

A POPULATION-LEVEL OVERVIEW OF CHILD FATALITIES AND CHILD PROTECTION INVOLVEMENT: SURVEILLANCE & RISK

July 10, 2014

Commission to Eliminate Child Abuse & Neglect Fatalities

Tampa, Florida

Emily Putnam-Hornstein, PhD

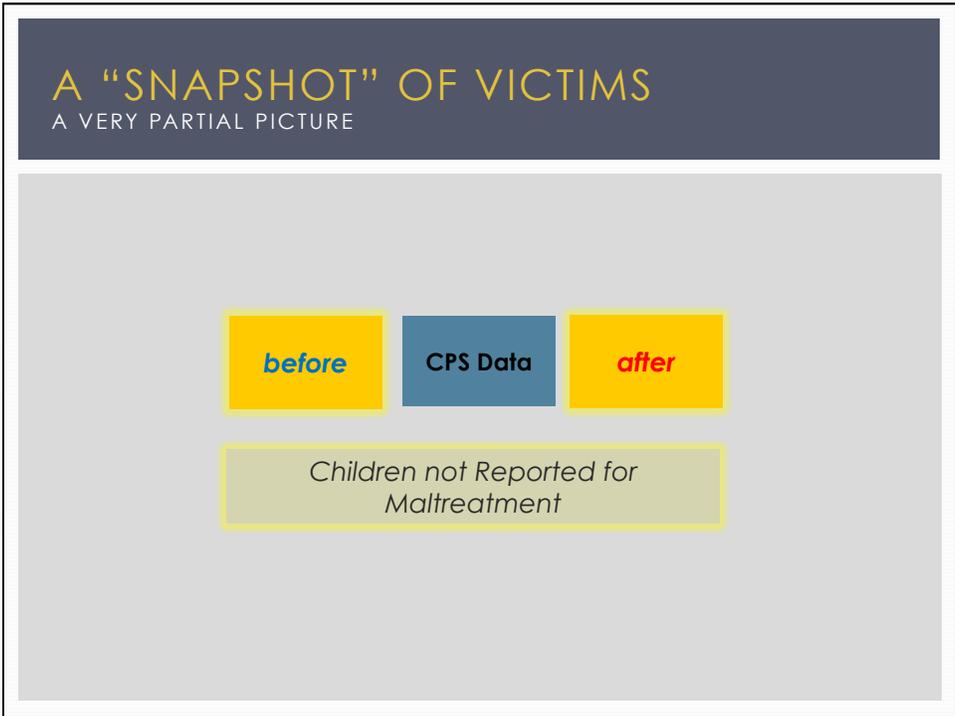
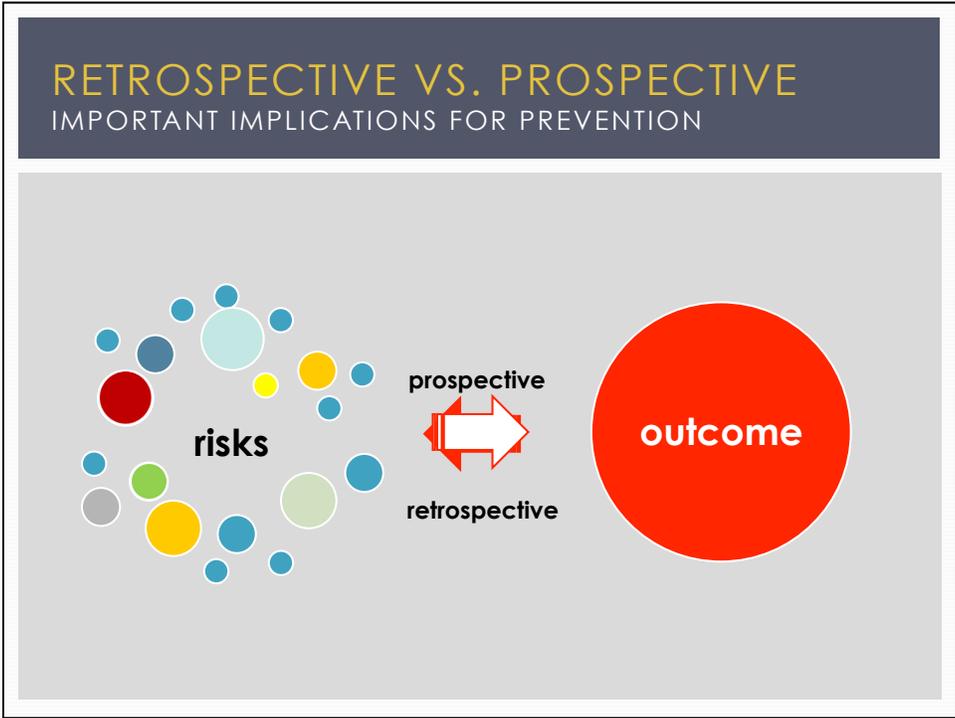
Children's Data Network
University of Southern California

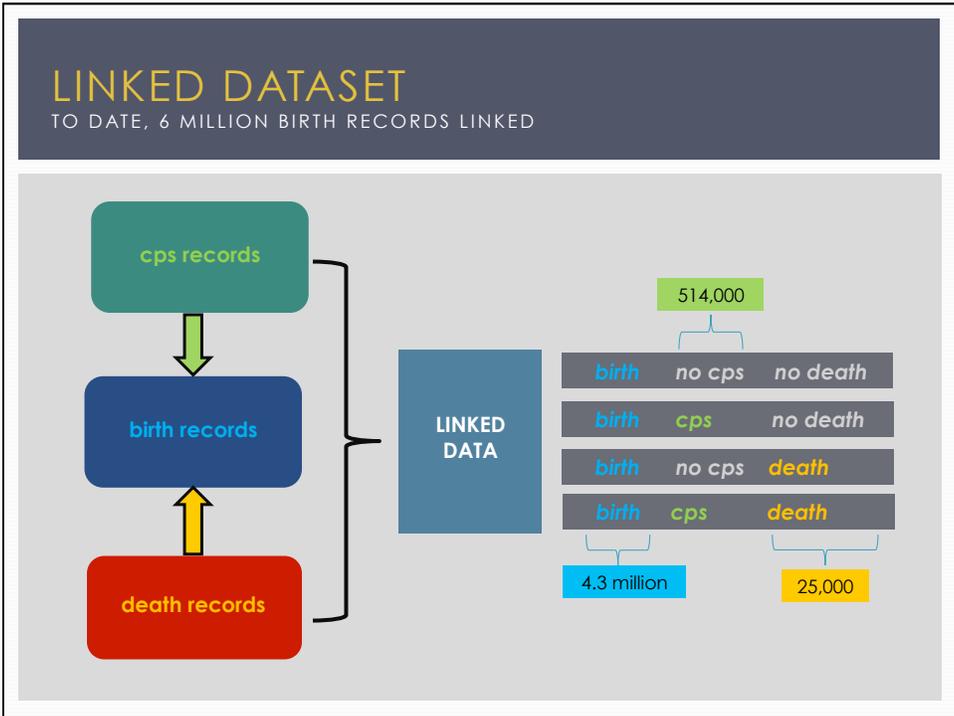
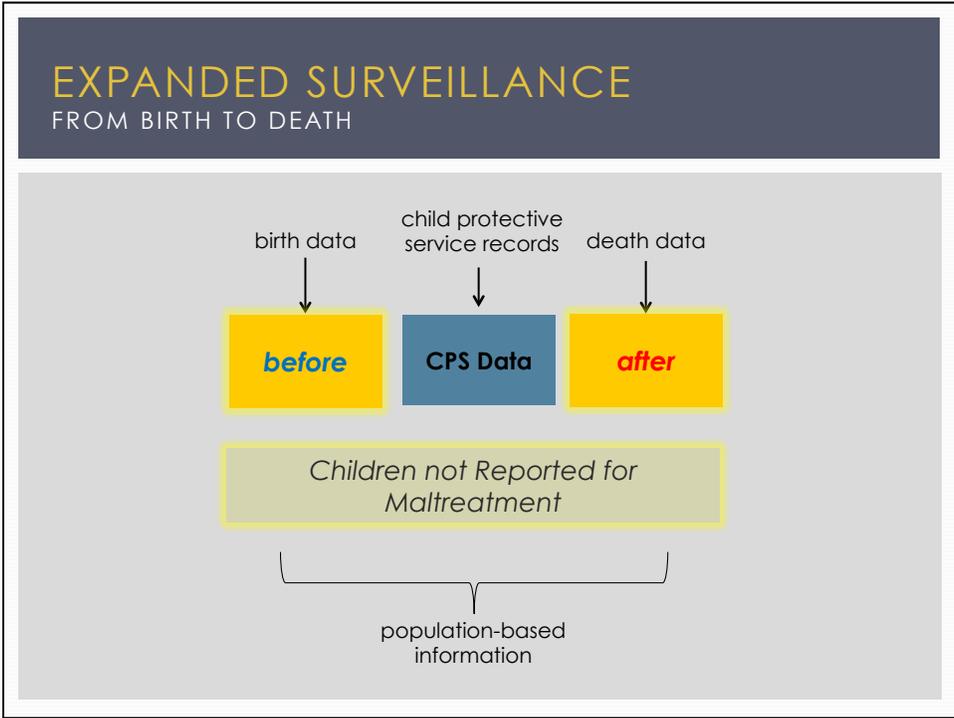
California Child Welfare Indicators Project
University of California, Berkeley

LIMITATIONS OF ANY ONE DATA SOURCE...
THE CONTINUING PROBLEM OF SILOS

The diagram illustrates the progression of data systems over time. On the left, labeled 'current.', three separate circles represent 'System A' (yellow), 'System B' (blue), and 'System C' (light blue), each with its own small satellite circle, representing isolated data silos. In the middle, labeled 'near-term.', two overlapping circles (one yellow, one light blue) represent 'linked data', with a white double-line arc above them. On the right, labeled 'future.', a single large green circle represents 'real-time access to integrated information', with a white double-line arc above it.

current. near-term. future.





THE STORY

THROUGH A POPULATION LENS

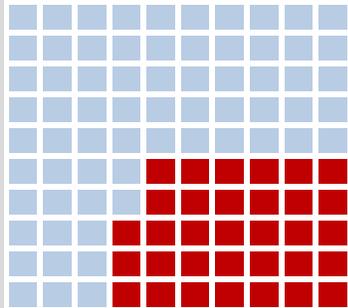
1. The problem is big
2. The signal is real
3. Scope should be considered
4. Limited response
5. Opportunities to be more strategic...

CONVERSATION #1:
THE PROBLEM IS BIG

THE PROBLEM IS BIG

CUMULATIVE REALITY, LARGE GROUP DIFFERENCES

children with missing paternity



33%

- Annual estimates of children reported for abuse/neglect understate how many children are involved with this system over time
- What we think of as a relatively rare event is much more common than has been appreciated...

SUBSTANTIATED AS A CONFIRMED VICTIM?

JAMA PEDIATRICS, WILDEMAN, ET.AL., 2014



- 1 in 100 US children is substantiated annually.
- But 1 in 8 children (12.5%) has been confirmed as a victim by age 18.
- The prevalence for black children is 20.9%

CONVERSATION #2: THE SIGNAL IS REAL

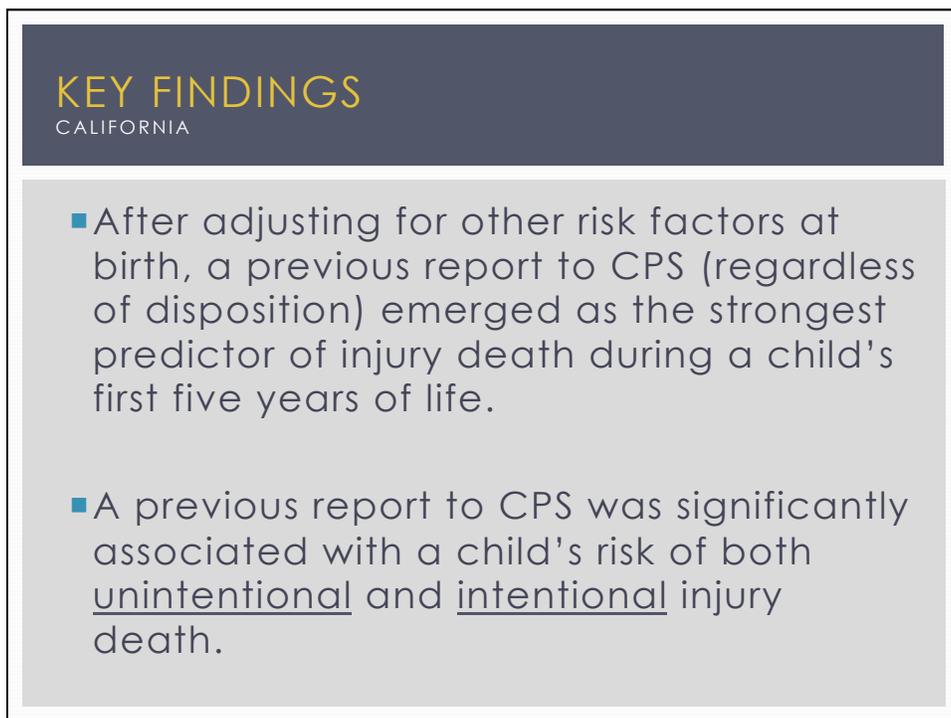
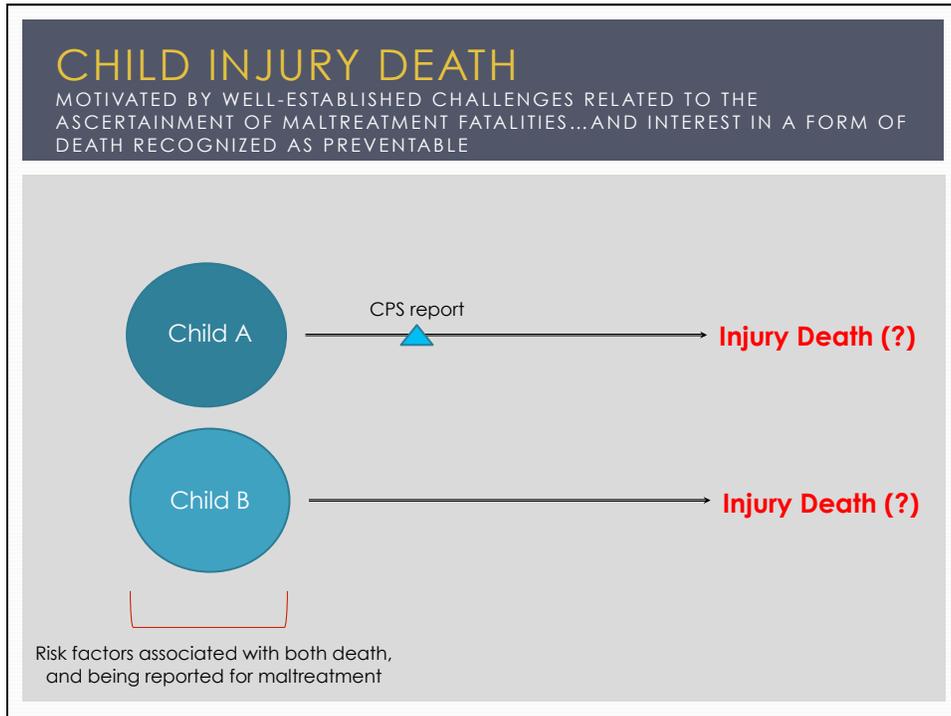
WHY STUDY DEATH?

OBJECTIVE MARKER

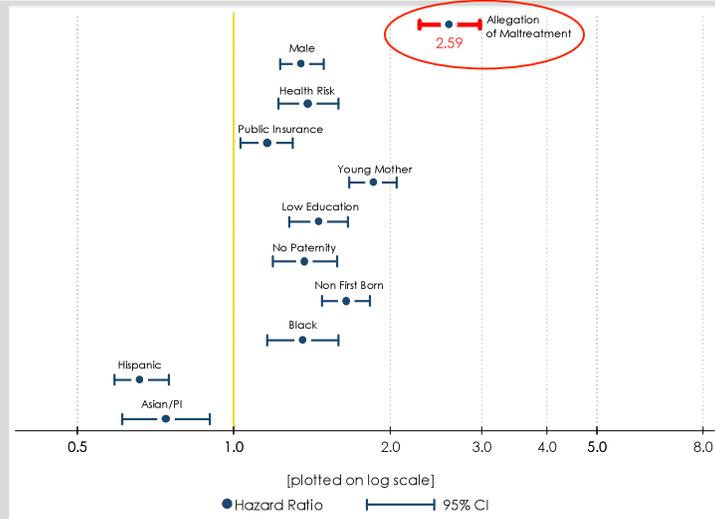
- A *mortality-based* standard for evaluating parental behavior may be the closest we can get to “culture-free” definitions of neglect and abuse.

(S.R. Johansson, 1987)

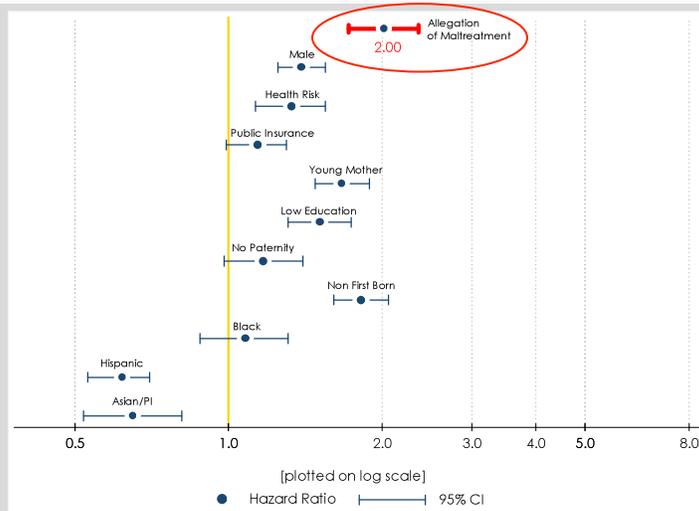
- Lends itself to broader insights about risk differences (classic approach in public health research).



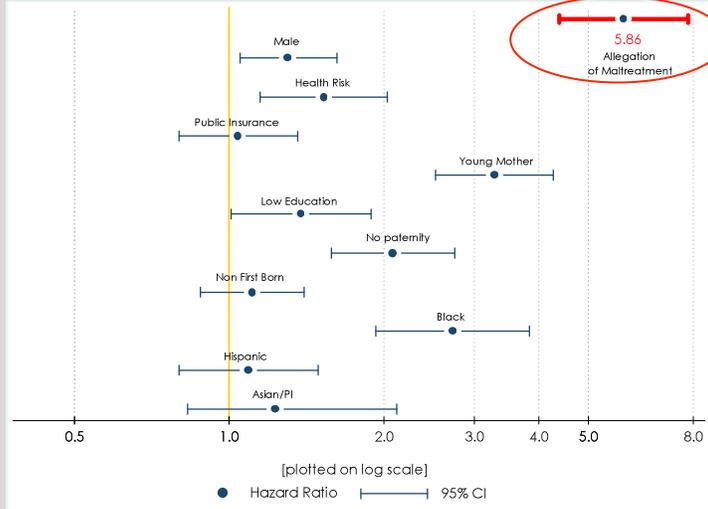
RISK OF INJURY DEATH AFTER ADJUSTING FOR OTHER FACTORS



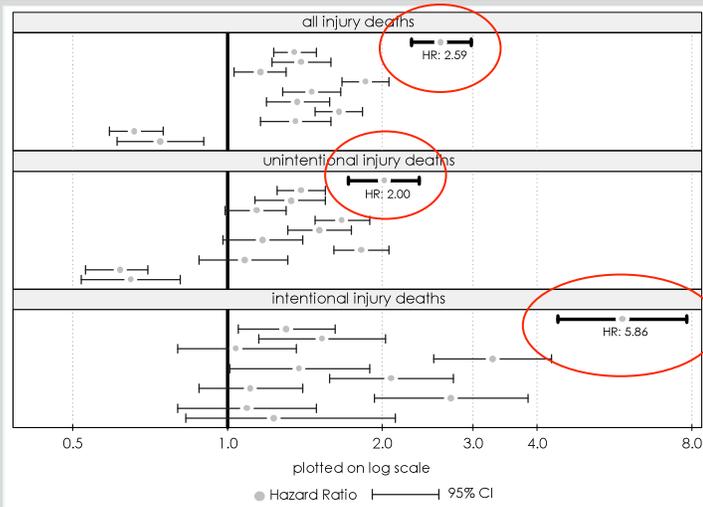
RISK OF UNINTENTIONAL INJURY DEATH AFTER ADJUSTING FOR OTHER FACTORS



RISK OF INTENTIONAL INJURY DEATH AFTER ADJUSTING FOR OTHER FACTORS



SUMMARY AFTER ADJUSTING FOR OTHER FACTORS



DIFFERENCES BY MALTREATMENT TYPE

CONSISTENT WITH CONCEPTUAL UNDERSTANDINGS OF NEGLECT VS. PHYSICAL ABUSE

- These data indicate that an allegation of physical abuse signals a consistently greater level of physical risk in the form of injury death than neglect or other forms of maltreatment.
- From a public health control and prevention stand-point, unique protocols for investigating and intervening in cases in which physical abuse is alleged for a child under the age of five may be justified.

TABLE 2—Multivariable Cox Proportional Hazard Models Estimating Children’s Risk of Intentional or Unintentional Fatal Injury Before Age 5 Years: California, 1999–2007

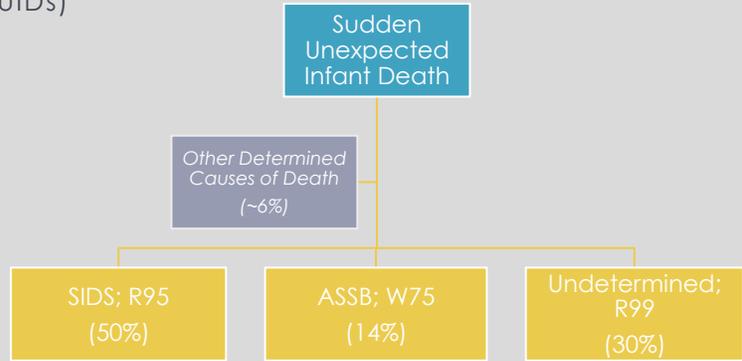
Variable	All Injury Deaths (n = 392), HR (95% CI)	Intentional Injury Deaths ^a (n = 123), HR (95% CI)	Unintentional Injury Deaths ^a (n = 247), HR (95% CI)
Allegation type (most severe)			
Physical abuse	1.70 (1.34, 2.17)	5.22 (3.61, 7.57)	0.59 (0.39, 0.90)
Neglect (Ref)	1.00	1.00	1.00
Other maltreatment	0.27 (0.17, 0.42)	0.18 (0.05, 0.56)	0.30 (0.18, 0.49)

CONVERSATION #3:
THE SCOPE SHOULD BE
CONSIDERED (PLUS A WORD
ABOUT MEASUREMENT
CHALLENGES)

A DIFFERENT "TYPE" OF DEATH

LESSONS FOR THINKING ABOUT MALTREATMENT FATALITIES

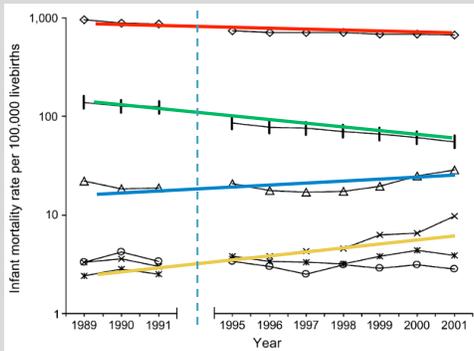
- Each year in the United States, more than 4,500 children die during the first 12 months of life with no immediately identifiable cause or explanation, deaths broadly defined as sudden and unexpected infant deaths (SUIDs)



A DIAGNOSTIC SHIFT

BUT A FLAT RATE OF POSTNEONATAL DEATHS...

- The current distribution of SUID classifications reflects a diagnostic shift that has occurred over more than two decades, largely attributed to growing medical examiner and coroner adherence to the 1991 definitional criteria for excluding all other causes of death before certifying a death as SIDS



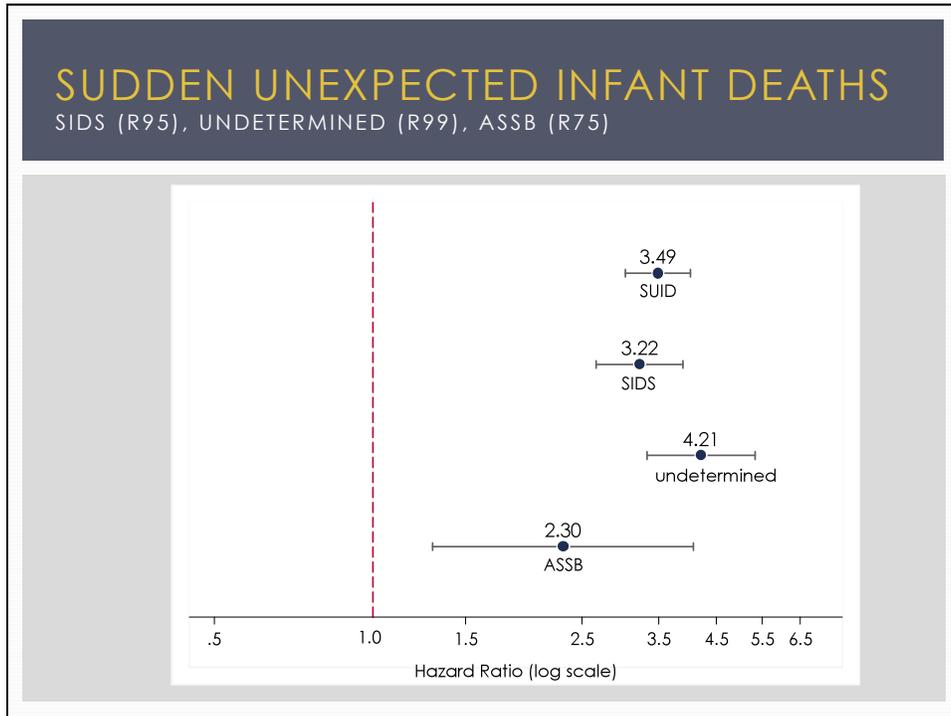
postneonatal death rate

SIDS (R95)

Undetermined (R99)

ASSB (W75)

1. Shapiro-Mendoza CK, Tomashek KM, Anderson RN, Wingo J. Recent National Trends in Sudden, Unexpected Infant Deaths: More Evidence Supporting a Change in Classification or Reporting. *American Journal of Epidemiology*. 2006;163(8):762-769.



(THREE POSSIBLE) INTERPRETATIONS

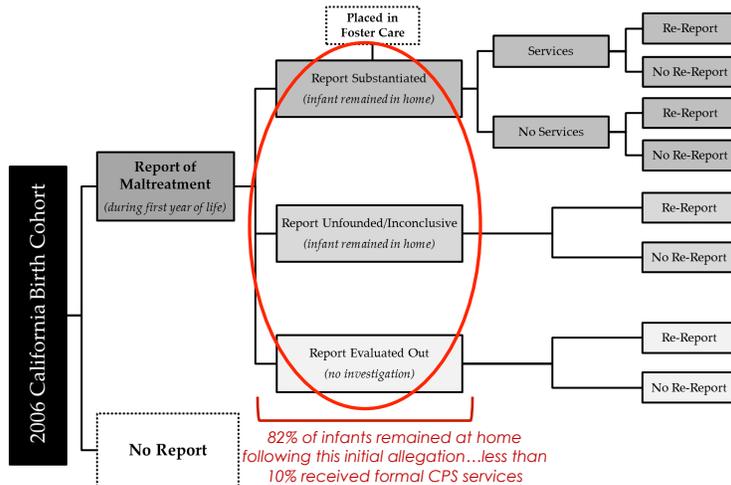
REGARDLESS OF WHICH INTERPRETATION HOLDS, IN ABSOLUTE NUMBERS, MORE INFANTS DIE OF SUID FOLLOWING A REPORT TO CPS THAN DIE FROM INFLECTED INJURIES

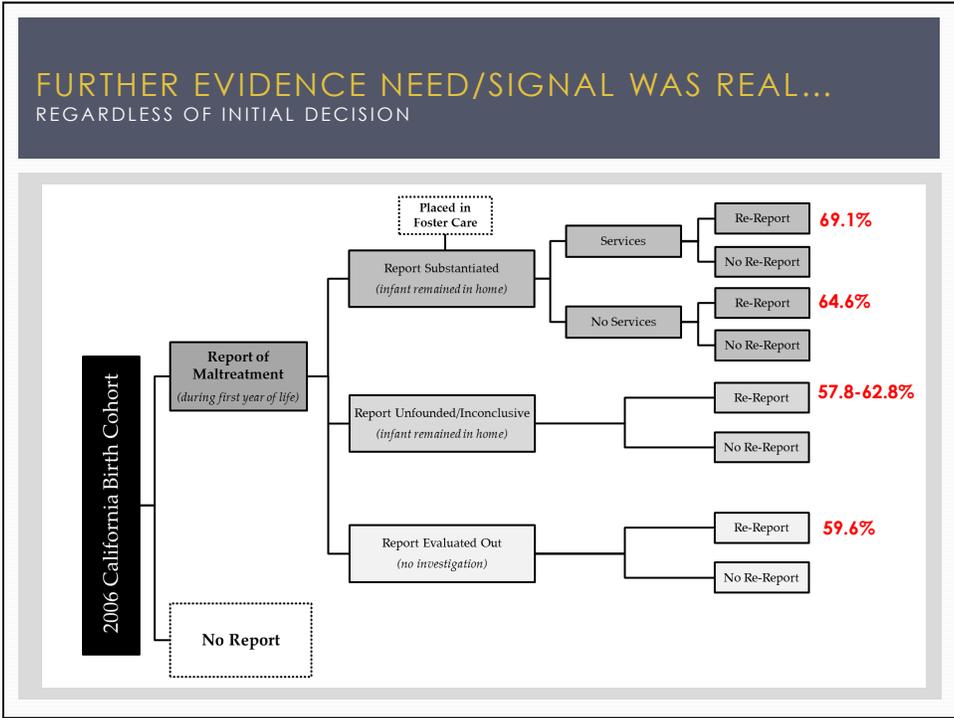
Prior Report to CPS as a Predictor of SUID	<ol style="list-style-type: none"> 1. Infants reported to CPS have unique risks associated with SUIDs that account for the relationship observed (e.g., prenatal alcohol or drug exposure) 2. Infants reported to CPS reflect a very high-risk subset of infants born into families in which there remains a partial or lagged penetration of public health safe sleeping guidelines 3. A continued inability to unequivocally differentiate SIDS from infant deaths caused by soft suffocation, whether accidental or inflicted
---	---

CONVERSATION #4: LIMITED CPS CAPACITY TO RESPOND

LIMITED RESPONSE

A LOOK AT OUR MOST DEVELOPMENTALLY VULNERABLE POPULATION (AND THE GROUP WITH THE HIGHEST MALTREATMENT FATALITY RATE): INFANTS





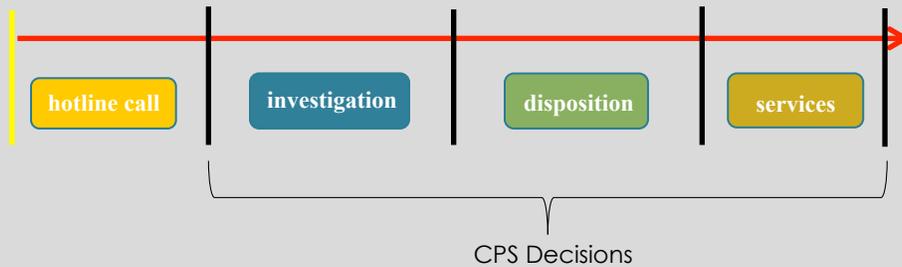
CONVERSATION #5:
WE CAN BE MORE STRATEGIC...

DECISIONS

WE PAY LITTLE ATTENTION TO FRONT-END DECISION-MAKING. EVIDENCE-BASED SERVICES ARE OF LIMITED USE IF THEY ARE NOT DELIVERED TO THOSE WHO NEED THEM.

"One might conceptualize child welfare agencies as social service agencies, but that would be incorrect. In reality, child welfare agencies are gate-keepers and the workers decision makers."

(Gelles & Kim, 2008)



DECISION-MAKING TOOLS / AIDS

CLINICAL JUDGMENT CAN NEVER BE REPLACED, BUT CAN IT BE IMPROVED?

- Consensus based assessment tools (*not great*)
- Actuarial risk assessment tools (*operator driven problems, not validated on local population...*)
- Predictive risk modeling (?)
 - Vast amounts of high quality administrative data (*we are just beginning to explore what is possible*)
 - No new data entry required by front-line workers (*no "gaming" the tool, focus on client engagement*)
 - Advances in technology / computer science (*very feasible, methods advancing*)

A PUBLIC HEALTH FRAMEWORK

POTENTIAL OPPORTUNITIES FOR PREDICTIVE RISK MODELING

■ Primary Prevention:

- requires an upstream data system which captures a sufficiently rich set of variables to support risk classifications & an adequate proportion of children who will later be maltreated
- could be used to prioritize children for early intervention and maltreatment prevention services

■ Secondary Prevention:

- could be deployed at different child protection decision-points to support hotline screenings, investigations, etc.
- linkages with other data could be used to provide a more accurate/complete assessment of present and future risk

■ Tertiary Prevention:

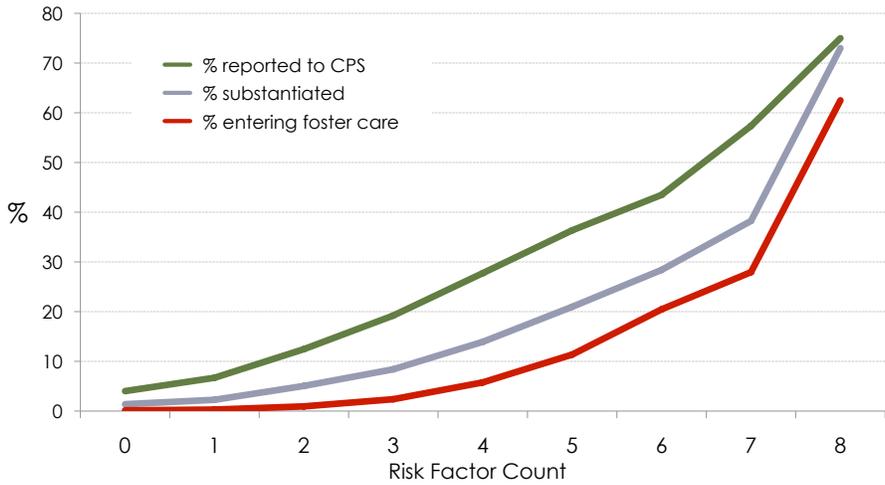
- May lend itself to a more effective and efficient means of minimizing negative consequences of child abuse or neglect
- Empirical basis for tailoring services (vs. "one size fits all")

CASE STUDY FROM NEW ZEALAND

APPLICATION OF PRM TO MALTREATMENT PREVENTION

- **Reality:** 83% of children substantiated as victims of maltreatment by age 5 could be found in an open public benefit case between birth and age 2
- **Question:** Could the country's integrated data system be used to develop a statistical model to predict which of these children would later become victims?
- **Results:** A maltreatment model was developed that achieved a similar accuracy as digital or film mammography as a method for predicting breast cancer among women without symptoms.
 - *Prevalence of maltreatment among children 0-5 in NZ is more than 20 times that of breast cancer among women 50-60 years who are offered screening*
- **Ethics and next steps...**

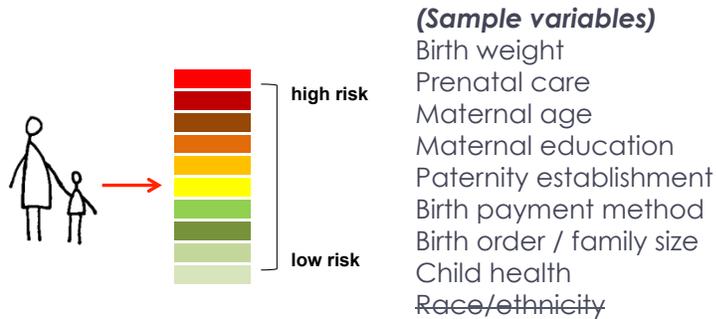
PARALLEL THOUGHT EXERCISE IN CALIFORNIA...
 SIMPLE COUNT CAPTURES GRADATIONS IN RISK. BUT HOW DO WE MOVE THE NEEDLE?



CAN WE STRATIFY RISK AT BIRTH?

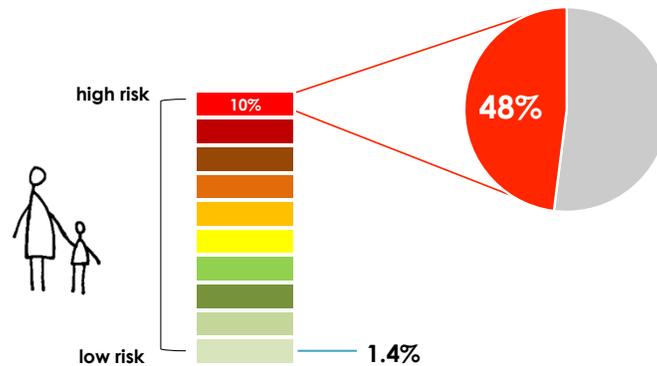
POTENTIAL FOR PLACE-BASED SERVICES AND INDIVIDUAL SUPPORTS

- Predictive models focused solely on identifying characteristics (predictors) that serve to risk stratify children in the overall birth cohort based on the likelihood that a child will be reported to CPS.



TARGETING SERVICES

STRATEGICALLY ALLOCATING LIMITED SERVICE SLOTS



UNREALIZED POTENTIAL

OPPORTUNITIES FOR FEDERAL LEADERSHIP AND SUPPORT

- Policies and programs have been designed based on a very partial understanding of our children over time.
- Linked administrative records provide a powerful, cost-effective, population-level source of information.
- ***No simple answers, but by making better and smarter use of existing data – we can do more to monitor risk, develop thoughtful policies, ensure strategic preventive efforts, evaluate program effectiveness, and protect children.***

ACKNOWLEDGEMENTS

THANKS, THANKS, THANKS

■ **Colleagues:**

- Children's Data Network (at USC)
- California Child Welfare Indicators Project (at UCB)
- California Department of Social Services (CDSS)

■ **Funding support for ongoing data linkages, research, and technical assistance:**

- First 5 LA
- The Conrad N. Hilton Foundation

■ **Other funding support for work at CDN and CCWIP:**

- CDSS
- Stuart Foundation
- HF Guggenheim Foundation
- Casey Family Programs

QUESTIONS?

ehornste@usc.edu

MORE INFORMATION?

www.datanetwork.org



PUBLISHED RESEARCH

1. Putnam-Hornstein E, Cleves MA, Licht R, & Needell B. (2013). Risk of fatal injury in young children following abuse allegations: evidence from a prospective, population-based study. *American Journal of Public Health, 103*(10), e39-e44.
2. Wildeman C, Emanuel N, Leventhal J, Putnam-Hornstein E, Waldfogel J, & Lee H. (2014). The prevalence of confirmed maltreatment among American children, 2004-2011. *JAMA Pediatrics*.
3. Putnam-Hornstein E, Schneiderman JU, Cleves MA, Magruder J, & Krous HF. (2014). A prospective analysis of sudden unexpected infant death following reported maltreatment. *Journal of Pediatrics, 164*(1), 142-148.
4. Vaithianathan R, Maloney T, Putnam-Hornstein E, & Jiang N. (2013). Children in the public benefit system at risk of maltreatment: identification via predictive modeling. *American Journal of Preventive Medicine, 45*(3), 354-359.
5. Putnam-Hornstein E, Wood JN, Fluke J, Yoshioka-Maxwell A, & Berger RP. (2013). Preventing severe and fatal maltreatment: making the case for the expanded use and integration of data. *Child Welfare, 92*(2), 59-75.
6. Putnam-Hornstein E. (2011). Report of maltreatment as a risk factor for injury death: a prospective birth cohort study. *Child Maltreatment, 16*(3), 163-174.
7. Shapiro-Mendoza CK, Tomashek KM, Anderson RN, Wingo J. Recent National Trends in Sudden, Unexpected Infant Deaths: More Evidence Supporting a Change in Classification or Reporting. *American Journal of Epidemiology*. 2006;163(8):762-769
8. Putnam-Hornstein E, Webster D, Needell B, & Magruder J. (2011). A public health approach to child maltreatment surveillance. *Child Abuse Review, 20*, 256-273.
9. Putnam-Hornstein E & Needell B. (2011). Predictors of child welfare contact between birth and age five: an examination of California's 2002 birth cohort. *Children & Youth Services Review, 33* (11), 2400-2407.



UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

Preventing Child Abuse Deaths Using Birth to CWS Matches

Richard P. Barth

Presented to the Commission to Eliminate
Child Abuse and Neglect Fatalities

Tampa, Florida

July 10, 2014

Predicting Harm

- Best predictions likely to be made when the child is highly vulnerable and the parent has clearly demonstrated inadequate or unsafe parenting
- **INFANTS + PARENTS WITH PRIOR COURT FINDING OF "INADEQUATE PARENTING" = OPTIMAL PREDICTION OF HARM**

Many Newborns have Parents with Prior TPRs

CY2013 Entries	2012-2013 Births	Birth Cohort		Prior TPRs	
		Percent of All Entries	Prior TPR	Percent of Birth Cohort	CY2013 Entries
2,370	540	22.78	56	10.37	2,370

22.78% of all entries in 2007 were children between the ages of 0-1. Of those 540 entries (637), 10.3% (56) had an indication of a prior TPR associated to one or more of their parents.

So 10% of the very young children entering care in MD in 2007 had a prior family TPR.

The percentage would be higher if we included those who have lost a previous child to "guardianship".

Full Maryland Data Table

CY2013 Entries	BIRTH COHORT		PRIOR TPR	
	2012-2013 Births	Percent of All Entries	Prior TPR	Percent of Birth Cohort
2,370	540	22.78	56	10.37
CY2012 Entries	2011-2012 Births	Percent of All Entries	Prior TPR	Percent of Birth Cohort
2,564	576	22.46	58	10.07
CY2011 Entries	2010-2011 Births	Percent of All Entries	Prior TPR	Percent of Birth Cohort
2,941	595	20.23	52	8.74
CY2010 Entries	2009-2010 Births	Percent of All Entries	Prior TPR	Percent of Birth Cohort
2,926	603	20.61	65	10.78
CY2009 Entries	2008-2009 Births	Percent of All Entries	Prior TPR	Percent of Birth Cohort
2,821	633	22.44	72	11.37
CY2008 Entries	2007-2008 Births	Percent of All Entries	Prior TPR	Percent of Birth Cohort
2,870	683	23.80	51	7.47

Birth Match Options

- **Do nothing** and assume that the existing system of care (hospital referrals or births to mothers that quickly become known to CWS) will identify these high risk mothers & newborns
- **Match births to TPRs** (and other indicators of exceptionally high parental risk) and conduct a timely preventive visit

Post-Match Follow-Up Actions by CWS

- Have no pre-existing expectations about follow-up decision
- Visit to conduct an assessment with no prejudice about whether to open case
- Require opening of a case
- Expect removal of the infant unless there is an administrative waiver

Current Status

- MD, MN, and MI all have a birth match protocol in place
 - MI includes additional parent characteristics
 - The way that they approach the contacts with parents varies
- CDC is intrigued by the possibility that the significant national investment in gathering birth data for vital records analysis could also yield real-time benefits in injury and violence prevention
- States currently have the opportunity to share birth data with CWS agencies, at the discretion of the Secretary of their Health Departments. FEW DO!

Using Birth Data in Real Time

- Is allowable, reasonable, and achievable
- We have precedent with regard to responding differentially to protect children born to parents who have previously been involved with TPRs (AFSA)
- With more analysis of existing programs, the Birth Match approach could become the standard of care

Other High Risk Mothers

- 40% of children, born to teen mothers who were involved with CWS as victims, will be reported for child abuse by age 5 (Putnam-Hornstein, 2014)
- Children who are born following the birth of a small for gestational age child have 3Xs the likelihood of dying by the age of 1 than other children (Salihu, et al., 2012).

Other Birth Match Options

- Higher Risk Parents to Match
 - Include matching of parents who have had other serious offenses and are on sex offender registry or have been suspected, but not convicted, of serious crimes like homicide
 - Match those who have lost a child to guardianship (circumstances may be similar to parents with TPR)
- Lower Risk Parents to Match
 - Prematurity, low-birth weight, smoking, medically indigent (these were part of the NC Maternal Care Coordination program that generated their LONGSCAN sample)
 - Adolescent parents who were previously foster children

Birth Match: Significance & Challenge

- This is an opportunity to use available data in REAL time to identify high risk children and bring protective resources to them
- CHALLENGE: To overcome our reluctance to identify any false positives using the heavy hand of CPS.
 - The responsibility to use parents prior performance to determine whether to bypass reunification efforts has now been integrated into CWS policy and practice; Birth Match is a logical next advance

Action Items

- Build on the momentum of the Information Memoranda from the CB (ACYF-CB-IM-13-02) and the OMB (M-11-02) to increase data sharing:
 - Make sharing of birth data for research purposes and for the identification of children who may need child protection, an expectation for federal funding. (Leave a state option not to share with the presumption to share.)

PART II: Preventing Child Abuse Deaths of Adopted Children

- Children who were reported for abuse and neglect die in foster care and adoption every month
- **More precise estimates are unavailable**
- Although these death rates are probably lower than for maltreated children remaining at home, or who were reunified from foster care (Barth & Blackwell, 1998), the rate of murder of children in foster care and adoption is certainly unacceptably high
- **Better data needs to be collected about such filicides**

Yes, Adopted Children, Too

- *Child Maltreatment* reports the proportion of child fatality cases that had prior contact with CWS.
- We count children who were in family preservation and then go on to be killed by parents
 - About 12% of all the child abuse fatality cases were previously known to have received family preservation services and 2.5% had been reunified.
- Abused children who later go into foster care or adoption and are then killed are not counted in NCANDS.

We Need to Gather Data on Adoption Deaths

- **Child Fatalities Who Received Family Preservation Services Within the Past 5 Years** (CM, 2012; Table 4-5).
- **Child Fatalities Who Were Reunited With Their Families Within the Past 5 Years, 2012** (CM, 2012; Table 4-6).
- **WHY NOT: Child Fatalities Who Were Placed Out of Home (Foster Care, Guardianship, **Adoption**) Within the Past 5 Years**

The Precedent is Set

- *Fostering Connections for Success* (PL 110-351), requires parents of children who have been adopted from foster care and who receive a subsidy to show that the children are in school.

This is the first federal law to require any check on a child's well-being be made on an annual basis (although some states have had such checks).

- Keeping statistics on abuse or murder by foster and adoptive parents is consistent with the responsibility of the government to ensure quality long-term care of former foster children that promotes their well-being.

CAPTA Changes

- As a first step, CAPTA should be revised to clarify the importance of providing information, in the child-level child maltreatment fatality reporting, on child fatalities of children or children who have been adopted from foster care.
- All deaths of children in foster and adoptive care should be captured so that a comprehensive and complete picture can be drawn.

“Nonparent” Perpetrators in CM 2012

- Child Daycare Provider
- **Foster Parent (Female Relative)**
- **Foster Parent (Male Relative)**
- **Foster Parent (Nonrelative)**
- **Foster Parent (Unknown Relationship)**
- Friend or Neighbor
- Group Home and Residential Facility Staff
- **Legal Guardian (Female)**
- **Legal Guardian (Male)**
- More than One Nonparental Perpetrator
- Other
- Other Professional
- Partner of Parent (Female)
- Partner of Parent (Male)
- Relative (Female)
- Relative (Male)

But these are not
“nonparents”!

How about:
Caregiver Perpetrators
as the Supra-title and
Adoptive Parent as a
sub-category

Additional Preventive Steps

- Make progress toward a standardized home-study for foster and adoptive parents that allows for some predictive analytics of seriously harmful and fatal, foster care and adoptive placements.
 - Include known child maltreatment and filicide risk factors
 - Require it of foster and adoptive families
 - Enter and keep the home study data
 - Match it up against an array of “untoward adoption outcomes” (e.g., disruption, set aside, displacement, filicide)

Implement Case Reviews of Serious and Fatal Maltreatment Cases

- Protocols for state reviews of serious and fatal maltreatment cases should be developed and disseminated
 - A federal review mechanism—requiring some sampling—could also be instituted
- These reviews can build on the work of scholars (e.g., Brandon et al., 2008) who have worked on these for more than a decade and identified opportunities for procedural improvements to protect children in the U.K.

I welcome your questions today or at
any time

Thank You

References

Barth, R. P., & Blackwell, D. L. (1998). Death rates among California's foster care and former foster care populations. *Children and Youth Services Review, 20*, 577-604.

Barth, R. P., & Hodorowicz, M. T. (2011). Foster and adopted children who die from filicide: What can we learn and what can we do? *Adoption quarterly, 14*, 85-106.

Brandon, M., Belderson, P., Warren, C., Howe, D, Gardner, R., Dodsworth, J., Black, J. (2008). Analysing child deaths and serious injury through abuse and neglect: What can we learn? Department of Children, Schools and Families (Research Report No. DCSF-RR023). London, UK: University of East Anglia.

Crea, T. M., Barth, R. P., & Chintapalli, L. K. (2007). Home study methods for evaluating prospective resource families: History, current challenges, and promising approaches. *Child Welfare, 86*, 141-159.

Crea, T. M., Barth, R. R., Chintapalli, L. K., & Buchanan, R. L. (2009). The implementation and expansion of SAFE: Frontline responses and the transfer of technology to practice. *Children and Youth Services Review, 31*, 903-910. doi: 10.1016/j.childyouth.2009.04.005

Putnam-Hornstein, E. (2014). Non-fatal and fatal maltreatment of infants and young children: *Lessons for Practice, programs, policy*. Paper presented to the National Human Services Training Evaluation Symposium, May 21, 2014.

Shaw, T.V., Barth, R.P., Mattingly, J., Ayer, D., & Berry, S. (2013). Child welfare birth match: The timely use of child welfare administrative data to protect newborns. *Journal of Public Child Welfare, 7*, 217-234

STATEWIDE SYSTEM OF CHILD PROTECTION TEAMS IN FLORIDA

Randell Alexander MD PhD

CPT Statewide Medical Director
University of Florida - Jacksonville

deeper understanding, better care.



CHILD PROTECTION COMES FIRST



IMAGINE IF:



Premature infants were seen by any doctor regardless of status/complexity, neonatal units were self contained, and there was no overall system



Trauma cases were possibly seen by any doctor, and the ambulance service decided if and where a child might be seen

You have just imagined child “protection” in 49 states

How does this protect children?



WHO PROTECTS?

- It is the state's responsibility to protect its children
- They have the obligation to provide vital child abuse services
- They need to be taught to do so

Martin Finkel and Jay Whitworth



Child Protection Team Program

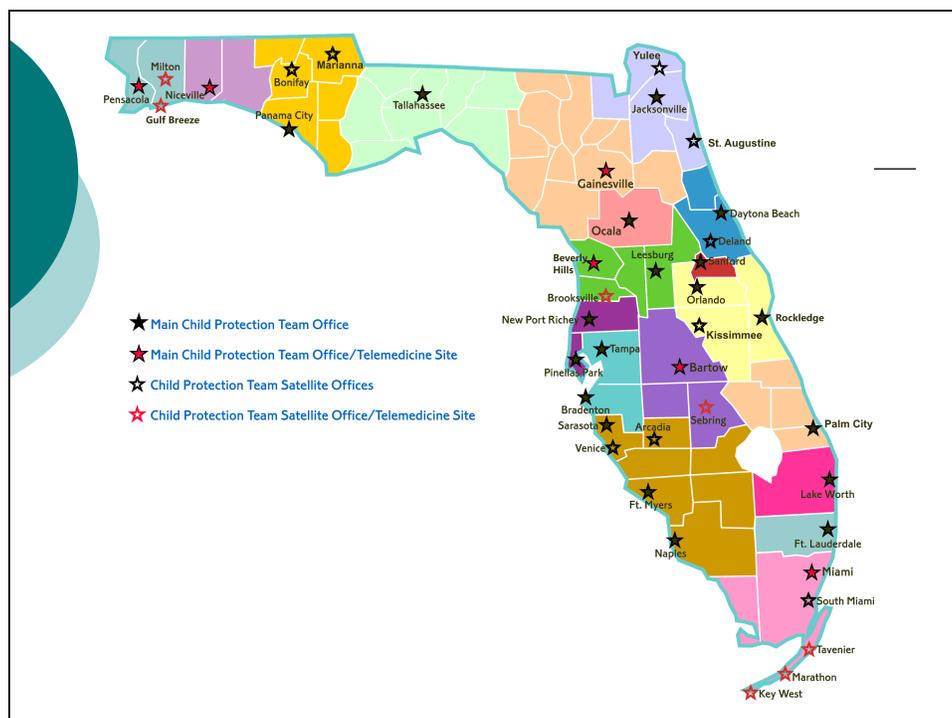
A medically directed, multidisciplinary program based on the idea that child abuse and neglect involve complex issues and require the expertise of many professionals to protect children.

Florida's Child Protection Teams

- Statewide program for 36 years
- Telemedicine program for 17 years
- State population served is 19 million
- Nearly 200,000 reports of child abuse/year
- State funding for teams \$19,200,000

Florida's Child Protection Teams

- 24 teams in statewide system
- Medically directed
- Provide Multidisciplinary Service
- Available 24hours/day, 7 days/week
- Employ expert physicians, social workers, psychology services, team attorney



CPT Services

- ✓ Medical Evaluations
- ✓ Child and Family Assessments
- ✓ Psychological Evaluations
- ✓ Multidisciplinary Staffings
- ✓ Coordination of Services
- ✓ Expert Court Testimony
- ✓ Forensic Interviews
- ✓ Consultation and Training

Services Provided FY 08-09

- Reports reviewed: 186,533
- Trainings Provided: 1,615

- **Children served: 28,791**
- **Total services: 44,002**

Breakdown

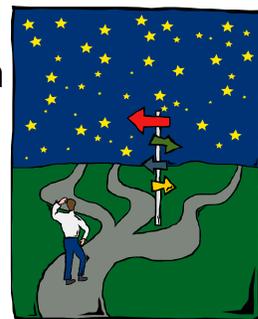
- | | |
|--|--------|
| • Medical Evaluation: | 14,226 |
| • Medical Consultation: | 3,196 |
| • Specialized Interviews: | 17,425 |
| • Forensic Interviews: | 5,606 |
| • Psychosocial Evaluation: | 614 |
| • Psychological Evaluation & Consultation: | 397 |
| • Multidisciplinary Staffing: | 1,837 |
| • Court Activity: | 695 |

Personnel

- Medical providers – about 111
- Case coordinators – about 189
- Psychologists – over 50

CHOOSING THE RIGHT PATH

- In 1978, the first CPT began in Jacksonville
- Child abuse is a health issue
- Decided it should be medically led
- Multi-disciplinary community based
– not hospital based
- We sweep up all the kids

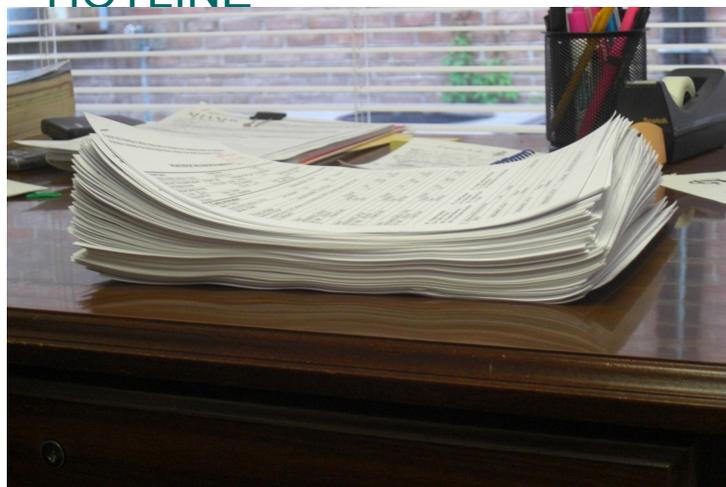


4 year olds with buttock bruising



- How would you ever know if these cases exist?
- What mechanism do you have to see them?
- They are not hospital or sex abuse clinic cases
- Do you know if you would see them all in your geographic area?

DAILY REPORTS FROM THE HOTLINE



Mandatory Referral Criteria

Abuse reports that must be referred to CPTs include cases involving:

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age
- Bruises anywhere on a child five years of age or younger
- Sexual abuse of a child in which vaginal or anal penetration is alleged; or other unlawful sexual conduct has been determined to have occurred

Mandatory Referral Criteria (continued)

- Any sexually transmitted disease in a prepubescent child
- Reported malnutrition or failure of a child to thrive
- Reported medical neglect of a child
- Symptoms of serious emotional problems when emotional or other abuse, abandonment, or neglect is suspected

Mandatory Referral Criteria (continued)

- Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home

THINGS WE DO



- See a child in another hospital where we don't have privileges
- Multiple layers of quality review
 - Continuous contract standards review
 - Statewide meetings, Medical Director meetings, Team Coordinator meetings
 - On-site team review every 2 year
 - Teleconference peer review

OTHER



- "Sovereign immunity"
- Medical Directors are paid 8 or 16 hours/week NOT to see children [reimbursement systems don't work]
- 2nd opinion system (ALWAYS SUPPORTED)

OTHER



- Often leaders of Death Review
- Substance abuse experts – our definition of substance abuse
- State data base – tracking of cases, potential for research
- Developmental referrals common

CPT Time Frames

When we see children after they are reported

- For skin injuries: see today or tomorrow
- For acute sexual assault: immediately
- Others: reasonably soon

Notification

- Must report positive findings to CPS (and police when applicable) within 24 hours. Often it is immediate.
- Reports are due within 10 days.
- We monitor this!



Use of Telemedicine

- To facilitate access to CPT services, the program uses telemedicine technology to extend the availability of medical assessments to rural and other hard to reach areas throughout the state.





DEATH REVIEW

- Death review and serious cases



FLORIDA CPT = CHILD PROTECTION

- Challenges:
 - Maintaining money in a time of serious budget problems
 - Retaining medical personnel and recruiting new ones
 - Keeping the health focus

FLORIDA CPT = CHILD PROTECTION

- Future:
 - Statewide database (EHR)
 - More effective impressions and recommendations
 - Adapt more health consequences into our work
 - Shift more emphasis from tertiary to primary prevention



Child Protection Teams - Authority

- Section 39.303, F.S., provides for the establishment and maintenance of one or more Child Protection Teams in each of the service districts or zones of DCF.
- Chapter 64C-8, F.A.C., establishes specific definitions, standards, policies, and procedures for the operation of the Child Protection Team program.
- http://www.cms-kids.com/providers/prevention/documents/handbook_cpt.pdf



❖ Statewide Medical Director

Provides medical oversight for the teams and the team medical directors

Provides oversight in coordination with the _____ Division Director of Prevention and Intervention and under the direction of the Children's Medical Services Deputy Secretary



❖ **Team Medical Director**- Responsibilities

Medical oversight of the Team.

Available 24/7 for consultation

Recruit team physicians and medical providers

Participate in peer reviews

Assist with the recruitment of Team Coordinator
or Case Coordinator positions.

Provide training and professional development



❖ **Medical Providers** - Responsibilities

Provide diagnostic evaluations and medical consultations and written reports

Attend staffings

Provide expert court testimony

Participate in "after-hours" call

Complete 8 hrs of training per year in child abuse.



Medical Evaluations

Performed by a Board certified Pediatrician, PA, or
an Advanced Registered Nurse Practitioner
(ARNP)

Evaluator has specialized training in abuse and
neglect

Purpose of evaluation is to render a professional
opinion regarding abuse or neglect allegations and

Provide recommendations for further assessment
or treatment



el

❖ Team Coordinator – Responsibilities

Coordinate the daily activities of the CPT

Train, coordinate, and supervise team staff.

Coordinate services with DCF and other agencies

Assist with development of the team budget.

Provide training for team staff and the community.

Complete 8 hrs of training per year in child abuse.



❖ **Case Coordinators** -Responsibilities

Interview children, family members

Complete written assessments.

Coordinate services and community referrals

Arrange for and conduct team staffings

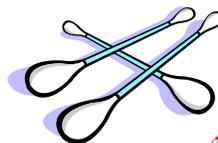
Maintain client records.

Conduct training in the community

Participate in scheduled “after hours” on call.

Complete 8 hrs of training per year

Not just a social worker



Case Coordination

Upon referral of a child, a case coordinator is assigned to coordinate the CPT team assessments and provide coordination with the CPI throughout the investigation.

The case coordinator evaluates the extent of assessment activities that are necessary and appropriate.

May conduct Psychosocial Assessment.



Specialized Clinical Interview

An interview with a child or a member of the child's family for the purpose of gathering clinical data, family functioning, family history, or other information for assisting with the assessment of alleged child maltreatment.

Information gathering in nature; primary focus is not for legal purposes

Serves as the key component in the assessment process.



Forensic Interviews

A structured interview conducted in a legally sound manner by an interviewer who has received specialized training

Conducted by a qualified CPT interviewer.

A forensic interview is conducted with the alleged victim child only.

Generally children should be at least 4 years old.



Psychosocial Assessments

Conducted by a case coordinator or other trained professional

An evaluation of the history of the child and the child's family system:

- Identify risk factors
- Identify pertinent family dynamics
- Assess family strengths/weaknesses
- Determine the needs
- Identify when a psychological would be beneficial

Results in a written report



❖ Psychologist - Requirements

Provide psychological evaluations of children and adults

Clinical interviews with children

Referral of children/adults to psychotherapy

Participate in Team staffings

Provide expert court testimony

Complete 8 hrs of child abuse training per year



Psychological Evaluations

Performed by, or supervised by, a licensed psychologist

Provides a comprehensive assessment of an individual's emotional, behavioral, psychological, or intellectual functioning.

Must meet the Frye Criteria for expert testimony in court



❖ Attorney - Responsibilities

Provide legal services

Provide training, as appropriate

Attend staffings

Assist in the development of recommendations.

Represent the team or individual members who are acting in their official capacity as team members in court.



❖ Other Professional Consultants

- Each CPT may employ or contract for professional consultants on an as needed basis.
- Responsibilities:
 - Provide diagnostic evaluations and medical consultations
 - Attend team staffings, on children for whom they have provided services
 - Provide written reports



Staffings

- Teams may assist CPIs and CBC case managers by facilitating or attending multi-disciplinary staffings.
- Information presented and shared during reviews and staffings is confidential and participants must be informed of the required CPT confidentiality.



Multidisciplinary Staffing

Purpose: to assess risk, family strengths and needs, and develop recommendations.

Case History	Family strengths
Assessment of safety and risk	Services needed
Consensus and recommendations	

Scheduled and led by the CPT

Participants determined by the needs of the child

Physician or ARNP	Psychologist
Attorney	CPI
Case Coordinator	Service providers
Others deemed necessary	

Expert Court Testimony

Florida Statutes require CPTs to provide expert medical, psychological, and related professional testimony in dependency court cases.

Court activity only includes sworn or affirmed testimony in or out of court by a member of the CPT, and includes the time spent in reviewing records and in team consultation for court preparation.

Community Outreach and Training

Florida Statutes require that CPTs provide training to physicians and other professionals in the identification or determination of abuse or neglect.

Training includes public and media presentations on child abuse as well as specific training designed to develop and maintain the professional skills and abilities of those handling child abuse, abandonment and neglect cases



**ECKERD RAPID
SAFETY
FEEDBACKSM
COMMISSION TO
ELIMINATE CHILD
ABUSE & NEGLECT
FATALITIES
JULY 10, 2014**

LORITA SHIRLEY, CHIEF OF
PROGRAM SERVICES-FLORIDA

| 1

The first name in second chances.™

Eckerd | **Background and Purpose**



MYFLFAMILIES.COM

- Unprecedented history of child fatalities in Hillsborough County. Worse, there was a pattern of **homicides** (9 in less than three years)
- All affected children under 3 years old. All but one were in-home and killed by a parent or paramour
- Other Common factors: Young Parents, Intergenerational Abuse, Substance Abuse, Mental health, and/ or DV history



Eckerd.org | 2

The first name in second chances.™

Eckerd | Eckerd's Research and Analysis




- Conducted a Review of State of Florida Findings Regarding all 9 Homicides
- Launched Quality, Safety, and Improvement Review (100 % file review: 1,470 records involving 3,000 children)
- Consulted with Statewide Child Abuse Death Review Coordinator

Eckerd.org | 3

The first name in second chances.™

Eckerd | Themes From This Analysis




- **Children** in home **under 3** at highest risk
- **Safety Plans** were not tailored to individual cases and **lacked family input**
- **Background Checks/** Home Studies were **not updated** to reflect changes in family circumstances
- The **core family issues** bringing the child into dependency were **not addressed** on home visits or in case documentation
- **Behavior change poorly monitored** with providers and other case participants
- **Supervisory reviews** either failed to identify the issues or more likely repeated prior concerns **without resolution**

Eckerd.org | 4

The first name in second chances.™

Eckerd | **Safety Focused Review Tool-
Nine Core Questions**



1. Is safety planning sufficient?
2. Is case planning individualized for family's needs and related to known dangers?
3. Is the parent's behavior change monitored related to known dangers?
4. **Is CM aware of emerging dangers and are they followed up on urgently?**
5. Is the **quality** of contacts sufficient to ascertain and respond to known threats and emerging dangers?
6. Is the **quantity** of contacts sufficient to ascertain and respond to known threats and emerging dangers?
7. Are background checks/home studies sufficient and responded to appropriately?
8. Is communication with case stakeholders sufficient to ascertain if emerging dangers are present?
9. *Does supervision identify concerns in service provision related to ALL of the above and are recommended actions followed up on urgently?*

Eckerd.org | 5

The first name in second chances.™

Eckerd | **Preventive Analytics**



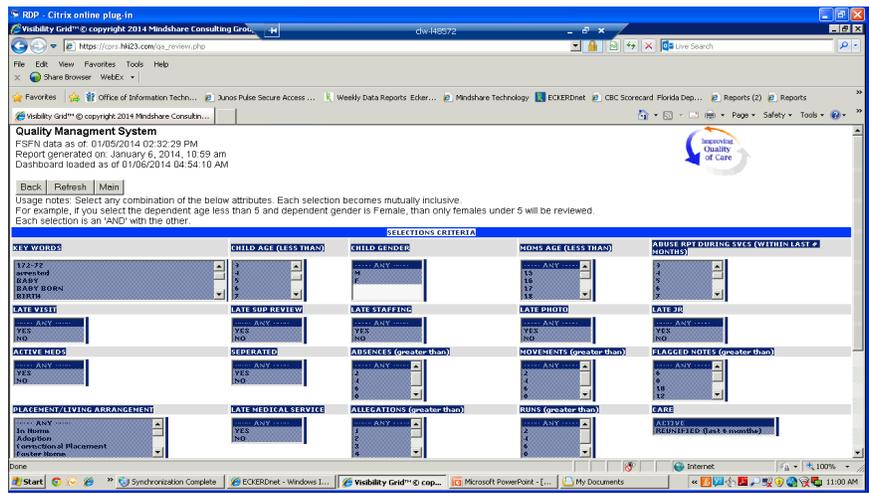
- Eckerd identified **key risk factors** that were present in cases **resulting in child fatalities**
- Eckerd, in Partnership with Mindshare (Software Company), developed a **preventative analytics software system** that served as an overlay to Florida's SACWIS System providing the ability to mine thousands of case notes that matched key risk factors
- **Equipped with** specific case **information identifying children at greatest risk**, Eckerd, proactively engaged field staff to address risk factors immediately, thereby mitigating the likely of a child fatality



Eckerd.org | 6

The first name in second chances™

Eckerd's Quality Transformation RSF Technology

Quality Management System
 FSNM data as of: 01/05/2014 02:32:29 PM
 Report generated on: January 6, 2014, 10:59 am
 Dashboard loaded as of: 01/06/2014 04:54:10 AM

Usage notes: Select any combination of the below attributes. Each selection becomes mutually inclusive. For example, if you select the dependent age less than 5 and dependent gender is Female, then only females under 5 will be reviewed. Each selection is an AND with the other.

SELECTIONS CRITERIA				
KEY WORDS	CHILD AGE (LESS THAN)	CHILD GENDER	MONS AGE (LESS THAN)	ABUSE RPT DURING SVCS (WITHIN LAST # MONTHS)
17A-7P abused/ab BABY BORN BIRTH	3 4 5	ANY M F	15 16 17 18	3 4 5 6 9
LATE VISIT	LATE SUP REVIEW	LATE STAFFING	LATE PHOTO	LATE JR
ANY NO	ANY NO	ANY NO	ANY NO	ANY NO
ACTIVE HOUS	DELEGATED	ASSISTERS (greater than)	INDICATORS (greater than)	PLACED NOTES (greater than)
ANY NO	ANY NO	2 4 6	2 4 6 8	6 10 15 18
PLACEMENT/LIVING ARRANGEMENT	LATE MEDICAL SERVICE	ALLEGATIONS (greater than)	RUNS (greater than)	CARE
ANY In Home Adoption Childhood Placement Foster Home	ANY NO	2 4 6	2 4 6	ACTIVE REINTEGRATED (Date & month/year)

Eckerd.org

The first name in second chances™

Coaching and Mentoring Review Process



- Cases Identified by Preventative Analytic Software System are Reviewed by an Eckerd QA Specialist
- All cases with an identified safety concern are staffed within 1 business day with field staff
- Eckerd uses a non-punitive coaching and mentoring approach to engage in a dialogue about safety threats.
- Staffings are focused on Supervision- follow up tracked to completion
- Cases reviewed every quarter (by same QA Specialist) until closure or youngest child turns three



Eckerd.org | 8

The first name in second chances.™



Initial Results: Breakdown by Question

Question	1	2	3	4	5	6	7	8	9
Baseline	53%	81%	74%	72%	60%	50%	49%	30%	27%
Current	77%	97%	90%	90%	86%	63%	65%	60%	56%



- Improvement noted in all categories: an average of 21%
- In-Home Abuse During services also reduced 21% from 7.09% to 5.58% on all in-home cases
- Cases needing a safety staffing reduced from 71% to 44%

Eckerd.org | 9

The first name in second chances.™



Initial Results: Staffings

Circuit 13	Q1 Reviewed	Q1 Needed Staffing	Percent Needing Staffing Q1	Q3 Reviewed	Q3 Needed Staffing	Percent Needing Staffing Q2	% Improvement
ECA	163	128	78.53%	149	73	48.99%	29.54%

- Almost 30% reduction in Staffing Needs Q1 to Q3
- Most gains accrued quickly Q2 required 53% of cases to be staffed

Eckerd.org | 10

The first name in second chances.™

Eckerd | **How are we better?**

- Quality of documentation improved
- Quality of supervision improved
- Improved ownership/ follow up by case managers
- Improved Safety Plans
- Visit Quality improved
- **No Child Murders during State Supervision since Eckerd Rapid Safety FeedbackSM was implemented**



Eckerd.org | 11

The first name in second chances.™

Eckerd | **Additional benefits**

- Positive feedback from CMO's due to *shared risk* and staffing process "*mentoring and coaching*"
- Change field perspective of QA: large case sample with *critical thinking questions* vs. small case sample of compliance driven questions
- *HIGH* level of interaction between CMO's and lead agency – **WE ARE A TEAM**
- Identified need for centralized data collection and action step follow up



Eckerd.org | 12

The first name in second chances.™

Eckerd | **Moving Forward/ Next Steps**

- Expansion to CPI and other CBCs in Florida effective January 2014
- Analysis with turnover-tenure
- Less than 20% of reviewed cases result in staffings
- Evaluate the “best sample” for other challenges using predictive analytics
 - Permanency
 - Returns to Care
- Create Supervisor Reports



Eckerd.org | 13

The first name in second chances.™

Eckerd | **Questions or Materials?**

Lorita Shirley
 Chief of Program Services-Florida
lshirley@eckerd.org
 P:(727) 631-6241

Bryan Lindert
 Director of Quality Management
 P: (813) 951-0055
blindert@eckerd.org

Eckerd.org | 14

Thank You



The first name in second chances.SM
Eckerd
Eckerd.org





**Improving Outcomes:
A Technology Approach**

Applying Predictive Analytics to Child Welfare

Accuracy, Productivity, Awareness, Outcomes

TRACKING ← ANALYZING → PREDICTING

Innovations for Information Visibility

Predictive Analytics

- **Machine Learning**
Learn from existing data
Based on what is learned, produce results on unseen data
- **Data Science**
Extraction of knowledge from data
Pattern recognition
High Performance Computing
- **Forecast**
Establish statement re: outcomes that have not yet been observed
Based on the data, what is likely to occur

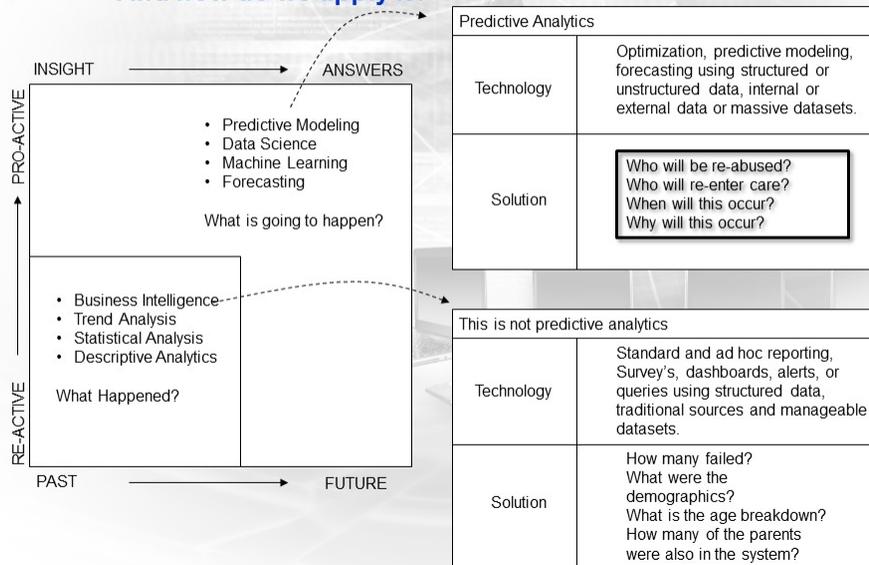
**If the results are accurate
and we can determine the likelihood of re-abuse, reentry, etc
can we readily and measurably improve outcomes and safety**

What do we Achieve using the Predictive Models?

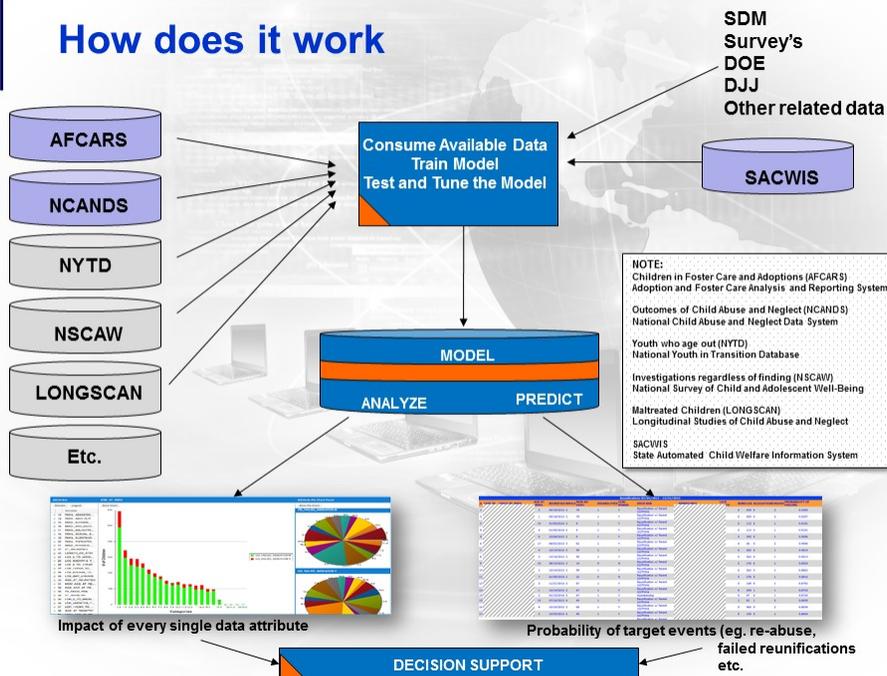
- New and Improved Insight
- Actionable Answers
- Probability of Future Events
- Ability to Use Results to Inject Case Practice
- Ability to Track Results of Case Practice Changes
- Ability to Measure Improvements

What is Predictive Analytics?

And how do we apply it?



How does it work



How accurate is the prediction?

Detailed Accuracy By Class							
TRUE POS RATE	TRUE NEG RATE	FALSE POS RATE	FALSE NEG RATE	TRUE POSITIVES	FALSE POSITIVES	TRUE NEGATIVES	FALSE NEGATIVES
98%	78%	22%	2%	2575.0	119.0	416.0	52.0
78%	98%	2%	22%	416.0	52.0	2575.0	119.0
Stratified Cross Validation							
Correctly Classified Instances	94.59%	Percentage of predictions that were correct across all test datasets					
Incorrectly Classified Instances	5.41%	Percentage of predictions that were incorrect across all test datasets					
Kappa Statistic	0.79754494	Comparison of accuracy when testing across random test sets (proportion of times the model value was equal to the actual value.)					
Mean absolute error	0.10299637	Average of the difference between predicted and actual value in all test cases; it is the average prediction error					
Root mean squared error	0.20050417	Variance of error in the model.					
Total number of instances	3162.0						

Operationalize the Predictive Model

Lets look at all children who have been reunified this month/last month
 What is the probability a given child will re-enter

Cross Tabulation Analysis		Back to Configuration			
Reunifications					
#	CASE	CHILD	RMVL	REUNIFIED	PROBABILITY OF FAILURE
1	yMeRy	aBuqa	12/11/2013	01/23/2014	0.9570
2	ehYJe	ujaSu	12/11/2013	01/23/2014	0.9570
3	yneNy	apuma	04/03/2013	08/22/2013	0.9523
4	eDyGe	uvaHu	12/11/2013	01/23/2014	0.9395
5	ySeqy	aNuva	10/05/2012	09/30/2013	0.9363
6	ePyre	uzaju	04/03/2013	08/22/2013	0.9346
7	yZepy	aWuTa	07/31/2012	01/17/2014	0.9296
8	eGyve	uhaju	09/03/2012	09/30/2013	0.9263
9	yjeSy	aBuSa	12/14/2012	11/25/2013	0.9141
10	emySe	uPaMu	05/02/2013	09/24/2013	0.9130
11	yqeQy	aDuJa	05/02/2013	09/24/2013	0.9130
12	eryXe	umaqu	05/02/2013	09/24/2013	0.9130
13	yTepy	aHuna	05/02/2013	09/24/2013	0.9130
14	emySe	uQagu	05/02/2013	09/24/2013	0.9130
15	yTeZy	aRuSa	07/31/2012	01/17/2014	0.9110
16	eGyVe	utaNu	07/31/2012	01/17/2014	0.9071
17	yPepy	aPusa	09/03/2012	09/30/2013	0.9045
18	eHyHe	uqanu	02/01/2013	12/24/2013	0.8902
19	yBeNy	aBuJa	02/01/2013	12/24/2013	0.8902
20	eZyZe	uvamu	12/05/2012	12/22/2013	0.8809
21	yDeHy	aMuXa	07/09/2012	01/27/2014	0.8805
22	ebyze	udaQu	05/07/2012	10/21/2013	0.8593
23	ySeJy	atupa	07/11/2013	10/09/2013	0.8539
24	etyXe	ugaDu	05/07/2012	10/21/2013	0.8489
25	yVeZy	amuRa	05/07/2012	10/21/2013	0.8489

What data is having an impact?

Attribute Ranking		
RANKING	ATTRIBUTE NAME	WEIGHT
1	NUM_RMVLS	0.31739388
2	NUM_DAYS_MOM_LATE_VISIT	0.09152000
3	NUM_WRKRS	0.03712666
4	NUM_DEN_LATE_VISITS	0.03355011
5	NM_LUNIT	0.03242292
6	TX_DSCH_RSN	0.02217161
7	LENGTH_OF_STAY	0.01274776
8	DIS_CLNC_DGNSD	0.01116367
9	DIS_NUM	0.01116367
10	NUM_RUNS	0.00474499
11	MOM_RACE	0.00163676
12	DIS_OTHER_SPC_CARE	0.00142530
13	DIS_LRN_DISABILITY	0.00131913
14	RACE	0.00101995
15	DIS_MNTAL_RETARDATN	0.00084721
--	DIS_VIS_HEARING_IMPR	0.00042323
--	DIS_PHYS_DISABLED	0.00033853
--	RMVL_PHYSICAL_INJURY	0.00031634
--	RMVL_INVAD_SUPERVISION	0.00028998
--	DAD_RACE	0.00020026
--	RMVL_ABANDONMENT	0.00013934
--	RMVL_THREATENED_HARM	0.00011955
--	RMVL_SEXUAL_ABUSE	0.00011460
--	DIS_EMOTION_DSTRBD	0.00007636
--	RMVL_SUBSTANCE_MISUSE	0.00005670
--	RMVL_ENV_HAZARDS	0.00004511
--	RMVL_BIZARRE_PUNISHMENT	0.00002086

- Systemic Findings Showing significant impact**
- Missed visits with parents
 - Missed visits with child
 - Worker turnover
 - Specific Care Management Organization
 - # of unsubstantiated findings before a removal
 - Placement disruption
 - Missing / late Supervisory Reviews
 - Late case notes
 - Short, curt and copied case notes

How is Prediction Used

- System of Care uses the prediction as a decision support tool
- Prioritize the Quality Assurance Review based on highest probability of risk
- Review case, inject required case practice changes
- Re-run prediction, track impact. The desire is to see the probability decrease or eliminated all together

How can the prediction be used?

Select a Case from the Probability Listing to see more detail:

These children are nearing their reunification. The prediction shows probability of failure is high. Attribute ranking shows issues with:

- Safety Plan
- Home Study
- Case Notes
- Psychotropic Medications
- Placement Stability

Safety Plan
No update since April.
NOTE: reunified set for end of August

Home study:
Highlights mom still unemployed
*Case note is one sentence (6 words)

Active meds
Plcmt stability (# plcmts)
Medical on file
Last Visit was Within 12 months

Flagged (see other sides for how this is used)
Case Notes

NOTES:
Electricity turned off 8/15
Mom still unemployed
Another allegation of neglect ----
(4 months prior to reunification date)
PI closes allegation of neglect; (no indicator)

Priors and maltreatments in care

COMPLIANCE				DEMOGRAPHICS				INDICATORS				IN CARE				MALTREATMENT					
#	VISIT	REVIEW	STAFFING	SAFETY PLAN	HOME STUDY	NAME	AGE	REPS	ABS	PLC	MEDICAL	NOTES	FUS	PHYS	SEP	DT	RRVL	DT	INCD	ALLEGATION	FINDING
2	5	24	32	OK	OK	[Image]	7	0	0	OK	OK		N	N	N	removal	removal	removal	2009-09-04	Threatened Harm	Some Indicator
3	6	24	32	OK	OK	[Image]	5	0	0	OK	OK		N	N	N	removal	removal	removal	2008-10-20	Physical Injury	No Indicator
																			2009-09-04	Physical Injury	Some Indicator
																			2011-03-25	Inadequate Supervision	No Indicator
																			2010-06-10	Inadequate Supervision	No Indicator
																			2010-06-10	Death	No Indicator
5	5	24	32	OK	OK	[Image]	8	0	0	OK	OK		N	N	N	removal	removal	removal	2002-07-04	Bone Fracture	Verified
																			2002-07-04	Bone Fracture	Verified
																			2002-07-04	Bone Fracture	Verified
																			2008-05-20	Physical Injury	No Indicator
																			2008-10-20	Physical Injury	No Indicator
																			2009-09-04	Threatened Harm	Some Indicator
																			2010-06-09	Physical Injury	Verified
																			2010-06-09	Failure to Protect	Verified

View Impact of Case Action Steps

Is my case practice having a positive impact



Case File Action Steps

Action Step	Status	Assigned Date	Due Date
Complete safety plan if it has not been done	COMPLETED		HH (REMOVED)
Complete homechecks as to the father and background checks to include all household members	COMPLETED		HH (REMOVED)
Document communication with the father	COMPLETED		HH (REMOVED)
Document communication with the father's probation officer	COMPLETED		HH (REMOVED)

IMPACT MEASUREMENT
LAST 12 MONTHS



RISK MEASUREMENT
LAST 12 MONTHS



Mother's Name: oquZa eWyNe **Mother's DOB:** uZaSu yWaWy

Case Manager: [] **CM Agency:** 2326 **Supervisor:** []

Spouse/Paramour's Name: atuNo etyme **Spouse/Paramour's DOB:** udaVu yhaftY

Reason for Dependency: substance misuse and family violence threatens child **ESI Date:** 05/22/2013

Last Contact - Mx: 05/22/2014 **Supervisor Approved:** 6/7/2013 **Staffing Required:** Yes No

Most Recent Family Assessment: **Staffing Date:** []

Number of Priors: 5 **Alleged Maltreatment of Priors:** bruise/welts, substance exposed child, physical injury, environmental hazards, substance misuse, ...

Abuse during services: Yes No

Removals as child: Mx N/A Yes No

Does Child have previous removal: Yes No **If yes, which maltreatment lead to removal:** []

Current Risk Level: Low Medium High **Risk Level Appropriate:** Yes No **Date of most recent Safety Plan:** []

Safe Sleep? Yes No **Water Safety?** Yes No

Date: 05/23/2014 **Reviewer:** []

	1	2	3	4	5	6	7	8	9	%
	N	N	Y	NA	Y	Y	N	NA	Y	57.14

Survey Questions

1. Is safety planning sufficient to risk?
2. Is the case plan individualized for family's needs and related to known dangers?
3. Is the parent's behavior change monitored related to these risks?
4. Is the case manager aware of any emerging dangers? If so, are they followed up on urgently?
5. Is the quality of contacts sufficient to ascertain and respond to known threats and emerging dangers?
6. Is the quantity of contacts sufficient to ascertain and respond to known threats and emerging dangers?
7. Are background checks/home studies sufficient and responded to appropriately?
8. Is communication with the case stakeholders sufficient to the known dangers and to ascertain if emerging dangers are present (Court, Providers, Collaterals, etc)?
9. Does supervision identify concerns in service provision related to all of the above and are recommended actions followed up on urgently?



Thank you.

Mindshare Technology
www.mindshare-technology.com
1-866-949-3293

Innovations for Information Visibility

The first name in second chances.SM



Eckerd Rapid Safety FeedbackSM **Perpetual Performance Improvement** **Bringing Business Intelligence to Child Welfare**

“We had 9 child deaths in 18 months in open child welfare cases under a previous Lead Agency– and it had to stop. Once Eckerd became the Lead Agency, DCF and Eckerd worked together to develop an approach to quality assurance that would prevent any further child tragedies from occurring if at all possible. Eckerd’s Rapid Safety Feedback approach has done that and, fortunately, we have had no new abuse related child tragedies since that time. “

– Mike Carroll, Interim Secretary, Florida Department of Children and Families

Introduction

In Florida, the child welfare system is a community-based system of care in which 20 lead agencies across the state are contracted by the Florida Department of Children and Families and responsible for the safety, well-being and permanency of children and families. Eckerd acts as the Lead Agency in three Florida Counties – Hillsborough, Pasco and Pinellas – serving over 6,000 children every day.

Eckerd was selected to manage the child welfare system in Hillsborough County in June 2012, after a series of over 9 child homicides had occurred. Eckerd and the local Department of Children and Families agreed that a new approach to quality assurance in child welfare was critical if we were going to prevent additional child injuries and fatalities from occurring.

Prior to assuming case responsibility in Hillsborough County, Eckerd organized, funded and completed a multidisciplinary Quality and Safety Improvement review of all open cases in the County - over 1,500. The purpose of this review was to ensure that children were safe while providing Eckerd with valuable information on system gaps and the roadblocks that were adversely impacting the ability to reach timely permanency for and ensuring the well-being of our children.

After gathering information from this process and then reaching out to national experts for additional input, two distinct sets of criteria emerged. The first was a profile of those cases with the highest probability of serious injury or death occurring. These cases had multiple common factors to include child under the age of 3; paramour in the home; substance abuse/domestic violence history; and parent previously in foster care system.

This research and analysis also identified nine child welfare practice skills that were critical to ensuring that children in the target cases remained safe. Among these were quality safety planning; quality supervisory reviews, and the quality and frequency of home visits.

Lastly, the Florida SACWIS system (state child welfare data system) had limitations in its ability to provide real time data. Eckerd contracted with Mindshare to provide system overlay software allowing real time data and dashboards.

Eckerd Rapid Safety FeedbackSM Approach

Having identified the cases with the highest probability of a child homicide and the critical child welfare practices necessary to keep children safe, Eckerd launched its Rapid Safety Feedback process in January 2013.

The Process is as follows:

- Each of the high probability cases are reviewed by Eckerd quality assurance staff utilizing the Eckerd Rapid Safety FeedbackSM tool which focuses on the nine critical case practices. These cases continue to be reviewed quarterly until the case closes or youngest child turns 3.
- Eckerd quality assurance staff meets with the case manager and supervisor within 1 business day to discuss any safety concerns and develop a plan to ensure they are quickly mitigated. This meeting provides an opportunity for immediate coaching and support of case management staff.
- Agreed upon tasks are tracked to completion by Eckerd Quality staff.

Initial Results

- No abuse related deaths since implementation of Eckerd Rapid Safety FeedbackSM.
- 21% improvement in nine critical case practices.
- Quality Assurance staff are now directly changing case practice in real time.

Implications and National Attention

Eckerd Rapid Safety FeedbackSM has been successfully replicated in the other Counties where Eckerd is the Community Based Care Lead Agency in Florida. In addition, the State of Florida Department of Children and Families is rolling out of Eckerd Rapid Safety FeedbackSM in response to a statewide increase of child tragedies.

Eckerd Rapid Safety FeedbackSM has been identified as a national best practice by Casey Family Programs, a leading national child welfare foundation, as it recognized Eckerd at two national forums on predictive analytics and fatality prevention. Eckerd has made presentations at multiple state and national meetings at the request of Casey Family Programs, the Alliance for Children and Families and the Child Welfare League of America about this approach.

This unique program has also been identified as a promising practice by the bipartisan federal Commission to Eliminate Child Abuse and Neglect Fatalities. Eckerd is presenting at the next Commission meeting in Tampa on July 10th to share additional information.

Eckerd Rapid Safety FeedbackSM was similarly recognized by Los Angeles County's Blue Ribbon Commission on Child Protection.

Finally, the program has been featured on NPR, in the Atlanta Journal Constitution, in the Wall Street Journal and was the subject of a favorable editorial by the Tampa Bay Times in January 2014 available here: <http://www.tampabay.com/opinion/editorials/editorial-a-better-way-to-protect-children/2162642>

Eckerd is now working with these national partners as well as specific local and state entities to replicate Eckerd Rapid Safety FeedbackSM.

About Eckerd:

Eckerd is a national nonprofit organization that has given much-needed second chances to over 150,000 children and families since 1968. Founded by philanthropists Jack and Ruth Eckerd who believed every child deserved the opportunity to succeed, Eckerd serves about 15,000 children and their families each year through a life-changing child welfare, juvenile justice and behavioral health programs and services in seven states. To learn more visit Eckerd.org.



Why
is
ICWA
SO
IMPORTANT?



Student body at Carlisle Indian Industrial School, Pennsylvania circa 1905.

-National Archives and Records Administration

Introducing... The Family Services Department

Seminole Tribe of Florida Reservations



- 0 Hollywood
- 0 Broward County
- 0 Big Cypress
- 0 Hendry County
- 0 Brighton
- 0 Glades County
- 0 Immokalee
- 0 Collier County
- 0 Tampa
- 0 Hillsborough County
- 0 Fort Pierce
- 0 St. Lucie County

Family Services Department Programs

- 0 Clinical Program
- 0 Family Preservation Program
- 0 Prevention and Aftercare Program
- 0 Psychological and Psychiatric Program
- 0 Utilization Program
- 0 Guardianship Program

Family Preservation Program and the Exercise of ICWA

- 0 FSD has designated Family Preservation staff at each site
- 0 Support during all child abuse/neglect investigations
- 0 Mutual (with DCF) development of Safety Plans
- 0 Regular follow-up on Safety Plan compliance
- 0 Location of placements (according to Seminole Tribe Placement Preferences) for children in need of out-of-home care
- 0 Act as Qualified Expert Witnesses at all court hearings
- 0 Mutual development of case plans
- 0 Intense case management of all cases
- 0 Facilitation of Tribal Parenting Course
- 0 Facilitation of supervised visitation

Family Services Department Services

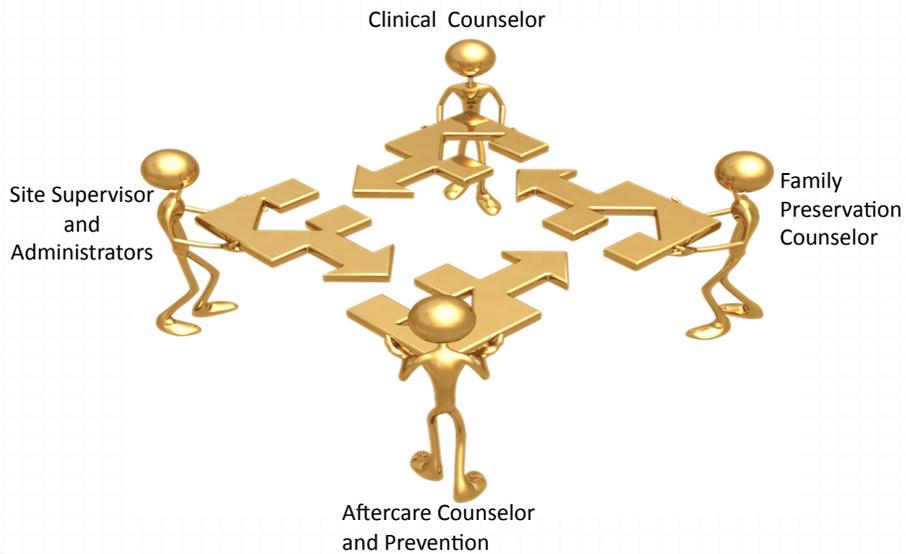
- 0 Advocacy & Referral Services
- 0 Support for Child Abuse and Neglect Problems
- 0 Family Support and Parent Education
- 0 Tribal Foster Care
- 0 Psychological and Psychiatric Evaluations
- 0 Prevention Programs and Events
- 0 Youth Counseling (in-school & after-school)
- 0 Individual & Family Counseling
- 0 Substance Abuse Counseling
- 0 DUI Counseling
- 0 Aftercare Services
- 0 Re-Entry Program
- 0 We Do Recover work program
- 0 Women and Youth Groups & Circles
- 0 On Call services
- 0 John's Place Inc. residential treatment
- 0 E•lá•mash•ke Che•ke (EMC) three-quarter-way house
- 0 Youth Home (coming soon)

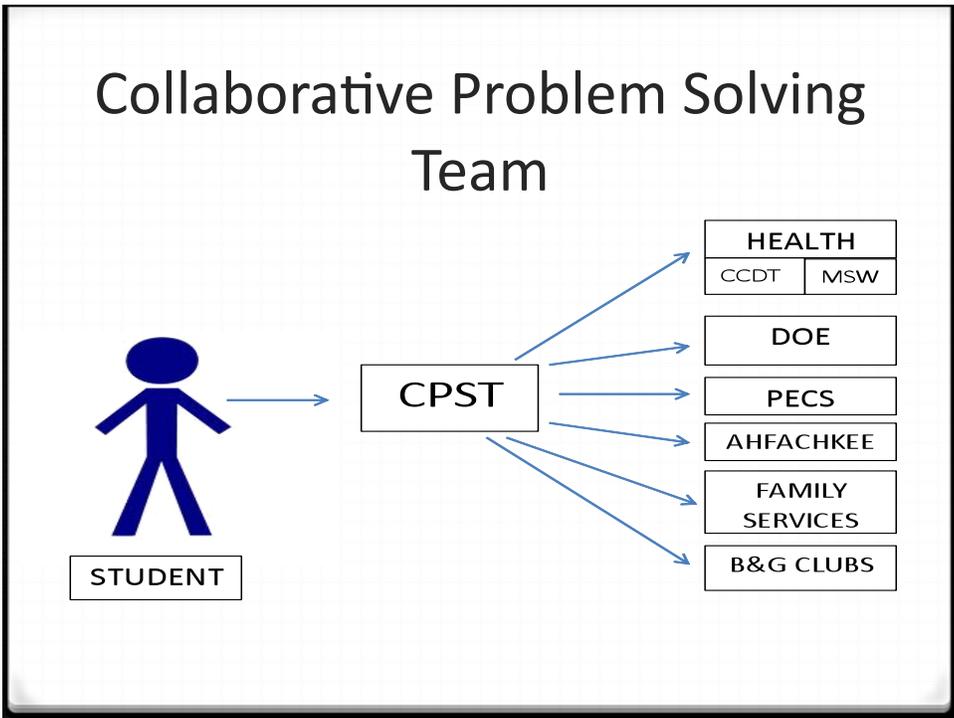
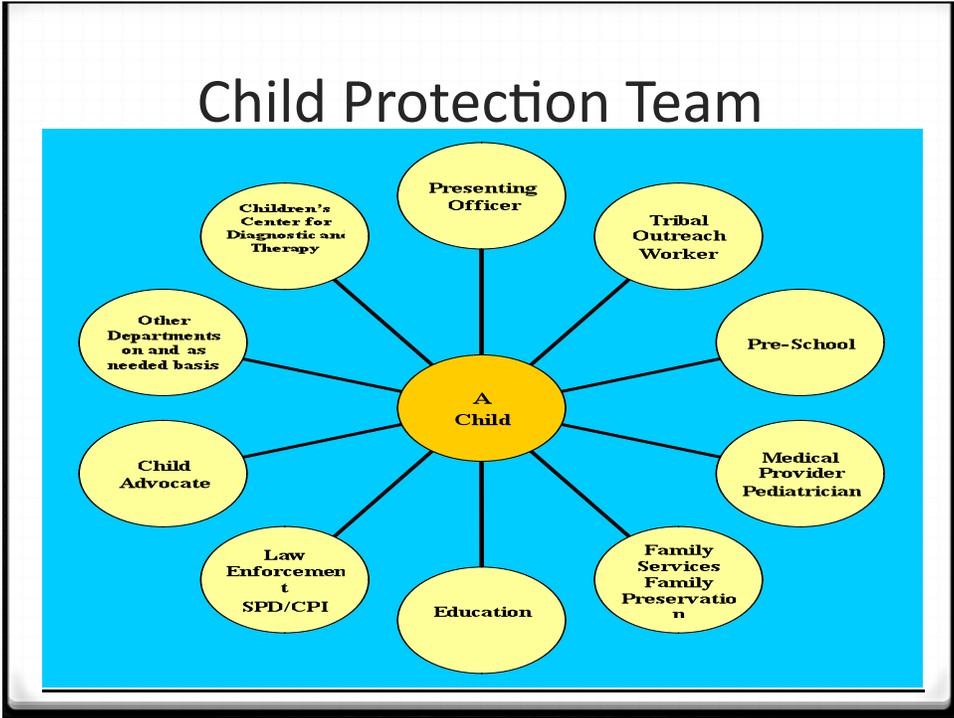
System of Care Guiding Principles

- 0 Inter-departmental and Inter-agency Collaboration
- 0 Individualized and Strength-Based Care
- 0 Cultural Competence
- 0 Family and Youth Involvement
- 0 Community-Based Services
- 0 Accountability

System of Care Products

Treatment Team





Questions?

Contact Information:

Kristi Hill

kristihill@semtribe.com

(954) 965-1314

Sharing Child Protective Information to Save Children's Lives

Howard Davidson, JD
Director, ABA Center on Children and the Law

Privacy/Confidentiality/Information Sharing Timeline

- 1974: *CAPTA* is enacted with a mandate to "preserve the confidentiality of all records"; FERPA is also enacted
- 1983: *CAPTA* regulations are issued, with 11 permissible CPS information release categories if authorized by a state law (none involve public release)
- 1996: *HIPAA* is enacted; Elisa Izquierdo death in NYC prompts NY law on information release; *CAPTA* is amended to "allow" CPS to release post-death data
- 1997-present: HHS issues "PIQs" to clarify confidentiality issues (but no changes to HHS regulations since 1990 on this subject)
- 2002: HHS Privacy Rule is issued clarifying very strict alcohol /drug treatment patient information confidentiality
- 2003: *CAPTA* amended to mandate certain disclosures of CPS information
- 2006: Federal *Adam Walsh Act* addresses CPS information access issues related to child safety
- 2008: 1st "State Secrecy and Child Abuse Deaths in the U.S." report (2nd ed. in 2012)
- 2010: U.S. Senate Report on *CAPTA* calls for HHS to issue regulations to guide states on CPS agency release of information to public
- 2012: HHS says what post-death CPS information must be released to the public
- 2013: Congress passes *Uninterrupted Scholars Act* to ease accessibility to school records by child welfare agencies; GAO releases report on importance of human services agency data sharing

Release of Records and Information After a Child Fatality or Near Fatality

- 1996: CAPTA was amended, for the first time, to specifically authorize release (“*allowing* for public disclosure”) of what was termed “findings or information” held by CPS
 - Note that Congress did not use the words “required to release”, left open whether releases were only to be done upon a request, and didn’t specify what was meant by “findings” or by “information” – and use of the word “or” was ambiguous
 - Although there were CAPTA confidentiality regulations (45 CFR 1340.14 that preceded the date of the 1996 amendment, the regulations were never changed to address this amendment, but rather HHS relied on Policy Interpretation Questions (questions and answers or “PIQs”) in the “Child Welfare Policy Manual” to help with clarifying interpretations of the 1996 amendment’s effect

- The most important PIQ was, in September 2012, one that finally specified the minimum of what must be disclosed upon a request.

Earlier PIQs had clarified:

 1. What constitutes a “near fatality”
 2. That “findings or information really meant “findings and information”
 3. That a report, which had the requisite information, released by a child fatality review team could suffice as the “public disclosure”
 4. The “discretion” CPS has to release is only the public’s discretion to seek access, but once requested, disclosure is then mandatory
 5. That, upon request, CPS need not turn over entire case records, nor did it have to give out a dead child’s name, date of birth, date of death, or information on siblings or other children in the home of the dead child

After much confusion of what **MUST** be released upon a request, HHS in September 2012 listed what, at a minimum, has to be released...

Here's what HHS said has to be released, at a minimum, upon request:

1. Causes of and circumstances regarding the fatality or near fatality
 2. Age and gender of that child
 3. Information on any previous reports of abuse or neglect
 4. Investigations pertinent to the abuse or neglect that led to the fatality or near fatality
 5. Result of such investigations
 6. Services provided by, and actions of the State, on behalf of that child, that are pertinent to the abuse or neglect that led to the fatality or near fatality
- In Senate Report 111-378 (Dec. 18, 2010, accompanying a CAPTA reauthorization bill) the authorizing committee stated they were aware not all states were in compliance with the disclosure requirement, so it called upon HHS to “develop clear guidelines in the form of regulations” instructing states of their responsibilities to release, and that HHS should provide technical assistance to States on full disclosure procedures

July 2011 GAO Report: “Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention”

- Found states were not adequately gathering fatality data from non-CPS sources, that better synthesis of data from multiple sources could provide more accurate fatality counts, and that states indicated a need for additional assistance from HHS on collecting fatality & near fatality data and using that data for prevention efforts
- Recommended data quality be strengthened, by sharing state best practices, that information be more available, and shared, on circumstances surrounding child maltreatment fatalities, and that HHS estimate the costs & benefits of collecting national data on *near fatalities* (which is now not a part of NCANDS)
- Congressional Response (P.L. 112-34): As of 2012, all State Child Welfare Plans must describe sources used to compile information on child maltreatment deaths, and to extent they do not include death information from State vital statistics department, child death review teams, law enforcement agencies, medical examiners, or coroners, each State must describe why that information is not so included and how it will later include it

“State Secrecy and Child Deaths in the U.S.” (2nd edition 2012) Children’s Advocacy Institute (U. of San Diego) and First Star

- Grades states on fatality public disclosure policies: statewide, mandatory, written into law, cover fatalities and near fatalities, not having vague (e.g., “best interests of child”) or inappropriate limitations on release (but non-disclosure is O.K. if disclosure would jeopardize an investigation or prosecution), and which largely track information release elements HHS mandated in its 2012 PIQ. They also look at state “open access” to dependency court hearings.
- 10 states got A grades (AR, AZ, IN, IA, ME, NH, NV, OR, PA, UT); 4 states got D or F grades (CO, DE [in part due to non-release while any case is “being prosecuted”], MT, NM)
- Highlights under each state’s “illuminating information” section include interesting details on state compliance and limitation on disclosures
- Not in their criteria: a) Requiring publication/dissemination of recommendations made in the death review process; b) Mandating states collect/report on aggregate fatality data & related CPS information (as in a 2011 MI law), & c) Assuring a state’s summary of fatality reports will be posted on the internet

To Prevent Child Deaths: CAPTA Must Continue to Evolve from “You Must Keep Confidential” to “You Must Disclose”

- Original CAPTA state requirement focused on keeping records private with limited exceptions: i.e., states were required to have methods “to preserve the confidentiality of all records in order to protect the rights of the child and the child’s parents”
- There was concern this provision endangered kids, so in 2003 CAPTA was amended to require state provisions mandating disclosure of confidential information to any government entity with a “need for such information in order to carry out its responsibilities under law to protect children from child abuse and neglect” (KS law 38-2210 calls for “freely exchanging information”)
- There are 8 HHS PIOs on CAPTA confidentiality interpretations, but there are NONE on the meaning of that 2003 mandatory disclosure language!
- The old regulations at 45 CFR 1340.14 require states to *criminalize* disclosures that lack state statutory authority, which may have inhibited full implementation of the CAPTA 2003 mandatory disclosure provision

Need to Improve State Laws on Permissible and Mandatory Disclosures

- The CFR had a list of permissible CPS disclosures if authorized by state law, but since it was last amended in 1990, and the field has developed, it omits: licensing agencies; children's advocacy centers; reporting of observed animal cruelty; reporting to protective agencies for persons with disabilities or older adults ; reporting to the military or to tribes; reporting of domestic violence to appropriate authorities/checking records for civil orders of protection
- CPS information can be disclosed, if there's a relevant state law, to "properly constituted authorities" and their designated "multidisciplinary case consultation team" but those terms have never been defined in the CFR or in the PIQs; same is true with release to physicians, where law says they must have a suspected victim "before them". What if, instead of diagnosing abuse of a child before them, they are (post-substantiation) doing diagnostic or treatment work with a child? What about CPS disclosures to mental health professionals, or school personnel, doing therapeutic interventions with a child? What about disclosures to probation officers supervising offenders?

- Although it is permissible to release CPS information, assuming state law so specifies, to properly constituted agencies authorized "to diagnose, care for, treat, or supervise a child" after a report of abuse or neglect, HHS has not clarified this provision:
 - Does it include schools? Private agencies providing foster/group care? CASA programs? Medical examiners? Juvenile justice agencies? And should CAPTA be changed to authorize release not just to "agencies" but also to "individuals" (e.g., foster/kinship providers)?
- Disclosure of CPS information is also permissible to persons "legally authorized to place a child in protective custody" (e.g., police) but only for deciding whether a placement is needed– Sharing of CPS information with police should be clearly permitted for both protective custody and any child protection related purposes
- The CFR has not been revised since federal law mandated CPS information release for employment/licensing screening & to Citizen Review Panels
- Other "oversight" related release should be clarified by CAPTA & HHS: e.g., to Foster Care & Child Death Review Teams; Children's Ombudsmen/Child Advocate Offices

Ten Other Key Issues in Release of CPS Records and Access to Information Related to Child Safety

1. State laws should mandate "feedback" to reporters of abuse/neglect, upon request, that includes investigation results and actions later taken
 2. Cross-state CPS record sharing and access should be mandated (important due to mobility of families involved in child maltreatment) for social services, licensing, and law enforcement agencies upon request, especially if a maltreating parent has left the state
 3. States should consider, and CAPTA may need to explicitly permit, laws (as in AK, AZ, CO, CT, IL, KS, KY, LA, ME, MI, MT, NB, NY, SC) permitting some CPS information disclosures to the public, in other than fatality/near fatality cases, if those cases become otherwise publicized, so that CPS actions in that case can be made clear
 4. There should be explicit legal authority for public release of information about children missing from foster care, group care, or from homes where they've been under protective supervision
-
5. State laws should improve immunity protections for those who CPS asks to assist it in serving abused or neglected children (fear of liability inhibits professionals from sharing information and aiding maltreated children)
 6. CPS agencies should develop and utilize – with parents – voluntary, standard, and clearly understandable consent/release of information forms permitting release of otherwise confidential information that not only addresses child welfare information but also acknowledges HIPAA, FERPA, and Substance Abuse Treatment record protections
 7. State laws (often misapplying a CAPTA provision) have limited a future child protection/safety tool: Use of earlier unsubstantiated reports by, for example, expunging them from access. This should be changed
 8. State laws should clearly mandate appropriate "cross-reporting" from CPS to police and prosecutors, and vice-versa (e.g., in physical and sex abuse cases)
 9. State laws should permit the sharing of abuse/neglect information, as appropriate, about a child at Family Team Meetings (e.g., NJ permits this)

10. The federal Adam Walsh Child Protection and Safety Act of 2006 (P.L. 109-248), in addition to mandating prospective foster and adoptive parent background checks, and requiring CPS Central Registry checks from all states where a parent/adult has lived in the last 5 years, includes a little-known provision giving CPS agencies an opportunity for direct access to the FBI's National Crime Information databases for use during "an investigation relating to an incident of child abuse or neglect"
- That FBI data includes felony arrests and convictions, sex offender data, probation/parole information, etc.
 - Child safety should be enhanced by doing record checks of adults in the home during an investigation, and especially after substantiation or prior to reunification – so workers will be aware of adults with violent criminal histories that suggest they may endanger children
 - Child welfare agencies should apply for FBI NCIC terminal access to securely run these checks from *within the agency* (FL was first to do so)
 - State law should also authorize, for any adult in the home, that their state criminal history be accessible for child protection purposes as part of an investigation [e.g., VA §63.2-1505(C)]

Beyond CPS Record and Information Sharing: HIPAA, FERPA, and Substance Abuse Record Access

HIPAA

- Disclosure of abuse/neglect related information is addressed in three sections of the regulations
- Restrictions on health record release don't apply where a state law addresses the reporting of injury or child abuse, or for "public health surveillance, investigation, or intervention" – thus, health records should be disclosed to multidisciplinary teams, CACs, child fatality review groups, or CPS itself if their work is deemed "related to public health" (which I contend that child abuse and neglect certainly is)
- Parents can't prevent release of a child's health information, or obtain that information, if the medical institution has a reasonable belief they've subjected their child to abuse or neglect
- HIPAA gives police, courts, and those determining the cause of child deaths the ability to access relevant health information

FERPA

- The federal Uninterrupted Scholars Act (P.L. 112-278), effective 1/14/13, changed FERPA by creating a new exception to school record release that makes it easier for schools to give child welfare agencies a child's education records without prior consent of the child's parents, and it eliminated an earlier requirement that schools notify parents before those records are released pursuant to a court order, where the parent is a subject of a child welfare court proceeding
- FERPA has always allowed release of what it calls "directory information" including dates of a student's attendance (i.e., so CPS can check on whether a child known to them has been chronically truant or recently absent) -- But what about a "home schooled" child?
- A student's education records can only be re-disclosed to those addressing the student's education needs who are authorized by the child welfare agency to receive those records (such authorizations should include foster parents, children's attorneys, GAL, CASA)

Alcohol and Drug Abuse Patient Records

- Privacy protections apply to clients of substance abuse treatment programs that are federally-assisted (rules/regulations are in 42 CFR Part 2, called "Part 2" which were initially authorized under the federal Drug Abuse Prevention, Treatment, and Rehabilitation Act, and the Public Health Service Act)
- These protect information on the identity, diagnosis, prognosis, or treatment of patients
- Courts can issue orders for release of this, with due process to the parent and treatment program, and upon good cause – or, with the patient's clearly voluntary consent, that information can be released
- Any restrictions on release do not apply to reporting, under state law, of suspected child abuse and neglect, but the restrictions still apply as to information use in civil or criminal proceedings arising out of that report
- Disclosures are permitted to "criminal justice agencies" but only when they made program participation a condition of disposition (the rules say nothing about release to "child welfare agencies" or dependency courts)

Six Recommendations for Effective Multidisciplinary Work to Prevent Child Deaths

1. Congress and HHS should assure, through adequate funding, that recommendations from all state/local child fatality & near fatality review groups are -- annually -- centrally consolidated, organized by topic, reported on (through national dissemination), and followed up on to assess adequacy of implementation
2. The Children's Bureau should work with their counterparts elsewhere in HHS that address privacy/record access, to produce and disseminate materials and models for: a) informed parental consent form language for information release; b) inter-agency data sharing agreements; and c) data exchange warehouse processes, that make information accessible to and from CPS agencies
3. CAPTA should be amended to provide, and new state laws should promote, targeted financial support for maintaining effective state and local multidisciplinary teams that address child abuse and child neglect
4. CAPTA should also be amended to tie state receipt of CAPTA Title II Community-Based Prevention Grant funding to an independent careful review, and implementation, of the findings and recommendations of fatality/near fatality review teams
5. CAPTA, and state child abuse/neglect laws, should be amended to give explicit authority to CPS to subpoena the production of documents, records, and other materials deemed relevant to an investigation of child abuse or neglect
6. CAPTA, HHS, and state laws should provide a mandate to promptly share an agency's, organization's, or individual's information with other agencies and professionals that are engaged in work to protect children



FCADV's Child Protection Investigation (CPI) Project: Increasing Safety for Families Experiencing Domestic Violence

CPI Project Overview

Protecting children from the effects of domestic violence is a mutual priority of the Florida Coalition Against Domestic Violence (FCADV), the Department of Children and Families (DCF), and the Office of the Attorney General (OAG). 'Family violence threatens child' is one of the highest maltreatment offenses reported to the Statewide Florida Abuse Hotline. With this in mind, and the knowledge that children in the foster care system often have poor life outcomes, FCADV, DCF, and the OAG worked together to create a groundbreaking program focused on reducing the removals of children from the non-offending parent in domestic violence cases.

FCADV and DCF utilized American Recovery and Reinvestment Act (ARRA) funding in 2009 to initiate seven pilot Child Protective Investigation (CPI) projects in which each Certified Domestic Violence Center was funded to employ full-time domestic violence advocates, co-located within the seven Sheriffs' Offices, where the Legislature privatized the CPI functions. This highly successful pilot program provided expert consultation in cases involving domestic violence to child protective investigators; while providing case management services to families that support permanency, safety, and the well-being of children. This immediate intervention, sometimes within hours of a child abuse report, helped to stabilize the crisis and increase protective factors in the home.

In 2011, when Governor Rick Scott transitioned the Services, Training, Officers, and Prosecutors (STOP) funding to FCADV, the organization utilized the dollars previously used for administrative functions to expand to six additional counties to replicate the highly successful CPI projects. The organization utilized the model to expand and provide funding for four additional sites serving six counties where the local Domestic Violence Center partners with the DCF regional offices and Community Based Care Lead Agencies. In addition, FCADV secured the leadership and participation of Attorney General Pam Bondi to partner with FCADV and DCF to expand and enhance these projects by increasing the leadership and participation with local law enforcement agencies and prosecutors. The current CPI Project partners include:

- The Spring of Tampa Bay and the Hillsborough County Sheriff's Office;
- Community Action Stops Abuse and the Pinellas County Sheriff's Office;
- HOPE Family Services, Inc. and the Manatee County Sheriff's Office;
- Salvation Army Domestic Violence Program of West Pasco and the Pasco County Sheriff's Office;
- Women in Distress of Broward County, Inc. and the Broward County Sheriff's Office;
- Citrus County Abuse Shelter Association, Inc. and the Citrus County DCF Office (previously the Citrus County Sheriff's Office);
- Lee Conlee House, Inc. and the Putnam County DCF Office;
- The Shelter for Abused Women and Children and the Collier County DCF Office;
- The Salvation Army Domestic Violence and Rape Crisis Program and DCF Offices covering Bay, Gulf, and Calhoun Counties; and
- Victim Response Inc./The Lodge and the Miami Dade County DCF Office.



FCADV conducts intensive training and ongoing technical assistance with partners in each of the participating communities to enhance and reduce barriers to ensure successful implementation of the CPI Project. In addition, FCADV conducts regional Learning Exchanges and on-site Train the Trainers with co-located domestic violence advocates to prepare them to train their child welfare partners on strategies for increasing domestic violence perpetrator accountability and family safety in the child welfare system. FCADV and David Mandel and Associates provide the highly touted *Safe and Together Model* training for domestic violence advocates and child welfare staff. This training helps to build their capacity to collaborate locally on reducing the removal of children from the non-offending parent while employing strategies to hold the perpetrator accountable. During the 2012 through 2013 Fiscal Year, FCADV conducted the following activities in support of Domestic Violence Centers and child welfare agencies:

- Three *Regional Learning Exchanges* on increasing perpetrator accountability in child welfare cases involving domestic violence;
- One two-day statewide *Child & Youth Institute*;
- One Train-the-Trainer and workgroup meeting for child welfare professionals who conduct home visits on working with survivors of domestic violence and their children;
- Two workshops at the *DCF Dependency Summit* and provided eight travel scholarships for local co-located advocates to attend;
- A statewide Community Readiness Assessment for improved domestic violence and child welfare service integration;
- Two onsite and six electronic service integration plan meetings with child welfare supervisors;
- 12 intensive onsite technical assistance visits to CPI projects;
- Four quarterly conference calls with co-located advocates;
- 267 units of electronic technical assistance related to domestic violence and child welfare collaborations;
- Four *Safe and Together Model* trainings for domestic violence advocates and child welfare staff in Brevard County and Miami-Dade County;
- One training for judges/attorneys on the *Safe and Together Model* in Miami-Dade County; and
- Four days of *Safe and Together Model* technical assistance for co-located advocates in Miami-Dade County.

Highlights of the CPI Projects

In FY 2012-13, FCADV's ten CPI projects were collectively able to create and utilize a holistic seamless system of wrap around services which allowed **4,166** children, whose families were involved in the child welfare system as a result of domestic violence, to remain in the home with the non-offending parent. This effort significantly reduced the need for foster care services and produced an approximate cost savings of **\$10,723,284** ($4,166 \times \$429 \times 6 \text{ months} = \$10,723,284$). The following are some examples local program successes:

- In January 2012, FCADV partnered with the Office of the Attorney General and the Department of Children and Families to launch a CPI Project in Bay, Gulf, and Calhoun Counties. From January 2012 through June 2012, domestic violence related removals represented **20.6%** of removals in Bay and Gulf Counties. This was the first six months of the project when co-located advocates were hired and staff were receiving *Safe and Together Model* training. During the next six months, from June 2012 to December 2012, the removal rate dropped to **13.6%**; and for the most recent six month period, January 2013 to June 2013, the removal rate dropped even more to **9.1%**. The decrease in removals is a direct result of this project including the staffing of co-



located advocates, implementation of the *Safe and Together Model*, and enhanced system collaboration between partners such as: DCF, the Salvation Army Domestic Violence and Rape Crisis Program, the Bay County Sheriff's Office, and the State Attorney's Office. The project also resulted in the creation of Domestic Violence Units in the Bay County Sheriff's Office and the local State Attorney's Office that staff investigators and prosecutors who work tirelessly to increase batterer accountability and survivor safety within the local criminal justice system.

- Manatee County created a comprehensive holistic child protection initiative that focuses on keeping the child safe and in the care of the non-offending parent. This cutting edge project includes partnerships between the Certified Domestic Violence Center, the Sheriff's Child Protective Investigations Division, Community Based Care Lead Agency, Probation, Batterer's Intervention Program, State Attorney's Office and Children's Legal Services. Project partners conduct court-ordered "one parent removals" which represents a significant transformation in the child welfare system's response to domestic violence. Instead of mandating services for both the offending and non-offending parent, this program focuses on holding the perpetrator solely responsible for the abuse to the family.
 - Also in Manatee County, the prosecution rate of domestic violence perpetrators has increased from 5% to 25% since 2011. This is a direct result of the successful collaboration between local CPI project partners and their shared vision of increasing family safety by holding domestic violence perpetrators accountable in their community.
- From July 2011 to June 2013, the number of children removed because of domestic violence in Pasco County decreased by approximately **37%**. CPI project partners in Pasco County have worked diligently to keep children safe with the non-offending parent in child welfare cases involving domestic violence.
- Three of the CPI Projects are focusing on providing culturally and specifically specific outreach to survivors and their children from underserved populations. In Immokalee and Palatka, this includes primarily Hispanic/Latina survivors, many of which are from farmworker communities. In Miami, project partners created a pilot program focused on utilizing Haitian-Creole speaking advocates co-located with staff from DCF to provide services to Haitian-Creole survivors and their children where domestic violence and child abuse co-exist.

From July 2012 through June 2013, CPI Project Domestic Violence Advocates provided approximately:

- **4,000** counseling, injunction assistance, and information/referral services to survivors and their children;
- **2,800** case plan and case staffing consultations involving families impacted by domestic violence; and
- Received and followed up on **2,000** survivor referrals from child protective investigators and case managers.