WCHSA

Wisconsin County Human Service Association
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MEMORANDUM

To: Honorable Members of the Legislative Council Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents

From: Vicki Tylka, Chair, Children, Youth & Families Policy Advisory Committee, Wisconsin County Human Service Association; and Director, Marathon County Department of Social Services Vicki Tylka

Ray Przybelski, President, Wisconsin County Human Service Association; and Director, Portage County Health and Human Services Department Ray Przybelski

Date: August 26, 2020

Subject: County Comments on Public Disclosure of Egregious Child Abuse and Neglect Incidents

Thank you to Chair Snyder and Vice Chair Bernier for inviting the Wisconsin County Human Service Association (WCHSA) to provide the county perspective as it relates to the work of the Legislative Council Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents. WCHSA is a membership organization representing all 72 Wisconsin counties, with 71 of those counties providing child welfare services. The state provides child welfare services in Milwaukee County.

The Wisconsin County Human Service Association would like to take this opportunity to once again extend appreciation to the Legislature for supporting the over $25 million increase in the Children and Family Aids allocation in the last biennial budget. As the demand on the child welfare system has increased significantly over the past five years, primarily due to the drug epidemic, these additional resources are vital to our ability to provide these mandated services.

We understand and appreciate the role the Legislature serves in providing oversight to Wisconsin's child protective services system, and believe that children and families are our greatest resource. Considering the full scope of child welfare services, egregious incidents of child maltreatment are small in number but devastating in impact. It is important to emphasize the impactful work that is done by child welfare agencies and their staff every day. Child welfare services are comprised of responding to all child maltreatment concerns reported by community members and professionals working with children, providing assessments to ensure child safety, and ultimately providing services to families to positively impact child safety, wellbeing, and permanence. This includes serving families in their homes, and sometimes placing children in out of home care. The child welfare system includes numerous partners beyond the child welfare agency: the courts, attorneys, law enforcement, the medical community, schools, providers of mental health and substance abuse services, and other community providers.

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Regarding the public disclosure reporting requirements for egregious incidents under current law, neither child welfare agencies nor our partners tend to find this information in its current form to be valuable or helpful in our practice. In some areas, smaller counties in particular, the concern remains that even the use of a high level summary that excludes names allows for public identification by people in the community. We believe that one of the issues that lead to the current public disclosure system was surrounding media inquiries into egregious incidents. WCHSA supports a system that continues to direct media inquiries to the Department of Children and Families for the purpose of providing consistent information in accordance with confidentiality standards.

The information gathered through the public disclosure process does not prove useful to child welfare agencies in assessing the facts surrounding the case in an effort to improve practice aimed at averting future egregious incidents. Rather, child welfare agencies respond and proactively address egregious incidents in three main ways: internal reviews at the child welfare agency, Act 78 Systems Change Reviews with the Department of Children and Families (DCF) and county experts, and local reviews and evaluation through various structured formats, including child death review teams. All three responses make a positive difference.

What happens at the local level when egregious incidents occur?

When egregious incidents occur, the local child welfare agency immediately conducts an internal investigation. Ensuring immediate safety is paramount, and action is taken when necessary to ensure safety not only for a child where maltreatment is alleged, but for any other siblings in the home or other children under the care of the alleged maltreater. Sometimes counties have had previous involvement with a family or are currently involved, and other times the family is not known to the county. In all cases, we look at what occurred, how we and others in our community system responded or could have responded, and what we need to do now. The internal review is not about assigning blame, but about accountability and learning to do better system wide. Practice concerns, while rarely identified, are immediately addressed. As an example of what can be learned through the internal investigation process, one county noted a practice concern related to lack of proper documentation, leading case reviewers to an inconclusive determination of actions taken by the case manager, even though proper protocol may have been followed.

Supportive services are offered to child welfare staff who may have been involved with the child to decrease the likelihood of the development of secondary traumatic stress. These services are important, as failure to provide such services impacts staff performance and may lead staff to leaving the field of child welfare altogether.

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Second, most counties have a well-structured child death review team in place, although they operate differently and vary in effectiveness and scope. Typical participants in the child death review team include the child welfare agency, medical examiner, physicians, law enforcement, and public health. The general goals of this local partner review are to understand the incident and learn if anything else could have been done. Sometimes, systems issues are identified and can be addressed with partners such as law enforcement, the medical community, and agencies serving children. In one county, to provide an example of a positive change based off of a child death review, public health and the child welfare agency began working with hospitals and physicians to ensure effective and timely deliverance of information about infant development, coping strategies, and concerns related to abusive head trauma to new parents.

What happens at the state level?

In the past, the Department of Children and Families conducted an investigation of the child welfare agency when an egregious incident occurred. DCF staff and other child protective services experts would interview all staff involved with an incident-based focus. This would often occur months after the egregious incident and after the agency's own internal review, resulting in staff re-traumatization. The investigation also happened so late in the process to not be effective in addressing any needed practice changes. In general, those investigations were not viewed as effective, nor were they trauma informed. Because of that, child welfare agencies have been supportive of the relatively new Act 78 System Change Reviews, commonly known as Systems Mapping process, that the Department of Children and Families has implemented as an innovative way to learn from egregious incidents.

In general, county child welfare agencies have found the Systems Mapping process to be very collaborative and focused on system improvement. The process also supports basic trauma-informed principles that are essential to support and maintain an effective child welfare workforce. The goals in the Systems Mapping process are to identify key elements that will result in positive outcomes for families, and implement system wide change. An example of an identified systems issue found in the context of a review is an over-reliance by the child welfare agency on law enforcement's determination regarding the safety of children in their homes, particularly after hours. This observation is not to suggest law enforcement does not have the ability to address safety; however, their role is more to assure an immediate need for safety, not to evaluate family and caregiver, along with environmental, issues regarding safety to the extent that child protective services is required to do. Additional education about the importance for social workers to independently conduct those assessments utilizing standardized child welfare tools to support their analysis, in addition to a need for increased focus on developing the plan collaboratively with the family and their supports to ensure the plan is uniquely created for the family and actively identifies roles in maintaining safety for those particular children is needed. This is a topic toward which an established statewide county state committee, is focusing improvements. At a local level, several counties are focusing efforts on improving the use of the Safety

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Plan by child protective services ongoing workers, who are involved with families beyond the initial assessment stage. This is especially important as the safety and risk levels present in families change over time.

However, in order to effectively implement the Systems Mapping process, there needs to be adequate resources to conduct Systems Mapping, as well as implement the systems changes identified through the process. Systems Mapping appears to be the most reasonable and effective path to further improve child safety outcomes.

Building on what county child welfare agencies generally believe to be working well, WCHSA recommends the following areas for this study committee to consider:

RECOMMENDATIONS

1. The study committee could recommend and support a process whereby counties could receive technical assistance or grants to improve their local processes related to their reviews, similar to what DCF implements statewide for Systems Mapping. While the child welfare agency may benefit from the Systems Mapping review, there may not be a local infrastructure that can receive that information and apply what is learned to community partners in the local child welfare system. Child death review teams, Citizen Review Panels, or other formalized community groups could benefit from participating in structured collaborative conversation that identifies local system needs and results in action plans for continuous improvement.
2. The current statewide Systems Mapping procedures could be made further available to child welfare agencies that voluntarily wish to have a specific case reviewed even if it does not meet the definition of "egregious." Currently if an incident does not meet the threshold for reporting, the case cannot be reviewed and some counties believe that is a missed opportunity for system improvement.
3. Ensure that there are proper resources to address the system wide issues that are identified through regional and statewide evaluation and addressed through the creation of a strategic implementation plan. Local grants could be made available for system wide improvement based on Systems Mapping analysis.
4. Lastly, as stated above, we encourage the committee to continue to look at the big picture regarding the child welfare system when evaluating the unfortunate egregious incidents. We always can learn from what is going well and apply those positive lessons to influence the areas where there are challenges.

In closing, the Department of Children and Families website contains a significant amount of data regarding the scope and delivery of child welfare services in Wisconsin for each and every county. In addition, many counties maintain an additional data system and would be happy to provide any

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requested information or data that the committee would like with regard to local child welfare services. Accessing and review of these data sources on a regular basis may be of greater use to members of the Legislature in making policy decisions related to the child welfare system as opposed to the annual review of egregious incidents.

Thank you for your time and attention and for your work in keeping kids safe.