

# Quality Assurance Review of the Division of Children, Youth and Families

New Hampshire Department of Health and Human Services

Submitted to:  
Governor Margaret Wood Hassan  
State of New Hampshire

Jeffrey Meyers, Commissioner  
New Hampshire Department of Health and Human Services

Submitted by:  
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**December 19, 2016**



## **Table of Contents**

**INTRODUCTION.....3**

**OVERVIEW OF THE REVIEW APPROACH, FINDINGS, AND  
RECOMMENDATIONS.....5**

**METHODOLOGY .....17**

**DESCRIPTION OF CASES REVIEWED.....24**

**DETAILED FINDINGS .....27**

**DISCUSSION AND RECOMMENDATIONS .....92**

## Introduction

In January 2016, the Center for the Support of Families (CSF) submitted a proposal to the Office of the Governor, State of New Hampshire, to conduct a quality assurance review of the Department of Children, Youth and Families (DCYF). The proposal was accepted and CSF began work on the review in April 2016.

The decision for an independent review stemmed, in part, from the deaths of two children known to DCYF in the months preceding the request for proposals from the State to conduct the review. Concerns about the increasing use of opioids in the State and its effect on child safety also contributed to the request for a review. The issues identified by the Office of the Governor and other child welfare stakeholders in the State led CSF to focus the review on the parts of the child welfare system most directly connected to child protection and safety. Specifically, we focused on understanding (1) how well the State's laws, policies, and practices are functioning to protect children who come the attention of the public child welfare agency, both from immediate threats of danger and the risk of future harm; and (2) the capacity of the child welfare system to protect those children. While we understand that reviewing other child welfare functions, such as foster care and adoption practices, may be needed, that has not been the focus of this review.

We reviewed assessments conducted by the New Hampshire Department of Children, Youth and Families (DCYF) of maltreatment reports in a total of 232 cases including 50 children in open service cases and 182 families who did not have open service cases when the sample was selected. In total, we reviewed 318 assessments resulting from reports of alleged maltreatment since some cases involved multiple assessments during the period under review. The size and random selection of the largest population group in the sample, i.e., the 182 families that did not have an open service case, allow us to generalize our findings to the broader universe of children coming to DCYF's attention under the same circumstances.

In addition to the case review, we reached out to a broad array of stakeholders in New Hampshire to solicit input on the functioning of the State's child welfare system through interviews, focus groups, and surveys. We also reviewed policy, statutes, practice-related documents, and data reports to reach the conclusions and form the recommendations included in this report.

Our hope is that we have provided an honest assessment of the primary safety and risk functions and performance of DCYF, and that we have provided recommendations that will

assist New Hampshire in taking essential steps to ensure that its children and families needing protection will consistently receive effective responses and services. We understand that some of our recommendations will require substantial investment on the part of the State of New Hampshire. However, we can say clearly that investments are needed and that if the State wishes to hold DCYF accountable for protecting the health, safety and well-being of its most vulnerable children, the agency must have the resources it needs to carry out that mission.

We are grateful to each stakeholder we interviewed or surveyed for providing candid and extremely helpful information, all of which would be impossible to reproduce in this report. We are grateful to the Office of the Governor and to DCYF for responding immediately and thoroughly to our every request for information, for providing support to the review process, and for never once attempting to influence the independence and objectivity of this review or our findings and recommendations.

## Overview of the Review Approach, Findings, and Recommendations

At the request of the Office of the Governor, State of New Hampshire, the Center for the Support of Families (CSF) conducted an independent review of the public child welfare program in New Hampshire during the summer of 2016. The primary activity in the process was the case review of 232 randomly selected families/children served by the New Hampshire Department of Children, Youth and Families (DCYF), involving a total of 318 assessments of reports of alleged maltreatment. The time period for which we reviewed activity in the 232 cases was January 1, 2015 through December 31, 2015.

Among the relevant points that CSF would like to emphasize concerning the review are the following:

- ◆ The review identified a number of areas that are functioning quite well and this report identifies them. However, if the findings of the report appear to emphasize areas needing improvement, that is because DCYF and the Office of the Governor have conveyed a desire to understand clearly where improvements are needed in order to help families and children in New Hampshire have the best possible opportunities for successful outcomes. Those areas have received the most attention in the report.
- ◆ The review focused on the State's primary concerns with regard to immediate child safety and risk of future harm, and the processes and procedures that most directly affect safety and risk of harm, rather than looking in-depth at all aspects of the child welfare system. Therefore, our findings and recommendations are directed toward those parts of the system that are concerned with receiving and assessing reports of child maltreatment.
- ◆ The children and families reviewed represent random samples of three groups of children and families served by DCYF, as described below. The findings from the largest of the three samples are generalizable to the broader population of children/families served from which the sample was selected<sup>1</sup>; the findings of the remaining two samples were not of sufficient size to generalize to the broader populations that they represent although they provide valuable insight into agency practices with these populations.
- ◆ The findings and observations of the case review informed and focused our inquiry in the other parts of the review, e.g., interviews, focus groups, and review of documents.

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<sup>1</sup> Findings of Population 1 are generalizable at the 95% confidence level with a confidence interval of +/- 7.

In addition to the case review, CSF also carried out the following activities:

- ◆ We conducted an inquiry of stakeholders within the New Hampshire child welfare system through individual interviews, focus groups, and electronic surveys. The focus groups and interviews consisted of more than 20 types of representatives of the New Hampshire child welfare system, within and outside DCYF. We also received over 700 responses to surveys that were distributed to a wide range of stakeholders inside and outside of DCYF.
- ◆ We conducted a review of relevant documents, data reports, and guidance directing the delivery of child welfare interventions and services in the State. The documents review emphasized the New Hampshire child welfare statutes, policies, and training materials.

The review was organized around three “research questions,” as follows, each of which included a series of sub-questions that allowed us to explore the broader research questions:

**Research Question 1: *Are children and their household family members who come to the attention of DCYF through reports of maltreatment receiving a response that ensures the children in the household are safe from immediate threats to their health, safety, and risk of future harm?***

The basis of our response to Research Question 1 came primarily from the review of a representative sample of families who had screened-in referrals of alleged child maltreatment to DCYF’s central intake between January 1, 2015 and March 30, 2015<sup>2</sup> who did not have an open DCYF service case as of January 1, 2015, or prior to the first screened in referral in the sampling period. These referrals constituted Population 1 in our analysis, and included 182 families and 280 assessments of alleged child maltreatment, since we reviewed all assessments and some families were the subject of multiple assessments during the review period.

**Research Question 2: *Are children and their household family members who are in open DCYF cases and receiving services, being served in ways that ensure the children are protected from immediate threats to their health, safety, and risk of future harm?***

The basis of our response to this question to Research Question 2 came primarily from the two remaining case review samples: (1) children in open services cases (in home or out of home) as of January 1, 2015 whose case was open at least 60 days in calendar year 2015 and who had a

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<sup>2</sup> Note that we reviewed activity in the cases for a 12-month period, January 1, 2015 – December 31, 2015.

referral of some sort to central intake (screen in or screen out) during the sampling period of January 1, 2015 to March 31, 2015 (Population 2); and (2) children in open services cases (in home or out of home) as of January 1, 2015 whose case was open at least 60 days in the PUR who *did not* have a referral to central intake during the sampling period (Population 2a). We reviewed a sample of 50 cases, 25 each, for these two populations.

**Research Question 3: Do systemic factors and DCYF's organizational capacity support the achievement of positive safety and risk outcomes for children?**

The information that informed our response to Research Question 3 came primarily from stakeholder interviews and focus groups, survey responses, documents review, and review of DCYF data reports. These findings helped to shape our recommendations with regard to Research Questions 1 and 2.

## Overview of the Review Findings

Throughout this report, we will make findings that distinguish the concepts of immediate safety and risk of future harm. By safety, we are referring to conditions that place a child in immediate danger, severe forms of dangerous family conditions that place a child in immediate danger and severe maltreatment that has already occurred. By risk of harm, we are referring to the likelihood of future maltreatment of a child which can range on a continuum of mild to severe.<sup>3</sup> As noted later in the report, we believe the child welfare system in New Hampshire is set up to focus primarily on assessing and acting on the *immediate safety of children* as affected by abuse and neglect, with correspondingly less attention to the serious *risks of harm* to children that, unchecked, may lead to serious harm or injury to children. While we acknowledge that addressing the immediate safety of children should always be the number one priority in child protection work, our concerns in this report stem from observations of multiple reports of maltreatment being received over time on the same children and families involving the same risky behaviors that, upon assessment, appear to be present; the reports being repeatedly determined “unfounded” because the child did not have physical injuries, even when the social worker determined the child to be at risk of future harm, sometimes at high risk; and when the

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<sup>3</sup> ACTION for Child Protection. *The Differences between Risk and Safety*. January 2003. Accessed at: <http://action4cp.org/documents/2003/pdf/Jan2003TheDifferencesbetweenRiskandSafety2.27.pdf>

parents' promises to meet their children's immediate safety needs in the face of serious risks of harm were among of the key determinants in calling the reports unfounded.

The factors we identified during our review that contribute to our findings and recommendations include the following:

- ◆ A seriously overloaded DCYF assessment work force;
- ◆ An assessment work force and legal staff that can benefit from additional training and support in identifying, documenting, and defending concerns that place children at risk of harm through neglect;
- ◆ A restrictive child protection statute that sets a high bar for determining neglect and risk of harm;
- ◆ A restrictive interpretation of the statute and a concern by DCYF that it is not able to take needed action to protect children at risk;
- ◆ The lack of options available to social workers to protect children in unfounded assessments; and
- ◆ The lack of an effective service array even if there were legal options for compelling families to engage in services to protect their children.

Our findings and recommendations for improvement are based on child welfare practices that are well-documented in the literature, albeit with significant variation from state to state depending upon state statutes. For example, our focus on the risk of future harm in addition to the actual harm that may have already occurred to a child is addressed in a number of publications, notably *A Framework for Safety in Child Welfare*, developed by the National Association of Public Child Welfare Administrators,<sup>4</sup> which distinguishes between safety threats and actual serious harm.

The effect of the child's abuse and/or neglect is the harm, not the threat. The threat is the underlying and/or contributing factor within the family system that is either causative or highly correlated with present or impending danger and insufficient protective capacities. This is important to distinguish because even though the serious

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<sup>4</sup> National Association of Public Child Welfare Administrators, *A Framework for Safety in Child Welfare*. 2009: The American Public Human Services Association, pp. 25 and 29. Accessed at: <http://www.aphsa.org/content/dam/NAPCWA/PDF%20DOC/Resources/FrameworkforSafety.pdf>

harm may cease, the safety threat or the propensity to inflict serious harm again may not be eliminated.<sup>5</sup>

It further notes that,

Risk of future maltreatment may be reduced with appropriate services, changes in the caregiver's or child's behavior, and family and community support. These measures are most effective when they enhance family and caregiver strengths and protective capacities and decrease child vulnerability. These changes often take significant time to accomplish . . . If child welfare professionals are able to address risk by providing services that specifically address the underlying conditions and behaviors, build and enhance protective capacities, and reduce child vulnerability the escalation of risk to active safety threats may be prevented and active (present) safety threats may be diminished or resolved.<sup>6</sup>

These concepts and practices in child protective services, together with Child Welfare League of America standards regarding the child protection workforce noted later in the report, helped to shape our recommendations for improvements in New Hampshire. Our findings and recommendations are organized according to what we believe should be the priorities for New Hampshire in improving the systemic capacity of DCYF to ensure the health and safety of children and families within the scope of its responsibility.

- ◆ The first priority should be to ensure that an adequate foundation is in place to provide needed services and responses to children and families in need.
- ◆ The second priority should be to make needed improvements in the quality of the services and responses to children and families in need.
- ◆ The third priority should be to monitor and adjust the response and capacity of the system on an ongoing basis in order to stay abreast of changing trends and needs within the State and to inform the State's leadership of the strengths and needs of the system.

We believe that in order to improve the timeliness and quality of safety and risk functions, a more solid organizational foundation must be in place upon which to build needed practice improvements. In particular, the existing work force will not be able to implement effective improvement strategies until it is not overloaded and stressed, as it currently is. Further,

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<sup>5</sup> Ibid., p. 25.

<sup>6</sup> Ibid., p. 29.

training should be adapted to the needs identified in this review, and needed statutory and policy changes should be implemented to support practice changes that should lead to improved outcomes for children and families in New Hampshire served by DCYF.

The sections of the report that follow describe our findings for each research question in detail. However, for purposes of this overview, we are highlighting the findings that we believe are the most encompassing for improving the safety outcomes for children and families. These include the following:

***While the immediate safety of children was generally prioritized, assessed, and acted upon, the risk of future harm was often not adequately assessed or addressed, often leading to a pattern of repeat reports involving the same unresolved risk factors, for example, parental drug abuse or underlying mental health issues.*** Generally, even when the parental risk factors were present, we did not see evidence that their effect on children’s risk of future harm was fully assessed. If parents/alleged perpetrators indicated they were willing to take steps to protect the child’s immediate safety and there were no obvious injuries to the child, the reports were usually determined unfounded. A letter was provided to the parents noting services that DCYF had determined they needed, but there was no follow-up on the parents’ initiation or use of the services as far as we could determine.

***Reports were often determined unfounded even when evidence of the alleged incidents existed or where DCYF rated the risk of harm to children as very high, high, or moderate, unless there was evidence of serious injury.*** A statute that is stringent in defining risk of harm, weak on addressing neglect and emotional harm, and the subject of very strict interpretations is a contributor to this finding. We also found that training of staff and attorneys does not focus sufficiently on the risks of harm to children, substantiating those risks, and taking action when children are at high risk of harm. Even if the DCYF social worker determined a report to be founded, there was a good chance the agency would not file for action in court and that the Administrative Appeals Unit (AAU) would overturn the founded disposition for lack of documentation of harm to the child. The constant refrain we heard from stakeholders was, “*where’s the harm,*” referring to the perception that if a child had not incurred serious injuries, no action could be taken in substantiating reports. We reviewed a number of cases where the risk factors were clearly present but the reports were determined unfounded, even when there were multiple reports alleging the same circumstances over time. We heard that decisions on the disposition of assessments were often based on what DCYF staff perceived that the court or the AAU would uphold versus the actual level of risk present for a child.

**Assessments of reports of alleged maltreatment usually were initiated within DCYF's policy guidelines, but most often remained open well beyond the 60-day limit for completing assessments.** Our analysis of social workers' contacts with children and families during the assessment periods indicated that there were usually few contacts beyond the initial 60 days of the assessment. Some stakeholders attributed the tendency to keep assessments open for long periods of time to a desire by social workers to address risk factors by checking back in on the families during the assessment process. We believe that assessments remain open beyond 60 days because of high caseloads for assessment staff relative to the number of incoming reports.

**The DCYF safety and risk assessment tools and processes were not, in our observation, used consistently to inform safety and risk decisions or actions taken with the families to address identified risk factors.** While we are not questioning the validity of the NHIA tools, we did not see them used effectively by DCYF staff in our review. Their use was, in our observation, often carried out more as a formality or requirement than as tools to inform dispositions of reports and follow-up actions. Completion of some parts of the instruments had been suspended by policy, further limiting their usefulness to staff.

**CSF is not confident that families undergoing an assessment for child maltreatment received the services they needed to reduce the risk of harm to their children.** There are at least three contributors to this. First, very few of the cases we reviewed were opened for services as a result of an assessment. Second, in unfounded reports where there were clear needs for services, families tended to most often receive a letter from DCYF suggesting they avail themselves of services and/or to suggest specific service providers. Because the letters do not carry any enforcement authority, there appeared to be no follow-up to determine if the families received the services. We acknowledge that DCYF is not required to follow up with families on the receipt of services in these situations. Third, our interviews and survey results indicated a shortage of some critical services, particularly related to drug abuse treatment which was relevant to many of the assessments we reviewed.

**There was a need to improve the depth and quality of assessments of reports of maltreatment in general.** In addition to lending more attention to assessing underlying issues within the families that contributed to the risk of harm to children, there were a few other areas where the quality of the assessments needed improvement. Examples include the following:

- ◆ Making appropriate collateral contacts with individuals who know the families' circumstances, as opposed to only the more typical contacts, such as local law enforcement and medical providers;
- ◆ Ensuring that the DCYF policy to see all children in the household during an assessment is carried out consistently in practice, and that the practice includes seeing children in the broader family who may live under another roof but are in the home or care of the alleged perpetrators routinely;
- ◆ Improving documentation of risk-related and neglect-related issues in assessments;
- ◆ Attending to situations where newborns and very young vulnerable children are the subjects of alleged maltreatment due to parental substance abuse; and
- ◆ Improving the identification of situations where safety plans are indicated to manage risk of harm and in crafting effective safety plans to address the identified risk.

At the systemic level, referring more to Research Question 3 than to Questions 1 and 2, we made several findings that affect the safety and risk outcomes for children in New Hampshire. The most substantial of those findings include the following:

- ◆ ***DCYF is seriously understaffed in the area of conducting assessments of alleged child maltreatment, and the quality of the work cannot be expected to improve until this is addressed.*** There is currently an insufficient number of assessment social workers in place to handle the volume of incoming reports of alleged maltreatment and to complete the assessments thoroughly and timely. Not only is there a need for more workers, but the current vacancy rate among assessment workers means even fewer workers are “on-the-ground” at all times responding to incoming reports. In building an adequate organizational foundation to handle reports of maltreatment, additional assessment staff and supervisors will be needed before qualitative improvements in the assessment process can be expected to yield major results.
- ◆ ***Training of social workers and DCYF attorneys does not provide the depth of information or the adult learning approach needed to address some of the practice areas of major concern.*** We did not find in the training materials the level of attention we think is needed to address risk of harm, safety planning, and underlying conditions within families that may place children at heightened risk. Also, we did not see substantive content devoted to emotional maltreatment and neglect of children; identifying and using collateral contacts in the assessment process; and, synthesizing information gathered from multiple sources to make an adequate determination about an assessment. In terms of the format of the training, like a number of other state child welfare training programs, it is weighted toward

a lecture style of sharing information without a strong emphasis on allowing trainees to practice the skills needed, receive feedback from trainers, and build their competence in assessment skills, which is how adults best learn. While we have no problems with the overall structure of the training program, i.e., the two tiers of pre-service training and requirements for training over time, we think the content and approach can be strengthened to support the key areas of practice needing improvement.

- ◆ ***Interagency relationships with law enforcement and the medical and education communities were particularly vulnerable.*** We base this on the responses that we received from the surveys and from some of our interviews. In interviews and the survey, interagency relationships often hinged upon after-hours coverage of intake and DCYF's response to incoming reports, including some miscommunication and possible misunderstanding of DCYF's processes. Building effective working relationships among organizations that serve the same children and families, and developing a common understanding or respective roles, responsibilities, strengths and barriers requires deliberate action. There are opportunities for DCYF to use the results of this review to work closely with stakeholder groups in supporting a strong child protection program in New Hampshire, particularly with regard to after-hours coverage and response to incoming reports of child maltreatment.

## Recommendations

CSF makes 20 recommendations that are listed below and described more in detail in the sections that follow, all geared toward making improvements in addressing the safety and risk of harm to children served by DCYF. It is important to note that we do not recommend trying to put into place major practice improvements, enhancements, or new initiatives until there is a solid foundation of adequate staffing and supervision in the assessment area. Otherwise, overloaded staff will not be able to implement and adopt the new practices effectively. Therefore, we have tried to categorize our recommendations according to whether they are "foundational" recommendations, i.e., to be implemented before attempting to implement major initiatives, and other recommendations that are associated with practice improvements and ongoing monitoring of improvements. While some of the recommendations may be implemented concurrently, we recommend a primary focus on implementing the staffing recommendations below and then proceeding with the recommended practice improvements. We have organized our recommendations into the following categories: organizational oversight, assessment staffing, staff and attorney training, services, policy and statute, interagency collaboration, and other practice improvements.

## Organizational Oversight

**Recommendation 1 (*Foundational and Monitoring*):** *Develop an implementation teaming structure to oversee the implementation of the recommendations of this assessment and to monitor progress and make adjustments over time as needed.*

## Assessment Staffing

**Recommendation 2 (*Foundational*):** *Hire a sufficient number of assessment social workers to bring the total number of filled positions to 120, with the intent of reducing the current vacancy rate to at least 25%.*

**Recommendation 3 (*Foundational*):** *Hire a sufficient number of assessment supervisors to bring the total number of filled positions to 24, with the intent of reducing the current vacancy rate.*

**Recommendation 4 (*Foundational*):** *Resolve the current backlog of overdue assessments by assessing and closing open assessments that can be safely closed, and opening those where harm or substantial threats of future harm exist, and enforce the 60-day policy time frame for completing assessments on an ongoing basis so that a new backlog does not accrue.*

**Recommendation 5 (*Foundational*):** *Make deliberate efforts to provide better for the well-being of assessment staff in order to reduce turnover and absences due to work demands.*

**Recommendation 6 (*Foundational and Monitoring*):** *Implement the current DCYF plan for after-hours coverage of incoming maltreatment reports, and monitor its implementation and effectiveness jointly with law enforcement.*

## Staff and Attorney Training

**Recommendation 7 (*Foundational*):** *Re-design and implement parts of the DCYF pre-service training curriculum for social workers (and include content for DCYF attorneys) to focus on the clinical aspects of working with children and families in maltreatment situations.*

**Recommendation 8 (*Foundational*):** *Ensure the availability of ongoing training that is targeted to building the skills of social workers and supervisors to do their jobs well.*

**Recommendation 9 (Foundational):** *End the reliance on existing overworked field staff to deliver training and consider a distance learning approach to training.*

## Services

**Recommendation 10 (Foundational):** *Reinstitute the voluntary services program and provide in statute and/or policy for using this option to get needed services to children and families where there is high risk of harm to the child.*

**Recommendation 11 (Practice Improvement):** *Expand the options and requirements available for addressing substance abuse issues that place children at risk of harm, including drug testing during the assessment process where indicated, increasing the availability of drug courts in the State, expanding the availability of mother-child drug treatment facilities, and giving priority to child-welfare involved families in existing drug treatment services.*

**Recommendation 12 (Practice Improvement):** *Expand and build on trauma-focused services to children and families.*

## Policy and Statute

**Recommendation 13 (Foundational):** *Align the standards of proof required for substantiating a report of maltreatment with what is needed in court to prove it (probable or reasonable cause vs. preponderance of the evidence).*

**Recommendation 14 (Foundational):** *Revise policy and/or statute to clarify that if the evidence in an assessment indicates that a child has been exposed to conditions that place the child at risk of future harm, the report should be determined founded and services for the family put into place.*

**Recommendation 15 (Practice Improvement):** *Revise the state's statute on retention of records beyond 3 years.*

**Recommendation 16 (Foundational):** *Strengthen the State statute on the definition of neglect.*

**Recommendation 17 (*Foundational*):** *Ensure in practice that all children involved in an assessment are seen and interviewed if possible and appropriate, regardless of parental consent.*

## **Interagency Collaboration**

**Recommendation 18 (*Practice Improvement*):** *Make deliberate efforts to work collaboratively with the medical, education, and law enforcement communities.*

## **Other Practice Improvements**

**Recommendation 19 (*Practice Improvement*):** *Re-conceptualize the process of identifying safety threats and risks of harm associated with incoming reports of maltreatment.*

**Recommendation 20 (*Practice Improvement*):** *Improve quality of assessments (including assessing for substance abuse and the risk it poses, particularly to infants and young children, collateral contacts)*

## Methodology

Given the State's interest in the safety and risk-related practice and outcomes of its child welfare program, CSF developed three research questions designed to focus on: assessments of children coming to the attention of DCYF through alleged maltreatment; the alleged maltreatment of children in DCYF care and custody; and the capacity of the New Hampshire child welfare system, i.e., staff, stakeholders, training, services, laws, and policies, to support effective practice with children and families. The three research questions and sub-questions are as follows:

**Research Question 1: Are children and their household family members who come to the attention of DCYF through reports of maltreatment receiving a response that ensures the children in the household are safe from immediate threats to their health, safety, and risk of future harm?**

**Sub-Questions:**

- *Were the reports screened in/out for investigation/assessment appropriately and in accordance with DCYF policy?*
- *Are investigations initiated and completed in a timeframe that is in accordance with policy and the type and priority of allegation?*
- *Is safety appropriately assessed and safety threats identified during initial contacts with the family?*
- *Is risk of future harm appropriately assessed and identified?*
- *Is there evidence of supervisory oversight of casework processes at this point in the process?*
- *Did the investigation appropriately lead to a case opening or not?*

**Research Question 2: Are children and their household family members who are in open DCYF cases and receiving services, being served in ways that ensure the children are protected from immediate threats to their health, safety, and risk of future harm?**

**Sub-Questions:**

- *Were children in open service cases who experienced an assessment during the PUR served in ways that ensured their safety from impending danger and mitigated risk of future harm while under the authority of DCYF?*
- *Is there an assessment in place (beyond the investigation) that addresses parental protective factors and risk factors for the child(ren)? If so, is it in accordance with agency policy?*

- *Are all relevant family members engaged in decision making/service plan development?*
- *Is there an identifiable strategy in place to ensure that safety threats and risk factors are being addressed on an ongoing basis and routinely monitored?*
- *Is information regarding protective and risk factors incorporated into the service plan?*
- *Are services provided to support parental protective capacity and address risk factors?*
- *Are services monitored and adjusted as needed based on progress/lack of progress or changes in the family's situation?*
- *Is the child's well-being (including health and education) addressed through assessment, case planning and service delivery?*
- *Are processes in place to assess safety, risk, child well-being, and protective capacity prior to closing the case, if applicable?*
- *Is there evidence of supervisory oversight of these processes?*

**Research Question 3: Do systemic factors and DCYF's organizational capacity support the achievement of positive safety and risk outcomes for children?**

**Sub-Questions:**

- *Are DCYF's standards, policies, and protocols, and New Hampshire statutes adequate to protect the health, safety, and life of children in the care and responsibility of DCYF?*
- *Is DCYF staff and attorney training adequate to carry out essential functions related to the health, safety, and life of children in the care and responsibility of DCYF?*
- *Are identified DCYF resources adequate to support child protection work by staff in the field and the agency's attorneys?*
- *Are interagency relationships and interactions adequate and functional to ensure the health and safety of children in DCYF's care and responsibility?*

Our review process was organized into three sets of activities:

- ◆ A case review of a randomly-selected sample of children and families served by DCYF during a designated period of time;
- ◆ An inquiry of stakeholders within the New Hampshire child welfare system through individual interviews, focus groups, and electronic surveys; and
- ◆ A review of relevant documents, data reports, and guidance directing the delivery of child welfare interventions and services in the State.

Each of the review activities is described below.



## Case Review

CSF conducted case review activities of three populations using a case review instrument designed to address Research Questions 1 and 2 and the accompanying sub-questions. The three populations reviewed were defined as follows:

<b>Population 1</b>
Screened In referrals to central intake that occurred during the sampling period on families who did not have an open services case as of January 1, 2015, or prior to the screened in referral.
<b>Population 2</b>
Children in open services cases (in home or out of home) as of January 1, 2015 whose case was open at least 60 days in the Period Under Review (PUR) who had some call to central intake (screen in or screen out) during the sampling period.
<b>Population 2a</b>
Children in open services cases (in home or out of home) as of January 1, 2015 whose case was open at least 60 days in the PUR who <i>did not</i> have a call to central intake during the sampling period.

At the request of CSF, DCYF identified the universe for each of the three populations for the sampling period and provided the data to CSF to identify the random samples and oversamples for the case review. The period from which the samples were randomly selected, i.e., *the sampling period*, was January 1, 2015 to March 31, 2015, and the period covered in the case review, i.e., the *Period Under Review* (PUR), was January 1, 2015 to December 31, 2015.

<b>Sampling Period:</b> January 1, 2015 to March 31, 2015
<b>Period Under Review:</b> January 1, 2015 to December 31, 2015

### Population 1

CSF identified a statistically representative sample of children from the universe of children served by DCYF during the sampling period using the metric of unduplicated assessments from an original population of 2,589. A representative sample from this population was identified because it is the largest population served in the State of New Hampshire and the population with the greatest potential for child maltreatment. Understanding this population provides the

greatest insight into how policy and practice affect the safety and well-being of children in the state and is where we wanted to concentrate our review efforts.

Using the sample generator calculator at [www.surveysystem.com/sscalc.htm](http://www.surveysystem.com/sscalc.htm) to determine the number of cases needed in the review, CSF determined that a sample with a 95% confidence level and a confidence interval of +/- 7 from a population of 2,589 children would require the review of 182 assessments. Because of the high proportion of unfounded dispositions for assessments in New Hampshire, we stratified the sample proportionally based on the findings of the assessments. Thirty-one assessments in the universe had no disposition and were excluded from the population, leaving 2,558 assessments. As noted here, we stratified the Population 1 sample to match the percentages of determinations in the entire population and deleted duplicates. Since we reviewed all assessments that occurred during the PUR in each case, we actually reviewed 280 assessments across the sample of 182 families. To ensure randomness in all three populations, we used the Microsoft Excel random number generator =RAND() to identify and select the specific cases that were included in the samples.<sup>7</sup> For example, in Population 1, having randomized the universe, we selected the first non-duplicative 182 families in the list to be included in the sample.

## Populations 2 and 2a

The only difference in populations 2 and 2a is that Population 2 children were the subject of a report of maltreatment during the PUR and the children in Population 2a were not. Both populations represent children in open service cases during the PUR.

CSF did not select a representative sample for these populations since the incidence of maltreatment in open cases is very low to begin with, as is the case in most states in the country. While the number of children in this sample does not allow us to generalize to the broader population of children in open cases within the State, it provides some insights into how this population is served when maltreatment is alleged. In the end, we reviewed the assessment(s) and open service case activities for 50 children that fell into the universe, 25 for Population 2 and 25 for Population 2a. We followed a similar process of selecting the random samples here as for Population 1.<sup>8</sup> For these populations, all of the children were or had been in

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<sup>7</sup> CSF also identified a random “over sample” list from which some families were selected for the case review if families in the original sample had to be eliminated due to duplication or other reasons determined to be ineligible for review.

<sup>8</sup> Although all 25 children in Population 2 were selected from the randomized list of assessments, they were not necessarily in the order of the first 25 cases on the list, since we reviewed some cases early in an attempt to return currently open cases to the offices from which they were selected.

foster care, since the universe only included seven children being served in their own homes as of the start date of the sampling period.

### **Onsite Case Review**

The onsite case review was conducted in May 2016, following a two-day pilot test of the instrument. A total of eleven CSF staff and consultants reviewed cases. All reviewers received training on the review instrument prior to reviewing cases. Training included an orientation to the New Hampshire child welfare system and an orientation to DCYF's BRIDGES information system. The case review supervisor was present for each week of the case review and was able to answer procedural questions and assist if reviewers found safety concerns in the cases that warranted DCYF's attention.

Case files were reviewed in the BRIDGES system where most of the case documentation is located. In addition, for most of the cases, DCYF provided CSF with "hard copy" files for assessments. In some situations those hard copy files were unavailable; for example, one of DCYF's offices had suffered flooding and the loss of some files.

### **Inter-Rater Reliability Checks of Completed Case Review Instruments**

To help ensure inter-rater reliability, the CSF case review supervisor or the CSF project director conducted an internal quality assurance review on 100% of the instruments completed, looking for completeness of instruments and consistency between responses and explanations of responses in the instruments. Reviewers made changes to the instruments based on the quality assurance review prior to considering the instruments completed and included in the analysis.

Also, CSF conducted an inter-rater reliability review (IR) for each reviewer in which reviewers and the CSF case review supervisor reviewed the same case and compared differences and similarities in responses to the questions. The consistency in responses between the case reviewers and the supervisor ranged from 79.21% to 93.94%. Through this process when concerns were identified in responding accurately to any particular questions, CSF used the opportunity to provide guidance to all reviewers on how to interpret or respond to the questions.

## Interviews and Focus Groups

CSF conducted focus groups or interviews with more than 20 types of representatives of the New Hampshire child welfare system. Some of the focus groups included 10-12 or more representatives and some of the smaller interviews also included multiple representatives.

For some stakeholders, the heads of the applicable advisory boards were contacted and asked to identify 6-10 individuals to participate. For internal DCYF staff, to avoid any concerns about DCYF hand-picking the individuals participating in the focus groups, DCYF provided a list of the universe of possible participants to CSF, which then randomly selected participants.

Focus Group and Interview Representatives
Current or former consumers of the New Hampshire child welfare system
Child welfare service providers
Advocates, review bodies, and legal/judicial representatives
DHHS and DCYF staff

## Surveys

In an effort to solicit the input from as many stakeholders as possible, CSF prepared a series of surveys that were administered to groups of individuals that were determined to have a relationship with DCYF and first-hand knowledge or experience in the areas being assessed in the review. As shown here, we received over 700 responses to the surveys. We did not propose to review the entire child welfare system in the State and were, regrettably, unable to survey all of the many stakeholders who have strong interests in how the system serves New Hampshire’s children and families.

Survey Respondents	
DCYF Social Workers	85 respondents
DCYF Supervisors	36 respondents
Law Enforcement	41 respondents
Medical Community	131 respondents
Educators	366 respondents
Child Advocacy Centers	6 respondents
Service Providers	23 respondents
Birth Parents	19 respondents

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We used a standard online tool to survey stakeholders, Surveymethods.com. For each of the groups above, a key contact was identified and the survey link was sent to that individual to distribute for the rest of the group via email. All groups were provided at least two weeks to respond, with at least one reminder email sent.

## **Documents Review**

DCYF was extremely responsive in providing any and all documents that CSF requested as part of the review. We reviewed an extensive list of documents and placed particular emphasis on the review of the New Hampshire child welfare statutes, policies, and training materials. Our review of documents was guided by issues identified in the case review, rather than conducting an exhaustive review of documents related to all of DCYF operations and functions.

We also identified and reviewed DCYF data reports that we deemed important to addressing the areas covered in this review. DCYF provided access to the reports produced by the DCYF child welfare information system (BRIDGES), the ROM reporting system, as well as ad hoc data requests made by CSF. These were valuable sources of information in the review.

## **Data Analysis**

In analyzing the results of the case reviews, we used simple tabulations and frequencies in Microsoft Excel to aggregate and sort the reviewers' responses to the many questions in the case review instrument, and to probe particular questions raised in the course of writing the final report. In analyzing the results of the surveys, we exported results from Survey Methods to Microsoft Excel to calculate frequencies of responses, and we conducted our own internal analysis of themes identified across survey respondents for open-ended questions in the surveys. Not all questions were required, and some respondents chose not to answer every question, so the denominators vary. In analyzing the information obtained from the interviews/focus groups, we reviewed the interviewers' notes of the meetings and identified the consistent themes that were identified by interview/focus group participants.

## Description of Cases Reviewed

CSF reviewed a total of 232 cases across three distinct populations, as noted below, selected randomly from the sampling period of January 1, 2015 through March 31, 2015:

- ◆ Population 1 (n=182): Assessments on families not involved with DCYF that were screened in during the sampling period.
- ◆ Population 2 (n=25): Children in an open service case who were the subject of a call to Central Intake during the sampling period.
- ◆ Population 2a (n=25): Children in an open service case who were not the subject of a call to Central Intake associated with them during the sampling period.

### **Key Points . . .**

**232 cases including 318 assessments were reviewed.**

**All 10 DCYF District Offices were included in the case review.**

All 10 District Offices were reviewed as part of the case review, as detailed in **Table 1**:

<b>Table 1 Distribution of Case Review by District Office</b>								
	<b>Pop 1</b>		<b>Pop 2</b>		<b>Pop 2a</b>		<b>Total</b>	
	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>
<b>Berlin</b>	8	4.40%	5	20.00%	4	16.00%	17	7.33%
<b>Claremont</b>	8	4.40%	6	24.00%	1	4.00%	15	6.47%
<b>Concord</b>	23	12.64%	1	4.00%	2	8.00%	26	11.21%
<b>Conway</b>	7	3.85%	0	0%	0	0%	7	3.02%
<b>Keene</b>	24	13.19%	1	4.00%	3	12.00%	28	12.07%
<b>Laconia</b>	8	4.40%	1	4.00%	1	4.00%	10	4.31%
<b>Littleton</b>	5	2.75%	2	8.00%	0	0%	7	3.02%
<b>Manchester</b>	27	14.84%	1	4.00%	3	12.00%	31	13.36%
<b>Rochester</b>	17	9.34%	2	8.00%	4	16.00%	23	9.91%
<b>Seacoast</b>	12	6.59%	0	0%	0	0%	12	5.17%
<b>Southern</b>	41	22.53%	6	24.00%	7	28.00%	54	23.28%
<b>Special Inv Unit</b>	2	1.10%	0	0%	0	0%	2	0.86%
<b>Total</b>	<b>182</b>	<b>100%</b>	<b>25</b>	<b>100%</b>	<b>25</b>	<b>100%</b>	<b>232</b>	<b>100%</b>

Across all District Offices and all populations, Southern (and Southern Telework) represented the largest proportion of cases/assessments reviewed (54, 23.3%) followed by Manchester (31, 13.4%) and Keene (28, 12.1%). These same three District Offices were also the highest

proportion for Population 1, while the three largest for Population 2 was Southern, Claremont and Berlin and Population 2a was Southern, Berlin and Rochester. Two hundred of the 232 total families/children reviewed experienced at least one screened in assessment during the PUR, and an additional three experienced a screen out for a total of 203 (87.5%) of the cases/assessments reviewed.

<b>Table 2 Results of the Assessment Case Review</b>					
	<b>Number of Assessments Across the Cases Reviewed</b>	<b>Number of Screen Outs Across the Cases Reviewed</b>	<b>Additional Information<sup>9</sup> Referrals Received Across the Cases Reviewed</b>	<b>Open for Service Cases During the Period Under Review</b>	<b>Case Closures During the Period Under Review</b>
<b>Pop 1 (Cases=182)</b>	280	38	148	8	4
<b>Pop 2 (Cases=25)</b>	38	7	30	25	7
<b>Pop 2a (Cases=25)</b>	0	0	1	25	9
<b>Total</b>	<b>318</b>	<b>45</b>	<b>179</b>	<b>58</b>	<b>20</b>

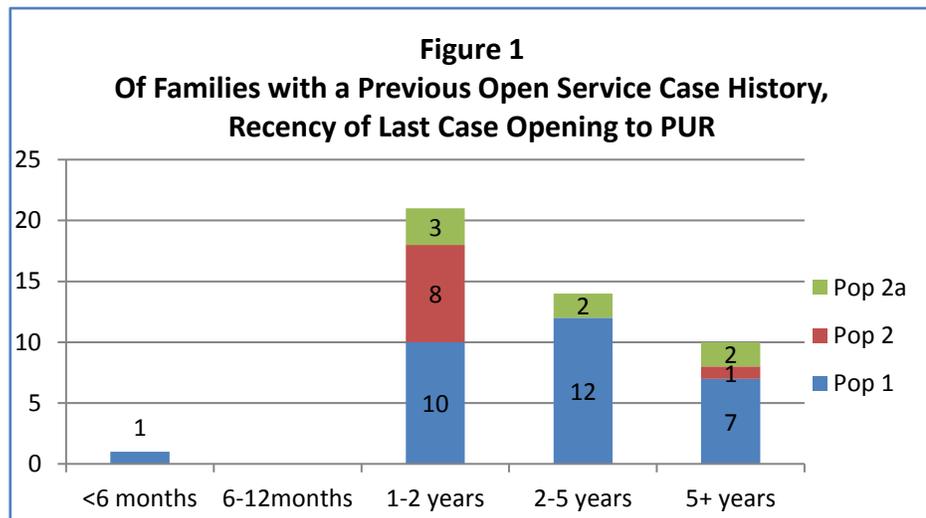
The number of referrals ranged from one to six for children and families who had a referral associated with them for a total of 318 screened in assessments and 45 screen outs that were assessed during the review. Not surprising based on population size, the majority of the 318 assessment referrals (280 of 318, 88.1%) occurred in Population 1. However, children already in open service cases during the review (Population 2) were more likely to experience multiple screened in referrals during the PUR than families not in open service cases (Population 1). Twelve (48%) of the 25 children in Population 2 experienced two or more screened in referrals compared to 65 (35.7%) of the 182 children in Population 1. In addition, Population 2 had more Additional Information (AI) referrals attached to cases (open service and assessment) than

<sup>9</sup> New Hampshire policy allows for a practice called “Additional Information” (AIs). If a referral comes into Central Intake and there is already an open assessment or open services case, instead of screening in for a new assessment, they may screen out for AI, and the current worker (assessment or ongoing) is informed of the allegations and/or information. While the number of AIs was determined for each assessment, the number of AIs for open service cases was not, so 179 AIs is on the lower end of the possible AIs captured.

Population 1. Ten of 25 (40%) children Population 2 experienced two or more AIs (either on an assessment and/or an open case) compared to 87 of 280 (31.1%) assessments in Population 1.

The pattern of referrals is also evidenced when looking at the history of the children and families who were assessed as part of the case review.

Almost 20.0% of the total cases reviewed (46 of 232) had at least one open service case episode prior to the PUR, including 30 of the Population 1 assessments, nine of the Population 2 cases and seven of the Population 2a cases. The majority of



families had not had a previous open case history in one to two years or longer. The same is not true for assessment history, where 95 of the 182 families (52.2%) in Population 1 had an assessment history (as opposed to a case opening history) prior to the PUR, as well as all children in Populations 2 and 2a.

## Detailed Findings

In this section, we provide a detailed analysis of the review findings for each of the three research questions.

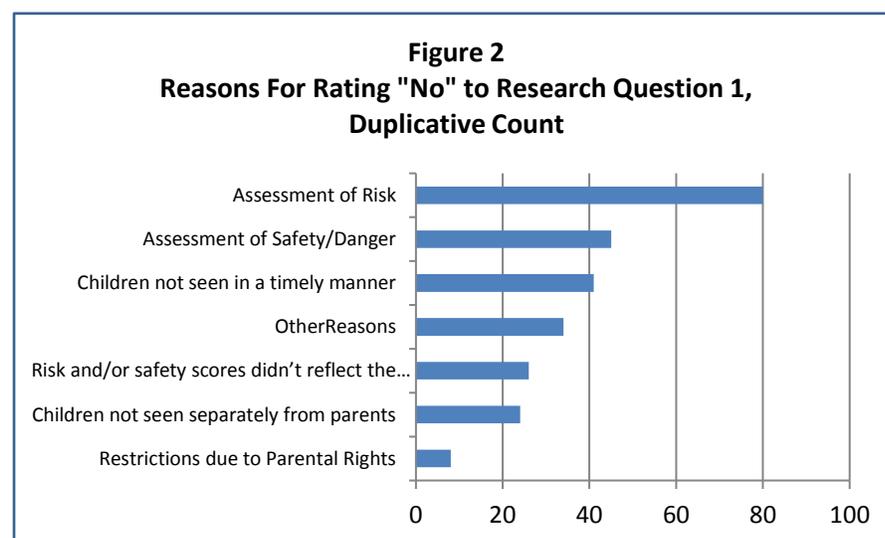
### Research Question 1: Are children and their household family members who come to the attention of DCYF through reports of maltreatment receiving a response that ensures the children in the household are safe from immediate threats to their health, safety and risk of future harm?

Considering all of the information assessed, reviewers provided an overall yes/no response to Research Question 1 for each of the 182 families reviewed (including the 280 assessments within those 182 families). Reviewers responded that 73 of the 182

families (40.1%) had received assessment response(s) that ensured that the children in the household were safe from immediate threats to their health and safety and from risk of future harm. If reviewers indicated that they did not find that families received adequate assessment

#### Key Point . . .

*Less than half the families reviewed who were not in open service cases at the beginning of the review period received a positive response to this question. The most common reason was failure to adequately address risk of future harm.*



response(s), they provided the primary reason(s) that led them to that conclusion, as shown in **Figure 2**.

An inadequate assessment of risk was the most common reason (73.4%) that reviewers identified as the reason for a “no”

response to Research Question 1, followed by inadequate assessment of safety/danger and children not being seen in a timely manner.

Information pertaining to the Research Question 1 sub-questions is provided below:

***Sub-Question 1: Were the reports screened in/out for investigation/assessment appropriately and in accordance with DCYF policy?***

A total of 318 screening decisions were made for Population 1 during the PUR: 280 screened-in referrals for assessment and 38 screened-out referrals (not including screened-out AIs).

Reviewers found that decisions to screen in reports were made appropriately in about 95% of the screened-in reports. Screen out decisions were appropriate in about 79% of screened-out reports.

***Key Points . . .***

***Screening decisions for reports accepted for assessment met the criteria in agency policy.***

***Response times in making screening decisions were within policy guidelines.***

The case reviews indicated that most screening decisions at Central Intake were made according to DCYF policy, both for timeliness and the criteria for screening reports in or out. Reviewers considered this to be a strong area of practice within DCYF. For the 15 screened-in assessments determined *not* to be screened in per policy, the reasons provided included allegations meeting the threshold not being included, untimely screening decisions, and incorrectly completing the response priority tree based on the information provided. In general, the priority assigned to incoming reports by Central Intake held up, as the priority was changed by supervisors in only nine of the screened-in reports.

Survey respondents were also asked to rate the effectiveness of Central Intake (appropriately screening in/out and prioritizing reports) in ensuring children are free from immediate danger and risk of future harm. As shown in **Table 3**, respondents from law enforcement, education, and DCYF social workers and supervisors rated the effectiveness of Central Intake approximately two-thirds “always” or “usually” effective, while medical community and service provider respondents did not provide as high ratings.

<b>Table 3 Survey Responses Regarding Central Intake Screening Decisions</b>				
	<b>Always Effective</b>	<b>Usually Effective</b>	<b>Sometimes Effective</b>	<b>Rarely or Not Effective</b>
Social Workers (79)	3/79 (3.8%)	45/79 (57.0%)	27/79 (34.2%)	4/79 (5.1%)
Supervisors (35)	4/35 (11.4%)	19/35 (54.3%)	11/35 (31.4%)	1/35 (2.9%)
Educators (358)	46/358 (12.8%)	176/358 (49.2%)	118/358 (33.0%)	18/358 (5.0%)
Law Enforcement (39)	3/39 (7.7%)	25/39 (64.1%)	11/39 (28.2%)	0
Medical Providers (104)	16/104 (15.4%)	38/104 (36.5%)	41/104 (39.4%)	9/104 (8.7%)
Service Providers (20)	1/20 (5%)	9/20 (45%)	9/20 (45%)	1/20 (5%)
<b>Total (625)</b>	<b>73/625 (11.7%)</b>	<b>312/625 (50%)</b>	<b>217/625 (34.8%)</b>	<b>33/625 (5%)</b>

***Sub-Question 2: Are investigations initiated and completed in a timeframe that is in accordance with policy and the type and priority of allegation?***

Policy indicates that all assessments are to be initiated within 72 hours of the referral from intake, including weekends. Initiating an assessment is defined as “beginning to work the assessment,” including reviewing history, making phone calls to schedule home visits, or contacting law enforcement. Per policy, assessments are to be completed within 60 days of the referral from intake.

***Key Points . . .***

***DCYF social workers were consistent in initiating assessments within 72 hours.***

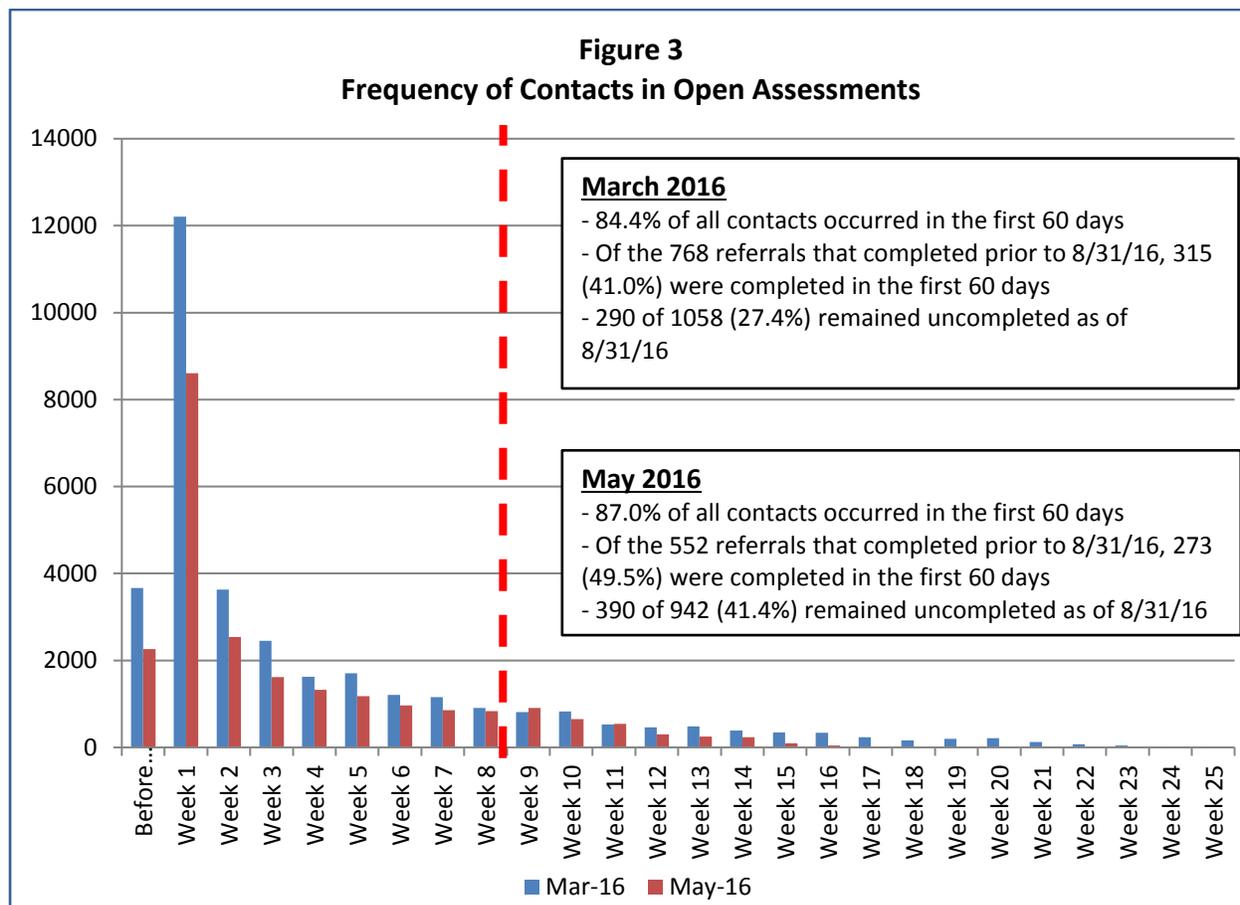
***About one-fifth of assessments in the case review sample were completed timely, even though statewide data indicated most of the assessment activity occurred within the first 30-60 days.***

Of the 280 assessments reviewed in the PUR, 268 (95.7%) were initiated within the 72-hour timeframe. Despite this finding, as shown in **Table 4**, there were misconceptions among stakeholders responding to the survey regarding the timeliness of initiating assessments, particularly among educators, the medical community, and service providers, more than 40% of whom responded “sometimes effective” to the question. This may be an area where DCYF will want to focus community education efforts.

<b>Table 4 Survey Responses on Initiating Assessments Timely</b>				
	<b>Always Effective</b>	<b>Usually Effective</b>	<b>Sometimes Effective</b>	<b>Rarely or Not Effective</b>
Social Workers (79)	11/79 (13.9%)	58/79 (73.4%)	10/79 (12.7%)	0
Supervisors (36)	6/36 (16.7%)	24/36 (66.7%)	6/36 (16.7%)	0
Educators (343)	20/343 (5.8%)	127/343 (37.0%)	155/343 (45.2%)	41/343 (12.0%)
Law Enforcement (38)	3/38 (7.9%)	24/38 (63.2%)	11/38 (28.9%)	0
Medical Providers (106)	12/106 (11.3%)	39/106 (36.8%)	46/106 (43.4%)	9/106 (8.5%)
Service Providers (19)	1/19 (5.3%)	10/19 (52.6%)	8/19 (42.1%)	0
<b>Total (621)</b>	<b>53/621 (8.5%)</b>	<b>282/621 (45.4%)</b>	<b>236/621 (38%)</b>	<b>50/621 (8%)</b>

Compared to initiating assessments timely, assessments were not usually completed timely. Of 271 assessments that were completed by the end of case review activities, only 56 (20.7%) were completed within the 60-day policy timeframe. Further, we observed that most of the case activity occurred in the early stages of the assessment, typically within the first 30 or 60 days, and that little activity occurred in the remaining months that the assessments were open.

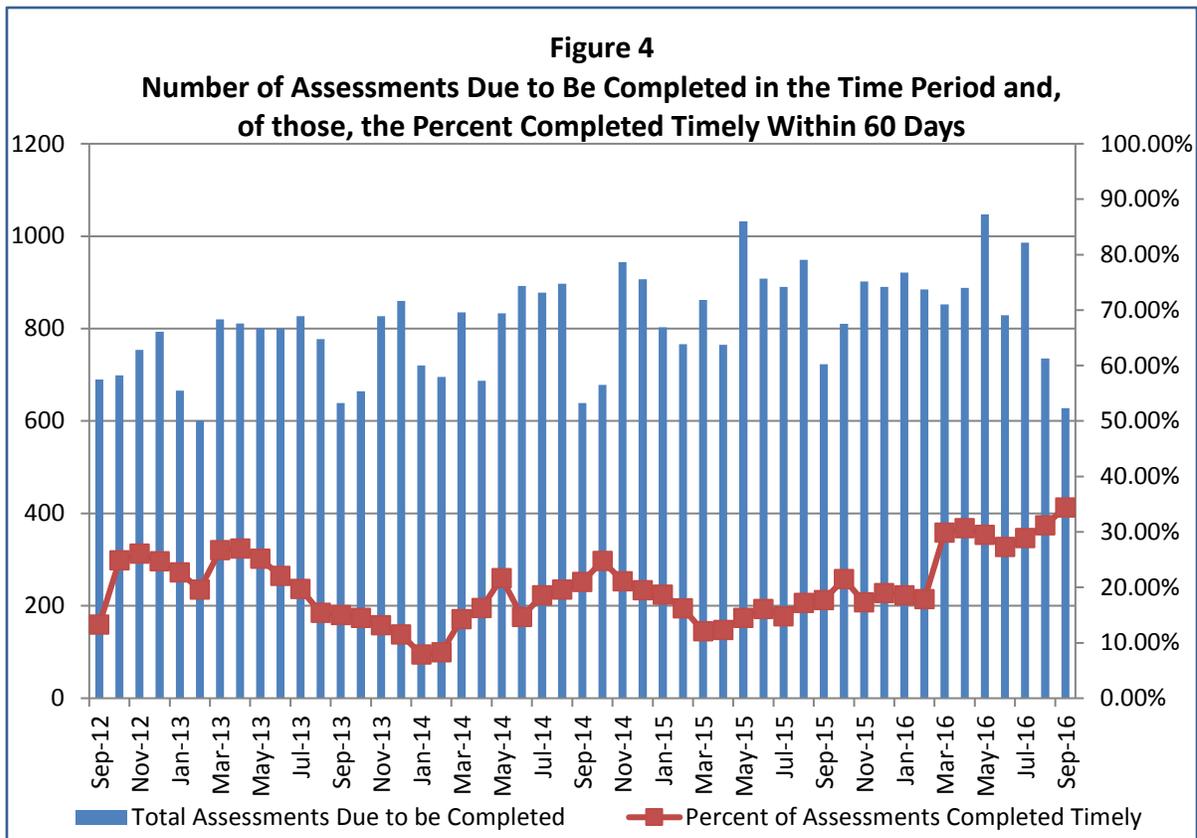
This observation was confirmed by DCYF’s aggregate statewide data. We identified all referrals that were screened in for assessment during the months of March 2016 and May 2016 and subsequently were completed by 8/31/16, and then identified the number of contacts (visits, phone calls, etc.) that occurred each week thereafter until the assessment closed, as a way to understand activity in assessments. **Figure 3** shows our findings.



Further, reviewing DCYF’s data over the last four years, assessments on average have been completed timely (within 60 days) in about one-fifth of the assessments completed monthly (7915/39,706 = 19.93%), as shown in **Figure 4**.<sup>10</sup> It should be noted that during 2016, the timeliness of completing assessments has been on the upswing, averaging 27.3% completed timely for the first nine months of 2016 (2122/7771).

Having assessments remain open for extended periods of time without a disposition is a problem for several reasons:

<sup>10</sup> Source NH ROM Report “Assessments completed within required time (of those due).” Note that in our Interim Report regarding DCYF staffing recommendations, we reported data going back to 2006 on the number of assessments completed and the percentage completed timely. Those data indicated a sharp upsurge in the number of reports completed monthly, beginning about mid-2012 and our footnote indicated we were unsure of the reason for the upsurge. Subsequently, we have determined that the purge of unfounded reports of maltreatment after 3 years, required at NH RSA 169-C:35-a, affected the data we used in the Interim Report. In this Final Report, we are looking back at assessments completed since 2012, since that is the time frame in which we have confidence in the accuracy of the data for this particular indicator.



- ◆ It suggests that active work is being done on assessments, when in fact data show that long time periods go by with little or no activity.
- ◆ If subsequent reports or Additional Information referrals come in during an open assessment, which did occur frequently in our case review, the lack of a proper disposition on the prior report may affect the priority designation of the new report. For example, if there is not a prior founded report the new incoming report may receive a lower priority rating for response.
- ◆ The lack of a timely disposition may delay the families’ understanding the need to obtain services to prevent re-occurrence or their accessibility to services if the agency is responsible for making referrals upon disposition.

***Sub-Question 3: Is safety appropriately assessed and safety threats identified during initial contacts with the family?***

Case reviewers determined whether children identified as victims in an assessment were seen timely by the assessment social worker. The response time to see alleged victim children is assigned initially at intake based on the completion of the Response Priority Tree, and varies

based on the severity and circumstances of the allegations. Level 1 assessments require contact within one business day, Level 2 within two business days and Level 3 within three business days.

As shown in **Figure 5**, victim children in Level 1 assessments were more likely to be seen timely than children in Level 2 or Level 3 assessments. Level 1 assessments represented the smallest number of assessments reviewed with a designated response priority, followed by Level 2 and Level 3. Level 3 assessments, the most common assessment priority level, had the lowest proportion of victim children seen timely, around 56.9%. Across all 280 assessments with a response priority indicated, all victim children were seen timely in 172 (61.4%) of the assessments.

**Key Points . . .**

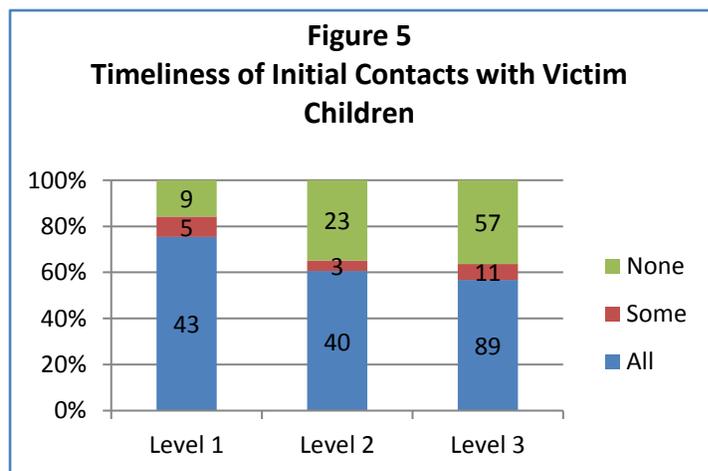
*Initial contacts with named children in assessments occurred timely in just over 60% of the assessments reviewed, more so in Level 1 assessments.*

*There was a quality assessment of safety, risk and underlying conditions in around half the assessments we reviewed, more so with children than with parents.*

*The usefulness of the 24-hour safety assessment tool to determine if children are safe during an assessment is questionable.*

*There was inconsistency in seeing all parents and non-victim children in the household as part of the assessments.*

Meeting initial timeframes in seeing children and parents was also a theme noted as a general strength across multiple focus groups and targeted interviews.

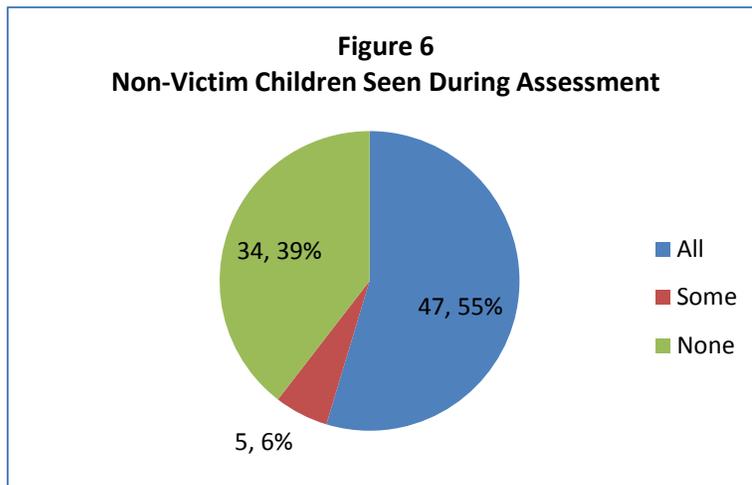


Of the 86 assessments that had non-victim children in the household, all of the non-victim children were seen in 47 assessments (55%), and in 34 of the assessments (39%), none of the non-victim children were seen during the assessment, as shown in **Figure 6**<sup>11</sup>.

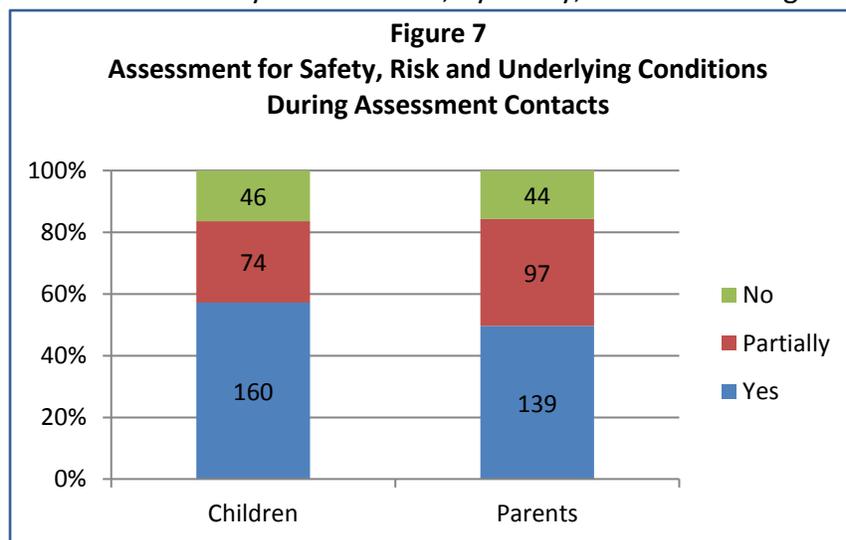
Note that we have defined non-victim children to include children who are part of the broader family and who may live in another house, but are routinely in the home of the alleged perpetrators, e.g., children of divorced or separated parents who visit in the home of the alleged perpetrator.

<sup>11</sup> Please note that the 'none' category includes 3 (3.3%) whose parents refused contact

Unlike victim children, there are no policy requirements for when parents are seen or contacted during the course of an assessment, only that they are contacted, including non-resident parents. All parents were found to be contacted, interviewed, and engaged in just over half of the assessments (58.6%), and sufficient attempts were documented in an additional almost nine percent of the assessments, leaving almost one-third of the assessments where all parents were not contacted, interviewed, and/or engaged during the course of the assessment.



In addition to reviewing for whether contacts were made with children and their parents, reviewers evaluated whether safety, risk, and underlying conditions in the family were assessed during the contacts with family members. In general, there was more evidence in contacts with children than parents that safety, risk and underlying conditions were assessed during the contacts. For clarity of definitions, by safety, we are referring to imminent danger to the child;



by risk, we are referring to risk of future harm to the child; and by underlying conditions, we are referring to factors existing in the family that may impact or lead to maltreatment to the child, such as substance use, domestic violence or unchecked mental health concerns.

As shown in **Figure 7**, the review provided indications that safety, risk and underlying conditions were well assessed in contacts with children in 160 of 280 (57.1%) assessments compared to

contacts with parents in 139 (49.6%) assessments for parents. Partial assessment of these factors was documented in contacts with children and parents in 74 (26.4%) and 97 (34.6%) assessments respectively. The review did not find adequate assessment of these factors in contacts with children and parents in 46 (16.4%) and 44 (15.7%) assessments respectively. Reviewers were also asked to determine if the recorded contacts in BRIDGES reflected the explicit assessment of parents' capacity to keep children safe in the home. Reviewers found documentation in 166 (59.3%) of the assessments.

Per policy, assessment social workers are required to conduct an assessment of child safety, which is documented in a New Hampshire Integrated Assessment (NHIA) tool, within 24 hours of the first contact with the victim child(ren). Twenty-four hour safety assessments are not required to be conducted

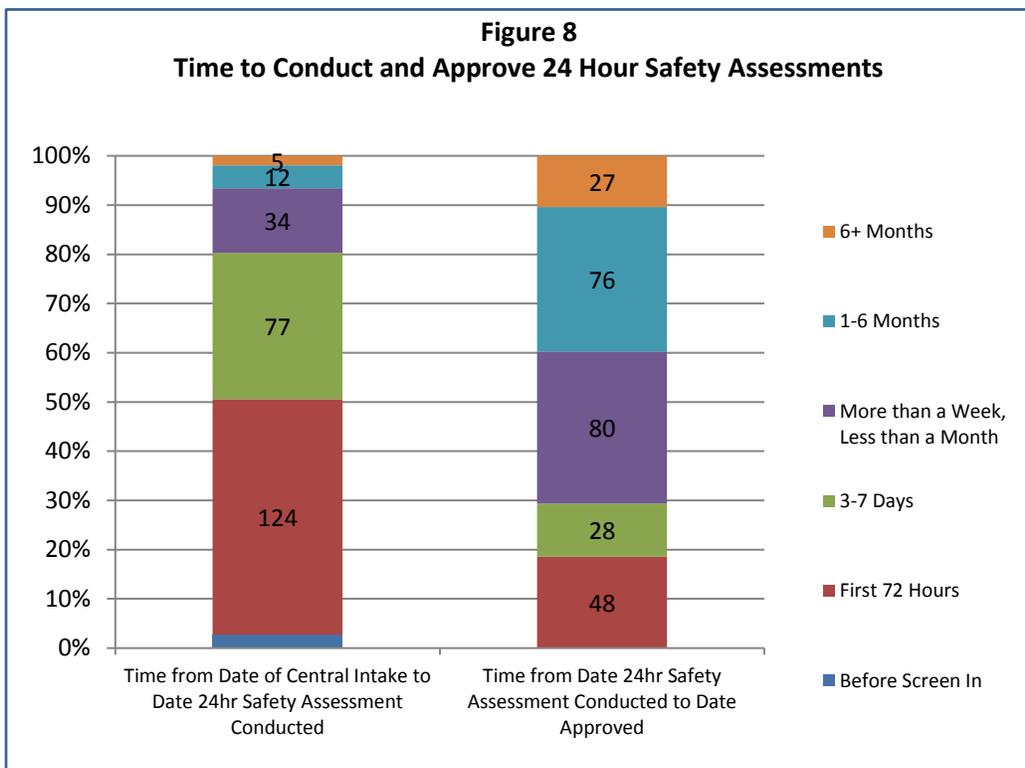
***Some stakeholders indicated that the NHIA tools did not assist them in determining safety of a child, and that decisions regarding safety are made outside of completing the tool.***

on assessments conducted by the Special Investigations Unit (SIU), i.e., assessments on foster homes or institutions or if not enough information is obtained to be able to assess for safety, such as when parents refuse access to the children and information about their safety cannot be obtained through collateral contacts.

The safety assessment instrument is a combination of radial buttons and comment boxes that are intended to inform the social worker's decision that the child(ren) is safe, conditionally safe, or unsafe. Of the 259 assessments that had a 24-hour safety assessment completed, 236 (91.1%) were scored safe, 21 (8.1%) were scored conditionally safe, and two (0.8%) were scored unsafe. However, some survey respondents suggested that the tool is simply cumbersome paperwork required to be completed as opposed to an assessment instrument used to determine the safety of children. When asked how NHIA tools support or inhibit their ability to ensure the safety and well-being of children in New Hampshire, social workers gave an average rating of 3.17, meaning scoring this question between '3-Not Very Helpful/Can Be a Barrier' and '4-Inhibits My Ability to Ensure the Safety of Children'.

As noted above, a total of 259 24-hour safety assessments were completed on the 280 (92.5%) reviewed assessments. Reviewers found that while around half of the safety assessments appeared to have been conducted within 72 working hours of the date the reports were received at Central Intake, the approval dates by the supervisor on the safety assessments were often far later. In fact, just over a quarter of the safety assessments were approved within 72 hours. This raised a concern for the review team that the NHIA safety assessment may not be

consistently used as a decision-making tool within the first 72 hours to determine if the children can remain safely in their homes. Rather, because of frequently late supervisory approvals, we were concerned that in some situations it may have been completed more as a policy compliance activity than as a part of the safety assessment process. **Figure 8** shows the discrepancy in the time frame for conducting the NHIA safety assessment and the approval of the assessments by the supervisor.



Among the outliers in **Figure 8**, seven safety assessments were dated *before* the referral to Central Intake, suggesting that the tool was completed

based on information from a prior assessment rather than the current assessment. Seventeen (6.6%) safety assessments were conducted over a month after the date to Central Intake, impacting the tool’s ability to help determine the children’s immediate safety and its actual use as a decision-making support tool.

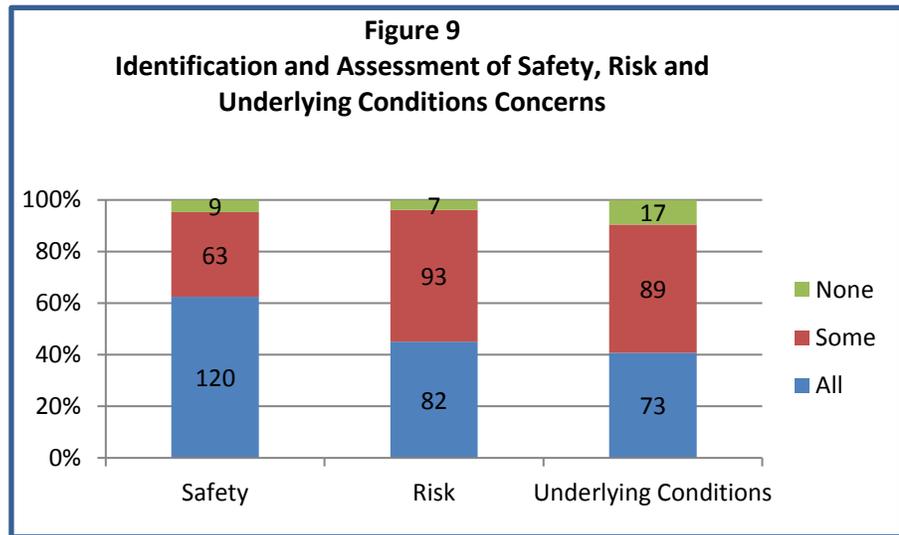
Utilizing an informal process to assess safety also appeared to occur in safety planning. Per policy, safety plans are required to be completed when the NHIA safety assessment returns a finding of ‘conditionally safe’, yet some kind of safety plan (formal/written/signed or informal/discussed in narrative/not written) was found in 57 assessments, 36 more than the 21 ‘conditionally safe’ noted above. Reviewers were also asked to identify when there was evidence of a safety plan, was it periodically monitored, and found that monitoring of safety plans was evident in 34 of the 57 (59.6%) assessments with a safety plan. We heard concerns from some stakeholders about situations in which safety plans are used in place of taking more definitive action. In our case reviews, we were concerned when we saw safety plans that

essentially asked drug abusing parents not to use drugs in the children’s presence or asked that one parent remain sober while the other parent used drugs.

Some stakeholders we interviewed noted that safety plans are not followed because they are based on parents’ promise not to use drugs and then they do. They noted that workers do all they can to make the plans [effective] but it is difficult to hold the parents to it.

Considering the information gathered in all assessments that occurred for a family during the PUR, reviewers were asked to determine if there was documentation that DCYF social workers had identified and assessed all relevant safety, risk and underlying conditions

concerns that were apparent in the case files. As shown in **Figure 9**, all presenting safety concerns were identified more often than not, but all risk factors and underlying conditions were *not*



identified and assessed more often than not. Concerns that would place the children at risk of future harm and the family’s underlying conditions that affected safety and risk were adequately addressed in less than half the assessments we reviewed.

In addition, just over one-fourth of law enforcement survey respondents indicated that the agency was very effective in addressing immediate safety issues, about 16% rated the agency as very effective in addressing risk of future harm, and 10% rated the agency as very effective in addressing the family’s underlying conditions.

**Sub-Question 4: Is risk of future harm appropriately assessed and identified?**

Of the areas we reviewed, this area is among our greatest concerns. The risk of future harm was less likely to be identified and assessed by workers as compared to safety, in spite of the fact that there is an NHIA risk assessment tool, which also asks workers to note “complicating factors,” i.e., underlying conditions. The NHIA Risk Assessment tool, per policy, is to be completed within 60 days of the referral from Central Intake, i.e., prior to assessment closure, for all assessments that will have a finding of founded or unfounded. Reviewers found that 247 of the 280 (88.2%) assessments in the PUR had a risk assessment completed. However, the tool seemed

**Key Points . . .**

*All relevant factors regarding risk of future harm and underlying conditions within the family were addressed in less than half the assessments reviewed for families not in open cases at the start of the review period.*

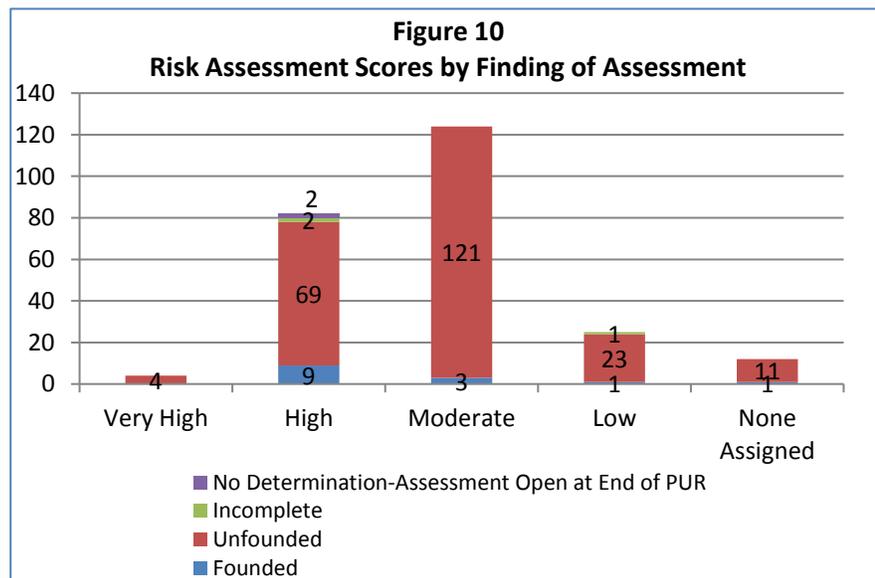
*Risk scores seemed to have little connection to determining if an assessment was founded or if the case was opened – even high and very high risk scores were present in unfounded dispositions.*

*There were multiple referrals/assessments involving the same families and similar allegations over time.*

*Collateral contacts in assessments did not always include individuals who knew and saw the family regularly.*

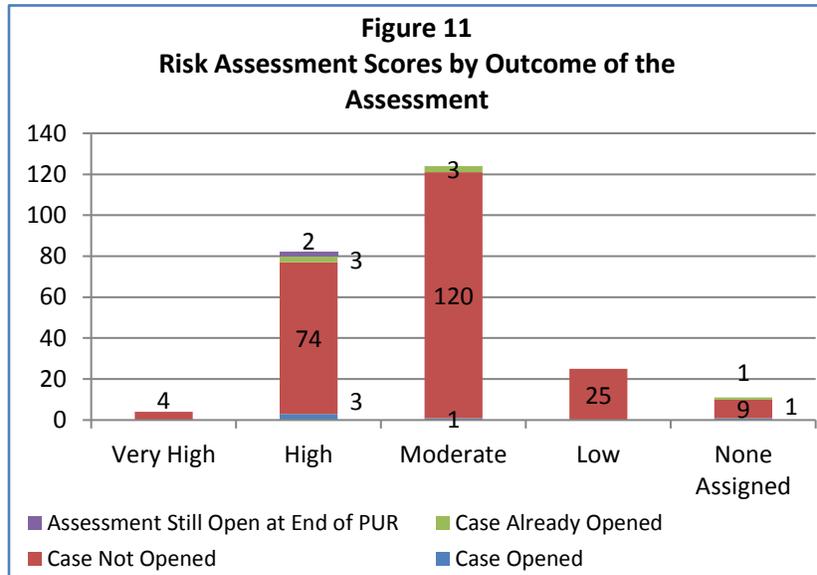
to have little or no bearing on whether the assessment was founded or unfounded, or whether the family was opened for services, as shown in **Figures 10** and **11**.

In the assessments with a risk score of “very high”, the assessments were neither determined to be founded nor were service cases opened to address the very high risk factors. Of the 82 assessments with a risk score of “high,” 84% were determined to be



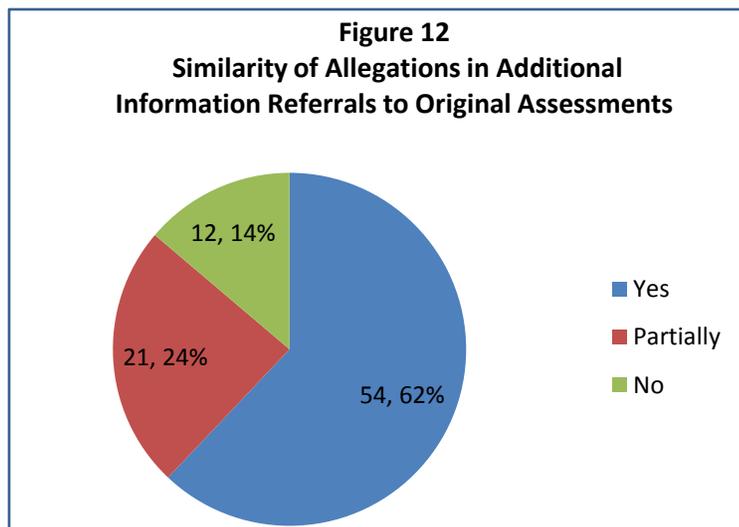
unfounded and over 90% did not have a case opened to address the risk factors.

Not surprisingly, with few cases opened for services despite high levels of risk being present, a pattern emerged of multiple assessments with similar allegations as well as additional information screen outs attached to assessments with similar allegations. As noted earlier, about two-thirds of the families in Population 1 (117 of the 182) had one assessment



conducted in the PUR. For the remaining 65 families, reviewers were asked to identify if the allegations were similar across the multiple assessments experienced in the PUR. Fifty-three (81.5%) of the 65 families who experienced multiple assessments in the PUR had assessments with similar allegations, while the remaining 12 (18.5%) noted assessments had different allegations.

Further, as noted in the Description of Case Review Activities section, over half of the families not in open cases on January 1, 2015 (Population 1) had an assessment history with DCYF prior



to the PUR. Of the 13 birth parents responding to the survey who had experienced multiple assessments, nine of them indicated that all or some of the allegations were the same.

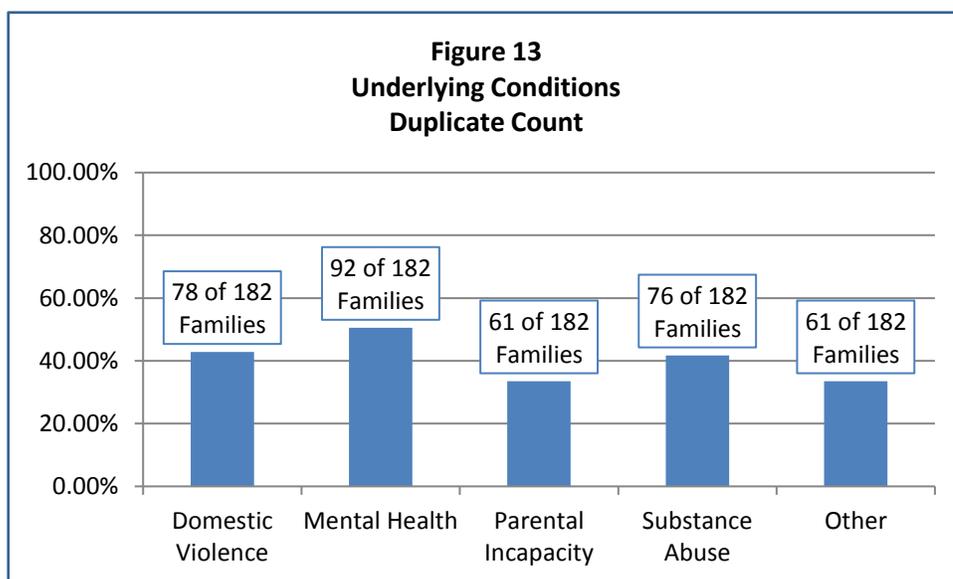
For almost one-third of the assessments in Population 1 (87), DCYF received at least one “additional information” (AI) screen-out attached to it. As shown in **Figure**

**12**, well over half of these AIs involved allegations that were similar to those in the original report/assessment.

With regard to the underlying conditions that might jeopardize the safety or risk of harm to children, those factors were less likely than either immediate safety or risk of future harm to be all identified and assessed in the Population 1 assessments that we reviewed.

As shown in **Figure 13**, the most common underlying condition in families was mental health (92) followed by domestic violence (78) and substance abuse (76). Among the most common ‘other’ complicating factors identified were children with a high level of needs (13), co-parenting and blended family complications (12) and sexual abuse history (nine).

DCYF’s policy requires that all assessments have a minimum of two collateral contacts before they can be closed, even if the assessment is being closed as “incomplete.” However, there are no requirements as to which collaterals



need to be contacted, and parents have the right to deny DCYF contacts with certain collaterals, even if they would be helpful to ensuring the safety of children and provide insight into risk of future harm.

For the 280 assessments in the PUR, reviewers indicated that collateral contacts were sufficient to assess the dangers, risks, strengths and needs of the household in just over half of the assessments (53.2%). Reviewers indicated that sometimes the collaterals contacted were not pertinent to the allegations or issues that arose in the assessment. Law enforcement, education, and medical providers seemed to be the most usual collaterals contacted. Particularly in regard to assessing for risk of harm, we would like to have seen more emphasis on talking with collaterals that know the family well or who are in positions to see family members’ interactions and behaviors in ways that law enforcement and medical providers may

not be in a position to observe regularly. According to the Child Welfare League of America’s *Standards for Service for Abused or Neglected Children and Their Families*, other potential sources include, but are not limited to, professionals such as teachers, law enforcement officers, and physicians. Other community agencies, institutions, caretakers, or individuals known to the child and the family, such as relatives and neighbors, also may be consulted.<sup>12</sup> To protect the family’s confidentiality, however, interviews or contacts with others should not be initiated without cause, should be pursued within the constraints of State law or clients may give permission for others to be contacted.<sup>13</sup>

***Sub-Question 5: Is there evidence of supervisory oversight of casework processes at this point in the process?***

Reviewers found little documentation in the assessments of supervisory oversight, although we understand from DCYF that it is not the agency’s practice to document supervisory activities in the case record. Rather, supervisors often keep notes in separate binders, which we did not review. We did query supervisors in the survey about supervisory practices, however. Thirteen of 22 (59.1%) supervisors who indicated they directly supervise assessment workers indicated that they provide, on average, weekly supervision, while the remaining nine (40.9%) suggested supervision was more likely to occur on a daily basis.

**Key Points . . .**

*While surveyed supervisors reported giving high importance to addressing underlying conditions and collateral contacts in assessments, those were two weak areas in the review.*

*Relatively low importance is attached to the quality of the NHIA tools in approving assessments.*

Survey respondents were also asked to describe what they look for in terms of safety, risk, and underlying conditions in their supervisory activities for assessments.<sup>14</sup> Of the most common responses, 14 of 29 respondents indicated that they look for collateral contacts, 12 of 29 noted quality interviews/contacts, 11 of 29 indicated they look to see if the allegations are addressed, and 10 of 29 noted prior reports. Supervisors were also asked to rate how critical certain activities were to their approval of assessments. **Table 5** illustrates the responses:

<sup>12</sup> As cited in U.S. Department of Health and Human Services, Children’s Bureau. *Child Protective Services: A Guide for Caseworkers*, by Diane DePanfilis and Marsha K. Salus, p. 52. 2003. Accessed at: <https://www.childwelfare.gov/pubPDFs/cps.pdf>

<sup>13</sup> Ibid. (U.S. Department of Health and Human Services)

<sup>14</sup> These were captured in comment form, and respondents may have identified multiple factors that they look for in assessments, and therefore the counts are not mutually exclusive.

<b>Table 5 Assessment Supervisor Responses Regarding Supervisory Reviews</b>					
	<b>1-Critical to My Approval</b>	<b>2-Important to My Approval</b>	<b>3-Somewhat Important to My Approval</b>	<b>4-Not Important</b>	<b>Average Score</b>
Underlying Conditions Affecting the Allegations	23	6	0	0	1.21
Adequacy of Collateral Contacts	16	24	3	0	1.48
Thoroughness of Caseworker Narratives	13	14	1	0	1.57
Completion of the NHIA Risk Assessment	14	7	2	6	2.00
Completion of the NHIA Safety Assessment	13	4	4	8	2.24
Supervision Notes from the Assessment	7	7	13	1	2.29
Quality of NHIA Risk Assessment	6	12	5	6	2.38
Quality of NHIA Safety Assessment	3	10	7	9	2.76
Length of time the Assessment has been Open	0	9	11	9	3.00
<b>Total</b>	<b>95</b>	<b>93</b>	<b>46</b>	<b>39</b>	<b>2.10</b>

While underlying conditions affecting the allegations was ranked highest among supervisors in factors critical to their approval criteria, that was a weak practice area in our case review as already described. Supervisors attached relatively low importance to the quality of the NHIA tools from the survey responses. The length of time an assessment has been open was also ranked low among criteria for approving assessments, and while we do not think approval should be based upon the length of time an assessment has been open, we do think monitoring the length of time and enforcing policy time frames is important.

***Sub-Question 6: Did the investigation appropriately lead to a case opening?***

Due to fiscal restrictions put in place in 2011, voluntary service cases cannot be opened on unfounded assessments even if risk factors are present (although the statute permits voluntary service cases). Therefore, only cases with a founded disposition may be opened for services (whether in home or out of home).<sup>15</sup> Of the 182 families in Population 1 that experienced 280 assessments, eight (4.4%) experienced a case opening during the PUR, three of which were opened as Children in Need of Supervision (CHINS) not due to assessment of safety and risk.

Birth parent survey respondents were asked whether or not, at the conclusion of their most recent assessment with DCYF, their families were better off and their children safer. Six of 17 (35.3%) respondents indicated “yes” and another six indicated “no,” while five (29.4%) indicated “sometimes.”

We believe that New Hampshire’s high rate of unfounded assessments relative to the presence of risk factors has a bearing on whether or not children and families receive what they need to address factors and conditions that place children at risk of future harm. As shown in **Figure 14**, New Hampshire has a founded rate in assessments that is consistently under ten percent.<sup>16</sup>

***Key Points . . .***

***Even when the allegations appeared true and the alleged incidents occurred, assessments were most often determined unfounded.***

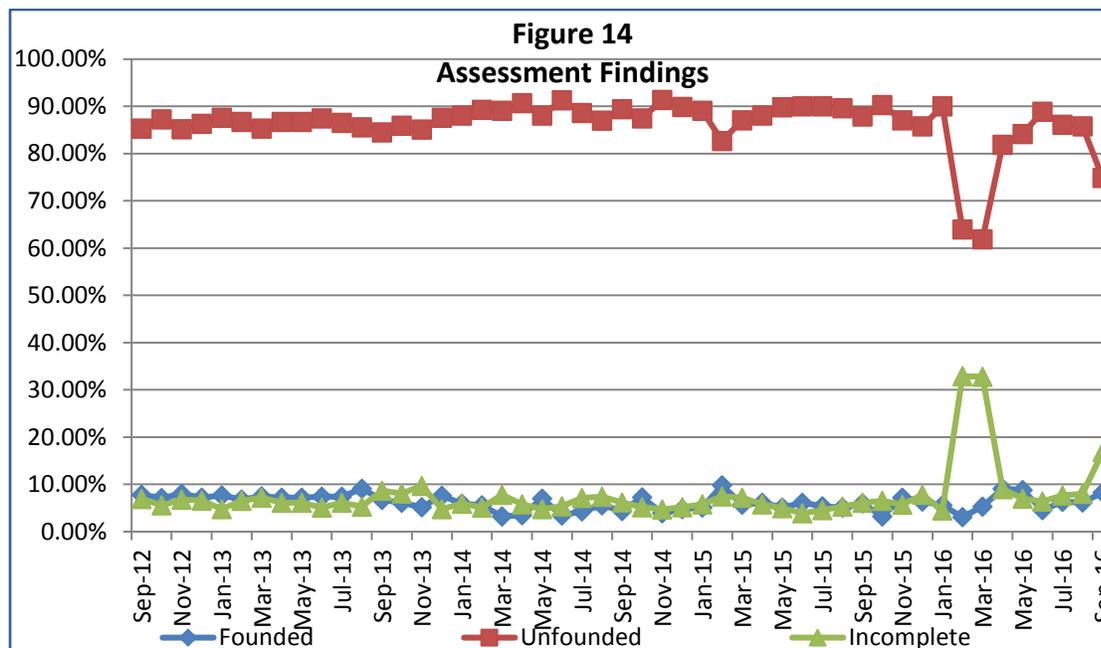
***Families had a pattern of multiple maltreatment reports in close succession.***

***The high rate of unfounded assessments affects case openings.***

***We are not confident families in unfounded reports received the services they need.***

<sup>15</sup> Another outcome for assessments are ‘B cases’. In these assessments, parents admit fault and agree to open a service case without the involvement of the courts.

<sup>16</sup> ROM Report



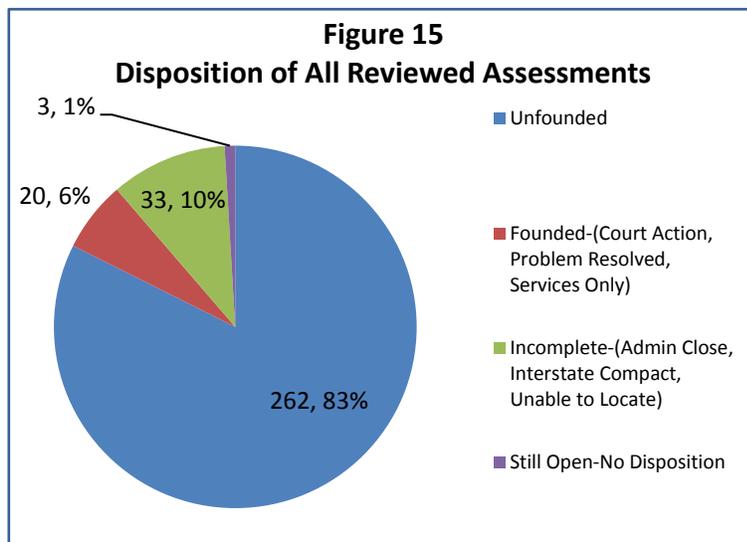
The great majority of assessments in the PUR had a disposition of unfounded (237, 85%), while 15 (5%) of the assessments reviewed had a founded disposition, and 26 (9%) assessments had an incomplete disposition.<sup>17</sup> Note that we stratified our sample of assessments to reflect the proportion of founded, unfounded, and incomplete dispositions in the universe. However, since we reviewed all assessments within the PUR for each family, we had no way of knowing how the additional assessments would be disposed. The findings indicate a similar pattern of determining reports to be unfounded apart from the assessments identified for sample selection.

As shown in **Figure 15**, the pattern was true across the populations we reviewed. Of the 318 total screened-in assessments across all three populations, 83% were unfounded, followed by 10% incomplete and six percent founded. This is higher than national studies have found. For example, the National Survey of Child and Adolescent Well-Being found that 62.1% of cases were unsubstantiated, 29.7% were substantiated and two percent were indicated (neither substantiated nor unsubstantiated).<sup>18</sup> Further, according to the 2014 Child Maltreatment report produced by the Children’s Bureau, New Hampshire has the highest unfounded rate of any

<sup>17</sup> Two assessments were screened in towards the end of the PUR and as of the censure date in the end of May 2016 still did not have a determination.

<sup>18</sup> [http://www.acf.hhs.gov/sites/default/files/opre/substan\\_child\\_0.pdf](http://www.acf.hhs.gov/sites/default/files/opre/substan_child_0.pdf)

state in the country.<sup>19</sup> The Children’s Bureau reported on children who received an investigation by the disposition of that investigation and found that 4.70% (652 of 13,878) of



children who were the subject of an investigation were substantiated, while the national average was 19.18% substantiation.

We want to be clear that having a low substantiation rate in investigations is not, in itself, a problem. The problem is not substantiating reports where real concerns about child safety or risk of harm exist, as was the case in some of the cases we reviewed.

The low substantiation rate may possibly be connected to New Hampshire’s relatively low foster care entry rate. In looking at foster care entry rates per 1,000 children in the population, national rates in 2013 ranged from 0.8 children per 1,000 in Puerto Rico to 8.6 children per 1,000 in West Virginia. The rate in New Hampshire was 1.7 children per 1,000, which was the lowest entry rate among the six states in the New England Region, including Maine (3.7), Vermont (5.5), Rhode Island (5.5), Massachusetts (3.9), and Connecticut (2.2).<sup>20</sup>

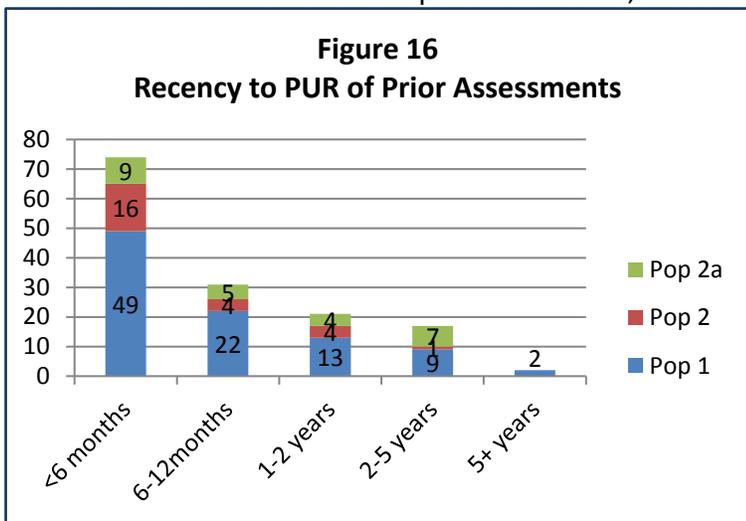
***Some stakeholders indicated that assessments are determined unfounded if the family is working toward ensuring the issues will not recur, and some comments suggested that more cases should be determined “founded.”***

Similar to the low substantiation rate, having a low foster care entry rate is not a negative thing in itself and, in fact, may be a very positive factor if children and families who are child welfare involved receive the services they need to ensure child safety otherwise.

<sup>19</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. *Child Maltreatment 2014*, Table 3-2. Washington, D.C. Accessed at: <https://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf>

<sup>20</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. *Child Welfare Outcomes Report Data (2013 Data Highlights)*. Accessed at: [http://cwoutcomes.acf.hhs.gov/data/overview/map\\_index](http://cwoutcomes.acf.hhs.gov/data/overview/map_index)

There was a pattern of multiple reports in the families we reviewed, as shown in **Figure 16**. Of the 182 families not in open services cases on January 1, 2015 (Population 1), 49 (26.9%) had an assessment within six months prior to the PUR, with an additional 22 (12.1%) families having an



assessment within six months to a year prior to the PUR. As noted in the Description of Case Activities section, 95 (52.2%) families in Population 1 had a prior assessment history. All 25 of the cases in open services cases with reports received (Population 2) cases had an assessment history prior to the PUR (as the cases were open prior to the start of the PUR). Not counting the six assessments that led the open service case opening in

Population 2,<sup>21</sup> 10 of the 25 (40.0%) had a screened-in assessment in the six months prior to the beginning of the PUR, with an additional three within six-to-12 months (not counting the assessment that led to custody). For those families in open service cases where reports were not received during the sampling period (Population 2a), five had screened-in assessments in the six months prior to the beginning of the PUR, with an additional two within six-to-12 months (not counting the assessment that led to custody).

*Some stakeholders noted that even if they demonstrate that child abuse occurred, it is still necessary to prove harm to the child as a result of the abuse or the finding will be overturned on appeal.*

Social workers were asked in the survey to describe the factors that contributed most to them making a founded or unfounded decision in an assessment. The two factors with the highest rating were assessment of safety and enough evidence for the courts to take action, both noted by 37 of the 48 respondents.

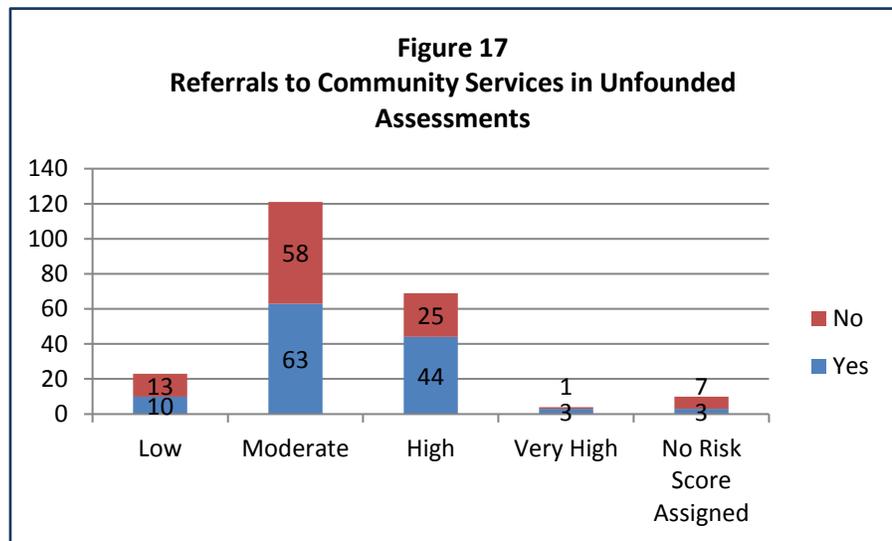
When asked about the low rate of founded reports in the State, stakeholders had a variety of opinions. Some discussed the practice of making an “internal” finding which may be different than a court finding in the assessment, but we heard that DCYF does not often make an internal finding of “founded” as they do not get support for it, and doing so does nothing to keep a child safe. Some stakeholders indicated that the statute ties DCYF’s hands and forces an unfounded

<sup>21</sup> If the case opening date was within 2 months of the assessment date, CSF made the assumption that it was the assessment that led to case opening.

assessment finding. In addition, we heard that, in an attempt to prove harm according to the statute, workers are not allowed to submit research on the detrimental effects of domestic violence on children, for example, but have to provide expert testimony which is not always easy to obtain. We heard from stakeholders that DCYF loses most cases on appeal and that it is because the assessment workers cannot prove the “harm” referenced in the statute, even if there is evidence the alleged maltreatment incident occurred.

While fiscal constraints may not allow for voluntary services to be put in place in unfounded assessments, something that approximately half of stakeholders interviewed stressed needed to be reinstated, DCYF recommends that referrals for needed services be made at the conclusion of assessments, and requires such referrals if the risk assessment score is moderate or higher. In our review, this typically involves noting a need for services to families in the letter that notifies the family that their assessment was unfounded. With the pattern of multiple reports involving similar allegations, we cannot have great confidence that this process leads to families receiving effective services to protect their children over time. **Figure 17** shows the results of our review with regard to referring families for services in unfounded assessments.

Referrals to community services were more likely than not to be made for assessments with a moderate or higher risk score (since that is a policy requirement), although we did not see the referrals in a substantial number of assessments with a risk rating of moderate or higher. We have no information to determine if those referrals were acted upon.



## Research Question 2: Are children and their household family members who come to the attention of DCYF through reports of maltreatment receiving a response that ensures the children in the household are safe from immediate threats to their health, safety and risk of future harm?

In contrast to Research Question 1, with the exception of eight children in Population 1 who became members of open service cases during the sampling period, this question pertains to children and families in open service cases at the start of the PUR. Fifty-eight children across all three populations were served in open service cases (in-home and out-of-home) during the PUR. Twenty-five of the children were in open cases that

were the subjects of referrals to Central Intake during the sampling period (**Population 2**), 25 were in open cases and were *not* the subjects of maltreatment reports during the sampling period (**Population 2a**), and eight were in the Population 1 analysis, were the subjects of maltreatment reports, and had cases opened for services during the PUR. Of the 58 children total, 40 (68.9%) were determined by reviewers to be served in ways that ensured that children are protected from immediate threats to their health, safety and risk of future harm.

Although Population 2a had a slightly higher percentage of “yes” responses to the overall Research Question 2 compared to Population 2 (19 of 25 compared to 16 of 25 respectively), we would expect these results since Population 2a children had no reports of maltreatment during our sampling period. For cases that reviewers determined not to have received an adequate response, **Figure 18**<sup>22</sup> shows the most common reason was inadequate ongoing

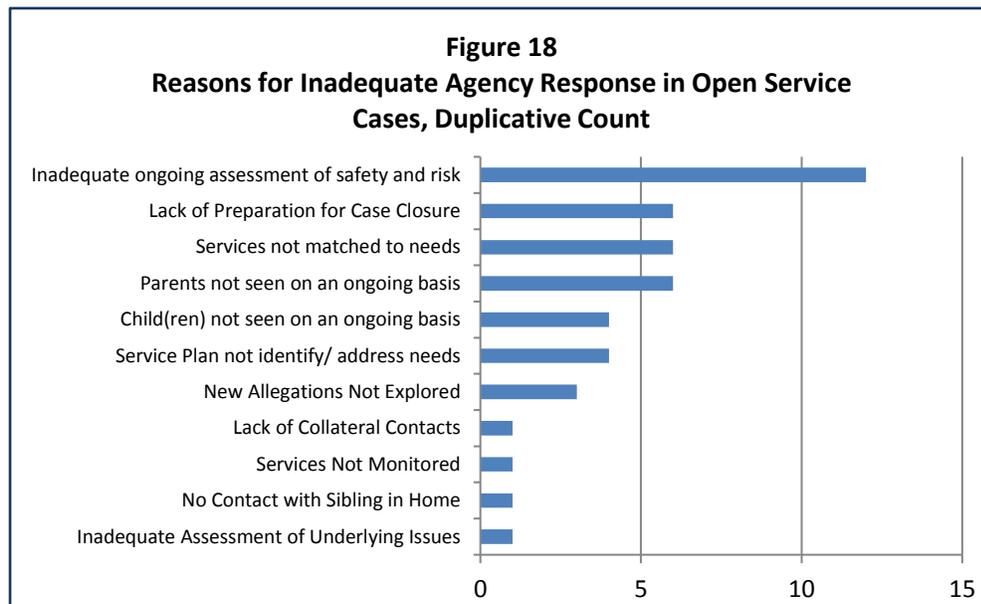
### *Key Points . . .*

*Forty of 58 children who had open cases at the start of the review (or were opened during the sampling period) were determined to have received a response that ensures their health, safety, and risk of future harm were addressed.*

*The major reason for a “no” response was inadequate ongoing assessment of safety and risk.*

<sup>22</sup>We included the 8 target children from Population 1 in the RQ2 analysis because they had cases opened during the PUR and we wanted to follow a child’s involvement with the department through the entire Period of Review, whether that was more assessments, or whether the case opened for services. However, we did not include Population 2 children in the RQ1 analysis because Population 1 is a statistically representative sample and we wanted to be able to generalize to the entire universe meeting the definition of Population 1, which we cannot do for Population 2.

assessment of safety and risk, followed by parents not being seen on an ongoing basis, services



not being matched to needs and lack of preparation for case closure.

***Sub-Question 1: Were children in open service cases who experienced an assessment during the PUR served in ways that ensured their safety from impending danger and mitigated risk of future harm while under the authority of DCYF?***

Eighteen of the 25 (72.0%) target children who had open service cases at the beginning of January 2015 (Population 2) experienced a total of 38 assessments during the PUR, and none of the children in Population 2a experienced an assessment in the PUR.<sup>23</sup> Similar to the findings for those children not in open service cases (Population 1), DCYF initiated the assessments timely for the most part (89.5%), although seeing the victim children timely occurred less often (68.4%), and completing the assessments timely occurred in only 44.7% of the assessments.

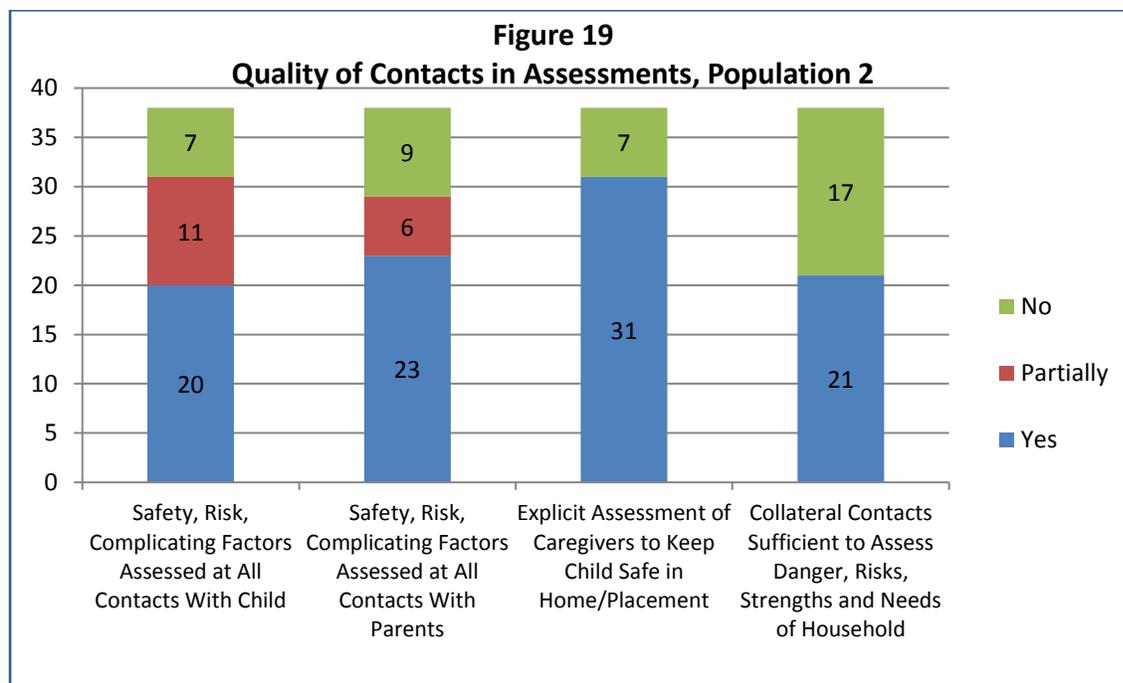
**Key Points . . .**

*Assessments were generally initiated timely.*

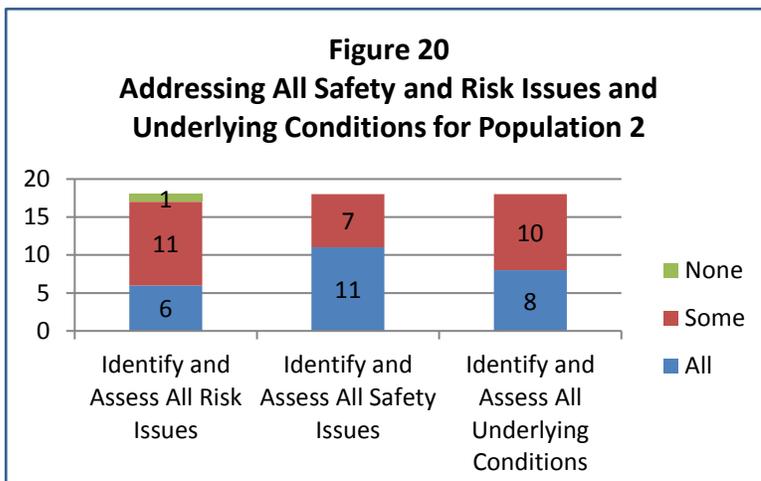
*Exploration of safety, risk and underlying conditions was more explicit for children in open service cases (Population 2) than those not in open service cases (Population 1).*

<sup>23</sup>The 8 children in Population 1 that had an open services case during the PUR will not be reflected in this sub question, as they were included in the detailed analysis for Research Question 1. They will however be included in the discussion of the other Research Question 2 sub questions.

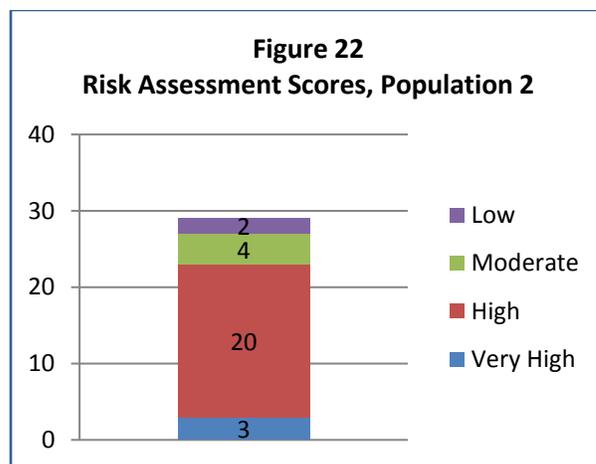
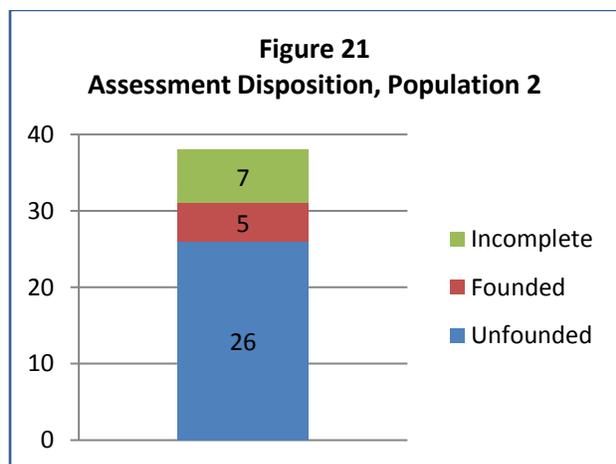
As shown in **Figure 19**, reviewers found that safety, risk and underlying issues were more likely to be adequately discussed with parents than children, as well as documentation of an explicit assessment of caregivers to keep the child safe in the home/placement (81.6%). Regarding the NHIA tool completion, safety assessments in Population 2 were usually conducted timely, (26/30 or 86.7% of the assessments with a safety assessment tool completed were conducted within a week of the referral to Central Intake) but approved later (13/30 or 43.3% of safety assessments completed were approved within one to six months after the assessments were conducted). In addition, the vast majority of the safety assessments had a “safe” rating, while 79.3% (23 of 39) of risk assessment scores conducted were rated as “high” or “very high.”



As shown in **Figure 20**, social workers were most likely to identify and assess all relevant safety issues, followed by underlying conditions and then risk issues. This is a bit different from our findings for Population 1.



Similar to the findings in Population 1, a number of assessments for children in open cases were determined by the social workers to be at high and very high risk, yet the assessments still received a disposition of unfounded, as shown in **Figures 21 and 22**.



Twenty-three of the 29 (79.3%) assessments with a risk assessment attached had a risk assessment score of high or very high. Twenty-six of the 38 (68.4%) assessments completed for Population 2 had an unfounded disposition.

***Sub-Question 2: Is there an assessment in place (beyond the investigation) that addresses parental protective factors and risk factors for the child(ren)? If so, is it in accordance with agency policy?***

When an assessment is determined to be founded, DCYF social workers complete a Strengths and Needs Assessment, which is part of the NHIA tools package. In addition, the Strengths and Needs Assessment should be reviewed routinely throughout the life of the case, as its purpose is to help inform the case plan.

**Key Point . . .**

***The NHIA Strengths and Needs Assessment was not used consistently to inform case plans.***

Reviewers found evidence that all information was used from the Strengths and Needs Assessment to inform the case about two-thirds of the time (65.9%). Children in open service cases with reports (Population 2) rated stronger in this area than children in open service cases without reports (Population 2a). Twenty of the 23 applicable cases in Population 2 had “all” indicated for use of the information in the strengths and needs assessment to inform the case plan, compared to seven of 17 applicable cases in Population 2a.

***Sub-Question 3: Are all relevant family members engaged in decision making/service plan development?***

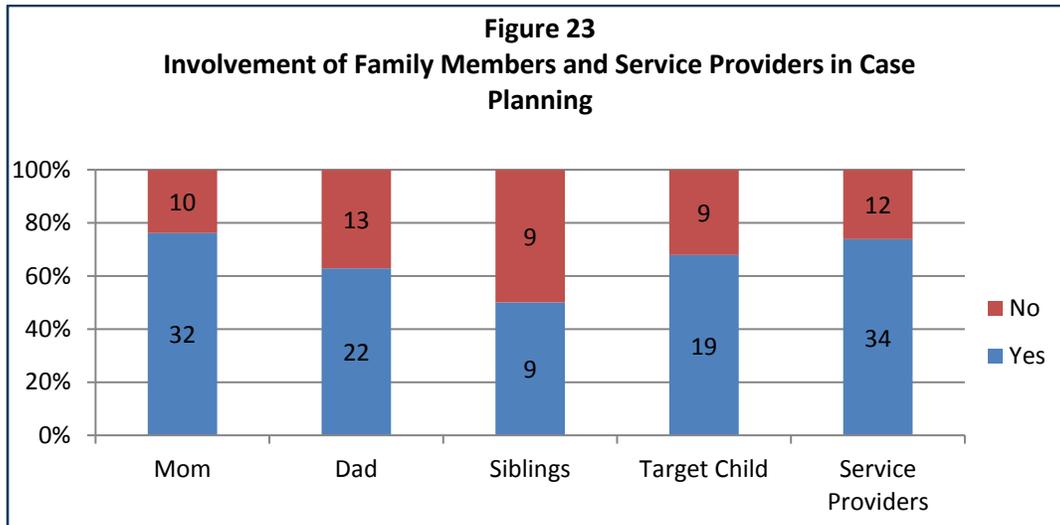
Case reviewers looked for documentation that family members and service providers were involved in decision making and case plan development throughout the PUR. As shown in **Figure 23**, mothers were the most engaged throughout the PUR (76.2%), followed by service providers (73.9%) and target children (67.9%). Siblings of target children were the least likely to be engaged in case plan development and decision making at just 50.0%.

**Key Points . . .**

***Mothers, service providers and the target child were the most likely to be engaged in decision making and service plan development.***

***Other children in the family were the least likely to be involved.***

Birth parent respondents to the survey were also asked if the contact they had with their ongoing service worker was sufficient to meet their needs, and nine of 15 (60.0%) respondents answered that the contact was sufficient. When comparing Populations 2 and 2a, minimal differences existed in the engagement of mothers, fathers and service providers. However, children and siblings were more likely to be engaged in decision making/service plan development in Population 2a versus Population 2.



Among consumers of the New Hampshire child welfare system who we spoke with, some indicated they did not think they had a voice in what happens to them, indicating that DCYF controls what happens to them.

***Sub-Question 4: Is there an identifiable strategy in place to ensure that safety threats and risk factors are being addressed on an ongoing basis and routinely monitored?***

For the children served in open service cases, we wanted to know how well safety and risk factors are monitored as part of the ongoing casework.

Social worker survey respondents were asked to identify how safety, risk and complicating factors were assessed on an ongoing basis in open service cases. The most common answers in the comments to this question were monthly contacts (25 of 30 respondents) followed by collateral contacts (21 of 30).<sup>24</sup>

**Key Points . . .**

*Children in foster care were seen monthly on a consistent basis, less so for children in in-home cases.*

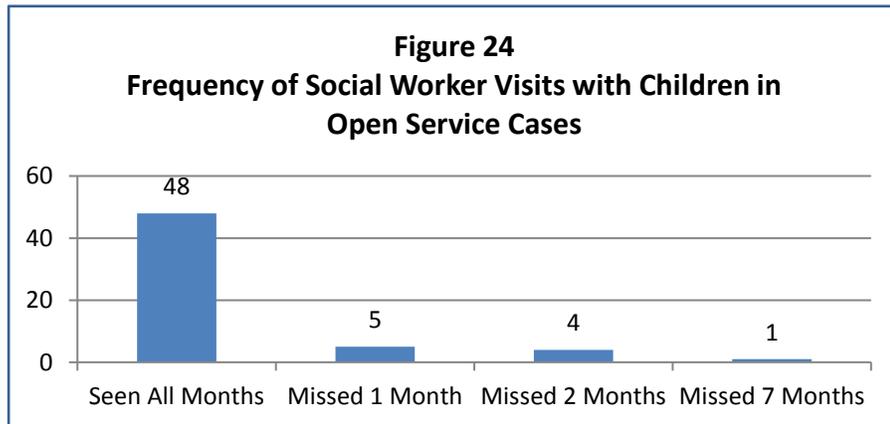
*Risk assessment tools were completed timely and accurately in about two-thirds of the open cases.*

*Visits with parents addressed protective capacities and underlying conditions about two-thirds of the time, more so with collateral contacts.*

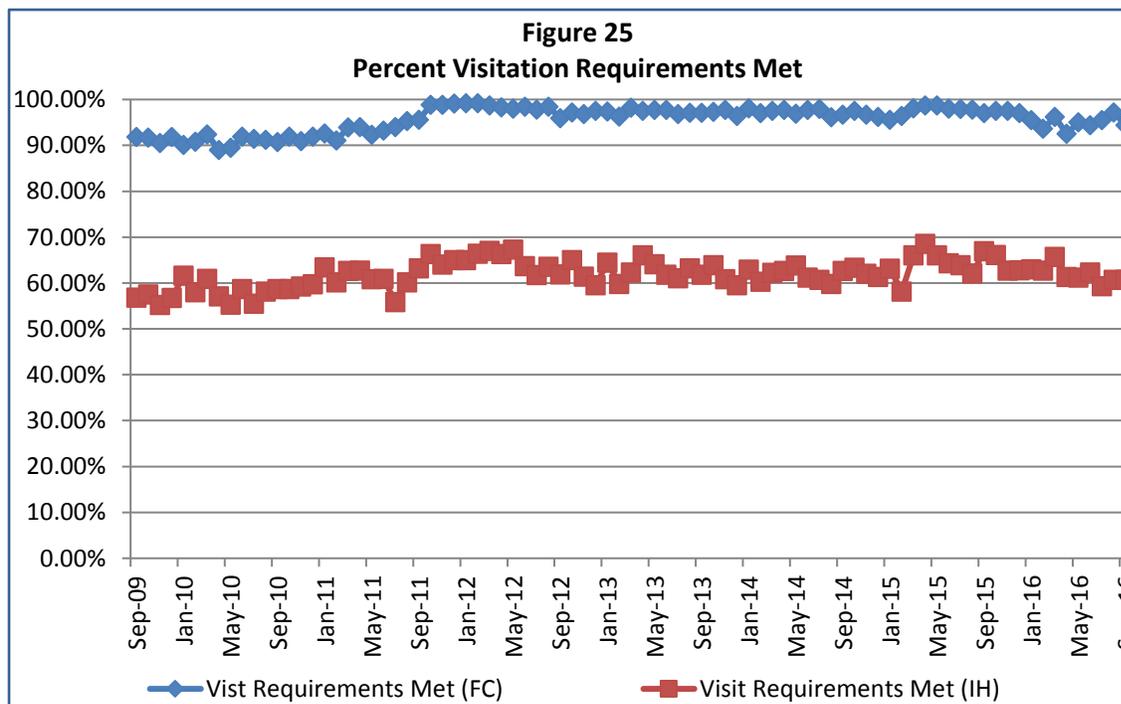
<sup>24</sup> Note: survey respondents noted multiple themes in their comments

As shown in **Figure 24**, 82.8% (48) of the 58 children in open service cases in the case review were seen by the social worker each month the case was open in the PUR. An additional 8.6% (five children) were seen monthly except for one month. Children in Population 2 were seen monthly slightly more often than children in Population 2a.

Reviewing DCYF’s historical data since 2009, social worker visits with children in foster care has been an area of strong performance, but less so for children in open services cases who are not in foster



care. **Figure 25**<sup>25</sup> illustrates this point. Over the last seven years, monthly visitation for children in open service cases has slightly increased and remained steady for the last five years, with children in foster care cases being seen approximately 92-99% of the time, and children in in-home cases being seen approximately 59-69% of the time.

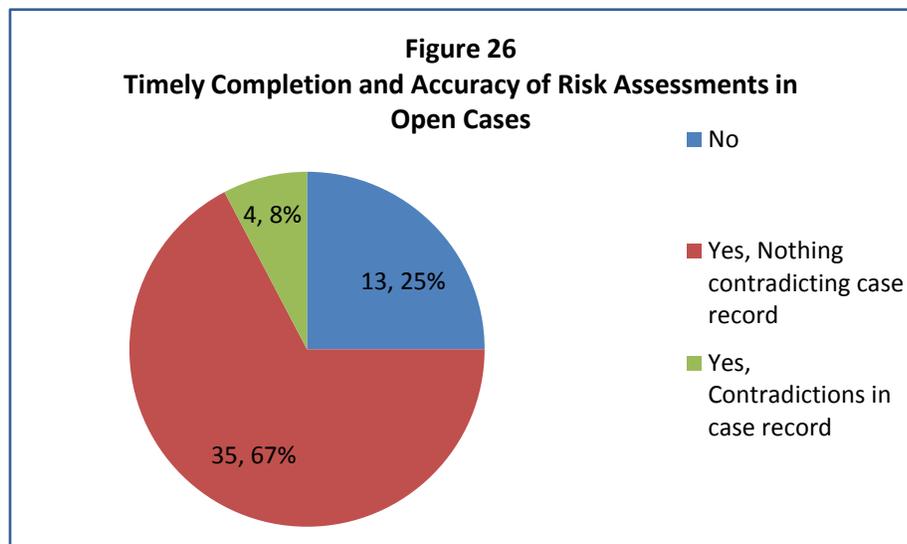


<sup>25</sup> ROM Report

In addition to knowing whether or not children were seen regularly by the social worker, we reviewed for whether safety and risk were addressed during the monthly visits by looking for documentation in the case narratives that indicated the social workers discussed or identified safety and risk concerns. Case reviewers found documentation that safety and risk were assessed at each visit with 43 of the 58 (74%) target children seen as part of the open service case, and no differences being observed between Population 2 and Population 2a.

Quality visits with parents were found to be less strong. For 34 of 57<sup>26</sup> (59.6%) target children in this population, visits between workers and their parents were of sufficient quality and frequency to assess underlying conditions and parental protective capacity. There was no difference in the ratings between Population 2 and Population 2a. Quality and frequency of contacts with collaterals was found to occur more frequently (81.8%).

While the NHIA safety assessment tool is not required to be completed on an ongoing basis unless there is an assessment, the NHIA risk assessment tool is required to be completed every six months on open service cases to monitor and manage risk concerns. For the 52 applicable cases,<sup>27</sup> risk tools were completed timely *and* were consistent with information in the case files



about two-thirds of the time, as shown in **Figure 26**. In four of the risk assessments that were completed timely, reviewers noted information in the case files that did not support information in the risk assessments.

There were small differences between

Populations 2 and 2a. Sixteen of 25 risk assessments tools were completed timely in Population 2 compared to 17 of 22 in Population 2a.

<sup>26</sup> This question was not answered for one target child in Population 2a who had undergone TPR.

<sup>27</sup> Only 52 applicable due to CHINS cases, cases post TPR and other similar reasons.

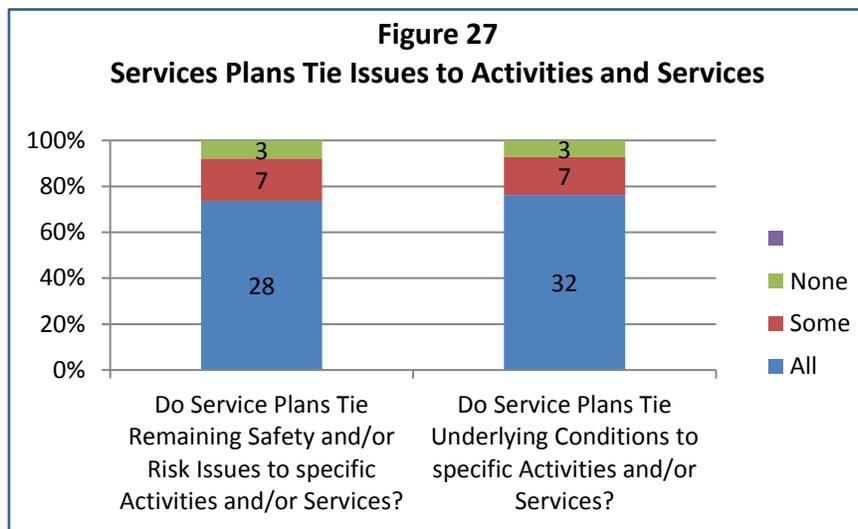
Responding to Additional Information referrals in open cases is also relevant to safety and risk assessment, since the AIs are often attached to the service cases and the assigned social worker handles them without necessarily initiating an assessment. A total of 19 open service cases in the case review experienced at least one AI during the PUR, 12 of which were similar to the reasons that led to the case opening. Reviewers found that in 15 of the 19 AIs, they were handled appropriately according to policy.

***Sub-Question 5: Is information regarding underlying conditions and risk factors incorporated into the service plan?***

Service plans were not found or reviewed in all the open service cases reviewed.<sup>28</sup> In the 42 service plans we reviewed, the plans tied activities and/or services to all identified safety/risk issues and to underlying conditions in the family about three-quarters of the time. When we add in those plans that addressed some, but not all, of the identified safety/risk factors and underlying conditions, the percentage rises to over 90%. See **Figure 27**.<sup>29</sup>

**Key Point . . .**

*In the open cases reviewed, service plans tied safety/risk factors and underlying conditions to activities and services most of the time.*

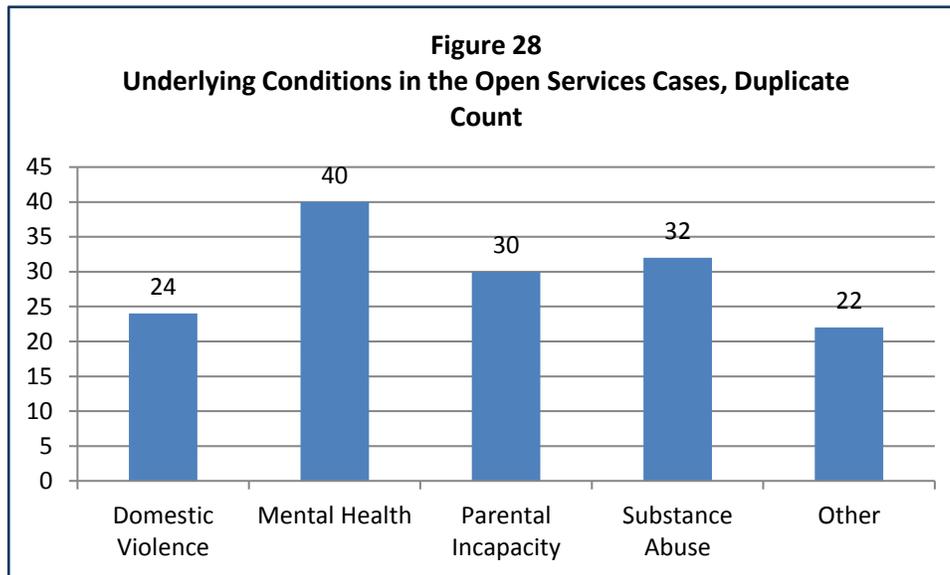


The identified underlying conditions in the open case reviews were similar to those in Population 1, in that mental health issues were predominant. However, whereas domestic violence was the second most common underlying issue in Population 1, there was a higher incidence of

substance abuse and parental incapacity than domestic violence for the 58 children in open service cases, as shown in **Figure 28**.

<sup>28</sup> Sixteen of the 58 cases did not have the service plan(s) reviewed. Eight of those cases were Population 1 children which opened into open service cases. In the remaining eight, the case file couldn't be found or the service plan could not be located in the hard case file.

<sup>29</sup> Both indicators do not add up to the 42 service plans reviewed as not all cases had remaining safety and/or risk issues identified.



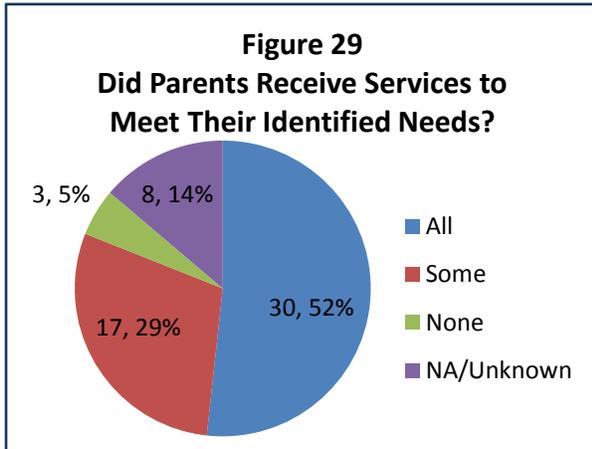
***Sub-Question 6: Are services provided to support parental protective capacity and address risk factors?***

Having service plans in place detailing needed services tied to underlying conditions and safety and risk concerns provides a road map and promotes accountability for the agency and the family. Actually receiving and engaging in needed services are vital to helping children avoid harm and risk of future harm, and help them to return or remain safely in their homes. As shown in

***Key Points . . .***

***About half of the families in open cases appear to have received all services needed to address identified needs.***

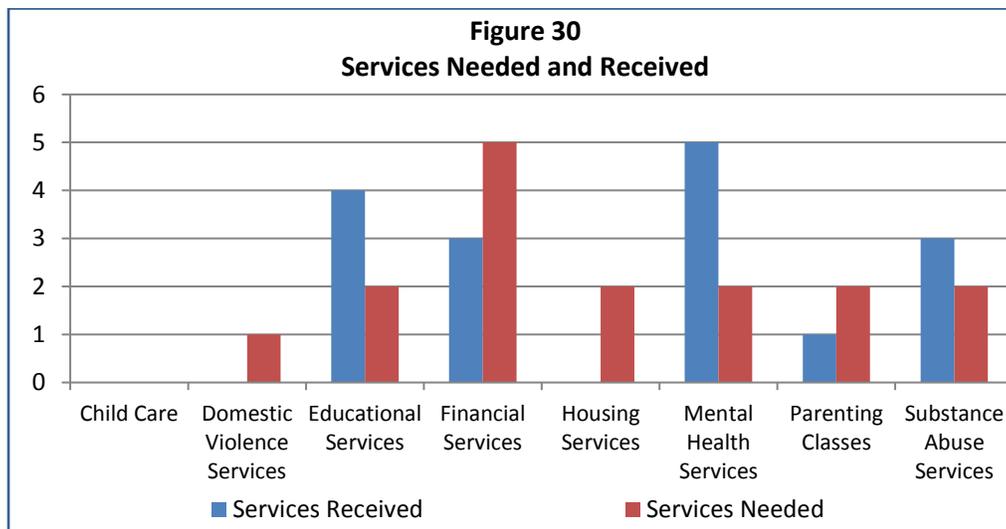
***Mental health and educational services were the most commonly received, but financial services were the most needed.***



**Figure 29**, just over half of parents of the 58 children in open services cases received all identified services to meet their needs, and an additional 29% received some, but not all, of the identified services. Comparing Populations 2 and 2a, of the 20 parents identified as needing services, 13 (65.0%) received all services in Population 2a compared to 11 of 24 (45.8%) in Population 2. Responses to the birth parent survey were not as favorable. When

asked “during your involvement did you receive the services you needed to keep children safe and protected”, seven of 19 (36.8%) respondents indicated yes, four of 19 (21.1%) indicated partially, and eight of 19 (42.1%) indicated they did not receive the services they needed.

Birth parents were also asked to indicate which services were received and which were needed. **Figure 30** provides that information. Mental health services were the most common service received, followed by educational services, while financial services was the most common service needed. When birth parent survey respondents were asked to identify which three services were least available, they noted mental health services (12 of 19)<sup>30</sup> and educational services (nine of 19), despite those being the most commonly received services.



<sup>30</sup> Note that while the Figure 30 provides number of responses (total of 19), not all respondents answered.

Six separate surveys asked respondents to give their opinion on the effectiveness of ongoing delivery of out-of-home services in ensuring children of New Hampshire are free from immediate danger and risk of future harm, as shown in **Table 6**.

<b>Table 6</b>				
<b>Survey Responses to the Effectiveness of Services in Addressing Safety and Risk</b>				
	<b>Always Effective</b>	<b>Usually Effective</b>	<b>Sometimes Effective</b>	<b>Rarely/Not Effective</b>
Social Workers (77)	0	31/77 (40.3%)	40/77 (51.9%)	6/77 (7.8%)
Supervisors (34)	0	15/34 (44.1%)	18/34 (52.9%)	1/34 (2.9%)
Educators (272)	3/272 (1.0%)	43/272 (15.8%)	136/272 (50.0%)	90/272 (33.1%)
Law Enforcement (23)	2/23 (8.7%)	8/23 (34.8%)	10/23 (43.5%)	3/23 (13.0%)
Medical Providers (81)	3/81 (3.7%)	12/81 (14.8%)	46/81 (56.8%)	20/81 (24.7%)
Service Providers (18)	1/18 (5.6%)	7/18 (38.9%)	8/18 (44.4%)	2/18 (11.1%)
<b>Total (505)</b>	<b>9/505 (1.8%)</b>	<b>116/505 (23%)</b>	<b>258/505 (51%)</b>	<b>122/505 (24%)</b>

Social workers and supervisors were more likely to rate the effectiveness of services higher than other respondents, particularly educators and the medical community. Most respondents (51.1%) rated the effectiveness of services as sometimes effective (not adjusted for the large educator representation relative to other respondents).

***Sub Question 7: Are services monitored and adjusted as needed based on progress/lack of progress or changes in the family’s situation?***

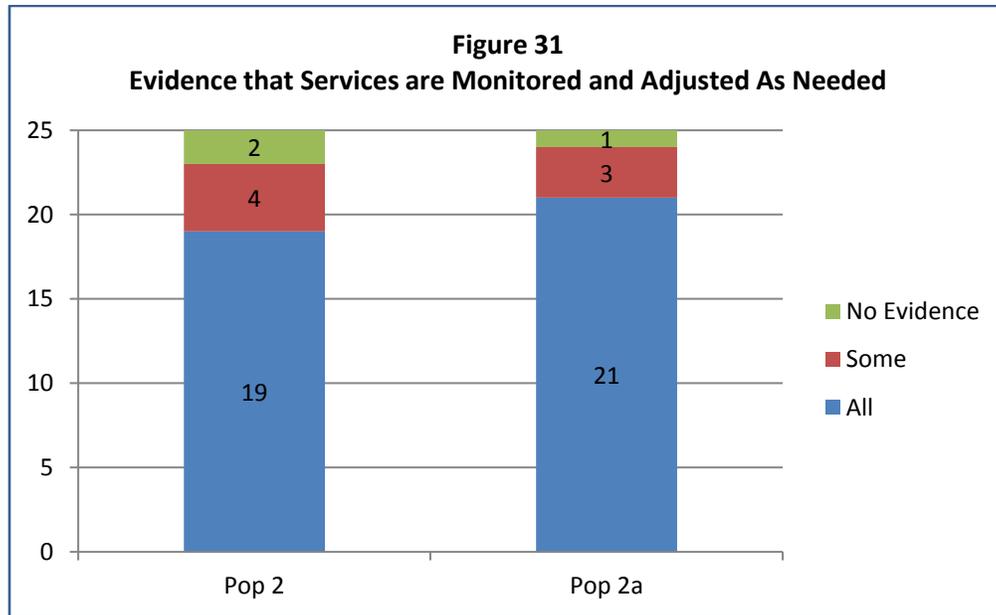
In order to know if services are effective in addressing the needs of children and families, they need to be monitored and adjusted as families’ strengths and needs evolve.

Service monitoring and adjustment were evident for all services for 45 of 58 children, with an additional nine showing some but not all services were monitored and adjusted if needed. As indicated in

**Key Point . . .**

*All services were monitored and adjusted as needed in just over three-quarters of the open service cases.*

**Figure 31**, Population 2a was slightly more likely to show evidence that all services were routinely monitored and adjusted as needed than Population 2.



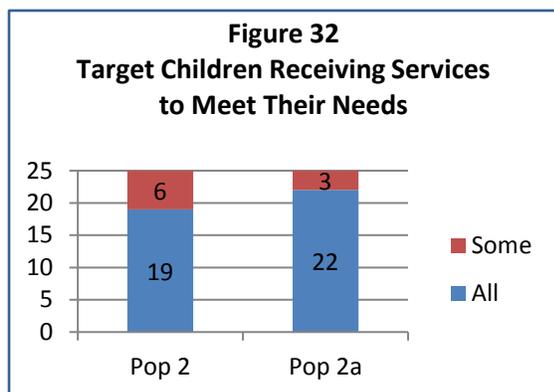
***Sub-Question 8: Is the child’s well-being (including health and education) addressed through assessment, case planning and service delivery?***

Reviewers assessed whether target children in open service cases had their well-being addressed through case planning and service delivery. In 53 of 58 (91.4%) target children reviewed, the child’s well-being was addressed. Target children received services to meet their needs in 81% of the cases. Forty-seven children received all needed services, and 11 children received some of the needed services. Slight differences were observed between Population 2 and Population 2a.

**Key Points . . .**

*Most children in open service cases who were not the subjects of maltreatment reports had their well-being needs assessed and addressed in case planning.*

*81% of children received all needed services to address well-being.*



On the other hand, some stakeholders interviewed noted that if parents do not agree that something is medically necessary, the child does not receive it, even if the child is in care for medical neglect. They provided several examples of children not receiving medical care because parents would not consent, or the agency could not reach the parents for consent.

***Sub-Question 9: Are processes in place to assess safety, risk, child well-being and protective capacity prior to closing the case, if applicable?***

Twenty (34.5%) of the 58 children with open service cases experienced a case closure in the PUR. The length of time the children’s cases were open ranged from 6.8 months to 96.6 months, with an average length of time of 21.8 months.

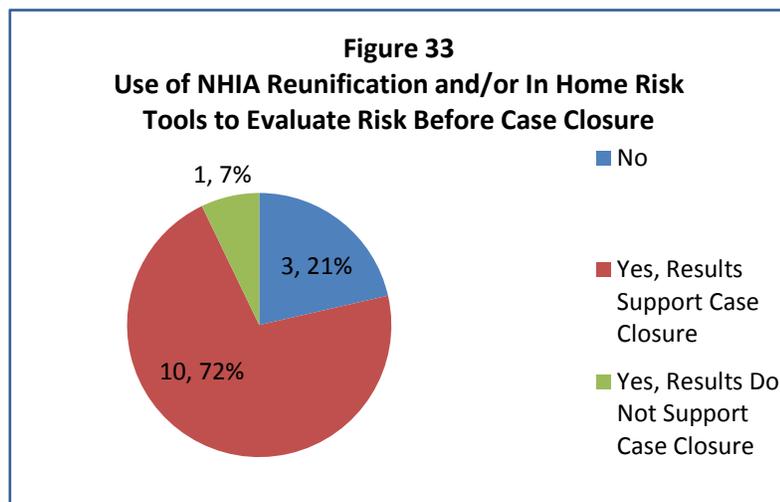
***Key Points . . .***

***In over three-fourths of the cases with a case closure, the NHIA risk assessment tool was completed prior to closure.***

***There was an informal risk assessment in about two-thirds of the cases prior to closure.***

As shown in **Figure 33**, in 79% of the cases, there was evidence that DCYF used the formal NHIA Reunification and In-Home Risk tool(s) to help assess risk prior to children being placed back with their families and their cases closed. In addition, reviewers noted that the majority of the results of the tool helped support the plan for case closure.<sup>31</sup>

<sup>31</sup> This may appear to be in contrast to our findings regarding the use of the NHIA tools in the Population 1 discussion, but Population 1 primarily included assessments, except for 8 cases that opened during the PUR, only 4 of which closed during the PUR.



In addition to using the NHIA tool to evaluate risk prior to case closure, there was evidence in the case reviews that about two-thirds of the children had some form of informal assessment of safety and risk prior to case closure. Reviewers noted that while case closures were done by and large “by the book,” social workers often seemed to close

cases quickly, despite sometimes needing to do additional work to address safety and risk factors.

Some stakeholders indicated to us that the system is geared too much toward reunification at any cost and cited examples of children returned to dangerous situations because DCYF could not prove that the parents inflicted the maltreatment. We heard from these stakeholders that newer workers are pushed so much to reunify that they don’t always see the needs of the child. They also expressed concerns that parents do not receive drug tests prior to reunification.

***Some stakeholders noted that cases are rarely open beyond 12 months or that the goal is to close the cases as quickly as possible.***

Supervisors and social workers responding to the survey identified the most prevalent factors influencing the decision to close an open service case. Thirteen of 22 supervisors (59.1%) identified behavior change/sustained positive change/conditions corrected as the most common factor, followed by safety and risk concerns mitigated by 10 of 22 supervisors (45.5%). The most common factor identified by social workers, was “when the case plan and/or court plan goals are met,” (13 of 30, 43.3%) followed by observed behavior change in parents and/or issues that led to involvement are addressed (12 of 30, 40.0%).

As shown in **Table 7**, six surveys asked respondents to give their opinion on the effectiveness of ensuring children are free from immediate danger and risk of future harm while achieving permanency and closing cases. Social workers and supervisors rated the agency’s effectiveness in this area the highest, while educators and the medical community provided ratings that were among the lowest. Most survey respondents rated this area as sometimes effective (not adjusting for the high representation of educators relative to other respondents).

<b>Table 7</b>				
<b>Effectiveness of Ensuring Children are Free from Immediate Danger and Risk of Future Harm while Achieving Permanency and Closing Cases</b>				
	<b>Always Effective</b>	<b>Usually Effective</b>	<b>Sometimes Effective</b>	<b>Rarely or Not Effective</b>
Social Workers (79)	4/79 (5.1%)	47/79 (59.5%)	26/79 (32.9%)	2/79 (2.5%)
Supervisors (34)	0	26/34 (76.5%)	7/34 (20.6%)	1/34 (2.9%)
Educators (278)	6/278 (2.2%)	46/278 (16.5%)	146/278 (52.5%)	80/278 (28.8%)
Law Enforcement (27)	0	11/27 (40.7%)	13/27 (48.1%)	3/27 (11.1%)
Medical Providers (78)	2/78 (2.6%)	12/78 (15.3%)	46/78 (59.0%)	18/78 (23.1%)
Service Providers (18)	1/18 (5.6%)	7/18 (38.9%)	10/18 (55.6%)	0
<b>Total (514)</b>	<b>13/514 (2.5%)</b>	<b>149/514 (28.9%)</b>	<b>248/514 (48.2%)</b>	<b>104/514 (20.2%)</b>

The most common response across all six survey respondents was sometimes effective with 48.2% of answers. It should be noted that this is highly skewed by the educators’ responses.

***Sub-Question 10: Is there evidence of supervisory oversight of these processes?***

As in Population 1, we found little evidence in the open services case of supervisory oversight, and we understand it is not DCYF’s practice to document supervisory activities in the case record. We also did not review supervisors’ notes which may be a record of supervisory activities. To address this sub-question, supervisors responding to the survey were asked how frequently they provide supervision to their social workers, on average. Sixteen of the 18 applicable respondents indicated that they

**Key Points . . .**

*Most supervisors in the survey indicated they provide weekly supervision to social workers.*

*Other stakeholders raised concerns about the quality and consistency of clinical supervision to support social workers.*

provide supervision ongoing social workers on a weekly basis, and the remaining two respondents indicated that supervision was provided monthly.

As to the quality of supervision provided, nearly one-half of stakeholders interviewed (who would be knowledgeable of this area and who were asked about it) raised concerns about the quality of supervision. Some concerns expressed in the interviews included supervision being inconsistent both week to week and supervisor to supervisor, as well as social workers not receiving as much clinical supervision as they need.

## Research Question 3: Do systemic factors and DCYF’s organizational capacity support the achievement of positive safety and risk outcomes for children?

*Sub-Question 1: Are DCYF’s standards, policies, and protocols, and New Hampshire statutes adequate to protect the health, safety and life of children in the care and responsibility of DCYF?*

### Statutes

The State’s child protection statute was one of the most commonly cited concerns among stakeholders we interviewed, particularly related to being able to take action on behalf of children in neglectful situations. About

half of the stakeholders noted that if harm to a child cannot be tied to a specific incident, a finding of abuse or neglect cannot be made in an assessment. The phrase “*where’s the harm?*” was often cited as the primary criteria for making decisions about whether a child was abused or neglected. Even in those situations where neglectful behavior was present, in our case reviews and in examples raised by stakeholders, there was a perception that if the child had not suffered an injury related to the reported incident, the report would be unfounded. Some stakeholders, reported that it is harder for DCYF to prove maltreatment than it is for law enforcement to prove criminal activity.

#### Key Points . . .

*The State statute on risk of harm, and/or its interpretation, is limiting in the perception that it requires proof that actual harm has occurred before taking action to protect children.*

*Some stakeholders indicated that even if the allegations in the reports are true, nothing can be done about it because of the limitations in the statute.*

*Others indicated that the requirement to prove the harm is difficult and that social workers spend much time trying to manage concerns that may be present in a case.*

*We heard that the State’s laws are more directed at protecting the parents’ rights than the children’s rights.*

Our review of the statute was conducted keeping in mind that New Hampshire has the lowest rate of substantiation<sup>32</sup> of child abuse/neglect reports of any State. Given the frequent references to the statute’s effect on substantiation, we

reviewed the statute to determine if it only allows for substantiation when there is serious

<sup>32</sup> “Substantiation” refers to a “founded” report.

harm or imminent danger; what constitutes threat of serious impairment; the adequacy of the State’s definitions of maltreatment; how drug use (specifically, opioid abuse) is treated; and the effect on substantiation of a parent’s ability to deny DCYF workers access to the home and child (while at home).

With regard to whether the statute only allows for substantiation when there is serious harm or imminent danger, the Child Protection Act, NH RSA 169-C, states that a report should be unfounded (not substantiated) if DCYF finds that there is no probable cause to believe that a child has been abused or neglected. Probable cause as defined in the statute “means facts and circumstances based upon accurate and reliable information, including hearsay that would justify a reasonable person to believe that a child subject to a report under this chapter is abused or neglected.” In other areas of the law, probable cause is often considered the lowest standard of proof. Occasionally, probable cause will be equated with preponderance of the evidence (meaning at least 50.1%); however, it is never considered a higher standard. Of the many standards of proof utilized in state child welfare investigations and assessments, preponderance of the evidence is the most common. New Hampshire is one of six states using a “probable or reasonable cause” standard.<sup>33</sup>

On the face, it does not appear that New Hampshire’s current standard of proof would contribute to the failure to substantiate reports when clear risks of harm are present. However, it is worth noting that the standard of proof in a New Hampshire child welfare *court* case is preponderance of the evidence, which, as stated above, is arguably a higher standard,<sup>34</sup> and DCYF’s policy cites the preponderance of the evidence standard.<sup>35</sup> This could potentially lead to a situation in which there was adequate proof to substantiate an assessment but the same proof was inadequate for the court to determine that the child was abused or neglected, i.e., the incident occurred. The state should consider aligning these standards.

The next inquiry is whether the terms “abused” and “neglected” are defined to require that the harm suffered is “serious” or that the risk of harm rises to the level of “imminent danger.” The New Hampshire Child Protection Act defines abused child and neglected child as follows:

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<sup>33</sup> Child Welfare Information Gateway. *Making and Screening Reports of Child Abuse and Neglect*, 2013, pp. 6, 83-84. Accessed at: <https://www.childwelfare.gov/pubPDFs/repproc.pdf#page=5&view=Assessment/InvestigationProcedures/>

<sup>34</sup> RSA §169-C:13 Burden of Proof. – The petitioner has the burden to prove the allegations in support of the petition by a preponderance of the evidence. 1979, 361:2, eff. Aug. 22, 1979.

<sup>35</sup> DCYF Policy 1213 Final Determinations and Closing of the Assessment, paragraphs VII and VIII.

"Abused child" means any child who has been:

- (a) Sexually abused; or
- (b) Intentionally physically injured; or
- (c) Psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect; or
- (d) Physically injured by other than accidental means.<sup>36</sup>

"Neglected child" means a child:

- (a) Who has been abandoned by his parents, guardian, or custodian; or
- (b) Who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, when it is established that his health has suffered or is very likely to suffer serious impairment; and the deprivation is not due primarily to the lack of financial means of the parents, guardian or custodian; or
- (c) Whose parents, guardian or custodian are unable to discharge their responsibilities to and for the child because of incarceration, hospitalization or other physical or mental incapacity;

Provided, that no child who is, in good faith, under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be a neglected child under this chapter.

Based on the statutory language, there is a substantial gap between what is required to substantiate an *abuse* report as opposed to a *neglect* report. Intentional and non-accidental physical injuries suffice for substantiation of abuse regardless of severity.<sup>37</sup> A child's health must have suffered or be very likely to suffer *serious* impairment to substantiate neglect, however. This is a troubling definition both for the severity required and the subjectivity involved, particularly when coupled with the statute's retention provision which requires the Department to purge all records of unfounded reports after three years.

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<sup>36</sup> "Physically injured" is not further defined. Sexual abuse is defined as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct; or the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children. With respect to the definition of sexual abuse, the term 'child' or 'children' means any individual who is under the age of 18 years."

<sup>37</sup> Though the statute doesn't define a threshold for severity of injury, there is some guidance in case law. In *In re Juvenile 2002-209*, a 2003 New Hampshire Supreme Court case, a mother alleged that her young child's father slapped her and left a bruise. The bruising was not corroborated by law enforcement or child welfare. The Court found there was no proof that the injury, assuming it existed, was intentional or a *threat to the child's well-being*. The Court took into consideration that it was a single event and that the father had no history of abuse.

With regard to what constitutes “threat of serious impairment,” we could find scant case law regarding the injuries or circumstances constituting threat of serious impairment. The three cases abstracted below (the only cases directly on point) demonstrate that it is a high bar.

In *In re P. CHILDREN* (2003), the health of young children was found to be at risk of serious impairment when the parent was dealing drugs out of the house; allowing older siblings to use and sell drugs in the house; and leaving the young children alone with unrelated adults and unsecured drugs in multiple locations throughout the house. The Court’s main concern appeared to be the children’s “unfettered” and continuous access to drugs, which the children could potentially ingest, leading to serious physical harm.

In *In re CRAIG T. and Megan T.* (1999), a three-year-old child and a five-year-old child were found to be likely to suffer serious impairment to their “physical, mental and emotional health” when their mother failed to protect the three-year-old from his physically abusive father and denied that the abuse occurred, despite the credible testimony of numerous eye-witnesses to the contrary. The Court noted that if the mother had claimed intimidation or given credible testimony, the outcome of the case may have been different.

In *In re HALEY K.* (2012), an appeal from a TPR case based on a neglect finding, a three-year-old child was found to be “very likely to suffer serious harm” because her father, who was incarcerated, had left her in the care of his mother, who subsequently turned the child over to foster care. The Court found: “[He] failed to make adequate provisions for his child's care and support during his incarceration. Much like a military parent who is deployed overseas, the respondent's physical unavailability did not absolve him of his parental obligation to provide for the care of his child.”

As currently defined, an abused child could have suffered physical abuse, emotional abuse and/or sexual abuse. The definition of each of these types of abuse is minimally descriptive and would benefit from clarification to ensure consistency in assessment findings. The definition of an emotionally abused (or “psychologically injured”) child is particularly inadequate. Many states have similarly succinct definitions of abuse (and neglect), though there appears to be a trend toward more descriptive definitions.<sup>38</sup>

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<sup>38</sup> For example: Arkansas – see definitions of abuse, neglect, sexual abuse <http://law.justia.com/codes/arkansas/2010/title-12/subtitle-2/chapter-18/subchapter-1/12-18-103/>  
Minnesota – see definitions of neglect, physical abuse <https://www.revisor.mn.gov/statutes/?id=626.556>  
Note that the above statutes vary the definition of “abused” depending on the age of the child.

While admittedly bare-bones, the State’s definition of an abused child is not likely to be a significant contributor to the low substantiation rate, as this is not a new definition and is similar to other States’ definitions.

On the other hand, the definition of neglect in the statute is minimal and would benefit from more specificity. The more pressing issue with this definition is the term “serious,” as discussed above. The cases we have cited above also emphasize this point.

With regard to drug (opioid) use in determining harm to a child, the legislature passed an amendment to the Child Protection Act, effective July 2016, creating a rebuttable presumption of harm when a custodial parent is dependent on or abusing opioids. This is a positive development, particularly in view of the opioid concerns within New Hampshire at the current time.

We also reviewed the statute with regard to a parent’s ability to deny DCYF workers access to the home and child (while at home) and whether that affects the disposition of the investigations. According to the New Hampshire Child Abuse and Neglect Protocol, Third Edition (2008), the statutory right to deny a caseworker access to one’s home and child (while at home) is relatively new, having gone into effect January 1, 2007. This provision (Section 169:C-134(VI)) is reproduced below, along with subsection VII, which was enacted later, apparently in some effort to mitigate the effects of subsection VI.

**VI.** At the first contact in person, any person investigating a report of abuse or neglect on behalf of the department shall verbally inform the parents of a child suspected of being a victim of abuse or neglect of the specific nature of the charges and that they are under no obligation to allow a social worker or state employee on their premises or surrender their children to interviews unless that social worker or state employee is in possession of a court order to that effect. Upon receiving such information, the parent shall sign a written acknowledgement indicating that the information required under this paragraph was provided by the person conducting the investigation. The parent and department shall each retain a copy of the acknowledgment.

**VII.** If the child's parents refuse to allow a social worker or state employee on their premises as part of the department's investigation, and the department has probable

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Florida – see definition of sexual abuse

[http://www.leg.state.fl.us/statutes/index.cfm?App\\_mode=Display\\_Statute&URL=0000-0099/0039/Sections/0039.01.html](http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0000-0099/0039/Sections/0039.01.html)

Wisconsin – see definition of emotional abuse <http://docs.legis.wisconsin.gov/statutes/statutes/48/1/02>

cause to believe that the child has been sexually molested, sexually exploited, intentionally physically injured so as to cause serious bodily injury, physically injured by other than accidental means so as to cause bodily injury, a victim of a crime, abandoned, or neglected, the department shall seek a court order to enter the premises. If the court finds probable cause to believe that the child has been abused or neglected in the manner described in this paragraph, the court shall issue an order permitting a police officer, juvenile probation and parole officer, or child protection service worker to enter the premises in furtherance of the department's investigation and to assess the child's immediate safety and well-being. Any juvenile probation and parole officer or child protection service worker who serves or executes a motion to enter issued under this paragraph shall be accompanied by a police officer.

We do not know how often parents choose to deny Department caseworkers access to their children, but this provision is concerning even if rarely elected. We did see it happening in some of the cases we reviewed. The other available methods to access potential victims are not ideal. Social workers can interview the children in a public place (typically, school) without parental permission in most circumstances. The child interviewed at school may be uncomfortable, and the social worker loses the opportunity to assess the home environment and corroborate details from the child's interview (if the abuse occurred in the home). In addition, the parents may keep the child out of school if they suspect the social worker will go there next. The youngest children, who are most at risk and may not be enrolled in daycare, could potentially be off-limits. With court orders, law enforcement officers and social workers can enter the home if access is denied and certain criteria are met, but taking this route may not be conducive to an effective working relationship between the parents and DCYF.

While we did not find the relevant Child Protection Act provisions to be significantly out-of-line with many other States' child welfare laws, there does appear to be a de-emphasis on neglect, as evidenced by the "serious" language in the definition of neglect (but not abuse) and the right-to-deny-access provision. In most neglect cases in particular, examining the home environment is a necessary component of a quality protective investigation/assessment. We are especially concerned about the implications of the provision for children aged 0-3, who may be at heightened risk of abuse and neglect, due to their age and inability to report their concerns. Though the definitions of different types of *abuse* would benefit from significant revision, it seems unlikely that these definitions stymie caseworkers to the extent the *neglect* definition may.

## Policy

We have cited DCYF policies throughout this report. Apart from those citations, we reviewed DCYF policy for areas that were directly related to the major findings from the case reviews. One of those areas pertains to making collateral contacts in an assessment.

DCYF policy 1205 notes that the social worker must make at least two collateral contacts during the course of the assessment. The collaterals can include any person in the community able to provide information about the family, including schools, medical staff, social service agencies, hospitals, police, friends, family, etc. If a “professional reporter” (see below) made the report, then contact with the reporter can be considered one of the collaterals.

The social worker can make contact without the parents’ knowledge if they can justify it with one of the following reasons.

1. The CPSW has reason to believe that a serious emergency exists, which endangers the health and safety of the child;
2. The CPSW has attempted to inform the parents of the intent to make collateral contacts;
3. Based on the intake referral, the CPSW does not have enough information to evaluate the seriousness of the referral; and/or
4. The CPSW believes the safety of the collateral could be in jeopardy if the parents are informed.

Because of the focus on confidentiality, collateral contacts can be provided very limited information only on a "need to know" basis.

In our review, contacts with law enforcement and the medical community (which were usually in the form of a letter or email to ask if they had any information about the family) were the most frequent collaterals, and we did not often see contacts with people who might have more first-hand knowledge of the families’ circumstances. In stakeholder interviews, we also heard that some social workers tend to make the most convenient collateral contacts in order to meet the requirement while others make contacts with persons who they deem knowledgeable about the family’s situation.

Given our concerns about adequate assessment of risk of harm to children and safety planning around the risks, we view collateral contacts in assessments as particularly relevant for improving the quality of assessments.

In another area, we did not find any policy pertaining to drug testing of DCYF-involved parents with regard to the recent statute on opioid use and child welfare. We understand that it is early to be looking for policy on a very recent statute. Our recommendations, however, are that DCYF take advantage of the opportunities provided by SB 515 and employ drug testing when indicated in assessments, particularly where newborns and very young children are involved in reports related to parental drug abuse, for example, when newborns test positive for illegal drugs.

***Sub-Question 2: Are DCYF staff and attorney training adequate to carry out essential functions related to the health, safety, and life of children in the care and responsibility of DCYF?***

There is not a process in place for DCYF's attorneys to receive pre-service training in child welfare, although there are some ongoing training opportunities through conferences, etc. Attorneys do receive training to earn Continuing Legal Education credits, but that training may or may not be in child welfare related issues. The areas of attorney training that we see as relevant and needed here are related to our findings in the case review, the following in particular:

- ◆ A clear understanding of what risk of harm entails and how that plays out in maltreatment assessments where immediate safety may not be in jeopardy but clear risks of future harm to children exist. There is simply too much room for interpretation of the State's statute on risk of harm for social workers to make accurate decisions and act on the children's behalf, and attorneys and DCYF assessment staff should have a solid grounding in these issues. Currently, we believe that some decisions are made about whether an assessment is founded or not based on what either the social worker or attorney believes will be acceptable to the court and AAU, rather than on the perceived risk of harm to the child. Training may not resolve all of this, but it should be a part of the solution.

***Key Points . . .***

***Staff attorneys do not receive pre-service training in child welfare.***

***Social worker and supervisor training needs strengthening to focus on clinical assessment of child maltreatment, trauma, and provide for an adult learning approach to training.***

***Supervisors need training sooner after becoming supervisors, and in clinical supervision.***

***In-service training should be focused on advanced skill-building in child protection for supervisors and workers.***

- ◆ Although the State has a vague statute on emotional maltreatment and neglect, our case review indicated a need for increased understanding of this important issue among DCYF social workers and attorneys so that it can be addressed appropriately in assessments.
- ◆ Training is needed on the implications of determining if a report of maltreatment is founded or unfounded, and the effects of those dispositions on future assessments of safety and/or risk of harm. We heard multiple times in our stakeholder interviews that it does no good to make an internal finding of founded in an assessment, since the only repercussion is to deny the perpetrator access to jobs involving contact with children. We disagree on the basis that a number of the assessments we reviewed, in our opinions, should have been determined founded and action taken to protect children, including filing in court if needed. Dispositions in past assessments also have an effect on whether or not a future report is determined to be high priority or not, e.g., it makes a difference if a child has had a string of founded vs. unfounded reports in determining the priority level of a new report. Finally, we believe that the practice of determining reports to be unfounded when serious incidents clearly occurred warrants further consideration.

***Some stakeholders interviewed about training indicated that ongoing training beyond the first year does not often occur. They noted that the training should be more focused on the work that CPSWs are required to do and that trainers are not always able to link policy and requirements to actual practice.***

With regard to training of social workers, there are both pre-service and in-service training programs in place. The first tier of the pre-service training is designed to be provided during a new social worker’s first three months on the job and prior to the social worker receiving active cases. The second tier must be completed within the first six months of employment, and after case assignments may already be in place. The division of the pre-service training was put into place to allow new social workers to receive cases sooner after employment.

We reviewed the training materials provided by DCYF and found that, while a great deal of the materials cover policy and requirements issues well, most of the materials are not focused on building the essential skills that new social workers need in order to work effectively with children and families. For example, from what we know about how adults learn, providing primarily lecture materials and new information is not generally effective. The literature tells us that training and coaching of staff based on a 70/20/10 model of adult learning is more effective, whereby adults learn 70% of what they know from doing the work (application of learning and coaching), 20% from observation of the practices by others including coaching and

mentoring, and 10% from traditional training and knowledge transfer.<sup>39</sup> Some learning professionals suggest that at least half to as much as 90% of class time in training should be spent on practice as opposed to content delivery in order to promote skill building.<sup>40</sup>

The current DCYF training is heavily weighted toward the 10% of traditional training and knowledge transfer with little opportunity for application of skills, practicing, and feedback. Our review of the materials, along with comments from stakeholders interviewed, suggest that there is a heavy emphasis on content without much interaction and practical application of the materials. We heard from some stakeholders that social workers are often unprepared to take on field work after completing the pre-service training. About half of the stakeholder interviews indicated that social workers may be rushed through training in order to assume a caseload. There were also some concerns noted that new social workers receive caseloads prior to completing the initial pre-service training.

In addition, concerns were raised about the content of the training. Some stakeholders noted that the trauma-focused training is helpful, but that everyone may not receive it. There was content devoted to the NHIA process for identifying safety and risk factors, but the practical application of those processes and tools in the cases we reviewed did not support consistent or substantive use of the tools/processes in actually identifying or acting on safety and risk factors in the field. Similarly, while the training materials are framed within the context of the Department's Solution Based Casework (SBC) practice model, we did not find widespread acceptance among stakeholders of SBC as a means of working with children and families, particularly as it relates to safety and risk. To be clear, some of the deficits noted in using SBC and NHIA may reflect implementation shortcomings in trying to roll out new initiatives when staffing pressures negate the agency's readiness for new initiatives, and may not be a reflection on the usefulness and applicability of the initiatives themselves.

Our own review of the training materials indicated that the practice areas that we have the greatest concerns about are not adequately addressed in the training, including the following:

- ◆ Identification of risks of harm to children, including the family's underlying conditions that contribute to the risks, are not well represented in the training;

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<sup>39</sup> McCall, Morgan, Michael M. Lombardo and Robert A. Eichinger. Center for Creative Leadership Greensboro, N.C. Accessed at: : <http://www.trainingindustry.com/wiki/entries/the-702010-model-for-learning-and-development.aspx>

<sup>40</sup> Pollock, Roy, Andrew Jefferson, and Calhoun Wick. *The Field Guide to the 6 Ds*. 2014, San Francisco, CA. Wiley Publishers.

- ◆ We did not see substantive content devoted to emotional maltreatment and neglect of children;
- ◆ There was insufficient attention to identifying appropriate collateral contacts in assessments and gathering information from collaterals about safety and risk of harm to children;
- ◆ There was little or no discussion on synthesizing information gathered in an assessment, reaching an appropriate conclusion, and documenting the information in ways that will stand up to the scrutiny of the courts and the Administrative Appeals Unit; and
- ◆ The training materials reviewed seemed heavily focused on assessing the “here and now” of whether a child has been injured (immediate safety), and were light on protecting children from less immediate and obvious injuries (risk of future harm). This finding regarding training seems to strongly support the findings of our case reviews.

With regard to training of supervisors, DCYF has an initial supervisory training that it offers every two years. It is a five-day training conducted by a contract trainer. New supervisors must wait until the training is offered after they are hired or promoted, which could be a considerable time. Supervisors may start their supervisory duties without going through the training. We also heard that this training is rudimentary and that greater focus should be placed on leadership through supervision. In addition, DCYF requires new supervisors to take the State-provided supervisor training, which covers issues such as performance appraisals.

We did not get a sense of a strong in-service training program for either social workers or supervisors. Although there are requirements for annual training and a number of ways to achieve the training hours, there does not seem to be an organized approach to skill-building or advanced practices in key areas on an ongoing basis, and staff may obtain in-service training hours in areas that are not directly focused on their work.

Based on the findings of the case review and the areas needing the most strengthening in our opinion, we believe that supervisory skill development should be focused on clinical supervision, helping social workers identify and address key areas regarding safety and risk of harm, and conducting thorough assessments.

In terms of the capacity of DCYF to deliver training effectively, our understanding is that the training unit is composed of two staff members. There is a contract with the University of New Hampshire that is staffed with administrative staff and four training coordinators who do not actually deliver the training themselves. With some exceptions, training to staff is delivered by

DCYF social workers and supervisors. While we heard information that suggests that the direct experience of social workers and supervisors benefits trainees, there is much more to suggest that a reliance on social workers and supervisors as trainers is ill-placed.

This report notes extensively that existing caseloads of assessment staff are unmanageable and contribute to undesirable results in assessments. In addition, we reviewed DCYF's March 2016 organizational charts and attempted to hand count the number of supervisors who were responsible for supervising more than five social workers (the CWLA recommended standard). We think this number might be close to one-third of current supervisors who directly supervise social workers, but there may be more reliable information on supervisor-to-worker ratios. With DCYF's high turnover rate among social workers, a number of stakeholders suggested that it is very difficult to ever have a solidly trained, experienced work force in place, placing high demands on supervisors to guide their often-new social work staff through casework processes. Asking supervisors and social workers to add training to their already overworked schedules further diminishes the support that staff in the field need to do their jobs well. In our opinion, social workers need to be available to work with children and families, including assessing reports of maltreatment, and supervisors should be supervising those staff diligently, rather than being called upon to train new staff in DCYF.

***Sub-Question 3: Are identified DCYF resources adequate to support child protection work by staff in the field and the agency's attorneys?***

### Assessment Staffing

As part of this sub-question, we examined the staffing resources for DCYF assessment staff since their sole responsibility is to assess incoming reports of alleged child maltreatment and make decisions about the immediate safety and risk of harm to children. While other DCYF staff are also concerned with child safety and risk, e.g., foster care workers, adoption staff, the assessment workers were the focus of our review.

#### ***Key Points . . .***

***The current number of assessment social workers and supervisors is insufficient to cover the incoming workload.***

***The backlog of overdue assessments and high vacancy rates among assessment staff contribute to the workload shortage and should be resolved.***

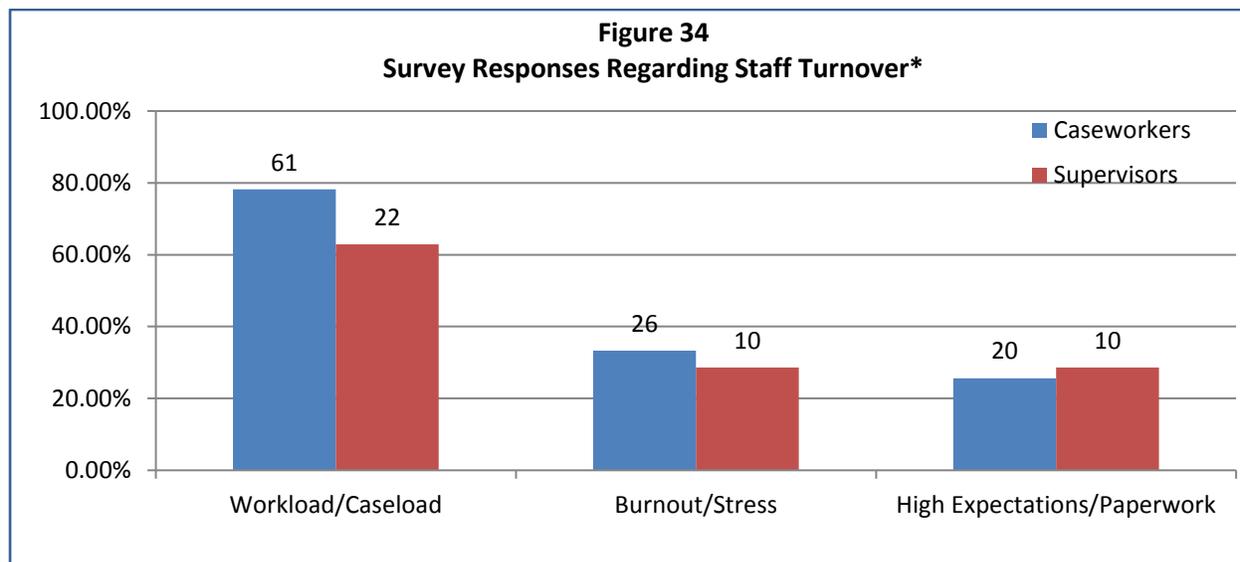
***There is not a voluntary services program in place for at-risk families and children, limiting the ability to prevent future maltreatment.***

Probably more than any other comment we heard across the range of stakeholder interviews was that DCYF staff are incredibly dedicated to their work and desire to do a good job. Even among stakeholders that identified other shortcomings within the system, there was general agreement that the current staff are committed and give much of themselves to ensuring the safety of children. Although we heard concerns about staff only being available during normal agency work hours, many stakeholders commented that the staff often work on their personal time to try and stay abreast of the incoming work.

***Stakeholders cited the effects of worker turnover, including starting all over with the family and not having time to dig into root causes of the families' problems.***

Nonetheless, most stakeholders we interviewed made references to the very high caseloads of assessment workers, and to the workers' need to move quickly from one new assessment to another, affecting the ability of staff to complete assessments timely and to conduct thorough assessments. Some comments suggested that the most the workers can do is to triage incoming assessments. We heard from some social workers that they had caseloads as high as 70 open assessments, and of the 33 social worker survey respondents responsible for assessments, the average current monthly caseload was 53.85 (range 8 to 134). Thirty-six survey respondents responsible for assessments added that the average number of new assessments newly *assigned* to them each month was 15.03 (range 4 to 23).

Approximately half of the interviewed stakeholders related the caseload problem to staff turnover. Caseworker and supervisor survey respondents were asked to identify the factors that contribute the most to staff turnover. Birth parents and foster parents interviewed noted that worker turnover is a problem and puts children in danger. For survey respondents, workload and caseload issues represented the overwhelming majority of reasons cited for staff turnover, followed by burnout and stress and high expectations/paperwork. **Figure 34** illustrates these responses:



\*Note: the 78 caseworker and 35 supervisor respondents to this question were allowed to identify as many reasons as they saw fit, so the counts are duplicative.

Stakeholders interviewed noted the flow of Child Protection Social Workers (CPSWs) to the Juvenile Justice side of the DCYF as a factor in staff turnover. We heard that whenever there is a vacancy among Juvenile Probation and Parole Offices (JPPO), numerous CPSWs inevitably apply for the positions. Primary reasons given are the lower caseloads among JPPOs, shorter working hours, and the ongoing opportunity to work with children with less stress than social workers incur on the child protection side of the house.

In addition to reviewing current staffing levels and turnover among assessment staff, we reviewed vacancy rates for assessment workers. We had access to DCYF assessment staffing numbers for the eight-month period of December 2015 to July 2016 showing 84-85 assessment worker positions allocated. However, on average for the eight-month period, almost 28 of those positions monthly were either vacant or staff occupying the positions were not available to conduct assessments due to being in training or on leave. That means that, on average, DCYF has a vacancy rate of about one-third of its assessment social workers, and that somewhere between 54 and 59 social workers are covering the work of 84-85 positions monthly.

We find DCYF’s vacancy rate of approximately 33% each month among assessment social workers to be high. For example, the University of Southern Maine reported that some vacancy rates for public child welfare workers were significantly higher than nine percent, as compared

to those of other state and local government workers (1.5%).<sup>41</sup> The Child Welfare League of America reported that child welfare position vacancy rates often surpass 12%.<sup>42</sup> A 2001 survey of 43 state and 48 county child welfare agencies reported an average annual worker turnover rate of 22% and a vacancy rate of 7%.<sup>43</sup> We did find a 2007 study citing child welfare vacancy rates nearly as high as New Hampshire, while calling for improvements in this area. The study cited the statewide child welfare vacancy rate at 31% with turnover rates highest in case management and investigations.<sup>44</sup>

The effects of worker turnover show up directly in the experiences of children and families with the system. For example, youth in care or alumni of the State's foster care system noted that social workers are not consistent. One youth indicated having had 10 different social workers, and that when they get connected, the workers leave.

The vacancy rate includes the following on average for the eight month period of staffing data provided:

- ◆ Of vacant positions, almost half were due to workers being off the job and in training which may possibly be attributed to a high turnover among assessment social workers. Although we cannot substantiate that as the reason, the American Humane Society cites 4.2 hours away from the job for training as a monthly average;<sup>45</sup>
- ◆ Of vacant positions, over a fourth were due to workers being on leave which may be attributed at least in part to the demands of the job, but which likely also includes other forms of leave, including maternity leave; and
- ◆ Of vacant positions, nearly a fourth was due to positions being unfilled.

For the one year period of July 2015 to June 2016, the number of reports screened in for assessment averaged over 873 reports per month. For an average of about 56 available social

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<sup>41</sup> University of Southern Maine. *Recruitment and Retention of a Qualified Workforce: The Foundation of Success (webinar)*, 2008. Accessed at: [http://muskie.usm.maine.edu/helpkids/tele\\_pastdetail.htm#april29](http://muskie.usm.maine.edu/helpkids/tele_pastdetail.htm#april29)

<sup>42</sup> Child Welfare League of America. *Child Welfare Workforce*. Research Roundup. September 2002. Accessed at: <http://66.227.70.18/programs/r2p/rnews0209.pdf>

<sup>43</sup> American Humane Association. *The Study of Workload in Child Protective and Child Welfare Services*. Protecting Children. Vol. 23, No. 3, 2008. Accessed at: [http://www.nccdglobal.org/sites/default/files/publication\\_pdf/workforce-estimation.pdf](http://www.nccdglobal.org/sites/default/files/publication_pdf/workforce-estimation.pdf)

<sup>44</sup> North Carolina Division of Social Services and the Children's Resource Program. *Child Welfare Worker Retention*. Children's Service Practice Notes, Vol. 12, No. 1, January 2007. Accessed at: [http://www.practicenotes.org/vol12\\_no1/cspnv12n1.pdf](http://www.practicenotes.org/vol12_no1/cspnv12n1.pdf)

<sup>45</sup>American Humane Association, 2008.

workers to conduct these assessments, that means each worker is responsible for an average of between 15 and 16 new incoming reports monthly.<sup>46</sup> Given these numbers, we believe that 84-85 hired, trained, and deployed on-the-ground assessment workers is insufficient to handle the average number of incoming reports of maltreatment timely and appropriately.

The Child Welfare League of America (CWLA), a long-time nationally recognized organization representing both public and private child welfare agencies in the country, provides recommended caseload staffing standards in child welfare. Many public and private agencies around the country rely upon CWLA standards as the primary set of expectations for staffing child welfare programs and, indeed, some settlement agreements resulting from class action lawsuits brought against many public child welfare systems refer to CWLA standards as remedies in the agreements.

The CWLA standards, which we believe to be reasonable, recommend no more than 12 active assessments per social worker at any time. Further, the standards recommend no more than five social workers be assigned to a single supervisor.<sup>47</sup> We are relying upon these standards in evaluating the New Hampshire system and in making our recommendations.

Our findings with regard to assessment staffing are as follows:

- ◆ Ninety assessment social workers trained and deployed on the ground each month are needed to keep up with the volume of incoming child maltreatment reports.

We used DCYF's data to compute what we believe to be an appropriate number of assessment social workers needed to maintain the standard and carry out assessment activities within DCYF's policy time frame of 60 days. We used the average number of incoming assessments monthly for the 12 month period noted above (874.33, with a standard deviation of 87.3912). We also used the average length of time in which social workers were able to complete an assessment *if they completed it within the 60-day policy time frame* (36.74 days, with a standard deviation of 7.1196 days). We did not use the actual time to complete assessments for obvious reasons, since so many of them exceed the 60-day timeframe, often by several months and our desire is to recommend what is needed to conduct thorough assessments within DCYF's prescribed timeframes.

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<sup>46</sup> Geographic distribution may vary on this number.

<sup>47</sup> Child Welfare League of America. *CWLA Standards of Excellence for Services to Abused or Neglected Children and their Families*, Revised 1999. Accessed at: <http://66.227.70.18/newsevents/news030304cwlacase-load.htm>

When we applied these numbers to a maximum case load of 12 open assessments, we determined that 90 is the minimum number of assessment social workers needed. This number assumes that there will always be a minimum of 90 social workers and 18 supervisors deployed on the ground and conducting assessments every month. However, simply allocating that number of social workers will not ensure availability of all the staff given DCYF's high vacancy rate among assessment workers.

When we factor in a 33% average monthly vacancy rate, the number of assessment social workers needed to ensure that 90 workers are deployed on the ground and conducting assessments in any month is adjusted to 134 social workers<sup>48</sup> and 27 supervisors (134 workers/5 workers per supervisor) if the current vacancy rate holds. This number is more than twice the current number of social work staff available for conducting assessments monthly.

- ◆ The vacancy rate may be mitigated by hiring and supporting additional assessment social workers.

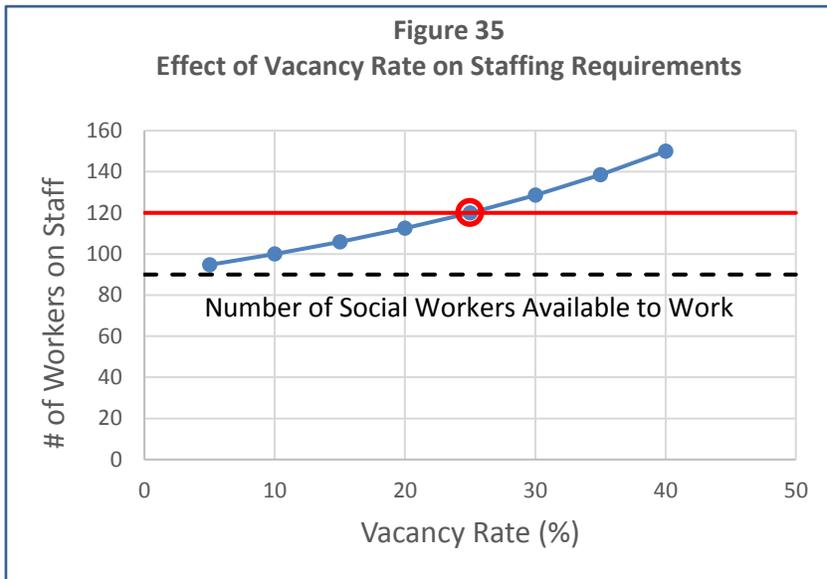
As noted above, we believe the current vacancy rate among assessment social workers is high. Since comments from many people that we interviewed indicate that absences are due in large part to (a) high staff turnover resulting in new workers continually being in training and not on the job, and (b) medical leave, some of which may be attributable to the demands of the job, we believe that New Hampshire has an opportunity to decrease the vacancy rate by adding a sufficient number of staff to reduce the demands of the job and keep more staff from turning over and/or being absent due to possible work-related stress. If New Hampshire can reduce the average monthly vacancy rate to at least 25%, and we believe that is possible, especially since nearly a fourth of the vacancy rate is due to unfilled positions, it would mean that 120 social workers and 24 supervisors would be needed to ensure the deployment of 90 on-the-ground assessment workers monthly. If further reductions in the vacancy rate can be achieved, fewer workers will be needed, as illustrated in **Figure 35**.

In particular, we believe that steps to address the work-related stress that likely contributes to worker absence and turnover may be effective in reducing the vacancy rate. For example, in addition to integrating trauma-informed practice into its work with children and families, DCYF has indicated interest and plans to implement organizational wellness strategies with a trauma-informed approach. Dartmouth University has indicated an interest in partnering

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<sup>48</sup> The formula we used to compute this is: 90 minimum workers is equal to 67% on-the-ground staff averaged monthly (100% less the 33% vacancy rate) multiplied by  $n$ . ( $90 = .67 \times N$ ,  $N = 90/.67$ ,  $N = 134$ )

with DCYF to train supervisors on addressing trauma with their staff. We understand that some training plans are in place, but that resource issues may affect full implementation. Given the stress identified among assessment social workers in particular, we believe that the steps DCYF is taking in this direction are positive and should be strengthened in order to promote a more stable and able work force.



### Services

Our understanding is that, until September 2011, children and families in New Hampshire had access to a voluntary services program that they could access by opening a case with DCYF, even when assessments of maltreatment in their families were determined to be unfounded. The current absence of such accessibility to voluntary services in unfounded assessments (due to DCYF’s fiscal constraints) can lead to some children remaining in their own homes at high risk of future harm without receiving services or DCYF involvement/monitoring. In founded assessments, the options available to DCYF in ensuring that needed services are put into place include making a court finding of ‘founded’ and opening a service case where either the child(ren) are removed from their homes and placed in foster care or the children remain in the home, and opening “B cases” where families admit fault and agree to open a service case without court involvement. For unfounded assessments, DCYF can recommend that the families seek out services on their own. Based on our concerns in seeing patterns of multiple reports on families, mostly determined to be unfounded but involving similar threats of harm to children, we believe that other options are needed to ensure that risks of harm to children are adequately addressed.

We heard from some stakeholders that social workers may leave assessments open because of concerns about harm or risk of future harm to children and, in the absence of a voluntary services program in the State, workers may use an extended assessment period to check on the

children’s safety. While we cannot dispute the intent and desire of the social workers to use the assessment period as a pseudo-service delivery period, we did not see this as an effective way to address the concerns that place children at risk of future harm.

Survey respondents were asked to give their opinion on the effectiveness of DCYF’s ability to place services in the home to ensure children of New Hampshire are free from immediate danger and risk of future harm. **Table 8** shows the results:

<b>Table 8</b>				
<b>DCYF’s Ability to Place Services in Homes to Ensure Children are Free from Immediate Danger and Risk of Future Harm</b>				
	<b>Always Effective</b>	<b>Usually Effective</b>	<b>Sometimes Effective</b>	<b>Rarely or Not Effective</b>
Social Workers (83)	0	25/83 (30.1%)	44/83 (53.0%)	14/83 (16.9%)
Supervisors (34)	0	9/34 (26.5%)	22/34 (64.7%)	3/34 (8.8%)
Educators (304)	2/304 (1%)	45/304 (14.8%)	153/304 (50.3%)	104/304 (34.2%)
Law Enforcement (37)	2/37 (5.4%)	18/37 (48.6%)	14/37 (37.8%)	3/37 (8.1%)
Medical Providers (94)	2/94 (2.1%)	24/94 (25.5%)	44/94 (46.8%)	24/94 (25.5%)
Service Providers (21)	1/21 (4.8%)	9/21 (42.9%)	10/21 (47.6%)	1/21 (4.8%)
<b>Total (573)</b>	<b>7/573 (1.2%)</b>	<b>130/573 (22.7%)</b>	<b>287/573 (50.1%)</b>	<b>149/573 (26%)</b>

***Some stakeholders indicated that access to in-home services is limited, and that many families need these services to prevent placement of their children. Some comments suggested that children must qualify for the services provided through the mental health system, and they may not always meet the qualifications.***

Most survey respondents indicated that placing services in the homes were either sometimes effective (50.1%) or rarely/not effective (26.0%). As noted in Research Question 2, sub question 6, birth parent survey respondents were asked to identify in their

most recent involvement with DCYF which services they received and which services were needed but not received. The most common answer for services received were mental health services, followed by educational services, and the most common service needed but not received was financial services. Birth parent survey respondents were also asked to identify which services were least often available. The three most common answers were mental health services (12 of 19), educational services (nine of 19) and housing and financial assistance (eight of 19). CASA focus group members also highlighted the difficulties with accessing mental health services noting months-long delays to get children in for mental health services, even when children are traumatized from removal or maltreatment.

Some stakeholders noted that one of the biggest problems is finding a treatment resource or other resources. The opiate crisis makes this worse as the rehabilitation centers have long wait lists. If someone has a dual diagnosis, they indicated that there is basically nothing available. Other concerns pertained to the prohibitive cost to some parents to receive services, difficulty of incarcerated parents receiving services, and difficulty in finding therapists to deal with the trauma that children experience in the system.

***Some stakeholder comments suggested that parents must locate needed services on their own, and if they are unable to obtain them, that is held against them.***

One of the service areas in which DCYF is making some gains is in trauma-informed practice with children and families. Trauma-informed work in child welfare is becoming a major focus nationally and the Children’s Bureau, U.S. Department of Health and Human Services, has funded several states to put trauma practices into place in child welfare. In New Hampshire, through a federal grant and DCYF’s work with Dartmouth, around 400 therapists have been trained in two evidence-based trauma-informed models, although there has been some turnover among trained providers and all are not within the State’s managed care system. DCYF staff have also been trained on trauma screening, although DCYF is aware that workload issues affect the ability of its staff to practice trauma screening with fidelity to the model. A concern is that trauma-informed treatment is not always available for reasons noted above, even when screening indicates the need. Trauma screening is also only performed in open cases, not in assessments.

Stakeholder interviews reinforced this lack of availability of services in their interviews. Some also identified the need for services related to trauma. We heard from some stakeholders that youth in care may not see their siblings regularly, sometimes for months at a time, and also

may not see parents routinely when in care. They noted a requirement to obtain permission for phone calls with family members and the length of time it takes to get permission. Over-medication was also described by some stakeholders. In our opinion, these issues point to the need for trauma-informed services to support youth in care and help them deal with behaviors and experiences that have the potential to worsen their foster care experiences.

As noted above, the case review found that mental health, domestic violence and substance abuse were among the most common underlying conditions impacting children and their families. **Table 9** provides a summary of the responses:

<b>Table 9</b> <b>Most Commonly Identified Needs by Survey Respondents, Duplicate Count*</b> *Percentages will not add up to 100% due to the duplicate count					
	Substance Abuse	Mental Health	Domestic Violence	Parenting or Supervision	Housing/ Financial Concerns
CAC (6)	1/6 (16.7%)	5/6 (83.3%)	0	0	0
Educators (337)	101/337 (30.0%)	32/337 (9.5%)	31/337 (9.2%)	69/337 (20.5%)	48/337 (14.2%)
Medical Providers (108)	46/108 (42.6%)	15/108 (13.9%)	7/108 (6.5%)	33/108 (30.6%)	12/108 (11.1%)
Service Providers (21)	8/21 (38.1%)	8/21 (38.1%)	3/21 (14.3%)	8/21 (38.1%)	8/21 (38.1%)
<b>Total (472)</b>	<b>156/472 (33%)</b>	<b>60/472 (12.7%)</b>	<b>41/472 (8.7%)</b>	<b>110/472 (23.3%)</b>	<b>68/472 (14.4%)</b>

Substance abuse as an underlying issue and service need was the most common need identified across all survey respondents to the question, followed by parenting/supervision concerns.

Further, nearly half of interview and focus group participants also identified that drug treatment services, including substance abuse inpatient and outpatient treatment were needed.

***Some stakeholders noted the effectiveness of drug courts as a means of dealing with parental substance abuse.***

We recognize that substance abuse is an important issue in child welfare in New Hampshire, and that the rise in opioid use is one of the

precipitating factors in requesting this independent review. Throughout the report, we have noted issues with regard to substance abuse, although in most cases we could not determine from the case reviews if opioids were the specific drugs involved. What we did see was a large number of families where parents seemed to be drug involved and, as was the case in the large majority of our cases, if specific harm to a child could not be observed and documented, those situations ended up being determined unfounded, possibly having referrals to services made, and no follow up to determine if the families actually engaged in the services.

Our findings with regard to the families and children reviewed were that identifying and addressing effectively the underlying conditions in the families that place children at risk of harm, including substance abuse by the parents, was a weak area of practice.<sup>49</sup> Further, the lack of clear assessment and addressing risk factors for children is among our greatest concerns in this review, and that is where we would expect identification of and attention to parental substance abuse concerns to occur.<sup>50</sup>

Among the underlying family conditions, i.e., complicating factors, identified for Population 1, substance abuse issues ranked third (about 42%), after mental health and domestic violence in what the cases revealed. This is similar roughly, to recent public information about the 44% incidence of parental substance abuse in child maltreatment reports in New Hampshire.<sup>51</sup> Our conclusion from this is that if there is over 40% of parental substance abuse involved in child maltreatment reports in the State, and less than 10% of *all* maltreatment reports are determined to be founded (regardless of parental substance abuse or some other reason), there is a substantial gap in getting services to families where children may be at risk of maltreatment. We are careful to note that simply because a parent abuses drugs does not automatically place a child at risk of harm. However, when a report of alleged maltreatment rises to the level of seriousness to meet the policy for screening in and assessment and parental substance abuse is identified as an underlying condition, but no finding is made and there is no way to know if families receive needed services, we are concerned. This is particularly true since we can only know whether families receive needed services if the report is founded and a service case is opened.

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<sup>49</sup> See Figure 9, Identification and Assessment of Safety, Risk and Underlying Conditions Concerns on page 33, and

<sup>50</sup> See Figure 2, Reasons for “No” Responses to Research Question 1 on page 23, and Figure 7 Assessment for Safety, Risk and Underlying Conditions During Assessment Contacts on page 30

<sup>51</sup> See recent news article, *44 percent of NH's DCYF cases involved substance abuse in 2015*, September 29, 2016. Accessed at: <http://www.nh1.com/news/44-percent-of-nh-s-dcyf-cases-involved-substance-abuse-in-2015/>

We will make recommendations with regard to treatment options for addressing the substance abuse issue in New Hampshire. However, unless DCYF social workers, the courts, and the AAU are willing to acknowledge situations where parental substance abuse places children at risk of harm, to require action in those situations, and to compel parents to receive needed services, specific treatment options and recommendations may be a little down the road at this point.

We do want to acknowledge the State's passage of an amendment to the Child Protection Act, effective July 2016, creating a rebuttable presumption of harm when a custodial parent is dependent on or abusing opioids. We view this as a positive development and believe it offers more opportunity than has previously been present to address this issue. However, DCYF staff will need to be trained and coached in assessment processes that lead to clear identification of these issues as risk factors, attorneys will need to be supportive of making findings, the courts and AAU must be open to considering these concerns in making decisions about the dispositions of assessments, and DCYF policy will need to take full advantage of the statute to protect children. At that point, the State will need to consider how effective its existing services are to meet the needs of families and children. Since we have no basis for knowing how many of the families in our review actually receive needed substance abuse treatment services, we are stymied in our ability to recommend the level and intensity of service additions needed at this point.

***Sub-Question 4: Are interagency relationships and interactions adequate and functional to ensure the health and safety of children in DCYF's care and responsibility?***

Information on the question of interagency relationships and interactions came primarily from stakeholder interviews and survey responses, although we were able to determine some interactions from information in the case reviews.

Interagency relationships that fell within the scope of our review seemed to be focused on reporting maltreatment to DCYF, sharing information, coordination of efforts in assessments/investigations (particularly for law enforcement), and after-hours coverage of maltreatment reports.

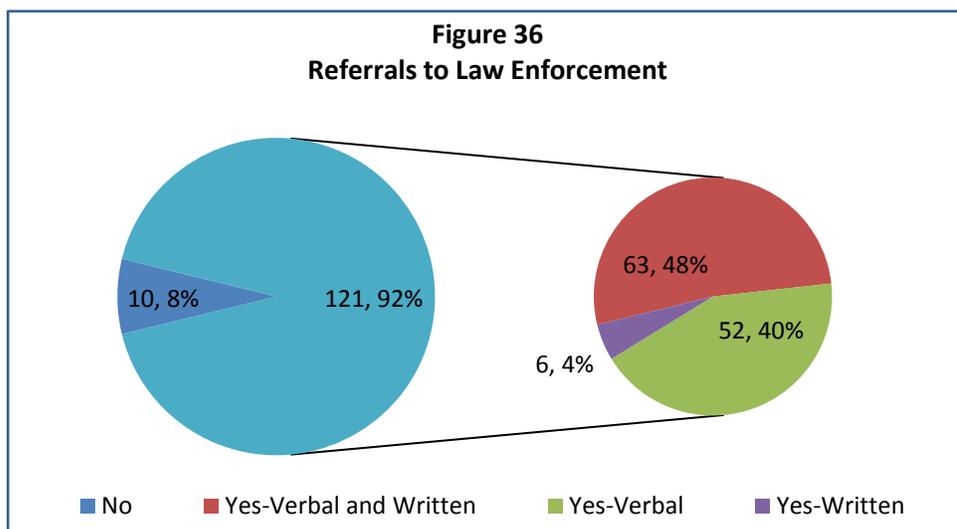
***Key Points . . .***

***More engagement of law enforcement in planning, implementing and monitoring after-hours assessment processes is needed.***

***Greater engagement and collaboration with education and the medical community are needed.***

There are clear concerns about sharing information between DCYF and law enforcement in situations where criminal investigations may be involved, with stakeholders indicating that both groups sometimes do not receive the information needed. Concerns also included the inability of law enforcement to access the Central Registry in responding to reports of child maltreatment after hours.

Policy requires that when a referral is made to Central Intake, if the allegations rise to the level which requires a law enforcement referral, a verbal referral is to be made immediately, and a written referral is to be made to law enforcement within 48 hours. Although we heard examples of DCYF staff not notifying law enforcement timely in appropriate situations, the findings of our case reviews indicated that there was



most often documentation of timely notification of law enforcement in the records, as indicated in **Figure 36**. Reviewers found that 131 (41.2%) of the 318 assessments reviewed in Population 1 and Population 2 required a law enforcement referral in the PUR.

In the reverse situation, after 4:30pm, callers to DCYF’s Central Intake are encouraged to either leave a message or call local law enforcement. If calls are made after hours to law enforcement, or if law enforcement goes out on another 911 call and observes a situation rising to the level of child abuse and neglect, they will call in the referral to Central Intake during business hours. Our case review found that 54 of the 318 (17%) screened in assessments were reported to Central Intake by law enforcement. In the assessments we reviewed, law enforcement typically reported referrals to Central Intake within 48 hours of the incident (70.4% of the time).

Documentation of ongoing engagement with the law enforcement community in the case reviews was not as strong, with just over half of the 131 assessments (55.7%) warranting law enforcement engagement based on the allegations containing documentation of ongoing

engagement. Five of 13 focus groups/interviews noted a breakdown in communication between DCYF and law enforcement.

While we heard that law enforcement and DCYF staff have a great deal of respect for each other’s work and commitment and both acknowledged functional working relationships, there seems to be much room for better understanding each other’s roles. The most positive examples of effective collaboration and meeting each other’s needs seemed to involve situations where law enforcement officials and DCYF staff had strong positive relationships and could ask for and receive the needed response in situations.

There is skepticism about DCYF’s plans for after-hours coverage of maltreatment reports and investigations, and we believe this is largely due to law enforcement not being involved in developing those plans. Since law enforcement is currently responsible for after-hours coverage and understands the issues involved, it makes sense to us that law enforcement would be involved in developing solutions to the after-hours concerns. As DCYF moves toward implementation of the after-hours coverage plan, we believe it will be very important to engage law enforcement in monitoring and evaluating the plan for coverage to ensure that law enforcement officials have access to social workers’ information and expertise in working with families in crisis situation, including checking background information that is relevant to immediate interventions.

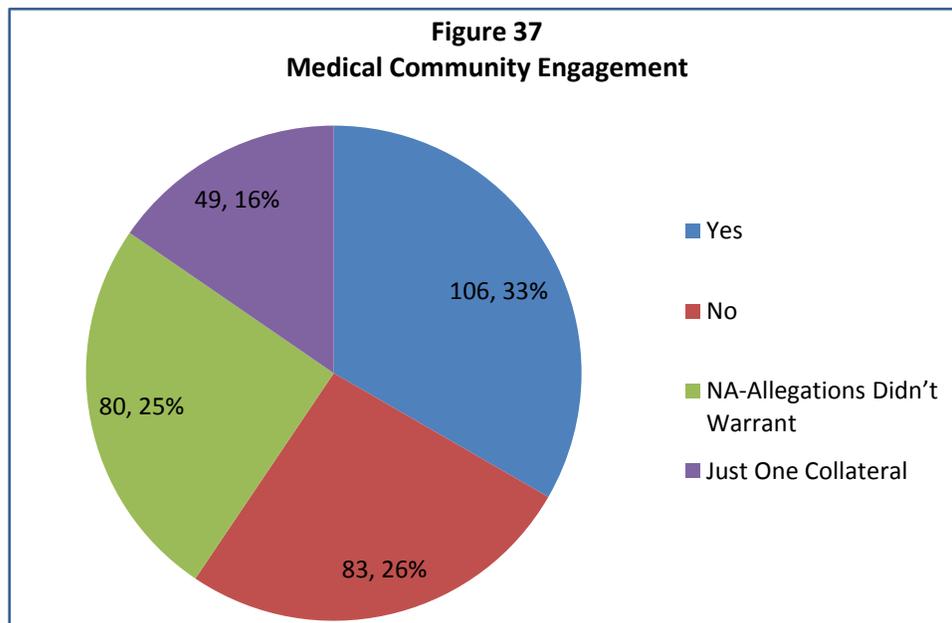
With regard to reporting maltreatment, our surveys asked respondents who they are most likely to contact if they have a concern. **Table 10** shows the responses:

<b>Table 10</b>				
<b>Who Stakeholders Contact with Concerns about Child Maltreatment</b>				
	<b>Central Intake</b>	<b>Social Worker</b>	<b>Both Intake &amp; Ongoing Worker</b>	<b>Law Enforcement</b>
Medical Providers (129)	59/129 (45.7%)	40/129 (31.0%)	20/129 (15.5%)	10/129 (7.8%)
Service Providers (22)	2/22 (9.1%)	12/22 (54.5%)	8/22 (36.4%)	0
Educators (364)	105/364 (28.8%)	141/364 (38.7%)	97/364 (26.6%)	21/364 (5.8%)
Law Enforcement (41)	13/41 (31.7%)	18/41 (43.9%)	10/41 (24.4%)	0

<b>Total (556)</b>	<b>179/556 (32.2%)</b>	<b>211/556 (37/9%)</b>	<b>135/556 (24%)</b>	<b>31/556 (5.6%)</b>
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With the exception of the medical provider respondents, who were most likely to contact Central Intake to report concerns, other respondents were more likely to contact social workers directly. While this may not support the functions of Central Intake, it may display some confidence in social workers’ attention to concerns that are raised directly with them.

Also among law enforcement survey respondents, asked if they were adequately engaged by DCYF in assessments that require a law enforcement referral, 26 of 39 respondents indicated they were very satisfied



or usually satisfied. The remaining responses were sometimes (12) or not satisfied (1).

Among the 130 medical provider survey respondents, when asked about their involvement in assessments involving medical issues, 47 (36%) respondents indicated they were either very satisfied or usually satisfied, 54 (42%) indicated they were sometimes or not satisfied, and 29 (22%) didn’t know or had no opinion. Although these responses indicate to us that work may need to be done in strengthening relationships with medical providers, the records in our case review showed that 16% had one contact between DCYF and medical providers during the assessments, and about one-third having more involvement, as shown in **Figure 37**. Checking with the medical provider was often done as one of two required collateral contacts in the assessment process. In 60 assessments (18.9%) where medical providers were not engaged or was contacted only once as a collateral, there were indications they should have been engaged based on the allegations of the assessment.

Survey respondents seemed to recognize the legal limitations and options available to DCYF in responding to reports of maltreatment, but also identified concerns with regard to general engagement of medical representatives, as indicated in the comments below.

Other survey respondents indicated that while referrals from DCYF to the Child Advocacy Centers have historically been appropriate, more recently they are receiving some referrals that are inappropriate for their process, e.g., infants. They indicated concerns that DCYF staff may not have all the information they need to make appropriate referrals. There were also a number of concerns expressed by survey respondents with regard to reporting child maltreatment and DCYF's response. A great deal of the frustration seems to go to the concerns that we have noted about focusing on immediate safety needs and requiring evidence of physical harm before intervening, as some of the comments here indicate. While we think some of this is due to limitations in the State's child protection statute, there are indications that some respondents believe this to be a reflection of DCYF's unwillingness to act in neglectful situations. Further collaboration with the education community might help to clarify perceptions that DCYF is not willing to protect children without evidence of physical injuries.

***Some stakeholder comments indicated frustration that DCYF is unable to act in situations where there is no visible evidence of maltreatment, and that verbal and emotional abuse are not addressed adequately. Some indicated noting the recurrence of incidents when DCYF does not take definitive action.***

## Discussion and Recommendations

As it currently exists, the child welfare system in New Hampshire is set up to focus primarily on immediate injuries to children suffered through abuse and neglect, with correspondingly less attention to the serious risks of future harm to children that, unchecked, may lead to serious injuries. Most parties we interviewed or surveyed acknowledge this shortcoming in the system, but the perceived reasons vary by stakeholder. Some think the statute is to blame, some think social workers do not dig deep enough or document well enough, some think the courts or the AAU set the bar so high they cannot reach it, and it goes on. Our concern, from the case reviews, is that when multiple reports of maltreatment come in over time on the same children and families involving the same risky behaviors that, upon assessment, appear to be present; when the reports are repeatedly determined to be “unfounded” because the child does not have physical injuries, even when the social worker determines the child to be at risk of future harm; and when the parents’ promise to meet their children’s immediate safety needs is one of the key determinants in calling the reports unfounded, the system is not effectively addressing the risks to children’s safety and well-being.

The factors we identified during our review that contribute to the current situation and that our recommendations will focus on correcting include the following:

- ◆ A seriously overloaded assessment work force;
- ◆ An assessment work force and legal staff that can benefit from additional training and support in identifying, documenting, and defending concerns that place children at risk of harm through neglect;
- ◆ A restrictive child protection statute that sets a high bar for determining neglect and risk of harm;
- ◆ A restrictive interpretation of the statute and a concern by DCYF that it is not able to take needed action to protect children at risk;
- ◆ The lack of options for social workers to take to protect children in unfounded assessments; and
- ◆ The lack of an effective service array even if there were legal options for compelling families to engage in services to protect their children.

In the Overview section of this report, we documented our concerns about addressing risk of future harm effectively in addition to immediate safety needs, along with the value of providing

services to families to lessen the risk of harm to children and prevent actual harm. Our findings and recommendations are organized according to what we believe should be the priorities for New Hampshire in improving the systemic capacity of DCYF to ensure the health and safety of children and families within the scope of its responsibility.

- ◆ The first priority should be to ensure that an adequate organizational foundation within DCYF is in place to provide needed services and responses to children and families in need.
- ◆ The second priority should be to make needed improvements in the quality of the services and responses by DCYF and providers to children and families in need.
- ◆ The third priority should be to monitor and adjust the response and capacity of the system on an ongoing basis in order to stay abreast of changing trends and needs within the State and to inform the State's leadership of the strengths and needs of the system.

We believe that in order to improve the timeliness and quality of safety and risk functions, a more solid organizational foundation must be in place upon which to build needed practice improvements. In particular, the existing work force will not be able to implement effective improvement strategies until it is not overloaded and stressed, as it currently is. Further, training should be adapted to the needs identified in this review, and needed statutory and policy changes should be implemented to support practice changes that should lead to improved outcomes for children and families served by DCYF.

We are describing our recommendations in several categories below, and indicating whether we regard each recommendation as *foundational*, i.e., in need of prioritized attention, *monitoring*, i.e., to track progress over time, or *practice improvements*, i.e., to follow implementation of the foundational recommendations where possible. We note that where some foundational recommendations may be delayed, e.g., where there is a need for statutory changes that should not necessarily delay the implementation of practice improvement recommendations. We do strongly recommend the addition of the recommended additional assessment staff and supervisors prior to attempting to implement practice improvement recommendations as that will only add to the current burden of assessment staff.

## Organizational Oversight

**Recommendation 1 (*Foundational and Monitoring*):** *Develop an implementation teaming structure to oversee the implementation of the recommendations of this assessment and to monitor progress and make adjustments over time as needed.* A well-established component

of the research and science of implementing major new initiatives is the use of a teaming structure to manage, provide oversight, and be accountable for implementing the initiatives effectively.<sup>52</sup> We recommend the formation of a statewide implementation team to provide broad management and accountability, in addition to sub-teams that are charged with overseeing the categories of recommendations identified here: staffing, training, policy/statutory, practice, and interagency collaboration. The sub-teams should report regularly to the statewide implementation team which will be responsible for routinely reviewing data to determine if progress is being made and/or if adjustments in the implementation strategy are warranted.

## Assessment Staffing

**Recommendation 2 (Foundational): Hire a sufficient number of assessment social workers to bring the total number of filled positions to 120, with the intent of reducing the current vacancy rate to at least 25%.** Without a commitment to address and reduce the current high vacancy rate, 120 workers will be insufficient to cover the incoming monthly workload. At this point, we do not recommend hiring up to 134 workers based on the current vacancy rate, since we believe the vacancy rate can be reduced with the recommended additional hires and the implementation of our recommendations noted below.

**Recommendation 3 (Foundational): Hire a sufficient number of assessment supervisors to bring the total number of filled positions to 24, with the intent of reducing the current vacancy rate.** CWLA standards recommend a supervisor-to-worker ratio of 1:5. We believe this is in keeping with standards that many other State public child welfare agencies strive to achieve. We also know that the quality of supervision has a major impact on the quality of work performed in the field and is the first line of quality assurance in seeing that work – in this case, the conducting of assessments - meets the State's expectations for timeliness, thoroughness, and accuracy.

**Recommendation 4 (Foundational): Resolve the current backlog of overdue assessments by assessing and closing open assessments that can be safely closed, and opening those where harm or substantial threats of future harm exist, and enforce the 60-day policy time frame for completing assessments on an ongoing basis so that a new backlog does not accrue.** If newly

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<sup>52</sup> See for example: Permanency Innovations Initiative Training and Technical Assistance Project. (2016). Guide to developing, implementing, and assessing an innovation. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.  
Accessed at: [http://www.acf.hhs.gov/sites/default/files/cb/guide\\_vol1\\_teaming.pdf](http://www.acf.hhs.gov/sites/default/files/cb/guide_vol1_teaming.pdf)

hired staff begin the rotation of receiving new incoming reports with the current backlog in place, 90 on-the-ground workers will not be able to meet policy time frames for a very long time, i.e., years. Therefore, our recommendation is for DCYF to develop a strategy to safely resolve the current backlog of assessments that have been open for longer than 60 days as an initial step. There are various ways to do this, for example, new staff could be assigned to resolve the backlog before receiving new reports, or a special effort using other staff could be deployed. If currently backlogged assessments need ongoing work and/or services to ensure child safety/manage risk, the dispositions and follow-up actions should reflect that. The goal is to get to a situation as quickly and safely as possible where the assessment work force is carrying no more than 12 open assessments and to maintain that level of work. Unless there are extenuating circumstances, where more than 60 days is needed to complete the assessment in a high quality manner, supervisors and managers should begin to monitor and enforce the 60-day completion time frame.

**Recommendation 5 (*Foundational*): *Make deliberate efforts to provide better for the well-being of assessment staff in order to reduce turnover and absences due to work demands.*** The addition of a substantial number of staff, the elimination of the current backlog, and a policy-compliant flow of assessments through the process have the potential to contribute to measurable improvements in staff well-being and the resulting vacancy rate. However, DCYF should consider additional methods to ensure that employee well-being is ensured, such as ensuring that assessment staff are fully supported and have the time needed to do their jobs well, have access to skilled supervision, and have access to resources to help them deal with the very difficult situations in children's lives that they must confront daily. In particular, we believe that the movement toward a culture of organizational wellness within DCYF through helping social workers deal with the trauma-associated stresses of their work should be continued and strengthened. Otherwise, there is a risk that newly hired staff may continue the turnover and absentee patterns that currently exist.

**Recommendation 6 (*Foundational and Monitoring*): *Implement the current DCYF plan for after-hours coverage of incoming maltreatment reports, and monitor its implementation and effectiveness jointly with law enforcement.*** Prior to and during the time period this review occurred, DCYF developed a plan for after-hours coverage of intake. DCYF administrators reviewed their plans with CSF and we found them to be reasonable, considering the fact that until the after-hours coverage is in place, specific information about the volume of after-hours intake may not be readily available. We did note some concerns by stakeholders within and outside of DCYF about whether sufficient staff had been allocated to after-hours coverage. At this point, CSF's recommendation is to proceed with full implementation and to schedule

regular meetings with law enforcement to determine the effectiveness of the after-hours coverage. Since law enforcement will continue to play a substantial role in after-hours coverage, it is important that their voices are included in determining the effectiveness of the process and in designing any modifications needed going forward. To the extent that data are available to track the volume and response of after-hours calls, that information should be used jointly with law enforcement in monitoring activities.

## Staff and Attorney Training

**Recommendation 7 (*Foundational*):** *Re-design and implement parts of the DCYF pre-service training curriculum for social workers (and include content for DCYF attorneys) to focus on the clinical aspects of working with children and families in maltreatment situations.* Areas where the current curricula need strengthening include developing a clear understanding of what risk of future harm to children entails and how that plays out in maltreatment assessments where immediate safety may not be in jeopardy but clear risks of future harm to children exist. While many stakeholders laid the concerns about not addressing risk of harm to children at the feet of the State's statute (and it is a problem), there seems to be a resignation among staff to not substantiating reports of maltreatment where risk of harm clearly exists, based on a perception of what the courts, the AAU, or the statute will support. Staff and attorneys need to make decisions based on the actual risk of harm to the child and not require that a child suffer visible injuries to determine that risk exists, and they both should have the knowledge and skills to do that. Other key areas where training curricula should be expanded include exploration of families' underlying issues that affect risk of harm to children, documentation of the existence and effects of safety and risk-related factors, presentation and defense of DCYF findings in court, use of collateral contacts to assess and determine the existence of safety and risk related concerns, and synthesis of information gathered to make appropriate dispositions of maltreatment reports. In view of the passage of SB 515, we strongly recommend training on assessing for safety and risk issues when parents' substance abuse is a factor, determining when and how to obtain needed drug testing to evaluate safety and risk to children, and taking the appropriate action based on the assessment and results of the drug testing.

The training should also be developed to be highly weighted in favor of skill-building and practical application of the competencies needed in their work, rather than focused heavily on lecture and transfer of information. In order for this to be effective, supervisors must also receive this training, and when it is implemented, our recommendation is that all current social workers and supervisors receive the training, regardless of the time they have been employed, and not limit it to new staff hired. This recommendation, coupled first with having an adequate

work force in place, will go a long way in ensuring that DCYF staff conduct thorough and accurate assessments and take the actions needed to protect children when that is appropriate.

**Recommendation 8 (Foundational):** *Ensure the availability of ongoing training that is targeted to building the skills of social workers and supervisors to do their jobs well.* Training for the sake of training is not helpful. The training should be focused squarely on skill-building in key areas of child protection work, beyond that which is covered in a basic way in pre-service training. Either training in essential skills at an advanced level or introducing new skills, ideally from the findings of DCYF's internal continuous quality improvement processes and trends in DCYF's data, would better equip staff to meet ongoing and emerging challenges in serving New Hampshire's children.

**Recommendation 9 (Foundational):** *End the reliance on existing overworked field staff to deliver training and consider a distance learning approach to training.* It is not a realistic alternative to draw staff from the field to keep pace with DCYF's pre-service and ongoing training needs. Either dedicated trainers are needed, possibly through the existing contract with the University of New Hampshire or from additional State training staff, or another alternative should be explored. In our opinion, consideration of developing a distance learning approach to both pre-service and in-service training may be a more viable alternative for DCYF than adding additional trainers. A distance learning approach, whereby DCYF designs interactive training modules covering the desired competencies for working with children and families would provide it with a flexible platform for modifying training from time to time, would accommodate travel concerns by trainees, would allow for immediate training of staff upon hiring, and would provide more active involvement of new social workers' supervisors in coaching and supporting the training while it is occurring, and permit application of learning to actual situations in the local offices. Depending upon the design, it might also alleviate concerns identified about rushing new staff through the training by allowing them the flexibility to complete the training at an individualized pace. Regardless of the format for transferring new information to staff, i.e., traditional "training," we believe it is important to include opportunities for application of learning, coaching of staff, and providing ongoing feedback, since we know these approaches affect how adults learn and develop new competencies.

## Services

**Recommendation 10 (Foundational):** *Fund the voluntary services program and provide this option to get needed services to children and families where there is high risk of harm to the child.* Children at high risk of harm in New Hampshire need options other than opening a

services case via a court finding for in home or out of home services, or having the parents admit culpability. A voluntary services program in unfounded assessments would provide another option, provided the program is funded and children and families can actually access the services needed.

**Recommendation 11 (*Practice Improvement*):** *Expand the options and requirements available for addressing substance abuse issues that place children at risk of harm.* We believe there are at least four areas of expanded services that should be seriously considered under this recommendation.

- ◆ First, increase DCYF’s capacity for screening of parents where drug abuse is alleged to have created safety threats and/or risks of harm for their children. The passage of SB 515 and subsequent amendments to State statute create the rebuttable presumption of harm to children when a parent is abusing opioids, and it permits rebuttal by evidence that a parent is complying with drug treatment. It also permits the courts to order drug testing at any point, under certain conditions, and allows discretion for DCYF to proceed with drug testing unless ordered otherwise by the court.<sup>53</sup> Given our observations in the case reviews where there appeared to be indications that parents’ use of drugs led to the reports of alleged maltreatment but where there did not appear to be drug testing, we recommend that DCYF use the discretion allowed in the new legislation to obtain drug testing when there are indications that a parent is abusing drugs to the detriment of the child’s safety or risk of harm. We believe this is particularly critical for newborn children who show signs of dependency on illegal drugs and for very young, vulnerable children. In those situations, we recommend strongly that any such referrals be screened in and assessed. Evaluation of parents’ drug use should be emphasized in assessments of maltreatment reports and appropriate testing and follow-up should occur when there is a serious risk of harm to children based on the parents’ drug use. In those situations, where it is determined, through the assessment and/or drug testing, that the parents’ drug use places the child at serious risk of harm, even if the parents are in a treatment program and promise not to engage in further drug use, the reports should be determined founded and appropriate action taken to ensure the safety of the children, including requiring that parents participate in services to treat the substance abuse in order to avoid removal of the children from the home.
- ◆ Training of DCYF staff will be needed on assessing for the presence of and harm imposed by parental drug abuse, along with collaborative work with other state agencies whose support in drug screening may be needed and available to implement this recommendation, e.g.,

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<sup>53</sup> SB 515, codified at RSA §169-C:12-e and §169-C:12-d

mental health. We recommend that DCYF refer to approaches in this area adopted by the State of Ohio for additional information.<sup>54</sup>

- ◆ Second, there is a need to increase the availability of “drug courts” in more geographical regions in the State in order to accommodate the large number of families affected by drug abuse, especially opioids. We heard of only one such court in the State, and in other places these courts have shown promise in addressing the treatment needs of substance-abusing parents who are child welfare involved, and there is a body of evidence supporting the use of drug courts for child welfare populations.<sup>55</sup>
- ◆ Third, expand the availability of mother-child substance abuse treatment facilities. Again, we heard about one (possibly two) particularly effective program in the State where mothers and children can go together and receive the services they need while protecting the delicate mother-child bond as long as the mothers continue in treatment. Such an approach has great potential for ensuring the protection of children while avoiding the trauma of separating children from their parents for purposes of receiving treatment.
- ◆ Fourth, where DCYF has the authority, through contract or otherwise, require drug treatment providers to give priority to serving child-welfare involved parents, so that the needed services can be put into place quickly and reduce the amount of time that children and parents are separated or that DCYF must monitor their situations. This will also require the development of strong collaborative and joint efforts with other State and private agencies.

**Recommendation 12 (*Practice Improvement*): *Expand and build on the trauma-focused programs of services to children and families.*** The trauma-focused services program is, in our opinion, a step in the right direction for serving children at risk in New Hampshire. Staff need to be fully trained in screening, and we believe screening is appropriate for children in the assessment process and not only those in open cases. There must also be a satisfactory array of trained trauma therapists in the State who fall within the State’s managed care system, which

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<sup>54</sup> *Child Welfare Opiate Engagement Project*, September 2014. Accessed at: <http://www.pcsao.org/perch/resources/downloads/cw-opiate-white-paper-final-9-18-14.pdf>

<sup>55</sup> Marlowe, Douglas B., J.D., Ph.D. and Shannon M. Carey, Ph.D. *Research Update on Family Drug Courts*, in National Association of Drug Court Professionals. *Need to Know*, May 2012. This article reports the following: A number of methodologically sound impact evaluations have been completed within the past several years, revealing significantly better outcomes in FDC as compared to traditional family reunification services. A recent review of the research literature concluded that FDC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations. Also, see *Increased availability and use of Family Dependency Treatment Courts in Ohio*, Accessed at: <http://www.pcsao.org/pdf/advocacy/PCSAOOpiateEpidemicChildProtectionBrief2016.pdf>

may require substantial collaboration with other State agencies to recruit and train these providers.

## Policy and Statute

**Recommendation 13 (*Foundational*):** *Align the standards of proof required for substantiating a report of maltreatment with what is needed in court to prove it (probable or reasonable cause vs. preponderance of the evidence).* Having two standards for determining if a child has been maltreated and needs the protection of the State does not make sense in our opinion, and further complicates the process of making appropriate findings in assessments of reported maltreatment.

**Recommendation 14 (*Foundational*):** *Revise policy and/or statute to clarify that if the evidence in an assessment indicates that a child has been exposed to conditions that place the child at risk of future harm, the report should be determined founded and services for the family put into place.* This policy and/or statutory revision should require a disposition of founded and action should be taken, even if the child does not have visible injuries. Also, the intent of the parent to harm the child or expose the child to risky situations should not preclude situations in which the parent has acted recklessly in regard to the child. When the reports are determined to be founded, we recommend that DCYF and its attorneys take a more aggressive stance in filing with the court for court-ordered services to the family, even when removal of the child from the home may not be necessary.

**Recommendation 15 (*Practice Improvement*):** *Revise the state's statute on retention of records beyond 3 years.* We understand that legislation proposing this recommended action was introduced but not passed by the Legislature. We believe, however, that extending the timeframes, particularly for reports that were screened-in, will assist caseworkers in their assessments when reviewing family history. This is especially relevant in view of the State's propensity to determine high risk situations to be unfounded. Assessment staff and law enforcement need access to the family's history in order to properly evaluate incoming reports and make appropriate determinations regarding protecting the child. Recommended standards of the Council on Accreditation, the body that accredits public and private child welfare agencies in the United States, are that records be maintained and secured for at least seven years post case closure.<sup>56</sup>

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<sup>56</sup>Council on Accreditation. Risk Prevention Management (RPM) 6.02. Accessed at:

**Recommendation 16 (*Foundational*): Strengthen the State statute on the definition of neglect.** Our findings are clear that the treatment of children in high risk situations is our major concern. The statute is a contributor, and the rigid interpretation of the statute, in our opinion, inhibits assessment staff from making appropriate determinations in assessments. At the very least, there is a need to provide a clear interpretation of what a threat of serious harm includes and to make it broad enough to protect children who have been the victims of neglectful parental behaviors and not wait until serious injuries occur. Likewise, a stronger statute on emotional maltreatment of children is needed in order to protect children from harm that may not always be physical in nature, but that may have long lasting consequences if unaddressed.

**Recommendation 17 (*Foundational*): Ensure in practice that all children in the household or who are related and visit the household routinely be seen and interviewed if possible during an assessment, regardless of parental consent.** The DCYF policy requiring that all children be seen should be routinely enforced. If one child in a household has been maltreated, others in the home or who reside elsewhere but are subject to the oversight of alleged perpetrators should be evaluated for maltreatment. Determinations about maltreatment should not be made, or assessments determined incomplete, because the parents refuse access to the children. In this situation, parents' rights should not supersede protection of the child. This may require statutory changes.

## Interagency Collaboration

**Recommendation 18 (*Practice Improvement*): Make deliberate efforts to work collaboratively with the medical, education, and law enforcement communities.** We believe there is much room for misunderstanding processes that must occur simultaneously within DCYF, law enforcement and medical providers. New Hampshire is not such a big State that having regular forums for exchanging information, airing concerns, and engaging each other in meaningful discussion and joint planning cannot occur. Particularly when plans as high-profile as after-hours coverage of child protection cases are involved, the relevant parties should be engaged and have opportunity for input. In this example, as DCYF implements its after-hours coverage plans, we recommend that regular conversations occur between DCYF and law enforcement on the outcomes and process of the plan and that both have opportunity for input into needed adjustments. Outreach to other stakeholder groups, whose survey comments in this report

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<http://coanet.org/standard/pa-rpm/6/>

reflect concerns about child protection work in the State, e.g., medical providers and educators, seem warranted and not unrealistic to accomplish. As we recommended earlier, collaborative relationships with mental health and substance abuse treatment providers and funders are needed to implement our recommendations regarding parental substance abuse and child welfare.

## Other Practice Improvements

**Recommendation 19 (*Practice Improvement*): *Re-conceptualize the process of identifying safety threats and risks of harm associated with incoming reports of maltreatment.*** Our case review indicates that the NHIA tools are not consistently used by field staff to identify, assess and act upon immediate safety threats and risks of harm for children. The fact that certain parts of the instruments are not required to be completed (through use of the Suspended Procedure guidance) and comments by field staff on use of the tools further emphasize their lack of use. We believe that a more useful process for identifying children at risk, assessing their situations closely and taking appropriate action is needed. While DCYF may choose to use the NHIA process in a strengthened way to achieve this goal, our recommendation is that DCYF consider a predictive analytics process, similar to what several other States have implemented. In a predictive analytics environment, the State's own data and experiences with children and families are used to identify children whose circumstances place them at high risk of maltreatment. Coupled with a modified internal CQI process that provides an initial and periodic review of children identified to be at risk and provides guidance to social workers assigned to the children, would provide added layers of protection and judgment to what is needed to respond appropriately. It would also take some of the burden off individual social workers and their supervisors to make decisions alone, and/or to assist them in building the case needed to ensure that the assessments are appropriately acted upon.

**Recommendation 20 (*Practice Improvement*): *Take steps to improve the quality of assessments generally, in areas not already addressed in our recommendations.*** In addition to lending more attention to assessing underlying issues that contribute to the risk of harm to children, there were a few other areas where the quality of the assessments needed improvement. Examples include making appropriate collateral contacts who know the families' circumstances, as opposed to the more typical contacts only to law enforcement and medical providers; improved documentation of risk-related and neglect-related issues in assessments; attending in particular to situations where newborns and very young vulnerable children are the subjects of alleged maltreatment due to parental substance abuse and ensuring

assessments of all such referrals; and, where safety plans are indicated to manage risk of harm, improvements in identifying those situations and in crafting effective safety plans.