

The Road Less Traveled By

**TOWARD REAL REFORM OF
CHILD WELFARE IN MISSOURI**

Second Edition, April 2003

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A report from the National Coalition for Child Protection Reform
By Richard Wexler, NCCPR Executive Director
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ABOUT NCCPR

The National Coalition for Child Protection Reform is a non-profit organization whose members have encountered the child protective system in their professional capacities and work to make it better serve America's most vulnerable children. **Board of Directors: President: Martin Guggenheim**, Director of Clinical and Advocacy Programs, New York University Law School. **Vice President: Carolyn Kubitschek**, attorney specializing in child welfare law, former Co-ordinator of Family Law, Legal Services for New York City. **Treasurer: Joanne C. Fray**, attorney with extensive experience with litigation involving the care and protection of children and termination of parental rights, Lexington, Mass. **Directors: Elizabeth Vorenberg**, (Founding President) former Assistant Commissioner of Public Welfare, State of Massachusetts; former Deputy Director, Massachusetts Advocacy Center; former member, National Board of Directors, American Civil Liberties Union; **Annette Ruth Appell**, Associate Professor, William S. Boyd School of Law, University of Nevada, Las Vegas; former member of the Clinical Faculty, Children and Family Justice Center, Northwestern University Law School Legal Clinic, former Attorney and Guardian ad Litem, office of the Cook County, Ill. Public Guardian; **Marty Beyer, Ph.D.**, clinical psychologist and consultant to numerous child welfare reform efforts; **Ira Burnim**, Legal Director, Judge Bazelon Center for Mental Health Law, Washington, DC; former Legal Director, Children's Defense Fund; former Staff Attorney, Southern Poverty Law Center; Prof. Prof. Dorothy Roberts, Northwestern University School of Law, author *Shattered Bonds: The Color of Child Welfare* (Basic Civitas Books: 2002). **Staff: Richard Wexler**, Executive Director. Author, *Wounded Innocents: The Real Victims of the War Against Child Abuse*. (Prometheus Books: 1990, 1995).

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Overview

Dominic James didn't have to die. When police were called to the two-year-old's home in Springfield, they say his birth mother was drunk and belligerent and possibly arguing with the boy's father.

"I kept asking what had happened to my son, and they kept telling me I was overreacting. One day I told them: 'Before you admit a flaw in children's services, you'll let my son die.'"

--*Sidney James*

When that happens in an affluent neighborhood, a friend or relative can be called, or a babysitter can be hired, to stay with the child until the mother sobers up. But the James family is not affluent, so those options don't apply.

The police also could have referred the case to the Missouri Division of Family Services* to send an Intensive Family Preservation Services worker into the home for several hours a day for up to six weeks, -- to be absolutely sure Dominic was safe -- while also arranging for alcoholism treatment if necessary. But the police didn't do

* Though child welfare in Missouri is being reorganized and this division apparently soon will no longer exist, for the sake of simplicity the name is used throughout this report.

that. And if they had tried, there might not have been such a worker available.

And when DFS got the case, DFS didn't do it either.

Nor did DFS convene a real team meeting in which anyone who might have helped the James family would gather around a table and work out a plan to get him home.

Nor did they place Dominic with his father, Sidney James. Sidney was not married to Dominic's mother, but was living at her home. The father allegedly had a substance abuse problem at one time, but he also reportedly was getting treatment. What really bothered DFS seems to be that Sidney James lacked housing of his own and employment. DFS did nothing to help him obtain either.

DFS also could have placed Dominic with his maternal grandparents. They didn't, and DFS has provided no explanation.

Instead, they decided to put "child safety" ahead of "family preservation." They stood up for Dominic's "children's rights." They "erred on the side of the child" and placed Dominic James with strangers.

Repeatedly, when he would visit Dominic, his father would be suspicious; he saw a new injury every week. But when he would raise this with DFS, they ignored him.

"I kept asking what had happened to my son, and they kept telling me I was overreacting," Sidney James said. "One day I told them: 'Before you admit a flaw in chil-

dren's services, you'll let my son die.'" He also put his concerns in a letter to DFS. And then, according to Sidney James' lawyer at the time, they threatened him, warning that if he kept complaining they would ship Dominic to a foster home in Kansas City, hours away, "and the commute [would be] the parents' problem."

Even after Dominic was rushed to the hospital with suspicious, unexplained seizures, DFS stood by the foster parents and refused to move the boy.

One week after being returned from the hospital, Dominic was dead. The foster father has been charged with second-degree murder.¹

Constance Porter didn't have to die.

She did not die because she had an abusive parent. She was not beaten by such a parent, or tortured, or starved. Constance Porter died in the name of "children's rights." She died in the name of putting "child protection" ahead of "family preservation." She died in the name of "erring on the side of the child."

Nearly two years after Constance died, *The Kansas City Star* told her story:

"It was winter 2000 when [Sha'Va] Porter, a single mother, lost her Kansas City job as an in-home personal care-giver. Within days, she and her two daughters were evicted from their rental house.

Staying temporarily with friends, she knew she was exhausting their kindness. Being homeless or living in a shelter was not something she wanted her children to experience.

"I saw those posters in the welfare office, about taking care of kids and loving them first. So I called the number and asked the state to help me," remembers Porter ... "I remember it was so cold out-

side. ... The state people, they were so nice helping me. They told me I was doing the right thing. ..."

So "the state people," that is, DFS, "erred on the side of the child" and placed Sha'Va Porter's children with a stranger.

A later *Star* story reports that DFS records claim that the agency did offer some kind of housing assistance, but by the time those records were obtained, Sha'Va Porter apparently could not be reached for comment.

Again, from the earlier *Star* story:

On the morning her daughters went to live with a foster family, Porter bundled them up and walked them to the welfare office. The sadness Porter felt about giving them to strangers was coupled with relief. She wouldn't have to worry about them while she looked for a job. ... She prayed that her situation would improve so they would be together again as a family soon.

"I remember kissing my girls goodbye and telling them they would be taken care of for a while by a nice lady with a warm home," she said. "I thought I was doing the best thing I could for them. ... That first night without them was hard, but I kept telling myself I was doing the right thing. It was only going to be a temporary placement. ..."

She called her children ... almost every night, including that evening when a police officer answered the phone instead of the foster care mother. Porter raced to first one hospital, then another.

The last time she saw Connie alive was Feb. 13, 2001. She was in a coma, curled into a fetal position. A machine breathed for her. Another machine showed that her brain was dead. ... Porter [held] her daughter's hand until she died.

The foster mother pled guilty to involuntary manslaughter. The judge sentenced her to five years' probation.

"I asked for help, and this is what happened," Sha'Va Porter has said.²

The later *Star* story also reported that DFS claims Sha'Va Porter twice had boyfriends whom DFS accused of sexual abuse.

After taking the children following Ms. Porter's request for help, the records show, DFS said Ms. Porter, now jobless and homeless, could not get them back until she got rid of the current boyfriend. (There is no indication that DFS offered an alternative, such as an Intensive In-Home Services intervention). Nor do we know Ms. Porter's version of these events.

We do know this:

- Child welfare agency case records often are wrong.³

- Sha'Va Porter maintains that "my only crime was poverty." Nothing in the DFS file on this case, as reported by the *Star*, changes that.

- Sha'Va Porter did not kill Constance.

Sha'Va Porter's boyfriend did not kill Constance.

The foster mother killed Constance.

Nothing in the DFS file changes that, either.

Larry and Gary Bass did not have to die.

At least 11 times, credible calls to the state's child protection hotline alleged that the children were being abused. At various times, DFS workers saw multiple bruises on one of the children. And their mother refused to leave the room when workers tried to question the boys.

Repeatedly, workers who probably had little time to check out claims by the boys' mother fell for those claims – as when

she said Larry and Gary were with their father at an unknown address.

In fact, Larry and Gary were in the basement, beaten and starving. Two months later they died of starvation and infected burns.⁴

The cases of Dominic and Constance and the case of the Bass children are not "opposites." They are not suitable for any statement that begins with the words "On the other hand..."

All three cases illustrate the same fundamental problem: A child welfare system so overwhelmed with children who don't need to be in it, that workers do not have time to find all of the children who do.

All three cases illustrate the same fundamental problem: A child welfare system so overwhelmed with children who don't need to be in it, that workers do not have time to find all of the children who do. No case gets the care and attention it deserves. Workers err in both directions, leaving some children – like the Bass children -- in dangerous homes, even as other children, like Constance and Dominic, are taken from homes that are safe or could be made safe with the right kinds of help.

The *Springfield News-Leader* understands the heart of the problem. In an editorial last December, the paper said:

"The ultimate answer is to find ways to keep more children in their own homes, providing the family with the instruction and intervention to become stronger. ... Then,

DFS social workers could concentrate their attention on the stomach-turning cases. ... When DFS does this, it will serve a purpose no one can dispute. And children will be safer."⁵

The full editorial is included as Appendix A.

An overloaded system is not the only reason for tragic mistakes. Fear and hatred of the poor, a "gut feeling" that children would be "better off" in a middle class home where parents can provide for all their material needs, and sometimes outright racism all can lead to needless removal of children.

And incompetence or laziness can leave children in dangerous homes.

But most workers are not lazy. And most workers are not jack-booted thugs who relish tearing children from their homes, either. They are not Nazis. They are not storm troopers. They are not the Gestapo. That kind of rhetoric has no place in any debate over child welfare.

And neither does rhetoric attacking those who feel that family preservation is the more humane and the safer alternative for most children most of the time as supposedly wanting to "sacrifice" innocent children.

The biggest problem in child welfare is not the few bad workers who won't do their jobs, but the many more good workers who can't – either because they don't know how, or, even if they do know how, they have too many cases. And the reason they have too many cases is that too many families are needlessly investigated, and too many children are needlessly taken away.

Taken as a whole, the state of Missouri is by no means the worst. It is not another Florida, where a fanatical insistence on child removal took hold with such force that the entire system effectively imploded. And it is not another Maine, where hostility to birth parents and even extended families has

been ingrained for so long that many workers know no other way, leaving the state with one of the highest proportions of children in foster care with strangers in the country.

And Missouri has a history of innovation that other states lack, even though the innovations sometimes do not seem to have extended from the policy manual to the field.

But child welfare in Missouri is at a crossroads. Because the *News-Leader* would not allow the story of Dominic James to be buried as quickly as his body, the state is focusing renewed attention on the failings of child welfare.

That can take the state in two directions. The easy road is the one that would take the state full-speed backwards. The governor, the courts, the legislature, and DFS can listen to those whose inflammatory rhetoric is intended to thwart real reform; those who want to embrace an approach that can be boiled down to a single sentence: Take the child and run. Many states have tried it; all have found that it backfired. It is the road to failure and despair.

It is the road that the state auditor wants Missouri to take. She wants Missouri to ignore the real lessons from child abuse tragedy. She says the deaths of Constance Porter and Dominic James should not be allowed to obscure the fact that most children who die of child abuse die in their own homes.⁶ Of course, they do. But that's because most children *live* in their own homes, and not in foster care. Proportionately, there is strong evidence that foster care actually is more dangerous. But even if one doesn't believe that, what exactly are we supposed to infer from the statement that more children die in their own homes? Does it mean that deaths in substitute care don't matter?

We must never allow children like Constance Porter or Dominic James to be demeaned and dismissed as some kind of

“collateral damage,” something to be expected in the course of someone’s misbegotten crusade against child abuse – a crusade that is sure to backfire.

We must never allow children like Constance Porter or Dominic James to be demeaned and dismissed as some kind of “collateral damage,” something to be expected in the course of someone’s misbegotten crusade against child abuse – a crusade that is sure to backfire.

The state auditor tells us that “we are sacrificing children on the altar of parental rights.”⁷ She does not say what altar was used for the sacrifice of Constance Porter and Dominic James.

The alternative is to take the road less traveled by. It is the road to real reform using safe, proven programs to keep families together. It is far more difficult politically to travel this road. But the few places that have done so are the only ones that have truly improved child welfare and made their vulnerable children safer.

History:

In George Orwell’s 1984, the job of the protagonist, Winston Smith, was, literally, to rewrite history, sending the facts down the “memory hole” and substituting whatever version he was ordered to provide.

Both nationwide and in Missouri, the debate over child welfare has been similarly

shrouded in myth. A revisionist history, in which “family preservation” becomes an all-purpose scapegoat whenever a child dies, particularly if that child was previously known to child welfare authorities, has come to be accepted as fact. It is claimed, repeatedly, that family preservation “dominates” child welfare systems, causing children to languish in foster care or be left in unsafe homes.

It is not true.

Nationwide, since the early 1980s, the foster care population has more than doubled. If advocates of family preservation truly “dominate” the system, how did all those children get into foster care in the first place?

When children are left in dangerous homes it is not because of a desperate desire to preserve families. It’s almost always because overwhelmed workers missed warning signs. And the reason children languish in foster care is not because states do too much for families, but because they do too little. Once children are taken away, they are filed away and forgotten as workers rush on to the next case. (For more on the recent history of child welfare nationwide, see Appendix B, *A Child Welfare Timeline*.)

The false history of child welfare may be even more enshrined in Missouri. We were told by one journalist that “Missouri is a family preservation state.”

But it isn’t.

Yes, Missouri was one of the first states to use a program called Intensive Family Preservation Services, and Missouri was the first state to try a “family assessment” approach to handing some calls referred to DFS offices from the hotline. But the IFPS program is inadequate and the family assessment approach is not working nearly as well as it should, for reasons discussed later in this report.

The data make clear that the talk about family preservation has not been

matched by reality. Missouri is a family preservation *rhetoric* state.

The state auditor tells us that "we are sacrificing children on the altar of parental rights." She does not say what altar was used for the sacrifice of Constance Porter and Dominic James.

In Missouri, the number of children in foster care on any given day has increased by more than 75 percent between 1991 and May, 2002.⁸ The most recent comparative data, from 2000, show that the proportion of children in foster care in Missouri is now above the national average.⁹ Since May 2002, the Missouri foster care population has declined from 12,265 to 11,975.¹⁰ But that's still more than 70 percent higher than 1991, and still above the national average.

And in some places, the number of children in foster care is obscene. In Greene County, 15.6 of every thousand children are in foster care, a rate more than double the national average and nearly double the Missouri average. Poverty doesn't explain it. The proportion of children in poverty in Greene County is actually below the statewide average.

The other way to measure foster care placements is to measure the number of children taken away over the course of a year. And here, too, Missouri is above the national average. Nationwide 4.02 children per thousand were removed from their parents at some time during the 2000 fiscal year, the most recent for which federal data are available.¹¹ In Missouri, according to DFS, it was 5.25 per thousand, rising to 5.3 per thousand in fiscal year 2002. The num-

ber of children taken away has gone up slowly but steadily every year since 1993 – with a big jump after the deaths of Larry and Gary Bass made headlines.

There is one possible note of good news: If the pattern seen during the first six months of fiscal year 2003 continues, Missouri will see its first decline in removals since 1993. But DFS cautions that its month-by-month data are highly preliminary.

And the overall statewide increase in removals through fiscal year 2002 comes even though the locality with the most severe problems, St. Louis City, has been able to buck the trend. The number of children in foster care in St. Louis City actually has declined by 25 percent since 1997.

And when measured in terms of children taken away over the course of a year, there was a sharp drop in fiscal year 2001, the most recent year for which data were available on the DFS website, compared with previous years.

One possible reason: St. Louis City was one of the first four places in the nation to adopt one of the most promising innovations in child welfare: Community Partnerships for Child Protection. (See page 50).

Thus, if not for the relatively good performance in St. Louis City, the overall state data for Missouri would look even worse.

St. Louis still could do more, however, when compared to a national leader in child welfare reform, New York City.

In St. Louis City 37 percent of children live in poverty, and 22 of every thousand are in foster care. In New York City, 30.3 percent of children live in poverty, but only 13.5 percent are in foster care.¹²

Missouri's statewide failure is most apparent when compared with neighboring Illinois.

As recently as 1997, Missouri was considered a leader in trying to reform child

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welfare, while Illinois was considered among the worst systems in the nation.

WHERE THINGS STOOD IN JUNE 1997:

STATE	FOSTER CHILDREN	FOSTER CHILDREN PER THOUSAND
Illinois	51,331	17.2 ¹³
Missouri	10,645	7.8 ¹⁴

Then Illinois began a dramatic reform of child welfare, discussed later in this report. Illinois cut its foster care population by more than 57 percent. As the foster care population declined, safety improved -- re-abuse of children left in their own homes has decreased. Also at the same time, the number of foster children in Missouri increased by just over 12 percent.

WHERE THINGS STOOD IN JANUARY 2003

STATE	FOSTER CHILDREN	FOSTER CHILDREN PER THOUSAND
Illinois	21,518	6.6 ¹⁵
Missouri	11,975	8.3 ¹⁶

The gap between Illinois and Missouri widens when one factors in one of the few positive trends in child welfare in recent years, the growth in “kinship care” – that is,

placing children with relatives, often grandparents, instead of strangers.

Kinship care does a lot to “cushion the blow” of foster care. Though the child still often will desperately miss mom and dad, at least someone familiar and loving will be there for him. And since kin often live close by, it is less likely that the child will have to change schools – so he still can see friends, classmates and teachers.

Stereotypes about extended families notwithstanding, Illinois also has found that kinship care placements are, on average, safer than what should properly be called “stranger care” placements.¹⁷ Perhaps that’s why Illinois seems so much more willing to use these placements than Missouri.

In Illinois, of all children placed in any form of substitute care, 37 percent are in kinship foster homes.¹⁸ In Missouri, the figure appears to be somewhere between 16.3 and 26.3 percent.¹⁹ And while Illinois has worked to find new ways to aid extended families reaching out to help their children, Missouri cut eligibility for its “Grandparents as Foster Parents” program.²⁰ And just last month, one legislative committee actually voted to slash payments to those still eligible.²¹

The failure of left and right

Imagine, for a moment, that Attorney General John Ashcroft has just proposed a new anti-terrorism bill. Imagine that under this legislation:

- Police could enter any home and search it without a warrant; in fact, they could do it based on no more than an anonymous tip. (Or, in the alternative, a warrant is required, but there is no obligation to issue a “Miranda warning” so people don’t know they can refuse, and the act of refusing entry is grounds for arrest in and of itself anyway).

- Not only can police search the home, they can stripsearch the occupants.

- They can detain any member of the household for at least 72 hours, and often 30 days or more, before they even see the inside of a courtroom. In fact, detention will probably last for the duration of the proceeding because no judge in the special anti-terrorism court wants to look “soft on terrorism.”

- The standard of proof never reaches “beyond a reasonable doubt” as in criminal cases. Instead, it never rises beyond “clear, cogent, and convincing” and sometimes it is even less.

- Those arrested under this statute may – or may not – get a lawyer if they are indigent.

- And all of the trials and court documents are secret.

Were Attorney General Ashcroft to propose such a law, it is likely that the political left would be furious. The American Civil Liberties Union probably would declare a state of emergency. And Ashcroft might well reply that “Citizens have no reason to fear this kind of investigation if they are behaving appropriately.”

But what we have just described *is* the current law in Missouri governing the child protection system. It is basically the same system in all 50 states. It is the *left* that appears most anxious to defend this system and oppose any changes that might protect children by protecting their civil liberties. And when organizations like NCCPR, which approach child welfare from a liberal perspective, question this system, we often are stereotyped as part of the far right.

This is different, some on the left might say. This time we’re protecting innocent children. But the terrorists who bombed the federal building in Oklahoma City blew up a day care center. More important, the fact that it is innocent children who are stripsearched and detained, often needlessly, should only make civil libertarians more alarmed, not less.

The political right also has failed.

It was that champion of conservative “family values” former House Speaker Newt Gingrich who suggested that the children of the poor should be thrown into orphanages. It is in that stronghold of conservative family values, Greene County, where the proportion of children in foster care is nearly double the Missouri state average. If someone proposes spending more on drug treatment, or day care, or affordable housing, so impoverished and/or addicted mothers can keep their children, the opposition is likely to come from the right.

And it was the conservatives on a committee of the Missouri Legislature who recently voted to cut health insurance for children and are considering further slashing Medicaid for their deeply-impooverished parents – something that is sure to result in more allegations of “medical neglect” and more parents who become too disabled by illness to care for their children.

The American child welfare system is a tragic combination of the worst of liberalism and conservatism. It will take the best of both to fix it.

The most dangerous words in child welfare:

To some, of course, all this is good news. If Missouri really isn't "a family preservation state" they argue, then it must

be doing more to keep children safe. It must be "erring on the side of the child."

There probably is no phrase in the English language that has done more harm to children than "err on the side of the child." They may be the most dangerous words in child welfare.

- A child abuse investigation is, in and of itself, a traumatic experience for a child, particularly when, as often happens, it is accompanied by a stripsearch.

The more that workers are overwhelmed with children who don't need to be in foster care, the less time they have to find children in real danger. So they make even more mistakes in both directions.

So it was disturbing to see the actual comment that inspired our hypothetical John Ashcroft remark coming from Judge Susan Block, a member of the Commission on Children's Justice. Judge Block's dedication to and passion for helping children are well known. She also is willing to hold herself accountable by opening her courtroom

to press and public. So it was disappointing to read her comment that: "Citizens have no reason to fear a DFS investigation, if they are treating their children appropriately."²²

Even if the parents have nothing to fear, the children have plenty to fear.

Where there is, in fact, "reasonable cause to suspect" maltreatment, then the investigation must be done despite the trauma to the child. But any parent who loves his or her child does indeed have reason to fear a DFS investigation, and the parents who are "treating their children appropriately" have the most reason to fear - because those are the cases in which the only harm done to the children is the harm of the investigation itself.

It is a judge's job to *decide* if the results of the investigation are valid. If DFS is infallible in determining whether parents "are treating their children appropriately" why bother having hearings -- or judges?

Sha'Va Porter had no fear when Constance was taken from her. She believed the assurances of DFS. But, in fact, she should have been afraid. Sidney James had plenty of fears for his son Dominic. And his worst fears were realized.

- When a child is needlessly thrown into foster care, he loses not only mom and dad but often brothers, sisters, aunts, uncles, grandparents, teachers, friends and classmates. He is cut loose from everyone loving and familiar. For a young enough child it's an experience akin to a kidnapping. Other children feel they must have done something terribly wrong and now they are being punished. In other words, even had Constance Porter and Dominic James lived, and even had they been placed in the best possible foster homes, they suffered serious emotional abuse at the hands of the Missouri Division of Family Services. Such emotional

trauma can last a lifetime. How is that “erring on the side of the child?”

- And that assumes the foster home will be a good one. The majority are. But, as is discussed later in this report, the rate of abuse in foster care is far higher than generally realized and far higher than in the general population. The record of institutions is even worse. Furthermore, the more a foster care system is overwhelmed with children who don’t need to be there, the less safe it becomes, as agencies are tempted to overcrowd foster homes and lower standards for foster parents. If a child like Dominic James or Constance Porter is taken from a safe home, or one that could be made safe, only to be beaten, raped or killed in foster care, how is that “erring on the side of the child?”

- But even that isn’t the worst of it. As noted at the start of this report, everyone knows how badly caseworkers are overwhelmed. The workload issues in Missouri are well-documented elsewhere and will not be repeated here.

Because they are overwhelmed, workers often make bad decisions in both directions – leaving some children in dangerous homes, even as more children are taken from homes that are safe or could be made safe with the right kinds of services. The more that workers are overwhelmed with children who don’t need to be in foster care, the less time they have to find children in real danger. So they make even more mistakes in both directions.

And that is true even when workers who investigate child abuse hand the cases over to other workers once the decision is made to take the child away. The investigating workers still have to deal with all the paperwork involved in the removal and the transfer of the case, and they still usually have to testify in court. Workers also are overwhelmed when child protective hotlines send them cases indiscriminately, without a

rational screening process – another crucial problem in Missouri.

Meanwhile, the workers who oversee children in foster care also are overwhelmed, so they can’t properly monitor foster homes, make sure families get the help they need to reunify, or make good judgments about when reunification is appropriate.

Yet the “err on the side of the child” myth persists.

Judge Block has written: "When in doubt, we must always err on the side of a child's safety."²³ Judge Block’s view almost certainly would be upheld on appeal in Missouri. Chief Justice Stephen Limbaugh Jr., a former juvenile court judge, laced his State of the Judiciary speech with demeaning stereotypes about birth parents, portraying them not as three-dimensional human beings, but as mere collections of pathologies.

Perhaps that’s what happens when cases race by quickly, and every family is boiled down to reports filled with psychobabble. And then, in words one can only hope Sha’Va Porter and Sidney James will never have to read, he declared: “I hope you understand why most judges tend to err on the side of protecting the kids.”²⁴

But when it comes to how to rule in these cases, another judge is far closer to the mark. Frederica Brenneman was for many years a distinguished juvenile court judge in Connecticut. Now, she may be best known as the mother of Amy Brenneman, the actress who plays such a judge in the television series “Judging Amy.”

The real judge Brenneman has written:

"Removing children because it is better to be ‘safe than sorry,’ a slogan that I believe has no place in child protection, may be a good way to avoid black headlines. It is also a good way to traumatize a child for life."²⁵

The title of Judge Brenneman's speech is a phrase that should be inscribed over the entrance to every child welfare agency and juvenile court; and though it is not, in fact, in the Hippocratic Oath, it is a phrase every medical student is never supposed to forget: First, do no harm.

Who is in the system?

The inherent emotional trauma of placing a child in foster care is largely undisputed among child welfare scholars. The argument has been that this trauma is worth inflicting because it is supposedly the only way to keep children physically safe.

In some cases, that is true. There are some children, such as Larry and Gary Bass, who are, in fact, brutally abused, raped, tortured, beaten, starved and sometimes murdered. These are children who must be found, rescued, and immediately removed from their homes.

But most children who enter the system are nothing like that. Nationwide and in Missouri, the vast majority of cases involve no physical or sexual abuse at all, they involve neglect.

Of course, neglect also can be agonizing and life-threatening for a child. Locking a child in a closet is neglect, starving a child is neglect, leaving a child alone to vacation in Acapulco is neglect.

But in Missouri and most other states, poverty itself is defined as "neglect." Under Missouri law neglect is defined as "failure to provide, by those responsible for the care, custody and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical or any other care necessary for the child's well-being."

There is probably no poor family in the state which has not at some point been guilty of "neglect" by that definition. Which of those families gets caught up in the DFS

net and which escapes may be a matter of nothing more than chance.

"Removing children because it is better to be 'safe than sorry,' a slogan that I believe has no place in child protection, may be a good way to avoid black headlines. It is also a good way to traumatize a child for life."

--Judge Frederica Brenneman

Thus, if Dominic James and Larry and Gary Bass are at two ends of a continuum, the cases seen by DFS workers more often will be closer to the James end of the continuum than the Bass end. Other cases fall on a broad continuum between the extremes, the birth parents neither all victim nor all villain.

There is evidence for this from all over the country:

- A study of "boarder babies," children who spent months in hospitals, found that the biggest single factor causing their forced hospital stays was lack of housing.²⁶

- Families struggling to keep their children out of foster care are stymied by two major problems: homelessness and low public assistance grants, according to two New York City studies.²⁷

- A study of "lack of supervision" cases by the Child Welfare League of America found that in 52 percent of the cases studied, the service needed most were what one might expect -- day care or babysitting.²⁸ But the "service" offered most often was foster care.

- Courts in New York City and Illinois found that families repeatedly were kept apart solely because they lacked decent housing.

“The child welfare system seems quick, in some instances, to remove children from natural parents without the benefit of adequate family support efforts.”

--Report of the Investigation of the Child Welfare System in Greene County, Missouri

- In Washington, D.C., where the foster care system was run for several years by the federal courts, the first receiver named by the court to run the agency found that between one-third and one-half of D.C.'s foster children could be returned to their parents immediately -- if they just had a decent place to live.²⁹

- In California, homeless children were given emergency shelter only on condition that they be separated from their parents, until a successful lawsuit put an end to the practice.³⁰

- The National Commission on Children, one of the most distinguished groups ever convened to study these issues, found that children often are removed from their families "prematurely or unnecessarily" because federal aid formulas give states "a strong financial incentive" to do so rather than provide services to keep families together.³¹

In Missouri, the *St. Louis Post-Dispatch* reports that one reason Judge Block wants to open her court to the public is so that people might be more willing to "support money for housing if they saw families at risk of losing their children to

foster care simply because they are homeless."³²

It has been argued that people really shouldn't pay much attention to all those families who waited hours for just five minutes to tell legislators or others what had happened to them, at various hearings that sometimes went on for six hours or more; the implication being that they're probably mostly a bunch of child abusers anyway.

But Judge Frank Conley and Richard Dunn are not child abusers. They were asked by Governor Holden to examine the system in Greene County. Conley is a retired judge, Dunn's past jobs include running Boys Town of Missouri. People who run institutions for foster children do not generally have a bias in favor of birth families. And Judge Block has praised Conley and Dunn's report, calling its recommendations "sound, thoughtful and comprehensive."³³

Among the report's conclusions:

- "The child welfare system seems quick, in some instances, to remove children from natural parents without the benefit of adequate family support efforts."

- "After the child is removed from the home, there is little evidence of reunification efforts by DFS or the courts. Any reunification efforts that do occur appear to be complicated by the unrealistic expectations for parents by the court."

- "Available treatment services for children and families are not incorporated into wraparound programs due to lack of funding and/or coordination."

- "Examples were found involving unilateral decisions being made by DFS relative to removal and placement outside the state without court action and a failure to follow DFS guidelines and rules."³⁴

Still another indication of wrongful removal comes from DFS' own annual

report concerning its version of an Intensive Family Preservation Services Program, known in Missouri as Intensive In-home Services.

This program is intended to be for children who otherwise would be placed in foster care. According to the most recent

program report available on the Department of Social Services website, from the 2001 fiscal year, 276 Missouri children were placed in foster care simply because this program was not available as an alternative.³⁵

Justice Limbaugh's typical (or is it "extreme"?) case

Justice Stephen Limbaugh's "State of the Judiciary" speech might better have been characterized as a "defense of taking away so many children" speech. And perhaps on the theory that the best defense is a good offense, Justice Limbaugh, a former juvenile court judge, tarred birth parents with a very broad brush.

In contrast, he portrays a foster-care fantasyland in which "the salvation is that ...when the system works properly the children will be removed and placed in a nurturing and loving foster care setting..."

Justice Limbaugh appears to be a dedicated and concerned jurist, who cared deeply about the children and families who came before him, and truly wanted to help them.

But as the cases speed by and families are boiled down to the reports prepared by DFS and the juvenile office, it's far too easy to view these families only as a collection of pathologies; ignoring all dimensions of their character, in particular their strengths. As a result, Justice Limbaugh both overstates the pathology of the typical birth parent and understates the harm of foster care.

The evidence presented in this report, and the evidence compiled by former judge Frank Conley and Richard Dunn show that in a great many "typical" cases, the children are *not* "clearly in danger." And, the notion that a child might love a deeply-flawed parent and therefore be severely harmed by removal appears entirely absent from his reasoning.

Most revealing is Justice Limbaugh's description of one case he handled in juvenile court.

On the one hand, he implies that this is a less serious case than others he calls "typical." But at another point, he calls the case "extreme." Below are excerpts from that portion of his speech interspersed with our comments. Justice Limbaugh writes:

"I recall, in particular, a case I had as a juvenile court judge involving an 18-year old woman -- an 18-year-old girl -- who already had five children by five different fathers. This is no exaggeration! She was not a drug addict or an alcoholic,

nor did she abuse her kids or allow others to harm them, at least physically, and those facts dictated against removing the kids.”

Comment: In truth, those facts indicate an enormous reservoir of strength which, if properly tapped, could have turned that mother around long before Justice Limbaugh saw her.

“But her home was a revolving door for boyfriends who were often drugged or drunken, and she and the kids survived on little more than food stamps, Medicaid, and family housing subsidies. She had few parenting skills, just an eighth-grade education, and no relatives she could count on, and, as you would expect, most of the time she was rather desperate.”

Comment: Is the act of receiving public assistance a character flaw that makes one a “bad mother?” And isn’t a woman with no education and no skills sometimes going to feel so “desperate” that she’ll stay with a drugged or drunken boyfriend?

“DFS efforts to teach parenting skills and household management were only marginally successful.”

Comment: DFS’ efforts probably involved traditional “counseling” and “parent education” which only added to her burdens, instead of real help to build a support system to replace the one she lacked. She also would have benefited from concrete help – like a worker who actually rolled up her sleeves and helped with the cleaning while providing the “counseling” and “parent education.” (See the description of Intensive Family Preservation Services on page 47).

“Under any conception of ‘the best interests of the children’ -- the legal standard by which all court interventions are governed -- the children should have been removed. And from time to time, they were removed, and more than once at the request of the mother, herself. The likelihood was that those kids would flourish in most any other environment, and that they would only fail with their mother.”

Comment: On the contrary, these children almost certainly would have been split from each other as well as a mother who clearly loved them. They probably would have bounced from foster home to foster home, emerging years later unable to love or trust anyone. And at least one of the children almost certainly would have been abused in foster care. (See “How safe is foster care?” page 17). In contrast, with the right kind of help, the chances are good that the children and the mother could flourish together.

“But a competing presumption of law in effect at the time of the case required all-out efforts for reunification of the family -- which meant that the kids stayed with the mother.”

Comment: Actually, only “reasonable” efforts were, and are, required. It is, perhaps, fortunate that Justice Limbaugh interpreted the law differently, since in

the absence of a belief that “all out” efforts were required, it seems he would have destroyed this family, when the right kind of “reasonable efforts” almost certainly would have saved it early on.

“Under the law, then as now, kids are to be taken from their homes only if they are abused or neglected, not if the parents are poor and uneducated. And so it was, that for many months, until I left for my new position on the Supreme Court, I supported the rather valiant efforts of the juvenile officers and DFS workers on the outside chance that the young mother might eventually learn to adequately care for her own children. ...”

[Justice Limbaugh asked the juvenile officer who handled the case for an update]. “And he told me this: Ten and a half years, and two more kids later, she is alive and well, she is stable and relatively self-supporting, and she has a job -- a full-time job! -- a job working for a sheriff's department across the river in Illinois, and even the kids have enjoyed a fair measure of success! My goodness, how would it be if all the other families like hers fared half so well! But in my experience, unfortunately it is not that way. There are many failures, and the successful preservation of families, at least in the extreme cases like hers, is more the exception than the rule.”

COMMENT: But it could become the rule, with a different approach. Justice Limbaugh does not say how this woman turned her life around. Perhaps it was just good luck. But another possibility is this: Someone, somewhere finally saw in her the strength that DFS, the juvenile office, and Justice Limbaugh never noticed. Perhaps it was a friend or a neighbor, perhaps it was a formal helper, with a private agency, perhaps it was a good, perceptive DFS worker.

Whoever it may have been, perhaps that person finally gave this mother what she had gotten from no one else, something poor people almost never get: Respect. Perhaps for the first time, someone offered a genuine helping hand instead of a wagging finger. Perhaps this person offered the basic, concrete help this mother needed to provide a foundation of necessities, so she then could deal with her other problems, get more education, get a job – and not have to rely on a succession of men.

Provide that kind of help to all the other similar cases – be they “typical” or “extreme,” and the successful preservation of families would become the rule in Missouri instead of the exception.

Is foster care safe?

The cases cited in these state and national reports are the cases for which removal is *not* necessary; these are the cases for which there are interventions that are not

only more humane and less expensive than foster care, but safer than foster care as well.

For these children, there is no danger at home that outweighs the emotional suffering caused by removal itself. And there is no danger in the home that matches the risk of abuse in foster care itself.

And that is why, when the state auditor blithely tells us that more children die in

their own homes than in foster care, she is engaging in statistics abuse.

As noted earlier, nationwide, the reason more children die in their own homes

than in foster care is simply that more children *live* in their own homes than in foster care. To understand the risks, one has to look at the *proportion* of deaths, not the raw numbers. Federal data show that a child is more than three times as likely to die of child abuse in foster care than in the general population.³⁶

Some have argued that “the general population” is the wrong comparison, since children removed from their homes presumably come from a population that is more at risk of abuse. To some extent that is true; but recall the definition of “neglect” under Missouri law and how it could encompass almost any poor family. The population from which children are removed is closer to the general population than defenders of the take-the-child-and-run approach would like to believe. And this population would have to be more than three times more dangerous than the general population for the average risk of fatal abuse to equal the risk of such abuse in foster care.

On the other hand, there are limits to the usefulness of almost any conclusion based on fatalities (a lesson the state auditor has yet to learn, as will be discussed later in this report). The raw number of child abuse fatalities in foster care, even nationwide, is so low that the data need to be looked at with caution.

But there are other data which raise serious concerns about the safety of foster care.

- A study of reported abuse in Baltimore, found the rate of "substantiated" cases of sexual abuse in foster care more than four times higher than the rate in the general population.³⁷

- Using the same methodology, an Indiana study found three times more physical abuse and twice the rate of sexual abuse in foster homes than was found in the general population. In group homes there was more than ten times the rate of physical abuse and more than 28 times the rate of sexual abuse as in the general population, in part because so many children in the homes abused each other.³⁸

Those studies deal only with reported maltreatment. The actual amount of abuse in foster care is likely to be far higher, since when abuse is reported in foster care, agencies are, in effect, investigating themselves, giving them an enormous incentive to see no evil, hear no evil, speak no evil, and write no evil in the case file.

- In New York City, for example, where Children's Rights Inc. settled a lawsuit against the child welfare system, they have found that "abuse or neglect by foster parents is not investigated because [agencies] tolerate behavior from foster parents which would be unacceptable by birth parents."³⁹

- A lawyer who represents children in Broward County, Florida, said, in a sworn affidavit, that over a period of just 18 months he was made personally aware of 50 instances of child-on-child sexual abuse involving more than 100 Broward County foster children. The official number during this same period: Seven – because until what the lawyer called “an epidemic of child-on-child sexual abuse” was exposed, the child abuse hotline didn’t accept reports of such abuse.⁴⁰

Studies not limited to official reports produce even more alarming results.

- Another Baltimore study, this one examining case records, found abuse in 28 percent of the foster homes studied -- more than one in four.⁴¹

- Even what is said to be a model foster care program, where caseloads are kept low and workers and foster parents get special training, is not immune. When alumni of the Casey Family Program were interviewed, 24 percent of the girls said they were victims of actual or attempted sexual abuse in foster care. And this study asked only about abuse in the one foster home the children had been in the longest. A child who had been moved from a foster home precisely because she had been abused there after only a short stay would not even be counted.⁴²

The tragic paradox of foster care is that the more its proponents get their way and put more children into it, the less safe it becomes.

Officials at the program say they have since lowered the rate of all forms of abuse to “only” 12 percent, but this is based on an in-house survey of the program’s own caseworkers, not outside interviews with the children themselves.⁴³

This does not mean that all, or even many, foster parents are abusive. The overwhelming majority do the best they can for the children in their care -- like the overwhelming majority of parents, period. But the abusive minority is large enough to cause serious concern.

And abuse in foster care does not always mean abuse by foster parents. As the Indiana study and the Broward County data indicate, it can be caused by foster children abusing each other. The more a system is overwhelmed with children who don’t need to be there in the first place, the greater the temptation to overcrowd foster homes and

lower standards for foster parents. The tragic paradox of foster care is that the more its proponents get their way and put more children into it, the less safe it becomes.

Compare the record of foster care to the record of Intensive Family Preservation Services programs which, like foster care, serve an “at risk” child population. The first such program, Homebuilders, in Washington State, has served 12,000 families since 1982. No child has ever died during a Homebuilders intervention and only one child has ever died afterwards, more than 15 years ago.⁴⁴

Michigan has the nation's largest Intensive Family Preservation Services program. It rigorously follows the Homebuilders model. Since 1988, the program has served 100,000 children. During the first two years, two children died during the intervention. Since then, there has not been a single fatality.⁴⁵ In contrast, during a time when Illinois got caught up in a frenzy of child removal and effectively abandoned family preservation, there were five child abuse deaths in foster care in just one year.⁴⁶ That’s part of the reason Illinois subsequently reversed course.

Some of the best evidence of the safety of approaches that emphasize family preservation can be found in the real-world experience of the relatively few communities that have embraced it. (See “Four places that get child welfare right,” page 24).

Children, not averages

Although we believe that, on average, real family preservation programs are safer than foster care, in one sense, boiling this debate down to averages – as the state auditor has tried to do -- misses the point.

Several studies suggest that there is some kind of abuse in about one in four foster homes. Many foster children wind up

bounced from foster home to foster home, increasing the odds of winding up in a foster home that is abusive.

But even though we believe family preservation is, on average, safer, advocates of family preservation do not believe that it is right for every child. When caseworkers are sure that a child has been brutally beaten or sexually assaulted or tortured, the odds of safety – for that particular child – are better in foster care.

Conversely, in the many cases in which poverty is confused with “neglect” and many of the “in-between” cases, the odds of safety are better in a real family preservation program. That’s the reality that the state auditor’s rhetoric seeks to obscure.

The limits of “known to the system”

It is probably the most shocking statistic in all of child welfare. It also is probably the most misleading. It’s the one about the proportion of fatalities, or other abuse, involving children previously “known to the system.”

When the state auditor tells us that 70 percent of Missouri child abuse fatalities over the past five years – 103 of 147 -- involved children “known to the system” it conjures up a mental image of something very different from the actual meaning of the number: It sounds like 70 percent of the children the system heard about wound up dead.

Even when we know in our heads that this is not what the number means, it is hard to shake that feeling. At a minimum, it sounds like workers are constantly ignoring obvious signs of maltreatment and leaving children to die.

And that is simply not true.

For example, suppose in a hypothetical community 10,000 children were in some way “known to the system” and one of

them died of child abuse. In the same community, one other child also died of child abuse. One could write a headline declaring that “50 percent of child abuse deaths involved children “known to the system.” Or one could say that 9,999 out of 10,000 children “known to the system” were protected.

Now, let’s try it with some real numbers from Missouri.

According to the federal government, there were 47,881 “screened-in” reports of child abuse in Missouri in 2000, meaning at least 47,881 reports where someone from DFS made contact with the family.⁴⁷ Each report may involve more than one child - on the other hand, some children are subject to more than one report.

If the 2000 figure is about average for the time period studied by the state auditor, then over five years 239,405 reports were investigated and the families contacted. That’s a lot of children “known to the system.”

The state auditor uses a stricter definition, however. To be considered “known to the system, she uses only cases in which the family has been contacted more than once. Federal data don’t break down the number of times each family is contacted, so we do not know how many of the children represented in the 239,405 reports were contacted more than once. But if only five percent of these reports represent instances in which a child was seen more than once, that would be nearly 12,000 children. If 103 of those children subsequently died, that means that, in terms of avoiding a fatality, DFS got it right about 99 percent of the time.

In some cases among the 103, the children almost certainly died after what were repeated, detailed warnings that investigators never should have missed; cases with more red flags than a Soviet May Day parade. But it is likely that in many other cases, what the workers found did not indicate that the parent was likely to kill the

child. In fact, it is likely that what the worker found was exactly the same as what workers found in ten, 50, 100, maybe a thousand other homes. How were the workers to know which one in 10, 50, 100 or a thousand would escalate into a fatality?

Of course, those other cases undoubtedly include some in which the child was not killed, but *other* abuse was missed. But again, that usually happens because workers are too busy to do a complete investigation – and *that* is a problem made worse by taking many children needlessly.

Using the proportion of children “known to the system” as a guide to anything may be particularly dubious in Missouri. That’s because Missouri is almost the child abuse reporting capital of America.

Nationwide in 2000, the last year for which figures are available, for every thousand children, there were 38.7 reports alleging child abuse phoned in to child abuse hotlines. In Missouri there were 73.2 such reports. Only in Alaska were more children reported as maltreated.

All states screen out a certain proportion of reports. When looking only at reports passed on for investigation, the national average is 24 per thousand. Missouri again is well above average at 33.5 per thousand.⁴⁸ In addition, there are some circumstances in which a child in a case that is “screened out” still might become “known to the system.”*

NCCPR will take second place to no organization in demanding that, when it comes to avoiding child abuse fatalities, DFS never stop *trying* to reach 100 percent success. But if fatalities among chil-

* For example, as is discussed later in this report, in cases where a “mandated reporter” files a report that is screened out, the information still is passed on to the appropriate county DFS office which has discretion concerning what to do with the information. It is not clear if these cases are included in the state auditor’s figures.

dren “known to the system” is to be the only criterion by which DFS is measured, it will only wind up making the entire system worse.

Again, there are limits to conclusions that can be drawn by examining fatalities. But it is not advocates of family preservation who have chosen that measure above all others, it is our opponents, like the state auditor. And at times, she has taken the measure to absurd extremes.

The limits of fatalities as a measurement

The basic reason there are limits to what can be proven by referring to child abuse fatalities is, in fact, good news: Though every fatality is a tragedy, and, again, the goal should be to reduce the number to zero, the number of fatalities in any one jurisdiction typically is too small to draw conclusions.

It is a number that can rise or fall based on circumstances entirely beyond the control of a child welfare agency.

This can be seen in an example from criminal justice that most readers will remember. In a typical year, there are about 20 homicides in Montgomery County, Maryland. Decades from now, when journalists and scholars look back on 2002, they are likely to find a figure that, in percentage terms, is much higher. Will those journalists and scholars conclude that in 2002 the police force in the county must have been a dreadful failure, filled with incompetent officers and leadership? Or will they remember that this was the year when one pair of snipers allegedly was responsible for so many murders in the county that it created a spike in the homicide rate?

But if trying to make a judgment based on 20 fatalities a year is problematic – and that’s just about the total number of child abuse deaths “known to the system”

that typically occur in Missouri, -- trying to make such a judgment based on three deaths over five years is ludicrous. Indeed, it is still another act of statistics abuse.

But that is exactly what the state auditor has done.

Noting that Greene County, in particular, has come under fire for its high proportion of children in foster care, the auditor said that the county had fewer fatalities among children known to the system than the state average. Therefore, she said, "It looks to me like they might be doing a better job of protecting children."⁴⁹

Greene County had a grand total of three deaths of children previously known to the system over the past five years. It is unlikely that there is a statistician in America who would claim that that number could be used to prove anything about anything.

Indeed, had there happened to have been just one more such fatality during this period, Greene County's proportion of such fatalities would have been slightly above the state average. Would the state auditor then have rushed to reconsider her endorsement of Greene County's take-the-child-and-run approach and say that Greene County children were *more* endangered than their counterparts elsewhere?

And if the state auditor is serious about suggesting that Greene County is a model, it raises another question:

If the entire state kept children in foster care at the rate they are held in Greene County, another 12,000 children would have to be taken away.

Where would the state auditor like to put them?

Of course one of the three Greene County fatalities "known to the system" was Dominic James. Or, to use numbers the way the state auditor has been using them: 33 percent of the Greene County fatalities known to the system were in foster

care. But only 1.6 percent of Greene County's children are in foster care. To then conclude that a Greene County child is 20 times more likely to die in foster care than in the general population would be an absurd misuse of data. But no more absurd than the auditor's conclusion about child safety in the county.

If the entire state kept children in foster care at the rate they are held in Greene County, another 12,000 children would have to be taken away. Where would the state auditor like to put them?

And it is not even clear that the state auditor's figures are accurate. Using data from county child fatality review boards, the auditor said that there had been five fatalities among foster children, but in two of them, the foster children were with their birth parents at the time. That leaves three, including Constance Porter and Dominic James.

But in 2000, according to a DFS investigation, two children, aged two and six, died in a fire at a Kansas City group home. DFS said the fire was set by a nine-year-old who poured lighter fluid on some stuffed animals, then ignited a piece of paper on a gas stove and threw it on the toys. Only one staffer was on duty – state regulations require two – and she was asleep; the regulations require at least one worker to be awake at all times.

This case may not have fit review board criteria for an abuse or neglect fatality and the auditor may not have known about it. (Though it happened in the state

auditor’s home county, and the story was on the front page of her hometown paper.⁵⁰⁾

But if a birth parent previously known to the system had let her own young child have easy access to lighter fluid, and been asleep during the fire that followed, it is likely that the auditor would have considered this neglect.

So if one were prone to throw around big percentages involving small numbers the way the state auditor does, one could argue that the state auditor underestimated foster care fatalities by 40 percent.

Foster care panics

There are a few jurisdictions that are so large and a pattern has emerged among them that is so consistent, that they do lend themselves to one conclusion about fatalities: They go up, instead of down, when a community goes through a “foster care panic.”

Such panics occur after the well-publicized death of a child previously “known to the system.” Every caseworker fears having the next such case on her caseload, so she rushes to tear away huge numbers of additional children from their homes.

The following chart illustrates the impact of a foster care panic in Missouri.

FISCAL YEAR	CHILDREN REMOVED DURING YR.	INCREASE OVER PREVIOUS YEAR
1997	6548	
1998	6652	104
1999	6712	60
2000	7346	634
2001	7425	79
2002	7572	147

Source: Missouri Division of Family Services, *Missouri Children’s Services Reports* for Fiscal years 1997 through 2001 and Missouri Division of Family Services, *Children’s Services Management Report*, January 2003, chart, page 52. .

Why the huge jump in the 2000 fiscal year? Because that time period includes

October, 1999, when Larry and Gary Bass, children well known to the system, died in their own home.

In other localities, foster care panics have been even more dramatic.

Illinois: In April, 1993, three-year-old Joseph Wallace was killed by his mother. Joseph was "known to the system." "Family preservation" quickly became the scapegoat. It was attacked relentlessly by politicians and much of the media -- even though most of the programs in Illinois bore little resemblance to the effective models used in other states – and even though one of the few people to oppose Joseph’s return was a family preservation worker.

As a result, workers and judges became terrified to leave or return any child home for fear of becoming the next target of politicians and the Chicago media. Almost all efforts to keep families together were effectively abandoned amid claims that such efforts contradict "child protection."

The Illinois foster care population soared from 33,088 before Joseph died, to more than 51,000 in 1997.⁵¹

But instead of saving lives, child abuse deaths went up, because workers were so overwhelmed with children who didn’t need to be in foster care that they missed more children in real danger. Fatalities soared from 78 before family preservation was abandoned to 82 the first year after, to 91 in fiscal 1997.⁵²

Then Illinois reversed course, reduced its foster care population and improved child safety. (See “Four places getting child welfare right,” page 24).

New York City. Again, this time in late 1995, a child “known to the system” died. Again officials blamed “family preservation.” Once again, the attacks set off a foster care panic, overwhelming the system. The result: Thousands of children were forced to sleep, often on chairs and floors, in a violence-plagued, emergency

makeshift shelter created from city offices,⁵³ a four-year-old foster child was beaten and starved to death in a foster home opened by one private agency, apparently desperate for beds, after another had closed it down.⁵⁴

Since the real reason children “known to the system” sometimes die usually is because workers are overwhelmed, overwhelming them some more is bound to make things worse.

Between 1996 and 1998, the number of children taken from their parents over the course of a year increased by 50 percent⁵⁵ and so did deaths of children previously “known to the system.”⁵⁶ Then, as in Illinois, officials realized that the take-the-child-and-run approach had failed, so they reversed course, and that led to dramatic improvements.

Florida: The death of a child “known to the system” and the appointment of a state child welfare agency chief whose views appear to have been identical to those of the current Missouri State Auditor combined to set off a foster care panic in 1999. Again, the foster care population soared. And again, deaths of children “known to the system” increased, from an average of 25 per year in the four years before the Florida Foster Care Panic to 30 in 1999, 30 again in 2000 and 35 in 2001.⁵⁷

None of this is surprising. Since the real reason children “known to the system” sometimes die usually is because workers are overwhelmed, overwhelming them some more is bound to make things worse.

These data don't prove that child abuse deaths always will go up when family preservation is abandoned or curtailed. But critics of family preservation, like the state auditor premise their entire “sacrificed on the altar...” argument on the assumption that if family preservation is eliminated, or at least drastically curtailed, such deaths will decrease.

At a minimum, the results of foster care panics in Illinois, New York and Florida -- particularly when compared to success stories like those discussed below -- suggest that it's the people who want to abandon family preservation who have a lot of explaining to do. It's time for the burden of proof to shift from those who want to keep more children with their parents to those who want to take them away.

You're only damned if you don't

Foster care panics also illustrate one of the most common myths in child welfare – one repeated over and over by caseworkers – that they are condemned if they take away too many children as well as if they leave children in dangerous homes. In other words, they're supposedly damned if they do and damned if they don't.

Sometimes, such disingenuousness goes all the way to the top.

Shortly before she resigned, Kathy Martin, then Director of the Missouri Department of Social Services, said:

“No matter where in the state you go, you have half the people saying you intervene too often, that you are too abusive with your powers. Then you have the other half saying you're not stepping up to the plate enough, that you're not reading all the signals and signs.”⁵⁸

Here's what Martin didn't say, and every frontline worker knows:

If a worker leaves even one child in a dangerous home and something goes

wrong, that worker can be fired, suspended, demoted, and/or attacked in the media. But the same worker can take hundreds of children needlessly from their homes and while the department as a whole might be criticized in reports like this one, nothing at all will happen to the caseworker.

In every meaningful way, when it comes to taking away children, workers are not damned if they do and damned if they don't. They are *only* damned if they don't.

Four places getting child welfare right

The failures in Missouri are typical. Some child welfare systems are worse, some are a little better. Very, very few systems are getting child welfare right – or at least making significant progress.

The few success stories in child welfare have one thing in common: They occur in places that have rejected the take-the-child-and-run approach, and embraced safe, proven programs to keep families together. They have proven that “family preservation” and “child safety” are not in conflict. On the contrary, they have proven that you can't have child safety *without* family preservation.

ALABAMA: Thanks to a lawsuit that led to a landmark consent decree, Alabama is rebuilding its entire child welfare system to emphasize keeping families together. In the counties that have reformed their systems, far fewer children are taken away, the rate of reabuse of children left in their own homes has been cut in half, and an independent, court-appointed monitor has found that children are *safer* now than they were before the changes.

PITTSBURGH: In the mid-1990s, the county-run child welfare system in Pittsburgh and surrounding Allegheny County, Pa. was typically mediocre, or worse. Foster care placements were soaring and those in charge insisted every one of those placements was necessary. New leadership changed all that.

Since 1997, the foster care population has been cut by 30 percent. When children must be placed, more than half stay with relatives and siblings are kept together 82 percent of the time. They've done it by tripling the budget for primary prevention, more than doubling the budget for family preservation, embracing innovations like the Annie E. Casey Foundation's Family to Family program and adding elements of their own, such as housing counselors in every child welfare office so families aren't destroyed because of housing problems. And as in Alabama, children are safer. Reabuse of children left in their own homes has declined. And since January, 1997, there has been only one child abuse fatality in a family previously known to the agency.

ILLINOIS: As noted earlier in this report, at the height of the foster care panic, the Illinois foster care population reached 51,000. A child was more likely to be in foster care in Illinois than anyplace else in the country. Today, the Illinois foster care population is under 22,000.

But contrary to popular belief, this did not happen primarily because of adoption. And it was not a result of simply turning over cases to private agencies.

Adoption was a part of the Illinois success story – in particular, an emphasis on letting extended family members adopt the children in their care or keep them under a form of permanence called “subsidized guardianship.” But the largest single change in Illinois was a reduction in the number of children coming into care in the first place.

When the foster care panic was at its worst, the state child welfare agency took away 9,037 children in one year. By the 2002 fiscal year, removals in Illinois had dropped to 4,943.⁵⁹ At the same time, both the state agency’s own data⁶⁰ and an independent evaluation from the University of Illinois have found that child safety has improved. Indeed, University of Illinois Prof. Mark Testa told the *St. Louis Post-Dispatch* that, as the story put it: “Children are safer now than they were when the state had far more foster children.”⁶¹

The reason for this success, however, is not because the state turned over foster care to private agencies. Back when Illinois had one of the worst foster care systems in the country, most foster care already was provided by private agencies. The key to Illinois’ success, described in more detail later in this report, was changing the financial incentives under which these agencies operate.

NEW YORK CITY: New York City has followed a pattern similar to Illinois. First, foster care panic and failure, then success through family preservation.

The settlement of a class-action lawsuit called for creation of an advisory panel of national experts. They persuaded the head of the city’s child welfare agency to take their advice, change course, and do far more to keep families together. The number of children taken away over the course of a year is now below where it was before the panic⁶² and the proportion of children returned home who have to be placed in foster care again has declined,⁶³ indicating that the reduction in the foster care population did not compromise safety.

The head of the child welfare agency for much of this time, Nicholas Scopetta, began his tenure holding views much like those of the Missouri State Auditor. But by the time he was getting ready to leave the job, in August, 2001, Scopetta was telling *The New York Times*: “I’m absolutely convinced we have too many children in foster care.”⁶⁴

Some have pointed out that Illinois has been much in the news because of recent horror story cases. This time the horrors involve foster and adoptive homes, not children left with their birth parents.

But that could change tomorrow.

All of the problems that plague the worst child welfare systems in the country also happen in the best such systems – but they happen less often.

To suggest that a system has not reformed because terrible things sometimes still happen to children is like saying that a police department has not improved because crime still exists.

Privatization: the great irrelevancy

In New York City almost all foster care is provided by scores of private agencies. It's been that way for 150 years. For the past four of those years, there has been significant improvement. For most of the previous 146, child welfare in New York City was lousy.

It also was lousy in Illinois before the recent reforms, and, as noted earlier, for much of that state's history, most foster care was provided by private agencies.

Turning more child welfare services over to private agencies in Missouri will solve nothing. It won't make services worse, but it won't make them better either.

But there is a way to use privatization to improve a child welfare system. The key to making privatization work is one, simple concept: You get what you pay for.

In most of the country, private agencies are told that their first job is to return children safely to their birth parents or, if that is not possible, work to find the children adoptive homes. But the more they succeed at that, the more they are penalized financially. That's because, typically, agencies are paid for each day they keep a child in foster care. If they do what they're supposed to do – find permanent homes for the children – the payment stops.

Much has been said about the problem of addiction in child welfare. But the biggest addiction problem in child welfare is not the one that afflicts some birth parents. The biggest addiction problem in child welfare involves well-heeled, well-connected

private child welfare agencies with blue-chip boards of directors that are addicted to their per-diem payments. And sadly, these agencies are putting their addiction ahead of the children.

The biggest addiction problem in child welfare is not the one that afflicts some birth parents. The biggest addiction problem in child welfare involves well-heeled, well-connected private child welfare agencies with blue-chip boards of directors that are addicted to their per-diem payments. And sadly, these agencies are putting their addiction ahead of the children.

We know this because of what happened in Illinois.

Like many addicts, the Illinois agencies were “in denial.” They insisted that per diem payments had no impact on their decisions. They said they truly wished they could find permanent homes for children but, they said, the parents were so very, very dysfunctional and the children's problems were so very, very intractable.

But finally, the state worked up the political courage to force private agencies to kick the per-diem habit. Private agencies in Illinois now are rewarded for keeping children safely in their own homes. They also are rewarded for adoptions. But they are

penalized financially if they allow children to languish in foster care.

When the financial incentives changed, an amazing thing happened. Suddenly the “intractable” became tractable the “dysfunctional” became functional, the foster care population plummeted, and child safety improved.

Not every place has had that kind of success. The results in Kansas have been mixed. As a result of early failures, the state reportedly has backed away from using financial incentives to achieve change. That is a serious mistake.

Kansas began with a different model for privatization than used in Illinois. Illinois had scores of agencies already in place and used a competitive approach, in which agencies that performed poorly stopped getting referrals.

Kansas awarded what amounted to regional monopolies to a small number of agencies, which, in turn subcontracted with other private providers.

This is not necessarily an inferior approach. But in Kansas it failed for two key reasons:

- The state did not pay enough per child.
- The payment structure was complicated, with too little of the money provided at the start of the placement.

If Missouri chooses to adopt the “franchise” approach to privatization, as opposed to the competitive model in use in Illinois, then it must learn from Kansas’ mistakes:

- Agencies should get a large per-child payment as soon as a child comes into care, calculated to equal the average cost of caring for a foster child. That payment should be all that the agency receives for that child. The more quickly the agency achieves permanence for the child, the more money the agency saves.

- The contract must also have penalties if a child is returned home too soon and must return to foster care – or if the child is placed in an adoptive home and the adoption “disrupts.”

When the financial incentives changed, [in Illinois] an amazing thing happened. Suddenly the “intractable” became tractable the “dysfunctional” became functional, the foster care population plummeted, and child safety improved.

Agencies also should receive only limited rewards if all they do is move children from one level of foster care to another – from a group home to a less expensive family foster home, for example.

While a foster home is better than an institution, real permanence almost always means returning the children to their birth parents or getting them adopted.

Most private agencies operate substitute care in various forms. They should not be unduly rewarded simply for moving a child from one pocket to another.

Some help from Uncle Sam?

One of the reasons it is so difficult for states to change financial incentives is because the federal government’s own incentives to the states are so skewed.

The federal government has two major “funding streams” for providing aid to states to provide child welfare services. (There also are at least 28 other federal programs that *can* be used for child welfare

under some circumstances). One of these "streams" is more like the Mississippi River at flood stage, the other is closer to a shallow creek.

The first funding stream, called Title IV-E is used almost exclusively for foster care and adoption. It's an open-ended entitlement, meaning that for every eligible child placed in foster care, the federal government reimburses 50 to 79 percent of the cost, through Title IV-E. In the 2002 federal fiscal year, Title IV-E spending totaled about \$5 billion,⁶⁵ of which roughly \$3 billion went to foster care.⁶⁶ The other funding stream, called Title IV-B, funds family support, family preservation, family reunification and adoption. Under some circumstances some of this money can be used for foster care as well. Title IV-B is not an entitlement. When the money runs out, there is no more. In the 2000 fiscal year, Title IV-B spending totaled less than \$500 million⁶⁷ - one tenth what the federal government spends under IV-E.⁶⁸

The gap is almost as large in Missouri. According to the Urban Institute, Missouri received nearly \$85.7 million in Title IV-E funds in the 2000 fiscal year, the most recent for which comparative data are available. The state received only 11.6 million in Title IV-B funds.⁶⁹

What all this means is that even though family preservation is cheaper in total dollars, perverse federal financial incentives sometimes make foster care cheaper for the state making the placement decision.

President Bush's proposed fiscal 2004 budget includes a radical change. Under this plan:

- States would have the option of taking their title IV-E foster care payments over the next five years in the form of a lump sum, instead of being reimbursed for part of the cost of each placement in foster care. It appears that the lump sum would

be calculated to equal what the state would have gotten under the existing entitlement.

- Instead of the money being restricted largely to foster care, the money could also be used on any program now funded by the much smaller Title IV-B. That includes family support and family preservation, (which are *not* the same) as well as family reunification and adoption services.

- The existing Title IV-B program is *not* affected by this change - that is, IV-B money could *not* be diverted to foster care. This "IV-B firewall" is extremely important. Had the two streams been combined, the "foster care-industrial complex," huge, powerful public and private foster care agencies, "residential treatment centers" etc. would use their clout to swallow up the prevention money.

- States would get each year's allotment upfront.

- States that opted in would have to stay in for five years.⁷⁰

If Congress approves this plan, it would be the most important change for the better in federal child welfare policy in 23 years. In Missouri, it would mean that tens of millions of dollars, now reserved almost exclusively for foster care, would become available for prevention as well.⁷¹ But that will happen in Missouri only if the plan is approved by Congress, and even then, only if the state agrees to take part.

Private agencies, especially those heavily invested in institutionalizing children, are likely to fight this proposal both at the federal level and in the states, since this change could reduce their size and power and, in some cases, maybe even threaten their existence.

In addition, states will have to negotiate with the federal government a payment equal to an estimate of what they would have gotten under the old system. Some states may balk if they think they will

get less – even though spending the dollars on prevention will serve far more children and serve them far more effectively.

The teens [in orphanages] felt “less loved, less looked after, less trusted, less wanted ...Teens described a powerful code of behavior dictated by institutional peer-group subculture, encompassing drugs, sex, and intimidation.”

Any state willing to stand up to special interests and remember that the purpose of the child welfare system is to help children, not agencies, will opt into this new system if, in fact, it becomes law in its current form.

What *not* to do

Before discussing the many good ideas for fixing the child welfare system in Missouri, it’s important to note three really bad ideas that often are mentioned when child welfare systems are in trouble; ideas that only will make the system worse.

Bad idea #1: Orphanages.

Whenever the failings of foster care get attention, someone is sure to suggest that even orphanages can’t be worse. But not only can they be worse, they are.

Orphanages generally are suggested as an answer for two groups of children, those for whom there supposedly isn’t room in foster care because of an alleged “shortage” of foster homes, and those children who supposedly have such severe be-

havior problems that there is no other alternative.

But the research is virtually unanimous: Orphanages are the least effective and most expensive option for children in either group. They provide all the drawbacks of family foster care, with none of the benefits.

The North American Council on Adoptable Children (NACOAC) has reviewed the scholarly literature concerning children raised in institutions.⁷² The findings are grim:

- In one study, 25 percent of adult women institutionalized before age five exhibited a personality disorder, compared to none in a control group. The institutionalized women had a great deal of difficulty functioning as parents themselves.

- “Children denied the opportunity to form a consistent relationship with a caregiver in their early years, such as institutionalized children, are at serious risk for developmental problems and long-term personality disorders.”

- Children who grow up in poor quality institutions are more likely to have lower IQ scores and retarded language development. Children in such institutions are more likely to exhibit anti-social behavior and be unable to form supportive relationships with others. “Even good institutions fail to provide children with long-term, stable affectionate relationships that are critical to later social relations.”

- Even teenagers fare worse in institutions than in other settings. Institutionalized teens fared worse even than teens in foster homes according to one major study.⁷³ And a survey of teenagers with a history of long term out-of-home placement found that the teenagers found institutions to be a significantly worse option than their own families, care by relatives, adoption, or even foster care.⁷⁴ The NACOAC review aptly summed up the study findings: The teens

felt “less loved, less looked after, less trusted, less wanted ...Teens described a powerful code of behavior dictated by institutional peer-group subculture, encompassing drugs, sex, and intimidation.”

A building in which children, most of them strangers to each other, are thrown together to be cared for by paid staff hired to dispense indiscriminate pseudo-love to whoever walks in the door – staff likely to change every year or two – is not a home. It’s a dormitory. And a collection of dormitories is an orphanage.

A review of 100 years of research and medical knowledge concerning orphanages concludes:

“[I]nfants and young children are uniquely vulnerable to the medical and psychosocial hazards of institutional care, negative effects that cannot be reduced to a tolerable level even with massive expenditure. Scientific experience consistently shows that, in the short term, orphanage placements put young children at increased risk of serious infectious illness and delayed language development. In the long term, institutionalization in early childhood increases the likelihood that impoverished children will grow into psychiatrically impaired and economically unproductive adults.”⁷⁵

The research on the harm of institutionalization is so overwhelming that the federal government now rates state child welfare systems in part on their ability to *reduce* the number of children under age 12 in institutions.⁷⁶

Last November, former DFS Associate Director Robin Geier had to deny rumors that the state is working to get every child under age 11 out of group homes and institutions.⁷⁷ Too bad. That’s exactly what Missouri *should* be doing.

- Orphanage proponents often claim that institutions provide children with “stability” since the children don’t have to move from foster home to foster home. But orphanage workers often work in shifts, the caretakers changing every eight hours. And even in institutions using a so-called “house parent” model, the house parents typically quit every year or so.⁷⁸

That makes orphanages every bit as unstable as multiple foster home placements. The real way to promote stability is to get the children who don’t need to be in foster care back into their own homes. That would eliminate overcrowding in foster care and leave room in good, stable foster homes for the children who really need them.

- Orphanage proponents also say institutions keep siblings together. Not if they’re brother and sister. And not if there’s much difference in ages. It’s not safe to institutionalize boys and girls or children of different ages together. In contrast, as noted earlier, ever since Pittsburgh and surrounding Allegheny County, Pa. started freeing up foster care beds by emphasizing efforts to keep families together, they’ve been able to keep siblings together in foster homes 82 percent of the time.

Changing the architecture doesn’t change the result. Although policymakers and journalists sometimes confuse architecture with love, children do not. Children are not fooled because dorms are now called cottages and staff are now called “house parents.” They are not seduced by a fresh coat of paint or a well-manicured lawn.

A building in which children, most of them strangers to each other, are thrown together to be cared for by paid staff hired to

dispense indiscriminate pseudo-love to whoever walks in the door – staff likely to change every year or two – is not a home. It's a dormitory. And a collection of dormitories is an orphanage.

In addition, any orphanage is extremely expensive.

In 2000, DFS spent an average of \$4,793 per child in a family foster home.⁷⁹ In 2001, DFS spent nearly two thirds of its foster care budget on the 17 percent of foster children who are institutionalized.⁸⁰

And yet, the institutional providers say it's still not enough. Indeed, they seem to want it both ways.

Even as the executive director of the Missouri Catholic Conference was bragging that "We know we could do this much more efficiently ... We could do it at better cost to the state"⁸¹ the agencies were in court, successfully suing to force the state to pay them even more of Missouri's scarce funds for the worst form of care, institutionalization.⁸²

Orphanages: The harm in Missouri

The following is an excerpt from an article that appeared in the *St. Louis Post-Dispatch* on June 20, 2001:

According to a study conducted by the University of Illinois, children who grow up in residential facilities often end up being less educated and are more likely to be arrested, convicted of a crime or have drug or alcohol problems as adults.

Research shows that children in residential care have "a mental age" below the norm, are less likely to have deep attachment to adults and can be disruptive because they seek more attention.

Life in residential facilities is rigid and restrictive, almost like a juvenile custody facility. Children must adhere to a fixed schedule day in and day out. Once they come home from school, they are rarely allowed to leave the facility. School friends can't casually drop by and visit. The residents have little or no privacy.

"Sometimes they don't get to relax," said Stacey Miller, a clinical therapist at St. Anthony's Health Center, which provides behavioral counseling for children. "You go home and follow the same schedule. Most of the time they don't get to be kids."

While some relatives can take children out of [a] residential facility during a visit, the children aren't allowed to leave with others without a rigorous screening of the visitor. Teen-agers rarely get to enjoy their adolescence.

"You are not going on a date with a boy," Miller said. "They can't just get up and go to the movies with their friends."

It is hard for the children to develop close personal ties at residential facilities because they interact with caretakers on three different shifts and facilities often have high turnover rates, she said.

Additionally, they could be placed with a child who acts out aggressively because of neglect or physical or sexual abuse or who exhibits psychotic behavior.

"When you put a child in a situation where you have kids like that, they may pick up on those behaviors," said Miller, who has worked with children at Missouri Baptist Children's Home and Faith House, both residential facilities. "The longer a child stays in a residential facility they almost get institutionalized. They don't know another way."

Mary Taylor, executive director of St. Louis Court Appointed Special Advocates, said when children are placed in a residential home, their chances of being adopted are lessened.

"Most of the kids who are successfully adopted are adopted out of foster care," Taylor said. "The foster parent falls in love with the foster kid and the foster kid falls in love with the foster parent."

Children in residential facilities don't have that opportunity, she said. Also, there's a stigma attached to children in institutional care, even though they may not be there because they have a problem, she said.

Rossie Summers, 30, director of training and family development at Foster Care and Adoption Coalition, was an assistant director at Faith House, a residential care facility for children up to age 12.

In her five years there, Summers said she saw the impact on the children of being in a residential facility. "It's really hard," Summers said. "Those kids have seen a lot of kids get adopted. It causes their behavior to be disruptive because they don't know how to express how they are feeling on the inside."

All of this harm takes place even in good institutions – and often the institutions are not good.

- In 1987, New York City set up 17 mini-orphanages for infants and toddlers. The city called them "congregate care facilities" but they soon acquired another name: Baby warehouses. In the two years between the time they were set up and the time the state ordered them closed:

--Two children died of infectious diarrhea because of unsanitary diapering practices. A third child died because -- like 91 percent of the children -- he was not properly immunized. There may have been more deaths, but the record-keeping was as shoddy as the sanitation. Inspectors found that "all but five of the shelters have had

consistent problems with roaches, flies, mice, or rats. Food practices are often unsafe."

--Disease was not the only hazard. Inspectors also found "unshielded wall outlets, broken cribs, playpens, and highchairs, play areas with broken glass, toxic chemicals leaking from containers within easy reach of toddlers. Children were cared for in eight-hour shifts by untrained workers who often did not even know their names. At one of the baby warehouses, the children were spoken to only when they did something wrong."⁸³

The "baby warehouses" were not aberrations. As noted earlier, an Indiana study found that children in "group homes" are 10 times more likely to be physically

abused and 28 times more likely to be sexually abused than children in their own homes.⁸⁴

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There have been other tales of terror from America's modern orphanages. Among them:

- SOS Children's Village in Florida repeatedly has been cited by orphanage proponents as proof that orphanages can work. But between 1999 and 2001 33 reports were filed with Florida's child abuse hotline alleging abuse of children at the 50-bed facility; 21 were "substantiated" or "indicated." During the same time period 13 "house parents" and 14 "parent assistants" quit or were fired. (So much for orphanages providing “stability.”)⁸⁵

- Another facility touted as a national model, Maryville, near Chicago, has been revealed as a place of terror for many of the children confined there, according to documents obtained by the *Chicago Sun-Times*. The newspaper reports that “the place is often up for grabs, with staff struggling to handle suicide attempts, sex abuse, drug use, fights and vandalism...”⁸⁶ In 2001, police were called to Maryville 909 times.⁸⁷

After a 15-year-old left her Maryville “cottage”, was gang raped by other Maryville residents and escaped from her attackers, she says the kindly staff at her “cot-

tage” wouldn't let her in until they finished filling out a report about her “running away.”⁸⁸

- A 1997 Los Angeles County Grand Jury report found, according to the *Los Angeles Times*, that “Many of the nearly 5,000 foster children housed in Los Angeles County group homes are physically abused and drugged excessively while being forced to live without proper food, clothing, education, and counseling...” [emphasis added.]⁸⁹

A year later, the *Times* found that “children under state protection in California group and foster homes are being drugged with potent, dangerous psychiatric medications, at times just to keep them obedient and docile for overburdened caretakers...Under the influence of such drugs, children have suffered from drug-induced psychoses, hallucinations, abnormal heart activity, uncontrollable tremors, liver problems, and loss of bowel control...”

The *Times* found that it happens to children as young as 3 “and even a 22-month-old knew the word ‘meds.’”⁹⁰

- Mission of the Immaculate Virgin on Staten Island, N.Y. became so well known for brutality that youths would run away and sleep on the subway rather than spend even one night there. According to *New York Newsday*, “Adolescents returning from temporary placements ... described a pattern of incidents in which longer-term residents raped, robbed, or assaulted newcomers while night-shift staff slept on the job.”⁹¹

- Linden Hill and Hawthorne Cedar Knolls, two institutions in Westchester County, New York were, according to *New York Newsday*, “plagued by violence, unchecked sex, and poor supervision. ... ” Said one counselor: “They have lost sight that the program is no longer safe to kids. It's outrageous.”⁹²

- At Mooseheart, near Chicago, over five years, four "house parents" were convicted of molesting the children in their care. In one case, a houseparent was convicted of molesting six pre-teen boys in less than a year.⁹³ And now, it's happened again. In February, 2003, another Mooseheart house parent was convicted of sexually abusing seven children.⁹⁴

The argument for orphanages is that there is no choice because of a "shortage" of foster parents. But Missouri doesn't have too few foster parents. Missouri has too many foster children.

- And then there was Missouri's own JDM Residential Treatment Center near St. Louis, where, according to a former director, "there were days when there wasn't any food. The whole thing was just a way to make money off the state."⁹⁵

The argument for orphanages is that there is no choice because of a "shortage" of foster parents. But Missouri doesn't have too few foster parents. Missouri has too many foster children.

Get the children who don't need to be in foster care back into their own homes, and there will be plenty of room in good, safe foster homes for the children in real danger.

The other argument for institutionalizing children is that some of them are so emotionally disturbed – either because of what was done to them by their parents, the system, or both, that they can be "treated" only if they all are assembled in one place in a "residential treatment center."

Thus, the head of one such center in Missouri tells us that "the complexity and severity of needs presented by some of these children requires immediate and comprehensive services that are offered by residential treatment ..."⁹⁶

But here again, the research shows that institutionalization is a failure.

A U.S. Surgeon General's report found only "weak evidence" of RTCs' effectiveness.⁹⁷ Another study found that within six years, 75 percent of the children released from the centers were back to living in the only places they understood - institutions - either mental health facilities or jails.⁹⁸

And University of Chicago researcher Michael Little has found that when children with serious behavior problems are institutionalized, they tend to "deteriorate together as a group."

The head of the Missouri RTC goes on to claim that RTCs can provide "more extensive therapeutic services than a foster of natural parent can provide..."⁹⁹

But that is true only if that foster or birth parent is left on her or his own. There is no law that says therapists can't make house calls. So can home health aides and people who do whatever else an institution can provide – in shifts, around the clock if necessary.

A comprehensive survey of the literature by the University of North Carolina School of Social Work found that "when community-based services are available, they provide outcomes that are equivalent, at least [to RTCs]."¹⁰⁰

In Alabama they call it "moving the system instead of the child."

In Milwaukee, they call it "wrap-around." And it has been an enormous success.

But, of course, community-based services can't be made available as long as large, powerful institutions are scarfing up

all the money and opposing any diversion of funds to better, more humane alternatives.

In Milwaukee, the community was able to break the grip of the institutions lobby.

Milwaukee vs. the “institutions lobby”

The Westchester County, N.Y. *Journal News* devoted an enormous amount of time and effort to three separate multi-part series about Residential Treatment Centers in 2002. The series should be required reading for all policymakers involved in child welfare. It is available at www.nyjournalnews.com/rtc. Here's what the newspaper found in Milwaukee (excerpts from the *Journal News* story are in italics):

“[Wraparound] cut the number of Milwaukee children in RTCs by 90 percent, dramatically shortened their stays, reunited hundreds of families, reduced the incidence of crime and saved millions of dollars in treatment costs. It became a national model for treating emotionally disturbed children, offering a more effective and economical means of helping youngsters without the traditional reliance on costly and controversial institutions. ...

"Wraparound Milwaukee demonstrates that the seemingly impossible can be made possible: Children's care can be seamlessly integrated. The services given to children not only work, in terms of better clinical results, reduced delinquency, and fewer hospitalizations, but the services are also cost-effective," the President's New Freedom Commission on Mental Health said in October. "Imagine the nationwide impact on our juvenile justice system if this program were implemented in every community."

"Residential treatment has had the luxury of basically being the sole tool out there for a very high-risk population, and they've convinced people that the only way to be safe is to have them locked up," said Stephen Gilbertson, clinical program coordinator for Wraparound Milwaukee. "We've shown that's simply not true. We've taken extremely high-risk kids and shown they can live successfully in the community."

Institutions have long argued that their role is crucial because most of the children have no stable homes. But Wraparound advocates say institutions have been too quick to write off families; Wraparound seeks out families and finds ways to make them work.

Of course, Milwaukee's institutions didn't simply accept all this. On the contrary, they fought it every step of the way.

"I remember meeting with groups of people and folks saying, 'Let's get some reports out that show they (Wraparound) are going to start hurting kids now,' " said Cathy Connolly, president of St. Charles Youth & Family Services,

which operates Milwaukee's largest institution. "Well, nobody could ever bring the reports to the meetings, 'cause there were none that existed that said we were doing anything all that great. We didn't really have any solid anything that demonstrated we were able to fix kids."

Connolly and her colleagues lobbied fiercely for the status quo. She was remarkably candid about the reason:

"There were a couple big fears. ... The first was, 'How are we going to financially sustain ourselves?' "

Eventually, however, Connolly's agency embraced the new approach: *"I think, looking back on it now, what we're doing for kids today is far more helpful."*¹⁰¹

RECOMMENDATION #1: Missouri should adopt Milwaukee's wraparound model, and dramatically reduce the proportion of children warehoused in residential treatment centers and similar facilities.

Milwaukee is not alone.

Patrick Lawler runs Youth Villages, one of the largest residential treatment programs in Tennessee. But he began to get the feeling that what he was doing wasn't really helping children.

"The state would ask us at the end of each year what we did with their money," Lawler says, "and we would tell them the truth. We spent it."

When a study he commissioned confirmed that his own program wasn't working, Lawler could have buried the study. Instead, he redesigned his program to keep more children in their own homes. He rebuilt his programs to emphasize keeping families together, and finding foster and adoptive homes for children when that wasn't possible.

When children still must be institutionalized, families play an important role in treatment, with regular contact encouraged.

Today, Youth Villages serves one-third more children for the same cost, and has far more success.

The biggest problem, Lawler says, was getting the State of Tennessee to change

its funding system to pay for the new approach.¹⁰²

"The state would ask us at the end of each year what we did with their money, and we would tell them the truth. We spent it."

--Patrick Lawler,
Executive Director, Youth Villages

Writes Lawler: "In the 28 years I have been entrusted with caring for other people's children, some of whom come from dire circumstances, I have learned firsthand there is no substitute for a child's birth family. I used to think we could do a better job of raising these children. We know better now. The best way to help a child is to help his or her family."¹⁰³

Bad idea #2: Rearranging the deck chairs

It seems to be the near-universal reaction when a tragedy puts the spotlight on a child welfare agency: Fire a few people and move around the boxes on the table of organization.

Sometimes, firings make sense. New leadership was crucial to the changes

in Pittsburgh and New York City. At other times, however, agency chiefs are simply convenient scapegoats.

The "Council on Accreditation" doesn't really accredit agencies at all. It accredits file cabinets.

We have no opinion on the firings and resignations in Missouri. But we do have a recommendation for those considering reorganizing the various branches of the Department of Social Services involved with child welfare:

Don't waste your time.

There have been all sorts of schemes around the country.

When scandal engulfed the state-run system in Florida, there were proposals to let individual counties run their child protection systems. When scandal engulfed Colorado, where child welfare is run by counties, there were immediately calls to let the state do it.

Similarly, as noted earlier, there is no evidence that privately-run systems are any better - or worse - than publicly-run systems.

Some say children's services should be in their own freestanding agencies as in Illinois. But Illinois had a freestanding agency when it was lousy just as it has now that it has gotten better.

Others say children's services should be a part of larger social services agencies. That is the structure in Alabama now that it is among the nation's best child welfare systems. That also was the structure when Alabama was among the worst.

Aside from providing employment for the printers who produce stationery with new letterheads, there is no evidence that

reorganization improves anything. And there may be some harm.

Reorganization can be a wonderful excuse for inaction.

"We can't get to that now, we're too busy planning for the reorganization" can be followed by "that's going to have to wait while we complete the reorganization" which can be followed by "we can't deal with that yet, we're still coping with the reorganization."

Reorganization is what you do when you don't have *real* ideas.

Bad idea #3 "accreditation"

According to the state auditor's 2000 report on the Missouri child abuse hotline, DFS is pursuing "accreditation" from an organization called the Council on Accreditation of Services for Families and Children. Though the state auditor describes COA as "a leading independent accreditor..." it is anything but independent.

Accreditation is a way for agencies to get an unearned seal of approval by keeping their paperwork in order - and then throw it in the face of critics, in order to prevent real change. That's why child welfare agencies rush to embrace the idea whenever the alternative is real reform.

Indeed, it is quite possible, depending on the circumstances, for an agency to become fully "accredited" without the "accreditors" so much as laying eyes on one real live foster child.

To understand the limits of accreditation, it's important to understand the group that is pushing it. The "Council on Accreditation" is a creation of the agencies themselves and their trade association, the Child Welfare League of America.

The name notwithstanding, CWLA is not a child advocacy organization - it is an *agency* advocacy organization. It is funded by the dues of its member agencies and exists to support them. It is to children as a

hypothetical National Nursing Home Association is to the elderly.

Of course there are some very good people at CWLA and sometimes the interests of the agencies and the children coincide. But when they don't, CWLA puts the interests of its members first - just as any trade association does.

This became apparent in 1999 when the *Dayton Daily News* exposed hideous conditions at an Ohio-based private agency.

Among the findings:

- Foster homes that were wretched.
- Group homes that were worse.
- The head of the agency had a conviction for contributing to the delinquency of a minor - a foster child who had been in his care.¹⁰⁴

When the *Dayton Daily News* e-mailed its findings to CWLA's acting director, (who is not the current director) she *should* have said that such conditions would not be tolerated in a CWLA member agency. But she didn't. The *Daily News* describes what happened instead:

"After reading the series, Shirley Marcus Allen, the league's director, sent an e-mail to Joyce Johnson, the group's director of public relations, saying 'These are all horrible stories. I have no desire to talk to the reporters on this if I don't have to. Find something more positive for me to report on.' Although intended as an internal document, Allen sent the e-mail to the newspaper by mistake."¹⁰⁵

One more thing worth knowing about the agency that was the subject of the *Dayton Daily News* series:

It was "accredited."¹⁰⁶

The Council on Accreditation is self-policing and the self-policeman is almost always the laziest cop on the beat.

As noted above, it is possible for an agency to be fully accredited without the accreditors actually even seeing a foster child.

That's because:

- The accreditors don't inspect foster homes.
- The accreditors don't do surprise inspections of anything. Group homes and institutions get "no more than" a month's advance notice. (There were no inspections at all until the *Dayton Daily News* exposed that fact).
- They inspect group homes only if the agency seeking accreditation is running them directly.
- The accreditation process does nothing to examine whether a decision to remove a child in the first place is appropriate.¹⁰⁷

In short, the "Council on Accreditation" doesn't really accredit agencies at all. It accredits file cabinets.

An ombudsman won't help either

However well-intentioned, creating the position of "ombudsman" to handle complaints about DFS also is likely to backfire.

There are several reasons:

- No ombudsman is likely to get a budget sufficient to investigate cases thoroughly. That means the ombudsman will be dependent on DFS records, and all the built-in bias that implies.
- Even with an adequate budget, an ombudsman cannot be truly independent. Even if the ombudsman is located outside the child welfare agency, he or she is likely to be appointed by the governor.
- If the ombudsman and the child welfare agency chief are appointed by the same governor, they are likely to have the same general philosophy and outlook. So if DFS believes in a "take the child and run" approach to child welfare, the ombudsman isn't likely to have any problems with that.
- This is compounded by the fact that take-the-child-and-run is usually the

more popular position politically. Like journalists, the ombudsman is likely to be attracted to high-profile, high-publicity fatality cases. The ombudsman's work, therefore, is likely to reinforce the misimpression that errors in agencies like DFS go only one way.

Indeed, the combination of a similar mindset and what's popular politically helps explain why ombudsmen in Washington State and Connecticut have spent much of their time trying to outdo child welfare agency chiefs in showing who is "tougher on child abusers."

In Washington State, the ombudsman is crusading to make the state's child neglect law even broader.

In Connecticut in the late 1990s, when the head of the state child welfare agency resigned, she was replaced by the ombudsman, who helped fuel, instead of calm that state's foster care panic.

Only in New York City has the ombudsman been truly effective. But that's because in New York City, the ombudsman, called the Public Advocate, actually is a separately elected official with her own, substantial budget. And, of course, she deals with many issues besides child welfare.

- In Missouri, the role of any ombudsman is likely to be complicated by the peculiar role of the "juvenile office" which plays a role much like DFS, but is part of the judicial, not the executive branch.

- But perhaps most important, an ombudsman is likely to create a false sense of accountability where none really exists.

Presumably, the ombudsman would be allowed to examine case records and other documents that normally are shielded by confidentiality laws, and attend closed court hearings.

Once that happens, DFS, the juvenile office and legislators no longer will be under pressure to release such information to the

public at large and let press and public into these hearings.

Legislators will be able to send form letters to constituents asking for help that say "I have referred your complaint to the ombudsman..." And whenever the ombudsman rubber-stamps DFS, the agency will through it in the faces not only of the families, but of reporters as well: "The ombudsman saw the records," DFS will say, "and s/he said we did a good job." It will be a double blow against true independent inquiry.

Real accountability in a democracy requires that we *all* serve as ombudsmen. As is discussed later in this report, that means we all have to be able to see most records and attend court hearings.

The hotline: where reform should begin

The state auditor has recently been urging all Missourians to read an audit she released in 2000 concerning the Missouri child maltreatment hotline.¹⁰⁸ As this is written, she is preparing a follow-up report.

The audit offers 32 specific recommendations. Every one of these recommendations is sound, and DFS should implement them immediately – though, as is discussed below, not always in precisely the form the auditor recommends.

Sadly, however, these sound recommendations are overshadowed by the profound anti-family bias that permeates every page of the document. The inflammatory language and selective use of data create the false impression that endangered children are regularly missed by hotline call takers and caseworkers who screen calls at county DFS offices. In fact, the limited evidence the auditor provides suggests the opposite.

And the audit leaves the impression that the hotline, and the system in general, err in only one direction – wrongfully leaving children in dangerous homes. In fact, child protection hotlines, and entire systems, are arbitrary, capricious and cruel. They do indeed leave some children in danger, even as they remove others from homes that are safe or could be made safe with the right kind of help. But that is entirely excluded from the auditor’s analysis.

The auditor’s biased presentation leaves a misimpression of the overall skill and dedication of Missouri’s caseworkers.

The bias begins with whom the auditor chose to talk to, and whom she chose to ignore. According to the description of the audit’s “scope and methodology” the audit staff:

“Discussed child abuse concerns with various groups and individuals who often come in contact with abused and neglected children.

“Solicited information from current and former DFS social workers, supervisors and county directors and from mandated reporters of child abuse such as police officers, juvenile officers, school employees, and officials and hospital employees.”¹⁰⁹

There is no mention of soliciting information from birth parents, defense attorneys or advocates for the poor – in other words, anyone who might contradict the auditor’s preconceived notions.

After a call is taken by the hotline, it is referred to a county DFS office, where a screener decides whether the call should

be handled as an investigation or a family assessment.

The audit included giving a sample of five actual cases to 17 local caseworkers to see how they would classify the reports.¹¹⁰ There were several problems with this approach and its interpretation:

- Five cases is a very small sample.
- All of the cases appear to have involved serious abuse; thus the auditor tested only for mistakes in giving calls a low priority. She did not offer any cases in which a case should have been screened out entirely or given a lower priority to see if caseworkers would wrongfully subject children to a traumatic investigation.

- The workers actually did better than the auditor’s narrative suggests. In the two most serious cases, 11 of 14 and 15 of 17 workers handled the case correctly, referring it for a full-scale investigation instead of a family assessment. In a third case, the workers unanimously chose “family assessment” as the correct classification.

In the remaining two cases, the workers were evenly split between referring the case for a full-scale investigation or a family assessment.

But the auditor constructed the survey in a manner sure to obscure these results. She used as the first two cases, examples in which the real-life workers who handled them got them wrong, and children subsequently died. By using these actual cases, the auditor uses the enormous emotional power of the actual result to overshadow the fact that her own test reveals that the vast majority of Missouri workers recognize a potential case of serious abuse when they see one.

In contrast, when independent agencies without preconceived agendas performed similar tests in New York State and Florida they used hypothetical cases,

designed to test workers' ability to make more difficult decisions.*

Anything short of 100 percent correct on every call leaves room for improvement, and the actual recommendations made by the auditor for such improvement are sound. But her biased presentation leaves a misimpression of the overall skill and dedication of Missouri's caseworkers.

Similarly, the auditor offers a selection of several horror stories involving cases classified "unable to investigate" when in fact, had the hotline worker been more diligent or knowledgeable s/he would have found enough information. Mentioned only in passing is the fact that, by the auditor's own estimate, when hotline operators label a case "unable to investigate" they are right 97 percent of the time.¹¹¹

Again, the goal should be 100 percent, and the specific recommendations for improving accuracy are sound. But this section of the audit leaves a wholly misleading impression.

Later the Auditor discusses the process by which families can appeal a finding "substantiating" maltreatment. These decisions are made by individual caseworkers using a standard of "probable cause" which appears to be roughly the equivalent of "preponderance of the evidence." That is a far lower standard than used to convict a criminal; it is lower even than the middle standard used in some court cases, "clear and convincing" evidence. The "preponderance of the evi-

* The New York State study gave hotline workers 12 hypothetical scenarios, the Florida study only three. Both found differences among hotline workers that were so wide that whether a call was accepted or rejected seemed to depend on who happened to pick up the phone – results much worse than the Missouri audit. But the studies also are quite old, the Florida study was done in 1991, the New York State study in 1986.

dence" standard is the one used to decide which insurance company pays for a fender-bender.

Families have the right to appeal these decisions to a "review board." The membership of this board is prescribed by law, and is dominated by professions that are likely to bias the boards toward upholding DFS.¹¹²

By the auditor's own estimate, when hotline operators label a case "unable to investigate" they are right 97 percent of the time.

Yet despite the low standard of proof, and the nature of the review boards, during the 1999 fiscal year, 40 of every 100 substantiation decisions were overturned. The auditor zeroes in on the 10 of 100 decisions which were overturned because of poor casework. She is silent about the 30 more of every hundred cases in which the decision apparently was overturned because the review board considered the family to be innocent.

The auditor notes that the review board defined poor case management as "incomplete interviews with child abuse victims, incomplete interviews with collateral witnesses, failure to collect available evidence or documentation to support allegations, improper investigation procedures, incomplete reports, poor question formulation in interviews, poor writing skills and poor case presentation skills." But she fails to note that almost every one of these failings can as easily lead to wrongfully accusing the innocent as it can to requiring the board to wrongfully exonerate the guilty.¹¹³

Similarly, at one point the auditor recommends that families be notified of their right to appeal by registered mail – but not because a family might actually lose its right to appeal because they did not receive proper notice. That, apparently, is of no concern to the auditor. On the contrary, her sole concern is that a guilty – and sneaky -- family member might pretend not to have been notified and thereby get the chance to appeal after the statutory deadline.

The auditor did note that when DFS fails to correct its computerized records to note that a probable cause finding had been overturned, that “can subject DFS to litigation, and it is unfair to the alleged perpetrator.”¹¹⁴ Note the order of her priorities.

The auditor would no doubt respond that this just proves that *she* cares about children while her critics supposedly care only about “abusive parents.” But that “logic” overlooks several points:

- The point of an appeals mechanism is to *determine* if the accused is abusive or not.

- A listing in the state’s Central Register makes it more likely that a child ultimately will be removed from the home – with all the harm that can cause, discussed earlier in this report.

- The accused might actually *be* a child. Children sometimes abuse each other. And children sometimes are falsely accused of abusing each other. Most states list children in their central registers right along with adults.

In Illinois, the lead plaintiffs in a successful class-action suit concerning the hotline process¹¹⁵ included a girl who, at the age of ten, was labeled a child abuser and listed in that state’s central register because she had pulled up the pants of some younger boys found “playing doctor” in the family’s day care home. The ordeal of being accused, and all that followed, nearly drove the child to suicide.

Perhaps most serious, the audit found many cases in which reports were referred to field offices but not acted upon, sometimes for days, sometimes not at all. The audit also found that in 1999, fully one-third of all investigations were not completed in a timely manner. Both of these problems can seriously compromise safety. (The audit reports that the biggest backlog problem was in Springfield. That would seem to contradict the auditor’s claim that Greene County may be doing a better job of keeping children safe than the rest of the state.)¹¹⁶

But the auditor failed to understand the implications of her own findings. Reports that go unexamined or uncompleted are symptoms of an overloaded system. They mean that too many cases are being screened in and sent on for investigation in the first place. That illustrates the biggest problem at the Missouri child abuse hotline: The failure to screen out enough reports.

Fixing the hotline

Current Missouri law allows almost no real screening of calls at all. Every call must be accepted if it meets the following criteria:

- The alleged child victim is under 18.
- The accused “has care, custody, and control of the child.”
- The alleged acts or omissions are having an adverse effect on the child.
- The report meets the definition of abuse or neglect in Missouri law.¹¹⁷

Since as noted earlier, Missouri’s definition of neglect is breathtakingly broad, it’s hard to imagine a call about an impoverished family that wouldn’t have to be screened in, as long as the caller offered enough information about the accused for an investigator to find him or her.

A call cannot be screened out if the same caller has made the same false allegation repeatedly, but not maliciously. The family would be subjected to an investigation over and over and over, causing repeated trauma to the children – and using up scarce time and resources.

Nor does a caller need to offer any evidence for his or her assertion. The caller might, in fact, have “reasonable cause to suspect” maltreatment, or he might have no cause at all.

The Missouri hotline referral and screening process seems to resemble nothing so much as an old cartoon about the post office, in which a dozen different slots for different kinds of mail all wind up emptying into the same basket.

And though Missouri law prohibits deliberate false reports, it still allows anonymous reports, so malicious callers can simply cloak their malice in anonymity.

Furthermore, even if, somehow, a call doesn’t meet the criteria for a report, if the report was filed by a “mandated reporter,” such as a doctor or a teacher, it must be passed on to a local office anyway, which then has discretion about what to do with it, but still must waste time on it.¹¹⁸

In fact, the entire Missouri hotline process is far more complex than most states, involving numerous categories and subcategories. There are “N” reports and “A” reports and “P” reports and reports that will be screened in each county and then placed in the “Investigation” track or the

“Family Assessment” track. And they all wind up piling up in local offices.

Indeed, the Missouri hotline referral and screening process seems to resemble nothing so much as an old cartoon about the post office, in which a dozen different slots for different kinds of mail all wind up emptying into the same basket.

And that is a formula for disaster.

That is the lesson from Florida, where the failure to properly screen hotline calls has been a major contributor to the collapse of the child welfare system.

After a case similar to the Bass brothers case made headlines across the state, the Florida legislature drastically reduced the ability of the hotline to screen calls. And even where hotline workers have discretion, they are afraid to use it. As a result, 95 percent of all reports are passed on for investigation.

But according to a state-mandated study of the hotline, at least 35 percent of those calls should have been screened out. As a result, the study concludes, workers have less time for each investigation, increasing the likelihood that serious abuse will be missed.

The state auditor has called the Missouri hotline, “the gateway to child protection.”¹¹⁹

The researcher who conducted the Florida study used similar terminology, but drew a crucial conclusion: “The hotline is supposed to be a gate,” he said. “They’ve got the gate rusted, stuck open.” As a result, cases pile up, creating a backlog of uncompleted investigations.

“I equate that to the game of playing Russian roulette. It’s just a matter of time before some child in the backlog pool is really badly injured.”¹²⁰

RECOMMENDATION #2: Before a call is accepted and referred for investigation, the caller must be able to demonstrate that s/he does, indeed, have

“reasonable cause to suspect” maltreatment.

The caller must be able to offer something more than a guess that a child really is being abused or neglected. To help hotline operators accomplish this goal:

RECOMMENDATION #3: A rational method must be established for screening hotline calls, with state law modified to allow this. This is, in fact, consistent with the auditor’s recommendation that the hotline adopt a “structured decision making” instrument.

However, the place that the auditor suggests the state go to obtain such an instrument tends to produce assessment materials with a bias against families. The state should hire a consultant with a track record for keeping children safe and families together, such as the Child Welfare Policy and Practice Group, run by the former head of the child welfare system in Alabama, to examine and possibly modify any proposed hotline screening instrument before adopting it.

RECOMMENDATION #4: Cases that do not meet the criteria for a child abuse or neglect report should not be forwarded to local offices. If a mandated reporter has a concern that does not meet even the minimal criteria for a report, the mandated reporter should be told about other resources in his or her community that could be used to help the family.

RECOMMENDATION #5: Anonymous calls should not be accepted.

Of all the sources of child abuse reports, anonymous reports consistently are the least reliable. They’re almost always wrong.

A study of every anonymous report received in The Bronx, New York, over a two year period found that only 12.4 percent met the incredibly low criteria for “substantiating” reports – and not one of those cases involved death or serious injury. The re-

searchers found that “one case was indicated for ‘diaper rash’ one case for welfare fraud, and two cases because the apartment was ‘dirty.’”¹²¹

Anonymous reporting should be replaced by *confidential* reporting. If someone who may have a grudge or someone who simply may be clueless wants to claim that a neighbor is abusing a child, that person should be required to give the hotline operator his or her name and phone number. That information still should be kept secret from the neighbor in almost all cases,¹²² but the hotline needs to know. That will immediately discourage false and trivial reports.

Of course, the objection to banning anonymous reports, and the objection to any kind of serious screening mechanism is, that some anonymous calls may be legitimate.

That’s true.

If you ban anonymous reports, some real cases might be missed – though anyone who is sincere and has genuine reason to suspect maltreatment should be comfortable with confidential reporting.

But more real cases are missed now by overloading the system. The more cases that cascade down upon investigators the less time they get for each one. So, as the auditor’s own report demonstrates, some get short shrift. It is far safer for children if cases are screened rationally by eliminating anonymous reports, rather than irrationally based on which file floats to the top of the pile on a caseworker’s desk, or which one is left in an automated retrieval system unread.

As the authors of the Bronx study put it, in recommending that anonymous reports be rejected: “The resources of child protective agencies are not limitless. The time and energy spent investigating false reports could better be given to more serious cases, and children may suffer less as a result.”¹²³

Reassessing family assessment

Missouri deserves credit for its pioneering effort to find a less adversarial approach to less serious cases of alleged maltreatment. But there are inherent flaws in the family assessment model as it exists today.

Whatever it once may have been, today the difference between an “investigation” and an “assessment” seems to be little more than the tone of voice used by the workers when they ask their questions.

In its current form the decision to treat a report as a full-scale investigation or a family assessment is made by a DFS worker in each county. But no matter what the process is called, it’s always DFS coming to the family’s door. Indeed, the same worker may be expected to wear her adversarial “investigator” hat on one case and her family-friendly “assessor” hat on the next. And DFS expects its workers to be equally vigilant and ask the same questions. Whatever once may have been, today the difference between an “investigation” and an “assessment” seems to be little more than the tone of voice used by the workers when they ask their questions.

Indeed, Missouri ranks third in the nation for taking away children from their homes even when the children are *not* listed as victims of child maltreatment, taking four times more such children than the na-

tional average,¹²⁴ suggesting that many “assessment” cases may lead to removals.

In some cases, that may mean the case was truly serious and should have been assigned to the investigation track in the first place. In other cases, it may mean the worker misunderstood her role.

RECOMMENDATION #6: The family assessment system should be radically restructured.

- **The decision concerning whether a report should be referred for an investigation or an assessment should be made by the worker who initially takes the call at the hotline, using the structured decision-making instrument discussed earlier.**

- **If the case is deemed suitable for assessment, it should not be referred to DFS at all. Rather it should be referred to a private agency that has contracted with DFS to do assessments and offer voluntary help to the family.**

This should not be done because a private agency is inherently better; rather it should be done to send a signal to the family that an investigation and an assessment truly are different processes.

- **The private agency worker must attempt to make face-to-face contact with the family, but the family must have the right to refuse.** The worker’s sole job is to offer voluntary help. If the private agency worker, as a result of what he or she sees or hears in the home has reasonable cause to suspect maltreatment then s/he should call the hotline and report it for an investigation. But the voluntary worker should not be a “mandated reporter.”

Without these limits, family assessment becomes an empty term; essentially an investigation in all but name.

Again, the risk is that the family will slam the door in the worker’s face, and serious abuse will take place behind that closed door.

But without these changes, the greater risk is that even more real abuse will be missed by overwhelmed DFS workers, even as families that simply need some voluntary help are too suspicious of DFS to accept it.

Other recommendations for reforming DFS

RECOMMENDATION #7: Make “hard services,” such as assistance with housing, jobs, and day care, readily available to ameliorate the worst effects of poverty and avoid the confusion of poverty with “neglect.”

Chief Justice Limbaugh suggested that a “typical” case involving lack of supervision is one in which “a six-year-old boy had been locked alone in the basement of a house in Cape Girardeau by the boy’s mother and her boyfriend, who then left the house for a weekend jaunt out of state.”¹²⁵

But it’s not.

A far more common “lack of supervision” case is one in which a single mother will be sanctioned off the welfare roles if she doesn’t show up for her make-work job, even if her child is sick. So she leaves the sick child home alone.

A parent who uses every dime she has to buy drugs and winds up on the streets is not providing adequate shelter for her children. But neither was Sha’Va Porter. And Sha’Va Porter is closer to the norm.

RECOMMENDATION #8: Be sure that Missouri’s Intensive In-Home Services program rigorously follows the model of the first such program, Homebuilders in Washington state; then expand it to serve every family that needs it.

IIS is Missouri’s version of Intensive Family Preservation Services. For

such a program to succeed, it must meet several criteria.

- The intervention begins when the family is in crisis. An IFPS intervention is designed for families whose children otherwise face imminent removal to foster care.

- Because it is a crisis intervention, the IFPS worker is at the family’s door within 24 hours of the initial referral.

- The intervention is short -- usually four to six weeks -- but extremely intense. Caseworkers have caseloads of no more than three, so though they usually are with a family for no more than six weeks, they can spend several hours at a time with that family -- often equivalent to a year of conventional “counseling.”

The end of the intervention does *not* mean the end of support for the family. The IFPS model requires that the family be linked to less intensive support after the intervention to maintain the gains made by the family.

- The worker spends her or his time in the family’s home, so she can see the family in action, and intervene as problems develop -- and so the family doesn’t have the added burden of going to the worker’s office. The worker gives his or her home phone number or pager number to the family and is on call 24-hours-a-day seven-days-a-week.

- The worker begins with the problems the family identifies, rather than patronizing the family and dismissing their concerns.

- Workers are trained in several different approaches to helping families, so they don’t become hostile to those families if their first attempts to help don’t work.

- But perhaps most important, family preservation workers combine traditional counseling and parent education with a strong emphasis on providing "hard" services to ameliorate the worst aspects of poverty.

Family preservation workers help families find day care and job training, and get whatever special educational help the children may require. They teach practical skills and help with financial problems. They even do windows. Faced with a family living in a dirty home, a family preservation worker will not lecture the parents or demand that they spend weeks in therapy to deal with the deep psychological trauma of which the dirty home is "obviously" just a symptom. The family preservation worker will roll up her or his sleeves and help with the cleaning.

It is extremely difficult to take a swing at "bad mothers" without the blow landing on their children. Therefore, if we really believe all the rhetoric about the needs of the children coming first, we must put those needs before anything – even our anger at their parents.

It is not clear if Missouri's Intensive In-Home Services program meets all of these criteria. It clearly falls short of one: Nearly a quarter of families are not seen within 24 hours in the 2000 fiscal year.¹²⁶ In fiscal year 2001 the data in the state's annual In-Home Services report are unclear.¹²⁷

As noted earlier, in the 2001 fiscal year, 276 Missouri children were placed in foster care simply because Intensive In-Home Services was not available as an alternative.¹²⁸

RECOMMENDATION #9: The state of Missouri should make substance abuse treatment available immediately for any parent who needs it.

Many of the cases that fall "between the extremes" in child welfare involve substance abuse. And that raises an obvious question: Why even bother with such parents? Why not just rush to terminate parental rights?

The answer is that we should not provide help for the sake of the parents. We should do it for their children.

In a University of Florida study of "crack babies" one group was placed in foster care, another with birth mothers able to care for them. After six months, the babies were tested using all the usual measures of infant development: rolling over, sitting up, reaching out. Consistently, the children placed with their birth mothers did better. For the foster children, the separation from their mothers was more toxic than the cocaine.¹²⁹

It is extremely difficult to take a swing at "bad mothers" without the blow landing on their children. Therefore, if we really believe all the rhetoric about the needs of the children coming first, we must put those needs before anything – even our anger at their parents.

This does not mean that addicts simply can be left alone to raise children. It does mean that the answer in most such cases is drug treatment.

Missouri, therefore, should have treatment available for every parent who needs it. In some cases that can be outpatient treatment. Where inpatient treatment is required it should be in places where parents can keep their children with them.

And since the custodial parent usually is the mother, it needs to be treatment geared to the needs of women, for whom the approach generally needs to be different than that used with men.

Until enough treatment is available, parents with children in foster care, or at risk of losing their children to foster care, should be “moved to the front of the line” for the programs that are available.

**RECOMMENDATION #10:
Missouri needs to implement Team Decisionmaking* statewide – both in letter and in spirit.**

Missouri already has “teams” in each county that are supposed to confer about each case. But if the Dominic James case is any indication, the teams lack key players and often don’t show up at game time.

Greene County’s “team” generally seems to consist only of birth parents, the juvenile officer, the DFS worker and the guardian ad litem appointed for the child. Foster parents sometimes are included as well. Others may take part, generally if they were part of the initial investigation¹³⁰ That is not nearly enough.

In true Team Decisionmaking, anyone and everyone who can help a child is gathered together, preferably before placement is required, and certainly no more than 72 hours after. That includes the child welfare agency, the birth parents, the guardian ad litem, the child, if s/he is old enough and comfortable with the process, and sometimes the foster parents. But it also includes extended family, friends, neighbors, clergy and others.

The entire group draws up a safety plan for the child; with DFS having final approval.

The program now exists on an experimental basis in St. Louis County, using the Family Group Conferencing model, and in theory, full-scale team meetings are supposed to take place statewide. But it appears that in much of Missouri, the much skimpier team meetings are used, and even they don’t always happen.

The case of Dominic James would have been perfect for Team Decision-making.

In that case, after Dominic was taken from his mother because she allegedly was drunk and belligerent, a plan might have been drawn up in which the child would be returned home and a neighbor, or member of a community group or the family's minister might stop by every day for a couple of weeks to make sure everything was o.k. Or a community agency might have found housing for Dominic’s father, so he could take the child. Or someone else sitting around the table, a friend or a relative, might have agreed to take Dominic in. Whatever else the family might need would be discussed around the table, then the DFS worker would draw up a plan to provide it. But there was no real “team” working for Dominic, only the much smaller group that regularly meets in Missouri. And in the case of Dominic James, the initial meeting of even this small group was delayed.

Worse, DFS spokeswoman Deb Hendricks said that even had the meeting been held on time, it “would not have had a significant impact on the outcome, I don’t believe.”¹³¹ That suggests an agency in which many people are clueless about the real purpose and the real value of Team Decisionmaking.

And it appears that the Dominic James case is not unusual. The investigation

* The practice actually has several names, including Team Decisionmaking, Family Group Conferencing, Family Team Meetings, and Family Group Decisionmaking. The differences among them are small, and for convenience, the term Team Decisionmaking is used here.

of the Greene County system concluded that “the family support team is in many instances nonexistent.”¹³²

In addition, key players in Greene County seem to view the team process as a way for the professionals to dictate to the birth parents. If the professionals don’t agree on what marching orders to issue, they go to court.¹³³ In fact, Team Decisionmaking is a collaborative process in which the family, extended family and other helpers should work together with DFS to draw up a workable plan.

RECOMMENDATION #11: Two promising national initiatives, now underway in St. Louis City, should be expanded statewide.

Family to Family recruits foster parents from the neighborhoods foster children come from, so if children must be taken from their parents, they at least can visit those parents easily, and they don’t have to lose their friends or change schools.

The foster parents are trained to work as mentors to the birth parents, instead of seeing themselves as adversaries.

Team Decisionmaking also is an important part of Family to Family.

Family to Family has been evaluated by a team from the University of North Carolina. They found that, where Family to Family was implemented, fewer children were taken away, placements were shorter, and there was less bouncing of children from foster home to foster home.

Most important: Even though cases in which children *were* taken away and placed in foster care were more difficult, there was no increase in the recidivism rate, that is, the rate at which children returned home had to be placed in foster care again, and in some locations recidivism decreased. That means all this positive change was accomplished while making children safer.¹³⁴

The **Community Partnership** model is similar. At the heart of the partnership is mobilizing residents of some of the poorest communities in the United States to support each other, watch out for each other, and build trust among themselves and with child protective services.

In Jacksonville, Florida, for example, the partnership brought residents together by first showing that it could help them. Residents got concrete help to ameliorate the worst problems of poverty; then they could help each other.

So when a mother left her young children home alone and was arrested for child neglect, there already were neighbors taking in the children by the time police arrived. Partnership staff knew the neighbors, and they knew the people at the state child welfare agency, so they could persuade the agency that the children would be safe this way – and the neighbors would keep an eye on the mother and help her to keep the family together when she got out of jail.

In another case, a family in a housing project was about to be evicted because they couldn’t keep their house clean.

“The two were not friends,” according to a report on the partnership, “but the neighbor said she hated to see a family thrown out on the street.” So she and her son offered to help the mother clean her apartment.¹³⁵

When the Jacksonville partnership used its version of Team Decisionmaking, reabuse of children left in their own homes dropped by 23 percent.¹³⁶

Under a Community Partnership or Family to Family model, DFS workers might be based at a community center in a poor neighborhood. They would become a part of the life of the community, meeting residents, taking part in local activities, and finding out about the wide array of formal and informal supports that exist in even the poorest neighborhoods. Local community

groups and churches would have a chance to build bridges and overcome their often understandable suspicion of DFS.

In a Community Partnership, the neighborhood centers also become “one-stop shopping” centers, where a wide array of supportive services are made available to families in order to help them keep their children out of foster care.

RECOMMENDATION #12: raise the pay for DFS caseworkers.

As we said at the start of this report, most DFS workers are dedicated, well-meaning people who are underprepared, undertrained and terribly overwhelmed. Their decisions are literally matters of life and death. So pay them accordingly. Don’t just give them a token raise. Let Missouri be a trendsetter and pay its child welfare workers more than anyplace else in the country. Then DFS can set standards for training and experience commensurate with that pay.

Spending more on the caseworkers DFS already has would be a better investment of scarce funds than hiring new workers. Caseloads do need to be cut – but the way to do that is to stop taking away so many children who could remain safely in their own homes.

CHANGING THE COURTS:

The myth of due process

The best way to tell when anyone in a child protection system is being disingenuous is if they start talking about “due process” as if it really exists. If they start saying “we can’t take away children by ourselves” or “everything we do is approved by the court” then you may as well forget about a serious dialogue – because the people telling you this know that in every meaningful way, it’s not true.

Yes, a DFS worker can’t literally take away a child on the spot. But all she has to do is call a juvenile officer or a police officer to do it for her. The first chance a parent has to fight to get his or her child back is at a hearing that is supposed to take place within 72 hours. So for up to three days (more if a weekend or holiday is coming up), DFS has a free shot at any child in the state.

But the parent will get that 72-hour hearing only if he or she knows to ask for it, and sometimes not even then. Indeed, it appears the hearings don’t happen too often.

The best way to tell when anyone in a child protection system is being disingenuous is if they start talking about “due process” as if it really exists.

In 1997, Missouri initiated a “Juvenile Court Improvement Project” (JCIP) in two judicial circuits, Circuit 23 (Jefferson County) and Circuit 2 (Adair, Knox and Lewis Counties). Under the pilot project, these preliminary hearings became automatic in almost all cases – though sometimes it took up to ten days instead of three. But before the pilot, in Circuit 2 they took place in only 46 percent of cases – in Circuit 23, in less than ten percent of cases.¹³⁷

That suggests that in all the still “unimproved” counties, DFS has a “free shot” at any child for at least 30 days, or possibly longer, until there is actually a hearing where parents get into the courtroom.

Even if the 72-hour hearing is held, the standard of proof DFS and the juvenile

office must meet is almost non-existent. They need show only “probable cause to believe” maltreatment occurred. As with the standard for “substantiating” maltreatment to list someone in the state’s central register, this standard is extremely low. Only at later hearings does the standard rise even to “clear, cogent and convincing” evidence – and even that standard is lower than the standard required to convict a child murderer in a criminal trial.

“[Jefferson] County provided no resources for attorneys for indigent parents. The judge sought volunteers ... but most such requests were reportedly not able to be met.”

--The Missouri Juvenile Court Improvement Project: Final Report

So it’s no wonder that, according to an evaluation of the court improvement project, it appears that when the 72-hour hearings are held, the real purpose is not to determine if custody is really necessary – that, apparently is simply assumed. Rather, court and DFS officials in the improvement project circuits said they liked having the hearings because it showed the parents how much trouble they were in, and “changes on their part would be required within a limited timeframe in order to have the child returned to them.”¹³⁸

Whenever the parent finally gets to court, she is likely to feel lonely. On one side, there will be a lawyer from the juvenile office, who has had plenty of time to read up on the case and prepare a presentation. And the juvenile office is part of the court system itself. That means, unlike any other state we

know of, the lawyer who, in effect, acts as prosecutor is an employee of the same branch of government as the judge, creating the potential for conflict of interest.

Further conflict may occur if the same office also funds the Guardians ad litem who are appointed to represent the “best interests” of children in abuse and neglect proceedings.

On the other side is usually a bewildered, impoverished parent who, if she has a lawyer at all, may have just met him in the hall five minutes before the hearing. That lawyer is himself probably a terribly overwhelmed legal aid attorney, or perhaps a private attorney working on the case for minimal compensation, or maybe a volunteer.

Or maybe not even that.

According to the JCIP evaluation, in Jefferson County, “the county provided no resources for attorneys for indigent parents. The judge sought volunteers ... but most such requests were reportedly not able to be met. Some interviewees indicated that, as a result, a number of parents who could not afford counsel appeared not to be able to adequately understand the proceedings, and that when they tried to represent themselves, they often delayed the hearings by their mistakes.”¹³⁹

There are far more serious consequences for families if they lack representation than a delay in a hearing because of “their mistakes.” The fact that this apparently is the only consequence reported to the people who evaluated the JCIP pilot project says a lot about the mindset in Jefferson County.

Presiding over all this is a judge who knows that, if she sends the child back home and something goes wrong, her career on the bench probably is over. But if she holds the child in foster care indefinitely, the child may suffer enormously – but the judge almost always is safe.

In New York City, judges actually admitted to a panel of national experts that they regularly hold children in foster care even when they don't think the city's child welfare agency has made a good case – because they are so afraid of what the media will do to them if they send a child home and something goes wrong.¹⁴⁰

The fact is, if DFS and the juvenile office want to hold a child in foster care, judges will almost never disagree; they are far more prone to wield rubber-stamps than gavels.

RECOMMENDATION #13: Whenever a child is taken into custody by a juvenile officer or anyone else so empowered, whether a court-order was obtained first or not, there must be a hearing, with full notice to parents so they can take part, within 48 hours, with no exceptions for weekends or holidays.

Police and fire stations don't close at night and on weekends, neither do hospital emergency rooms. The removal of a child is just as urgent, and a court should be available seven-days-a-week to step in and take a serious look at whether the removal was necessary.

RECOMMENDATION #14: At this hearing and all subsequent hearings, the standard of proof that the state must meet shall be at least “clear and convincing.” Again, this is still a lower standard than is used to keep a murderer of children off the streets. Before DFS or the juvenile office can tear a child from everyone he knows and loves, they should be able to meet a standard higher than “probable cause to believe” which is little more than a hunch.

RECOMMENDATION #15: From the moment a child is removed until the first hearing at which all sides are represented, the juvenile office shall be responsible for arranging daily visits, unless it can show, by clear and convincing evi-

dence, that this would cause severe emotional harm to the child.

This would help ease the emotional trauma done to the overwhelming majority of children by the act of removal itself. But it also serves another purpose.

There are very few “front door” methods to prevent wrongful removal of children. This is a way of getting at the problem through the “back door.”

This idea was first proposed as part of a very good model law written by Prof. Michael Wald of Stanford University Law School in 1976, and revised by an American Bar Association Committee in 1981.

A requirement for daily visits, unless the juvenile office can show by clear and convincing evidence that this would cause severe and lasting emotional trauma to the child, (physical trauma can be prevented by having the visits supervised) will help *ease* the trauma of the removal itself.

The juvenile office will scream about how burdensome it is. But that's the whole idea. If a juvenile officer knows that taking a child on his or her own authority will be followed by a requirement that he or she set up several days worth of visits, that officer might be more careful about who is taken away.

The reason for placing this burden on the juvenile office instead of DFS is described in the section about the juvenile office below later in this report.

RECOMMENDATION #16: All indigent parents shall have the right to free legal representation from the moment a child is taken from them. That representation shall be provided by an “institutional provider” such as a legal aid society or public defender's office, and that provider shall be funded sufficiently to provide meaningful representation.

It is difficult to understand how anyone can claim with a straight face that due process exists for families, if families

have no meaningful representation in court. And meaningful representation means more than a warm body in the courtroom. It means someone with at least as much time and resources as are available to DFS and the juvenile office; otherwise the deck is

stacked, the judge can hear no reasoned argument against removal, and the children suffer.

Leveling the playing field in Washington State

In Pierce County, Washington, the judge in charge of the county's juvenile courts was dismayed at the escalating rate of terminations of parental rights – knowing that he was dooming some of the children to a miserable existence in foster care.

So he persuaded the legislature to provide enough money for defense attorneys to have resources equal to those of the Attorney General's office, which represents the state child welfare agency in juvenile court. The result: successful reunification of families increased by more than 50 percent.

And that's not because lawyers "got their clients" off.

Where the parents are innocent, lawyers have time to prove it. Where there is a problem in the home that must be corrected, the lawyers have time to sit down with the parents, explain early on what they are up against and guide them through the process of making whatever changes are needed.

Since 2000, of 144 cases in the program in which families have been reunified, not one has been brought back to court.

"These children aren't coming back," says Washington State Supreme Court Justice Bobbie Bridge, a supporter of the program, "and we do get them back when we make bad reunification decisions."

The National Council of Juvenile and Family Court Judges is publicizing the results, and even the State Attorney General, who has to face the better-prepared lawyers, supports the project and wants it expanded.¹⁴¹

Missouri's fifth wheel

The problems discussed in the previous section are common in much of the country; but in Missouri, there is an extra problem that may be unique: The juvenile office.

Although there are some communities in which child protection investigations are done solely by law enforcement agencies, typically those

agencies hire civilian investigators to make removal decisions, and the child welfare agency is not involved at all. There is one "front door" to the system.

And even in cases where police don't normally do child protective investigations, but they happen to be first on the scene and find children in danger, they typically call the child welfare agency to come and join them and decide whether children need to be

removed from the home. Again, one front door.

Missouri may be the only child protection system in America with two front doors.

As in all states, citizens are encouraged to call the child welfare agency if they have “reasonable cause to suspect” maltreatment, and some professionals are required to report.

But in Missouri, citizens can simply call their county juvenile office instead –or as well. (Mandated reporters must call DFS, but they also can call the juvenile office).

Thus, while it is not clear how often it happens, it is possible for DFS and the juvenile office to wind up doing duplicate investigations of the same case. And even if the DFS worker does not think the child needs to be removed, if the juvenile officer disagrees, the juvenile officer can take the child on the spot.

Even when both organizations agree on removal, parents may wind up whipsawed between conflicting requirements. They may do everything DFS asks, only to go to court and find that the juvenile office isn’t satisfied – or vice versa.

And the fact that two entities that apparently don’t always get along must sign off on plans developed through Team Decisionmaking before they can take effect, is likely to further impede the Team Decisionmaking process.

And it is the juvenile office, not DFS, that actually performs the role equivalent to a prosecutor in a criminal trial. Thus, if DFS thinks a child should return home and the juvenile office doesn’t, (or vice versa) DFS sometimes may finally have something in common with the parents: The agency may not be adequately represented in court. DFS does have its own lawyers and they do appear in some, but reportedly not all, cases.

In addition, as noted earlier, the juvenile office is a part of the court system, which means that in any conflict between the juvenile office and an agency of another branch of government, the judge might be tempted to favor the “home team.”

The situation is like a criminal court in which the judge decides to supplant the police and hire someone to do an investigation. Then he hires a colleague of the investigator to replace the district attorney.

It also adds to the cost of the entire process. There is nothing that the juvenile office does that someone else – either DFS or the guardian ad litem -- isn’t supposed to be doing already, aside from prosecuting the case. Indeed some juvenile officers are former DFS employees.

RECOMMENDATION #17: The juvenile office should be eliminated from all child abuse and neglect investigations and court proceedings. The prosecutorial functions now handled by the juvenile office should be turned over to lawyers for DFS.

To those who may say the juvenile office sometimes does a better job than DFS, we reply: Use the money saved through this recommendation to improve DFS.

Opening courts and records

RECOMMENDATION #18: All court hearings in child maltreatment cases and almost all documents should be subject to a “rebuttable presumption” of openness.

The public should be allowed to attend all hearings except the very first “72-hour” hearing (which, under a previous recommendation would become a 48-hour hearing). Documents would remain closed until the next hearing.

At that time they would be opened unless the lawyer for the parents or the

guardian ad litem for the child could persuade the judge, by clear and convincing evidence, that opening a given record would cause severe emotional damage to a child.

The judge then would keep closed only the minimum amount of material needed to avoid the severe damage. Portions of hearings could be closed for the same reason, with the party seeking closure required to meet the same standard of proof.

As noted above, the people who work for DHS are not evil. But even the best of us would have trouble coping with nearly unlimited power and no accountability. One caseworker in another state allegedly told some parents: "I have the power of God." It's alarming if he said it. But what's even more alarming is: It's true. Caseworkers *do* have the power of God.

To give a young, inexperienced worker the power of God, send her out on what she is convinced is a Godly mission to rescue innocent children from the scum of the earth and then expect her to exercise *self-restraint* is more than can be expected of most human beings. Rarely is the power of God accompanied by the wisdom of Solomon.

The power must be checked by accountability. And accountability is not possible in secret.

It's not supposed to work that way in a democracy. That is why it is so urgent that all court hearings and almost all records in child welfare cases be presumed open.

An exception would be made to the presumption of openness for portions of documents that name people who reported child abuse in confidence. Though even then, if a parent claims to be a victim of harassment, that parent should be allowed to ask a judge to review the record and, if the judge agrees there has been harassment, open this record as well.

Only the lawyer for a parent and the guardian ad litem for a child should be allowed to request secrecy. Neither DFS nor the juvenile office should even be allowed to *ask* for it. DFS and the juvenile office have no interest in secrecy other than as a way to cover up their failings. If secrecy is truly needed to protect a child, that's what the guardian ad litem is there to ask for.

This, of course, goes much farther than existing Missouri law, which depending on interpretation, permits or requires the opening of records, with some exceptions, only after a fatality or near fatality.

To give a young, inexperienced worker the power of God, send her out on what she is convinced is a Godly mission to rescue innocent children from the scum of the earth and then expect her to exercise *self-restraint* is more than can be expected of most human beings. Rarely is the power of God accompanied by the wisdom of Solomon.

While that is better than nothing, it has an unintended consequence: Because, as the state auditor is quick to point out, in raw numbers, more children die in their own homes than in substitute care, this limited degree of openness reinforces the misperception that the system errs only in one direction, leaving children in dangerous homes.

The hundreds of families who say their children were wrongfully removed still

have no way to prove it; they remain thwarted by the “veto of silence.”

They can tell their stories to reporters, but even if they have some limited documentation, the reporters may decline to write about the case, rather than risk the possibility that people at DFS are telling the truth when they say, as they so often do, “Oh, there’s really so much more to it, and we wish we could tell you, but our hands are tied: Confidentiality, you know.”

“So far so good on the media. The TV stations haven’t picked it up yet.”

--E-mail from a DFS hotline worker concerning the Dominic James case.

In fact, many journalists have found that when child welfare agencies really have a good case, they leak the information. But this veto of silence often is effective in stifling the stories of families whose children have been wrongfully taken.

At a minimum, Missouri should adopt New York’s law which allows, but, unfortunately, does not require, child welfare agencies to provide information when a parent has come forward to say his or her child was wrongfully removed. (The text of this law can be found in Appendix C).

The urgent need for more openness was reinforced by DFS’ behavior in the Dominic James case.

First, DFS claimed that all procedures were followed. The former Assistant Deputy Director for Children’s Services declared that “I don’t see any policies or procedures we did have or didn’t have that would have prevented this.”¹⁴²

Then, in response to a formal freedom of information request from the *Springfield News-Leader*, DFS released a summary

of its handling of the case that acknowledged that two policies were not, in fact, followed. But, as noted earlier, a DFS spokeswoman said that in the case of at least one of those failures, the delay in holding the team meeting, she thought it wouldn’t have made any difference.

All the while, the juvenile office, Dominic’s guardian ad litem and Dominic’s father were saying they had asked that Dominic be removed from the foster home where he ultimately died, and DFS was saying there had been no such request – only a discussion about looking into such a move.

Then, after the *News-Leader* sued, DFS released hundreds of additional pages, but large sections of the documents were blacked out.

The records supported the claim of the juvenile officer and the GAL that they had sought to have Dominic removed – and thought all sides had agreed to it. Also among the documents, an e-mail, written while Dominic was on the verge of death, in which a DFS hotline worker tells her superiors: “So far so good on the media. The TV stations haven’t picked it up yet.”¹⁴³

And finally, DFS “discovered” the proverbial “smoking memo” – an e-mail from a DFS supervisor stating explicitly that yes, the juvenile officer and the GAL did want Dominic moved – but DFS would refuse to go along.

Frontline DFS workers in Greene County, furious that they had defended superiors who apparently deceived them and the public, staged a protest in front of their own office.¹⁴⁴

In addition to all the other reasons for opening court hearings and records, the case of Dominic James reveals one more: Complete openness is necessary because DFS has proven that it simply cannot be trusted.

The argument against opening hearings and records is that it would embarrass children.

That argument fails on several counts:

- The alleged potential for “trauma” does not explain why information is kept secret even after a child has died, as in the Dominic James case.

- In the overwhelming majority of cases there are no graphic details to report. Most cases involve “neglect.” A child will not be testifying about being beaten or raped because that’s not the accusation.

- The most traumatic cases are likely to involve not only child protection proceedings but criminal cases as well. These hearings already are public. And when parents who feel they have been wronged file their own civil suits, trials and records in those cases are public as well. Yet we have never seen nor heard a single account of a child saying that she or he was traumatized by the fact that such a trial was public. Nor do we know of any adult coming forward years after the fact to complain of such trauma.

- Ten states have opened child protection proceedings to the press and the public. Two more let in reporters only. In every one of these states, the same fears were expressed initially as in Missouri. But a comprehensive nationwide examination by the *Pittsburgh Post-Gazette* found that none of the problems materialized. Indeed, over and over, one-time critics became converts.¹⁴⁵

“Everyone complains about everything in New York,” says Judith Kaye, chief judge of that state’s highest court, the Court of Appeals. But, she says, in all the years since she ordered all of the state’s family courts opened, “we’ve had no complaints about this.”

Her deputy, Chief Administrative Judge Jonathan Lippman says “It has been 100 percent positive with no negatives ...

Our worst critics will say it was the best thing we ever did. Their fears were unfounded ... I wish other states would do it.”

One of those who initially opposed the change was Michael Gage, former administrative judge of the New York City family court. But now, Gage says, “I think it worked. From my view, it worked remarkably well.”

Another opponent was Jane Spinak, then head of the Juvenile Rights Division of the Legal Aid Society in New York City. But, Spinak says, “the consensus now is that [the court] is better open than when it was closed.”

Once the courts were opened, reporters saw the shabby conditions families had to endure. That led to funding for repairs. It’s also helped increase pressure to raise fees paid to the lawyers who defend impoverished parents – at \$40 an hour in court and \$25 an hour out of court, they’re the second lowest in the country.

And the head of New York City’s child welfare agency when the courts were opened, Nicholas Scopetta, said opening up the process helped him improve his agency. “We have not experienced a downside,” he said.¹⁴⁶

New York is not alone. In Indianapolis, Judge James Payne made an exception to his state’s closed courts policy for a national news program. He says well-run court systems can only benefit from openness. “I think we do a lot of good work in our system, and people don’t know about it ... because we keep the hearings closed.”

Payne argues that it is disingenuous for some child welfare agencies to demand closed hearings to avoid “embarrassing” children and then post the children’s pictures, and, sometimes, intimate details about their problems, on websites promoting their adoption.

In Illinois, the press has been allowed into juvenile court for more than a

century, and the head of the state's child welfare agency, Jess McDonald, says the public should be allowed in, too. "We will only make mistakes if we are hidden in the back room," McDonald says.

The reform-minded head of Allegheny County, Pennsylvania's child welfare system, Marc Cherna, also supports opening hearings, which now are closed in that state. And he supported the county's judges when they agreed to give regular access to a reporter from the *Post-Gazette*.

In Oregon, hearings in abuse and neglect cases have been open for more than 20 years. "The appearance of being treated fairly is compromised when things are done in secret," says Oregon Circuit Judge Daniel Murphy. "People are suspicious of anything done secretly."

And in Florida, the former director of the Children First project at Nova Southeastern University, Chris Zawisza, supports the state's open courts: "The newspapers in Florida have played an exceptional watchdog function and caused many significant changes in child welfare," Zawisza says, "and that is because they have had access to this stuff."

"Sunshine is good for children."

--Judith Kaye, Chief Judge,
New York State Court of Appeals

But perhaps most revealing is this: Of all the states to open proceedings, not one has closed them again. For example, after three years of experimenting in 12 counties, the Minnesota Supreme Court ordered open courts in child maltreatment cases statewide.¹⁴⁷ Surely if the experiment had been traumatizing children, it never would have been expanded.

And that shouldn't come as a surprise. Cases likely to be covered by the media are likely to fall into these categories:

- Cases where the child has been killed.

- Cases where the alleged abuse is so brutal that the details already are public knowledge because of police reports. These cases also are likely to be the subject of public, criminal proceedings.

- Overview stories about court systems, in which case examples can be used without revealing names.

No state court judge in America has a better reputation for concern about the welfare of children than Judge Kaye in New York. She stands by what she said when the courts first were opened:

"Sunshine is good for children."

Some opponents of opening court hearings have claimed that states will lose federal aid. But the requirements of federal law are a matter of dispute.

We are aware of no state with open courts that ever has actually been penalized. And the federal Department of Health and Human Services agreed not to withhold funds after it discovered how many states had gone ahead and opened their hearings. In fact, the only thing HHS has done is ask proponents to get federal law clarified.¹⁴⁸

Of course it is impossible to guarantee that no child ever would be embarrassed if hearings and case records were opened. But the embarrassment is far outweighed by the improvement Missourians would see in how the courts are run.

We all do better when someone is looking over our shoulder. We think things through a bit more. We're better prepared. We explore more options.

The chair of the commission on Children's Justice, former Chief Justice John Holstein has said "I have a theory that I'm a much better judge on the record than off, but

I'm not sure it's always good for the children."¹⁴⁹

Justice Holstein, when you're a better judge, it's good for the children.

Had the hearings and records in the case of Dominic James been public, he might someday have been embarrassed. But perhaps open hearings would have prompted everyone to think more carefully. Perhaps they would have led to alternatives to taking Dominic away. Or perhaps they would have led to placement with relatives. Perhaps had the hearings and the records been open, Dominic James might have lived long enough to blush.

RECOMMENDATION #19: In all places where it appears, the phrase "best interests of the child" should be replaced with the phrase "least detrimental alternative."

Currently, almost all state laws involving custody of children are liberally sprinkled with the phrase "best interests of the child."

But that is a phrase filled with hubris. It says we are wise enough always to know what is best and capable always of acting on what we know. In fact, those are dangerous assumptions that can lead us to try to fix what isn't broken or make worse what is.

Thirty years ago, three of the leading child welfare scholars of the 20th Century, Albert Solnit, Joseph Goldstein, and Anna Freud, proposed an alternative phrase. They said "best interests of the child" should be replaced with "least detrimental alternative."¹⁵⁰

"Least detrimental alternative" is a humble phrase. It recognizes that whenever we intervene in family life we do harm. Sometimes we must intervene anyway, because intervening is *less* harmful than not intervening. But whenever we step in, harm is done.

The phrase "least detrimental alternative" is a constant reminder that we must always balance the harm that we may think a family is doing against the harm of intervening. It is exactly the shot of humility that every child welfare system needs.

"ASFA made me do it"

Some may argue that the proposals in this document are incompatible with a federal law, the so-called "Adoption and Safe Families Act." Some in DFS or juvenile offices may claim they are forced to destroy families because of ASFA.

"ASFA made me do it" is the child welfare equivalent of "the dog ate my homework."

On the contrary. ASFA's proponents claim that the law was designed to promote speedy permanency for children. The recommendations in this report do just that. What they do not do is use permanency as simply a euphemism for adoption.

These recommendations recognize that for most children most of the time, the best route to a safe, permanent home is by leaving the child in his own home or returning him or her there as quickly as possible.

And though ASFA encourages the states to do many bad things, it generally does not require those things.

For example, ASFA requires states to seek termination of parental rights for children who have been in foster care for 15 of the previous 22 months – in some cases. But there are many exceptions, including kinship placements and cases in which DFS has not, in fact, provided services needed to reunify the family when that could have been done safely.

Furthermore, though ASFA requires child welfare agencies to ask for termination in some cases, it does not require judges to grant the request.

“ASFA made me do it” is the child welfare equivalent of “the dog ate my homework.”

The cost of change

We make these recommendations at a time when Missouri, like most states, is facing severe fiscal problems. Though saving money is not the goal of these recommendations, it is a beneficial side effect of many of them.

The argument has been made repeatedly that the answer to Missouri’s child welfare problems is to spend more.

In fact, that is part of the answer.

But Missouri will never solve its child welfare problems just by spending more. It also needs to spend smarter.

A very rough estimate, based on data compiled by the Urban Institute, suggests that, in Fiscal Year 2000, Missouri spent \$336 on child welfare for every child in the state – the 12th highest rate in the nation. The national average was \$277.¹⁵¹

Missourians should not take too much comfort in these figures, however. Just as the national average for the proportion of children in foster care is too high, the national average for spending is too low. And, of course, there have been cuts in child welfare spending since 2000.

According to State Rep. Roy Holand, a Springfield Republican, Missouri’s combined tax burden is the 45th lowest in the country. Rep. Holand writes that “a discussion of taxation is appropriate when we are faced with such a large gap in revenue and the fat has all been trimmed.”¹⁵²

Those who are unwilling to take even a few more dollars out of their pockets in taxes to help their state’s most vulnerable

children, should at least have the decency to spare us the pious rhetoric and cloying clichés about “our children are our future,” etc.

And those who would deny health insurance to a needy child or to that child’s impoverished parents – in a state which reportedly already has the lowest Medicaid eligibility levels in the country¹⁵³ -- those who would slash payments to grandparents taking in their grandchildren and those who would cut funds for home visiting programs like Nurses for Newborns in St. Louis are indeed committing what the *News-Leader* aptly described as “legislative child abuse.”

One Missouri legislator has argued that “You don’t abuse the power you have and then ask for more money. Uh-uh. That’s not the way it works. The fact is if they have more money, more social workers, they’ll just take away more children.”¹⁵⁴

This reasoning is flawed on several grounds.

Those who think that you can control the excesses of agencies like DFS by trying to starve them to death are kidding themselves. Child removal will be the last thing to go – everything else will be cut first.

First, some children truly are endangered by their parents, and providing sufficient resources to find and rescue these children is as important as adequately funding the police department. Police departments sometimes abuse their power; that is a reason to reform them, not starve them. The same is true for child protective services.

While it is true that hiring more workers may indeed have a “net-widening” effect, that is not an argument against spending more money; that’s an argument against spending more money to hire more workers. Missouri should spend more money on raises for the workers it already has, it should spend more on safe, proven programs to keep families together, and it should spend more on due process protections for families – so more workers won’t be necessary.

Those who think that you can control the excesses of agencies like DFS by trying to starve them to death are kidding themselves. Child removal will be the last thing to go – everything else will be cut first.

It is true, however, that *just* spending more won’t work. We know that because Florida tried it. That state has doubled its child welfare spending in the past four years. But all the new money went to hire more hotline operators to pass more false reports and trivial cases on to more investigators who took away more children and put them into more foster homes.

So for all the additional spending, Florida simply wound up with the same lousy system only bigger.

Had Florida put all that money into safe, proven programs to keep more families together, it could have been on the way to building one of the best child welfare systems in the country, instead of having one of the worst.

Similarly, Missouri spends at a comparatively high rate, yet, as the state auditor points out, salaries for caseworkers are among the nation’s lowest,¹⁵⁵ and a large portion of the foster care budget is poured into group homes and modern-day orphanages.

Missouri must spend more – but it must also put the money where it will do good instead of harm.

Fortunately, almost all of the recommendations in this report are cost neutral, and many save money. For example, nationwide, placing one child in foster care for a year typically costs about \$15,000.¹⁵⁶ Group homes and institutions cost far more. Keeping an entire family together by using an Intensive Family Preservation Services intervention typically costs about \$5,000. For every child kept out of foster care for a year thanks to such an intervention, government saves about \$10,000, typically more.¹⁵⁷

And both Constance Porter and Dominic James could have been helped with services that cost even less than an IFPS intervention.

It is true that the savings to states are reduced by the perverse federal financial incentives discussed earlier. But Missouri worsened this problem by failing to aggressively seek “waivers” that have allowed other states to divert some of their federal foster care funds to prevention.

Some recommendations, such as more drug treatment and increasing the pay of caseworkers, do require increased spending.

But at least some of that money can be found by reducing the use of the most expensive and least effective option: Institutionalization.

And if, in fact, some of these recommendations require raising taxes, aren’t the children worth it?

RECOMMENDATION #20: A final recommendation for the “Show-Me State:” See for yourselves.

The states, it is said, are laboratories of democracy. But that only works if people are willing to read the lab results. We have suggested four communities that have made significant progress in reforming child welfare: The cities of New York and Pittsburgh and the states of Alabama and Illinois.

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A delegation of Missourians concerned about child welfare has visited Illinois. But we are aware of no such delegations visiting the other three.

The members of the Commission on Children's Justice, other legislators, representatives of DFS and county juvenile

offices should take a "best practices" tour, and see what really works in child welfare.

Then put the lessons to work in Missouri.

They will find that those who succeeded took the road less traveled by, and that made all the difference.

NOTES:

- ¹ Information about the Dominic James case comes from Missouri Division of Family Services, *Findings of Fact relating to the case of Dominic James*, September 25, 2002, and the following stories by Laura Bauer in the *Springfield News Leader*: "2-year-old dies, shaking suspected," August 22, 2002, "DFS to release Dominic Files," September 25, 2002, "DFS: First report on Dominic inaccurate," September 26, 2002. Also: Connie Farrow, "Public gives input on foster care program," Associated Press, November 12, 2002, and David A. Lieb, "Father of deceased son testifies for changes in foster care system," Associated Press, February 25, 2003.
- ² Information on the Constance Porter case comes from the following stories in the *Kansas City Star*: Lee Hill Kavanaugh, "Pain, doubts linger in foster care death," January 23, 2003, p.B1; Glenn E. Rice, "Former foster mother sentenced to five years' probation in girl's death," January 24, 2003, Benita Y. Williams, "Foster mother charged in death," May 25, 2001, p.B1, Grace Hobson, Donna McGuire and Mark Morris, "Privacy concerns stall bill to open records after child abuse deaths," *Kansas City Star*, April 20, 2003.
- ³ A New York study found outright falsification in at least one in five case records. (City of New York, Office of the Comptroller, *Now We Are Four: Boarder Babies Growing Up in Foster Care, A Follow-Up Study*, December, 1989, p.18). Children's Rights Inc., which has sued child welfare systems all over the country, has alleged widespread falsification of records in New Jersey and Wisconsin in order to make their child welfare agencies look better. More often, errors are the result of misunderstandings and misinterpretation, which is why all interviews in DFS investigations should be tape recorded.
- ⁴ Donna McGuire, "Files reveal observations before deaths," *Kansas City Star*, October 6, 2000, Barbara Shelly, "Reaction to report is surprising," *Kansas City Star*, December 30, 2000.
- ⁵ Editorial, "Case reminds why DFS was created," *Springfield News-Leader*, December 5, 2002.
- ⁶ Editorial, "Foster care: At last, some movement," *St. Louis Post-Dispatch*, February 1, 2003.
- ⁷ Matthew Franck, "Most kids dying from abuse are known to state system," *St. Louis Post-Dispatch*, February 3, 2003.
- ⁸ 1991: Federal data compiled at www.childwelfare.com, see "Foster care report cards" and click on Missouri. 2002 data: State of Missouri, Division of Family Services, *Children's Services Management Report*, May, 2002.
- ⁹ Data from the Administration for Children and Families, U.S. Department of Health and Human Services show that, as of September 30, 2000, there were, on average seven children per thousand in foster care nationwide. For Missouri, the figure was 9.2 per thousand. DFS gives a lower number of foster children for this time than the HHS figures, but even using DFS' numbers, the proportion for Missouri is 8.4 per thousand – still above the national average, and it continued to rise until May, 2002.
- ¹⁰ Unless otherwise noted, all data on the number of children in Missouri, in Greene County and in St. Louis City come from the following Division of Family Services reports: The Annual *Missouri Children's Services Reports* from fiscal years 1997 through 2001, and monthly *Children's Services Management Reports* from May 2002 through January, 2003. They are available online at: http://www.dss.state.mo.us/rr_reports.htm Figures for child poverty are census data compiled by the Annie E. Casey Foundation Kids Count project, available online at www.kidscount.org.
- ¹¹ Nationwide, 291,000 children entered foster care in 2000 according to the federal government. U.S. Dept. of Health and Human Services, Administration for Children and Families, *The AFCARS Report, #7*, available online at <http://www.acf.hhs.gov/programs/cb/publications/afcars/report7.htm>
- ¹² New York City: Administration for Children's Services *ACS Update, December, '02*, available online at: http://www.nyc.gov/html/acs/pdf/monthly_update.pdf
- ¹³ Illinois Department of Children and Family Services, *Signs of Progress in Child Welfare Reform, January 2003*. Available online at http://www.state.il.us/dcf/com_communications_signs.shtml
- ¹⁴ Division of Family Services, Research and Evaluation Unit, *Children's Services Annual Report, Fiscal Year 1997*.
- ¹⁵ Illinois Department of Children and Family Services, *Executive Statistical Summary, January 2003*, available online at: http://www.state.il.us/dcf/com_communications_execstats.shtml
- ¹⁶ Children's Services Management Report, note 9, supra.
- ¹⁷ Signs of progress, note 12, Supra.
- ¹⁸ Executive Statistical Summary, note 14, supra.
- ¹⁹ Missouri Children's Services FY 2001 Report, note 9, supra. (The inability to be more precise is because of a category of placement in Missouri called "non-licensed/court-ordered" placements. There are a total of 1,229 such placements and some of these may be kinship placements. If every single one of these is a kinship placement, then the proportion of such placements in Missouri is 26.3 percent – still significantly lower than Illinois).
- ²⁰ Malcolm Garcia, "Missouri law cuts aid to many who have custody of grandchildren," *Kansas City Star*, August 13, 2001, p.B1.
- ²¹ Virginia Young, "Panel votes to cut child insurance," *St. Louis Post-Dispatch*, February 26, 2003.
- ²² Susan Block, "Assessing the system: 'Where did we go right?'" *St. Louis Post-Dispatch*, January 8, 2003.
- ²³ *ibid.*
- ²⁴ Stephen N. Limbaugh, Jr. *State of the Judiciary Speech*, January 22, 2003. Available online at <http://www.osca.state.mo.us/pressrel.nsf/fa1bcbaea6d7c117862567670079a321/1381bf50961e5c7386256cb6006a1893?OpenDocument>
- ²⁵ Judge Frederica Breneman, *First Do No Harm, Protecting from the Protectors*, speech to the Children's Law Center of Minnesota, October 2, 2002.
- ²⁶ City of New York Office of the Comptroller, Office of Policy Management, *Whatever Happened to the Boarder Babies?* January, 1989, pp. 11-12.
- ²⁷ Studies cited in Karen Benker and James Rempel, "Inexcusable Harm: the Effect of Institutionalization on Young Foster Children in New York City," *City Health Report*, (New York: Public Interest Health Consortium for New York City) May, 1989.
- ²⁸ Mary Ann Jones, *Parental Lack of Supervision: Nature and Consequences of a Major Child Neglect Problem* (Washington: Child Welfare League of America, 1987), p.2.

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29. Tamar Lewin, "Child Welfare Is Slow to Improve Despite Court Order," *The New York Times*, December 30, 1995, p.6.
30. Memorandum of Points and Authorities in Support of Motion for Preliminary Injunction, *Hansen v. McMahon*, Superior Court, state of California, No.CA000974, April 22, 1986, p.1; California Department of Social Services, *All County Letter No. 86-77* ordering an end to the practice.
31. National Commission on Children, *Beyond Rhetoric: A New American Agenda for Children and Families*, (Washington, DC: May, 1991) p. 290.
32. Matthew Franck, "Opening family courts would help foster care system, proponents say," *St. Louis Post-Dispatch*, Jan. 16, 2003, p.B1.
33. Judge Susan Block, "Foster care inquiry," letter to the editor, *St. Louis Post-Dispatch*, February 11, 2003.
34. Richard Dunn and Frank Conley, *Report of the Investigation of the Child Welfare System in Greene County, Missouri*, Undated, Fall 2002, available at http://www.springfieldnews-leader.com/webextra/dfs.dominic/childwelfare_report.pdf
35. Missouri Division of Family Services, *Intensive In-Home Services Annual Report, Fiscal Year 2001*, Chart, p.7.
36. Fewer than eight-tenths-of-one-percent of American children are in foster care, but 2.7 percent of child abuse fatalities are in foster care. U.S. Dept. of Health and Human Services, Administration for Children, Youth and Families, *Child Maltreatment 2000*, table 5-3, available online at http://www.acf.dhhs.gov/programs/cb/publications/cm00/table5_3.htm
37. Mary I. Benedict and Susan Zuravin, *Factors Associated With Child Maltreatment by Family Foster Care Providers* (Baltimore: Johns Hopkins University School of Hygiene and Public Health, June 30, 1992) charts, pp.28, 30.
38. J William Spencer and Dean D. Kundsden, "Out of Home Maltreatment: An Analysis of Risk in Various Settings for Children," *Children and Youth Services Review* Vol. 14, pp. 485-492, 1992.
39. *Marisol A. v. Giuliani*, Complaint, Paragraph 245, p.75.
40. Affidavit of David S. Bazerman, Esq., *Ward v. Fever*, Case# 98-7137, United states District Court, Southern District of Florida, Fort Lauderdale Division, Dec. 16, 1998, p.4.
41. Memorandum and Order of Judge Joseph G. Howard, *L.J. v. Massinga*, Civil No. JH-84-4409, United states District Court for the District of Maryland, July 27, 1987.
42. David Fanshel, et. al., *Foster Children in a Life Course Perspective* (New York: Columbia University Press, 1990), p.90.
43. *How Are The Children Doing? Assessing Youth Outcomes in Family Foster Care*. (Seattle: Casey Family Program, 1998).
44. Personal communication from Charlotte Booth, Executive Director, Homebuilders. Even in the one case in which a child died after the intervention, in 1987, Homebuilders had warned that the child was in danger and been ignored.
45. Personal Communication, Susan Kelly, former director of family preservation services, Michigan Family Independence Agency.
46. Peter Kendall and Terry Wilson, "Boy's Death Casts Shadow on Foster Care," *Chicago Tribune*, Feb.28, 1995.
47. U.S. Department of Health and Human Services, Administration for Children and Families, *Child Maltreatment 2000*, Table 2-1, available online at: http://www.acf.hhs.gov/programs/cb/publications/cm00/table2_1.htm
48. *Ibid.*
49. Matthew Franck, "Most kids dying from abuse are known to state system," *St. Louis Post-Dispatch*, February 3, 2003.
50. Donald Bradley, "Home where 2 died loses license," *Kansas City Star*, August 25, 2000.
51. *Signs of Progress*, note 12, *supra*.
52. State of Illinois, Department of Children and Family Services, Office of Quality Assurance, *Executive Statistical Summary*, January, 1998.
53. Rachel L. Swarns, "For Children Awaiting Foster Care, Another Night on Office Cots," *The New York Times*, November 29, 1997; Russ Buettner, "Foster Kids Glut System; Surge Worst Since Crack Heyday" *New York Daily News*, May 12, 1997; Russ Buettner, "Bid to End ACS Office Hell," *New York Daily News*, May 14, 1997.
54. Rachel L. Swarns, "Agency Was Warned About Foster Mother Charged in Girl's Death," *The New York Times*, July 2, 1997, p.B3.
55. New York City Administration for Children's Services data compiled by the Center for an Urban Future, *Child Welfare Watch* Winter 1999, available online at www.citylimits.org/suf/4/numb.htm
56. New York City Administration for Children's Services, *Progress on ACS Reform Initiatives: Status Report 3* (March, 2001) Chart, P.38.
57. 1995-1998: Florida Department of Children and Families, *Child Abuse and Neglect Deaths: Calendar Year 1999* (Tallahassee, FL: March 2001); 1999 and 2000: Florida Department of Health, Florida Child Abuse Death Review System, Slide Presentation to Florida Legislature, Nov. 29, 2001; 2001: Kathleen Chapman, "Report: Agencies fail in abuse deaths," *Palm Beach Post*, Jan. 3, 2002.
58. Laura Bauer, "Greene County takes kids at twice the state rate," *Springfield News-Leader*, December 1, 2003, p.A1.
59. Illinois Department of Children and Families, *Executive Statistical Summaries*. Data from 1999 to date is online at http://www.state.il.us/dcf/com_communications_execstats.shtml, earlier data available in hard copy form from Illinois DCFS.
60. *Signs of Progress*, note 12, *supra*.
61. Matthew Franck, "The Pendulum," *St. Louis Post-Dispatch*, February 1, 2003.
62. Data for 1998 through 2002: New York City Administration for Children's Services, *ACS Update Annual Report 2002*, available online at http://www.nyc.gov/html/acs/pdf/update_5year.pdf Earlier data, *Child Welfare Watch*, note 54 *supra*.
63. New York City Administration for Children's Services, *Top 12 Performance Reports*, available online at http://www.nyc.gov/html/acs/html/whatwedo/opireport_updates_out4.html
64. Nina Bernstein, "City Will Close Office Running Foster Program," *The New York Times*, August 21, 2001.
65. U.S. Department of Health and Human Services, Administration for Children and Families, *Justification of Estimates for Appropriations Committees, Payments to states for Foster Care and Adoption Assistance*, p.C-12.
66. Bess, et al., note 67, *infra*.
67. Roseana Bess et. al, *The Cost of Protecting Vulnerable Children III* (Washington, DC: The Urban Institute) December 2002, chart, p.15. Available online at: http://www.urban.org/UploadedPDF/310596_OP61.pdf
68. This is very much a simplified version of how child welfare funding works. For those interested in a much more detailed discussion, see the Urban Institute paper in note 65.

- ⁶⁹ Bess, note 65, *supra*, chart, p.34.
- ⁷⁰ *Justification of Estimates*, note 64, *supra*.
- ⁷¹ In FY 2000, Missouri spent \$85,670,883 in federal Title IV-E funds, but not all of this went to foster care, some probably went to adoption as well. (Bess, note 67, *supra*, chart, p.34).
- ⁷² North American Council on Adoptable Children, *There is a Better Way: Family-Based Alternatives to Institutional Care* (St. Paul, Minn: 1995) pp. 5-9.
- ⁷³ M. Colton, "Foster and Residential Care Practices Compared" *British Journal of Social Work*, 18(1), 25-42, 1988.
- ⁷⁴ M. Bush, "Institutions for Dependent and Neglected Children: Therapeutic option of choice or last resort?" *American Journal of Orthopsychiatry* (50)(2), 239-255.
- ⁷⁵ Frank, D., Klass, P., Earls, F., Eisenberg, L, Infants and Young Children in Orphanages: One View from Pediatrics and Child Psychiatry. *Pediatrics*, Vol. 97, No. 4, April 1996 (pp. 569-578).
- ⁷⁶ U.S. Department of Health and Human Services, *Child Welfare Outcomes 1998: Annual Report*. (Washington DC: 2000). Available online at <http://www.acf.dhhs.gov/programs/cb/publications/cwo98/>
- ⁷⁷ Matthew Franck, "State agency favors foster parents over group homes," *St. Louis Post-Dispatch*, November 21, 2002.
- ⁷⁸ NACOAC, Note 70, *Supra*.
- ⁷⁹ This figure is probably an underestimate. It may, in fact include little more than the cost of paying foster parents. When administrative and other costs are factored in, the national average for keeping one foster child in foster care for a year is about \$15,000.
- ⁸⁰ Denise Hollinshead, "Shortage of foster homes is hurting children, costing state, officials say," *St. Louis Post-Dispatch*, July 20, 2001, p.A1.
- ⁸¹ Aaron Deslatte, "Politicians, judges seek reforms in child welfare," *Springfield News-Leader*, January 15, 2003.
- ⁸² Matthew Franck and Bill Bell Jr., "State costs for some foster care could soar," *St. Louis Post-Dispatch*, January 21, 2003.
- ⁸³ All information about the "baby warehouses" is from Karen Benker and James Rempel, "Inexcusable Harm: The Effect of institutionalization on Young Foster Children in New York City," *City Health Report* (New York: Public Interest Health Consortium for New York City), May, 1989.
- ⁸⁴ J. William Spencer and Dean D. Knudsen, "Out of Home Maltreatment: An Analysis of Risk in Various Settings for Children," *Children and Youth Services Review* Vol. 14, pp. 485-492.
- ⁸⁵ Megan O'Matz, "Model children's home falls short of expectations," *South Florida Sun-Sentinel*, April 21, 2002, p.A1.
- ⁸⁶ Tim Novak and Chris Fusco, "Reports find Maryville's environment 'dangerous'" *Chicago Sun-Times*, Sept. 6, 2002.
- ⁸⁷ Ofelia Casillas and David Heinzmann, "A troubled Maryville attempts to heal self," *Chicago Tribune*, Sept. 7, 2002.
- ⁸⁸ David Heinzmann and Ofelia Casillas, "Maryville feeling stress of its kids," *Chicago Tribune*, Sept. 8, 2002.
- ⁸⁹ James Rainey, "Grand Jury Cites Abuses in Group Foster Homes," *Los Angeles Times*, April 9, 1997, p.A1.
- ⁹⁰ Tracy Weber, "Caretakers Routinely Drug Foster Children"(p.A1) and "Prescription for Tragedy"(p.A31) *Los Angeles Times*, May 17, 1998.
- ⁹¹ Nina Bernstein, "Probe of Foster Care Nightmares," *New York Newsday*, May 2, 1990, 16.
- ⁹² Michael Powell, "Violence Rife at Two Homes for Troubled Teens," *New York Newsday*, Nov. 14, 1990, p.6.
- ⁹³ "Ex-Mooseheart Staffer Guilty of Molesting Boys," *Chicago Tribune*, Nov. 5, 1993, Sec. 2, p. 7; Linda Young, "Mooseheart Aches After Sex Abuses," *Chicago Tribune*, Feb. 8, 1994, p.1.
- ⁹⁴ Alicia Fabbre, "Mooseheart worker pleads guilty to abuse," Arlington Heights, Ill. *Daily Herald*, February 7, 2003.
- ⁹⁵ Martha Shirk, "As Troubles Come to Light, Home Surrenders License," *St. Louis Post-Dispatch*, Oct. 3, 1993, p.1.
- ⁹⁶ Scott Hummell, "Our one-size-fits-all approach can cause more problems than it solves," Letter to the editor, *St. Louis Post-Dispatch*, February 5, 2003.
- ⁹⁷ Jorge Fitz-Gibbon and Shawn Cohen, "Costly system 'conspires to create failure'" Westchester County, N.Y. *Journal News*, June 23, 2002.
- ⁹⁸ *Ibid*.
- ⁹⁹ Hummell, note 94, *supra*.
- ¹⁰⁰ Richard P. Barth, *Institutions vs. Foster Homes: The Empirical Base for a Century of Action*. University of North Carolina at Chapel Hill, School of Social Work, Jordan Institute for Families, Chapel Hill, NC., February 17, 2002.
- ¹⁰¹ Shawn Cohen and Leah Rae, "Wraparound plan delivers success at less cost," *The Journal News*, December 15, 2003. The full series of which this story is a part is available at www.nyjournalnews.com/rtc
- ¹⁰² Jamie Satterfield, "Youth Villages lauded as one of nation's best in curbing youth crime," *Knoxville News-Sentinel*, June 6, 2001.
- ¹⁰³ Patrick Lawler, "Birth Family Is Best For Children," Memphis *Commercial Appeal*, March 20, 2001.
- ¹⁰⁴ See Debra Jasper and Elliot Jaspin, "Children often the last to benefit," *Dayton Daily News*, September 26, 1999 and a series of stories on the following four days.
- ¹⁰⁵ Elliot Jaspin, "Agency may get renewed scrutiny," *Dayton Daily News*, Sept. 30, 1999.
- ¹⁰⁶ Elliot Jaspin and Mike Wagner, "Inspection of foster homes lax," *Dayton Daily News*, October 5, 1999.
- ¹⁰⁷ *Ibid*, and personal communications from Richard Klarberg, President and Chief Executive Officer Council on Accreditation for Children and Family Services, October 4, 2001 and Nicole Hazard, Director of Standards and Evaluation, COA, October 16, 2001.
- ¹⁰⁸ Office of the state auditor, *Audit of Child Abuse and Neglect Reporting and Response System*, Report No. 2000-132, December 28, 2000; hereafter "Hotline Audit."
- ¹⁰⁹ Hotline Audit, p.35.
- ¹¹⁰ Hotline Audit, p.4.
- ¹¹¹ Hotline Audit, p.6.

- ¹¹² Members must include a doctor, nurse or other medical professional, a child or family psychologist, counselor or social worker, a lawyer who has represented either an alleged child victim or an accused family member, and someone from law enforcement or a juvenile office; (Hotline Audit, p.43).
- ¹¹³ Hotline Audit, pp. 12,13.
- ¹¹⁴ Hotline Audit, p.13.
- ¹¹⁵ *Dupuy v. McDonald*, 141 F. Supp. 2d 1090, 1136 (ND Ill. 2001).
- ¹¹⁶ Hotline audit, pp. 24,25.
- ¹¹⁷ Hotline audit, p.3.
- ¹¹⁸ Hotline Audit, p.49.
- ¹¹⁹ Editorial, "Child abuse hotline fails to protect," *Kansas City Star*, February 5, 2003.
- ¹²⁰ Shana Gruskin, "Child abuse workers call for curbs on hotline," Ft. Lauderdale *Sun-Sentinel*, January 14, 2001.
- ¹²¹ William Adams, Neil Barone and Patrick Tooman, "The Dilemma of Anonymous Reporting in Child Protective Services," *Child Welfare* 61, no. 1, January, 1982, p.12.
- ¹²² The law should allow the accused to go to a judge and explain why he feels he is being harassed by false reports, and by whom. The judge should check the record and, if the accused is right, and if the judge is persuaded that the reports are an act of harassment, the name should be released to the accused, who should have the right to sue for damages.
- ¹²³ Adams, et. al., note 119 supra.
- ¹²⁴ U.S. Department of Health and Human Services, Administration for Children and Families, Child Maltreatment 2000, Table 6-5, available online at http://www.acf.hhs.gov/programs/cb/publications/cm00/table6_5.htm
- ¹²⁵ *State of the Judiciary Speech*, note 23, supra.
- ¹²⁶ Missouri Division of Family Services, *Intensive In-Home Services Annual Report, Fiscal Year 2000*.
- ¹²⁷ *2001 In-Home Services Report*, note 34 supra.
- ¹²⁸ *Ibid.*
- ¹²⁹ Kathleen Wobie, Marylou Behnke et. al., *To Have and To Hold: A Descriptive Study of Custody Status Following Prenatal Exposure to Cocaine*, paper presented at joint annual meeting of the American Pediatric Society and the Society for Pediatric Research, May 3, 1998.
- ¹³⁰ Laura Bauer, "Team approach 'not working' in county," *Springfield News-Leader*, December 1, 2002.
- ¹³¹ Laura Bauer, "DFS: First report on Dominic inaccurate," *Springfield News-Leader*, September 26, 2003.
- ¹³² Dunn and Conley, note 33, supra.
- ¹³³ Bauer, Note 128, supra.
- ¹³⁴ Charles L. Usher, *Evaluation of Family to Family* (Jordan Institute for Families, School of Social Work, University of North Carolina at Chapel Hill and Health and Social Policy Division, Research Triangle Institute, Research Triangle Park, NC, December, 1998).
- ¹³⁵ Andrew White, *Citizen Power for Stronger Families: Community Partnerships for Protecting Children, Jacksonville Florida* (New York: Edna McConnell Clark Foundation, undated).
- ¹³⁶ Lee Rood, "Safe at Home," *Des Moines Register*, February 12, 2003.
- ¹³⁷ L. Anthony Loman and Gary Siegel, *The Missouri Juvenile Court Improvement Project: Final Report* (St. Louis: Institute of Applied Research, November 2000).
- ¹³⁸ *Ibid.*
- ¹³⁹ *Ibid.*
- ¹⁴⁰ Special Child Welfare Advisory Panel for New York City, *Advisory Report on Front Line and Supervisory Practice*, March 9, 2000, p.48. Available online at <http://www.aecf.org/child/frontline.pdf>
- ¹⁴¹ Heath Foster, "Relying on good advice can reunite troubled families," *Seattle Post-Intelligencer*, February 12, 2003, p.B1.
- ¹⁴² Laura Bauer, "Holden to Herald DFS reforms," *Springfield News-Leader*, December 17, 2002.
- ¹⁴³ Laura Bauer, "Dominic's death: How the system failed him," *Springfield News-Leader*, December 8, 2002.
- ¹⁴⁴ Laura Bauer and Paul Flemming, "We felt deceived, we felt duped," *Springfield News-Leader*, January 11, 2003.
- ¹⁴⁵ All of the quotes in this section are from the *Pittsburgh Post-Gazette* series, "Open Justice," by reporter Barbara White Stack. (Sept. 23-25 2001). The series is available at <http://www.post-gazette.com/headlines/20010923opencourt0923p8.asp>
- ¹⁴⁶ Barbara White Stack, "Freedom to speak can lead to reform," *Pittsburgh Post-Gazette*, Sept. 24, 2001.
- ¹⁴⁷ Associated Press, Minnesota wire "Court orders child protection records opened to public," Dec. 27, 2001.
- ¹⁴⁸ Open Justice, note 143, supra.
- ¹⁴⁹ Editorial, "Chief Justice right: Open juvenile court," *Springfield News-Leader*, January 26, 2003.
- ¹⁵⁰ Joseph Goldstein, Anna Freud, Albert J. Solnit, *Beyond the Best Interests of the Child*, (New York: The Free Press, 1973), p.53.
- ¹⁵¹ Bess, note 65 supra. The Urban Institute cautions that the figures are such rough estimates that state-to-state comparisons are questionable. So is dividing the dollars by the total number of children, as opposed to, say, the total number of children living in poverty or the number of children in substitute care. (Personal Communication with Rob Geen, Senior Research Associate, The Urban Institute).
- ¹⁵² Roy Holand, "Fat has been trimmed, perhaps taxes needed," *Springfield News-Leader*, March 9, 2003.
- ¹⁵³ *Ibid.*
- ¹⁵⁴ Laura Bauer, "Greene County takes kids at twice state rate," *Springfield News-Leader*, December 1, 2003, p.A1.
- ¹⁵⁵ Hotline Audit, note 106, supra.
- ¹⁵⁶ That's higher than the figure given for Missouri in connection with the relative cost of orphanages. We suspect the lower figure includes only payments to foster parents, and excludes administration and other expenses.
- ¹⁵⁷ The actual numbers will vary from state to state. For example, in 1997, it cost the state of Michigan \$12,384 to keep one child in family foster care. The state's Intensive Family Preservation Services program cost \$4,367 per family. (state of Michigan, office of the Auditor General, *Performance Audit of the Families First of Michigan Program*, July 1998, p.3).