OCA convened SLRs by geographic or district teams. Each team reviewed a case associated with their districts. SLRs are *not* designed to include individuals who had direct involvement on the case. The process is a review of the system. Therefore, the purpose of including local expertise involvement is to explain the environment in which practice occurs, not critique the actions of particular individuals. This allows participants to feel comfortable sharing information, while providing valuable explanation.

Ideally, each SLR district team consists of:

- Frontline DCYF staff
- DCYF supervisors
- DCYF field administrator
- DCYF safety specialist
- DCYF bureau chief or other administrator,
- Ad hoc members with special case-relevant expertise
- OCA facilitator
- OCA staff

The methods for each System Learning Review included:

- The OCA reviewed all relevant DCYF records: referrals, safety assessments, contact notes, risk assessments, communications, and other available records.
- The OCA created a time line and case summary from each child's record and distributed them to all SLR team members in advance.
- The OCA convened and facilitated an SLR team with the assistance of DCYF administration. The first two SLRs also included consultants from Collaborative Safety, LLC for guidance in applying the new process.
- The OCA established an atmosphere of restorative just culture to enhance participant comfort level, keeping the focus on learning and not blaming or judging.
- Using a specially designed Case Summary Support Tool that organizes data in a similar structure to steps of casework, the SLR Team reviewed the timeline and summary to identify learning points. Learning points are actions or decisions made in a case that stand out as
 - Deviations in policy or practice,
 - Work outside best practice, or
 - Other areas of practice that would benefit from study
- The SLR Team analyzed each identified learning point using the Collaborative Safety SLR Tool. The tool is designed to prompt teams to examine influences on decision making and actions in a case from several perspectives, including:
 - Local rationality or how decisions made sense at the time in the context of the situation
 - Tradeoffs influenced by conflicting pressures

- Demands and pressures of the system (e.g. imposed timelines, competing needs of workload)
- Resources and constraints such as available services or experts
- System interactions (e.g. service waiting lists, delays in court processes)
- Drift and variability or accommodations to system pressures (e.g. “work-arounds” to cumbersome policy or procedure)
- Once a learning point was thoroughly analyzed, the team identified considerations and key learnings that may improve systems or change practice for better outcomes
- The OCA synthesized all data collected from learning point analysis and identified emerging themes of systemic findings.
- The OCA conducted “member checking” by sharing draft findings with randomly selected frontline SLR participants to confirm accuracy and authentication of findings.

Context: Safety Assessment

“The primary goal of the Assessment process is to ensure the safety of the child(ren).”²⁹ To ensure safety, the CPSW must determine parent/caregiver capacity and willingness to keep children safe. Best practice further expects the CPSW to be prepared to assist families with potential needs of supports or services to maintain that capacity.³⁰ The child welfare system operates through the reporting/referring of allegations of abuse, neglect or need of services. The DCYF intake CPSW then determines if the referral meets the criteria for a assessment. The assessment CPSW is tasked with collecting evidence of abuse or neglect and identifying any child or family service needs.

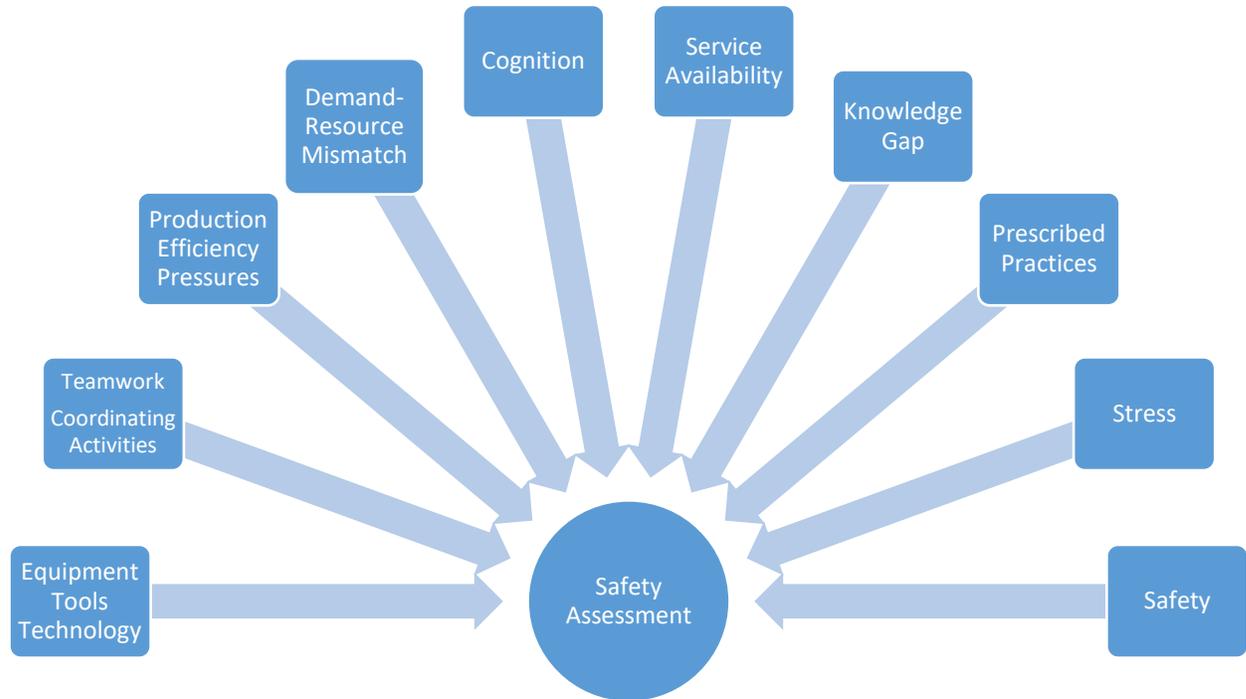
All of the six SLRs the OCA convened involved cases for which at least one DCYF safety assessment was currently underway or had recently been. Systemic findings from the reviews are therefore all related to that phase of child protection. The SLR themes of system findings reflect the process of assessment and the influences that effected decisions made.

²⁹ DCYF Policy *1172 Planning the Assessment* at 1.

³⁰ DCYF Policy *1172 Planning the Assessment* at 2-3.

Systemic Findings

Figure 6. Themes of Systemic Findings



Themes of systemic findings in this summary have operational definitions adopted from safety science literature³¹ in order to build consistency in analyses over time. Analysis of the considerations in each case and across cases revealed findings that we categorized by those themes. Ten emerged in and among the six cases reviewed, including: equipment/tools/technology, teamwork/coordinating activities, production/efficiency pressures, demand-resource mismatch, cognition, service availability, knowledge gap, prescribed practice, stress, and safety (see Figure 6.). Listed below are definitions of themes and relevant findings.

³¹ Collaborative Safety, LLC (2019). Systems Analysis Tool. <https://www.collaborative-safety.com/>

Equipment
Tools
Technology

The equipment/tools/ technology theme reflects an absence or deficiency in the equipment, tools and or technology utilized to carry out safe work practices.

In the cases reviewed, access to information was the most prevalent area of deficiency within this theme, largely in regards to DCYF's outdated Bridges, statewide child welfare information system (SACWIS). Areas of deficiency included:

- Accessing case history is overly cumbersome and time-consuming. To view multiple referrals, assessments or cases on a child or family, a user must exit the case record and log back into the case to search each item
- There is no alert system in Bridges notifying caseworkers of ongoing or prior DCYF involvement on children who are part of separate families in the same multi-family home
- There is no mechanism in Bridges for late data entry once a case is closed
- A substantial amount of case record is still kept in paper form, and therefore not accessible in Bridges (One case reviewed had paper records in two separate district offices)
- There is no mechanism to capture a periodic case summary to facilitate rapid update for assessments, change of child protection service worker (CPSW), oversight, and as means of monitoring trends in case history
- Bridges is not universally accessible from the field. A computer device, virtual private network (VPN) and reliable internet access are required. Department-issued laptops are heavy to carry. Authorization requires a form be filled out and many do not complete it
- Within the Department, the New Heights system houses the Medicaid database but does not communicate with the Bridges system. There is no mechanisms of alerting a CPSW to changes; such as interruption of a child's health insurance coverage
- The language of Bridges in case classification at closure and finding is limited in options and sensitivity to family circumstances.

CPSWs are unable to build a thorough family narrative to understand family needs without ease of access to entire family case history and notice of related cases.

Example: One assessment identified a grandparent's home as being unsafe for the children. A second assessment involving the same family closed with the determination that the children were safe, in part, because they were staying with the grandparent whose home was deemed unsafe in the previous assessment. There was no evidence the first assessment had been reviewed or considered when determining the grandparent's home was safe in the second assessment.

Example: Parent income change left a child ineligible for coverage just at the time of discharge from an emergency psychiatric hospitalization for suicidality. Without insurance, the child did not receive follow-up care. A system alert could have prompted the CPSW to assist with accessing alternative resources or services. At a minimum, the CPSW would have been aware the child was at risk without follow-up care.

CPSW are not able to accurately demonstrate case closure actions or sensitively demonstrate family circumstances in findings.

Example: Four cases were closed as Incomplete, Unable to Locate when in fact parents' location was known. The actual reason the case was closed incomplete was parents declining to be interviewed.

Example: The only options for Founded classifications are "Court Action", "Non-Court Action/ Services Only" or "Problem Resolved".³² An allegation of abuse/neglect was Founded, Problem Resolved because there was no option to describe the offending parent as deceased, which is accurate but somewhat insensitive.

CONSIDERATIONS: Equipment/Tools/Technology

SLR Participants identified specific changes to the Bridges SACWIS and technology in general that would enhance practice:

- Easy access to all case information
- Mechanisms of notification for related cases and New Heights changes
- Mechanism for periodic case summary
- Mobile workforce with lightweight secure digital devices
- Expanded descriptive/relevant language in the Bridges case classification fields that are more sensitive to capture case activity and family circumstance

The DCYF Bridges data system is currently under substantial revision. The 1993 federal Department of Health and Human Service regulations and funding for SACWIS have been shifted to a more integrated, comprehensive approach to child welfare data systems. The new Comprehensive Child Welfare Information System (CCWIS) will support modernization of technology and enable data sharing between multiple systems.³³

In an Implementation Advance Planning Document (IAPD), DCYF outlines the agency's plan of revising and integrating Bridges with DHHS enterprise assets as a means to improve and capitalize on existing resources. The five-year (2018-2022), approximately \$25 million plan outlines a system that will, "...enable a truly mobile workforce with advanced internet based products that reduce the burden of information entry and maintenance, establish real time information gathering, and support management reporting requirements. The new system will increase integration and coordination between DCYF and other state organizations through comprehensive data sharing interfaces."³⁴

The IAPD appears to address the considerations identified. Project funding beyond biennium budget is secured but allocation for 2022, the final year will be essential.

³² DCYF 1213 Final Determinations and Closing of Assessment

³³ Administration for Children & Families, (undated) Notice of Proposed Rulemaking (NPRM) for The Comprehensive Child Welfare Information System Frequently Asked Questions. Accessed 10-8-19 https://www.acf.hhs.gov/sites/default/files/cb/ccwis_nprm_faq.pdf

³⁴ New Hampshire Division for Children, Youth and Families, (undated). Implementation Advance Planning Document (IADP). New Hampshire Department of Health and Human Services. Accessed through DCYF record request.

Teamwork /
Coordinating
Activities

The teamwork/coordinating activities theme reflects ineffective joint coordination of activities between two or more entities including internal staff and external partners.

SLR participants acknowledged DCYF has historically experienced a reputation for difficult relationships with agencies and providers. They concluded that the quality of relationships influences the degree to which agencies communicate and assist each other. In the six cases subject to an SLR this was evident in interactions with:

- Law enforcement
- Other municipal authorities
- Providers
- DCYF consultants

Law Enforcement

In five cases reported on, law enforcement had knowledge of either domestic violence, illicit drug-related activity, acute mental illness crises, or condemned conditions of housing that signaled heightened risk to children. That information was essential in determining safety of the child and identifying family service or support needs. Although information was shared in some of the cases, sharing of information was inconsistent across all five.

Relationships and communication between DCYF district offices and law enforcement vary widely. Some SLR participants described having well-established collaborative working relationships with law enforcement characterized by routine periodic meetings for information sharing and proactive calls of child safety concerns. Other district offices reported having difficult relationships with law enforcement characterized by barriers to timely information sharing for assessments.

Example: An SLR participant reported that in her district, law enforcement is routinely an immediate collateral contact in an assessment.

Example: An infant was born exposed to illicit substances. Both parents had a history of illicit substance use. The assessment did not include a law enforcement collateral contact.

SLR participants attributed poor relationships with law enforcement to interference with assessments involving child deaths in particular. Tasked with ensuring the safety of surviving siblings in a home, CPSWs expressed a perception that the viewpoint of law enforcement is contrary to child-protection. One seeks to build criminal cases and the other must ensure immediate safety of all children. Participants noted police and prosecutors might avoid communications to keep information out of DCYF records, which, when accessed, may be used in defense by perpetrators. One participant expressed feeling that law enforcement does not trust DCYF personnel to maintain confidentiality.

Example: Police responded to a home where a child had died. There was a surviving sibling. The police did not notify DCYF of the child's death or the presence of the sibling. DCYF personnel learned of the death through media reports.

Example: A parent was arrested and charged for simple assault in a domestic violence situation. The DCYF record had no information about whether the parent's legal status included any limitations of contact with the spouse or children. The accused was reportedly living out of the house but also caring for the children at the house during the day.

Example: Law enforcement immediately contacted DCYF in one case where one child called the police to report concerns about the child's sibling's relationship with their father.

Other Municipal Agencies

Reviews also unearthed inconsistent relationships across districts between DCYF and local health departments and animal control officers. SLR participants acknowledged a correlation between animal abuse and child abuse, and the dangers for young children associated with unsafe housing conditions, but reported infrequent contacts with both health departments and animal control authorities. Some municipalities reportedly have no animal control officer.

Example: Hazardous housing conditions condemned by local health officials in one case were never reported to DCYF despite the known presence of children.

Example: DCYF received no reports from any local animal authority or health department about deplorable home conditions that included animals discovered to be eating feces from dirty diapers. Nor did DCYF staff recall notifying any animal authority or health department about the home conditions.

Providers

SLR participants reported difficulties of relationships and communication with medical, mental health and substance use disorder recovery providers. Mental health and substance recovery providers are key collateral contacts for assessing a parent's access to services associated with conditions that may interfere with safe parenting. SLR participants described the providers as difficult to reach and slow to follow up. Participants also routinely encountered difficulties with the providers accepting signed release of information forms. Providers may not accept DCYF releases and instead demand their own forms be used, which requires the CPSW return to the parent for another signature, further delaying an assessment's completion. SLR participants further discussed difficulties obtaining information from hospitals even in cases involving a child death. They explained that it often feels as though their role in protecting children is minimized and that providers perceive them as not important enough to share information.

Example: A CPSW had a parent complete a release of information form for the parent's recovery provider. The name of the provider had four words in it. The CPSW missed one of the words so that the name was close but not exact. The provider refused to honor the release and did not notify DCYF until DCYF followed up near the close of the assessment.

Intra-Agency

Family Violence Prevention Specialists (FVPS) are a resource to CPSWs serving families experiencing domestic violence. They are contracted specialists who take referrals and work with families but do not create any kind of shared documentation about the family for safety purposes. Confidentiality is central to protect family safety, however communication with the FVPS is equally important for the caseworker to confirm the connection was made and a family's needs are being addressed.

Example: In a case involving domestic violence, a CPSW made a referral to the FVPS. There was no documentation of follow-up and the victim parent declined any services. The SLR participants had a strong reaction to the case as "screaming domestic violence." They posited that an inexperienced caseworker might have concerns about sharing and documenting information in a domestic violence case. They suggested that a seasoned DCYF staff would know that information can be protected using a special face sheet to note domestic violence concerns for "no-release" status.

Post SLR OCA Findings

The OCA made observations from police records not discussed in the SLR. In one case, DCYF assessment records and those of law enforcement activities at the child's home indicated that both law enforcement and DCYF missed opportunities to inform each other in order to ensure child safety.

Example: A DCYF assessment was open for an infant exposed to illicit substances at birth. Law enforcement was not included as a DCYF collateral contact. Police records revealed that one parent was arrested for possession of illicit substances while the assessment was open. The assessment closed unfounded/Risk Level "moderate" without awareness of the parental risk behavior. Seven months after the assessment closed, law enforcement responded to reports of domestic violence at the family home. Three months later a parent was arrested on outstanding warrants which predated the child's birth. Law enforcement did not notify DCYF and did not include observations of a child present in the home during either arrest.

In post SLR review, the OCA followed up with district offices to explore further the inconsistencies of relationships between DCYF and law enforcement agencies. A DCYF district office administrator described the *State of New Hampshire Attorney General's Task Force on Child Abuse and Neglect Joint Investigation Protocol (Protocol)*³⁵ as structural guidance for those relationships. The purpose of the Protocol is to "promote the goals and procedures necessary to successfully respond to cases of child abuse and neglect, utilizing multidisciplinary/cooperative intervention. Understanding the diversity of the various roles, responsibilities and philosophies within each professional discipline, coupled with cooperation and mutual response, will result in a professional assessment with the least amount of trauma to the children and families involved."³⁶

The protocol requires the sharing of information between DCYF and law enforcement when crimes or serious injuries occur.³⁷ DCYF and law enforcement also have authority to request and receive

³⁵ <https://www.doj.nh.gov/criminal/victim-assistance/documents/child-abuse-protocol.pdf>

³⁶ Ibid, page 1.

³⁷ New Hampshire RSA 169-C:38

information from each other.³⁸ Law enforcement officers are mandated reporters, just as everyone else is.³⁹ There is, therefore, an infrastructure of communication and collaboration between DCYF and law enforcement. However, in criminal investigations for prosecution, the protocol does allow for delay of DCYF findings in abuse/neglect assessments – a stipulation with which SLR participants disagreed as potentially leaving children at risk or the caseworker out of compliance with case closure timelines.

The DCYF administrator described the Protocol, however, as having no mandate to comply and little to no training associated with it. SLR participants expressed the view that law enforcement does not understand the role and limitations of CPSWs, suggesting the goal of the Protocol, to promote understanding for the various roles, has not been achieved. A staff person with the Attorney General’s Office described training for orientation to the Protocol in 2009 that included six full-day sessions across the state. There were approximately 600 participants in those trainings. There have been no subsequent trainings specific to the Protocol since 2009.

The current iteration of the Protocol is from 2008, predating significant changes, including 24/7 DCYF Central Intake. The staff person with the Attorney General’s Office indicated an updated version of the Protocol is targeted for publication in spring 2020. Plans for training on the new Protocol are also under way.

CONSIDERATIONS: Teamwork / Coordinating Activities

Incomplete communication is the single most frequently occurring obstacle to positive child welfare outcomes – in fact, any human service outcomes. Relationships influence the flow of communication. In the 2000 IOM report on human error in health care, the authors further underscored the need for improved communication, especially between disciplines in complex systems.⁴⁰ The relationships between DCYF, law enforcement personnel and other professionals may be influenced by past experience and public reputation for DCYF. Child protective services are not only complex but highly distressing. It is not unusual for people to distance themselves from groups associated with tragic outcomes, regardless of cause. However a careful analysis of statements made in the SLR uncovered evidence that some of the incomplete communication among disciplines and agencies may be more deeply rooted in a lack of understanding of mission, legal or regulatory limitations, practice standards, and all of the pressures of the system. The quality of the relationships may be obscuring mutual knowledge deficit of competing missions. The purpose of the Protocol, promoting understanding of the various roles, responsibilities, and philosophies of multi-disciplinary agents, should be considered and addressed more aggressively.

Revisions to the Protocol should elevate child safety as prime. Widespread orientation and refresher training on the topic should be integrated into all core training for both DCYF and law enforcement staff. In addition to promoting understanding of the policy, greater effort building inter-professional

³⁸ New Hampshire RSA 169-C:34, III and RSA 169-C:38, II

³⁹ New Hampshire RSA 169-C:29

⁴⁰ Institute of Medicine, (2000). *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academies Press.

understanding, as outlined in the Protocol, would go a long way towards productive collaborative relationships and effective implementation. There have been significant advances in interprofessional education, a pedagogy that recognizes the effect of intentionally teaching roles and expertise of various disciplines as a means to improve outcomes.⁴¹ Creative alliances may contribute to an array of resources, including academic partnerships.

Outreach and collaboration with municipal agencies and providers would also increase understanding and communication. Systems that understand each other are more likely to respond and share information when possible. Increasing the knowledge base of all involved would create better understanding regarding respective roles, responsibilities, and practices. Communication and information sharing, problem solving, respect and appreciation, joint decision-making, clarifying of roles, responsibilities and expectations, and establishment and achievement of common goals, are consistent enhancements to practice through purposeful and supported interprofessional collaboration.⁴² In addition, because historically DCYF has struggled with public perception of the agency, proactive outreach to engage other agencies and providers would serve to break down barriers and build positive relationships.

Production /
Efficiency Pressure

The theme of production/efficiency pressure reflects demands to increase production and or efficiency that impact safe work practices.

Pressure to complete and close cases in a timely manner according to policy manifested in four ways:

- Limited number of collateral sources contacted for information about a child's safety
- Leaving messages for collateral sources, and closing cases before receiving responses
- Referrals made for parents with no follow up to ensure engagement with services or address barriers
- Incomplete documentation

Contact with two collateral witnesses is the minimal standard for assessment completion.⁴³ More witnesses or sources of information provide richer information, but SLR participants described pressure to close a case and move on. Participants reported feeling limited in their ability to contact multiple collaterals in an assessment due to the competing needs of other assessments on their heavy caseloads

⁴¹ Jones, B & Phillips, F (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education*, 52 (1): 18-29. <https://doi.org/10.1080/10437797.2016.1112629>

⁴² Phillips, JD & Walsh, MA (2018). Teaming up in child welfare: The perspective of guardians ad litem on the components of interprofessional collaboration. *Children and Youth Services Review*, 96: 17-26. <https://doi.org/10.1016/j.childyouth.2018.11.016>

⁴³ DCYF Policy 1205 *Collateral Contacts*

and the time within which they are required to close an assessment.⁴⁴ Other pressures identified as influencing case closure prior to completion included the time of year (holidays, end of school year) and sudden rise in number of referrals accepted for assessment. All but one of the cases reviewed had at least one assessment with only the minimum number of collaterals contacted.

Reviews also revealed an assumption that the lack of a return phone call from a collateral contact was indicative of a lack of concerns for the child by the collateral witness. Likewise, a CPSW might refer a parent to a resource, such as a licensed alcohol and drug counselor (LADC) or mental health clinician, but never follow-up to ensure the parent accessed, or had the ability to access, the services.

Example: Shortly before closing out an assessment, a CPSW contacted a child's pediatrician to obtain an update on the child's care and inquire about any concerns. The CPSW also referred one of the parents to a LADC who agreed to follow-up with the parent. There was no evidence the pediatrician was heard from or the parent connected with the LADC prior to the case being closed unfounded.

Example: A CPSW called a child's mental health counselor and closed the assessment without documenting any response.

Inconsistent documentation of casework and communications characterized the cases reviewed. SLR participants reported that delays and absences in documentation frequently result from the demands of multiple cases, pressure to close cases in a timely manner, and/or decision-making that prioritizes other case tasks. Inconsistent or absent documentation leaves progress of assessments uncertain, credibility of the CPSW and agency questionable, and veracity of late entries open to speculation.

Example: At several SLRs, DCYF staff discussed information that was known to the agency, but not documented in the case record.

CONSIDERATIONS: Production / Efficiency Pressures

Production /Efficiency pressures should be considerably relieved when Senate Bill 6 *relative to child protection staffing and making an appropriation therefor* is fully implemented. The legislation appropriated funding for 57 CPSW and 20 child protective supervisors over the next two years. Hiring has been slow, however. Although DCYF administrators reported to the OCA considerable changes in human resource processes, there have been significant delays. A DCYF administrator described delays for job description approval, a problem with the server where positions are posted, and lateral movement of staff. At the time of this writing, DCYF had hired 18 of the 27 positions allocated for this fiscal year. A DCYF administrator reported the lowest position acceptance in some time. The administrator conjectured that a recent salary increase for case workers across the border in Maine has contributed as a barrier to recruitment in New Hampshire. In fact, upon review, the OCA discovered significant differences in starting salary for child protection caseworkers across the region, with New Hampshire paying the lowest (see *Figure 7*).

⁴⁴ NH DCYF Workforce Capacity and Workload Analysis, 2018-2019. Note: During the reporting period, February 2018-September 2019 assessment caseworker workloads ranged 42-46 cases, but some district offices reported caseloads up to 60-65.

Figure 7. Social Work Salaries by State⁴⁵



If the logistical barriers to hiring are not yet resolved, the Commissioner and Governor should declare emergency hiring circumstances and insist on rapid position postings and application processing. If the barrier truly is salary disparity in the region, then reconsideration of CPSW and CPSW supervisor salaries should be emergently reviewed and adjusted as well.

Difficulties filling positions currently allotted to DCYF may be further complicated by shortages yet to be addressed. Administrators told the OCA that they only asked for the positions they need to operate. There is no leeway for disruptions of staffing despite nearly every DCYF district office reporting consistent shortages resulting from medical leave absences, staff shifting positions, or leaving upon recognizing they are in the wrong profession. There is no rapid response team or staff pool available to step in when regular staff shortages occur, leaving even a fully staffed district office without the necessary staff. An administrator explained they did not believe it politically expedient to ask for extra staff, saying, “The legislature would laugh at that.”

Numbers of people will not be the sole answer for better practice. Functioning for more than a decade with inadequate staffing appears to have established a culture of inadequacy that will need deep training, supervision and support to shift to a higher quality of service. Additionally, in the midst of limited staffing, an administrator told the OCA that out of necessity DCYF has held on to staff that might not have been the best fit or adequately capable. Administrators will have to adjust to making difficult decisions about fit for the role so as to ensure not only increased numbers of staff, but quality staffing.

⁴⁵ State salary data from state human resource sites: MA- <https://www.mass.gov/orgs/human-resources>; ME- <https://www.maine.gov/bhr/state-jobs>; NH - <https://das.nh.gov/HR/comp.html>; VT- <https://humanresources.vermont.gov/>

The outputs of the system must also be considered in terms of service array and other community supports with which families are served. Some of those barriers were addressed in Senate Bill 14 *an act relative to child welfare*, which, once implemented, will expand the system of care and supports for children and families. Ultimately, investment in family supports and upstream prevention services to minimize need for child protective services expected by the federal *Family First Prevention Services Act*⁴⁶ is the best and necessary approach to decreasing systemic pressures.

Demand-Resource Mismatch

The theme of demand-resource mismatch reflects when resources within the agency are not compatible with the needs of staff.

A mismatch of demand and available resources contributed to the production pressures described in the previous section. Most notably, staffing shortages in general and of specialty resource staff were a significant influence over case decision-making and trade-offs. The general shortages contributed directly to the pressures of competing case need in managing high caseloads. SLR participants described shortages in specific specialized staff as limiting support to families both directly and as a source of guidance and learning for the CPSW.

Beyond DCYF, review participants also identified basic community infrastructure and family resources as insufficient to meet demands or family needs in some cases. In addition to lack of appropriate mental or behavioral health services, housing, stable employment opportunities and reliable transportation were the most frequently cited barriers to family success and engagement. Access to health insurance or other sources of service financing was another example.

Example: Upon release from an emergency psychiatric hospital stay for suicidality, a child's family discovered the child lost insurance coverage due to a change in a parent's income. Without insurance, the child was unable to access post hospitalization treatment and medication.

CONSIDERATIONS: Demand-Resource Mismatch

Remedies for demand-resource mismatch have been described in the anticipated infusion of positions in the workforce (Senate Bill 6) and expansion of the system of care (Senate Bill 14). The issue of consistency of health care coverage for children in New Hampshire should be examined by the legislature, either in the form of comprehensive care for all without interruption or creation of a stop-gap measure for children with chronic conditions in urgent need of coverage. Review of housing supports and availability of transitional housing as well as transportation options should be conducted by the legislature, local municipalities, and, if not already done, by the Division of Economic and Housing Stability.

⁴⁶ PL 115-123 Bipartisan Budget Act of 2018 includes the *Family First Prevention Services Act*. The Act allows the use of Title IV-E funds, historically allocated for foster care, adoption and kinship assistance, be used for prevention services for children and families at risk of needing foster care. It also requires careful oversight of children placed in congregate care and special qualifications of staffing and evidence-based programming in those facilities.


 Cognition

The cognition theme reflects a faulty understanding of a situation due to cognitive fixation or cognitive biases.

Five forms of bias in practice emerged in the reviews:

- Chronicity
- Prioritizing of maternal needs
- Immediacy
- Routine risk
- Symptom versus cause

SLR participants described a need to “triage” when under pressure to manage workload overages and intensive timelines with limited means. Discussions among SLR teams unearthed often unconscious biases that minimized focus and breadth of assessments under the pressures described.

Chronicity

Weary child protection professionals may at times use an insensitive term to describe families with chronic need for child protective, law enforcement and health care services: “frequent fliers.” This kind of chronicity that appears to wear on DCYF staff characterized all but one of the five cases reported on. Those cases involved families who had repeated encounters with DCYF, law enforcement, other first responders, and mental health care. Caseworkers recognized that the frequency with which some families have encounters with DCYF and law enforcement influences a loss of system sensitivity to child and family needs or recognition of risk associated with those needs. Over-exposure to the same family with repeated system encounters by one CPSW appeared to increase desensitization. The bias of desensitization on all parties influenced a shift of perceived responsibility. SLR participants expressed frustration with law enforcement for not responding adequately to a family and acknowledged law enforcement’s frustration with DCYF in the same cases.

Example: One review involved six assessments on a family with repeated mental health and domestic violence related concerns, including frequent law enforcement and first responder contact. All but one of the assessments involved the same CPSW. While conducting one assessment on one child, a sibling was emergently hospitalized and released. The case was shortly thereafter closed without an assessment of the needs of the sibling, which were added stress on the family unit.

Maternal Needs

Maternal needs emerged in reviews as the priority in assessments, even in cases with two-parent families, and families with step-parents. SLR participants pointed to pressures of time and caseload as an explanation for this bias. Anticipating mothers would be primary caregivers focused efforts on their

needs even when fathers demonstrated risk. The federal Child & Family Services Review of 2018 identified engaging fathers as an area in need of improvement.⁴⁷

Example: In an assessment involving a substance-exposed infant, the focus of the home visits centered on the mother's care and treatment. The mother was able to engage in substance use treatment and services. The father repeatedly called attention to his treatment needs and the obstacles he encountered. The assessment closed unfounded with moderate risk and no assurance the father accessed treatment.

Example: In one case reviewed, the mother had remarried. The stepfather reportedly lived out of the home or was infrequently present at the home. Although the children primarily lived with the mother, and the focus was on her care, at no time during multiple assessments was contact made with the stepfather.

Immediacy

Reviews also underscored a bias towards the immediacy of safety in the focus of assessments: Are the parents abusing or neglecting the child *now*? The pressures to close assessments influenced decisions to be satisfied with assessed safety in the present and move on before assessing potential for long-term stability.

Example: A parent agreed with the CPSW to have her children reside with a grandparent for safety at case closure. The grandparent reported having the children for the coming week. The case closed unfounded. There was no account of who would provide care for the child after the week was up.

Example: In a case involving domestic violence, the father reported leaving the home, but returning during the day to watch the children while the mother worked. The assessment closed as unfounded with no discussion regarding the permanency of this arrangement or the long-term plan for the parents who remained married. A subsequent assessment was opened involving similar concerns for domestic violence.

Routine Risk

Concerns including substance use, mental illness, and poverty occur so frequently as to have routinely established pathways of response in the assessment process. This may distract from unique family needs that are not recognized or overlooked because of the focus on routine concerns or creative solutions to more complex needs. SLR participants described some things being "easier" to respond to such as substance use assessments, than complex or chaotic conditions.

Example: In an assessment involving two parents with substance use concerns, there was documentation about access or no access to treatment. There was no documentation reflecting consideration of whether either parent had a stable, legal source of income.

⁴⁷ U.S. Department of Health and Human Services, Administration for Children & Families, Administration on Children, Youth and Families Children's Bureau, (2018). *Child and Family Services Reviews, New Hampshire Final Report*. <https://www.dhhs.nh.gov/dcyf/documents/nh-cfsr-2018-report.pdf>

Symptom vs. Cause

Another apparent bias of the system, somewhat related to immediacy, is the practice of addressing a symptom, such as a behavior without addressing the underlying cause for longer-term effect.

Example: A child had an extreme addiction to tobacco that was never treated, only punished (school suspensions, facility infractions, police citations). Once while in residential placement the child received a smoking cessation exercise that had no evidence basis. There was no follow up to a team discussion about nicotine patches or any referral to a medical practitioner for treatment. Behavior around tobacco was consistently the underlying cause of much of the child's trouble: suspension from school for possession, infractions in the institution for possession and stealing, and multiple reports to police. The punishments imposed upon the child for addiction-related behavior isolated him from healthy social supports and impeded opportunities for his success.

Example: In a case involving repeated reports of unsanitary and deplorable home conditions, assessments were closed when the mother moved out of state or assured staff that the children would live elsewhere. There was no discussion of supporting parental capacity to understand the importance of, and support, a clean home.

CONSIDERATIONS: Cognition

Family complexity demands careful consideration. Inexperience and knowledge deficit may impede a full assessment of a family's strengths, weaknesses and ecological circumstances. Repeated exposure to this level of complexity can de-sensitize and distract. A similar "frequent flier" effect occurs in hospital emergency departments. Perceived overuse of care and frustration with lack of progress can have negative effect on how professionals view and value clients with chronic needs. However, it is likely that families who have frequent encounters with DCYF and law enforcement have a high burden of need, just as frequent emergency department users have a high burden of disease.⁴⁸

Whether a bias is towards maternal needs or away from frequently encountered family, bias must be acknowledged⁴⁹ and dealt with to prevent affecting decision-making. Supervision is essential to the remedy. Part of case and practice guidance is to assist the social worker to understand limiting personal viewpoints and broaden the assessment lens.⁵⁰ Supervision is also important to recognize the need to relieve or redirect CPSWs when self-care is indicated or a need to refresh and refocus on the child or family. The isolation of CPSW with heavy caseloads can contribute to biased decision making as well. Team "huddles" have proven useful in health care arenas in a variety of ways relevant to social work. They are a structured, routine, brief, face-to-face form of team communication that enhances decision-

⁴⁸ Billing, J. & Raven, MC, (2013). Dispelling an urban legend: frequent emergency department users have substantial burden of disease. *Health Affairs*, 32(12): 2099-2108. DOI 10.1377/hlthaff.2012.1276.

⁴⁹ Roberts, DE, (2014). Child protection as surveillance of African American families. *Journal of Social Welfare & Family Law*, 36(4): 426-437. <http://dx.doi.org/10.1080/09649069.2014.967991>

⁵⁰ Davidson-Arad, B & Benbenishty, R, (2010). Contribution of child protection workers' attitudes to their risk assessments and intervention recommendations: A study in Israel. *Health and Social Care in the Community*, 18(1): 1-9. doi: 10.1111/j.1365-2524.2009.00868.x

making, psychological safety, organizational communication and teamwork in general.⁵¹ Consistently available opportunities to hear other view points and examine one's own, contributes to creative solutions and raises awareness of bias while ensuring comprehensive and effective assessments. The concept of teaming in this context is not one of shared assignment but shared responsibility to families through support of colleagues. It would require administrative support to facilitate routine brief meetings in a district office and perhaps flexibility for accommodating busy schedules, for example by the use of video or tele conferencing.

Service Availability

The service availability theme reflects the absence of or difficulty accessing a particular external service or support.

A system that conducts assessments and makes referrals is not effective if the service does not exist or has limited availability. Wait lists for community-based services reflect an insufficient supply to meet demand. Several reviews revealed a lack of community-based services for substance use treatment, mental health treatment and residential care matching a child or family's needs.

Example: An adolescent was court-ordered to be placed at an institutional setting. There was no immediate placement available and the child returned home to wait. While at home, neither the child nor family received community-based services, the lack of which may have prompted the order to out of home care.

Example: A father reported wanting to get into a methadone treatment program for added support, but was wait-listed. The assessment closed prior to the father gaining access to the program.

CONSIDERATIONS: Service Availability

New Hampshire's array of services for children and families is currently experiencing wide review and investment for improvement. The state has reinstated Voluntary Services for families at risk. Prevention services for parental assistance have been expanded, and children's behavioral health services will grow with mobile crisis, care management, and universal assessment as Senate Bill 14 is implemented. The state has experienced millions of dollars invested in building substance use rehabilitation services. This fall DCYF is soliciting input from providers, consumers and advocates for assistance in developing a "more comprehensive and coordinated child-and-family-serving system."⁵² This system will include community-based voluntary services to serve families assessed as at high risk for abuse or neglect, but who may forego court-involvement with proactive service engagement.

Decisions about service development should be grounded in the experiences of children and families the SLR teams reviewed and informed by the system learning identified. However, building a comprehensive

⁵¹ Rodriguez, HP, Meredith, LS, Hamilton, AB, Rubenstein, LV, (2014). Huddle up!: The adoption and use of structured team communication for VA medical home implementation. *Health Care Management Review*, 40(4):286-299. DOI: 10.1097/HMR.0000000000000036

⁵² State of New Hampshire Department of Health and Human Services Request for Information RFI-2020-DCYF-01-REDES-01 for DCYF Service Array Redesign. September 26, 2019.

system of care requires investment in programs, staff recruitment and training, and reasonable rates for service reimbursement. Given the difficulties DCYF is experiencing hiring, due, in part, to regional salary disparities, it is likely provider agencies will experience similar difficulties. Reasonable rates that are competitive with other markets will assist with obtaining staff. Allocating money for training and continued support for providers to fulfill requirements of the federal *Family First Prevention Services Act* requirements will also ensure that providers are willing to implement evidence-based practices that meet the needs of New Hampshire's children and families.

Knowledge Gap

The knowledge gap theme reflects an absence of requisite experience and or knowledge and or difficulties applying knowledge and integrating it into practice.

Three themes of knowledge gaps emerged in the reviews including:

- Child development
- Domestic violence
- Community responsibility to child safety

Child Development

Knowledge of child development informs the assessment of a child's safety. The assessment determines both how a parent meets a child's needs and whether the parent requires assistance in understanding developmental needs in the first place. The assessment includes actions of the parents and conditions of the home. The CPSW's knowledge of child development informs the assessment and identifies need for support services. If DCYF staff do not have the knowledge, they will not recognize parental needs to ensure they facilitate optimal child development and safety.

Domestic Violence

Domestic violence was an aspect of family interactions in each of the five cases reported on. Knowledge of domestic violence: how it presents, how both victims and perpetrators behave, and what impact it has on children is essential to assessments. Confidentiality of documentation is covered above in Teamwork / Coordinating Activities themes. Knowledge informing communication and documentation of family details involving domestic violence is essential to family safety. SLR participants noted that content on domestic violence in CPSW core training occurs early in the curriculum and is forgotten by the time CPSWs are in the field. It is not aligned with experiential field work training for the benefit of experience and application of the knowledge. Participants explained addressing issues with a batterer in real life is different and daunting compared to classroom scenarios. Knowing safe places to meet with victims and how to speak with children are all skills the participants described as safe practice. There is some use of simulation in training but students felt unnatural. SLR participants also noted that FVPS are resources to CPSWs for consultation or to hand off for victim support.

Example: Law enforcement made a referral for exposure to domestic violence involving verbal and physical assault and threatening with a gun. Upon interview, the child reported, “there is a little yelling and hitting, but not much.” In the same case, the victim later reported starting the fight and escalating it. The perpetrator described the argument as “petty.” All services were declined. SLR participants noted that more knowledge about domestic violence would have caused the classic signs to be recognized and inform further questioning and sensitive efforts to understand what the child meant by “not much” hitting and ways to engage the victim.

Example: A referral to intake was made because of children’s exposure to ongoing yelling, swearing and aggressive behavior by mother’s boyfriend and the boyfriend’s controlling behavior with their mother. The screen out note explained that there was no information that the mother’s boyfriend physically hurt the children and that the emotional impact of the boyfriend’s ongoing and threatening behavior on the children was unclear.

Community Responsibility

All of the five cases reported on were characterized by activities at homes evident of family dysfunction or high-risk behaviors including mental health crises, domestic violence, problem school attendance, unsafe housing conditions, patterns of possible illegal activities and frequent presence of law enforcement. SLR participants from some districts expressed frustration with law enforcement, as described above in the section on Teamwork/Coordinating Activities theme. They also noted that other officials, neighbors and community members were often aware of conditions or circumstances in children’s homes but rather than report concerns to DCYF, only criticized DCYF inaction after a tragic event. Under RSA 169-C:29-31, New Hampshire has universal mandated reporting, meaning anyone who suspects abuse or neglect must report it to DCYF.

Example: A child was missing and truant from school during an assessment. The child frequently “couch surfed” at the home of another family. The host family never reported the child living with them.

Example: After a child’s death, neighbors reported suspected drug activity in the child’s home to news media. There was no record of referrals to DCYF for suspected abuse or neglect.

CONSIDERATIONS: Knowledge Gap

Effective casework and child protection relies on knowledge and evidence-based practice. Advances made in the science of child and brain development over recent years, if well understood and applied, would inform assessments as a measure of children’s wellbeing and safety. The dangers and long term negative effects of domestic violence require knowledge to recognize its presence and also how to manage and communicate in a case of a family at risk. Core training may need adjustments. SLR participants expressed a need to extend and intensify training in combination with field work and timely, supportive supervision and guidance.

Community knowledge of the obligation to report suspected abuse or neglect is being addressed in an educational initiative, *Know and Tell*, sponsored by the Granite State Children’s Alliance. The training is offered through in-person didactic or on-line training modules. To date over 5,000 people have

participated in the training. There is still much more work to do to raise awareness about the responsibility all community members have towards children. For example, having all state employees and state contractors complete the *Know and Tell* training would significantly enlarge the scope of knowledge, increase awareness and model community commitment to children.

Prescribed Practice

The prescribed practice theme reflects when practice prescribed by policy or practice standards is absent, conflicting, vague or does not adequately support work.

Two specific policies emerged as problematic during the course of reviews: the definition of psychological maltreatment⁵³ and the restriction of access to screened-out abuse/neglect referrals from assessment caseworkers.

Psychological Maltreatment

SLR participants reported a strong reluctance to bring forward cases of psychological maltreatment. Reviews disclosed that medical and psychological providers were frequently unwilling to submit testimony in cases involving psychological maltreatment, and that, in the absence of expert testimony, courts would not find that a parent committed psychological maltreatment. SLR participants expressed frustration at having multiple assessments with families in which children were exposed to forms of psychological maltreatment and feeling as though they are unable to bring forward a case to protect the child. The presence of parental mental illness or knowledge deficit complicates an assessment given related incapacity to understand or control behavior.

Example: A family of divorced parents continually argued and pressured the children to be with one parent over the other. One of the children displayed self-harming behavior and reported not knowing in which home to reside. Parents repeatedly failed to bring the child to see the child's clinician even after several significant self-harming episodes. Despite numerous verbal statements by the child's clinician, that the parents were unreliable in ensuring the child attended counseling and that the child needed additional psychological support, six assessments were all unfounded for abuse or neglect against the parents. SLR participants explained that DCYF attorneys focus on the burden to prove harm. They

⁵³ RSA 169-C:3, II(c) defines psychological maltreatment in the context of the definition of abuse: "An abused child means any child who has been...Psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect." The New Hampshire Supreme Court has determined that evidence, for at least RSA 169-C:3,II(d) regarding physical injury, "must include a determination of whether the alleged abusive act was committed under circumstances indicating harm or threatened harm to the child's life, health, or welfare." *Petition of Doe*, 132 N.H. 270, 564 A2.d 433 (1989).

operate with a bias based on their experience of being “thrown out of court” for not meeting the burden of proof.

Access to Information: Case History

SLR participants reported assessment CPSWs are not able to access information about screened out reports. “Screen-outs” are referrals that did not meet criteria for a safety assessment. Screened out referrals are logged in the Bridges system, however, assessment workers cannot access them. SLR participants expressed the viewpoint that having access to all referrals, whether screened in or not, facilitates a full picture of concerns about the child and family, including understanding of relationships derived from reporters who make referrals.

Example: A report was called in for a child’s mental health concerns, but was screened out. The caseworker on a subsequent assessment involving additional concerns about the child’s mental health did not have knowledge of the screened out report. SLR participants reported that having that information would have been helpful to providing a complete history during the assessment.

CONSIDERATIONS: Prescribed Practice

Policies are reflections of community values. DCYF policies and the laws that ground them should reflect the community value placed upon children and the agency mandate to protect them. Clear definitions of concepts such as psychological maltreatment and access to information like screened-out reports are integral parts of the infrastructure caseworkers require to assess safety and take appropriate action to protect children. Persistent exposure to domestic violence and substance use is well documented for its impact on child wellbeing. While a child may not experience physical injury encountering these behaviors, although many do, the psychological impact may have devastating effect far into the future.⁵⁴ The OCA identified the definition of psychological maltreatment as a problem in our 2018 Annual Report. A discussion of legislative remedy has commenced but is complicated by the complexity of defining or articulating the concept.

The American Professional Society on Abuse of the Child (APSAC) recently revised its conceptualization of psychological maltreatment as:

“[A] repeated pattern or extreme incident(s) of caretaker behavior that thwart the child’s basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another’s needs, and/or expendable.” Psychological maltreatment includes (a) spurning, (b) terrorizing, (c) isolating, (d) exploiting/corrupting, (e) emotional unresponsiveness, and (f) mental health, medical and educational neglect.⁵⁵

⁵⁴ Kimball, E, (2016). Edleson revisited: Reviewing children’s witnessing of domestic violence 15 years later. *Journal of Family Violence*, 31: 625-637. DOI 10.1007/s10896-015-9786-7

⁵⁵ American Professional Society on Abuse of the Child, (2016). Announcement: APSAC announces revisions to its definitions of psychological maltreatment and adds a cautionary statement regarding use to support parental alienation claims. <https://www.apsac.org/>

The American Academy of Pediatrics (AAP) has acknowledged the lack of consensus on a definition for psychological maltreatment, partly due to the lack of consensus on the distinction between maltreatment and poor parenting. A further complicating factor in defining psychological maltreatment is the fact it reflects characteristics of a relationship rather than an event or series of events such as physical or sexual assault⁵⁶. Most scholars and practitioners do agree the hallmark of psychological maltreatment is pattern in behavior that includes chronicity, severity and potential harm to the child⁵⁷. An earlier iteration of the AAP's explanation emphasized the pattern and its potential triggers: "Psychological maltreatment is a repeated pattern of damaging interactions between parent(s) and child that becomes typical of the relationship. In some situations, the pattern is chronic and pervasive; in others, the pattern occurs only when triggered by alcohol or other potentiating factors. Occasionally, a very painful singular incident, such as an unusually contentious divorce, can initiate psychological maltreatment."⁵⁸ The AAP's description⁵⁹ incorporates APSAC's with the following:

- Spurning (belittling, degrading, shaming, or ridiculing a child; singling out a child to criticize or punish; and humiliating a child in public)
- Terrorizing (committing life-threatening acts; making a child feel unsafe; setting unrealistic expectations with threat of loss, harm, or danger if they are not met; and threatening or perpetrating violence against a child or child's loved ones or objects)
- Exploiting or corrupting that encourages a child to develop inappropriate behaviors (modeling, permitting, or encouraging antisocial or developmentally inappropriate behavior; encouraging or coercing abandonment of developmentally appropriate autonomy; restricting or interfering with cognitive development)
- Denying emotional responsiveness (ignoring, failing to express affection, caring, and love).
- Rejecting (avoiding or pushing away)
- Isolating (confining, placing unreasonable limitations on freedom of movement or social interactions)
- Unreliable or inconsistent parenting (contradictory and ambivalent demands)
- Neglecting mental health, medical, and educational needs
- Witnessing intimate partner violence (domestic violence)

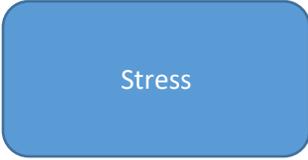
⁵⁶ Hibbard, R, Barlow, J, MacMillan, H, & the Committee on Child Abuse and Neglect & American Academy of Child and Adolescent Psychiatry Child Maltreatment and Violence Committee, (2012). Psychological Maltreatment, *Pediatrics*, 130: 372-378. (Reaffirmed in 2016).

⁵⁷ English, D, Thompson, R, White, CR & Wilson, D, (2015). Why should child welfare pay more attention to emotional maltreatment? *Child and Youth Services Review*, 50: 53-63. Doi10.1016/j.childyouth.2015.01.010

⁵⁸ Kairys, SW, Johnsons, CF, & the Committee on Child Abuse and Neglect, (2002). The psychological maltreatment of children – Technical Report. *Pediatrics*, 109 / Issue 4: 1-3, (p.1). (Reaffirmed in 2005).

⁵⁹ Hibbard, R, Barlow, J, MacMillan, H, & the Committee on Child Abuse and Neglect & American Academy of Child and Adolescent Psychiatry Child Maltreatment and Violence Committee, (2012). Psychological Maltreatment, *Pediatrics*, 130: 372-378. (Reaffirmed in 2016).

Recommendations for full access to child and family records has been made earlier in this report. Screened-out referrals, indicators of family health and relationships, should be made available to assessment caseworkers to maximize understanding of child and family circumstances. In post SLR inquiry, the OCA learned from a DCYF administrator that there is no formal policy on access to screened out referrals. At some point in DCYF history, casework supervisors made the decision to limit access. The practice has been for the supervisor to review screened out reports and share information with the CPSW if deemed necessary. Other administrators reported they would research the needed steps to give CPSWs the necessary permissions in the Bridges system to access such reports. Access to all relative information should be an essential feature of the new Bridges system.



Stress

The stress theme is reflective of unsafe or distracted work practices influenced by stress on personnel.

Child protection work is complex. It can be heartbreaking, traumatic and dangerous. Training, supervisory support, and manageable workloads all contribute to the CPSW's wellbeing and capacity to perform. Fit for the position is also essential. All of the system themes previously discussed contribute to worker stress: under staffing, heavy caseloads, demands and pressures of casework, competing needs, exposure to chronic family dysfunction, and physical danger. Each, including stress itself, influences case decisions.

Example: After a child death, an assessment of allegations of abuse that pre-dated the death was closed. Documentation in the assessment was incomplete. An official notice of case closure from the original assessment was delivered to the parent without any reference of the child's death or expression of sympathy for the loss. The surviving sibling was left in the care of a family member deemed unsafe in an earlier assessment. The extent of family dysfunction before and after the death appeared not to have been fully assessed or appreciated for associated risks. During the review, SLR participants stated, child welfare was the "wrong job for that CPSW." Carrying a reported 60-70 cases, the CPSW's stress was exacerbated by the realization of lack of fit for the career choice. That individual's stress prompted a cascade of stress when the supervisor had to shift attention away from other CPSWs under her supervision to support the distressed CPSW and ensure all assessments were completed safely before the CPSW left employment. The rest of the staff were left to manage with multiple staff on leave or lacking experience, without supervisory support.

CONSIDERATIONS: Stress

All of the systemic themes identified in the SLR are contributors to stress. Therefore, many of the remedies already suggested may ease the stress that DCYF personnel experience. Enhanced supervision, mentoring and team huddling on cases would also incorporate support and guidance for self-care.


 Safety

The safety theme is reflective of variability in work practices influenced by perceived threats to safety.

Comprehensive child safety assessments and investigative evidence collection is hindered by assessment workers perceiving situations or people as unsafe. For example, an assessment worker may feel intimidated by a parent with a history of perpetrating domestic violence.

Example: A family underwent two safety assessments related to domestic violence between parents. There was very limited interaction with the father in the assessment. SLR participants suggested an assessment worker might avoid meeting with an alleged perpetrator of domestic violence. "Someone who has pointed a gun at his wife's head is one scary dude," a participant stated. The team agreed the assessment worker might have wanted to just meet with the mother and "call it a day," for safety sake.

Example: In another SLR, DCYF shared a story of having an assessment involving a father who was known to be dangerous. Police did not initially respond to the caseworker's request for accompaniment to the home delaying the initial home visit.

In a post SLR communication, a seasoned SLR participant noted, "I always felt that DV assessments were the scariest ones to work because if someone was willing to assault someone they love, who knows what they would do to me if I pushed their buttons."

CONSIDERATIONS: Safety

Safety must be afforded to all DCYF personnel in the course of their employment. Unsafe conditions or unpreparedness for dangerous conditions causes, in addition to potential injury, severe stress that affects the safety of children. Training, team huddling, enhanced supervision and guidance are all measures to ensure the ability to assess the safety of a situation and means to manage it. Improved relationships with law enforcement and other community partners will also enhance safety for all partners. Decreasing stress with a better supported and resourced system and improved self-care and safety skills will overall lend itself to a healthier work environment for staff.

RECOMMENDATIONS

FINDING: Inter-professional understanding of roles, obligations and restrictions affects relationships, communications, and success of case outcomes.

RECOMMENDATIONS TO: All Parties

- Promote inter-professional education among all relevant partners in child protection
 - Ensure the Joint Investigation Protocol emphasizes the safety of the child
 - Develop system-wide, easy access and refresher education on the Joint Investigation Protocol, emphasizing the goal for role understanding and collaboration
 - Incorporate inter-professional education in all core training for DCYF, law enforcement, and other key partners
 - Institute proactive outreach, education and community engagement with DCYF district and central offices

FINDING: Comprehensive training, guidance and supervision of child protection caseworkers and juvenile probation and parole officers ensures positive child outcomes and workforce morale.

RECOMMENDATIONS TO: DCYF

- Improve quality of case work
 - Institute team huddling practices to enhance solution based casework with consistent support
 - Incorporate bias assessment and awareness in supervision to maintain sensitivity to all child and family circumstances
 - Enhance CPSW training content and integrate with fieldwork learning
 - Complete the 5-year overhaul of the Bridges electronic system and ensure it is responsive to caseworker needs for comprehensive information and language options sensitive actual child and family circumstances

FINDING: Clarity of child protection law facilitates protections of children.

RECOMMENDATIONS TO: The Legislature and DCYF

- Ensure responsive policy to child and family needs
 - Clarify and give meaning to the concept of psychological maltreatment in RSA 169-C
 - Provide multi-system education on the concept and legal implications of psychological maltreatment

FINDING: An infrastructure of adequate workforce, full array of services, and engaged, informed community will support comprehensive child and family rehabilitation from abuse and neglect.

RECOMMENDATIONS TO: DCYF, DHHS, Governor and the Legislature

- Stabilize the DCYF workforce
 - Approach recruitment and hiring with emergency level priority
 - Adjust salaries to be competitive with regional systems
 - Ensure intensive and ongoing training, guidance and supervision
- Build a comprehensive system of care and support for all children
 - Implement Senate Bill 14 expansion of system of care
 - Invest in a whole system re-design in line with the federal *Family First Prevention Services Act* and the needs of New Hampshire's children
 - Institute evidence-based full-family services such as multi-systemic therapy. To ensure positive outcomes for the entire family unit to better support a child's long-term rehabilitation
 - Assess and revise services for substance use recovery, including attention for affected children
 - Assess reimbursement rates to promote quality provider staff recruitment and retention
 - Take guidance through the DCYF request for information process on community based voluntary services
 - Review options for reliable, consistent health care coverage to ensure uninterrupted access to necessary services
- Universalize a release of information process for providers to streamline timely sharing of authorized information about parents' access to services and engagement in rehabilitation
- Require all state employees and contractors to participate in a *Know and Tell* training as a model for all mandated reporters