Bending the Curve to Improve Our Child Protection System

A Multiyear Analysis of Vermont's Child Protection System & Recommendations for Improvement

November 9, 2018

The Vermont Parent Representation Center, Inc., is a private, not-for-profit agency whose mission is to ensure, through advocacy and support, that children who can live safely with their parents are afforded a real opportunity to do so.

Larry Crist JD, MSW
Executive Director

Trine Bech JD
Founding Director

Vermont Parent Representation Center, Inc.
PO Box 4087
Burlington, VT 05401
802-540-0200 Office
802-343-8134 Cell
Larry.Crist@vtprc.org

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I. INTRODUCTION

A. The Goals

The goals of this analysis are fourfold:

1. To present the nine-year experience of Vermont's only nonprofit organization dedicated to educating families engaged with the state's child protection system, while also providing advocacy, legal services, service coordination, and support in an integrated, multidisciplinary fashion.

2. To outline methods by which Vermont's children can be kept safe through the strengthening of families, and when that cannot be achieved, to provide the courts with more and better information so that judicial proceedings occur in a timely manner and with the most accurate information possible.

3. To envisage how upstream community investments, in some cases, on an expenditure-neutral basis, reduce the number of adverse childhood experiences that often led to children's removal from their families.

4. To identify systemic failures in the current child protection system, as well as recommendations for comprehensive system improvements.

B. The Population Served

This analysis represents the experiences of the Vermont Parent Representation Center, Inc. (VPRC), between the years 2010 and 2018. During this period, VPRC served as the primary independent, statewide, multidisciplinary legal, and social service resource for more than 425 families who were at risk of having their children, especially very young children, enter state custody. These experiences came from both direct, in-person representation/support for approximately 73 families and remote assistance to more than 350 families via a statewide, toll-free helpline. The population served came from direct and indirect referrals from DCF, social service agencies, legal aid services, private attorneys, mental health practitioners, and clients.

A portion of the population served could be described as being self-selected, i.e., individuals who were already having difficulty dealing with the child protection system and as such, presented VPRC with only the problematic elements within the system. However, other portions of the population served were referred to VPRC prior to encountering challenges with the child protection system, while yet others contacted the organization simply to gain a better understanding of how the system worked and what they might encounter in dealing with various components of the larger child protection system. Taken as a whole, we believe that the hundreds of families served represent a broad cross-section of Vermonters who engage with the child protection system, that their individual and collective experiences are

representative of what most people dealing with the system routinely encounter, and finally, that the similarity and consistency of experiences was such that the issues raised were not outliers. The one population we did not serve involved families in which child sexual abuse was alleged. Aside from that exception, VPRC engaged clients from every quarter of Vermont, spanning the full range of issues typically found in child protection actions wherein abuse and/or neglect are at question.

C. The Problem

Caseloads (and the associated children placed in foster care) are largely driven by two factors: the number of people referred to the system, and system adeptness in triaging people and applying the appropriate level of service in an effective and efficient manner. Data shows that the number of families requiring investigation for alleged serious abuse and neglect is relatively small, while the number who could benefit from voluntary social service and financial help constitutes the vast majority of families engaged with the system and the associated increase in caseload. In effect, regardless of the many dedicated individuals hard at work within Vermont's child protection system, it is the system itself that appears to have lost sight of the difference between addressing the needs of these two distinct populations resulting in neither population's being served well. This may be due to a lack of resources at multiple levels, the multidimensional pressures placed upon the system, the magnitude of the challenges inherent in child protection or utilization of resources, but the reality is that Vermont's system is broken. If the goal of a child protection system is to safeguard children and reduce trauma, the current system is stretched beyond its capacity, capability, and focus to the point where it appears unable to differentiate between children in need of protection and children whose families simply need assistance in order to care for their children.

In any other field (medicine, public health, or public safety, for example), Vermonters would not long tolerate yearly increases in the rates of illness, disability, or death generation after generation without seriously questioning causation and the effectiveness of the interventions employed. However, in the arena of child protection and family services, our repetitive cycles appear to be the norm rather than the exception, and our only response appears to be punitive rather than the development and application of solutions. Although Vermont routinely implements pilot projects and new initiatives, at its core the child protection system has remained immune to meaningful change, leaving both families, and those whose job it is to serve them, engaged in endless cycles of frustration and failure.

Many professionals who interact with Vermont's child protection system question whether it can be fixed, or even if there is the political will to do so. It is our contention that it can be fixed, and that we have a duty to fix it. It is also the considered judgment of many experienced

professionals that effective change can only come about through an external effort capable of addressing the legal, political, philosophical, cultural, organizational, financial, and attitudinal elements present in the current system. Such an effort will require visionary leadership, managerial acumen, aggressive external oversight, and the pain that accompanies meaningful systemic improvement. We believe that Vermont's children, families, and those who serve them deserve no less.

This analysis is our attempt to identify system-wide problems and offer solutions with the intent of achieving a *better* system, not just better parts to a broken system. To facilitate this, we have divided this analysis into halves. The first half presents an overview of the system, findings, and recommendations; the second half explores the findings and recommendations in greater depth. We implore you to read the document in its entirety.

D. Our Observations and Experiences

The Analysis generates over sixty (60) findings and eighty (80) recommendations. These are described, both in overview and in detail. For simplicity, we have attempted to synthesize that information into six top findings and recommendations that, if implemented as a group, would make the greatest positive impact in improving the child protection system.

There are hard truths contained in this document, but they are truths nonetheless. It is important to remember that this analysis does not place blame or focus on a single individual or individuals, nor on a specific political party or parties. The conditions outlined have been in place for a very long time and will remain constant until we demonstrate the collective audacity that is necessary to acknowledge our mistakes and begin the difficult process of fixing them.

E. Cost and Cost/Benefit Analysis

This paper does not include either a cost analysis or a cost/benefit analysis for two reasons. First, to the best of our knowledge, no one can say with any degree of certainty how much the current child protection system cost Vermont taxpayers. Estimates for foster care range from $25,000 - $35,000 annually per child, however those figures are unlikely to include all costs such as court costs, attorney time, non-DCF investigative time, health assessment, educational and social service administrative time. Second, absent an accurate cost assessment, one cannot compare the cost of a more efficient and effective system as outlined in this paper.

E. Six Top Findings & Recommendations

These findings and recommendations represent a consolidation of multiple findings and recommendations contained throughout this analysis. They are presented here in an attempt to provide a succinct path forward in reforming the current system.

1. The current state child protection bureaucracy operates without effective external or internal oversight and accountability.

Recommendation:

Establish an external child protection Ombuds Office, charged with monitoring system outcomes, procedure, policy, practice, and complaints relating to the efficacy of the overall system. This entity should report to the secretary of the Agency of Administration, with an annual report to the governor, legislature, and the judiciary outlining findings and recommendations for improvements in efficiency and effectiveness. The entity should be adequately staffed and funded by state child protection resources. An initial task for the office should be to establish a comprehensive cost analysis of the current system, including all related costs, and a cost/benefit analysis associated with the recommendations put forth in this paper.

2. Families have no place where they can obtain accurate and credible information and effective representation/advocacy relative to their interaction with the child protection system.

Recommendation:

Establish a Parent Representation Office that resides outside of the Office of Defender General, consisting of multidisciplinary personnel, whose primary purpose is to educate families about their rights and responsibilities, provide advocacy and support prior to the submission of a CHINS (Children in Need of Services) petition, and provide legal representation once a CHINS petition has been filed. This entity should be funded as part of the overall child protection system state and federal funding stream and should maintain a state-wide Helpline.

3. DCF investigations and assessments constitute the foundation of state actions that can result in family disruption and foster care placement. Investigations are designed to focus on instances where there is criminal behavior or an imminent threat alleged, whereas assessments were designed to enhance the well-being of children and provide families with the support and assistance they may be otherwise lacking. In Vermont, today, assessments have become investigations by another name, and simply a mechanism by which families are monitored and children removed absent a court order. Lost in the system is the goal of making reasonable efforts to support families in their efforts to raise healthy children in safe homes.

Recommendation:
Review the current usage of differential response, and if it is determined that there is no fundamental difference in Vermont between investigations and assessments, cease the use of the assessment process. If it is determined that differential response has a viable role in addressing child welfare, ensure that the application of differential response in assessments complies with nationally recognized best practices[1], rather than its current use as a tool to remove children from their homes and institute ongoing monitoring absent a court order.

4. DCF writes investigative reports that are often poor in quality and accuracy, contain misinformation and outdated material, and are often based on assumptions rather than facts, yet these reports serve as basis for DCF affidavits and CHINS petitions. The mandated use of pre-determination risk assessment tools (safety decision making tools) guarantees that any family with historical risk factors (including parents having been foster children themselves), regardless of the passage of time, will be found to be "at high or very high risk" and in need of services regardless of whether they actually are in need of services.
Recommendations:
A. Investigative reports should be standardized in form, thorough in content and accompany all affidavits and CHINS petitions. Prior to the issuance of a CHINS petition, the state's attorney should be required to document a review of the investigative report and affirmatively state that both the report and affidavit support the petition. This report should be made available to the parent's attorney at the time of the first hearing.

B. The standardized risk assessment tool (SDM) must be re-validated and not serve as the only factor in opening a case for social services. When, as part of an assessment, services are recommended, families should be informed that their participation in services is voluntary in nature and their refusal to engage will not result in retaliatory threats of child removal.

5. Our judicial system, in child protection, is based upon the concept that prosecutors, parent attorneys, children's attorneys, the guardian ad litem (GAL), and the child welfare agency (in Vermont, DCF) provide accurate and comprehensive evidence of the family circumstances. It has been VPRC's experience that, because the process starts with inaccurate information, in the affidavits provided by DCF to support a CHINS petition, the attorneys (particularly court-appointed defenders) involved in the process do not routinely test the accuracy of the affidavits. The court does not have time to schedule timely hearings for the purpose of contesting affidavits. As a result, the judicial process is no longer an adequate check

[1] Lessons from the Beginning of Differential Response, Siegel, Institute of Applied Research, St. Louis, Mo, 1/2012

on the state's action. There is a chronic lack of personnel at all levels, resulting in unacceptably long delays in adjudication. Personnel turnover is high, resulting in situations where no one in the court room knows the particulars of a given case. Children remain in custody needlessly and for extended durations (including multiple foster home relocations). The bifurcation of prosecution between state's attorney and attorney general results in no one effectively being in charge. The co-location of children's attorneys and parents' attorneys in the Office of Defender General results in a lack of effective representation for parents.

Recommendations:

A. *Increase the number of judges assigned to child protection cases, with a judge remaining with a case for the entire case duration. This likely would require the creation of a Regional Family Court System, which would have added costs on the front end, but result in quicker case disposition and reduced use of foster care on the back end.*

B. *Consider eliminating the guardian ad litem program as it currently exists, and make the role of the child's attorney one of representing the child's legal interests, or adopt and implement the Court Appointed Special Advocate (CASA) model in place of the GAL program. Currently, each child is assigned both a GAL and an attorney; however with very young children, the attorney really represents the GAL, a seemingly needless redundancy since neither the GAL nor the attorney knows much about the actual child or the child's family, and the number of GALs remains insufficient to ever develop this knowledge.*

C. *If the guardian ad litem program is retained, ensure that there are sufficient numbers of guardians, that they are adequately trained and supervised and that they remain both neutral and independent in carrying out their duties. CASA guidelines should be followed.*

D. *Locate representation of parents in an established Parent Representation Office that resides outside of the Office of Defender General. If parent representation remains within the defender general's office, performance measures should be instituted relative to face-to-face meeting time with parents outside of court, motions filed, and oversight by the office.*

E. *Responsibility for child protection cases should reside with either the state's attorney or the attorney general, but not both.*

F. *The focus of all child protection should be to follow federal law and maintain children at home if such can safety be ensured, and if children must be removed, to place children with fit and loving relatives as a matter of priority whenever possible.*

G. *Before a TPR (termination of parental rights) hearing commences, the court should follow federal law and require a showing of the reasonable efforts made by DCF to reunite children with their biological families, including, but not limited to, grandparents, aunts, and uncles.*

6. Due process protections for placement on the Child Abuse Registry are weak. DCF notification of substantiation is often inadequate, and statutory requirements for timeliness are rarely followed. The standard for substantiation of abuse/neglect is the "reasonable person" [2], however "reasonable person" is not defined. However, the veracity of registry entries (of which there are thousands) is now suspect because underlying investigations are, in many cases, deficient, if not incorrect. The dramatic increase in substantiations for "risk of harm" based on the opinion of an undefined "reasonable person" appears to result from the bureaucratic application of a degree of subjectivity not contemplated in state law and further magnified by the absence of a definition of "significant danger" and "serious harm."

<u>Recommendations:</u>

A*. The "reasonable person" standard of proof is not, in fact, a "standard" as it is ill defined. As such, it should be replaced with a standard that requires "proof that an objective, reasonable person would find convincing". This change would make the standard one that is more in keeping with the severity of the ramifications for substantiation and placement in the registry.*

B. *Notification of substantiation, and entry into the registry, should be more comprehensive; the appeal process should be more informative; and timelines for appeals and opinions should apply equally to defendants and the state.*

C. *All substantiations for risk of harm should be reviewed to determine whether the specific allegation substantiated meets a commonly accepted standard as to what constitutes a significant danger that a child will suffer serious harm.*

D*. Individuals appealing substantiation/inclusion in the Registry should be provided an attorney if there is to be real due process.*

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[2] 33 V.S.A. 4912 (16)

II. Background to Understanding Our Child Protection System

A parent's right to care for his or her children is a fundamental liberty interest protected by both the United States Constitution and the Vermont Supreme Court.[3] Therefore, before the state can forcibly remove children from a parent, there must be a compelling state interest in protecting them, such as abuse or neglect, and a judicial determination that the parent is somehow unfit and demonstratively incapable of providing an appropriate home for the child. The determination only that it would be in the best interest of the child is insufficient to overcome the parental constitutional right to custody of their child. [4]

It is expensive to care for children in foster care. The federal government provides funding that heavily favors removing children from their parents. Approximately 50% of the cost of children removed to our foster care system is paid for by the federal government, but only a small amount of funding is available for remedying family problems that contribute to child abuse or neglect, such as poverty, homelessness, lack of transportation, substance abuse, mental health challenges, and domestic violence, before the child is removed. Federal funding laws have created an incentive for states to remove children rather than investing in efforts to ameliorate the cause of the family's problems. And despite a legal requirement that the state exercise reasonable efforts before removal, the standards of what constitutes reasonable have never been agreed upon, and the federal government has provided little useful guidance. The requirement is too often ignored, and rarely does a judge request evidence to see what efforts DCF made.

Thus our nation has a long history of using removal of children from the parents as the first rather than the last resort to keeping children safe. In Vermont we routinely return a substantial percentage of the children removed within 30 days, which raises the question of whether we could have avoided the trauma of removal in the first place. During the period October 2015 through September 2016, 15% of the children were discharged within one month of removal.[5] About 80% of our children are removed for neglect rather than physical or sexual abuse. There are many studies showing that there is substantial trauma to children associated with being forcibly removed from their homes. Although we have a dearth of long-term studies on the effects of these interventions into the family, our current research shows that children who are removed for neglect where social workers from the state differ on whether to remove the children, the children have better long-term outcomes by staying in their own homes.[6]

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[3] See Santosky v. Kramer, 455 U.S. 745, 753 (1982) (reaffirming parents' fundamental liberty interest in care, custody, and control of children, even when they have not been model parents).
[4] See In re K.M.M., 2011 VT 30.
[5] See http://fosteringcourtimprovement.org/vt/.html
[6] See Joseph Doyle, Jr., Child Protection and Child Outcomes: Measuring the Effects of Foster Care, The American Economic Review, 1583, December, 2007.

The foster care experience is a difficult experience for Vermont children. DCF moves children from placement to placement at an alarming rate (6.59 moves per 1,000 child days) and frequently over short periods of time. In addition, approximately 38% of our children in foster care as of March 30, 2018, had been in care more than 18 months.[7]

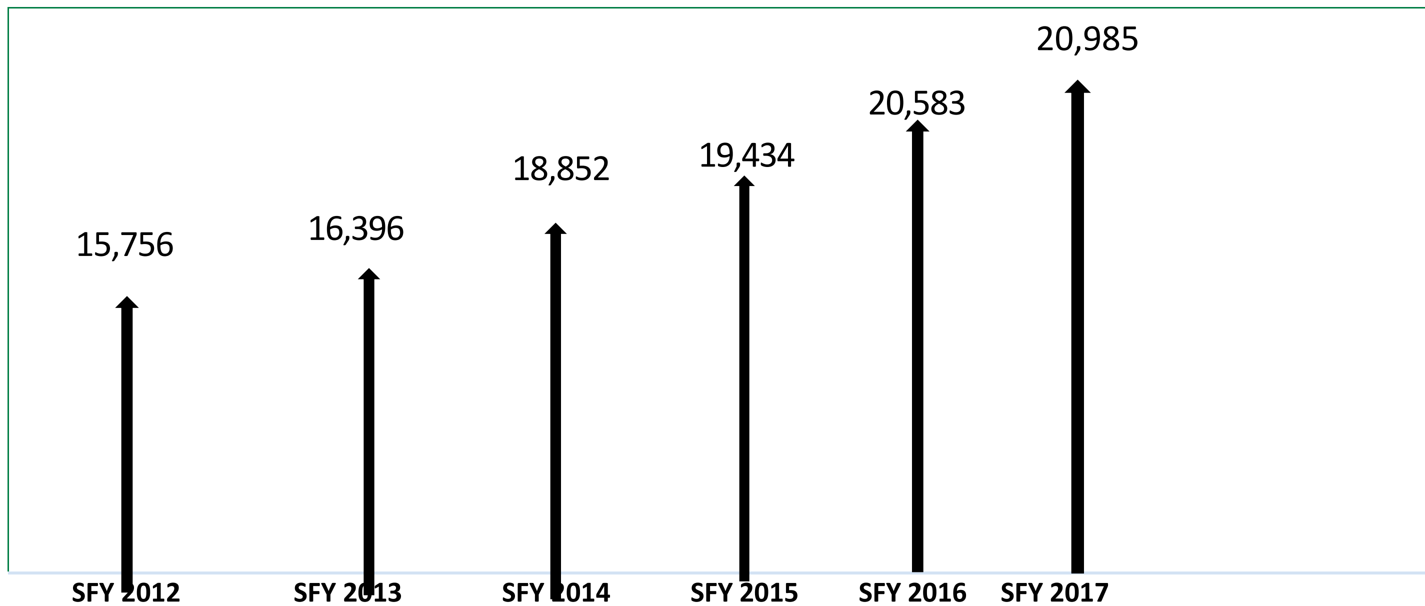
[7] See http://fosteringcourtimprovement.org/vt/County/incare_rank.html

III. WHY CASELOADS DRAMATICALLY INCREASED

A. Reports of Suspected Abuse & Neglect Skyrocket

Reports of abuse/neglect continue to rise far out of proportion to our population growth. Although the numbers are inflated, due to multiple reports' being made regarding the same incident, the trends remain valid representations of an ongoing increase, the percentages of which bear no resemblance to changes in Vermont's population.

Total Child Abuse & Neglect Intakes/Reports



Numbers extrapolated from Report on Child Protection in Vermont (years 2012-2017), Vermont Department for Children and Families

Note: the numbers depicted may vary slightly from those contained in some reports issued by DCF/AHS due to the multiplicity of reports generated containing differing numbers for the same time periods.

B. Assessments now almost equal investigations and result in open family service cases, regardless of whether there is abuse/neglect.

Between 2006[8] and 2016:

- Reports of abuse/neglect increased ***37%.***
- Investigations increased only ***17%***
- Yet, Substantiations remained ***unchanged***.
- While assessments have risen from **244 *to 2,674***.

With Investigations and Substantiations remaining static over a decade, the dramatic increase in DCF workload appears to be the result of DCF assessments that, more often than not, result in families' routinely having to participate in open services cases/monitoring when families have not abused or neglected their children. Legally, families can decline to participate; however it is VPRC's experience that families who wish to decline are coerced into "voluntarily" agreeing due to DCF threats to remove children even though DCF is legally precluded from doing so. Parents have no place to go to inform them of their rights, so they generally agree.

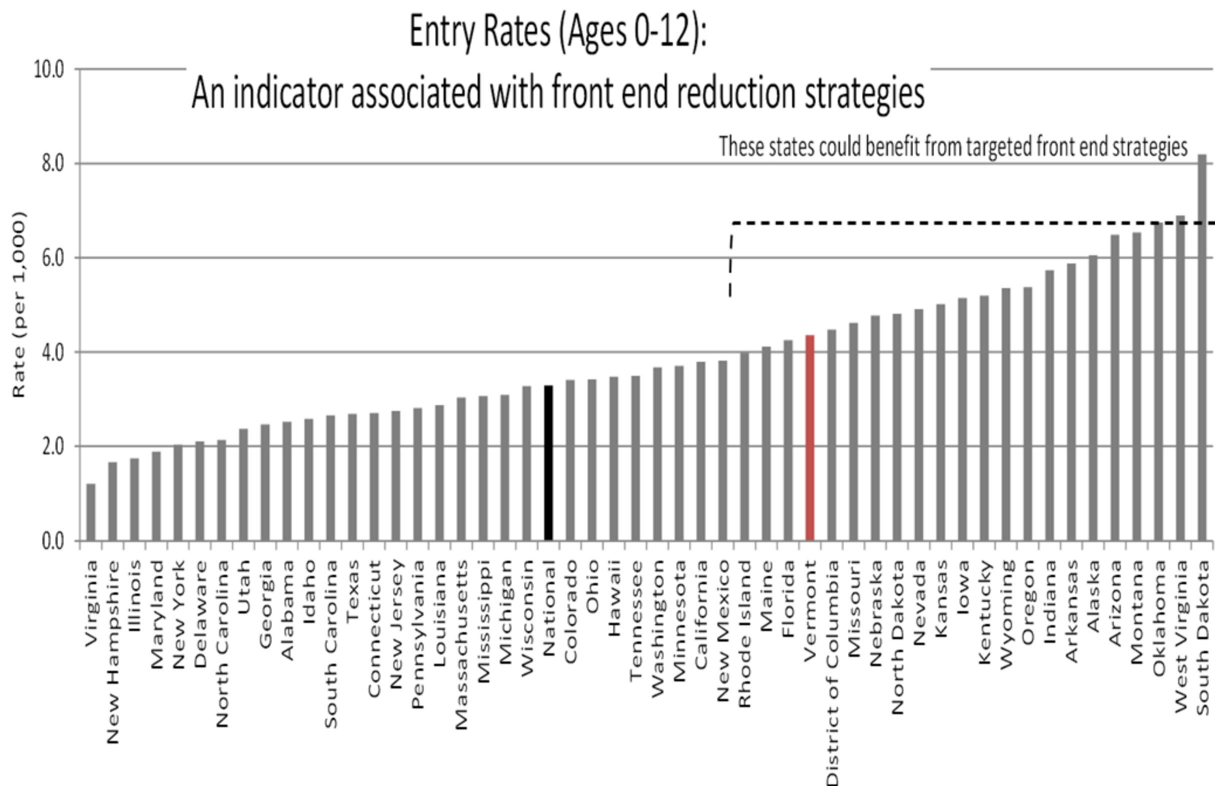
Year	**2006**	**2008**	**2010**	**2012**	**2014**	**2016**
Reports of Abuse/Neglect	**13,049**	13,434	15,379	15,760	19,288	***20,583***
Investigations	**2,528**	2,896	2,510	2,564	2,877	***2,835***
Substantiations	**770**	646	626	626	652	**737**
Child Abuse Assessments	n/a[9]	n/a	**1,058**	1,119	1,688	***1,421***
Family Assessments	**244**	630	1,078	1,044	1,281	***1,253***

Numbers derived from 2006–2016 Reports on Child Abuse in Vermont, VT DCF

[8] Differential Response came into being in 2007.

[9] For these years child assessments were not identified in reports.

C. An Absence of Front-End Prevention Strategies



Entry rate is the number of children (ages 0-12) entering care during the year for every 1,000 in the general population.
Data source is FY12 AFCARS (FY11 in CT, NM, SD and National) CA data from CWS/CMS

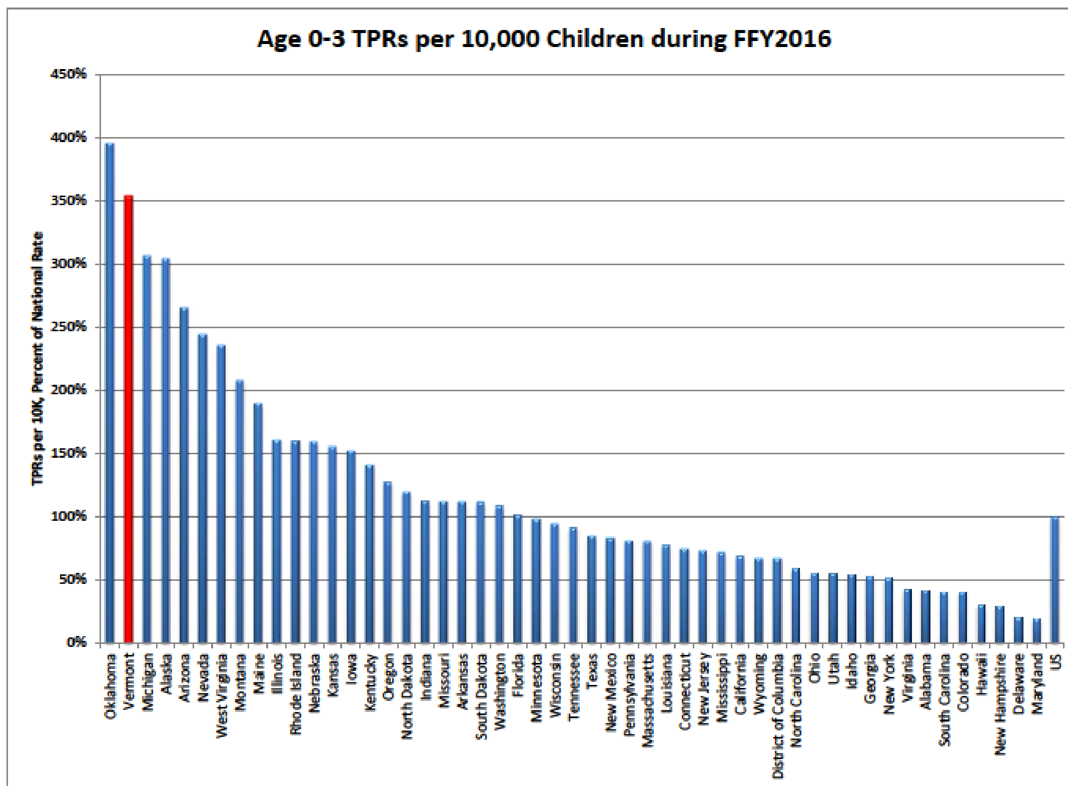
Vermont's front-end prevention strategies have historically been lacking. Although the state has a once-herald community-based services network, this network is largely under-funded and stands outside of the initial DCF assessment process. As a result, DCF conducts both investigations and social service assessments, processes that require differing skill sets, approaches, and culture. This leads to little difference between the two approaches as practiced. A chronic inability to conduct thorough and accurate investigations, or assessments, often results in the state's defaulting to removal of children before there is clarity as to whether rapid removal is necessary. Meanwhile, community-based service agencies, typically, sit on the sideline and are only brought into the picture after the fact. VPRC has demonstrated, in four pilot projects, that the availability to parents of a multidisciplinary (legal and social services) team providing accurate legal information, active social supports, and coordination significantly reduces the number of families who experience the removal of a child. For those who do

experience a removal, the availability of competent and knowledgeable legal representation almost always resulted in families' retaining custody of their children, or when children did enter custody, the period of custody was significantly shortened.

D. Termination of Parental Rights for Young Children

Vermont consistently ranks among the highest in the nation for its rate of terminating parental rights for very young children while also ranking as one of the best places for families and children. One must ask: What creates this paradox? Are Vermont parents more abusive and neglectful than parents in other, less family- and child-friendly, states? Or is the problem our child protection system and how it treats families?

Vermont – Ranked #2 in Termination of Parental Rights



Data obtained from the Fostering Court Improvement project, 2016

E. The increase in Very Young Children Entering State Custody

The number of very young children in state custody is frequently attributed to the increase in substance abuse (opioids), however "substance abuse" has been a significant presence in DCF reports since at least 2004. Additionally, the leveling-off of the number of young children at a time when the opioid crisis remains at high levels would appear to indicate that substance abuse may not be the only primary reason for increased caseloads. The dramatic increase in the number of young children in state custody also tracks the even more significant rise in "financial stress" among families (commencing in 2009), coupled with the death of two very young children (in early 2014) and the significant political fallout and administrative pressure to do something resulting from those deaths.

Number of children in DCF custody by age

Year:	2009*	2010	2011	2012	2013	2014**	2015	2016
0-5 yrs.	**242**	222	266	271	288	**397**	547	**525**
6-12 yrs.	231	213	237	232	240	274	347	397
13-17 yrs.	549	463	464	444	416	432	427	380
Total	1,022	898	972	947	944	1,103	1,321	1,302

*Denotes first full year of the Great Recession and opioid epidemic officially recognized in Vermont medical community.

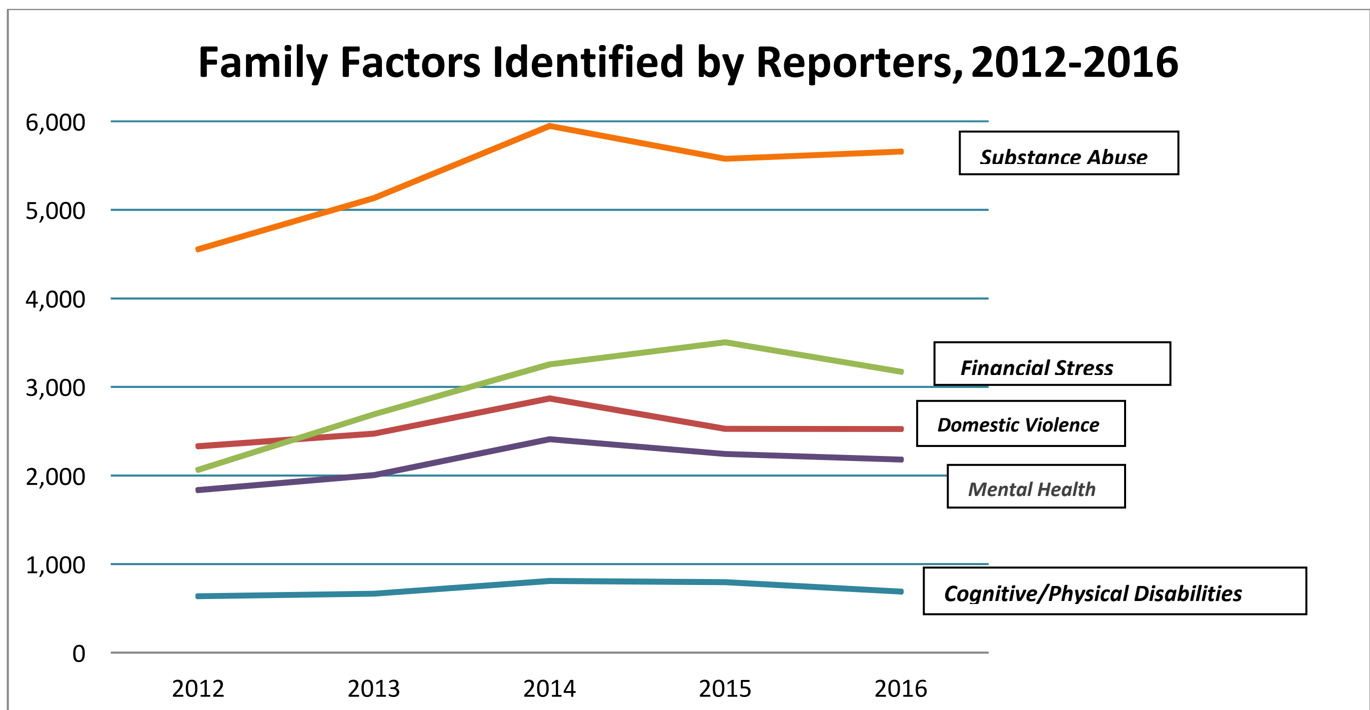
**Denotes death of two very young children

F. Financial stress grew at a faster pace than any other factor identified at DCF intake.

Financial stress rose from 6% to 17% as a factor in reports to DCF, rising by 2,320 reports. At the same time, Substance Abuse increased from 27% to 31%, rising by 1,459 reports.

Year	2010	2012	2013	2014	2015	2016
Cognitive/Physical Disabilities	519 (3%)	636 (4%)	664 (4%)	808 (4%)	795 (4%)	688 (3%)
Domestic Violence	1,763 (12%)	2,331 (15%)	2,473 (14%)	2,871 (15%)	2,527 (13%)	2,525 (12%)
Financial Stress	852 (6%)	2,066 (13%)	2,692 (15%)	3,256 (17%)	3,504 (17%)	3,172 (15%)
Mental Health Issue	1,349 (9%)	1,836 (12%)	2,005 (11%)	2,410 (12%)	2,243 (11%)	2,180 (11%)
Substance Abuse	4,198 (27%)	4,555 (29%)	5,130 (29%)	5,946 (31%)	5,575 (28%)	5,657 (27%)

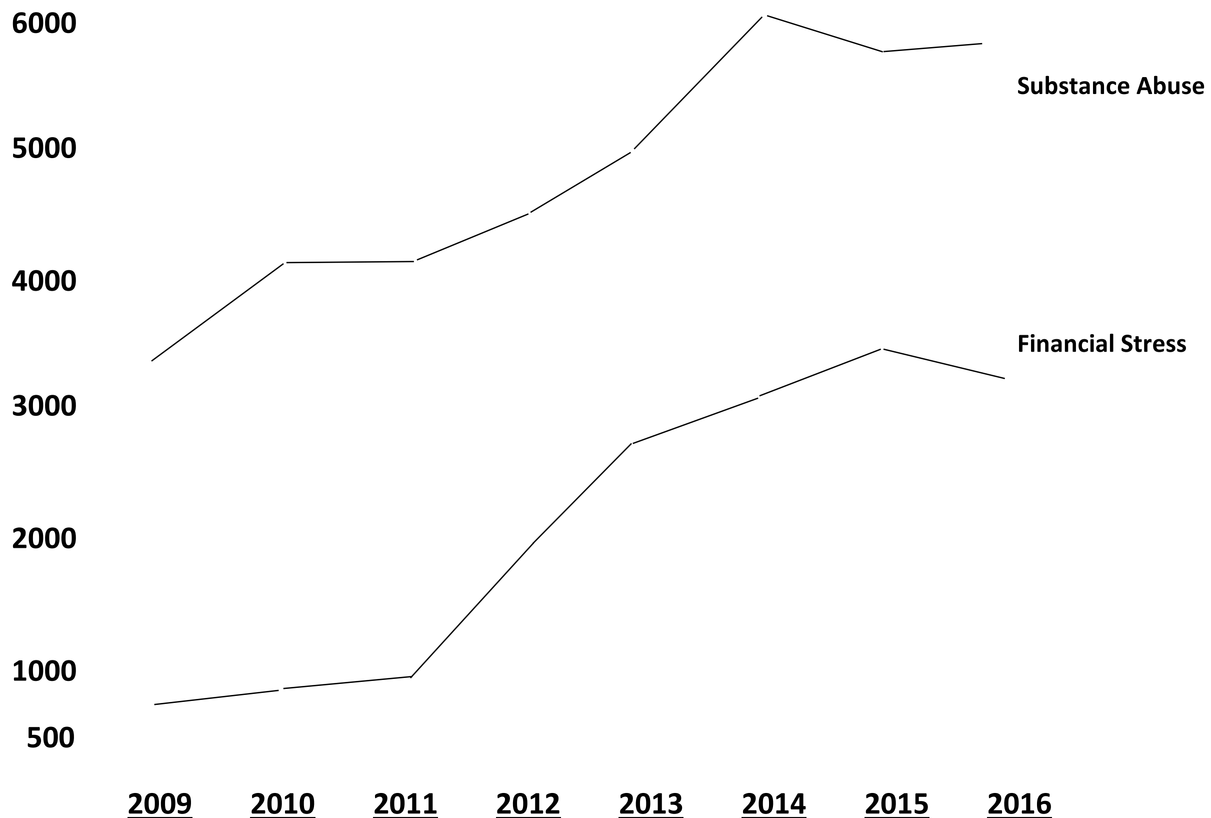
Numbers extrapolated from Report on Child Protection in Vermont (years 2010-2016), Vermont Department for Children and Families. Columns do not total 100% in the official reports so we did not attempt to do so in this analysis.



Numbers extrapolated from Report on Child Protection in Vermont (years 2012-2016), Vermont Department for Children and Families

Financial Stress & Substance Abuse: A historical perspective

Family Factors Identified by Reports/Intakes 2009–2016



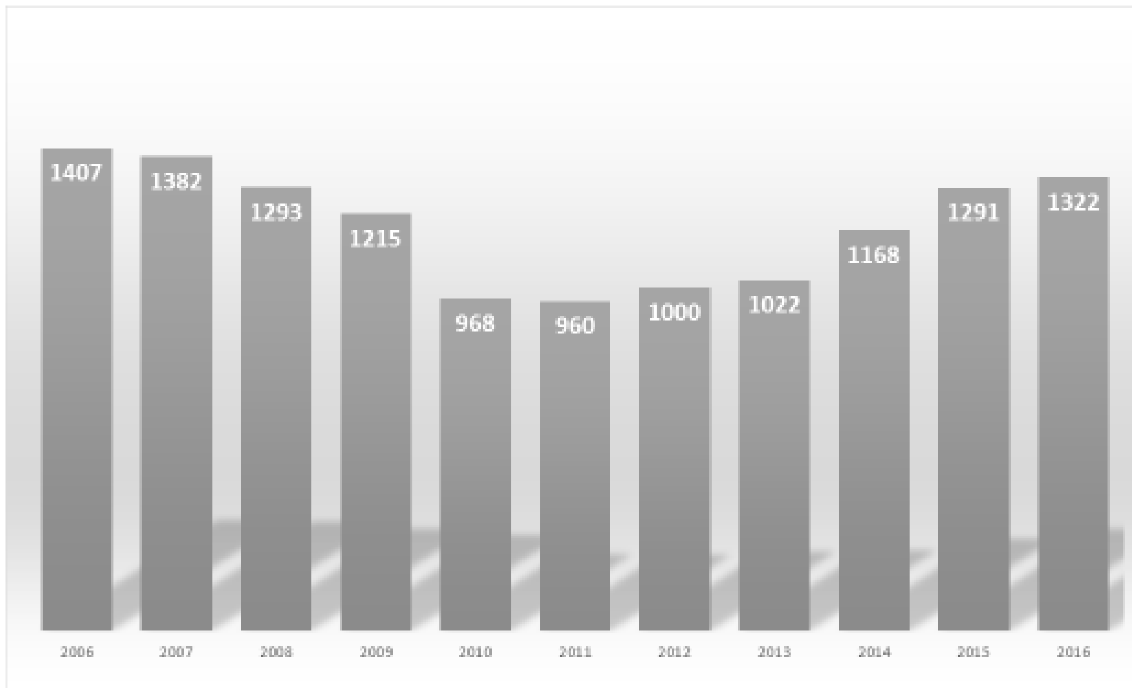
Numbers extrapolated from Report on Child Protection in Vermont (years 2009-2016), Vermont Department for Children and Families

Between 2009 and 2016, financial stress grew at a faster rate than did substance abuse, with financial stress growing by 2,791 reports over this period, while substance abuse grew by only 1,607 reports. Yet opioids have been considered the prime driver in caseload increase and the increase in the number of young children entering state custody. In reality, poverty has been as great a factor in child protection actions as has been substance abuse, yet we do little to address the fact of poverty (and accompanying homelessness) among families grappling with the child protection system, except to remove their children.

G. What produced a significant reduction in foster care placements during what would have been the height of the opioid epidemic?

DCF SFY 18 Budget Notes, February 1, 2017

DCF Custody Trend Over Time



As early as 2009, Vermont had already identified an opioid epidemic, and in 2014, Department of Health data show us that there were 1,751 people in treatment and another 513 individuals awaiting treatment. By July 2017, there were 3,148 people in treatment and another 110 awaiting treatment. Yet DCF data (above) shows a reduction in the number of foster care placements during what would have been the height of the opioid problem and the greatest dearth of treatment.

The primary question raised is what were the practices and circumstances that led to a significant reduction in the use of foster care placements from 2010 to 2013, and what factors drove the significant increase in placements from 2014 to 2016? In 2014, the system was deeply impacted by the death of two young children in care. These cases, of families known to DCF, rocked both DCF and the Agency of Human Services and resulted in several terminations at the highest levels. Morale was also shaken by rumors of the possible filing of criminal charges against DCF staff for negligence. As is the case in other jurisdictions, such fatalities often led to a spike in cases called in and accepted.

IV. Overview of Findings & Recommendations

(Note: Findings & Recommendations in detail are found beginning on page 57.)

1. There is no external or internal entity routinely providing oversight or holding DCF accountable with regard to its overall operation and complaints made against it.
Recommendation:
Establish a child protection Ombuds Office, charged with monitoring system outcomes, procedure, complaint allegations, and other elements of its overall operation.

2. There is no central place where families can obtain accurate and credible information about how the child protection system operates, their rights and responsibilities, or where effective legal representation and advocacy are provided.
Recommendation:
Establish a Parent Representation Office that resides outside of DCF and the defender general's office, and whose primary purpose is to educate families about their rights and responsibilities, advocate for them prior to the filing of a CHINS petition, and represent them once a CHINS petition has been filed. This entity should be funded as part of the overall child protection system state and federal funding stream.

3. DCF consistently demonstrates an inability to conduct thorough and accurate investigations or assessments, often resulting in the state's defaulting to removal of children before there is clarity that removal is necessary.
Recommendation:
Utilizing a multidisciplinary (legal and social services) team, working in tandem with the family, DCF and community-based social service agencies can provide the type of front-end prevention efforts that have proven successful in other jurisdictions.

4. Differential Response appears to have failed in Vermont. Its current application has resulted in little difference between investigations and assessments, except that assessments are used to achieve family separation absent a court order, something not allowed in an investigation.
Recommendation:
Review the current usage of differential response, and if it is determined that there is little fundamental difference between how investigations and assessments are conducted, cease the use of the assessment process. If it is determined that differential response has a viable role

in addressing child welfare, ensure that its application complies with nationally recognized best practices,[10] rather than its current use as a tool to remove children from their homes absent a court order.

5. DCF investigations and assessments are poorly conducted, yet there is little challenge to the resulting deficiencies by assigned public defenders, state's attorneys, or assistant attorneys general.

Recommendation:

The creation of both a Parent Representation Center and an Ombuds Office should serve as a check on the poor quality and accuracy of DCF investigations while providing the court with better information.

6. There appears to be no standardization or consistency in DCF investigation or assessment reports, which are often comprised little more than the initial allegation, historical file information, and incomplete investigative notes, yet serve as the foundation for affidavits and petitions for child removal. DCF files rarely contain positive family information.

Recommendation:

Investigative reports should be standardized in form, and affidavits and CHINS petitions should be accompanied by a report. Files should reflect strengths and weaknesses.

7. The relationship between DCF workers and families is frequently one of mutual suspicion, if not antagonism and hatred.

Recommendation:

Use of a multidisciplinary team is a demonstrated method of developing a positive relationship and more accurate determination of client need.

8. DCF workers control little in the way of helpful services or resources and no oversight of the efficacy of the services that are available. As a result, they primarily serve as monitors rather than social workers tasked with supporting families, removing barriers, and overcoming challenges.

Recommendation:

Establishment of a designated Case Coordinator charged with oversight of the universe of services with which a family is engaged will bring order to what is currently an un-manageable system.

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[10] Lessons from the Beginning of Differential Response, Siegel, Institute of Applied Research, St. Louis, Mo, 1/2012

9. DCF caseloads exceed recommended standards, ensuring that workers have little depth of understanding of families or the ability to build productive relationships.[11]

Recommendation:

An external review of current DCF policies and practices, and in particular casework supervision, will enable policy makers to accurately determine how much of the caseload problem is inadequate resources versus inefficient/ineffective use of current resources. Currently, no one can definitively answer this question.

10. DCF front-line workers operate in a highly stressful environment. Affected by political pressures, family antagonism, bureaucratic demands, and the inherent desire to protect children. DCF workers, and/or supervisors often take the most conservative (safest) course of action by bringing children into the system, therefore diffusing responsibility and liability.

Recommendations:

A*. The use of multidisciplinary teams can address the lion's share of current challenges.*

B. *Child protection investigations will always carry an inherent level of stress for workers. In light of the special duty and stresses they encounter, state government should consider creating a career track for DCF investigators, including supports and retirement options comparable to those provided for law enforcement.*

11. No one has ownership of, or responsibility for, success or failure in a given case.

Recommendation:

Identify case ownership, whether through a service coordinator or other mechanism as a means of introducing accountability into the system.

12. Coordination across multiple services is largely nonexistent. The current system is marked by a stovepipe approach to the application of multiple, complex services.

Recommendation:

A system that currently spends hundreds of millions of dollars on services should be able to establish a standardized case-coordination system, with related authority and responsibilities.

13. DCF workers routinely fail to inform parents about their rights, and the ramifications of relinquishing procedural/constitutional rights.

Recommendation:

The creation of a Parent Representation Center will eliminate this issue, as families will have access to accurate information early in the intervention process.

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[11] Vermont's 2019 Annual Progress and Services Report, p. 76. Vermont Department for Children and Families

14. The original intent of family safety plans to help families keep their children safely at home (a voluntary activity used during assessments) has been transformed into a mechanism routinely used by DCF, during investigations and assessments, as a means of removing children without a court order.

Recommendation:

DCF must have the legal authority with articulated reasons or basis for implementing a family safety plan including the facts underlying such reasons and, if out-of-home placement is contemplated, why less restrictive alternatives could not satisfy the child's safety.

15. Risk of harm has become a significant driver of both caseload volume and duration due largely to a failure to define significant danger or serious harm in statute.[12] Today, almost anything can be termed risk of harm.

Recommendation:

Clarify the statutory definition of significant danger and serious harm so as to make the determination of risk of harm objective rather than subjective.[13]Require DCF to specify the harm in its reports and affidavits, and require the state's attorney to do the same for CHINS petitions.

16. Parents successfully engaged in medication assisted treatment (MAT) for opioid dependency are viewed by DCF workers in much the same light as parents who are actively using illegal substances.

Recommendation:

Distinguish, in reports and affidavits between parents who are successfully engaged in medication-assisted treatment and those using illegal opioids.

17. Affidavits to support a CHINS petition often are not factual and undergo virtually no verification or quality assurance about the veracity of the document's content.

Recommendation:

Require that affidavits are reflective of the content of the investigative report, and not simply a rewriting of the initial abuse/neglect allegation. Each element of an affidavit should be directly linked to a section of the investigative report that serves as the foundation of the affidavit.

[12] 33 V.S.A. Sec. 4912 (14)

[13] 33 V.S.A. Sec. 4912 (14)

18. Investigations and assessments are not limited to the allegations made; rather they are used as the starting point for a review of a family's entire history, lifestyle, values, practices, economic well-being and customs in order to determine whether there is any possibility of a problem arising for which child protection workers could be held responsible at some future point.

Recommendation:

If abuse/neglect are not identified, but the investigator believes that the family could benefit from social services, a referral can be made to a community-based agency outside of the DCF system, an agency much better suited to working with families absent the coercive element inherent in DCF involvement.

19. DCF workers routinely assert legal authority they do not possess, while also telling parents that the family does not have legal rights, which, in fact, they do have. Parents have no effective way, at those times, of determining that this constitutes bureaucratic overreach.

Recommendation:

The creation of a Parent Representation Center will eliminate this issue, since parents will have access to accurate information early on in the child protection process.

20. There appears to be no routine mechanism for the DCF Intake system to detect, early in the complaint process, allegations of abuse/neglect that are being made by one parent against the other solely for the purpose of gaining a custody advantage.

Recommendation:

Establish DCF protocols in the Intake process to flag reports that appear to relate to custody disputes between parents.

21. The standardized risk assessment tool (the SDM Assessment of Danger and Safety), which is based on history, is routinely used by DCF to require families to engage in open Family Services Cases even when an investigation or assessment shows that there is no need for services.

Recommendation:

Review the changes made in the standardized risk assessment tool[14] in order to verify that it is still a valid instrument. Once the tool is revalidated, employ it as but one of several criteria in determining that a family participate in services. Eliminate the condition that merely having been a foster child is an indicator that a parent may pose a risk to their own children.

[14] SDM Assessment of Danger and Safety

22. Upon completion of a voluntary assessment, families are frequently told by DCF that they must enter into an open family services case, regardless of the results of the assessment; otherwise DCF may file an affidavit seeking custody. This is contrary to statute and policy. [15]

Recommendations:

A family's decision not to engage in services should be honored as statute dictates it should.

23. Although there is a new focus on "trauma" in the lives of children, there appears little recognition that trauma has had a similar impact on the child's parents, and in some instances, the grandparents. The trauma to a child arising from removal from home is largely ignored, as is trauma associated with multiple foster home placements over short periods of time.

Recommendations:

A. *Trauma training should include multigenerational trauma relative to trauma response and treatment modalities.*

B. *The trauma effects of forced removal and multiple foster home placements upon children and their parents should be recognized in both training and in the decision to take children into custody.*

24. Although the child protection system has identified opioid dependency as a major driver in caseload increases, the system has failed to adopt a recovery model of care and treatment for families involved with opioids.

Recommendation:

Incorporate a recovery model in both DCF and community-based social service agencies training in working with families experiencing substance abuse.

25. Homelessness and lack of transportation are often a direct outgrowth of poverty, and although poverty is not allowed by law to be the rationale for removing a child, children are removed, or threatened with removal, when homelessness and lack of transportation are present.

Recommendation:

When homelessness and/or lack of transportation are identified as the only service needs, other than in exigent circumstances, neither should be used as a rationale for removal of a child. The family should be provided housing and transportation rather than threatened with state custody or monitored by DCF absent other, overriding, child protection concerns.

[15] 33 V.S.A. Section 4915 a (c)

26. Duplication of services occurs routinely, particularly in cases involving very young children/infants.

Recommendation:

Establishment of a case coordinator within community-based service agencies should result in the elimination of service duplication, and when it must occur, families can be provided with a knowledgeable understanding as to why duplication is necessary and how long such might continue.

27. Preventive education about the child protection system and parents' rights, coupled with advocacy on behalf of parents, are largely absent in the current system. When effective education and advocacy are available in the early stages of a case, families almost always successfully engage in services and retain custody of their children. This is in stark contrast to what happens absent advocacy, especially with very young children.

Recommendation:

Establish a Parent Representation Center that is outside of the Office of Defender General and provides education about how the child protection system works, parents' rights, service advocacy and support, and in pre-petition instances, legal representation.

28. Vermont's adoption of "best interest of the child" in 2015 has left child protection decision making in a quandary. Best interest is not defined in statute, nor is there consistent guidance provided to the myriad parties involved in child protection cases.

Recommendation:

Review the criteria for determining best interest of the child. Create a consistent definition, and include the placement of children with relatives as a priority when such placement is appropriate.

29. When young children enter state custody, extended family members (typically grandparents, uncles, or aunts) are not routinely informed of what may happen to their children unless extended family members intervene early in the process.

Recommendation:

Require documentation that family members have been notified. Inform relatives, early on in the placement process, of the risks involved in failing to actively engage and assert legal standing.

30. Placement of very young children in pre-adoptive homes creates competition for the child between birth parents and pre-adoptive foster parents and appears to be a primary driver in Vermont's inordinately high rate of termination of parental rights for very young children.

Recommendation:

Review both the process and utilization of pre-adoptive homes for infants, and very young children, to ensure that foster parents are not being led to believe that the foster child will become their adopted child and that they are willing to become mentors to the birth parents. Require a statement from foster parents that no such promise has been conveyed to them so long as parental rights exist for the child's family.

31. Voluntary relinquishment of parental rights in exchange for a promise of visitation after adoption is, in reality, a deceptive technique. The promised visitation does not occur, because there is no effective enforcement mechanism, but this is rarely explained to the parent by DCF.

Recommendation:

Require that proposals made to parents or custodians eliciting them to relinquish a parental right, guardianship, or custodianship in exchange for another status or benefit are made only in the presence of a lawyer who can explain both the certainty and the uncertainty of what is being proposed.

32. Voluntary relinquishment of conditional custody as a result of an offer to become foster parents, which will ultimately lead to becoming adoptive parents, appears to be a technique used by DCF when, in reality, DCF has no intention of granting a foster care license once the custodians have relinquished their custodianship.

Recommendation:

Require that proposals made to custodians to elicit their relinquishing custodianship in exchange for a foster care license (or other status over which the Family Court has no jurisdiction) as a stepping stone to adoption are only made in the presence of a lawyer, who can explain the potential jeopardy to which the custodians are exposing themselves, since DCF can decide not to approve the custodian as a foster parent, or later can revoke the foster care license resulting in the former custodian being left with no legal rights to the child.

33. DCF performance measures are largely absent regarding "well-being outcomes" and do not reflect whether children or families are better or worse off following system intervention. The most significant tool for performance measures is the annual progress report that is primarily a 140+ page document that appears devoid of outcome measures.[16]

Recommendation:

Review current performance measures with a focus on measuring whether people are better off as a result of state intervention and employ the measures to improve system performance.

34. Accountability is nonexistent when it comes to DCF investigators' adhering to policy, procedure, and statute, and an effective, objective appeal process does not exist. Consumer complaints are typically referred back to the office/personnel about which the complaint was lodged. This is a primary reason why internal reform is beyond the capability of DCF.

Recommendation:

The creation of an Ombuds Office should have, as one of its primary functions, the review and resolution of citizen complaints regarding state action relative to child protection.

35. Quality assurance mechanisms are impossible to establish and effectively employ in a system that is closed to external review and works with information that is shrouded by confidentiality.

Recommendations:

A. *The establishment of both an Ombuds Office and a Parent Representation Center will bring an element of oversight absent in the current system.*

B. *Establish the equivalent of an after-action review at each case closing, detailing what was successful and what was not with the family and service provision/utilization. Make these available for both internal and external oversight bodies and for quality assurance purposes.*

36. Completion times for DCF investigations and assessments are routinely exceeded, sometimes by as much as a quarter to half a year.[17] [18]

Recommendation:

Require DCF to adhere to the statutory and policy timelines for investigations and assessments. Failure to adhere to the timelines, or to obtain extensions where allowed, should result in case closure with prejudice.

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[16] Vermont's 2019 Annual Progress and Services Report, Vermont Department for Children and Families

[17] 33 V.S.A. Section 4915a (d)

[18] Vermont's 2019 Annual Progress and Services Report, p.7. Vermont Department for Children and Families

37. Regular DCF case conferences and/or reviews frequently do not occur even after repeated requests by parents/guardians.

Recommendation:

Require that DCF case conferences and case plan reviews are regularly held and documented and that all parties leave with a clear understanding, in writing, of what has been accomplished and what remains to be done, including specific outcomes and completion dates. An Ombuds Office and/or Parent Representation Office would ensure compliance.

38. Case plans are routinely not family-specific nor readily available to families in a timely manner.

Recommendation:

Review the timing and purpose of case plans, with a particular focus on the development of family-specific plans and ensuring that plans specify the reasonable efforts being made to reunify families and the timing of those efforts.

39. Mandatory reporting appears to produce multiple reports regarding the same issue, resulting in skewed data. Reports are frequently made by individuals who have no firsthand knowledge of an event but who fear that their failure to report will result in disciplinary action.

Recommendation:

Consider reviewing the mandated reporter requirements to determine whether there have been unintended consequences to mandated reporting and how the duplication of reports affects our understanding of the severity of child abuse/neglect, as well as the threat of loss of employment and other penalties for mandated reporters.

40. DCF changes in nomenclature, how data is presented in reports, and the questionable veracity of data elements make it challenging to interpret data and to compare trends over time.

Recommendation:

Evaluate how DCF data relates not only to outputs (numbers and process), but more importantly, to outcomes, and maintain consistency about outcomes that are measured.

41. Public defenders, especially contract attorneys, assigned to indigent families rarely meet with their clients face-to-face outside of court, review material for factual accuracy, file motions, or even return client telephone calls or emails. This does not include all, but describes the preponderance of our experience.

Recommendations:

A. *Replace the current ODG–contracted public defender system for parents with a Parent Representation Office, operating outside of the ODG.*

B. *In the event that the current ODG contract system remains in place, require ODG attorneys (contract and other) to document the face-to-face time spent with clients outside of court hearings, the number and duration of conferences held with clients, and the number/type of motions filed on the client's behalf. Make this data a component of regular audits of the program by the auditor of state accounts.*

42. In its nine years of representing families and advising defense attorneys, VPRC demonstrated that utilization of a "motion practice" (filing motions to compel information and present evidence to the judge) almost always resulted in families' retaining custody of their children or obtaining favorable orders. However, few public defenders used motions on a regular basis, and many not at all.

Recommendation:

Establishment of a Parent Representation Center will address this critical missing component in ensuring effective representation to parents and due process throughout the rest of the child protection system.

43. State's attorneys have little ability or opportunity prior to filing a CHINS petition to verify that DCF affidavits are accurate reflections of a family's actual situation.

Recommendation:

Require that both the parents' attorney(s) and the state's attorney receive a standardized DCF investigative report serving as the foundation for an affidavit and the affidavit itself prior to the first hearing.[19]

44. The attorney general's office's termination of parental rights actions rely entirely upon the DCF assertion that reasonable efforts have been made to reunify a family, before DCF requests a TPR. Our experience is that "reasonable efforts" are rarely accurately portrayed.

Recommendation:

Require the attorney general's office to conduct an independent review to determine whether reasonable efforts were made and are documented, including whether effective services were offered, prior to a termination of parental rights proceeding.

[19] The Washington State bench/bar requires that an affidavit arrives an hour before a hearing for all attorneys. The child protection agency provides a Discovery Packet supporting the affidavit prior to the hearing. By contrast, Vermont's discovery appears abysmal.

45. Courts are chronically backlogged due to an insufficient number of judges, resulting in extended delays while children are in foster care.

Recommendations:

A. *Review the data from the Court Improvement Project in order to determine where backlogs exist, how significant they are, the number of additional days and placements in foster care children suffer as a result. Utilize this data to determine the shortfall in judges and how long it would take to reduce the backlogs if this additional number of judges was added and over what period of time it should remain in place.*

B. *Determine to what extent backlogs occur due to the actions, or inactions, of DCF, state's attorney, defense counsel and GAL.*

46. The current practice of routinely rotating judges has resulted in multiple judges' being involved in a single CHINS case. When coupled with the high turnover rate of DCF personnel, the shared responsibility between the state's attorney and the attorney general, an insufficient number of guardians ad litem, and children moved to multiple foster homes, there frequently is no one in the courtroom who has a complete understanding of the case, the child or the family.

Recommendation:

A. *Revisit the practice of rotating judges in child protection cases. Judges should follow child protection cases from beginning to end. This may require the creation of a Regional Family Court System, which might bring with it increased cost in the short run, but will reduce overall costs in the long run while enhancing the quality of judiciary service.*

B. *Establish a "one case, one judge" system that is adequately structured and staffed so as to address the current chronic backlog of cases.*

C. *The focus should be to safely maintain children within the immediate or extended family whenever appropriate and to provide the court with better information when making the placement decision.*

D. *Determine whether responsibility for representing DCF, in child protection cases, should reside fully with the state's attorney or the attorney general, but not with both.*

47. The current GAL program is understaffed and underfunded and frequently brings little value added to understanding the child's needs and situation or of the family from which the child was removed and to which the child may return.

Recommendation:
Review the option of adequately resourcing the GAL program, eliminating the program and replacing it with a change in the role of the child's attorney so as to have the child's attorney represent the legal interest of the child, or consider introducing the Court Appointed Special Advocate (CASA) program to Vermont as exemplified in New Hampshire and Massachusetts.

48. Under current law and policy, substantiation of abuse or neglect is based upon the reasonable person standard. However, there is no definition of "reasonable person", and the individuals rendering opinion/judgment in substantiations are DCF workers and supervisors, and the initial hearing officers are typically ex-child protection workers or former law enforcement personnel, neither of which are truly objective or fit a reasonable person profile. Rather, they are individuals whose training is designed to heighten sensitivities and err on the side of caution relative to child protection, far in excess of that demonstrated by a hypothetical reasonable person. Additionally, they are under considerable pressure to do so.

Recommendation:
The standard of proof should be redefined to be one of "proof that an objective, reasonable person would find convincing."

49. The appeal process, following substantiation, typically pits an untrained citizen against highly trained and experienced attorneys representing the government. The official documentation provided to the person appealing is difficult to follow, often partial in completeness, and frequently of questionable veracity.

Recommendations:
A. *Notification of substantiation and entry into the registry should be more comprehensive; the appeal process more informative; and timelines for appeal, hearings, and opinions should apply equally to citizens appealing and the state.*
B. *Individuals appealing substantiations should be represented by an attorney, as is the state. A Parent Representation Center can fill this role.*

50. DCF routinely holds parents to the statutory 14 day requirement for filing an appeal of a substantiation or entry into the Abuse Registry, yet DCF does not hold itself to the 35-day statutory requirement within which an administrative hearing is to be held, or the seven-day statutory time period within which the hearing officer opinion is to be rendered.[20]

Recommendation:

Timelines for lodging and conducting appeals should apply equally to the person appealing and to the state. Failure to meet the timelines should preclude, with prejudice, substantiation and/or entry into the Registry.[21]The current rationale for exempting DCF from the 35 day requirement appears to be based on two premises, both faulty: first, that the delay is due to the need to redact DCF files prior to an initial hearing, and the second being that if DCF was held to this timeframe, the system would collapse. Such rationale appear wanting in that the redacted files are almost useless to an individual seeking an initial hearing AND when the individual requests a full hearing before the Human Services Board, un-redacted files are provided. One has to question the purpose of providing only redacted files in the first place. More importantly, impending potential placement in the Abuse Registry has both a chilling and actual infringement upon an accused's right to work, contact with family and other limitations. These infringements clearly outweigh a large bureaucracy's inability to complete its tasks in a timely manner, much less complete tasks that have questionable usefulness in the overall scheme of appeals.

51. There appears to be no independent process other than legal appeals when misfeasance/malfeasance is alleged by families relative to DCF personnel.

Recommendation:

The creation of an Ombuds Office and a Parent Representation Center should bring a level of quality assurance to this system so that complaints of mal- or misfeasance can be addressed during the course of an investigation/assessment or initial substantiation.

52. A single day of missed school (children ages 6–16), absent an excuse from the respective school superintendent, constitutes truancy.[22] DCF policy states that "educational neglect" follows the statutory definition of truancy when a child regularly fails to attend school.

Recommendation:

Establish a clear, realistic, and uniform standard definition of truancy and educational neglect to bring both the definition and application into line with reality.

53. DCF's use of a remote physician, diagnosing the cause of injuries solely via photographs and questionable information provided by DCF as the basis for immediate removal of children

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[20] 33 V.S.A. Section 4916a. (d) and (g)
[21] 33 V.S.A. Sec. 4916a (d) and (g)
[22] 16 V.S.A. 1121

prior to an actual physical examination and absent other indicators, has produced multiple examples of children's being removed and kept in out-of-home placements unnecessarily even after local physicians have determined that the remote diagnosis is incorrect.

Recommendation:

Cease the use of remote physicians. Establish a protocol for physicians when they are requested to provide a professional opinion whether an injury may, or may not, be the result of abuse.

54. Cases that are open for assessments or family services can take months during which little or no information is gathered by DCF, there is little to no contact by DCF workers, and no helpful services are provided. Meanwhile, families remain on tenterhooks wondering whether children will be removed or what it is that they are expected to accomplish to ensure that a case reaches closure.

Recommendation:

The creation of a Parent Representation Center should address the historic delay in processing and closing cases in a timely manner, as would the creation of an Ombuds Office.

55. Where there is not sufficient evidence to warrant a CHINS petition, DCF uses the threat of obtaining a petition to coerce parents into agreeing to minor guardianships (MG) for their children, despite DCF's own policy prohibiting such a practice.

Recommendation:

DCF should reiterate, and monitor, its own policy prohibiting DCF workers from coercing minor guardianships. The creation of a Parent Representation Center and an Ombuds Office can further ensure that parents are not coerced.

56. DCF files routinely contain incorrect information. Parents rarely, if ever, have the opportunity to review the information, much less have the misinformation corrected. Additionally, attorneys find themselves having to make appointments at a DCF office, then painstakingly sort through paper files that are in no particular order, contain an array of observations, innuendo, unfounded concerns and information that can only be described as flotsam and jetsam in order to understand what evidence DCF actually possesses, virtually none of which is complimentary in any way to the family or identifies family strengths.

Recommendation:

A. *Establish a common platform whereby information can be electronically submitted to a family's file, including medical updates regarding urinalysis results, in real time and readily available to attorneys and DCF. This both expedites information gathering and analysis, and better ensures that the information is accurate and up to date.*

B. *Upon closure of a case in which abuse/neglect was not substantiated, the subject of the case should be permitted to review the DCF records (minus confidential elements) in order to ensure the factual accuracy of information contained and have incorrect information corrected.*

57. Unlike parents involved with a CHINS petition where a child has been removed and Reach Up support is available for 180 days, parents involved in minor guardianships do not qualify for Reach Up and its related supports, even when reunification is the goal. This increases the level of difficulty for parents attempting to overcome the challenges (often financially related) that led to the guardianship.

Recommendation:

Minor guardianship is a temporary status and should be provided the same legal rights of 180-day access to Reach Up support as a parent involved in a CHINS petition receives.

58. There is inconsistency from one DCF worker and DCF office to another regarding the amount and level of detail of information requested during investigations and assessments, or the method used to determine whether an investigation or assessment will ensue, or when a family services case will be open rather than a CHINS petition sought.

Recommendation:

The creation of an Ombuds Office should, as part of its routine monitoring include the degree of consistency/inconsistency in DCF's district office functioning.

59. When newborn children are taken into custody, nursing and non-nursing mothers have had to seek legal advocacy in order to obtain daily visitation with their newborn. Absent such advocacy, visitation did not occur sufficient to support breastfeeding and bonding.

Recommendation:

Establish a policy change wherein mothers of newborn children have a right to five-day-a-week visitation with their children, and breastfeeding arrangements are routinely provided for.

60. In VPRC's experience, it is not unusual to encounter families where there is a generational history of children in foster care. In some instances, VPRC experienced families with four successive generations having been in foster care.

Recommendation:

Create an annual report on the number of children in foster care whose parents and grandparents were in foster care. Use these findings as part of an assessment process that employs performance measures on whether foster care leads to positive long-term outcomes. A system that continues to see multiple generations of foster children would appear to be a system that either has failed to address the cause of abuse/neglect or is, itself a contributing factor.

61. Following the death of two young children in 2014, there were requests to pursue criminal investigations relating to the acts or omissions of DCF personnel involved in the respective children's cases. Those proposals, and the corresponding firing of senior managers and executives, appear to coincide with a significant increase in the number of children entering custody and/or the opening of family services cases.

Recommendation:

Review the impact of actions by past administrations and the legislature to determine to what degree, if any, discussion of pursuing criminal charges against DCF personnel, and the subsequent firing of management, have had the unintended consequence of DCF personnel's taking children and families into the DCF system as a form of worker self-protection as opposed to child protection and welfare.

Rachel's Story

"I have three children: Matt, age 9; Luke, age 6; and Joan, age 2. On Matt's first birthday, his father died. I felt overwhelmed with guilt and anxiety and for the first time used illegal drugs. I soon became addicted and entered a long period of substance abuse. I met my (now) husband, and together we led a life of illegal drugs. Three years ago, DCF brought a petition for neglect. My boys went to live with my sister temporarily, but I took care of them every day.

After a while my sister could no longer care for them. I was clean, and the court gave me the boys back. DCF said in their documents and in court that I was a good mom who met my boys' needs when I was sober. I had Joan shortly thereafter, and relapsed after her birth. My husband went to jail for three years for a drug offense and his sister-in-law took all three children for a few months. Then my mother-in-law took the baby. My boys went to a relative of my husband's. Then my oldest boy went to live with his father out of state.

I struggled with my sobriety for another six months. Throughout all of this, DCF, the judge and all the lawyers agreed that if I entered the Lund home, achieved stability, and stayed clean, it would be in Luke's and Joan's best interest to join me there and we would be reunited. The judge said that he would give me four months to show progress and set another status conference in six weeks. I entered Lund following a short stay at a drug treatment program, but learned that Luke was too old to reside at Lund with me. Joan joined me at Lund and she has been with me ever since. Then, DCF told me that they would terminate my parental rights of Luke, and I had two options: 1. I could fight it and lose all rights to see Luke, or I could agree to let my husband's relative adopt and I could see him as much as I wanted. My husband's relative *urged me to let her adopt and told me that I was his mother and she would never keep Luke*

from me. No one told me that the judge could give me a third option — to continue with visits with Luke and reunify with him after finishing Lund successfully. I understand now that the judge had left that option open, but no one told me about it.

I tried to call my public defender many times to better understand what all this meant but never received any return phone calls. I found out later that she had retired and no one had informed me. I was on my own, and I gave into the pressure and agreed to let my husband's relative adopt Luke so that I would not lose him completely.

The state filed a termination of parental rights petition which I did not see until I came to the status conference about how I was doing at Lund. This status conference turned into a "voluntary" termination of my parental rights. I was given a new attorney who knew nothing about the plan for Luke. We never discussed what had happened to the plan for Luke to come with me to Lund, nor any other options I may have had. I continued to see Luke while at the residential services program for a few times, but then all visits stopped even though I was clean and sober. DCF told me that the visits were not good for him because he wanted to come home with me after each visit.

I then learned about the Vermont Parent Representation Center and contacted them. The VPRC lawyer fought to get my file and explained it to me in ways I could understand. She then filed motions in court to overturn the termination of parental rights. I finished Lund successfully. Luke had not been adopted and I had been clean and sober for over a year. I got Joan back; I have a full time job, a subsidized apartment and I should be able to be Luke's mom. The court denied it all. I do not have any more strength to fight this. Had I had VPRC from the beginning, I am convinced that my children would be together with me. We deserve being together and that *will not happen now."*

V. History of Vermont Parent Representation Center (VPRC)

For years most professionals involved in child protection proceedings in Vermont called Child in Need of Care or Supervision (CHINS) agreed that improved representation of all parties was required to help families, comply with due process of law, and ensure improved outcomes for the involved children. In 1997 the permanency planning implementation committee (PPIC) of the Vermont Supreme Court[23] studied how to implement a system of improved legal representation as part of other strategies to prevent children from lingering in our foster care system. In 2000, a **Proposal for Pilot Project Concerning Specialized Juvenile Attorneys in Six Counties** was presented jointly by the Permanency Planning Implementation Committee, the Department of State's Attorneys and Sheriffs, the Office of Defender General, and the Department of Social and Rehabilitation Services,[24] which would have created full time, specialized attorneys for all parties in six counties, who would be recruited, trained, supervised, and subject to standards of practice and performance.[25] Despite having a modest budget for implementation, no action was taken either by the Supreme Court or by the legislature. When little improvement of our child welfare outcomes was realized over an eight-year period, a group of professionals with interest and experience in our child protection system decided that the best approach to improving outcomes for our abused and neglected children was to improve legal representation and social supports of parents, and to begin advocacy before any legal proceedings in the courts had begun. Thus the Vermont Parent Representation Center, Inc. (VPRC), a not-for-profit organization, was formed in 2009. Its mission, *"To ensure through advocacy and support that children who can live safely with their parents are afforded a real opportunity to do so,"* reflected the founders' vision that with effective interdisciplinary legal and social services, we would drastically reduce the number of children removed unnecessarily from their families into state custody, reduce child trauma, and save money.[26]

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[23] This 33 member committee, chaired by Justice James Morse, was created by the Vermont Supreme Court in 1997 as part of the Court Improvement Program funds under the Omnibus Budget Reconciliation Act of 1993 for state court systems to conduct assessment of their foster care and adoption laws and judicial processes, and to develop and implement a plan for system improvement.

[24] This was the name of the Vermont's child protection agency which was later changed to the Department for Children and Families (DCF).

[25] Our system of legal representation in effect then, and now, is derived primarily from the criminal model, in part because the court proceedings used to be heard by our criminal court. The state's attorney in each county brings the initial petition for child abuse/neglect based on an emergency or an affidavit signed by a DCF case worker or police officer. The public defender system represents most children, and parents are represented by private attorneys through a contract system set up by the Office of Defender General. If the state files a termination of parental rights petition, the attorney general's office represents the state.

[26] This interdisciplinary approach, using **an attorney** to educate and guide parents through complicated procedures and remove legal barriers to keeping children safely at home; a **social worker** to help parents identify their strengths and needs, find options for change, and access needed services; and a **peer advocate** who, through direct personal experience with the foster care system, would provide the necessary trust by listening without judgment, provide practical insight, and fill gaps in communication, was being used in other parts of the country, notably in New York

Vermont Parent Representation Center's Programs (and the Lessons Learned)

A. Pre-court Pilot Project in Franklin, Lamoille and Grand Isle Counties (2010–2012)

VPRC presented a pre-court interdisciplinary intervention program proposal to the Vermont Legislature. It would have provided legal advocacy and social supports for parents from the beginning of the state's investigation or assessment of child abuse/neglect and legal representation of the primary care parent if the state, through the Department for Children and Families (DCF), filed an affidavit with the state's attorney to support a petition for CHINS. This would have provided due process for the parents, legal and social work support, and problem solving without involving the family in the court. DCF, however, objected to any legal advocacy and social supports during the investigatory stages, and the ODG objected to anyone but parents' contract attorneys representing them in CHINS. The legislature ended up providing funding for our work after DCF had completed the investigatory stage and opened a family case for ongoing services.

Our target population comprised young parents who, beginning as young children, suffered extensive trauma with life-long consequences. Substance abuse, mental illness, learning disabilities, homelessness, a pattern of relationships with violent offenders, assaults, and sexual abuse were common characteristics. Many had never experienced nurturing parenting themselves or seen what positive parenting looks like. Living in poverty in rural Vermont added challenges because of no access to reliable transportation and great distances between housing and services.

VPRC served 26 families with 55 children in their own homes over a two year period using our multidisciplinary "legal wraparound" team, 19 of whom were pre-court, five had children in custody through probate court and two had children in custody and children at home. Seventy-eight percent of our families who did not have children in custody of the state or relatives when VPRC began providing services had no child removed by the state while being served by VPRC. This well-being outcome was exemplary for a new program with high-risk families and its long-term impacts, supported by 2007 research by MIT Sloan School of Management showing that children "on the margin of care" faced with two options — being allowed to stay at home or

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City. The approach had shown incredible outcomes by preventing unnecessary removals to foster care and shortening the time children had to be in foster care.

being placed into foster care — have generally better life outcomes when they remain with their families.[27]

Lessons Learned

- The power of DCF to remove children makes families afraid. Fear is not an effective motivator, and unless the families have an advocate at every interaction with DCF, communication breaks down. DCF is used to having unaccountable interactions with families before the matter has been brought to court and found it difficult to work with VPRC advocates, who often suggested alternate approaches to remove risks to children.

- As part of the agreed upon approach to this new work, DCF had agreed to refer cases where the families needed legal advocacy and were at high risk for abuse/neglect according to their risk assessment tool. Despite the explicit agreement from DCF state leadership that the local DCF offices would refer families to our program, only 50% of our families were referred from DCF: 29% from community providers who wanted legal advocacy for their clients; 13% from Probate Court with legal guardianship issues; and 8% others (Web; clients; 2-1-1). No amount of discussion and meetings changed the referral frequency from DCF. DCF workers and supervisors found it difficult to understand and respect the role of parent advocacy and too often saw VPRC not as a help but a threat. Where the worker and VPRC had good understanding of the difference in roles and the need for both, and where DCF articulated clearly the safety risks and expectations and the family understood them, the teamwork was successful and the children stayed safely at home.

- We found two points in the pre-court stage of our families' DCF involvement where legal education/representation and social service support particularly helped families and prevented the children from the trauma of being removed: 1) When DCF proposed a safety plan[28] for a family that included the removal of children, even short-term, from their parents' care, or otherwise limited the exercise of normal parental rights and responsibilities. These safety plans can be in effect for months without the family's understanding their legal options, without any court oversight, and under which the children and parents do not have frequent, meaningful contact. 2) When DCF signs an affidavit and requests the state's attorney to file a CHINS petition. By knowing the strengths of the families and how to keep the children safely at home, we were able to provide legal representation where a petition to remove the children was filed in five

[27] http://web.mit.edu/newsoffice/2007/sloan-fostercare-study-0703.html Children "on the margin" is defined as "those cases where investigators may disagree about the recommendation of removal."

[28] See Chapter Entitled Safety Plans

cases which resulted in the court's ordering the children to remain at home with specific conditions. Despite our finding that VPRC's role was crucial in the safety planning stage, DCF would not invite VPRC to the table. This stage clearly needed a legal advocate and family support, as DCF used threats of court action unless the parent agreed to send the child to live somewhere else. The parents did not understand their legal rights and the limitations of DCF's power to remove without using the court.

- Despite a DCF Policy that its staff should not encourage the use of minor guardianship in the probate court to remove children if they were unsafe, we had seven families where the children had been placed in guardianships when DCF had an open case but before VPRC became involved. All the families stated that DCF had threatened to bring a CHINS action if the parents did not agree to a minor guardianship. The policy implications of establishing minor guardianships in the probate court when DCF is the active party, despite not being named as a party, deprived parents, guardians, and children of needed services, and parents of due process of law. When DCF is involved in a CHINS in the Family Court, the judge will provide oversight and order a service plan with required services. Due process requires hearings with opportunities to be heard and parents and children to be represented by court-appointed attorneys. There are supposed timeframes to hold the system accountable. In minor guardianship cases the parents have no lawyers, there are no timeframes, and the children remain away from the parents for years, often without any court order for parent/child contact. This finding led us to our next project.

B. Minor Guardianship Project (2012–2014)

Custodial minor guardianships during this period was a court process in probate court (without state participation) used to transfer both physical and legal rights and responsibilities (custody) to guardian caregivers for an indeterminate length of time. It was either voluntary or involuntary, with the judge making findings of "unfitness." As the result of the experience of VPRC in the pre-court petition pilot project, where many of our parents reported that they had been coerced by DCF to place their children in minor guardianships without having any understanding of the legal implications or for how long, VPRC facilitated the creation of the minor guardianship study committee by the legislature. After two years, in December 2012, the committee filed the "Minor Guardianship Proceedings in Vermont" report to the Vermont Legislature,[29] recommending a complete revision of the minor guardianship law. The legislature

[29] A full report can be found on the website of Vermont Legislative Council https://legislature.vermont.gov/reports-and-research/

took two years to amend the statute based on recommendations from the committee.[30] The law provided no funding for services for the minor guardianship families despite the committee recommendation that a robust support system for the guardians, parents, and children be available. Thus, to date, when children are placed in minor guardianships, the families are not entitled to services or supports.

During the period while the legislature was debating the statutory revisions, VPCR, in partnership with K.I.N.-K.A.N. Vermont, a peer-based kinship organization, began the minor guardianship project.[31] The goal was to design and test an infrastructure legal advocacy and support roadmap to inform families, before they started the legal process, of the legal implications of minor guardianship, how they could structure their own plan for the purpose, length, obligations, and conditions, and under what circumstances the guardianship would terminate. We tested 11 families in two counties, both before the guardianship was entered and when parents wanted an ongoing guardianship to end.

Lessons learned

- Despite DCF Policy that its staff should not encourage the use of minor guardianship (MG) in the probate court to remove children if they were unsafe, 5 of 11, or 45%, of our MG families had an open case in DCF at the time guardianship was established. In four of these cases the families, both caregivers and parents, felt that DCF had threatened them with a CHINS petition unless the parents agreed to MG in the probate court.

- The legal and social issues for the parents in MG cases were virtually the same as in CHINS petitions in the Family Court. Substance abuse/mental health issues were the drivers of the MG petitions in all cases. This was followed by homelessness in nine of 11 families. These drivers were no different from the 84% of CHINS cases at that time where "neglect" was the identified issue. Kinship MG families and CHINS families have the same needs, and comparable information, but legal or support services were and are still not available to the families looking at MG.

- Where the establishment of MG was deemed voluntary, parents did not understand their legal rights or how they would resume parenting. Parental consent forms differed depending on the locale of the probate court, but no form used had enough information to show whether it was informed (understood), or whether there was coercion. In these court proceedings no one had the assigned responsibility to explain to the parents the

[30] See 14 V.S.A.§2621 et sec.

[31] Funded by the Annie E. Casey Foundation and produced by The Annie E. Casey Foundation Children and Family Fellowship Network.

legal consequences of their consent, including parental loss of their children for indeterminate amounts of time and the economic consequence of losing Reach Up.[32]

- Where DCF was involved before the guardianship took effect, no family had been referred to a community-based organization for any support or help with the reasons guardianship was necessary.

- Legal education for all family members about the difference between MG and CHINS cases helped families make informed choices.

- Community peer support by people who have personal experiences with the legal and social support system is effective when delivered outside the DCF and DCF-affiliated systems. It is relationship based, requires skilled staff with lived experiences, appropriate competencies, and supervision.

- Reach Up financial support is available to parents for 180 days after a child goes into custody in a CHINS case but not to MG parents. Reach Up needs to be restructured to provide the same for parents when reunification is the goal in MG.

- Families in MG have no social worker and no supports. Thus because no funding for such is available, the Probate Courts should be active participants in referring family members to kinship supports and create a legal education curriculum. In counties where the Probate Courts partner with multigenerational kinship peer support, families have opportunities to understand their options and access services that improve the possibilities for success. Multigenerational kinship peer support should be universally available to families at the time a petition is filed in Probate Court.

C. Rapid Intervention Prenatal and Parenting Project (RIPP) (2014–2016)

Both our pre-court pilot program and the minor guardianship project taught us that legal education/representation and social supports were most effective when the families were reached early in their decision-making process. We also found that opioid dependency and mental health issues were present in an overwhelming number of our families with very young children. Thus, we designed RIPP as an upstream service in pregnancy, and using a trauma-

[32] Under the new Minor Guardianship Act, there is still no one to help families understand the legal consequences.

oriented approach identified by research, to work: safety and trustworthiness, client choice, partner-consultant relationships, self-direction, and empowerment.[33]

Over a 24-month period, RIPP served 27 pregnant women or women with very young children, opioid dependent, in medication assisted treatment, and economically disadvantaged with early and effective legal education, legal representation, and recovery-oriented social services and navigation. Our service environment was designed to give the women primary control over decisions involving their own care. Of the 27 women, 21 were pregnant or had babies under 1 month old. 63% were successful in maintaining custody of their children within 12 months of being served by RIPP. Of the 21, 57% were successful in maintaining custody of their very young children while ensuring the safety and well-being of those children. When RIPP intervention occurred early in the pregnancy, and prior to the filing of an abuse of neglect petition with an affidavit by the state, children rarely entered state custody. When RIPP intervention occurred post the filing of an affidavit and a CHINS petition and children were taken into custody, those children were most often returned to the mothers we served, and foster care placement was brief in comparison to children without RIPP intervention.

Lessons Learned

- There were no standards for what a DCF investigation or assessment should cover. Some investigators had very thorough assessments with a demand that the women's substance abuse treatment history be released in full. For others no such demands were made. For many of our women, DCF demanded releases of information that included the right to share information with others, but DCF workers also accepted limiting the information once they understood the reasons for such limits. There were many cases in which the DCF workers never asked for urine analysis results, and no assessment was done of other needs for supports.

- There do not seem to be any standards for when DCF opens a case for ongoing services and when a petition is filed for child abuse and neglect (CHINS). RIPP families with similar facts had no case opened, a case opened but no petition filed, and a case opened and a petition filed. We had RIPP families where DCF did not open a case, and it appears that the only difference between them and those where a case was opened was that when families were middle class no case was opened. Once cases were opened, very different approaches were used. In one case, the family did not see a social worker for almost three months, so it is unclear what the purpose was for opening the case.

[33] See SAMHSA Technical Assistance Package: Implementing Trauma-Informed Approaches in Access to Recovery Program

- When an infant was removed from the hospital and a hearing held while the mother was still recovering in the hospital, the sound equipment in the courtroom was so poor that the mother could not hear what was said in the courtroom. In one of these cases, when the mother was represented by VPRC and filed a motion to have a full hearing, the state's attorney objected, claiming there had already been a hearing and she was not entitled to another one, but the judge provided a new hearing.

- Of the families where the infant was removed at birth or shortly after birth, effective legal advocacy had to be applied in order to get visitation at least five days per week. Such schedule is necessary for mother-infant bonding, but DCF objected every time. The only way to achieve this was when RIPP offered to provide transportation and supports during the visits.

- Effective advocacy by filing motions also resulted in more appropriate services, and the infants were returned home.

- Many of the mothers were homeless, but DCF provided no assistance to help with the complicated subsidized housing system, and the housing assistance is overwhelmed with applicants. Housing was often only obtained when RIPP provided advocacy and, in one case, filled out the housing application and physically took it to the State Housing Authority.

- The infants, when removed, were placed in pre-adoptive homes, and on at least on one occasion, the DCF social worker was friendly and worked effectively with the foster parents while repeatedly ignoring the birth parents or showing outright hostile behavior toward them. When legal counsel objected and made a report to DCF at the administrative level, she was met with more hostility and denial but no introspective look at what was going on.

- The mothers met so many obstacles and outright nastiness in their dealings with the legal and service system that it would be easy to just give up. Effective advocacy and social supports had to be applied at every level in order to set the stage for reunification when the infant had been removed shortly after birth.

D. Help Line

The VPRC Help Line has operated continuously over the organization's nine years and during that time has served as the only state-wide information line for families seeking accurate and balanced information regarding the child protection system. The Help Line operates seven

days a week and if calls are not answered in person, voice messages are returned within twenty-four hours. The primary services provided to the approximate 350 families, plus professionals and service agencies utilizing the system have been education and support in gaining an understanding of how the child protection system operates. In addition, the Help Line has served as an invaluable tool for assisting family members to gain the knowledge and confidence necessary to advocate on their own behalf. The Line has also served as a means for families to reach VPRC staff in emergency situations warranting VPRC direct support. The issues most frequently raised are: how family members can get their assigned attorneys to engage with them in a meaningful way, explaining DCF policy /procedure and practice, reviewing releases of information, exploring placement options and understanding how to advocate for themselves in hearings for which they are not assigned an attorney. Finally, the Help Line has been VPRC's eyes and ears state-wide and as such has kept the organization, and its programs, up to date with changing circumstances and occurrences.

Lessons Learned:

- Families have no place to go for current, accurate and balanced information.

- Parents engaged with DCF have little understanding of how the system operates and virtually no understanding of their rights.

- The predominant issue for families engaged with the Judiciary, and having assigned public defenders, is that the attorneys rarely meet with their clients and families are desperate in their attempt to ensure effective legal counsel.

- Most importantly, the systemic failings of the child protection system identified by VPRC beginning nine years ago, and encountered in each of VPRC's four other projects remain firmly in place today. It appears that the past nine years have produced little improvement.

Sara's Story:

Seven years ago, Sara voluntarily relinquished her parental rights to a son who was later adopted by her mother. At that time, Sara was addicted to opiates and not in treatment because medication assisted treatment was not available to her. Two years later, Sara had a second child. The father of the baby was physically abusive and Sara protected herself and her unborn child by seeking safe housing. Sadly, this child unexpectedly passed away. The police report stated that there was no evidence of intentional harm or neglect

and the hospital records stated that the baby died of SIDS. VPRC met Sara two years later, when she was pregnant with her third child. Sara had been in medication assisted treatment and sober for the entire pregnancy, as had the father of the baby. Prior to the birth of the child, VPRC provided to DCF evidence of the parents' sobriety through urine analysis documentation. Despite all this knowledge, upon the birth of the baby, DCF wrote an affidavit that blamed Sara for the death of her baby two years earlier and stated that DCF had no knowledge of the father's involvement with drug treatment. VPRC confronted the state's attorney with the fact that the DCF investigator had signed an affidavit with facts that he knew not to be true. The state's attorney said he would follow up on this, but to our knowledge he took no action.

DCF took custody of the baby from the hospital with an emergency removal hearing occurring while Sara was still in the hospital recovering from birth. The parents tried to participate in the hearing by phone but could not hear the testimony due to poor audio in the courtroom. The judge agreed with DCF that the parents were unstable, both living in the homeless shelter, and placed the child in DCF custody.

VPRC took over the representation of Sara after the emergency hearing and requested a temporary care hearing. The Assistant state's attorney objected, stating that the parents had had their hearing. VPRC had to file two motions regarding lack of due process because the parents could not hear the testimony. The judge agreed and allowed a hearing.

The affidavit was full of errors and omissions, which were cleared on the record at the first court hearing. It stated a very negative picture of the parents despite their being wrapped in community-based services and successfully engaged in treatment and recovery. The affidavit, despite the evidence provided about all the errors, was given great weight by the court at the temporary care hearing. The new judge relied on the previous judge's ruling, the past history of homelessness, mental health issues, and substance use disorders despite the fact that there was no evidence of current substance use or untreated mental health issues. The judge made it very clear, however, that if the parents continued their current services, reunification would happen and ordered parental visits three to four times per week, and upon clarification by Sara's VPRC attorney that if the DCF worker did not have the time to arrange more than three visits per week, the RIPP[34] project could help supervise the fourth visit. The judge ordered that DCF should work with RIPP to make that happen.

At the temporary care hearing, many significant events occurred:

***1**. The foster parent was at the courthouse, although he had no role at the hearing, and told the RIPP social service provider that he and his wife had agreed to become*

[34] Rapid Intervention Prenatal and Parenting Project, 2014-2016

foster parents because DCF has assured them that this baby would be available for adoption.

2. *RIPP observed that the DCF social worker totally ignored both the parents, only talked to the foster parent, and at the end of the hearing left with the foster parent without talking to the parents.*

3. *DCF requested that the hospital discharge the mother one day early so that the foster parents could spend at least a night at the hospital with the baby despite the fact that the mother was trying to breastfeed.*

4. *The DCF worker also told the parents that they would not be given a monthly bus pass because they were receiving supportive services from RIPP. DCF routinely schedules visits at the DCF office which is out of the way and requires the use of the bus for those without a car.*

It was clear that DCF had already decided that this baby should never go home. The parents had been homeless for a long time and, despite having done everything to obtain subsidized housing, had not been successful. But at this time a new unification voucher opened up for which the parents were eligible, but required DCF approval. When VPRC inquired about this voucher, the DCF worker told VPRC that they would not approve the voucher. VPRC appealed this decision to the supervisor and the District Director, who finally approved the voucher.

The wrap-around service system worked. The parents had a longtime substance abuse support worker who drove the housing application to Montpelier, and within a couple of months the parents were housed. It then took another four months to get the baby reunified with the parents. Reunification happened only because RIPP supported Sara by providing transportation, going to DCF meetings to ensure an accurate record, filing many motions to expand visitation, reduce the supervision of the visits, and to get home-based visits, and a judge who had to micromanage because DCF disagreed with every step towards reunification.

Without RIPP the baby would never have been reunified. It was an amazingly difficult journey with too many obstacles to mention them all.

Two and a half years after this family was reunified, the parents had another child. Sara continued to be successful in treatment and was stable in all other ways. Despite evidence of this, DCF opened a case because Sara scored high on the risk assessment tool. Her history, not her current status of success, determined the high scoring on the tool.

D. Bending the Curve Pilot Project (BTC), 2016–2018

Initially slated for Franklin County due to the high custody rate there, BTC was a community-driven project designed to build upon what worked well in RIPP, and designed to provide the family with support and education at the first contact with DCF. By teaming an attorney legal educator with a community agency service coordinator, in conjunction with a DCF investigator or caseworker, the goal was to educate the family about why DCF had gotten involved and what options they had, and if appropriate, work through their needs and find ways to meet them. Unfortunately, DCF opposed this public/private model and resisted making funds available to the local social service agency in a timely manner. As a result, the delayed recruitment and hiring process made it impossible to implement the project, as initially designed, in Franklin County.

VPRC redesigned the Project to provide early intervention to select cases on a statewide basis, with a focus on a diversity of types of cases and geography. Some involved fact-finding, some assessments, and some cases involved both. The primary services offered were investigation and social assessment, legal education and consultation, social work, and advocacy. The project was staffed by a consulting attorney and a law/social work professional who performed the direct client services, who teamed with attorneys (ODG contract and private practice) as well as just with the family when no attorney was involved. Additionally, the statewide VPRC Help Line, where parents and caregivers called for help in navigating the child protection system, continued in operation. Over the course of nine months, this team provided intensive services to 12 families at risk of having children enter custody or who already had entered custody, as well as telephone consultation to another 125 families. All 12 families served either avoided custody altogether, or had the children returned to their families' custody.

Lessons learned

The lessons learned in the previous pilot projects were present in this fourth pilot project. Additionally:

- DCF investigations were not conducted, or conducted only to the degree necessary to support the allegation while disregarding mitigating or conflicting information.

- Affidavits written by DCF were not supported by corresponding investigative reports, and DCF investigator testimony did not correspond with affidavits.

- Appointed attorneys rarely filed motions on behalf of their clients.

- Attorneys who did file motions challenging DCF evidence typically prevailed, due largely to the poor quality of DCF investigations and reports.

- Risk of harm was a central element in DCF's involvement when "abuse and/or neglect" could not be found. The definition of risk of harm was expanded far in excess of those examples outlined in the statutory definition.[35]

- Little to no distinction was made between family members engaged in active substance abuse use or medication assisted treatment. Additionally, multiple reports of abuse/neglect relating to the same allegation appear to be recorded as separate reports.

- Cases that could be resolved in days or weeks remained open in excess of half a year, primarily because investigations were not performed in a timely manner or not performed at all, resulting in investigations/cases languishing; or because caseworkers did not know what services should be engaged in by the family.

- Family services cases were opened on every family, including families for which there was no rationale for services. This practice was justified by applying the Standardized risk assessment tool score as the sole reason.

- Family safety plans were, typically, implemented under duress, and families were not involved in the changes or received a copy. Plans were used as a means of removing children from a family without DCF's having to present its case to the court, which deprived families of an appointed attorney. Where plans did exist, they were often unilaterally altered by DCF and frequently were not provided to families when changed. Essentially, families frequently had no clear idea of what was expected of them and what success looked like.

- DCF rarely met the statutory timelines for completing assessments or investigations and in some cases never actually closed an investigation; rather it was allowed to fade away absent any resolution.

[35] 33 V.S.A 4912 (14)

***Grace & the School Bus* – Episode One**

- *Grace is told, by a DCF investigator, that she is alleged to have failed to meet her preschooler's bus and that her child had excessive school absences. Because of this allegation, DCF tells Grace that she must relocate her preschooler to another home, or DCF will ask the court to place the child in foster care while sorting out the issue.*

- *Upon questioning by VPRC, the DCF investigator acknowledged that it is uncertain how many times Grace missed the bus or what the nature of the school absences was. The investigator acknowledged that no one had inquired at the bus company or with school personnel managing absence/tardy records.*

- *VPRC asked the investigator how DCF could threaten removal when an investigation had not taken place. The DCF investigator's response was, "This is just the way we do it. If there are problems with the affidavit it gets fixed when the case gets to court." It was suggested that the investigator return to the DCF office and consult with a supervisor before proceeding further.*

- *Over the next three hours, VPRC met with bus company personnel, who said that no one from DCF had contacted them and that Grace was late one time in picking up her child at the bus stop. A meeting with the school showed that there were multiple absences, however the number of unexcused absences did not violate DCF policy.*

- *Three days later, DCF convened a meeting at which Grace, her therapist, and VPRC were present. The meeting did not involve any discussion of the school bus or school attendance. Instead, the meeting involved a contract facilitator who commenced to develop a family genealogy and identify risk factors, of which there were none identified. When VPRC asked why the meeting was not dealing with the investigation, DCF stated that this meeting had nothing to do with the school bus or school attendance; rather, it was to focus on parental visitation rights (of which there were none) and reports that the child was coming to school "dirty."*

- *The issue of the child's arriving at school dirty was eliminated when VPRC asked the school it there was a record of this incident, and it was learned that no one could say when the child might have gotten dirty because a third of the students at the school arrived dirty and the school did not keep event records.*

- *DCF stated that it could not help Grace with her issues of child support and substandard housing conditions that the landlord refused to address. DCF declined because "Housing issues are not part of what we do," and, "We don't even know how to contact the office of child support."*

- *Finally, Grace requested assistance with taxi vouchers (she has no automobile) so that she could ensure that medical, counseling, and therapy appointments would not interfere with school attendance or her ability to greet the school bus. DCF tabled the request.*

- *When asked about the status of the investigation, DCF stated that the investigation would be dealt with later. In fact, it never was addressed because there is no legal requirement for a preschool child to be met by the bus, and truancy applies only to children age 6 and older. Should a child not be met by an authorized adult, school and bus policy is that the child is returned to the school, and the authorized adult is contacted and told to retrieve the child directly from school.*

- *DCF then opened a family services case (stating that it was voluntary but if Grace refused, DCF might have to ask the court for removal to foster care). The next three months were spent having Grace gather medical, dental, and counseling records, none of which related to any of the stated DCF concerns. DCF then closed the case.*

- *Grace was evicted from her apartment by her landlord in apparent retaliation for lodging complaints regarding housing code violations.*

- *DCF never responded to the request for transportation assistance.*

- *When VPRC presented DCF management with the failure to investigate, the DCF response was, "We don't need to investigate; we know these families."*

- *This process lasted approximately five months.*

Grace and the School Bus - ***Episode Two***

Approximately six months later, Grace is notified by DCF that a report of physical abuse had been made due to bruises on her 6-year-old child's backside noticed by a teacher's aide at school. Grace and child were questioned (separately) as to how the bruises might have occurred and they each stated that it could have happened while sledding, or when the child fell down.

DCF took photos of the bruises and sent them to a physician, in another part of the state, who reportedly told DCF that the bruises were highly suspicious, although this physician never examined the child.

- *DCF filed an affidavit, which became a CHINS petition, and the court ordered the child into foster care, where the child remained for approximately four weeks while being moved to three foster homes.*

- *VPRC advocated for the child to be examined by the child's local pediatrician, who upon examination declared that there were no indications of abuse.*

- *In court, DCF continued to allege physical abuse in spite of the pediatrician's statement that there was no abuse, as well as educational neglect and medical neglect (based in part on the records that DCF required the previous year).*

- *After approximately four and a half months and three court hearings, it was determined that the bruises were caused by a sledding accident at school (the school nurse treated the accident and entered the incident in her log, but DCF never consulted with the nurse). The abuse charge was dropped.*

- *Medical neglect, which DCF alleged due to the child's having two cavities as the result of missed dental appointments, was dismissed due to dental records showing consistent dental care and the dentist's being aware of the cavities at an earlier appointment and intending to address them at the next appointment.*

- *The school absences were found not to violate DCF policy as there were fewer than 20 unexcused absences. VPRC testified to Grace's active participation in advocating for an IEP for the child and perfect attendance at all IEP team meetings. VPRC also testified to Grace's earlier request for taxi vouchers so as to minimize school absences due to appointments, a request that was denied by DCF.*

- *After six months, including four weeks in which a child was in foster care, four half-day court hearings involving four lawyers, multiple witnesses, and tens of thousands of dollars in costs, the court dismissed the abuse and medical neglect charges. Contrary to the evidence that Grace was an active advocate and participant in her child's education, the court did determine that Grace had engaged in educational neglect, this due to some of the school absences occurring as a result of Grace's own appointments, not the child's. It did not appear to matter that the child accompanied Grace to the*

appointments in order that Grace would not miss picking up the child at the bus stop and thereby risking yet another charge by DCF. At this point, this decision is pending appeal, however regardless of the outcome, the court did not attach any penalty or action to the judgment and DCF has closed the case.

Note: Grace was the beneficiary of a level of social support, advocacy, and legal assistance that (in VPRC's experience) few economically challenged parents receive, but that all are, in theory, supposed to receive.

VI. FINDINGS & RECOMMENDATIONS – IN DETAIL

A. Reports of Child Abuse & Neglect

Reports of child abuse and neglect continue to rise each year, with a slight decrease occurring in 2017. The picture is somewhat complicated in that the total number of intakes/reports is a cumulative number, i.e., a number of intakes/reports can be received regarding the same child for the same event. This happens both inadvertently, when individuals notify DCF without knowing that others may be making the same report, and purposefully as an educator becomes aware that a child in their class has been the subject of an abuse report and the educator does not want to run the risk of being accused of not reporting. In such instances, a child might have five people making the same report but only one with first-hand knowledge.

Regardless of duplicated intakes/reports, what remains essentially the same each year is that, although the number of reports/intakes increases, the percentage of the reports/intakes accepted for DCF response remains almost exactly the same at roughly 25% each year as reported by DCF annually. Equally striking is that regardless of the increased intakes/reports, the number of investigations remains at about 2,800 year after year, and substantiations average about 700 each year since 2004, based on DCF annual reports.

Between 2005 and 2016:

Reports of abuse/neglect increased ***37%.***

- Investigations, essentially, remained ***the same*** (fluctuating between 2,500–2,800)
- Substantiations remained ***unchanged***.
- While Assessments have **risen** from ***0 to 2,674***.

The dramatic increase in DCF workload appears to stem from an explosion in the number of abuse/neglect reports *and* the concurrent opening of monitoring/social services cases having little to do with abuse/neglect substantiations. The workload increase does not appear to be the result of an increase in actual abuse/neglect; rather it appears to result from DCF's opening cases in order to monitor families that are not abusing or neglecting children, but that DCF believes might do so at some future point, and which might benefit from services even if no specific need or service can be identified and the family is not interested, or sees no need. Key to this picture is that the vast majority of families involved with DCF are families struggling with severe financial stress that carries with it issues of housing and transportation insecurity.

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Reports of Abuse/Neglect	***12,910***	13,049	12,829	13,434	14,488	15,379	15,526	15,760	17,485	19,288	20,233	***20,583***
Investigations	***2,666***	2,528	2,633	2,896	2,831	2,510	2,591	2,536	2,657	2,877	2,634	***2,835***
Substantiations	**n/a**	**756**	687	646	631	626	690	626	642	652	773	**737**
Child Abuse Assessments	n/a	n/a	n/a	n/a	***639***	1,058	1,192	1,119	1,409	1,688	1,618	***1,421***
Family Assessments	n/a	n/a	n/a	***305***	1,021	1,078	1,128	1,044	1,069	1,281	1,378	***1,253***

Numbers extrapolated from Report on Child Protection in Vermont (years 2005-2016), Vermont Department for Children and Families

Financial Stress

Financial stress reports to DCF rose by 2,320, from 6% to 17%.
At the same time, substance abuse increased by 1,459 reports, from 27% to 31%.

Year	2010	2012	2013	2014	2015	2016
Cognitive/Physical Disabilities	**519 (3%)**	**636 (4%)**	**664 (4%)**	**808 (4%)**	**795 (4%)**	**688 (3%)**
Domestic Violence	**1,763 (12%)**	**2,331 (15%)**	**2,473 (14%)**	**2,871 (15%)**	**2,527 (13%)**	**2,525 (12%)**
Financial Stress	**852 (6%)**	**2,066 (13%)**	**2,692 (15%)**	**3,256 (17%)**	**3,504 (17%)**	**3,172 (15%)**
Mental Health Issue	**1,349 (9%)**	**1,836 (12%)**	**2,005 (11%)**	**2,410 (12%)**	**2,243 (11%)**	**2,180 (11%)**
Substance Abuse	**4,198 (27%)**	**4,555 (29%)**	**5,130 (29%)**	**5,946 (31%)**	**5,575 (28%)**	**5,657 (27%)**

Numbers extrapolated from Report on Child Protection in Vermont (years 2010-2016), Vermont Department for Children and Families

Although increased caseloads have routinely been attributed primarily to the "opioid epidemic," and it is evident that families are experiencing untreated substance abuse

dependency, the issue of financial stress has been given far less scrutiny as a primary driver in the increased utilization of foster care. At the same time, we have known for years that stress, particularly financial stress, is one of the key elements in the increase of substance abuse.[36] Yet, when we look to address child abuse and neglect, our focus is on substance abuse and inadequate housing and transportation, rather than on addressing the core issue of financial stress (aka poverty).

B. System Transparency/Accountability/Oversight/Consistency

1. Transparency

The current system is one of the least transparent systems within state government. Its actions are shrouded in confidentiality and there exists no external or internal oversight mechanisms capable of piercing that confidentiality. In effect, it is one of the few entities within state government that do not experience the sanitizing effect of sunlight. The importance of this cannot be overstated in that the system is granted some of the most extensive powers that exist in a free society (the ability to facilitate the separation of children from their families), while the entity charged with facilitating the execution of that power (state's attorneys, the attorney general, and the Family Court) are all almost entirely reliant upon the veracity of the work of a single department (DCF), which operates absent effective or knowledgeable oversight.

2. Accountability

There are no checks and balances on the department with its front-end work. Checks and balances only come into being on the back end with the court, long after DCF has asserted its authority. There exists no external review board or commission, nor is there an external or internal Ombuds Office to ensure that the work product is what it purports to be. Although there are two appeal processes (an internal appeal and an appeal to the Human Services Board), these are insufficient, both in scope and timing. The powers granted to DCF are extraordinary, yet oversight is notably nonexistent. When families or their attorneys, are confronted with situations involving the abuse of discretion and/or authority, or violations of policy or procedure there is no entity with the authority to evaluate the complaint and rectify the matter other than an appeal to the DCF commissioner or deputy commissioner. The VPRC experience, and that of others, is that such reviews rarely result in the specific problem being remedied, much less the remedy being applied to the overall system. In effect, even if the problem is fixed in a specific instance, the cause of the problem is rarely fixed because there is no entity in a position to identify the systemic nature of the problem and insist on repair.

[36] Al'Absi, M. (Ed.). (2007). Stress and Addiction: Biological and Psychological Mechanism. San Diego, CA, US: Elsevier Academic Press.

3. Absence of Information

A family which requests DCF intervention for services has no one to go to once the department has taken custody of a child but failed to offer timely services. Appeals to DCF, or AHS, administration typically result in the appeal being forwarded down the chain of command until it rests with the district office, which frequently was the entity whose actions were being appealed in the first place. The judge does not often get involved in issues of service delivery.

4. Absence of Internal Oversight

Complaints of misfeasance (common) or, in some cases malfeasance, relating to the day-to-day work of investigators/caseworkers and/or their supervisors, are generally met with defensiveness by managers. The department's most frequent response to such claims is, "We must protect our workers," and, "We know more than we can say about this matter." There is no independent grievance process for families relative to the day-to-day practice within DCF district offices, as the central administrative office does not concede that individual or systemic problems exist, regardless of the information indicating otherwise.

The primary assessment of DCF activities is the 2019 Annual Progress and Services Report.[37] The report, some 141 pages, covers a multiplicity of activities, and rates the success and failure of achieving those targeted activities. However, what is almost entirely missing from the report is any description of how the veracity of the data was tested, or the depth of the issues presented. As an example, completion time for investigations and assessments was rated at a scale of 72% against a federal standard of 90%. However, within the 72% there appears to be little, or no, detail as to how far off the mark timewise the completions were: one day, one week, one month, four months, six months late? In VPRC's experience, as noted in the included case studies, few investigations were completed in a timely manner, and when they were, the investigations were typically found wanting. Additionally, in the report, there is no reference to the accuracy of the information contained in an investigation or assessment.

5. Consistency

Consistency is almost entirely lacking in the current system, both within the same case or cases with similar facts. DCF workers depart at such high rate that case specifics are rarely known when cases have been open for extended periods. State's attorneys typically do not maintain a case-specific relationship with DCF workers. Guardians ad litem frequently know little about the many cases to which they are assigned. Assigned defense attorneys frequently know little about their client, much less the case itself. Vermont's system of rotating judges frequently leaves the court as unknowing as the other parties. Finally, lawyers cannot advise

[37] Vermont's 2019 Annual Progress and Services Report, Family Services Division, Vermont Department for Children and Families

their clients as to what it is that DCF or the court is likely to do under a given set of circumstances. As a consequence, cases extend far longer than necessary, children remain in out-of-home placement longer than necessary and in the end, no one is actually responsible for any of this.

Recommendations:

1. *Establish an external Child Protection Oversight entity (Ombuds Office), charged with monitoring system outcomes, procedure, policy, practice, and complaints relating to the operation of the overall system. This entity should report to the Secretary of Administration, with an annual report to the governor, legislature, and the judiciary. The entity should be adequately staffed and funded by current state/federal child protection resources. The primary focus of the entity is to ensure that DCF fulfills its responsibility to protect children, strengthen families, and reduce the utilization and duration of foster care placements, and that all components of the child protection system are operating as a unified system with defined points of responsibility and accountability.*

2. *Establish a Parent Representation Office that resides outside of the Office of Defender General (ODG), and whose primary purpose is to represent families in all matters for which they are entitled to legal counsel; additionally, to educate families as to their rights and responsibilities and advocate for them relative to access to services. This system would replace the current contracted public defender program employed by the ODG for child protection cases. It could take the form of a new entity or become a program within an established legal aid program. This entity should be funded as part of the overall child protection system state and federal funding stream.*

3. *Consolidate the myriad child protection system reports into a single comprehensive report that includes processes and outcomes from DCF, state's attorney, defender general, attorney general, and the judiciary so as to provide a coherent overview of the entire child protection system, including not just its activities, but its successes, failures, challenges, and opportunities. When reporting success/failure rates of activities, the reports should provide the depth necessary to understand the extent of the failure (an investigation that is late may have one impact when a week late and quite another impact when four months late and children are in out-of-home placement.*

4. *Revisit the practice of rotating judges for CHINS cases. Ideally, a judge should remain with a case from start to finish, as recommended by the National Council of Juvenile and Family Court Judges and found in research to improve timelines and reunify more children.*[38] *In this manner,*

[38] Research Snapshot, National Council of Juvenile and Family Court Judges, December 2013.

at least, there is one entity in the system who understands the case in its totality and can hold all parties to account in each separate case.

5. *Revisit the practice of having the state's attorney commence CHINS procedures while having the attorney general enter the process if a termination of parental rights petition is filed. The current system does not lend itself to clear accountability. It may be preferable to have one or the other take ownership of the case from beginning to end in order to ensure both an understanding of, and accountability for, each specific case.*

C. Investigations & Assessments (in general)

Investigations are, historically, an incident-based child protection process, the purpose of which is to decide whether a child is subject to criminal behavior or is at imminent danger. If an alleged abuser is found to have committed abuse or neglect, the abuser is placed in a child protection registry and steps are taken to safeguard the child from further abuse/neglect. In the early part of this century, with widening definitions as to what constituted abuse and neglect, the investigative process was seen as too limited and punitive, while doing little to strengthen families or mitigate future abuse/neglect within the family. As a result of this new thinking, another approach was added: assessments, designed to be a respectful and supportive approach consistent with sound family-centered practice, focusing on family strengths and needs. This approach was envisioned to involve the family as partners, identifying strengths, resources, and needs consistent with assisting the family in addressing identified challenges. Vermont adopted this approach in 2007. Over the past 10 years, VPRC has observed these two separate approaches to child protection begin to morph, to the extent that, today, it is difficult to distinguish which approach is being employed at the outset of a case by the Department for Children and Families (DCF). Often, DCF workers have been unsure as to whether they were conducting an investigation or an assessment in a given case. In VPRC's experience, DCF never informed the family and never explained the difference between an investigation and an assessment unless prompted to do so by VPRC. In many cases, what began as an investigation that did not produce evidence of abuse or neglect simply ceased to be an investigation, and somehow turned into an assessment, but with the same punitive elements (coerced or forced removal of children, relocation of adults, onerous family safety plans) as would have occurred had the investigation produced evidence of abuse/neglect. State statutes allow for assessments to become investigations (when new information arises), however an investigation transforming into a coerced assessment is not provided for in law.[39] However, the expanded use of the standardized risk assessment tool has now become the method by which DCF can open a case for services or monitoring, regardless of the outcome of an investigation or

[39] 33 V.S.A. 4915 (d)

assessment, simply because a family has a history (as an alleged perpetrator, victim, or both). In effect, the mandatory use of the risk assessment has effectively supplanted investigations and assessments insofar as determining whether a family should be monitored by the state and required to engage in services. This result was not envisioned by the legislature when it added assessments to the law.

D. Investigations by the Department for Children and Families

Investigating allegations of abuse/neglect is the single most important component in any child protection system because the quality of an investigation sets the stage for virtually all that comes afterward. Over the past nine years VPRC's experience has been that investigations are frequently lacking in both thoroughness and veracity. The past four years have proven these concerns to be true to a degree not anticipated beforehand, with virtually all of the VPRC cases selected for intensive client services showing investigations that were either not conducted to a professional standard, or not conducted at all.

In cases where investigations (the act of determining the veracity of an allegation) were conducted, they were typically performed only to the degree necessary to validate the initial report of alleged abuse/neglect, seemingly without an equal effort to show that the allegations were not true. Further, DCF file notes rarely contained positive or otherwise mitigating information. This resulted in misleading or incorrect information as the foundation for affidavits in support of the state's petition for child in need of care and supervision (CHINS). The "facts" contained in affidavits were typically accepted on face value by the state's attorney, the result being the filing of petitions that were based on incorrect information. The information contained in these underlying affidavits persists throughout the judicial process and becomes part of DCF's historical record, a record that does not diminish over time. This historical record was, and is, rarely challenged, primarily because too few contract public defenders have the time or resources to test the facts by investigating and litigating through the procedural right of a due process temporary care hearing. Since the entire child protection system is premised on what is effectively an automatic acceptance of DCF affidavits, at each stage the system assumes that the material alleged in an affidavit resulted from a competent investigation. In VPRC's experience, this assumption is rarely found to be accurate. A careful reading of affidavits shows that they are frequently a rewriting of the information contained in the reported allegation, buttressed with historical information taken from DCF records.

As a result of the aforementioned, affidavits have become the facts in subsequent proceedings regardless of whether they are factually accurate. Effectively, the system provides plausible deniability at each subsequent step since no one is charged with verifying that the initial

information is correct or complete. This is hugely problematic when defense attorneys fail to spend the time necessary to reinvestigate and show the inaccuracies contained in affidavits and/or fail to challenge the inaccuracies in merits hearings.

Investigations frequently far exceeded the allowable time frames for closure (60 days is allowed, whereas some investigations now extend for double that period absent any rationale other than excessive caseloads) with no discernable penalty.[40] Additionally, families are frequently not informed of the termination of an investigation or assessment, or provided a final report and thereby an opportunity to correct errors that typically become part of the official record. When confronted with these facts, investigators routinely respond with "That is just the way we do it," or "I write an affidavit and if there are problems with the facts they get fixed once the case gets to court."[41] The result is an absence of effective due process, almost from beginning to end, initiated by the failure to adequately perform the primary task associated with child protection — the investigation of allegations and the assessment of conditions.

Department investigators frequently lack the training, experience and the time with which to competently investigate the allegations in a thorough, balanced, and timely manner. The dynamic between investigators and families is one of fear and suspicion, thwarting the free and accurate exchange of information. Finally, investigations are currently not limited to the allegations contained in a report of possible abuse/neglect, but routinely morph into wide-ranging explorations. As a result, cases are prolonged for lack of information, and decisions are made by individuals at all levels who really do not know what a given family's situation currently is. Families understandably become resentful and antagonistic because they feel mistreated, while workers feel overwhelmed and under attack. Systemically, non–life threatening allegations tax the limited resources capable of conducting competent investigations producing deleterious effects across the entire system. For those historically familiar with the child protection system, the apparent deterioration in investigative skill level within DCF is alarming. Investigations are the most critical element in determining whether a child is safe. When the ability of an agency to objectively conduct investigations is called into question, one is left with little choice except to question the integrity of the ensuing stages in the child protection system.

Recommendations:

1. *Review the current philosophy within DCF so as to ensure that thorough investigations are considered the key element in determining whether a child is at risk.*

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[40] DCF Family Services Policy Manual 52

[41] Mom and the school bus, VPRC interaction with DCF investigator, 2017

2. *In light of the role and skill level required of child protection investigators, coupled with the complexity, emotion, and stress inherent in resolving abuse/neglect allegations, develop and institute:*

a. *a career track for DCF investigators;*

b. *selection of only the best and brightest candidates for this track;*

c. *a salary that is sufficient to keep them in the job for an extended period;*

d. *training, support, and supervision of them to the degree necessary for the delivery of thorough and accurate reports;*

e. *professional supports to address the stress inherent in the job role;*

f. *an early retirement provision, comparable to that of the state police, if they remain in the job a comparable period of time.*

3. *Design and implement a rigorous quality assurance system regarding investigators and investigative reports. Include consumer input into the reviews.*

E. Assessments by the Department for Children and Families

The assessment process appears to have become so entangled with the investigation process that its original value has been brought into question. Initially intended to provide a method for families to access needed services,[42] assessments are frequently initiated without informing the family that, if there is no basis found for a child protection intervention, the services offered (if any) will be voluntary in nature on the part of the family. As a result, families are led to believe that they must sign overly broad releases of information, resulting in overbroad intrusion into the life of the family far and above what is necessary to address the specifics of the initial allegation or concern. The department frequently opens a formal family services case without informing the family that they may decline, or it opens a case despite the family's declining the services, and informs the family that failure to engage in the open case may result in DCF's requesting removal of the child, even though this is prohibited by statute.[43] The initiation of an assessment following an investigation is not provided for in law; however, the state's practice is to move to an assessment, thereby continuing the family's involvement with DCF regardless of the outcome of the initial investigation. This is one of the primary drivers

[42] Lessons from the Beginning of Differential Response, Gary L. Siegel, Ph.D, Institute of Applied Research, Jan. 2012
[43] 33 V.S.A. 4915a (c)

in both the increase in caseloads and the extended duration of open cases. Once a family comes to the attention of DCF, it is likely that the family will be pressured into an open family services case. Not to do so exposes state employees to liability that can arise simply because the initial assessment was poorly conducted and critical elements of a family's situation were overlooked. The routine use of the standardized risk assessment tool virtually guarantees that families with a prior DCF history (including being an abuse victim or foster child themselves), criminal justice history (regardless of the eventual outcome or severity of the matter), and having young children, will be earmarked for continued monitoring regardless of the need for services. This is the genesis of the current self-inflicted wound that drives caseloads upward and results in the need for ever-increasing resources; in short, a self-fulfilling prophecy.

There seem to be no standards by which to judge whether DCF opens a case for services after an assessment or Investigation. In cases with very similar facts, a family safety plan is created and the case is closed, whereas in others, DCF opens a case for services but then does little except inconsistent monitoring. If a family is told that opening a case is voluntary, they are frequently also told that if they do not agree, DCF will file an affidavit with the court.

Recommendations:

1. *DCF assessments should be conducted in a manner consistent with best practices[44] in that the intent is not to investigate whether a report is true, but whether the well-being of a child and family require some kind of assistance and how best to engage the family with that service. This, effectively, would constitute the front-end services that the current system lacks, and which have been found to be highly effective in both keeping children safe, while significantly reducing the number of children entering foster care.*

2. *Assessments should be voluntary in nature and tailored to the specific family being served.*

3. *DCF's monitoring of families should be reserved for families in which investigations have found that monitoring is necessary. Monitoring following voluntary assessments would appear to be and unnecessary expenditure of finite DCF resources and defeats the original intent of differential diagnosis and assessments.*

4. *DCF management, supervisors, and line staff should adhere to the law[45] wherein a family's decision not to accept voluntary services following an assessment is not a rationale for threatening removal of children or coercing a family into other restrictive activities.*

[44]Lessons from the Beginning of Differential Response, Gary L. Siegel, Ph.D., Institute of Applied Research, Jan. 2012

[45] 33 V.S.A. 4915a (c)

F. Social Work Skills and Services

DCF social workers (non-investigative caseworkers) do not perform tasks normally associated with the social work profession. Rather, they function primarily as case monitors and reporters. Their engagement with families is rarely of a therapeutic or supportive nature since their primary tasks are related to monitoring and reporting on a family's compliance. In effect, DCF social workers performing casework are viewed as an extension of DCF investigators, only with a lighter touch. What makes this all the more challenging is that these individuals do not serve as either direct service providers or coordinators of services, so there is little that they can actually do for families except to monitor them. The lack of training in working with clients in a therapeutic or helping context and lack of understanding of the client culture or the trauma associated with involvement in the child protection system, coupled with a general fear of the clients themselves, frequently results in a continual breakdown in worker/client communication and trust.

DCF social workers are often engaged in family services cases simultaneous to the family's being in the midst of an open DCF investigation, open family services case, or both. As a result, family members are reluctant, at best, to confide in social workers who are there to "help them," since those same social workers are the coworkers of other DCF employees whom the family views as being there to "take my children away." In many cases experienced by VPRC, neither DCF worker is fully aware of what the other worker is doing, if they are aware at all. It was not uncommon to have a DCF caseworker tell a parent that the parent will probably know what is happening with the investigation before the DCF caseworker knows because the investigative side does not always communicate with the social service side.

The dual function by DCF (investigation and social work) results in mixing two distinct skill sets, but typically fails to achieve the goal of either. Investigators mix safety with client service needs, while caseworkers become little more than people who perform safety checks and monitoring rather than attempting to build a worker/family dynamic focused on family self-determination.[46] Families feel embattled regardless of which type of DCF worker they may be engaged with. It is not uncommon for parents or other custodial relatives to have a caseworker tell them in the morning that their child will not be placed in foster care, only to have an investigator arrive a few hours later and remove the child.

The most telling indicator of the failure of the current approach wherein there is little actual difference in how DCF employs investigations and assessments is found in the dramatic increase in cases opened for services by DCF. In 2011, the number of substantiations for abuse/neglect was greater than the number of cases opened (presumably opened for services).

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[46] University of Pennsylvania, School of Policy and Practice, 5-16-11, Child Welfare Social Work and the Promotion of Client Self-Determination, Ginneh L. Akbar

By 2016, cases opened for services had grown some 31% greater than substantiations. In effect, a child protection/investigative agency (DCF) is now engaged in the active long-term management of social services, over which it has little or no direct control and even less expertise. Commencing in 2013, the majority of DCF's work became the monitoring of families whose primary need is social services assistance, not child protection intervention. Yet, DCF does not have the social work expertise, or service coordination capability to provide the needed assistance. Thus, DCF defaults to the ongoing monitoring of families who need help, not monitoring. This conundrum is depicted in the following chart:

Abuse/Neglect Substantiations vs. Cases Opened for Social Services

The explosion in caseload relates to social services, not abuse and neglect.

Year		Investigations Substantiated	Cases Opened for Services
Year:	2011[47]	**690** Investigations Substantiated	**629** Cases Opened for Services
Year:	2012[48]	626	529
Year:	2013[49]	642	790
Year:	2014[50]	654	916
Year:	2015 [51]	773	1,050
Year:	2016[52]	**737**	**1,068**

Recommendations:

1. *Retrain and redirect DCF management, supervisors, and personnel so as to reestablish differential response, particularly the assessment component, according to best practices. In the absence of doing so, eliminate assessments from the DCF toolbox.*

2. *DCF investigators and caseworkers should not operate out of the same administrative entity regardless of the type of firewalls put into place. Investigators and social workers employ different skills; however, families see no distinction between the two when they both operate under the auspices of an investigative entity with powers to remove their children.*

3. *The focus of DCF social workers performing ongoing casework should be to engage families with services and then to act as service coordinators for those services. These service*

[47] 2011 Report on Child Protection in Vermont, Vermont Department for Children and Families
[48] 2012 Report on Child Protection in Vermont, Vermont Department for Children and Families
[49] 2013 Report on Child Protection in Vermont, Vermont Department for Children and Families
[50] 2014 Report on Child Protection in Vermont, Vermont Department for Children and Families
[51] 2015 Report on Child Protection in Vermont, Vermont Department for Children and Families
[52] 2016 Report on Child Protection in Vermont, Vermont Department for Children and Families

coordinators should be the point of responsibility for the success or failure of a family receiving services.

4. *Establish the equivalent of an after action review[53] at the time of each case closure, the purpose of which is to determine the reason(s) for success or failure and the lessons learned. Then incorporate those lessons into ongoing practice and policy, with performance measures in order to determine whether the system is improving.*

5. *DCF should maintain an inventory that tracks services needed as a result of assessments, services offered, services accepted, and services delivered. Relative to services delivered, any shortfalls in the services delivered (unavailability, unacceptably long waiting list) should be identified and reported in a standardized, periodic report to the Agency of Human Services and the legislature. In this manner, Vermont will have a window into whether the social service system is capable of meeting the needs of Vermonters to the degree that DCF identifies those needs. Of particular note, both housing and transportation needs should be tracked.*

G. Failure to Inform

Families are not routinely informed about the child protection system with which they are becoming engaged or about their rights relative to the system, nor is there any place where they can routinely obtain this information in a thorough and objective fashion. This frequently results in parents' waiving critical rights without understanding the ramifications of doing so, and agreeing to DCF demands without understanding that these are voluntary, not mandatory. The request to waive rights to confidentiality is a standard component in investigations and assessments; equally standard is the investigator's failure to explain that a parent has the right to decline or to limit a waiver. Additionally, DCF frequently uses the term "investigation" to mean several things: an investigation as outlined in the law,[54] an investigation as it relates to an assessment, or an investigation when in reality the action is an assessment. As a result, service providers extend confidential information available to the state only in an investigation when, in fact, it is an assessment that is under way and the necessary releases of information were not obtained by DCF. This lack of clarity, sometimes inadvertent and at other times seemingly purposeful, can result in breaches of confidentiality as well as memoranda of understanding, particularly in regard to medical records and substance abuse disorders, the latter having expanded federal confidentiality protections.

Recommendation:

The establishment of a Parent Representation Center would ensure that families have routine access to information regarding the child protection system, their rights and obligations

[53] After Action Review (AAR) a standardized process by which to review actions and their results/consequences, typically utilized in emergency preparedness and response.

[54] 33 V.S.A. 4912 (7)

prior to parents' waiving constitutional rights, or rights to medical confidentiality. This information would be provided in simple, easy-to-understand language, and there would be a formal acknowledgement that this information has been conveyed and tested for understanding.

H. Family Safety Plans

Different states use family safety plans in a variety of ways. The objective is to control or manage threats of danger to a child.[55] They range from suggestions by child welfare workers of how to keep children safe to heavy-handed decisions to remove a child without judicial oversight. According to U.S Department of Health and Human Services, Administration of Children and Families, Children's Bureau, in its training document for the evaluation of the states' child welfare services and outcomes,[56] "A safety plan is a written agreement that the child protective services (CPS) caseworker develops with the family that clearly describes the safety services that will be used to manage threats to a child's safety. Safety services assist families to engage in actions or activities that may logically eliminate or mitigate threats to the child's safety. These activities must be planned realistically so that they are feasible and sustainable for the family over time. The safety plan will clearly outline what these actions and activities are, who is responsible for undertaking them, and under what conditions they will take place. It is designed to control threats to the child's safety using the least intrusive means possible. In all cases, the safety services outlined in the safety plan must have an immediate effect and be immediately available and accessible. . . The important thing is that everyone who is part of the safety plan understands his or her role and is able and willing to carry out their responsibilities." Thus the federal government does not contemplate that Family safety plans should be used as a tool for forced removal of children. The definition does not even contemplate voluntary relocation.

In Vermont, DCF creates family safety plans without a policy that describes how they should be used, under what circumstances, for how long, and with what safeguards. Under the best of circumstances, safety plans should be truly voluntary tools jointly developed and employed in order to keep a child safely at home while determining which, if any, services the family can best draw on. Plan development should be facilitated through the use of an independent contract agency that engages both the family and the child protection agency as full partners in

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[55] See Therese Roe Lund & Jennifer Renne, *Child Safety: What Judges and Lawyers Need to Know, in CHILD WELFARE LAW AND PRACTICE: REPRESENTING CHILDREN, PARENTS, AND STATE AGENCIES IN ABUSE, NEGLECT, AND DEPENDENCY CASES §15.7.2 (*Donals N. Duquette, Ann M. Harlambie & Vivek S. Sankaran eds., 3d ed. 2016)

[56] https://training.cfsrportal.acf.hhs.gov/section-2-understanding-child-welfare-system/3016

determining what assistance the family would like, what success will look like, and how the plan will be utilized and monitored, including a schedule for reviews.

The following outline was used originally for safety planning by all DCF-contracted facilitators:

Danger/Harm: *Details re: incident(s) bringing the family to the attention of the agency
*Pattern/History
Risk Statements: * Risk to child(ren)
* Context of risk
Complicating Factors: *Condition/behaviors that contribute to greater difficulty for the family
*Risk factors
Safety: *Strengths demonstrated as protection over time
*Pattern/History of exceptions
Strengths/Protective Factors: *Assets, resources, capacities within family, individual, community
*Protective Factors
Purpose of Consultation
NEXT STEPS
Note: This outline has no further explanation or definitions.

VPRC has extensive experience with how safety planning is played out in practice. We found that the safety planning tool, when used to keep children safely at home or to facilitate a short parental absence, was very useful when the planning session was scheduled in advance; parents were thoroughly prepared for the session; they were able to get the right people to the table; articulate their history, strengths, and protective factors; and insured that the plan included details of who, what, and by when for all the participants, with a follow-up date for another session.

This, unfortunately was not the norm. VPRC often got involved after a family safety plan had been created and the plan had been used to remove children from the home without parents' understanding the reasons or circumstances, without any notice, and after DCF investigators or caseworkers' threat to remove the child unless the parents agreed to a family safety plan. Many times there had been no facilitator, there was no written plan, there was no end date, and rather than using the least intrusive approach, the safety plan had been a tool used to remove children from their homes, both during and after investigations, and without a court order. The checks and balances to parents' constitutional rights by a judge's deciding whether the child's

immediate welfare requires the child's continued absence from the home were completely absent.[57] Although the initial intent of the family safety plan was to ensure the well-being of children so that they could remain at home, the plan is today routinely employed when the social worker is unsure of the safety of the children and tells the parents that unless they agree to moving the children out of the home, DCF will file a CHINS petition. When DCF is asked how it can remove children without a court order, it has stated that the parents voluntarily agreed.

Parents told a different story. They felt they had no choice; that they were threatened with court unless they agreed. If there was a written plan, families frequently were not provided with copies of the plan; plans were altered unilaterally by DCF; and they frequently did not include an end date. Once a plan was in place, families were frequently unable to meet with DCF to review plan status or contest new interpretations of the contents of a plan. Finally, failure to fully comply with a plan (both written and/or as reinterpreted by individual DCF workers) was frequently used as a rationale for seeking a court order to remove the child even when the original allegation was not substantiated.[58]

Finally, although the intent of family safety plans was to provide services to assist families to engage in actions or activities that may logically eliminate or mitigate threats to a child's safety, the plans often do not include any services to the family at all.

The following is an example of how one VPRC-supported family experienced a family safety plan:

***Mimi and Richard's Story**: (Failed Safety Plans and Investigations)*

Joan, the biological, noncustodial mother, took her 2-year-old to the doctor who diagnosed two skull fractures of undetermined origin or time. At the time, the mother alleged that she was the custodian and that the child lived with her, but that the injury probably could have happened while the child was visiting with the father (Richard). The medical team could not determine whether the fractures were accidental or resulted from intentional harm and forwarded medical records to Medical Center in New Hampshire. DCF forwarded records to a Vermont pediatrician, who determined that the injury was highly suspicious but provided no detail and did not examine the child. As the child was clumsy and had had many accidental injuries, the team was inclined to believe the father's statement that the injuries could have been incurred

[57] 33 V.S.A.§5302.

[58] There is a dearth of court opinions about the constitutional requirements in the implementation of safety plans. Two federal appeals courts have taken two different approaches: The 7th Circuit calling them voluntary so that constitutional protections did not attach, See Dupuy v. Samuels 465F.3d 757 (7th Cir. 2006); the 3d Circuit holding that unless the state actor had objectively reasonable grounds to believe that the child had been abused or was in imminent danger of abuse, the state could not remove the child absent procedural safeguards.

from the child's having fallen down from his highchair and later, from a picnic table upon which he had climbed, except that law enforcement and DCF told medical professionals that there were no accidents reported by father, and that the father had colluded with two witnesses to fabricate the stories.

In reality, the child and his 5-year-old sibling had been living with their father and visiting with their homeless mother (Joan,) who had voluntarily relinquished physical custody, and in addition to the parents, there were several day-care providers and two sets of grandparents who also had substantial access to the child. Richard's partner, Mimi, was also living in his house with her 3-year-old child, of whom she had full legal and physical custody.

While the injuries were being investigated, both by DCF and the state police, DCF in Vermont and New Hampshire, without involving or consulting with the custodial father, created a family safety plan with the noncustodial mother that stated that the latter should take the children to New Hampshire to their maternal grandparents, with whom the noncustodial mother said she resided. In fact, neither Vermont nor New Hampshire DCF verified the living arrangement (Joan was not living with her parents, nor was she allowed by her parents to do so). Additionally, neither the Vermont nor the New Hampshire child protection agency spoke with Richard, the custodial father, in creating the family safety plan. He first learned of the family safety plan through the noncustodial mother.

DCF also created a hastily written Family safety plan for the 3-year-old child of Mimi, after DCF told her it had to be done or her child would enter foster care. DCF told Mimi nothing about her rights' including a judicial hearing, a court-appointed lawyer, and a judicial decision before her child could be removed to foster care. This family safety plan required the 3-year-old to reside with Mimi's noncustodial ex-husband. The ex-husband was not prepared to take on the responsibilities for the child, as he lacked transportation and would rely on Mimi to drive him to work and appointments both for himself and the child each morning and afternoon. This written, coerced family safety plan was later unilaterally altered by DCF to the effect that Mimi was not allowed to be with her child absent another adult present, something not written into the family safety plan itself.

There was no formal safety planning meeting for either family safety plan, nor did either plan have an end date. DCF rarely communicated with either Richard or Mimi for months, even as the couple pressed for meetings.

DCF did not monitor the first family safety plan (children in New Hampshire) despite the fact that Joan, the noncustodial mother, was a possible perpetrator of the child's injuries. The children did not go to their grandparents, but instead, Joan took them to a homeless shelter in New Hampshire, from which she applied for emergency housing due to the presence of young children. After two court hearings in New Hampshire, and the expiration of over six months, neither DCF in Vermont or New Hampshire's being involved any longer, Richard and Joan agreed that the original arrangement where children should live with Richard and visit with Joan should stay in place, and the children moved back to Richard and Mimi's home full time.

The second family safety plan was initially in place for four months[59] *during the investigation. Despite Mimi's requesting DCF to hold safety plan–update meetings during this period, DCF declined. So Mimi made her own arrangement and had her out-of-state mother visit her home for several weeks and serve as a third adult in compliance with the original safety plan. Three months after the original family safety plan was written, Mimi and VPRC met with DCF to raise issues relating to what appeared to be a long-overdue investigative report and the failure of DCF and the state police to interview all witnesses. DCF district office at that meeting developed a new family safety plan and promised to distribute this plan the next day. The new plan required DCF to conduct additional witness interviews over the next five days. DCF failed to provide a copy of the new plan to Mimi, nor did DCF interview any of the witnesses as they had agreed to do.*

After several weeks of attempting to get DCF to respond to queries about the new family safety plan, Mimi sent her 3-year-old child to reside with Mimi's mother out of state. VPRC engaged the state's attorney's office with specific concerns regarding the missteps involved in the law enforcement investigation as determined by VPRC's own review of the facts and re-interviewing key witnesses, who signed statements to the effect that both law enforcement and DCF had mischaracterized earlier testimony and had failed to interview additional witnesses who had been offered by Richard. Shortly thereafter, state police determined that there was insufficient evidence to bring charges since it could not be determined that the child's injuries were non-accidental or who might have caused the injuries. Nonetheless, DCF failed to communicate this status to Richard or Mimi despite many inquiries by them. They sat for hours in the DCF office hoping that someone would speak with them, to no avail. After a total of seven

[59] Investigations are by DCF Policy 52 to be completed in 60 days from acceptance of the case. See file:///C:/Users/famil/AppData/Local/Microsoft/Windows/INetCache/IE/YEVDAEOA/52.pdf

months from the date of the initial investigation, DCF sent four letters to the family acknowledging that the investigation was closed as to Mimi (with no substantiation), but was still, possibly, open with regard to Richard, but with no substantiation, and finally, that the allegation had been substantiated but the perpetrator would be listed as "Unknown." It should be noted that these letters contained critical dates that were divergent from one another, by as much as a full year in the identification of events. DCF never acknowledged what became of the promised new family safety plan, nor did DCF meet with the parents in over five months (except for the single safety-planning meeting that VPRC facilitated). Eight months after the original start of the investigation, DCF finally, via a phone call, informed Richard and Mimi that the entire case was closed.

Approximately two months later, Richard was notified by Joan that the younger child had broken his ankle falling off of a couch during a visit. Richard went to New Hampshire and retrieved the child and had a medical exam performed in Vermont. The exam showed that the child had sustained two breaks in one leg. The examining physician verbally instructed Richard that the child should not be returned to mother. Shortly after this, while being questioned by New Hampshire Department of Children, Youth, and Families (DCYF), Joan acknowledged that the child had actually fallen out of a second story window while being watched by his 5-year-old brother. New Hampshire DCYF requested that the child be brought back to New Hampshire for an eyes-on session. With VPRC assistance, Richard declined, offering instead that New Hampshire DCYF could come to Vermont or have Vermont DCF conduct the eyes-on. New Hampshire DCYF indicated that it would not come, because this was "not a priority case since the child was now in Vermont."

Richard then took the steps necessary to establish both paternity and legal custody of the two children, and also developed a family safety plan that limited Joan's contact with the children to "in-Vermont, supervised visits." Vermont DCF contacted Richard and said that an investigation was being opened and that Richard and Mimi would need to submit to a home visit. The next day, Richard was notified that the visit would be at the DCF office because the assigned DCF investigator did not feel safe in Richard's home. A day later, Richard and Mimi were notified that a new investigator had been assigned and the visit needed to be at the home, but would not happen for another five days. The visit occurred as scheduled (three days beyond the mandated 72 hours for the commencement of an investigation).[60] After viewing the child, the DCF investigator discussed the general situation with Richard and Mimi, then announced, "Everything

[60] 33 V.S.A. Sec. 4915 (b)

seems OK here," and indicated that Richard had taken all appropriate steps to protect the child. Approximately a month later, Richard received a letter from DCF saying that the investigation was being closed due to a lack of information.

Recommendations:

1. *DCF personnel create plans all over the map and without parents having a clear understanding of their rights. If the practice is to continue, DCF should create a policy that outlines the purpose and circumstances for the use of family safety plans: one that needs to be uniform, with clear guidelines for contractors and DCF social workers alike*.

2. *DCF must have the legal authority with articulated reasons or basis for implementing a family safety plan, including the facts underlying such reasons, and if out-of-home placement is contemplated, why less restrictive alternatives could not satisfy the child's safety.*

3. *The policy should include that DCF must inform the families of the specific grounds for the need; parents' rights under the circumstances, including their options; the voluntary nature of a plan; and that DCF cannot use implied or direct threats of removal.*

4. *In the development of a Family Safety Plan, DCF must use a facilitator whenever possible. When a facilitator is not possible, a follow-up FSP meeting should take place as soon as possible utilizing a facilitator.*

5. *Each plan must have a sunset provision.*

6. *DCF must hold regular plan review meetings in which any change in the plan is identified, as well as the reason for the change and what constitutes progress, success, or challenges.*

7. *Caregivers and other participants at a safety planning meeting must be given copies of the plan at the meeting at the time that it is developed.*

8. *Standard forms should be used that are easy to understand. If the child is to be removed from the family, the plan should be reviewed in person with the family and the family supports every seven days, and the total length of time for the child to remain out of the home cannot exceed 30 days unless DCF files an affidavit and a CHINS petition is filed by the state's attorney.*

I. Risk of Harm

Risk of harm is now tied with sexual abuse as the most frequently substantiated finding by DCF, representing a meteoric rise since 2014. This coincides with the death of two young children in Vermont due to abuse by family members. The state now routinely turns to risk of harm when there is no indication of actual abuse or neglect, but rather there is the possibility of such, regardless of how slight the possibility may be, if it exists at all. In many cases, DCF identifies risks that appear to be far beyond the bounds of what would normally be considered to constitute a significant danger of serious harm. Because neither of these terms has been defined in law relative to risk of harm, the concept has been left open to overly broad interpretation. In doing so, DCF ensures that a far wider net is cast than that characterized by any of the examples of the types of significant danger and serious harm contained in law.[61] This has become a key driver in the upward curve of caseloads.

Growth in risk of harm substantiations far outstrips any other category for substantiation of abuse/neglect, growing from 19.2% of all substantiations in 2010, to 36.3% of all substantiations in 2016. In 2016, risk of harm and sexual abuse each constituted 36.3% of all substantiations, a figure that indicates something of a slowing of the rate for substantiating sex abuse, but a virtual explosion in the substantiation for risk of harm:

Type of Substantiation: 2010–2016[62]	Range as a percent of all reports:		
Physical Abuse	14.4%	-	19.8%
Sexual Abuse	36%	-	45%
Risk of Sex Abuse	9.4%	-	14%
Risk of Harm	***19.2%***	***-***	***36.3%***
Emotional/Neglect	2.9%	-	4.4%

Based on the cases in which VPRC has been involved in 2017 and 2018, we believe that the number, and percentage, of risk of harm substantiations will either remain at the same high level or reflect an even higher number and percentage in the 2018 Annual Report, so long as DCF is permitted to apply increasingly subjective decision making as to what constitutes risk.

However, the state statute clearly, and narrowly, defines, risk of harm as *"a significant danger that a child will suffer serious harm by other than accidental means."*[63] Our experience,

[61] 33 V.S.A. 4912 (14) (A-F)
[62] 2010 – 2016 Reports on Child Protection in Vermont, Vermont Department for Children and Families
[63] 33 VSA, Sec. 4912 (14)

particularly over the past two years is that DCF routinely expands the definition of risk to include virtually any circumstance in which a child might be harmed: real, suspected, or imagined. The result is that there is little defense available for a family to appeal such determination since risk appears to reside in the eye of each DCF investigator and supervisor. The department is aided in this approach by the fact that few, if any, appointed attorneys contest this routine overreach when a CHINS petition is filed by the state's attorney, since to do so requires the public defender to research the home situation, something few if any attorneys have shown a willingness to do, and then make their own subjective analysis of the purported risk. VPRC has, over the past year, worked with families who have experienced wildly subjective determinations by DCF workers, including: laundry being dried above a wood burning stove; garbage in a backyard due to a bear; pets with suspected fleas; a broken toilet in a second bathroom; a preteen walking down a country road from the school bus stop; a mother who is late to the bus stop; an 11 year old sitting alone at a pizza parlor; a mother who uses prescription marijuana to aid her in addressing insomnia; and a parent who received a speeding ticket while having a middle-school child riding, buckled, in the back seat, to name just a few of the instances experienced. Substandard housing, homelessness and lack of transportation have also been identified as constituting risk of harm. All are reasons for which DCF workers have insisted that families enter into open cases or threatened to have their children taken into custody by court order or family safety plan. In one case in the past year, a DCF investigator enlisted the assistance of law enforcement to remove a teenager from his home (absent a court order) due to a perceived risk associated with the family's off-the-electric-grid lifestyle and having more household pets than the investigator thought were advisable, even though a law enforcement officer verified that all of the pets were well cared for.

In the same vein, the law specifically prohibits substantiation for neglect as a result of conditions caused solely by the lack of financial resources.[64] However, DCF workers routinely threaten both substantiation and the removal of children for risk of harm due to deficient housing, lack of transportation, and nonparticipation in substance abuse treatment that result solely from the lack of financial resources (a person without health insurance can spent $500 per month for medication assisted treatment for opioid dependency). In essence, DCF removes children, or threatens to remove children, because their family is poor, as opposed to addressing the poverty itself. Since an indigent family (the majority of DCF-involved families) has no recourse to legal counsel at this stage of involvement with DCF, there is no one to explain to the family that DCF is exceeding what is legally allowable, or to tell DCF no.

[64] 33 VSA, Sec. 4915b (f)

Recommendations:

1. *Risk of harm as the basis for a substantiation of child abuse or neglect should be better defined as to what constitutes a significant danger and serious harm.*[65] *This would appear to be an issue of applying common sense; however as the examples above indicate, greater definition of terms appears necessary.*

2. *An investigative report supporting a substantiation for risk of harm should specify the particular risk and provide the rationale for the determination. Short of this, citizens will be left to the subjective whim of the state.*

3. *A review of all risk of harm substantiations should be conducted by an entity outside of DCF in order to determine whether the substantiations pass the straight-faced test. Those instances in which the substantiation does not pass the straight-faced test should be expunged from DCF records and the abuse and neglect registry.*

J. Medication Assisted Treatment for Opioid Dependency

Opioid addiction and epidemics, unfortunately, are not new to the United States. The current epidemic is either the third or the fourth, depending on how you count. Not until recently, however, has treatment for opioid addiction been available on a large scale. Vermont currently has one of the highest percentages of available treatment slots per people wanting treatment nationally. The long waiting lists have shrunk. We have created the hub-and-spoke treatment system, with hubs offering intensive treatment and all methadone treatments, and the spokes, who are medical practitioners providing mostly buprenorphine treatment in the community.

There is consensus that addiction is a medical disease. Thus it should follow that it should be treated as any other disease. Many in the treatment community and our social service providers, however, still view people in medication assisted treatment (MAT) for opioid dependency as people who have to deserve their treatment. There are rules, pill counts, and urine analysis testing requirements which, if not followed, may cause the withdrawal of treatment. Unfortunately, too many providers of MAT use threats to discontinue treatment for breaches. It is yet another of a long line of disrespectful and at times mean behavior by those who are supposed to help. This approach is not supported by SAMHSA (Substance Abuse and Mental Health Services Administration) federal practice which emphasizes client choices of

[65] 33 V.S.A. 4912 (14)

care; partner-consultant, nonhierarchical relationships between the provider and the client; empowerment; and self-direction and so they can advocate for themselves.[66]

VPRC's experience is that our parents who have medical providers of MAT, who create a relationship with them and work with them to find ways for them to function effectively with the rules, are successful in their treatment. Unfortunately, our experience has also been that treatment has been withheld from our clients after the provider also admitted breaching their confidentiality, only to have the treatment restored after VPRC provided legal advocacy on appeal.

VPRC has also encountered that many of our parents have had a long history of addiction and extensive history with DCF before they began their treatment in MAT. In all of our RIPP clients' experiences, programs wherein a team of multidisciplinary professionals meet to discuss the needs of pregnant mothers with opioid addiction never provided any help. The program required that the expectant moms sign releases, and the only action they saw was a report to DCF. VPRC advocacy, again, was required to help the moms get the treatment they needed without feeling that they gave up their confidentiality and their dignity.

Our parents do not trust that the system will treat them fairly. Such fear is supported by DCF's use of history as a reason to open a case and to petition the court for removal of the child. We experienced, again and again, that history, rather than current conditions, was the moving factor in DCF's getting involved with our families. In addition, one major challenge is that many in our social service provider community, in addition to DCF, view our parents in MAT in the same manner as parents who are actively dependent upon illegal opioids and not in treatment. This presents two significant problems. First, it distorts the characterization of DCF intakes showing active drug use. Second, parents in MAT have been assumed to pose the same threat of child abuse/neglect as are parents who are actively dependent upon illegal opioids. This is akin to taking the position that anyone who is in Alcoholics Anonymous or who takes a prescribed alcohol inhibitor poses an inherent risk of child abuse/neglect. This position is not supported by either science, medicine, or common sense.

It is important to note that research done by Dr. Anne Johnston on the outcomes of babies born to mothers in MAT[67] showed no developmental delays at age 12 months, and VPRC's experience in the RIPP program was that parents who are successful in treatment are no better or worse parents than people without an addiction disorder. Despite this, our parents who were successful in treatment during their entire pregnancy had their children removed from

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[66] See footnote #34 supra

[67] See Presentation to Committee on Child Protection by Anne Johnson M.D., Associate Professor of Pediatrics, UVM, August 12, 2014, Improving Care for the Opioid-exposed Newborn: The Vermont Experience

the hospital. Only aggressive legal action and intensive supports got the babies back to their parents.

Recommendations:

***1**. Educate the social service and medical community to distinguish between parents' successful treatment in MAT and those using illegal opioids without treatment.*

***2.** Support the developing approach of not reporting parents in MAT to DCF.*

***3**. Train MAT practitioners to use a trauma informed approach to recovery.*

***4.** Use community-based agencies and pediatricians and their staffs, in concert with DCF, to develop, with parents, a strength-based plan of safety for infants and young children.*

K. Affidavits (to Support a CHINS Petition)

Affidavits are typically written by DCF so as to contain primarily, if not exclusively, negative information. They frequently contain little more than the elements contained in the initial report of possible abuse or neglect as though the allegations have been determined to be true when, in fact, they have not. Then they are supplemented with historical material that may, or may not, have anything to do with the family's current functioning but is phrased as though it is relevant and current. The result is an affidavit that is difficult for a state's attorney to refuse to act upon as the basis for a CHINS petition. This then becomes a petition that is difficult for attorneys representing parents to defend against and the court to rule against, since the attorneys and the court assume that the information in the affidavit is based on accurate investigative findings. The current system is based almost entirely on trust as it relates to the universal expectation that the state has conducted a credible investigation into the merits of the original complaint and any additional information gleaned through the investigation. There is virtually no mechanism by which a family can contest the contents of the affidavit prior to judicial proceedings wherein families are at a distinct disadvantage due both to timing and the frequent absence of effective legal counsel. The judicial process is now so slow that even when parents do get an evidentiary hearing to challenge the affidavit, children have been in out-of-home placement for months. The reality for most families is that once a DCF worker puts pen to paper in the construction of an affidavit, families are not afforded an opportunity to correct the record before an affidavit is turned into a petition, at which point it is frequently too late.

Recommendations:

1. *Require that an affidavit be accompanied by an investigative report which contains a thorough and complete accounting of the investigative findings that serve as the basis for submitting the affidavit.*

2. *Where historical information is referenced, the report should specifically identify the material as historical, the dates involved, what subsequent activities have occurred (both positive and negative) regarding the historical issues identified, and state why the historical material is pertinent to the current situation.*

3. *Where substance abuse is referenced, the report should identify whether the parent is in medication assisted treatment and the particulars of that treatment, including a specific rationale as to why participation in MAT is germane to the case.*

4. *Ensure that a state's attorney reviewing an affidavit also reviews the accompanying investigative report and acknowledge such.*

L. Expanded Nature of Investigations/Assessments

When an investigation or an assessment is initiated, the ensuing DCF action is not limited to the allegation(s) stated in the report. This results in an overly broad DCF involvement in a family's life, an involvement by the state that frequently violates the family's constitutional right to raise their children as well as the right to privacy. This contributes significantly to cases being open for inordinate periods, due both to the amount of time that investigations and assessments take as they meander through a family's life and the lack of effective legal counsel to curtail the state's overreach. Examples abound in the cases handled by VPRC, with but one example being a preteen for whom a report of neglect was made because the preteen was seen at a store alone. The initial investigation showed that the child was eating pizza before walking home from school. However, the investigation then entered the family home and involved itself in matters relating to a household living off the electric grid (this is the same family as referenced on page 73), in a highly rural environment and heating with wood. The investigator determined that not having electricity round the clock (the home was solar powered, augmented by lamps), coupled with what appeared to be an inadequate supply of firewood (it was fall and wood was scheduled for delivery later in the week), a number of household pets common to rural households, along with a broken toilet in an unused bathroom, all constituted a risk of harm to the preteen. This led to the DCF investigator's requesting a police escort to assist in the removal of the preteen. Upon arrival, the police evaluated the home, pets, and toilet and informed the DCF investigator that they would not remove a child based on what

they observed. Nonetheless, the investigator returned to the office and wrote an affidavit that was accepted by the state's attorney for purposes of initiating an intervention. Among other concerns, the investigator felt that the parents should not have any pets in the future, although there was no concern regarding pets when law enforcement inspected the pets a few days earlier. When viewed from this perspective, it is no wonder that caseloads exceed national guidelines.

Recommendations:

1. *Determine the veracity of the initial allegation formally. If the allegation of abuse/neglect is not determined to be true, close the investigation. If the allegation leads to a finding of abuse/neglect, proceed with legal remedies.*

2. *If additional concerns are discovered during the investigation, formally identify the specific child protection issues and formally resolve whether the issue presents a level of abuse/neglect that would, in and of itself, merit an investigation.*

3. *If the additional concerns do not rise to the level of an investigation, refer the family for voluntary services and close the case.*

M. Assertion of Statutory Authority

In multiple cases we found that DCF investigators and/or caseworkers incorrectly asserted authority that Vermont law does not give DCF. This happens verbally during initial contact as well as in written form after approval at the supervisory level. Examples are: laws regarding meeting kindergartners at bus stops (there are none); writing affidavits prior to investigations absent emergency or other exigent circumstances; opening assessments after investigations fail to substantiate allegations; requiring families to participate in open cases following investigations or assessments that produce no substantive findings; and threatening affidavits based solely on a family's declining participation in an open case service plan driven solely by a standardized risk assessment tool. Typically, families do not have access to education regarding either the law or the processes to which they are subjected so these violations of law and policy go unchecked. Again, there is no enforcement mechanism by which the DCF can be held accountable for these potentially egregious errors.

Recommendation:

Through the creation of a Parent Representation Center or other administrative entity, ensure that families have access to competent individuals who can ascertain whether the assertion of statutory authority by DCF investigators and others is verifiable.

N. Entanglement with Child Custody disputes

Allegations of abuse, neglect, or risk of harm, when made by parents engaged in divorce proceedings or custody disputes, entangle DCF in matters frequently having nothing to do with actual abuse or neglect. There appears to be no early identification of these types of reports, which results in the department's engaging in activities from which it cannot easily extricate itself once it learns that allegations were made for the purpose of gaining an advantage in subsequent or current proceedings between parents, where each parent is seeking custody or parent/child contact.

Recommendations:

***1**. At the intake screening phase, have the screener ask the reporter if this is related to a parent child custody dispute and if it is, note such in the screening report.*

***2.** If it is determined that this relates to a custody dispute, the intake screener should inform the parent reporting to file a petition with the Family Court, requesting protection in a divorce or parentage action.*

O. Standardized Risk Assessment Tool

The SDM Assessment of Danger and Safety checklist is a tool used by DCF to assess the potential level of risk within a family. The tool was originally designed to be part of an overall assessment, not the sole determinant of the need for services. In Vermont, the tool has become the primary tool by which DCF requires a family to engage in services despite an investigation or assessment that has indicated there is no need for services.

In some of its elements, the tool is designed in such a manner as not to take into account a distinction between past and present behavior, nor does it always distinguish whether the subject was a victim or a perpetrator of past events. The result is that many, if not most, families with small children that have had any involvement with DCF in the past (going back multiple generations) will, in theory, be found to be in need of mandatory DCF monitoring according to DCF policy and practice, as stated by DCF workers in VPRC's presence:

1. Policy

Scoring in the high or very high range of the tool results in a mandatory case opening (unless countermanded by a supervisor). However, should a supervisor countermand the case opening, responsibility falls squarely upon the supervisor should any harm come to the child.

2. Scoring of the Tool

- A score of 5 or higher automatically pushes the scoring to high or very high
- Report of abuse/neglect/risk of harm = 1 prior; investigations = 1 or 2; prior ongoing case or custody = 1; child under age 2 = 1; past alcohol or drug history = 1 or 2 points.

In effect, parents with a young child, who were in foster care as children themselves and have had any history of substance abuse (regardless of how many years past or what the substances might have been) and now find themselves the subject of a report that is found to be untrue, will still be required to enter into an open case with DCF even if it is determined that the family is not in need of services. In a number of cases experienced by VPRC, the only rationale for opening a case was the fact that a parent had been a foster child and now had a young child.

The standardized risk assessment tool has been found to be another major driver in the increased caseload in Vermont and appears to be employed as a means of avoiding the prohibition contained in state law,[68] which specifically forbids coercing a family into services when an investigation or assessment has failed to substantiate abuse or neglect. In all but one VPRC case over the past year, the risk assessment tool was completed by a DCF investigator or caseworker absent input from the family. In that singular case it became apparent that although the case had been open for months, the DCF worker had virtually no knowledge of the case particulars, and the case record itself was rife with inaccuracies, all to the detriment of the family. When families request to see the risk assessment document, they are frequently told that the results are not available to them. In essence, a family cannot correct the record without an advocate to insure that the record is both made available and correct.

In light of the workload increase related to the use of the SDM risk assessment tool as the only rationale for opening a family services case, some DCF workers have developed techniques for complying with the DCF mandate while recognizing that the family does not require additional service: the primary technique is to ask the family to identify two to three services the family is already using or has already completed. These are then entered into the case plan goals as though they are new activities or activities not yet completed. The caseworker then calls the family monthly to ask if the parent is still doing the required activity or has completed it. Unfortunately, this charade still requires worker time that could otherwise be directed toward families that actually require attention, and leaves families questioning the logic of the system as a whole.

[68] 33 V.S.A. 4915a (d)

Recommendations:

1. *Independently re-validate the changes made in the SDM since its inception, in order to verify that it is still a valid instrument. At present, almost anyone who has had prior involvement with DCF will score high or very high, regardless of current improved circumstances or passage of time. Using the current tool as a sole, or primary, indicator of the need to open a case negates the philosophy that people can change. Additionally, using the tool in this manner results in further deterioration of DCF investigative and assessment skills, since the tool effectively supplants the need for accurate investigations and assessments.*

2. *DCF should cease the current practice of using the tool to coerce families into participating in Open Family Services Cases. Effectively, DCF uses the risk assessment tool in place of an assessment. Assessments, by law, cannot be used to coerce families into services.*[69]

3. *Require that parents are active participants in completing the questions contained in the tool and provided a copy of the scoring.*

4. *DCF should review the scoring of the tool, relative to the current practice of penalizing parents for having been victims of child abuse/neglect themselves and/or having been foster children. If, having been a foster child is considered an element in creating a future abusive or neglectful parent, why is the state placing children in foster care?*

P. Placement Decisions

As in many other states, Vermont's child protection agency, DCF, has changed its decisions regarding removal to foster care based on children's dying in the care of caretakers where the agency had knowledge of unsafe conditions. This often results in a rapid increase of children's being removed and not enough safe homes where they can be placed. This in turn makes it hard to place children into homes that can appropriately care for them, and children are being moved from home to home. What VPRC has also seen is an alarming lack of consistency in placement decisions made by DCF. This experience, again, strengthens the notion that children would be better off by supporting them and their parents at home to prevent the trauma of removal and the trauma of multiple out-of-home placements.

1. Best Interest of the Child

Once the court has made the decision that a child needs to be removed from their home, the difficult decision about where to place the child must be made. Until 2015, Vermont law provided a placement hierarchy as follows:[70]

[69] 33 V.S.A. 4915a (d)

[70] This is a general outline. The previous law had many conditions for each preference.

a. Return the child home with conditions;
b. A noncustodial parent;
c. A relative;
d. A person with significant relationship with the child;
e. DCF

As part of the reaction to the tragedies in 2015 where two children died who were known to DCF, the legislature eliminated the hierarchy and instead replaced it with "the best interest of the child."[71] There is no definition of the best interest of the child.[72] The application of such standards without definitions requires an unreasonable degree of subjectivity in a child protection system where no one at the time of removal of the child has an in-depth understanding of the family and its resources. Thus, in VPRC's experience, the placement decisions are arbitrary at best. With insufficient investigations, high worker turnover, and the reliance on unverified information, few people involved in a case actually know the facts of the family to the extent necessary to make an accurate determination as to what is in the best interest of the child.

The change in the law eliminating the placement hierarchy frequently also results in DCF's not contacting grandparents and other relatives as potential placements for children upon removal. This is problematic because, unless they are contacted, blood relatives are often hesitant to interject themselves into the initial stages of state action and are often unaware of the repercussions that can arise by not doing so. The former law required DCF to look for relatives and educate them about the fact that if the child was not able to reunite with the parents, then later, in a termination of parental rights process, it would be too late for blood relatives to assert their willingness to assume custody, because the child may have bonded with the foster parent. VPRC has experienced under the new law that DCF has denied relatives attempts to get regular contacts with a child in DCF custody, only to change its mind, and upon termination of parental rights proceedings, the foster parents were deemed to be a better choice despite blood relatives' having a biological, cultural, and religious tie to the child. The shift from a focus on relatives first to one of best interest of the child has demonstrated unforeseen challenges, is contrary to federal law, and merits legislative revisiting as it may be producing more problems than initially intended.

[71] 33 V.S.A.§5308
[72] The best interest of the child is defined in 33 V.S.A. Sec. 5114 but the statute does not include the removal hearing or hearings before the merits of the case have been established. Thus there are no standards.

2. Placement of very young children in pre-adoptive foster homes[73]

It has been VPRC's experience that DCF, in the last few years, has increased the number of removals of babies directly from the hospital and placed them in pre-adoptive homes. The mothers have had to fight to get sufficient number of contacts with their babies to establish the necessary bonding and relationship.[74] This DCF policy apparently was adopted as a means of reducing the number of foster placements that very young children would experience. Although this may have accomplished that aim (we have no data either way), what it has done is create a dynamic in which foster families wishing to adopt a child have little motivation to help biological parents in their reunification efforts. The result, all too often, is a tug of war over the emotions of the child, with little cooperation among the parties, visitation interfered with or cancelled, and prolonged legal battles. We know from our experience that with sufficient legal advocacy and social supports, mothers get their children back. We also know that without such, mothers lose this battle too often, as Vermont has in the last 10 years been in the top six states in rates of termination of parental rights of young children ages 0–3 and is currently second in the nation.

Vermont is also one of only a few states where placement decisions, once a child is in state custody, are beyond the purview of judges, so the only effective advocacy early on is to request the judge to order the parents to obtain very frequent contact with their baby and to ensure that the parents have transportation to get to their baby. Advocacy and availability for such is uniformly lacking.

3. Voluntary Relinquishment of Parental Rights with a promise of regular visitation

The 2015 child protection legislative revisions also added post-adoption contact agreements.[75] This new law, despite lacking enforcement teeth, initially appeared to be a reasonable way of accommodating the needs of a child relative to adoption, ensuring that biological parents could maintain post-adoption contact with their child while avoiding a lengthy court action. However, VPCR has had some troubling experiences that this process may sometimes be used in such inappropriate manners that:

- **a.** The biological parent voluntarily relinquishes parental rights in exchange for a promise of regular contact with the child, post adoption;
- **b.** The adoptive parents are told by DCF that they are not to allow post-adoption

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[73] See "Sara's Story" p. 95-97, this document.

[74] See Candice L. Maze, JD, American Bar Association Policy Brief, October 2010, Advocating for Very Young Children in Dependency Proceedings: The Hallmarks of Effective, Ethical Representation,

[75] See 33 V.S.A. §5124.

visitation and that if they do allow such, DCF will consider it a basis for DCF to initiate a family services case involving the adoptive parents.

c. Once the adoption is complete, the biological parents seek visitation but are denied such by the adoptive parents.

d. There is no provision in law to compel the adoptive parents to allow visitation, nor will DCF involve itself in the matter since there is no longer an open case.

4. Voluntary relinquishment of conditional custody (in order to achieve permanency via foster care transitioning to adoption)

A judge at the initial temporary care hearing routinely issues a temporary conditional custody order to a grandparent or other relative, based on everybody's agreement. This practice is common and typically involves biological relatives of a child whose parents may face termination of their rights later. The conditional custody is possessed by grandparents or aunt or uncle, whom the parents have agreed should have custody of their child. The conditional custody order can only stay in effect for up to two years and a permanent custody order must be issued when the parents are not able to resume custody.

Here is a chilling experience by a family with a conditional custody order who contacted VPRC for help: Rather than DCF's agreeing to the grandparents' being granted permanent guardianship for the child:

a. DCF suggested that the grandparents voluntarily relinquish conditional custody in order to become foster parents and then transition to adoption. This would also have allowed the grandparents to receive a financial subsidy. What DCF did not inform the relatives is that once DCF has full custody, the department can place the child where the department wishes and controls the adoption.

b. The grandparents voluntarily relinquished the conditional custody to DCF and hen applied to become foster parents as they were requested to do.

c. DCF then denied the application for foster parent licensing, on the basis of an issue that DCF was aware of prior to the grandparents' relinquishing their conditional custody, but that was not disclosed to the grandparents earlier.

d. The grandparents were then left with no legal rights (since they no longer had legal standing in the case) nor legal representation unless they hired a private attorney (which most cannot afford).

e. If the grandparents had pursued a legal remedy, DCF then would have opposed the grandparents' request to the court based on the fact that the grandparents did not qualify as foster parents.

f. The grandparents then borrowed from their life insurance policies, hired their own attorney, and were successful in gaining permanent custody of the child over DCF's objections.

Recommendations:

1. *The new law eliminating the hierarchy of placements at the initial hearings should be reviewed and relatives should get priority, as is the law in most states and encouraged by federal law. There is, to our knowledge, nothing in current law that precludes DCF and/or the court from using the pre-2015 placement hierarchy, provided the placement within that hierarchy is in the best interest of the child. In the meantime, although current law requires that best interest of the child be the guiding principle for placement decisions, DCF should continue the previous practice of contacting relatives when, or shortly after, a child is taken into custody. The relatives should be provided with an understanding of the proceedings and queried as to their possible willingness to assume responsibility for the child and what would be required of them should the family choose to do so. There is nothing in the current law that precludes DCF from doing this.*

2. *The post-adoption contact agreement law should be reviewed to see how it is working.*

3. *When DCF proposes to provide a benefit to parents or guardians in exchange for their voluntary relinquishment of parental rights not covered by post-adoption contact agreements, the agreement should be in writing and in the presence of an attorney. The agreement should be explained in detail to the parties, and the benefit to be gained and possible risk should be clearly delineated. The agreement should be signed by the parties and witnessed by the attorney. Finally, the agreement should be provided to prospective adoptive parents for their signatures, as well. In this manner, there will be no confusion as to what is expected of all parties.*

4. *When DCF encourages the application for foster parent licensing in lieu of a voluntary relinquishment of guardianship, DCF should clearly specify, both verbally and in writing, that the party relinquishing guardianship is, in fact, giving up their legal status in the hope that they will be licensed by the state, but that there is no guarantee that licensing approval will be granted. This will require DCF to openly acknowledge a*

practice that is often not evident to the average Vermonter with whom DCF is engaged.

Q. Performance Measures

Although the department maintains performance measures, these are typically tied to federal reporting criteria, have little to do with quality, and where these do exist, the department is not accountable to Vermonters for improving them. There appears to be no effective internal quality control regarding investigations, affidavits, or the accuracy of content in official records and no recognizable method of identifying and improving areas of substandard performance. Effectively, the only things measured appear to be processes (formerly referred to as outputs), not outcomes, and the veracity of the processes was successfully challenged in a significant number of VPRC reviewed cases.

The absence of performance measures is a direct outgrowth of the absence of system oversight. Oversight demands measures, and without oversight, there is no chain of accountability, much less accountability for, in this instance, demonstrating that children and families who come into contact with the child protection system are better for the experience (the ultimate measure of success in child protection).

1. Investigation/Assessment Completion Time

Although both statute and policy dictate the length of time allowed for the commencement and closure of investigations and assessments, in many cases DCF views these as guidelines rather than enforceable policies. Additionally, when confronted with the failure to meet these guidelines, DCF district office personnel frequently misidentify the official start/closure dates in an effort to justify the timeline. There currently exists no enforcement mechanism by which to correct this behavior. Additionally, when completion time is evaluated, there appears to be little or no quality assurance mechanism to verify that the date entered into the official record is the date on which the activity was actually completed.

2. Reasonable Efforts

When it comes to the removal of children from their families, whether temporarily or permanently, the primary measure justifying state actions is whether the child protection system made reasonable efforts to maintain the family unit. In fact, reasonable efforts, in both quantity and quality, should be a primary performance measure for any child protection agency. There is little record in DCF files as to whether reasonable efforts have been made in a given case, much less a standardized enumeration of the efforts. Unfortunately, this failure is rarely addressed by appointed defense counsel for parents or the court in either upholding a temporary removal or the termination of parental rights. To the contrary, DCF rarely delineates

its own efforts at ensuring family unity, but relies upon its enumeration of perceived parental failures.

Recommendations:

1. *Institute a reporting system consisting of both outcomes and process while identifying the nexus between the two. Ensure that family case plans contain both expected processes and outcomes for each family.*

2. *Institute a reporting system wherein DCF specifically enumerates the reasonable efforts put into place in order to avoid removal of a child, including the extent of effort involved in making those efforts and the resulting outcome. Absent this, the state's attorney and the court should decline to accept an affidavit or CHINS petition.*

3. *Institute an internal Q/A system whereby adherence to timeline requirements for initiating investigations, completing investigations and assessments, holding substantiation reviews, and providing review results are accurately monitored, reported on, and used to improve performance.*

4. *Institute a formal notification, written in plain and easy-to-understand language, informing parents of their rights and the distinction between voluntary and mandatory elements of investigations and assessments. Have both the investigator/assessor and the parents sign the document and be provided copies.*

5*. Review the DCF practice of employing group events as a method of meeting federal standards for monthly eyes-on observation. Such group observations, especially when large groups of children are involved, do little to provide insight relative to how the child is adapting in foster care and how well the foster home is meeting the child's needs.*

R. Assessing Services, Volume, Duplication and Information

The department operates with a standardized format for service provision, despite all the research and best practices showing that services must be tailored to the families' needs and what they want. In reviewing case plans, one is struck by the sameness of the plans, regardless of the specific needs of a family. Virtually all services to families are funded through DCF directly or indirectly through its parent agency, the Agency of Human Services, yet neither DCF nor AHS has control over these services insofar as prioritization or coordination. The most needed service, housing, DCF does not help with or actively follow up with if a subsidy requires a DCF signature. In too many instances where a subsidy could have made a real, positive difference for a family, DCF actively opposed the subsidy. The addition of new bureaucratic

structures via pilot or demonstration projects appears to have served the primary purpose of making service offerings redundant and more onerous for families to manage while rarely translating into fundamental improvement of the underlying administrative structure or practices. Families not in need of services, as well as families that have developed and maintained their own extensive service network, are nonetheless referred to additional service structures. When families elect not to further complicate service plans that are working well, DCF file notations reflect only that "client refused services," without explaining why the family declined. In future encounters with DCF or the court, only the "client refused service" notation is presented as evidence of a family's past unwillingness to engage in services. The rationale for the refusal is not noted.

Recommendations:

1. *Once service delivery commences, a service coordinator should be authorized to oversee all service-related actions including the prioritization and organization of specific client services.*

2. *Families should be engaged as partners in designing their service packages.*

3. *Service plans should take into account not only the actual services needed by the family, but also the ancillary services required in order to participate in the services, with transportation's being one of the largest. It makes little sense to agree to a service plan absent the means to actually get to the services. Bus vouchers and gas vouchers, although greatly helpful in many instances, do little good if the family does not have a car, or the sites to be accessed (particularly DCF offices) are not located near the population served.*

4. *Housing is one of the most frequent challenges faced by economically disadvantaged DCF clients. It is also one of the rationales for removal of children. Yet, housing is a direct outgrowth of poverty and poverty is not a basis for removing children. The parent agency of DCF is the Agency of Human Services, an agency that spends a great deal of money on housing. Until the nexus between DCF client housing needs and AHS housing funding is bridged, Vermont will continue to threaten child removal, or actually remove children, simply because a family does not have a suitable structure in which to reside. State funds utilized to match federal funds for foster care purposes can be diverted to assist with housing, when the acquisition of housing can negate the need for a foster care placement. Doing so does not cost the state any more financially.*

S. Service Coordination/Accountability

The more than 30-year absence of system-wide service coordination across AHS continues to date. No single entity is responsible for coordinating multiple services or guiding families through the service system. No service provider or individual is responsible for the

success or failure of a given case. When families have a plethora of services with which they are engaged, it is virtually impossible to find any of the many service agencies or structures willing to accept responsibility for overall service coordination. Additionally, when a family is involved with DCF family services but requires assistance seeking child support, housing, transportation, or help dealing with landlord violations, DCF routinely declines the provision of assistance, sometimes stating, "We don't deal with child support or landlord/tenant issues; in fact we do not even know how to contact the office of child support [OCS] or the town health officer [THO]," although OCS is part of DCF, and the THO program is located in the same agency (AHS) as is DCF.

1. Service Selection and Input

Families have little input regarding what service they want or what they think is helpful once service begins, nor do they have an understanding as to what exactly it is that a service is supposed to achieve. This despite the law contemplating that DCF collaborate with the family in order to create a service plan that reduces risk of harm and improves family well-being (33 V.S.A., Sec. 4915(3).

2. Absence of Overall Service Coordination

Where service coordination does exist, it is typically limited to a single service or single agency that might provide more than one service. Effectively, this means that a family receiving services from multiple service agencies will have multiple service coordinators, all of which require coordination by the family itself. In the most extreme example, one VPRC family had 15 services with which the mother of a newborn was required to be engaged, yet not one fulfilled the role of overall coordination. When DCF instructed the client to engage with yet another service-delivery system, VPRC proposed that, rather than refer the client for service, the list of services already in place should be submitted to the new agency for a determination as to whether or not there were any service gaps and if the agency would accept responsibility for overall coordination. Within just a couple of days, the agency responded that there were no gaps and that they were not in the role of service coordination. No more referrals were required by DCF at that point because VPRC made it clear that future referral directives would be addressed in similar manner.

3. Redundancy

Where infants are involved, a family can have as many as four separate services routinely weighing, measuring, and evaluating the child simultaneously, although at separate appointment times. There is no sharing of this information between one agency and another, or attempts to reduce the impact on the time required of post-partum mothers.

4. Absence of Case Ownership

There is no case ownership except at the DCF level, and DCF does not actually control the services for which it, or AHS, contracts. Consequently, no one is held responsible for the success or failure of a family, although Vermont spends hundreds of millions of dollars in the service provision arena. There are rarely any performance measures to determine whether the family is better off as a result of the services that they receive.

5. Confidentiality

Families are not told what their confidentiality rights are. Due to the high number of services that may be involved in a single case and the wide variety and number of umbrella agencies and associated committees, coupled with the absence of a single point of service coordination, breaches of confidentiality become commonplace. Additionally, in the mixing and matching of the terms investigation and assessment, service providers find themselves unsure whether they can, or cannot, legally release information. This has been found particularly in the area of HIPAA-protected medical records. The result is frequent violations of both state and federal confidentiality laws.

Recommendations:

1. *The Agency of Human Services should create a comprehensive service coordination system, either within the agency or via community-based service providers.*

2. *Case ownership and responsibility for services should reside within a specific entity. This entity should be responsible for ensuring that service plans are client driven and matched to client needs, and that redundancy is eliminated, performance measures are met, and after-action case reviews of success/failure are completed and identified improvements integrated into the system.*

3. *Success should be rewarded with increased resources and replication of best practices.*

T. Case Plans, Case Conferences/Reviews

After investigations and assessments, the most important component in the state's intervention into a family's life is the development and distribution of a case plan, which enumerates the issues, the activities, and the outcomes sought. Absent a competent case plan, neither DCF nor the family has a roadmap to follow. Although there are policy guidelines for case plans, as well as for the case conferences/reviews that are to follow the implementation of case plans (and family safety plans), families are typically not provided either with any consistency. In many cases, reviews don't occur; in others the reviews are conducted absent

family input and the family is simply sent notes informing as to what DCF did. Essentially, parents can go months without knowing what they are initially expected to do, and months thereafter being unsure if they are successfully complying with a case plan. There is little purpose in having output and outcome measures if neither parents nor DCF workers know what they are supposed to be doing and whether a meaningful difference is being achieved.

Case conferences and reviews frequently involve several state employees, or retired state employees, and a single parent, with DCF personnel informing the parent as to what they should be doing. Rarely, if ever, does a meeting go beyond referral for services or ask the parents whether any current service is helpful. Management of services is left to the parent(s). In some instances, if a parent becomes agitated or angry, state workers interpret the response as threatening and parents are excluded from future meetings. Often, DCF workers feel under attack when families are displaying anger or opposition to departmental actions. Case conferences are not made easier when there are frequent changes in DCF personnel and when individual workers are overwhelmed by their caseloads and are unable to provide accurate information. Additionally, the respective parties leave conferences/reviews with differing understandings about what work remains to be accomplished and what the mutual end goal of a case is. Unless there is a formal safety planning meeting with a designated third-party facilitator, DCF routinely does not provide the family with any written information regarding what was discussed and specific expectations arising from the meeting. This opens the door for assertions and counter-assertions later on, with no formal document that clarifies the issues that were being discussed.

Recommendations:

1. *Establish standardization for the development of case plans, case plan reviews, and family safety plan reviews that always include the family. Monitor adherence to these standards and include performance in the process (output) section of a reporting system.*

2. *At each review (case/safety plan) inform the parent at the time of scheduling that the parent is entitled to be accompanied by a support person and can record the meeting.*

3. *Conclude all case/safety plan meetings with a written overview of the meeting that reports what was accomplished, what remains to be accomplished, timelines for each, and what challenges (if any) were identified.*

4. *When an investigation is underway and families have been dislocated as a result, status conferences should be conducted by the investigator and regularly scheduled. The purpose is to*

keep the parents apprised of progress relative to the investigation and what they can do to assist in bringing it to closure.

5. *When an assessment is underway, or when services are being provided post-assessment, case conferences should be regularly scheduled and managed by service coordinators and should involve both the family members and specific service providers engaged with the family.*

U. Recognizing Trauma as Multigenerational

Currently, trauma is recognized as a prime concern regarding children, and there is a strong movement to identify trauma, which may be an indicator of future behavioral problems. What is generally lost in today's discussion is that a prime source of trauma for families is the multigenerational cycle relating to state custody and foster care. Many of the mothers losing their children to state custody are former wards of the state themselves, as are many fathers. In some cases, so were their mothers, fathers, and grandparents. This raises profound questions as to the overall comparative efficacy of removing children from families of origin (where trauma is present) and then placing them in foster homes (where new trauma occurs because they are living in an unfamiliar environment).

Recommendations:

1. *Training regarding trauma and its impact on children and adults (who also were children once), as well as how to appropriately use it in service provision, should become part of the routine training for DCF and contract agency personnel working with families. Trauma should never be used as a reason for separating families.*

2. *Supervisors must follow the practice of treating adult trauma victims with understanding and respect, just as is expected when engaging with child trauma victims.*

3. *In addition to intra-family trauma, the trauma resulting from the forced removal of children and frequent placement in multiple foster homes should be included in training.*

V. Failure to Adopt a Recovery Model of Service

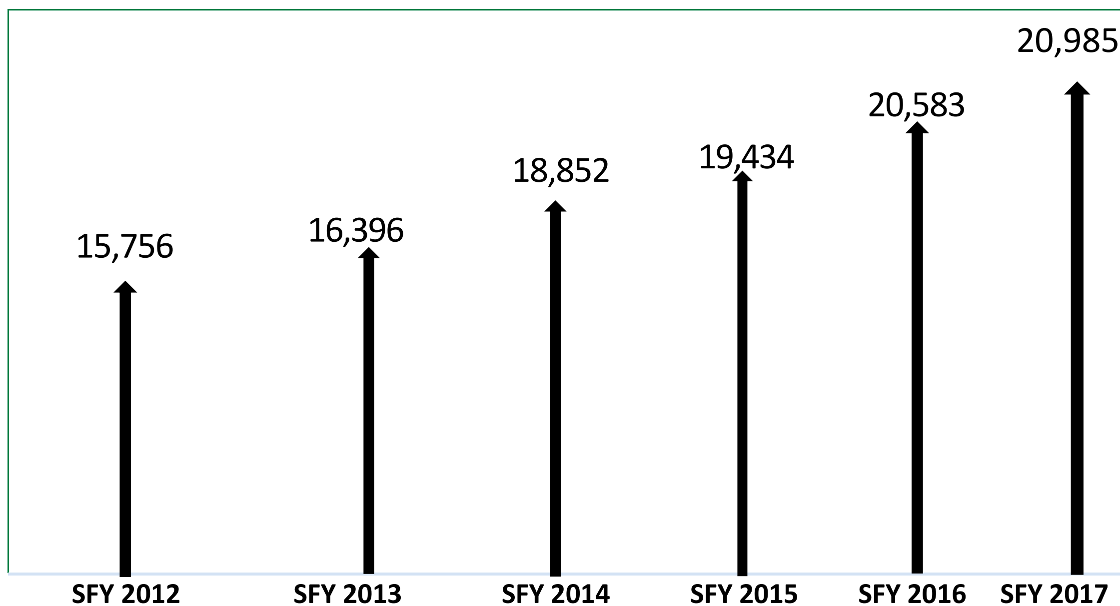
Historically Vermont has used a criminal justice model in responding to allegations of child abuse or neglect. Investigations are performed, evidence gathered, and if abuse/neglect found, the perpetrators are separated from the children and often prosecuted and entered into an abuse registry. Simultaneously, Vermont has used a treatment model when instances of less severe abuse or neglect have been highly suspect or behaviors led investigators to believe that some corrective action is required, short of removing a child from home. The treatment model is directive in that parent(s) or guardian is told what to do and may be referred to services with

the expectation that services will be used. With the increase in opioid dependency among parents of young children, it has been discovered that neither of these historic models works well insofar as successfully addressing both the addiction and a family's social service needs.[76] As a result, the recovery model has evolved, wherein professional practitioners engage parents by including them in decision making relative to both their need to address their dependency if they wish to retain custody of their child, and the strategies and supports with which to do so. Additionally, the recovery model includes intensive service coordination if there is to be any realistic expectation of progress with families experiencing deficits in the degree of executive functioning required to coordinate multiple services simultaneously. Currently, the Department for Children and Families does not appear to have the infrastructure or culture in place with which to operate from a recovery model approach.

Recommendation:

In addition to Trauma Training, DCF workers need to be trained in the theory and practice of the Recovery Model of treatment. Through direct engagement with community service providers, there is a greater likelihood that treatment approaches more akin to the recovery model can, and will, be implemented and that performance measures are used to improve performance rather than simply record activities (aka outputs).

W. Reports of Child Abuse & Neglect



Annual Report on Outcomes for Vermonters, January 2018 Vermont Agency of Human Services

[76] See SAMHSA Technical Assistance Package: Implementing Trauma-Informed Approaches in Access to Recovery Program

1. Mandatory Reporting

The number of reports of alleged abuse and neglect increases each year, yet the number of investigations remains relatively constant, as does the number of substantiations. One must question if the reasons for this are related to the expansion of the definition of who is a mandated reporter, and whether issues such as truancy distort the reporting system. Additionally, there appears some confusion in state law, school supervisory district, and DCF policy as to when school absences are a school district matter to be handled by a district truancy officer, or a social services matter to be handled through an assessment by DCF, or educational neglect to be handled by a DCF investigation.

Recommendations:

1. *Evaluate the impact that mandatory reporting is having on DCF workload at the intake, assessment, and investigation stages; look for how many affidavits of educational neglect are being submitted to the state's attorneys (rather than the school truancy officer) and how many of these end in petitions submitted to the court.*

2. *Evaluate how truancy is being reported and the cases managed between schools and DCF.*

3. *Evaluate whether mandatory reporting is an efficacious method to address child protection.*

2. Duplication of Reporting/How Reports Are Tabulated

With regard to schools and truancy, there exists a lack of clarity as to how truancy is handled generally, and a lack of consistency in how it is reported from school district to school district, as well as how DCF handles these reports. In some school districts, 10 unexcused absences trigger a truancy report, whereas in others the number is 20 unexcused absences and some undetermined number of tardy reports.

To further complicate this issue, some school districts refer cases to a school truancy committee, while others refer them to DCF. One school in particular has been instructed to notify DCF every time a student has 20 or more absences (with no distinction between excused and unexcused). The school sends DCF a monthly report; DCF then contacts the school and queries the number of unexcused, and if that number is under 20, DCF typically does nothing with the report. The next month, the school repeats the process, frequently with the same numbers and children's names. In one school (700 students), the principal estimates that slightly less than one fourth to one third of the student body is reported for excessive absences each year, with DCF's initiating an action in approximately 1% of the cases.

Additionally, with a potential loss of employment as the result of a mandated reporter's failure to report, there appears to be a tendency for multiple professionals in a given setting to submit individual (duplicative) reports in order to ensure that the individual professional is not

later accused of failing to report. The result is a plethora of reports, which can result in an issue that was initially little more than a cautious suspicion taking on the appearance of a solid allegation primarily because it is reported by numerous professionals, each of whom might have heard about it from the other and then felt compelled to report.

Recommendations:

1. *Create a statewide, uniform law or policy so that children and families from different parts of the state are treated uniformly with regard to truancy and DCF involvement. Toward this end, evaluate and address, in law or policy, how the various school districts interrelate with DCF district offices relative to mandatory absence and tardy reports, and how the various reports are counted and impact the resulting data.*

2. *Evaluate how many reports are duplicates, how they are managed in the data system, and how the duplicates arise.*

X. The Judicial Process

The federal government, through its purse strings, has promulgated laws that govern child welfare services, mandatory reporting laws, and foster care. The laws are extensive and complicated. For the purposes of our analysis and the role of the courts, prosecutors, defenders, and child welfare workers, a few principles require mentioning:
Parents have constitutional rights to raise their children free of governmental interference.[77] This parental preference is based on the notion that "[t]here is a presumption that the natural affection of a parent for a child will insure the faithful execution of the trust which he holds as natural guardian."[78] Therefore, before a child can be removed from his or her parents, a court has to decide that the parents have in essence breached that trust and a showing that "the child has been abandoned or abused by the parent, or that the child is without proper parental care or subsistence, education, medical or other care necessary for his well-being."[79]

The federal government has guaranteed that states will receive foster care reimbursement for eligible children in foster care if they follow federal laws, which include inter alia:

- States have to make reasonable efforts to prevent out-of-home placements and to reunify children who have been removed and to find permanent homes for children who have been re-placed.[80]

[77] For a long line of Supreme Court and Vermont Supreme Court decisions see in re K.M.M., 2011 VT 30
[78] Bioni v. Haselton, 99 Vt. 453, 458, 134A 606, 608 (1926)
[79] In re K.M.M.
[80] Unfortunately, neither federal law nor rules have defined reasonable efforts and the Vermont Supreme Court has held that it is not a substantive right. See In re K.H., 154 VT.540, 542-43 (1990)

- In making decisions, the court has to make safety of the child paramount.[81]

A judge can only decide a case based on competent evidence provided in the judicial process. This requires that all the judicial players — the prosecutors, parent attorneys, children's attorneys, the guardian ad litem, and the child welfare agency (in Vermont, DCF) — provide accurate and comprehensive evidence of the family circumstances. It has been VPRC's experience that because the process starts with inaccurate information in the affidavits provided by DCF to support a CHINS petition, the attorneys (particularly court-appointed defenders) involved in the process do not routinely test the accuracy of the affidavits, and the court too often does not have time to hear, in a timely fashion, requests for hearings to contest affidavits. As a result, the judicial process is no longer an adequate check on the state's action.

1. Affidavits (to support a CHINS petition)

The process of a child abuse/neglect petition starts with a request to the state's attorney from DCF in the form of an affidavit. The affidavit, typically, has no investigative report attached but is in the words of a DCF investigator/caseworker and signed off by his/her supervisor. The result is that the affidavit must be accepted on face value unless the state's attorney initiates an inquiry, at which point DCF is asked to self-verify the information, or the state's attorney can initiate a separate verification inquiry, essentially reinvestigating the matter. VPRC is unaware of any state's attorney's taking advantage of the latter option. In VPRC's experience more than 90% of the affidavits reviewed have had serious mistakes or, in some cases, intentional misinformation. This error rate undermines both the integrity of the child protection system and any attempt to ensure that fairness and justice can occur. In effect, it creates a tilted field of play upon which parents rarely prevail.

Affidavits typically contain primarily, if not exclusively, negative information and frequently contain little more than the elements contained in the initial report of possible abuse or neglect, as though the allegations have been determined to be true. Too often, however, there has not been a thorough investigation of facts, and the information contained in the affidavit is plainly not true. The allegations are also supplemented with historical material that may, or may not, have anything to do with the family's current functioning but which is phrased as though it is relevant and current. The result is an affidavit that is difficult for a state's attorney to refuse to act upon as the basis for a CHINS petition. This then becomes a petition that is difficult for attorneys representing parents to defend against and the court to rule against since the attorneys and the court assume that the information in the petition is based on accurate investigative findings.

[81] See Adoption and Safe Families Act, 1997, P.L. 105-89

The current system is based almost entirely on trust as it relates to the universal expectation that the state has conducted a credible investigation into the merits of the original complaint and any additional information gleaned through the investigation. There is virtually no mechanism by which a family can contest the contents of the affidavit prior to judicial proceedings, wherein families are at a distinct disadvantage due to timing and the frequent absence of effective legal counsel. The judicial process is now also so slow that even when parents do get an evidentiary hearing to challenge the affidavit, children have often been in out-of-home placement for months by the time the judge has heard the evidence. The reality for most families is that once a DCF worker puts pen to paper in the construction of an affidavit, families are not afforded an opportunity to correct the record before an affidavit is turned into a petition, at which point it is frequently too late.

2. State's Attorneys

In Vermont, the state's attorney by law represents the people and not DCF. DCF is represented by the attorney general's office, which often does not get involved unless there is a petition for termination of parental rights (TPR). Thus the initiation of the CHINS process is completely dependent on the accuracy of the DCF information and the state's attorney's ability to ascertain the accuracy of the information.

DCF investigators have acknowledged to VPRC that they operate with the mindset that "mistakes in the affidavit will be worked out in the court process." This is an assumption that does not prove to be accurate in light of the frequency of parent and children's attorneys stipulating to the merits, based on the affidavit, without ever having conducted an independent investigation, or even challenged the DCF investigator's factual accuracy in the affidavit.

The absence of any challenge from either a state's attorney, or a defense attorney, further facilitates the production of future affidavits of the same substandard quality primarily because affidavits of this quality become the standard by which future affidavits are modeled and evaluated.

3. Public Defenders and Contract Attorneys

The Office of Defender General represents both parents and children in CHINS proceedings, either through staff attorneys or contracted attorneys. Most often the public defender staff attorneys represent the children and the contracted attorneys represent the parents. Public defenders and contractors are the most important link in ensuring due process in the child protection system as they are the elements that hold the system accountable. Unfortunately, they are, frequently, the weakest link. Although there is a state granted right to legal representation, the Vermont Supreme Court has yet to rule that that right includes the

right to effective representation. What leaves families with all too often is the pretense of due process without the necessary substance.

Parents and their attorneys enter the child protection arena at the bottom of a tilted field, since their first encounter with one another is frequently only minutes before an initial hearing, for which both DCF and the state's attorney's office may have had days to prepare. The attorneys don't have the resources, or most often the inclination, to reinvestigate allegations or effectively challenge testimony; nor do they have the inordinate amount of time required to fully understand the scope and depth of the families subjected to having their children removed or threatened with removal. The result is that, too frequently, contract attorneys advise parents to accept the state's contentions and "do what DCF asks because you are going to lose, anyway." This advice should not be particularly startling for students of the legal system. Although there is little data in regard to child protection cases,[82] there is a history of legal studies evaluating outcomes in criminal cases when a person is assigned a private attorney (a private attorney who contracts for a stated portion of professional time but otherwise maintains a private practice, which is the type of attorney indigent parents typically are assigned in child protection cases) versus appointment to a full-time public defender (which parents rarely obtain in child protection cases):

A study conducted by the American Bar Association in 2012 determined that conviction rates were 19% more favorable to the defendant when a full-time public defender was appointed than when assigned counsel was used.[83] The same study found a decrease of 24% in expected prison sentences and the likelihood of a life sentence was decreased by 62%. The ABA found these outcomes to be "an enormous and troubling chasm." Although this study involved criminal cases, the reported findings can be assumed to apply equally to child protection cases wherein parents are primarily represented by private counsel employed for a percentage of their time, as opposed to being represented by full-time, salaried public defenders.

In order to gain a greater understanding of the aforementioned issue, one need only consider the following:

- A contracted (assigned) lawyer is paid approximately $75,000 by the Office of Defender General to work full time handling Defender General cases. There are no benefits or staff assistance attached to this contracted employment and, effectively, no oversight in how cases are handled, since it is a contract for professional services. Effectively, indigent parents are assigned an attorney who has little financial incentive to devote the level of attention child protection cases demand, and no

[82] An outcome study is currently being conducted on the efficacy of the multidisciplinary parent representation modelused by the Center for Family Representation in New York City, NY

[83] American Bar Association, *Criminal Justice*, Volume 27, Number 1, Spring 2012

oversight as to whether he/she devotes any attention at all, other than appearing in court just minutes before a hearing for which he/she may have done no preparation.

- An attorney, in private practice and hired directly by a family, typically requires a $10,000–$20,000 retainer to represent a parent, or other family member, in a single child protection case. The fee can be as high as $30,000 in VPRC's experience, but much higher if it includes a petition for termination of parental rights. This disparity in compensation, alone, ensures that an indigent family will receive considerably less attorney time than will a private pay client if the assigned attorney handles more than a handful of indigent family cases each year. Added to this challenge is the fact that an attorney who handles only a few cases per year, or devotes little time and attention to the cases that he/she does get assigned to, is far less knowledgeable than an attorney who handles similar cases on a full-time basis, as would be the case when there is a system where families are represented by public defenders who work on a full-time basis and on salary, with the requisite supports and supervision that accompany such status. Vermont's current system of contracting these services has, over the course of VPRC's experience, been observed to provide a veneer of representation, absent effectiveness.[84]

- Conversely, over the past nine years, it has been VPRC's experience that, when attorneys — particularly contract attorneys — worked with VPRC and its projects such as the rapid intervention prenatal and parenting program[85] in gaining a better understanding of the families, or the child protection system, or the effective use of filing motions in the court, as well as availing themselves of VPRC's willingness to assist with research and assessment, those attorneys have been uniformly successful. VPRC, in its programs, found teaming of an attorney with a social worker or social services coordinator to be the most effective way to represent parents. This model is supported by the American Bar Association, Children and the Law, National Alliance for Parents Representation,[86] and almost always produced an end result in which children were either able to remain safely at home while families were strengthened,

[84] Between 2016 and 2018, VPRC encountered a total of five contract public defenders who appeared to effectively represent their clients, as defined by a willingness to engage with the client outside of the court setting, file motions on the client's behalf, and actively argue their clients' cases. In virtually every other instance over that period, clients repeatedly complained that they never saw their attorneys prior to a court appearance, never engaged in preparation, and never had a motion filed on their behalf. Much of VPRC's work, over this period, involved assisting families in how to advocate for themselves and pressure their appointed attorneys to actively represent them.

[85] See page 36 for a complete description of the RIPP program.

[86] See https://www.americanbar.org/groups/child_law/project-areas/parentrepresentation.html

or if the children were removed, the children's returning home much earlier than they would have without such teaming.

a. Stipulating to the merits: Contract attorneys are not compensated, trained, or supervised to the degree necessary to adequately research the charges brought by the state, meet with the families in between court hearings, or file motions with the court to achieve particular results for their client parents. They frequently do not meet their clients until they appear in court, and have few resources for conducting independent investigations through which to challenge the state's allegations. As a result, attorneys frequently stipulate to the merits without actually having reviewed the facts with their clients or otherwise attempted to verify the veracity of the allegations. Additionally, there is a general failure on the part of contract attorneys (and others) to request a temporary care hearing, the hearing designed to test the state's evidence early in the case.

b. Face-to-face time with clients: Contract defenders are paid for a percentage of a full case load, not for the time that an actual case requires. Too often the contracted attorney will have another caseload of paying clients who get most of their attention. Unlike other states (where attorneys are required to indicate the number of out-of-court hours spent in face-to-face meetings with clients), there is no such accountability in Vermont. The most common complaint, made by parents to VPRC and anyone else who is willing to listen, is that contract defenders do not return phone calls, meet face-to-face or otherwise adequately prepare for hearings, if they prepare at all.

c. Effective representation: With the exception of a small number of exceptional contract attorneys, parents do not feel they have any allies, do not believe they are getting adequate representation, and feel the whole court process is rigged. This view of court-appointed legal representation is buttressed by VPRC's experience. The single largest reason for parents to contact VPRC over the past two years has been to seek assistance in getting the parents' attorneys to do more than merely appear in court only minutes before session begins, sit mute, and recommend that parents do whatever it is that DCF requires. Clients who are able to gather necessary evidence find that their appointed attorneys don't submit the evidence, don't attend critical meetings, don't file motions, and, most frequently, do not return telephone calls or ever meet with clients prior to hearings. Of particular concern is the rapid turnover of attorneys assigned to a parent. In VPRC's experiences, a parent can have two, three, or even four attorneys over a period of a year or two. In 2018, one parent experienced four attorneys, while never actually meeting attorney number three, even though this attorney represented the parent for several months. It was only when the parent sent attorney number three a certified letter requesting a meeting (as recommended by VPRC) that the parent discovered that the attorney was no longer handling cases, nor was at the legal firm any longer,

and that the case had been relocated to another attorney, but attorney number three's firm did not know where the new attorney was located. It took the parent three days to locate the new attorney.

d. Supervision/oversight of contract attorneys: Because contract attorneys are contract employees, the Office of Defender General does not provide supervision or extensive oversight. This is not only true due to the contractor relationship, but also because the Defender General typically represents the child. As a result, the degree of oversight relative to the quantity and quality of services provided by contract attorneys is minimal, if it exists at all. It has been VPRCs experience over several hundred cases that the most frequent requests we receive come from parents seeking advice as to how to get their assigned attorneys to actually represent them in a meaningful manner. To address this absence of oversight, VPRC routinely recommends that parents send a series of certified letters to their appointed attorney when the attorney is not responsive. The first letter is to the attorney, with the second letter being to the attorney but copied to the Defender General. The third letter is to the attorney, the Defender General, and the Bar Association. In VPRC's experience, most attorneys respond with receipt of the first letter, although a number have required the second letter.

e. Teaming attorneys with social workers: VPRC created, based on the nationally recognized model, a team approach to representation. The lawyer educated, and sometimes represented, the parent, and the social worker provided additional depth and scope to the evaluation of a family's overall needs, then advocated for the specific services needed while serving as an overall coordinator of those services. In instances involving contract attorneys, VPRC provided legal guidance/consultation/training while compiling a social service assessment. Typically, these assessments produced more comprehensive, accurate, and balanced information than was obtained through the DCF investigations, which were frequently found to contain significant errors and/or gaps.

4. Guardians ad litem (GAL)

In Vermont, children in CHINS cases are assigned a guardian ad litem (GAL) who shall act as an independent advisor and advocate and safeguard the child's interests and rights.[87] The GAL is a volunteer whose duties include meeting with the child, the child's attorney, and others necessary for an understanding of the issues in the case. Their courtroom role is limited. When young children are involved, the GAL is the client of the public defender. This model of representation for very young children is now questioned, and the legal-interest model is recommended.[88] In the legal-interest advocacy model, there are no GALs, and attorneys for

[87] See Vermont Rules for Family Proceedings Rule 6 (e).
[88] See Until the Client Speaks: Reviving the Legal-Interest Model for Preverbal Children,

preverbal children are charged with ensuring that the many rights given to infants are enforced, thus eliminating attorneys' and GAL ability to impose their values on the child client. In Vermont, in addition to questions about the model of representation of children, there are too few volunteer GALs to adequately serve the children requiring them. The majority of GALs come from different socioeconomic backgrounds than the families with whom they are involved, and are unable to spend the amount of time needed in order to understand the needs of the families. GALs have minimal or no supervision and too often, are primarily reliant upon DCF social workers/investigators for information regarding the families. Finally, the insufficient number of GALs significantly impacts the court system's ability to schedule and process cases in a timely manner. Contrast Vermont's GAL system to that of the Court Appointed Special Advocate (CASA) system operating in New Hampshire and Massachusetts wherein CASA national standards are adhered to, ensuring that CASAs have a thorough and balanced understanding of the child and family, work with manageable caseloads and serve as a thoroughly independent and knowledgeable resource for the court.

Recommendations:

1. *Evaluate whether the GAL program should be continued in light of the bias currently observed, and historical difficulty of recruiting and retaining GALs.*

2. *Consider replacing the GAL program with a "representation of children's interests" system in which the child's attorney assumes responsibility for representing the child's legal interests.*

3. Consider replacing the current GAL program with a Court Appointed Special Advocate (CASA) program operating under national CASA standards akin to that of New Hampshire and Massachusetts.

5. Judges

When children are removed from their parents in a judicial process, a just result is completely dependent on judges' having the time and interest to resolve the cases before them quickly. There are too few judges to hear the number of family cases in a timely manner and the judges who do hear cases are provided with incomplete, and often contradictory information with which to work, and frequently a court room of attorneys and DCF workers who possess little more, and sometimes less, knowledge about the case than does the judge. This results in extended placement of children, change of placement absent court review, and an almost total reliance on paperwork provided by DCF, paperwork that is frequently suspect, if not entirely unreliable.

Lisa Kelly, Alicia LeVezu, 50 Fam. L.Q. 383–426 (2016)

a. Introduction of new material:

At first court appearance, DCF frequently introduces new concerns that were not identified in the original affidavit. Although this may be appropriate in cases where there are emergency circumstances, it occurs in nonemergency cases as well. This places families and their lawyers in the position of having no foreknowledge as to what they are expected to respond to and in essence requires either the postponement of the hearing or another hearing, and all too often children entering custody absent a real understanding as to whether they should be in custody. Unfortunately, it is a rare occurrence that parent attorneys ask the court for more time to investigate the truth of the new allegations or request more hearing time, and rotating judges have little history to fall back upon in evaluating the lateness of new concerns. Cases which begin with an affidavit alleging physical abuse mutate into cases alleging medical neglect which, in turn mutate into cases alleging educational neglect and in each instance the court, and parent's attorneys spend months sorting through a revolving door of allegations which, in VPRC's experience, result in findings that the allegations are baseless.

b. Rotation of judges:

Because Vermont has a system of judicial rotation, these court cases frequently have multiple judges with different knowledge and approaches. Parents are bewildered by one judge's saying something very different from another judge and lose confidence in the fairness of the court. As most of the parents' attorneys do not regularly spend time with their clients after a hearing to explain what happened, the parents are bewildered and disenchanted by a process they do not understand.

Recommendations:

1. *Evaluate the gap in the number of judges needed to handle the increasing caseloads in Family Court and estimate the financial cost of the gap in the context of extended foster care placements and associated expenditures. The establishment of a Regional Family Court should be considered as an alternative to the current under- performing system.*

2. *Evaluate a shift from rotating judges in family court to a system wherein the same judge hears a case from beginning to end. Establishment of a Regional Family Court would facilitate this critical change.*

3. *Establish a Parent Representation Office that resides outside of the Office of Defender General (ODG), and whose primary purpose is to educate families as to their rights and responsibilities and advocate for them within the child protection system. This entity should be funded as part of the overall child protection system's state and federal funding stream. The office should utilize multidisciplinary teams of salaried attorneys and social workers. Creation of*

such an office would resolve the vast majority of problems relating to chronic ineffectiveness of counsel as currently experienced.

4. *Evaluate a mechanism for ensuring that parents and their attorneys are afforded the opportunity to review the DCF affidavit and investigative report prior to their first appearance before the court. The Washington State bench/bar model of requiring a complete affidavit and accompanying file at least one hour before a hearing should be explored.*

5. *Require DCF/state's attorney to produce new material and the underlying documentation supporting that material in sufficient time for parents and their attorney to review it prior to the next court appearance.*

6. *In instances where attorneys recommend that parents stipulate to the merits, require that attorneys, in writing, explain in easy-to-understand terms what it is that "stipulating to the merits" means, what the ramifications are likely to be, and the factual basis for their recommending this action. The written statement should be signed by the attorneys and parents.*

7. *Require that attorneys document the amount of time spent with clients in the following categories: amount of out-of-court, face-to-face time with clients; number of out-of-court meetings with client, and hours spent in prehearing preparation; and a statement detailing whether or not the client stipulated to the merits and the basis of this stipulation. This document should be presented as part of the invoice system for payment.*

8. *Require that the Office of Defender General review the time-on-client data, as well as the stipulation data, and issue an annual report detailing such, by county, if parent representation remains within the ODG.*

9. *In the event that the contract public defender system remains in place, require the Office of Defender General to establish an oversight mechanism whereby complaints regarding effective representation by contract attorneys can be lodged and addressed. Basic information generated by this mechanism should be included in the annual "time on client" report.*

10. *Establish an orientation and training program for contract attorneys, as well as a help desk for consultation.*

11. *The establishment of a Regional Family Court system would appear to be the most comprehensive, effective and efficient method of addressing the current failure of the judiciary*

in expediting cases, addressing backlogs and ensuring that each of the parties involved (DCF, parent's attorneys, State's Attorneys, GALs and the Attorney General are held accountable.

Y. Substantiation of Abuse/Neglect and Placement in the Abuse Registry

Substantiation of Abuse Neglect

Due process protections for placement on the Child Abuse Registry are weak. DCF notification of substantiation is often inadequate, and statutory requirements for timeliness are rarely followed. The standard for substantiation of abuse/neglect is the reasonable person. [89] DCF workers proposing substantiation, their supervisors, and the initial hearing officers do not fit the reasonable person profile. Rather, they are individuals whose training is designed to heighten sensitivities and err on the side of caution relative to child protection, far in excess of that demonstrated by a hypothetical reasonable person. Additionally, the veracity of registry entries (of which there are thousands) is now suspect because underlying investigations are, in many cases, deficient, if not incorrect. The dramatic increase in substantiations for "risk of harm" appears to result from the bureaucratic application of a degree of subjectivity not contemplated in state law and further magnified by the absence of a definition of "significant danger" and "serious harm." Finally, when substantiation is proposed, untrained and often poorly educated Vermonters are expected to defend themselves in hearings armed with little more than highly redacted, and often unintelligible, DCF documents, in contrast to DCF which is represented by highly skilled and experienced government attorneys.

<u>Recommendations:</u>

1. *The "reasonable person" standard of proof should be replaced with a standard that requires "proof that an objective, reasonable person would find convincing" that is more in keeping with the severity of the ramifications for substantiation and placement in the registry. The initial determination of substantiation is not made by a "hypothetical person," but rather by state employees whose bent is heavily in favor of child protection and risk avoidance, rather than an objective determination as to what the evidence indicates.*

2. *Notification of substantiation, and entry into the registry, should be more comprehensive; the appeal process should be more informative; and timelines for appeals and opinions should apply equally to defendants and the state.*

[89] 33 V.S.A. 4912 (16)

3. *All substantiations for risk of harm should be reviewed to determine whether the specific allegation substantiated meets a commonly accepted standard as to what constitutes a significant danger that a child will suffer serious harm.*

4. *Individuals appealing substantiation/inclusion in the Registry should be provided an attorney if there is to be real due process. Otherwise, these individuals are typically without the education or experience needed to defend themselves, are provided incomplete and heavily redacted evidence, and are opposed by a highly trained and experienced state attorney.*

5. *Currently, only individuals alleged to have engaged in child sexual abuse are entitled to a commissioner's report justifying the proposed substantiation. In light of the severe personal and professional implications of a substantiation, a commissioner's report should be required in each proposed substantiation detailing the specific rationale for the substantiation. Short of this, how is a person expected to defend themselves in an appeal.*

6. *When an accused individual appeals the proposed substantiation they should be provided with either an un-redacted copy of the official file upon which the substantiation is based. Providing such will both enable an individual to present an effective defense AND will significantly speed the appeal process since much of today's backlog in hearings is, allegedly, due to DCF's inability to redact files in a timely manner.*

Post Script

In the final week of writing this analysis, VPRC received a telephone call on the Help Line. The caller identified herself as a professional mental health worker and someone who wanted to help young women involved with the Department for Children and Families. When asked what sparked her desire she related the following:

About 25 years ago, I found myself a single parent with three young children, depressed and without resources. I realized that I could not take care of my children alone, so in desperation I picked up the phone and called SRS (Department for Social and Rehabilitation Services, the child protection agency that was incorporated into today's much larger DCF) and I asked for help. Almost immediately I found myself surrounded by caring, competent social workers and educators who helped me identify what I needed, found the help I needed, and continued to provide support and guidance until I was back on my feet and able to care for my children properly. Today, I look at what happens to women who are in the situation I was in 25 years ago and I don't see the help from DCF. What I see, over and over again, is a system that is focused on taking children rather than helping parents take care of their own children. I don't know what happened to the system that helped me — I don't know where it went — but today I don't see a system that is focused on helping families and I would like to do something about it. How can I help?

Glossary

Affidavit A written statement by the Department for Children and Families confirmed by oath or affirmation, for use by the state's attorney and attached to the CHINS petition.

Bending the Curve Generic name for the attempt to reduce rates of young children entering state custody. Also referred to as BTC.

BTC Bending the Curve

CHINS Children In Need of Services: A= abandoned or abused child; B= child without proper parental care, subsistence, education or medical care; C= child beyond control; D= child habitually truant.

Contract Attorney A private attorney, under contract with the defender general's office for a percentage of his/her overall time, representing parents when the Office of Defender General is representing the children of the parent(s) or the other parent. Also known as a public defender.

Office of Defender General State office charged with providing legal representation to children and/or parents in matters involving CHINS petition.

ODG Office of the Defender General

Department for Children and Families State department charged with ensuring the well-being of children and families. Oversees assessments, investigations, foster care, adoption and economic services among other responsibilities.

DCF Department for Children and Families

Differential Response Dual approach to addressing child protection concerns wherein situations involving criminal behavior or imminent danger to a child are

investigated, and situations that do not present criminal behavior or imminent danger to a child are assessed for the purpose of offering social and economic services to a family so as to increase the family's ability to raise healthy children.

GAL Guardian ad litem

GAO General Accounting Office (U.S.)

Guardian ad litem A volunteer the court appoints to represent the best interests of a child. Also referred to as a GAL.

Individualized Education Plan (IEP) An educational plan designed specifically for a child by a school system.

Medication Assisted Treatment (MAT) Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

Minor Guardianship An individual, appointed by the Probate Court, to act in the best interest of a child. May be voluntary or involuntary.

Office of Child Support (OCS) An office with DCF charged with ensuring that child support is assessed and maintained where warranted.

Petition A written request made by the state's attorney to the court, asking for custody or supervision of a child based upon an affidavit submitted by the Department for Children and Families.

Petition Stage Activities involving judicial involvement beginning with the filing of a petition by the state's attorney requesting state custody.

PPIC Permanency Planning Implementation Committee

Pre-Petition stage Activities occurring prior to judicial involvement, usually involving an assessment or investigation and an open DCF case for services.

Preponderance of the evidence — The more convincing evidence and its probable truth or accuracy.

Reach Up — A DCF program providing services that support work and monthly cash payments to meet basic necessities such as food, clothing, housing and utilities.

Reasonable Person — Denotes a hypothetical person in society who exercises average care, skill, and judgment in conduct and who serves as a comparative Standard for determining liability.

RIPP — Rapid Intervention Prenatal and Parenting Project providing opioid involved mothers with legal education, advocacy, social service coordination and legal representation when at risk of having their very young children enter state foster care. The Project was a collaborative effort involving the Vermont Parent Representation Center, KIN-KAN Vermont and Vermont FACES Network from 2012 to 2014.

Recovery Model — A mental health and substance abuse treatment concept wherein a service environment is designed such that parents are included in decisions regarding their care relative to Opioid dependency and related challenges, and wherein there is parity between the service provider and the service recipient. This differs from a Treatment Model wherein parents are told what actions they should take, with little if any input by the parent(s).

SAMHSA — Substance Abuse and Mental Health Services Administration, U.S. Dept. of Health and Human Services.

Social and Rehabilitation Services (SRS) — The Vermont department dedicated to child protection which was incorporated into the new Department for Children and Families in 2004, and which, in addition to child protection, today includes Medicaid, Child Support, Disability Determination, Economic Services and Economic Opportunity.

State Custody — A judicial determination that a child becomes a ward of the state, most often involving placement in a location other than with the child's family of origin.

Term	Definition
Social Worker	Individual employed by the Family Services Division within the Department for Children and Families. May be identified as an investigator, assessor, caseworker or other title. Primary role is to determine veracity of allegations, determine service needs and monitor families with open cases.
Structured Decision Making (SDM)	The use of validated decision making tools in order to attempt to predict child safety.
Termination of Parental Rights (TPR)	A judicial action removing a parent's legal rights regarding their child.
Town Health Officer (THO)	Individuals assigned and trained to address public health matters in each town. They work under the auspices of the Department of Health, within the Agency of Human Services.
Vermont Parent Representation Center, Inc.	Nonprofit organization founded in 2009, with the mission to educate advocate for families engaged with Vermont's child protection system. Also known as VPRC.
VPRC	Vermont Parent Representation Center, Inc.
Vermont Statutes Annotated (V.S.A.)	Laws of the State of Vermont. Also referred to as V.S.A.

The Authors

Trine Bech
Trine was the founding director, then staff attorney of Vermont Parent Representation Center, Inc., now recently retired. A lawyer, she spent her professional life working to improve legal, social, child, and family services systems, including several senior management positions in state and county governments. She led Vermont's Court Improvement Project and served as a Vermont Family Court Magistrate. She is an Annie E. Casey Foundation Children and Family Fellow and was a major force in the creation of the Vermont Family Court.

Lawrence (Larry) Crist
Currently the executive director of the Vermont Parent Representation Center (VPRC), Larry has dual degrees in law and social work. With an earlier background in prison and juvenile justice reform, family services, forensic mental health, and inner-city settlement houses, Larry moved to Vermont in 1985. He has served as Vermont's Director of Child/Foster Care Licensing, Deputy Commissioner of Health, and Commissioner of Aging & Disabilities, Director of Public Health Preparedness and Health Protection, executive director of the Vermont Red Cross and, for the past two and one-half years, as executive director of VPRC. His area of specialty is the analysis and reform of public and nonprofit sector agencies. He has served on numerous state, regional, and national boards and commissions, authored studies, and provided expert testimony in state and federal hearings, as well as chairing local, state, and national committees and task forces.

Contributors

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