Healthy Families Subcommittee

Tuesday, November 5, 2013
3:30 PM - 5:30 PM
12 HOB

Will Weatherford
Speaker

Gayle B. Harrell
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Healthy Families Subcommittee

Start Date and Time:	Tuesday, November 05, 2013 03:30 pm
End Date and Time:	Tuesday, November 05, 2013 05:30 pm
Location:	12 HOB
Duration:	2.00 hrs

Overview of the Sexually Violent Predator Program by the Department of Children and Families

Briefing on the Casey Family Foundation's "Review of Florida Safety Model and Front-End Assessment Tools"

NOTICE FINALIZED on 10/29/2013 15:31 by Villar.Melissa

Casey Family Program

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CASEY FAMILY PROGRAMS FLORIDA CONSULTATION TEAM

Page B. Walley, Ph.D.
Managing Director, Strategic Consulting
Casey Family Programs

Dr. Page Walley leads a Casey strategic consulting team that works with 15 states across the country. Prior to coming to Casey, he served as the Commissioner of the Alabama Department of Human Resources, a 4,500 employee, $1.3 billion department. Under Dr. Walley's leadership the Department successfully exited from long-standing federal oversight of its child welfare program, and garnered national recognition as a leader in providing safety, permanency, and well-being for the state's vulnerable children and families.

Dr. Walley also served as the Commissioner of the Alabama Department of Children's Affairs and the Commissioner of the Tennessee Department of Children's Services. He is a licensed clinical psychologist with over 25 years of experience in the field, and is also a licensed minister. He was elected to and served in the Tennessee House of Representatives from 1990 to 2000.

Dr. Walley received his bachelor's degree in psychology from Davidson College and received his master's and doctorate degrees in clinical psychology from the University of Georgia. He serves as an Adjunct Professor in the Department of Psychology at the University of Alabama-Birmingham and as a Graduate Faculty Member at Alabama State University.

Linda Jewell Morgan, MSW
Senior Director, Strategic Consulting
Casey Family Programs

Linda Jewell Morgan leads Casey's work with Florida. She is a veteran national child welfare consultant who has provided technical assistance and training to over 75 counties and states over the past 20 years. She has evaluated child welfare systems, facilitated multi-system collaboration, designed programs and trained on child protection and permanency. Ms. Morgan has authored numerous publications and delivered frequent national, state and local presentations on child welfare practice, systems change and family engagement.

In 2008, Ms. Morgan co-developed the Georgia Permanency Roundtable model, a multi-level systems intervention to expedite permanency for children in foster care. This model is currently in use in 125 jurisdictions in 34 states.

Early in her career, Ms. Morgan served as a child welfare social worker, supervisor, trainer and manager. She is a graduate of the University of Maryland and holds a Master of Social Work degree from the University of Washington.

Wanda Pena, MSSW, LMSW-AP
Senior Director, San Antonio, TX Field Office/Strategic Consulting, Clark County, NV
Casey Family Programs

As the Senior Director of Casey Family Programs' Field Office in San Antonio, Wanda Pena leads intensive work in south Texas to improve outcomes for children and youth who have been in long-term foster care. She also provides consultation to the Clark County, Nevada child welfare on systemic issues, including parent mentoring, staff development, and permanency roundtables.

Prior to joining Casey in 2011, Ms. Pena served the state of Texas for 30 years, working in all aspects of child welfare. She served as Implementation Director for Texas' statewide abuse/neglect intake reporting system; led the team that integrated risk and safety assessment tools into the Texas automated child welfare data recording system; and served as Texas' first Child Safety Director.

Ms. Pena has also served as a child welfare caseworker; supervisor; program director; state community relations specialist and state director for policy development in intake, investigations, family based safety services, and child fatality review.

Ms. Pena received her Master of Science in Social Work from the University of Texas at Austin. She is a Licensed Master Social Worker-Advanced Practitioner for the State of Texas.

Alan Puckett, Ph.D.
Systems Improvement Advisor, Knowledge Management
Casey Family Programs

Dr. Alan Puckett supports Casey's Systems Improvement efforts through research and reporting on child welfare policy, legislation, and best and promising practices. His recent journal publications include "Addressing Common Forms of Child Maltreatment: Evidence-Informed Interventions and Gaps In Current Knowledge" in *Child and Family Social Work* (2012) and "Effects of Moral Outrage on Child Welfare Reform" in *Archives of Pediatric & Adolescent Medicine* (2011).

Dr. Puckett has 20 years of experience in the child welfare field, including work as a case manager, management analyst, and a researcher.

Dr. Puckett holds Master of Social Work and Ph.D. in Social Welfare degrees from the University of Wisconsin.

Susan Smith, Ph.D.
Senior Director, Data Advocacy
Casey Family Programs

Dr. Susan Smith leads Casey's work with public jurisdictions to support data-driven decision-making and also internally tracks the impact of Casey's investments. She has worked in nearly all states and territories to improve measurement in child welfare and has led national initiatives to improve outcome-driven, child-focused child welfare practice and policy. Dr. Smith's expertise is in public and child welfare policy. She has published extensively on child welfare and public welfare finance and reform.

Prior to coming to Casey, Dr. Smith served on the faculty at the University of Southern California, School of Social Work, and taught child welfare policy and research there, as well as at the University of Washington and the University of Chicago.

Dr. Smith earned a doctorate in Social Service Administration from the University of Chicago and an MSW from the University of Washington. She currently holds an Adjunct Lecturer position at the University of Southern California School of Social Work where she teaches occasional courses on social policy.

Dee Wilson, MSW
Director, Child Welfare Services, Knowledge Management,
Casey Family Programs

Dee Wilson writes and speaks on a wide variety of child welfare subjects and has special expertise in child protection, chronic neglect and child fatalities. Most recently, Mr. Wilson co-authored the article, "Extent and Nature of Child Maltreatment Related Fatalities: Implications for Policy and Practice" which will appear in an upcoming special issue of Child Welfare journal on child maltreatment deaths, which he co-edited. He is the author of *Sounding Board*, a monthly commentary on child welfare issues.

Prior to coming to Casey Family Programs in 2010, Mr. Wilson served as the Director of the Northwest Institute for Children and Families at the University of Washington School of Social Work and child welfare training director for five years. From 1978-2004, Mr. Wilson worked as a CPS social worker, supervisor, regional administrator and training director for Washington State's Children's Administration.

Mr. Wilson is a graduate of Colorado College and holds a Master's in Social Work from Eastern Washington University. He teaches courses on child welfare and on trauma at the University of Washington School of Social Work where he is an adjunct faculty member.

Barry Salovitz, MSW
Senior Director, Strategic Consulting
Casey Family Programs

Barry Salovitz leads Casey's work in both Indiana and Kentucky and has provided several training sessions in Florida this year on developing safety plans in child maltreatment cases. He is a veteran national child welfare consultant who has provided technical assistance and training across the country and internationally. With 38 years of child welfare experience, Mr. Salovitz has worked at the state, county and private provider level and is a former Director for the National Resource Center on Child Maltreatment. He was the principal developer of the most widely adopted front-end child safety model used in the U.S. today.

Mr. Salovitz is a prolific writer on child safety decision-making and frequent conference speaker. In 2006, he co-authored the journal article "Evolving a Theoretical Model of Child Safety in Maltreating Families" (Child Abuse and Neglect, 12/06). He has also co-authored "Essential Safety Constructs in Child Maltreatment Cases". Mr. Salovitz has been a faculty member on Casey Family Programs' National Breakthrough Series Collaborative on Safety and Risk Assessment. He was also a member of the National Association of Public Child Welfare Administrators Safety Committee, and a primary reviewer, writer and editor of the National

Association of Public Child Welfare Administrator's "Framework for Safety in Child Welfare" (2009).

Mr. Salovitz is a graduate of the University of Vermont and holds a Master of Social Work degree from the University of New York at Albany.

House Healthy Families Subcommittee

Linda Jewell Morgan, Senior Director

November 5, 2013

casey family programs

Review of Florida Safety Model and Front-End Assessment Tools

September, 2013

RECOMMENDATIONS

The effectiveness of this, or any, safety model largely depends upon CPI (Child Protection Investigator) skills, workload, and available guidance and support.

- Rigorously train CPI in the development and implementation of safety plan.
- Carefully assess the amount of time required for CPI to implement the model.
- Create and implement “real-time” quality improvement methods that provide coaching and feedback to CPIs, case managers and their supervisors on open cases.
- Assure that CPIs have timely access to expert consultation on substance abuse, mental health and domestic violence issues.

RECOMMENDATIONS

The Safety Model offers the promise of greatly improved safety assessment and planning. However, it does not attend sufficiently to preventing at-risk children from becoming endangered.

- Fully integrate risk assessment into the model.
- The presence of significant child vulnerabilities (i.e. ages 0-3, disabled) in a family assessed at being at moderate, high or very high risk for future child maltreatment should trigger the development of a safety plan.
- Strengthen the manual and training with guidance regarding chronically neglectful families and those with parents with chronically relapsing conditions (substance abuse, mental health).

RECOMMENDATIONS

Safety management services need to be available and accessible statewide in order to increase the safety of endangered and at-risk children. Coordination among CPIs, law enforcement, case managers and service providers is critical.

- In cooperation with the CBCs, DCF should develop safety-related services such as respite care, poverty-related concrete services, home visitors, safety network facilitators, and rapid response to families in crisis in every county of the state.
- Establish processes for ongoing improvement of communication and coordination among agencies, especially between CPIs and case managers at the point cases are transferred.

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Review of Child Fatalities Reported to Florida DCF

November, 2013

CHILD FATALITY SAMPLE

- 40 child fatalities reported to the DCF Hotline between January and July, 2013
- Families of children in the sample had previously and/or were currently receiving services from CPIs an/or Case Managers at the time of the child's death.
- Asphyxia due to unsafe sleeping practices was the most common cause of death of children in the sample.
- Several children died from drowning or physical abuse.
- A few children died in unusual ways, for example, form gunshot wounds inflicted by a parent or a sibling, from being placed overnight in restraints by residential care staff, or from a drug overdose.

RECOMMENDATIONS

Safety assessments during previous Child Protective Services investigations were usually narrowly focused on the reported allegations in the most recent report. They often did not appear to consider the family's prior CPS history or to explore domestic violence, substance abuse which increase risk to vulnerable children.

RECOMMENDATIONS

In many CPS investigations prior to a child's death an in-home safety plan, while clearly warranted, was usually absent, or not adequate to control safety threats. In most cases, CPIs did not follow up on safety plans to assess their effectiveness.

- Ensure that CPIs, case managers and others have the time and willingness to be actively involved in the implementation of safety plans.
- Develop a statewide comprehensive array of safety management services.

RECOMMENDATIONS

In some cases, the CPI did not adequately assess or address the safety of other children in the household following a suspicious child death.

- Develop and implement a policy that mandates a structured assessment and decision-making process regarding the safety of siblings and other children in a household following a suspected child maltreatment fatality.

RECOMMENDATIONS

The new Florida Safety Model has the potential to reduce the number of future child maltreatment fatality tragedies. However, since full statewide implementation may take two to three years, it is critical that all involved staff receive safety assessment and safety planning training in the interim.

- Provide ongoing training and coaching for new and existing CPI, Case Managers, as well as for court and legal staff on safety assessment and safety planning.

Casey Family Programs

Review of Florida Safety Model and Front-End Assessment Tools

September, 2013

I. Introduction

This report was prepared in response to a request by Esther Jacobo, Interim Secretary of Florida's Department of Children and Families (DCF), for Casey Family Programs' help in reviewing and providing feedback on the state's new child Safety Model and related safety and risk assessment tools intended for use by Child Protection Investigators (CPIs). Secretary Jacobo requested feedback and suggestions for possible improvements on both the safety framework and the CPI assessment tools.

Casey Systems Improvement Advisor Alan Puckett and Dee Wilson, a Director in Casey's Knowledge Management unit, reviewed several safety and risk assessment tools together with Chapter 4 of the draft Child Welfare Practice Manual, which describes the Safety Model and outlines how it is to be applied in child protection investigations. Other documents reviewed include a 2012 report titled *Safety Decision Making Methodology: Formative Review*, prepared by the Ounce of Prevention Fund and Casey Family Programs, which describes findings from a survey of DCF staff who implemented elements of the new Safety Model on a pilot basis.

Before commenting on Florida's safety model, it is important to note that the effectiveness of practice frameworks, assessment tools and policy manuals is contingent upon the context in which they are implemented. CPI investigative skills, knowledge and experience; caseloads and broader workload demands; the extent and availability of supervisory oversight and support for front-line investigators; and the attitudes of investigators and supervisors toward the frameworks, tools and policies in question are fundamental to determining the effectiveness of child protection efforts. The ability of child protection investigators to apply critical thinking skills to issues of safety and risk is especially important.[1]

While this summary is focused on Florida's safety and risk assessment tools and the state's new Safety Framework, we believe it is critically important for DCF and policymakers to be mindful of these and related contextual factors, which are as important as tools and policies in determining child safety outcomes. We will address and provide recommendations regarding these and related contextual issues in Section V of this report, following comments on the Safety Model, CPI assessment tools, and the draft Child Welfare Practice Manual.

II. The Florida Safety Model

DCF's newly developed Safety Model offers the promise of greatly improved safety assessment and safety planning. However, the model is narrowly focused on protecting children in danger, and does not attend sufficiently to the goal of preventing at-risk children from becoming endangered. Because safety assessment amounts to a snapshot in time while danger may be episodic, many children found to be safe on initial referral may subsequently be harmed or endangered. A more balanced approach to risk and safety and ongoing investments in early intervention services would better serve Florida's child protection system, in our view, by helping to prevent future harm to children and by reducing repeat referrals to the child protection system.

In addition, careful thought needs to be given to how to adequately serve chronically neglecting families given the Safety Model's emphasis on present danger and impending danger, concepts that frequently do not illuminate the risks to children in families with multiple neglect reports. A 2010 study by Jonson-Reid and colleagues based on a sample of more than 6,400 child welfare cases found that over 26% of children in the sample had at least two child protection referrals; about 18% had three referrals; and nearly 13% had four or more referrals over a seven-year period. A majority of referrals in each group involved child neglect.[2]

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[1] This perspective is addressed in greater detail in a forthcoming article in the journal *Child Welfare* (Volume 92, No.2) titled "Safety and Risk Assessment Frameworks: Overview and Implications for Child Maltreatment Fatalities" by Pecora, Chahine and Graham. We recommend this article to anyone seeking an in-depth look at issues related to safety and risk assessment in child protection work.

[2] Jonson-Reid, M., Emery, C.R., Drake, B. & Stahlschmidt, M.J. (2010). "Understanding Chronically Reported Families". *Child Maltreatment* 15, 271-281.

The Florida Safety Model was developed by DCF in consultation with the National Resource Center for Child Protective Services (NRCCPS) and the Children's Research Center (CRC). The model is designed to identify children in Present Danger or Impending Danger and to assist staff in deciding whether in–home safety plans can sufficiently protect children identified as unsafe. The Safety Model includes several tools, three of which—the Present Danger Assessment (PDA); the Family Functioning Assessment (FFA); and the initial Family Risk Assessment of Child Abuse and Neglect—were reviewed in preparing this report. Guidelines for use of these assessment tools and for development of safety plans for children found to be in danger are provided in Chapter 4 of the draft Child Welfare Practice Manual.

The Safety Model's conceptual framework views child safety as an interaction between and among specific safety threats, child vulnerabilities, and parent or caregiver protective capacities. In this conceptual framework, children are more or less vulnerable in relationship to specific safety threats, not based solely on child characteristics such as age, physical health or disability, or developmental status.

The Safety Model endorses the importance of CPIs and case managers engaging an active parental partner in developing in-home safety plans, and sets forth several conditions that must be satisfied before caseworkers enter into agreements with parents or caregivers regarding an in-home safety plan.

The Florida Safety Model categorizes children as safe or unsafe based on application of the Present Danger Assessment and the Family Functioning Assessment tools. The safe vs. unsafe paradigm is not universally accepted in the child protection field. Some safety assessment tools used in other states provide for a determination that a child is "conditionally safe" in situations where effective steps can be taken to reduce risk of future maltreatment. In the Signs of Safety framework developed by Andrew Turnell and utilized in some states, a safety team rates child safety using a ten-point scale, and may re-assess safety at frequent intervals. Other implications of a safe/unsafe perspective on safety are discussed elsewhere in this report.

Under Florida's Safety Model, parents of children classified as safe by a CPI, but determined to be at risk of future child maltreatment based on completion of the risk assessment tool, can be referred for community services prior to or at the time of case closure. However, Chapter 4 of the draft Child Welfare Policy Manual appears to indicate that ongoing case management services are available to families only when children are found to be unsafe, regardless of the assigned risk level. Given the importance of supportive and preventive services for families at significant risk of future abuse or neglect, even when children are determined to be "safe" at a point in time, agency policy regarding eligibility for case management services has significant implications for child safety.

Another questionable aspect of the Florida Safety Model is its conceptual approach to child vulnerability. Florida's Safety Model acts to counter child vulnerabilities only in relation to specific identified safety threats in the home, not in relation to identified risks. Very young children, however, and children with physical disabilities, chronic health conditions, or developmental delays, are more vulnerable to a range of risks and conditions than other children, whether or not a corresponding danger is present in the home at the time a safety assessment is conducted. Very young children are also much more likely to suffer serious harm when they are maltreated than are older children. The Safety Model's guidelines are incongruent with child protection practices designed for babies and toddlers, the age groups at greatest risk for serious inflicted injuries and maltreatment fatalities.

Beyond Danger: Prevention and Early Intervention for Moderate- and High-Risk Families

Florida's Safety Model categorizes children as being either safe or unsafe, while also proposing that some unsafe children are living in a pervasive "state of danger" which may not be apparent during a CPI's initial contact with a troubled family. Florida's Safety Model focuses on child protection responses for children in present or impending danger, and incorporates emerging agreement among experts regarding the importance of parents' protective capacities and the need for CPIs and other professionals to have an active parental partner in safety planning. Safety planning is presented as an approach to controlling danger to children, not as a means of anticipating danger or preventing danger from occurring.

A strength of Florida's Safety Model is its emphasis on caregiver protective capacities. The section of Chapter 4 of the Practice Manual on caregivers' protective capacities is detailed, insightful and practically useful. The Practice Manual's discussion of parent-child interaction is also strength of the model.

Children who live with parents who have chronically relapsing conditions such as substance abuse and depression, however, may be safe from physical danger for periods of time and then in danger at other times. Danger to children may not be pervasive; it is often sporadic. Many child welfare experts see child safety as a continuum ranging between safe and unsafe, rather than as a dichotomy in which children are either safe or unsafe.

The Safety Model as described in the Practice Manual does not clearly convey the cumulative emotional and developmental harm which children may suffer from chronic neglect or from the combination of chronic neglect with physical abuse or sexual abuse. In many chronically referring families, children may be neither in present or impending danger nor truly safe given the cumulative developmental and emotional impact, and occasional significant harm, which may result from low level chronic maltreatment.

Florida's Safety Model relies significantly on use of safety plans for children who are not removed from their homes. There is little recent research in the field, however, regarding the effectiveness of in-home safety plans, and there is very little research available regarding how well different types of safety plans work with specific types of families, or what elements of safety plans are most or least effective. In addition, there is a lack of recent research regarding the sustainability of safety plans and how often these plans need to be renewed. Safety assessments often turn out to be more like snapshots of how families are functioning at a point in time rather than a reliable means of distinguishing safe homes from unsafe homes.

Recommendations

1. Families whose children are found to be safe, but where risk of future maltreatment is moderate, high, or very high at the close of an initial investigation, should be eligible for ongoing case management services.

2. Families whose children are found to be safe, and where risk of future maltreatment is low, should be eligible for referral to community based services without case management. The provision of effective prevention and early intervention services to such families could significantly improve child safety and well-being and reduce subsequent maltreatment reports.

3. For families with chronically relapsing conditions such as substance abuse and some mental health conditions, safety plans should include a relapse plan component when children are found to be at moderate or high risk for future abuse or neglect, regardless of whether children are assessed to be safe or unsafe.

4. The presence of significant child vulnerabilities in a family assessed as being at moderate, high or very high risk for child maltreatment should trigger development of a safety plan which includes effective steps to protect the child, and should also lead to a referral for appropriate early intervention services, with or without identified danger threats in the home.

5. Because inflicted injuries in very young children are strongly associated with subsequent harm, safety planning should be implemented when any child aged 3 years or younger is found to have even minor inflicted or suspicious injuries.

6. Consensus building exercises should be conducted using the tools throughout Safety Model implementation in order to increase consistency in safe vs. unsafe determinations and in the development and use of safety plans.

III. Tools Used by Child Protection Investigators

The Present Danger Assessment (PDA) Tool
This initial safety assessment tool is concise and appears relatively simple to use; it does not appear likely to require excessive time to complete. In terms of item content, the PDA includes many child safety-related items which are similar to items in safety assessment tools used in other states.

Unlike the child protection safety assessments used in a number of other states (e.g.: CA, IL, MN), the PDA does not include specific items pertaining to allegations of child sexual abuse, caregiver drug or alcohol abuse, caregiver mental illness, or domestic violence in the home. A category for "Other" is included and could be used to list these or other concerns if they are noted by the CPI and rise to the level of safety threats. Particularly in the absence of specific safety assessment items assuring attention to these issues, clear policy guidance for CPIs on assessment and safety planning with families in which one or more of these factors is present will be especially important.

Recommendations

7. Specific examples and concrete guidelines for assessing child safety and for developing and using safety plans with families in which a parent/caregiver has significant substance abuse issues, significant mental health problems, or severe cognitive impairments, and for families in which there is a history of domestic violence, should be added to the Manual.

8. Consider adding an item to the PDA that asks: "Is there an escalating pattern of maltreatment severity, injury or frequency of abuse or neglect?"

9. Consider adding an item to the PDA: "How have the parent(s) harmed or endangered the child(ren) in this family?" Concise factual information that addresses child safety issues will make the PDA easier to review by supervisors and Quality Assurance staff.

The Family Functioning Assessment (FFA) Tool
The FFA is a comprehensive assessment tool intended to gauge safety threats termed "impending danger" under the Florida framework. Like the PDA tool, the FFA does not include specific items for child sexual abuse, caregiver drug or alcohol abuse or domestic violence in the home.

The FFA leads the CPI to assess a number of issues related to parent/guardian protective capacities. Information gathered in this section of the FFA will be important in determining whether identified dangers or safety threats can be offset or controlled by the protective capacities of one or more adults in the home, and in subsequent safety planning. Completion of the FFA leads to a safe/unsafe determination and, if one or more impending dangers are identified, to either an in-home safety plan or out-of-home placement of the child.

Depending on how much narrative is required and other details regarding how the FFA is used in practice, we are concerned that the tool may require a significant amount of time to complete and could become a burden for CPIs unless their workloads allow sufficient time for completing the assessment as intended. If CPIs resort to completing the FFA in a superficial manner, the integrity and effectiveness of the Safety Model could be compromised.

Recommendations

10. DCF should carefully assess the amount of time required to complete the FFA tool in practice and assure that CPIs are actually given sufficient time to use this core assessment tool as intended.

11. Consider adding an item to the Protective Capacities Assessment of the FFA: "How have the parent(s) acted to keep the child(ren) safe?" Answers to this question may prove useful in developing in-home safety plans.

The Initial Family (Household) Risk Assessment of Child Abuse/Neglect Tool

The initial Family Risk Assessment is an actuarial risk assessment tool developed by the National Center on Crime and Delinquency Children's Research Center (CRC), and is similar to Structured Decision-Making (SDM) risk assessments used in many other states. The combination of NRCCPS safety assessment tools (the PDA and FFA) and use guidelines together with an SDM actuarial risk assessment tool is unusual in the child protection field, and has been implemented in only two other states that we are aware of (New Mexico and Washington).

The Initial Risk Assessment incorporates two separate scales to assess risk for abuse and risk for neglect, with an overall risk level determined on the basis of the highest score between the two scales. The overall risk score is used to classify families according to risk level category (Low; Moderate; High; Very High) and is intended to guide referrals and service levels following the close of an investigation.

The Initial Risk Assessment tool is relatively concise and should be straightforward for well trained staff to use. This is a research-based actuarial assessment tool, and any modifications to item scores or to the "cut points" which separate risk categories could affect the tool's validity.

Information and guidance related to use of the Initial Risk Assessment tool is currently covered in less than two pages. We understand that a Resource Guide is available, but the risk assessment tool has not yet been fully integrated into the Safety Model.

Recommendations

12. The risk assessment tool should only be used in a form approved by, and with the full support of, the CRC.

13. DCF should take steps to assure full integration and effective use of the Initial Risk Assessment tool within the DCF safety framework, including adequate staff training and the provision of complete and clear written guidance regarding use of the tool. Training and CPI guidance on use of the risk assessment tool should be developed with input from the CRC, and should be provided in the same Manual and format alongside other elements of the Safety Model.

IV. The Draft Child Welfare Practice Manual

Based on our reading of Chapter 4 of the draft Practice Manual, the Florida Safety Model seems complex and likely to be challenging or confusing for less experienced CPIs due to the conceptual and practical overlap among the PDA, FFA and Initial Risk Assessment tools and the level of abstraction with which concepts are presented. We also find the Manual to be written in language which often makes concepts and practices seem more complicated than they need to be.

Nine types of Safety Threats are named in the safety assessment tool and discussed in the Manual. Similarly, the Manual lists seven Safety Actions for in–home safety plans. We are concerned that these lists imply that these are the only safety threats to be assessed and the only safety actions that can be used to protect children. These artificially narrow constructions of important concepts may reduce rather than encourage critical thinking around issues of safety and risk, especially among less experienced CPIs.

We also find the distinction between safety plans and treatment or service plans, and the relationship between the two, to be poorly explained in the Manual. This is likely to foster confusion and may lead to the creation of ineffective or poorly conceived safety plans.

Further, the Manual lacks discussion of how safety plans can strengthen parents' "protective vigilance" by developing practices and habits that increase child safety; does not provide clear guidance regarding time limits for the duration of safety plans; and lacks guidance for determining appropriate monitoring schedules for safety plans.

Recommendations

14. Streamline the Manual to incorporate greater clarity on key points (e.g.: the distinction between present and impending danger; the difference between impending danger and risk of future abuse or neglect; and which types of supports, services, and safety plans are needed based on case characteristics and presenting issues).

15. The Manual should incorporate case examples and other adult learning approaches intended to stimulate critical thinking with regard to child vulnerability, parental protective capacities, and the development of safety plans which build on existing family strengths.

16. The Manual should include specific examples and concrete guidelines for assessing child safety and for developing and using safety plans with families in which a parent/caregiver has significant substance abuse issues, significant mental health problems, or severe cognitive impairments; and for families in which there is a history of domestic violence.

17. The Manual should include a statement to the effect that no list of potential safety threats or safety actions can be all-inclusive, and that CPIs must use judgment and critical thinking in order to recognize and respond to additional threats or protective factors when they exist.

18. Strengthen the Manual through the inclusion of concrete and explicit guidelines regarding how to assess and work with chronically referred families, i.e., families with multiple CPS reports accepted for investigation. These guidelines should reflect an understanding of and concern with cumulative emotional and developmental harm, and episodic danger to children, potentially resulting from chronic maltreatment.

19. The Manual should make clear to CPIs that child vulnerabilities including very young age, disability or chronic health conditions, and developmental delays may interact with risk factors such as a caregiver's substance abuse or mental health problems to expose children to harm, whether or not a corresponding danger threat has been identified in the home.

20. The Manual should provide clear guidance regarding the distinctions between safety plans and treatment or service plans; and guidance for determining the effective duration of safety plans once they are implemented and for determining the frequency with which safety plans are monitored while in effect.

21. For children who are truly in danger, infrequent monitoring (e.g.: every 30 days) will often be inadequate. In-home safety plans for children assessed as being in present danger should be monitored weekly by the CPI or case manager, including contact with the endangered child(ren), unless a supervisor gives written authorization for less frequent monitoring; in-home safety plans for children assessed as being in impending danger, but not in present danger, should be monitored every two weeks by the CPI or case manager, including contact with the endangered child(ren), unless a supervisor gives written authorization for less frequent monitoring.

22. We recommend adding a section to the Manual regarding the development of safety plans that build on parents' demonstrated safety enhancing behaviors.

23. Rigorously train CPIs and in the development and implementation of safety plans. Training exercises should be based on multiple types of families and a variety of presenting problems rather than on a single case vignette.

24. The Manual should make clear that treatment of chronically relapsing conditions takes time and is likely to proceed with periodic setbacks. Assumptions regarding child safety resulting from parents' entry into treatment are inappropriate for inclusion in safety plans, which should focus on immediate and short-term protection of children.

Strengthening Family Engagement to Improve Assessment and Safety Planning

Chapter 4 of the draft Manual refers to family engagement but lacks specific strategies for bringing parents, children, and extended family members into active roles in assessment and safety planning processes. Some jurisdictions use the Signs of Safety approach or other family engagement models, such as Family Team Meetings or Family Group Decision Making, to incorporate more assertive family engagement strategies early in the child protection process. Such approaches can be effective at uncovering critical information, and can help to lay the groundwork for effective safety planning.

25. Consider the use of formal family engagement strategies to strengthen assessment and safety planning processes at the "front end" of the child protection system.

V. Strategies to Improve Child Safety

Useful decision-making tools, a well-designed policy framework and clear written guidance are necessary but not sufficient conditions for effective child protection practice. Other resources and strategies are also needed in order to build a system in which errors are minimized and the best possible child safety outcomes are achieved.

Immediate availability of community based family support and intervention services during the investigative phase of child protection cases can help to address in a timely way some of the urgent issues of families reported to the child protection system, and can transform the adversarial interactions families often have with child protection agencies into more positive experiences. Involving a variety of community agencies in outreach to troubled families can reduce the burden on child protection agencies by framing child safety as a responsibility shared among families, communities and the child welfare system.

Evidence-based prevention and early intervention programs should be available for referred families even while initial investigations are ongoing in order to begin assisting families and protecting children as soon as possible.

Skilled and well-trained CPIs, manageable caseloads and workloads, and experienced supervisors with appropriate supervisor to CPI ratios are also essential to effective child protection work. "Real time" quality improvement processes that provide feedback and coaching to CPIs and case managers on open cases is essential.

Basic and advanced trainings in child development, effective family engagement approaches and the application of critical thinking skills to child protection investigations and decisions are important in helping to build and improve critical workforce skills.

In a system highly dependent upon community agency partners to implement child welfare policies and practices, effective and ongoing efforts to improve information-sharing and coordination among public agencies (i.e.: DCF and law enforcement) and between DCF and local / regional partner agencies, particularly at the point of hand-off to CMOs at the close of an initial investigation, are also critically important.

Recommendations

In addition to the specific recommendations included in sections above, we believe that implementation of the following steps has the potential to improve the effectiveness of child protection investigations and safety planning activities.

26. Consider delaying implementation of the Safety Model until any significant planned changes to the model are completed so that CPIs and other staff do not have to learn, then unlearn, elements of the model. Phase in the new model beginning with a few selected counties, and incorporate "lessons learned" from early implementers to make any additional changes as rollout of the model is expanded.

27. In cooperation with the CBCs, develop safety related services such as respite care, poverty related concrete services, home visitors, safety network facilitators and rapid response to family crises in every county in the state.

28. Conduct a workload analysis to determine the time CPIs will need in order to effectively apply the new safety methodology and request additional staff if needed.

29. Create and implement 'real time' quality improvement methods that provide coaching and feedback to CPIs, case managers and their supervisors on open cases.

30. Develop methods for learning from the vast experience of CPIs and case managers and their supervisors. Assure that CPIs receive timely feedback from case managers regarding the outcomes of safety plans they developed during their investigations, and that case managers are informed of child protection reports, or lack of reports, on families following case closure.

31. Assure that CPIs have timely access to expert consultation regarding substance abuse assessment and treatment, mental health assessment and treatment, and domestic violence during child protection investigations. Liaisons located in DCF offices, consultation networks that can be immediately accessed by phone, DCF staff with certifications in key subjects, and multi–disciplinary case staffings are a few approaches to providing expert consultation to CPIs at key decision points.

32. Establish processes for ongoing improvement of communication and coordination between DCF and law enforcement agencies around initial referrals and investigations, and between DCF and CMOs at the point where cases are transitioned from initial investigation to ongoing services and/or case management. Effective communication and coordination between DCF and CMOs regarding the design, implementation and monitoring of safety plans is especially important.

33. Consider funding a research entity to carefully study implementation of the Safety Model, and report on a range of outcomes 2-5 years following the initial date of implementation as well.

VI. Summary

Florida's DCF has an unusual opportunity to develop an approach to child protection that incorporates greatly improved safety assessment, risk assessment, and safety planning practices that identify and serve families requiring early intervention to prevent children from being harmed or seriously endangered. However, developing a balanced practice model which give due weight to both risk and safety issues presents both conceptual and practical challenges.

The Safety Model as described in the Practice Manual is highly conceptual (as compared, for example, to the California Structured Decision Making System) and would benefit from the addition of specific guidance for assessment and safety planning with families having substance abuse, mental health and domestic violence issues. It will be important as the model is implemented to build in feedback loops that will allow CPIs and CMO case managers to learn from their experience with safety plans. A variety of factors affecting CPIs and supervisors, including size of caseloads and the workload demands of the Safety Model, should be carefully tracked. Developing a core set of safety related services in all counties of the state would greatly enhance the potential effectiveness of safety plans.

Department of Children
And Families

Rick Scott, Governor
Esther Jacobo, Interim Secretary

Sexually Violent Predator Program
An Overview

Esther Jacobo, Interim Secretary

November 5, 2013

Mission: Protect the Vulnerable, Promote Strong and Economically Self- Sufficient Families, and Advance Personal and Family Recovery and Resiliency.

Key Terminology

Sexually Violent Predator: Small number of extremely dangerous sex offenders who have a mental abnormality not appropriately treated under the Baker Act. (§ 394.910, F.S.) (civil commitment)

Sexual Predator: A person convicted of enumerated sexual felonies against certain minor victims, or a person convicted as a repeat sexual offender against any victim, if a prior offense involved a minor victim; a person committed as a sexually violent predator. (§ 775.21(4), F.S.)(registration/notification)

Sexual Offender: A person convicted of enumerated sexual offenses against certain minor victims. (§ 943.0435(1)(a), F.S.) (registration/notification)

Legal Basis: Federal

Kansas v. Hendricks, 521 U.S. 346 (1997):

State can involuntarily civilly confine an individual upon a finding the person poses a danger to self or others, if the dangerousness is caused by a present mental condition that creates a likelihood of dangerous conduct in the future. Dangerousness alone is not sufficient.

Kansas v. Crane, 534 U. S. 407 (2002):

Civil commitment must be founded upon a mental abnormality which causes "serious difficulty in controlling behavior" sufficient to distinguish the individual from the "dangerous but typical recidivist."

Mental Abnormality

- **Sexually Violent Predator**:
  1. Convicted of sexually violent offense
  2. Suffers from a mental abnormality or personality disorder that makes the person likely to engage in acts of sexual violence if not confined in a secure facility for long-term control, care and treatment

- **Mental Abnormality:**

  > A **paraphilia**, such as pedophilia or sexual sadism

  > A **personality disorder**, usually anti-social personality disorder

Legal Basis: State

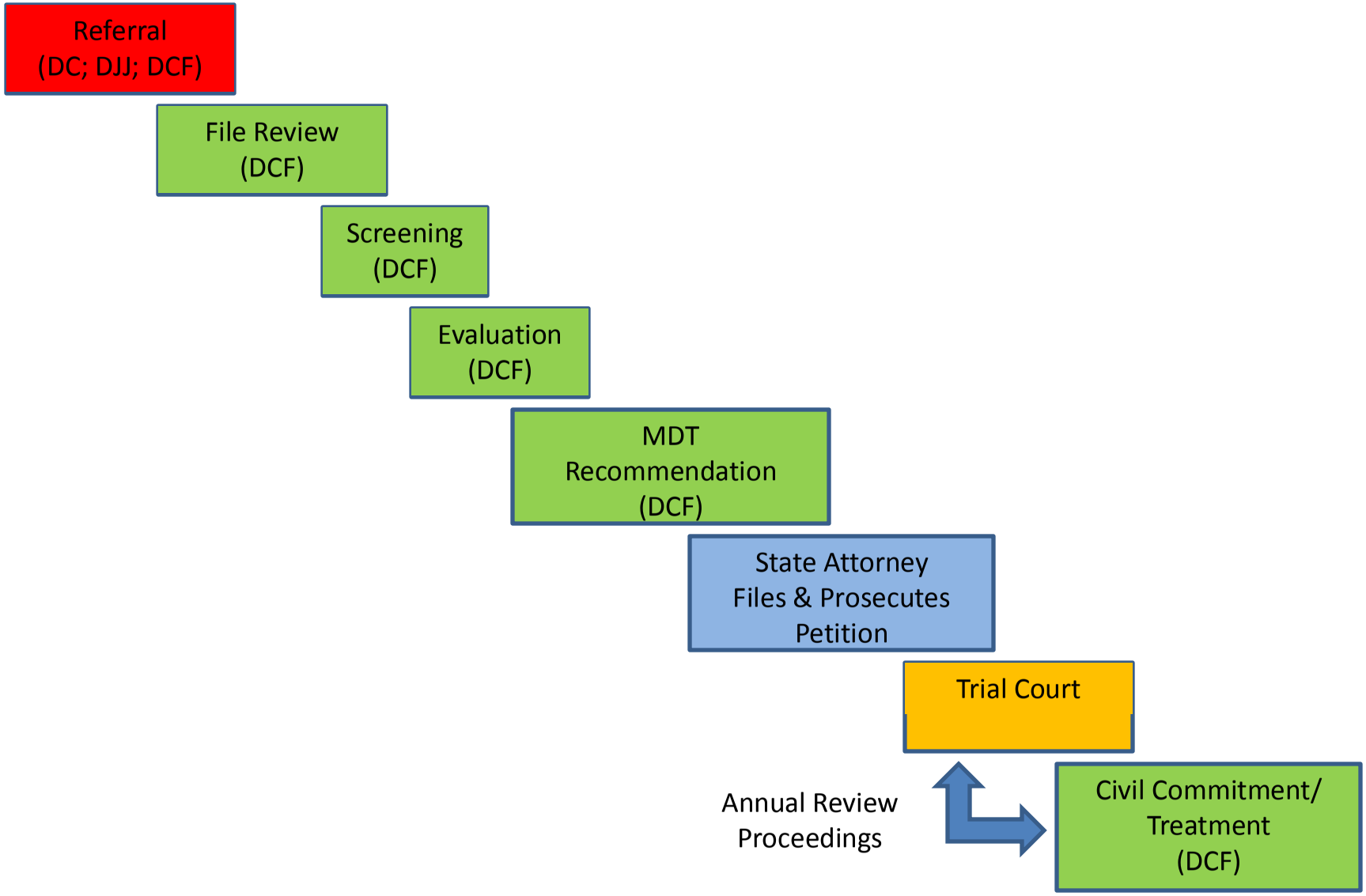
- Involuntary Civil Commitment of Sexually Violent Predators Act: chapter 394, part V, Florida Statutes.

- Modeled on Kansas sexually violent predator civil commitment Act upheld in *Kansas v. Hendricks.*

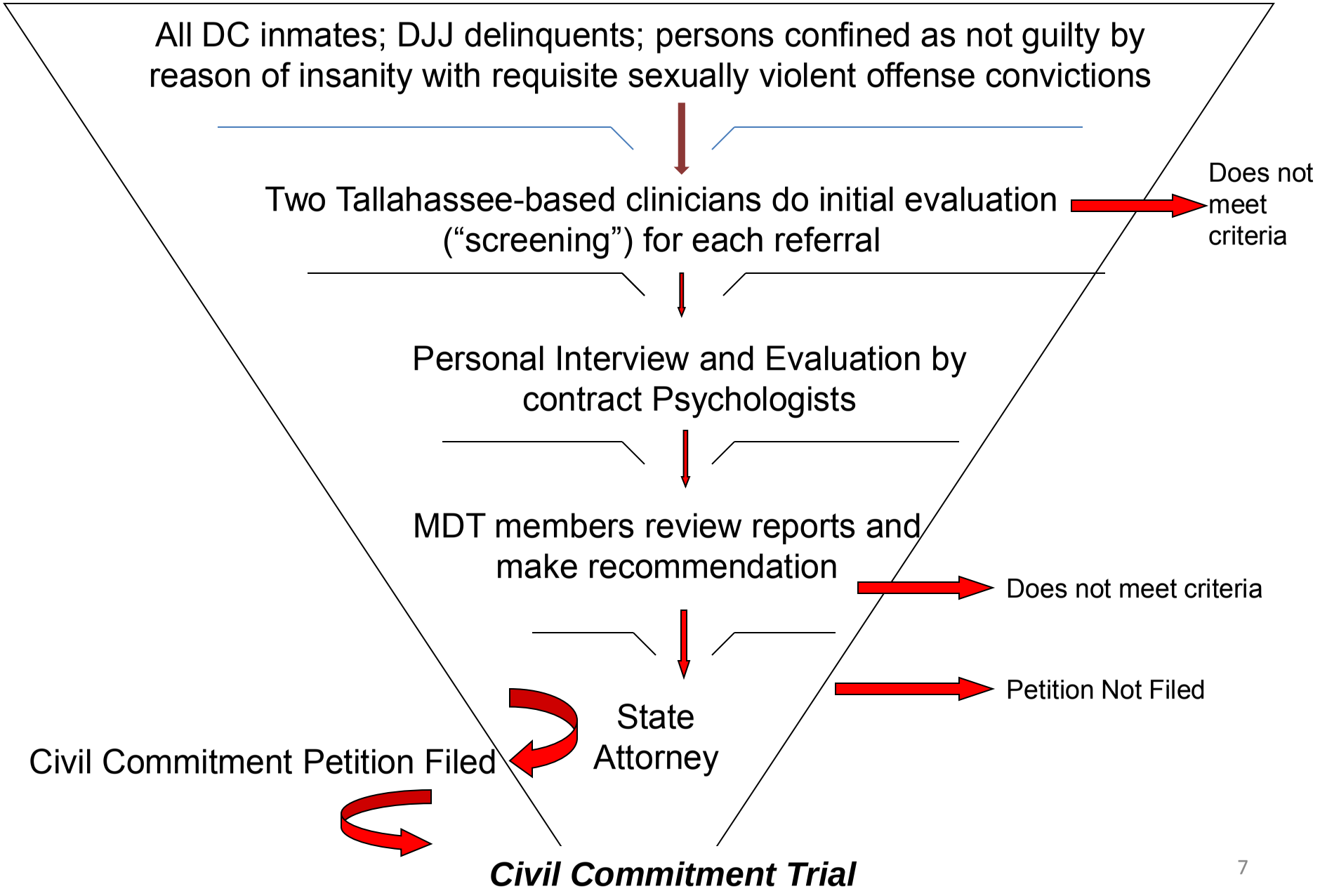
- *Westerheide v. State*, 831 So. 2d 93 (Fla. 2002)

  Act upheld as constitutional under federal and Florida law, relying on *Hendricks* and *Crane*.

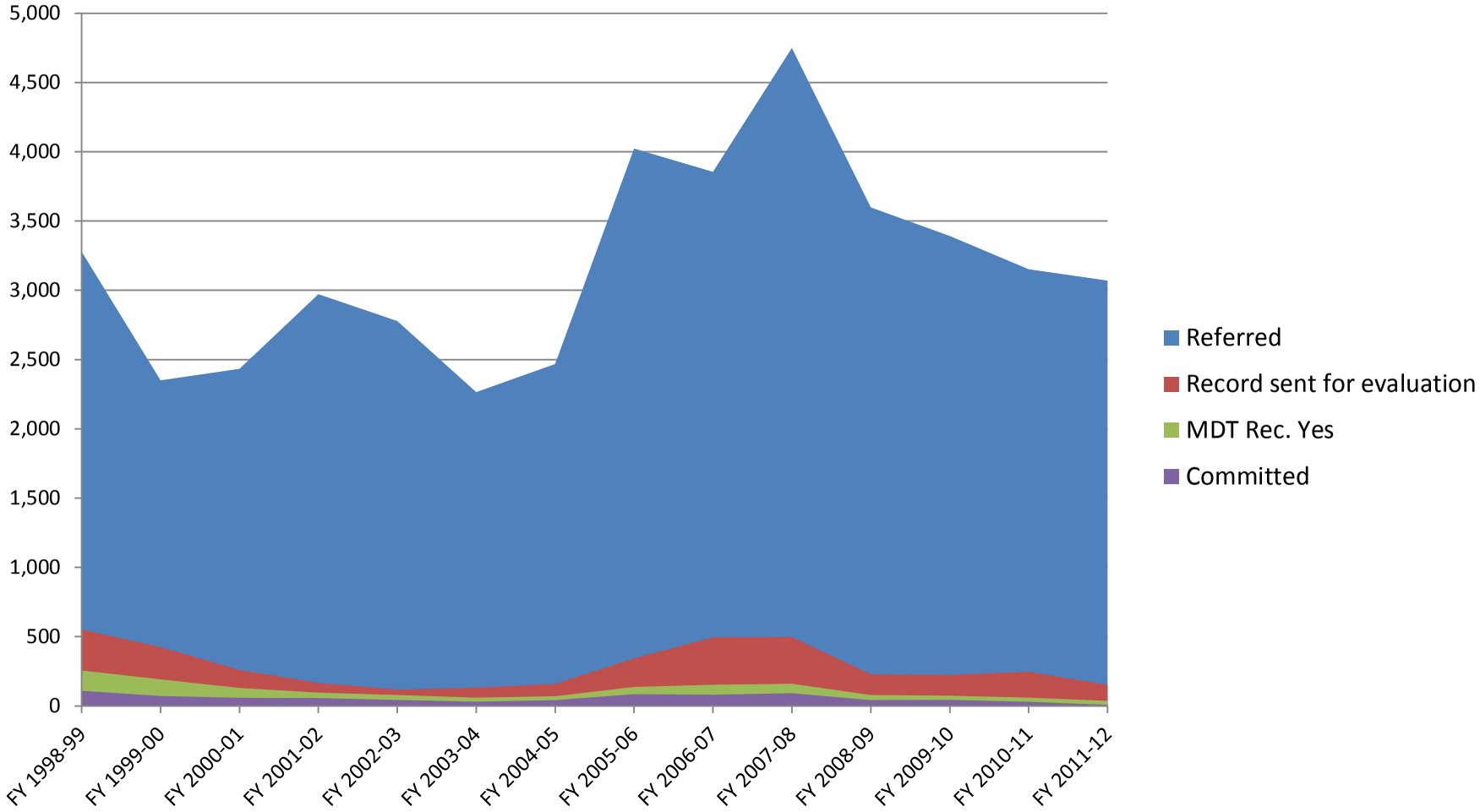
Involuntary Civil Commitment and Treatment of Sexually Violent Predator Act - Process Steps



SVPP - Referral through Petition

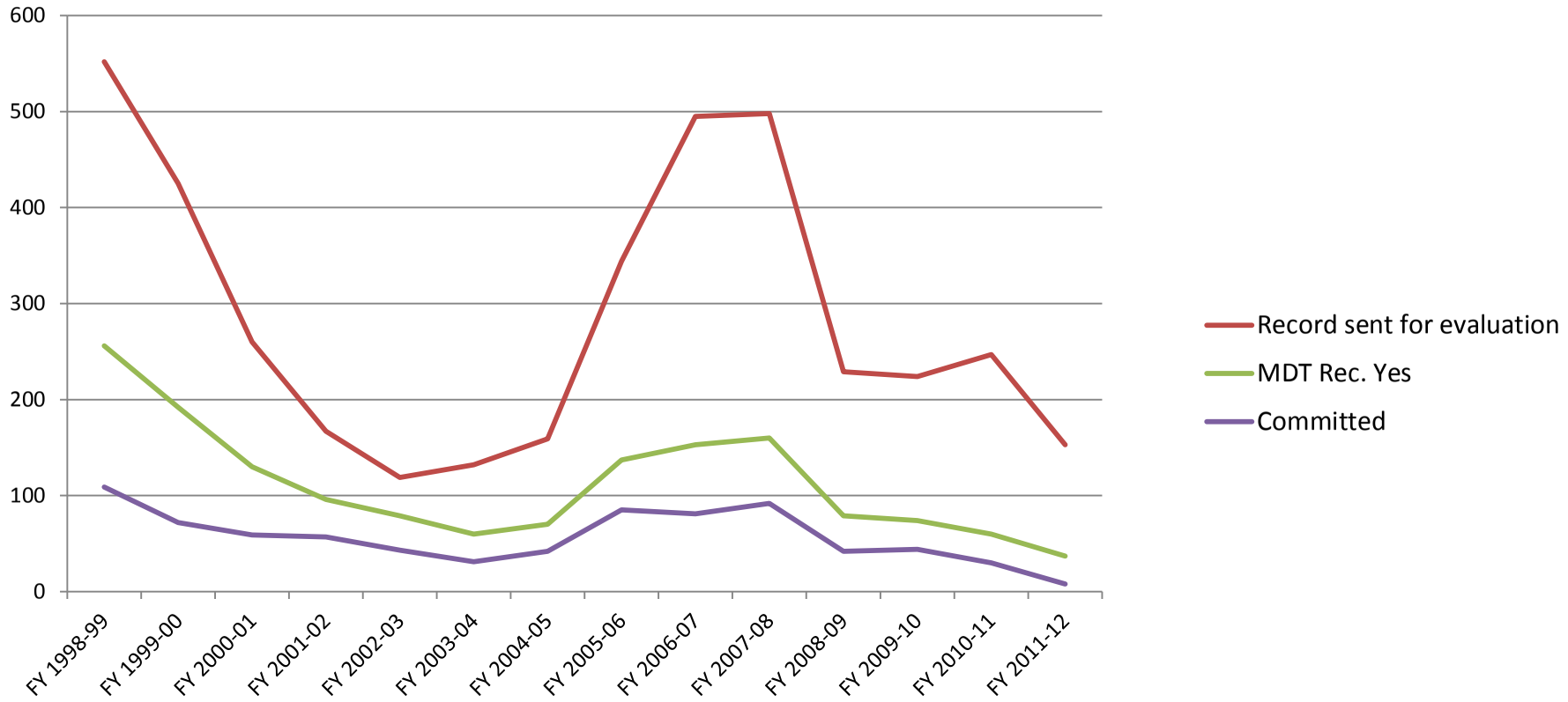


Status of Referrals to SVPP by Fiscal Year Received (with total referrals)



The graph terminates at FY 11-12 because the large number of referrals with pending dispositions precludes the availability of meaningful data for FY 12-13 and FY 13-14.

Status of Referrals to SVPP by Fiscal Year Received
(without total referrals)



The graph terminates at FY 2011-12 because the large number of referrals with pending dispositions precludes the availability of meaningful data

Risk Assessment Process - Referrals

Referral Sources (known as “agencies with jurisdiction” in s. 394.913, F.S.):

- Department of Corrections (≈ 93.5%)
- Department of Juvenile Justice (≈ 3.5%)
- Department of Children and Families (≈ 3%)

Agencies with jurisdiction refer all persons nearing release from confinement who have a conviction for one of the sexually violent offenses enumerated in s. 394.912(9), F. S.

Risk Assessment Process - Screening

- At least two licensed psychologists independently screen each case to determine whether clinical evaluation should be ordered
  - Validate information compiled by reviewer
  - Analyze sexual offense; sexually-motivated offense; and violent offense history
  - Identify likely diagnostic issues
- Cases are referred for clinical evaluation if either screener believes referral might meet commitment criteria

Risk Assessment Process - Evaluation

- Conduct clinical evaluation on those persons referred by DCF.
  - Administer Static-99R – Required by rule/contract
  - Address dynamic factors - such anti-social orientation; evidence of sexual deviance; substance abuse; community supervision (success and failure); supervision to follow; etc.
  - Administer other assessment tools
    - Clinically appropriate
    - Generally Frye -approved
    - PCL-R recommended
    - May include additional tools at evaluator's discretion
- Provide an opinion as to whether referred individual meets the statutory criteria for commitment as a sexually violent predator
- Report must be in the DCF-approved format and must include key facts and clearly stated reasoning supporting the clinical opinion

Risk Assessment Process - Evaluation

Evaluator Qualifications:

- Florida-licensed psychologist or psychiatrist
- 24 hours bi-annually of continuing education related to sex offender risk assessment and/or treatment
- SVPP Annual Training
- Stay current with research/studies/articles relating to sex offender risk assessment, including actuarials
- Clinical evaluation reports meet MDT requirements

Risk Assessment Process – Multidisciplinary Team

MDT defined in s. 394.913(3), F.S.:

- At least two licensed psychologists or psychiatrists
- At least one MDT member must attempt to conduct personal interview with individual under consideration

Composition defined in Rule 65E-25.001, F.A.C.:

- Screeners (at least two, sometimes three licensed psychologists)
- Non-evaluating psychologists (generally two)
- Evaluator(s) (one or two licensed psychologists or psychiatrists)

Risk Assessment Process – Multidisciplinary Team

MDT Tasks:

- Review evaluator reports
  - -- Comprehensive assessment
  - -- Accurate treatment of record information
  - -- Diagnosis supported by record
- Discuss clinical presentation and risk factors
- Resolve discrepancies in reports, diagnoses, static scores, etc.
- Reach consensus or majority recommendation:

  -- two evaluator “meets criteria” opinions requires an MDT “meets criteria” recommendation

  -- two evaluator “does not meet criteria” opinions requires an MDT “does not meet criteria” recommendation

Risk Assessment Process – Multidisciplinary Team

- MDT considers cases for recommendation in bi-weekly meetings
- Prior to the meeting, each team member studies the complete record, including the evaluation(s) for each referral to be considered
- For each referral, the MDT consists of the screeners and non-evaluating psychologists in attendance, with the evaluators represented by their evaluation reports
- SVPP clinical director signs MDT recommendation and sends notarized letter to State Attorney.

Civil Commitment Trial

- State attorney typically files commitment petition based on MDT "meets criteria" recommendation – s. 394.914, F.S.

- Statute provides for jury trial. Must be unanimous verdict to commit, based on clear and convincing evidence – s. 394.917(1), F.S.

- Persons determined to be sexually violent predators are committed to the Department for secure confinement and treatment – s. 394.917, F.S.

Petition Dispositions through 9/30/13

- MDT “meets criteria” recommendations = 1,611

- Petitions filed = 1,497
  Petitions not filed = 70
  Pending = 44

- Petitions dismissed without trial ≈ 362 (24%)

- Petitions resolved by settlement stipulation ≈ 186 (12%)

- Trial Estimates:
  Trials ≈ 855 (57% of petitions);
  Commitments ≈ 711 (83% commitment rate at trial)

Florida Civil Commitment Center

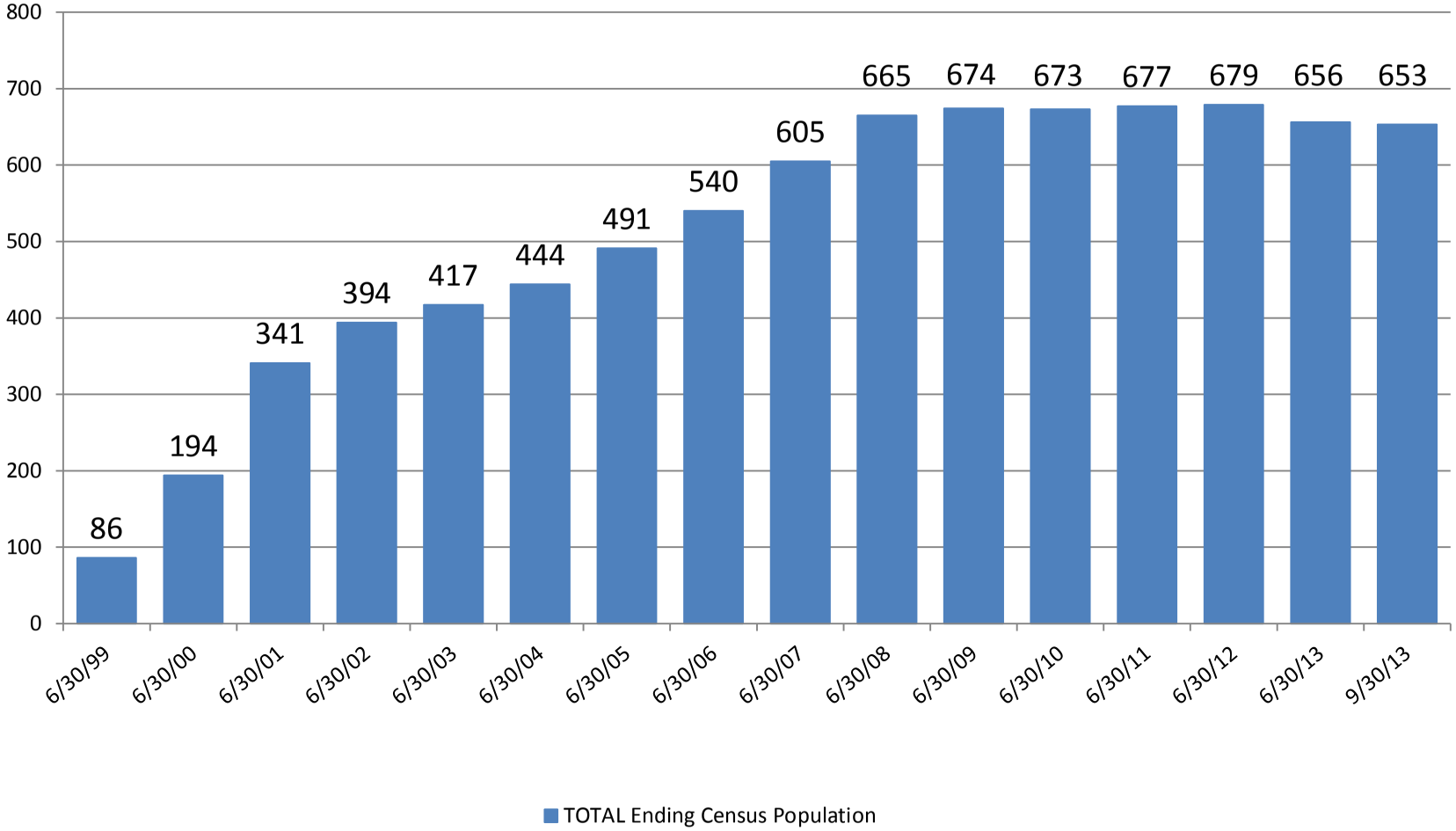
- Program initially operated “Martin Treatment Center” and “South Bay Detainee Unit”

- FCCC opened in the old DeSoto Correctional Institution Main Unit in December 2000

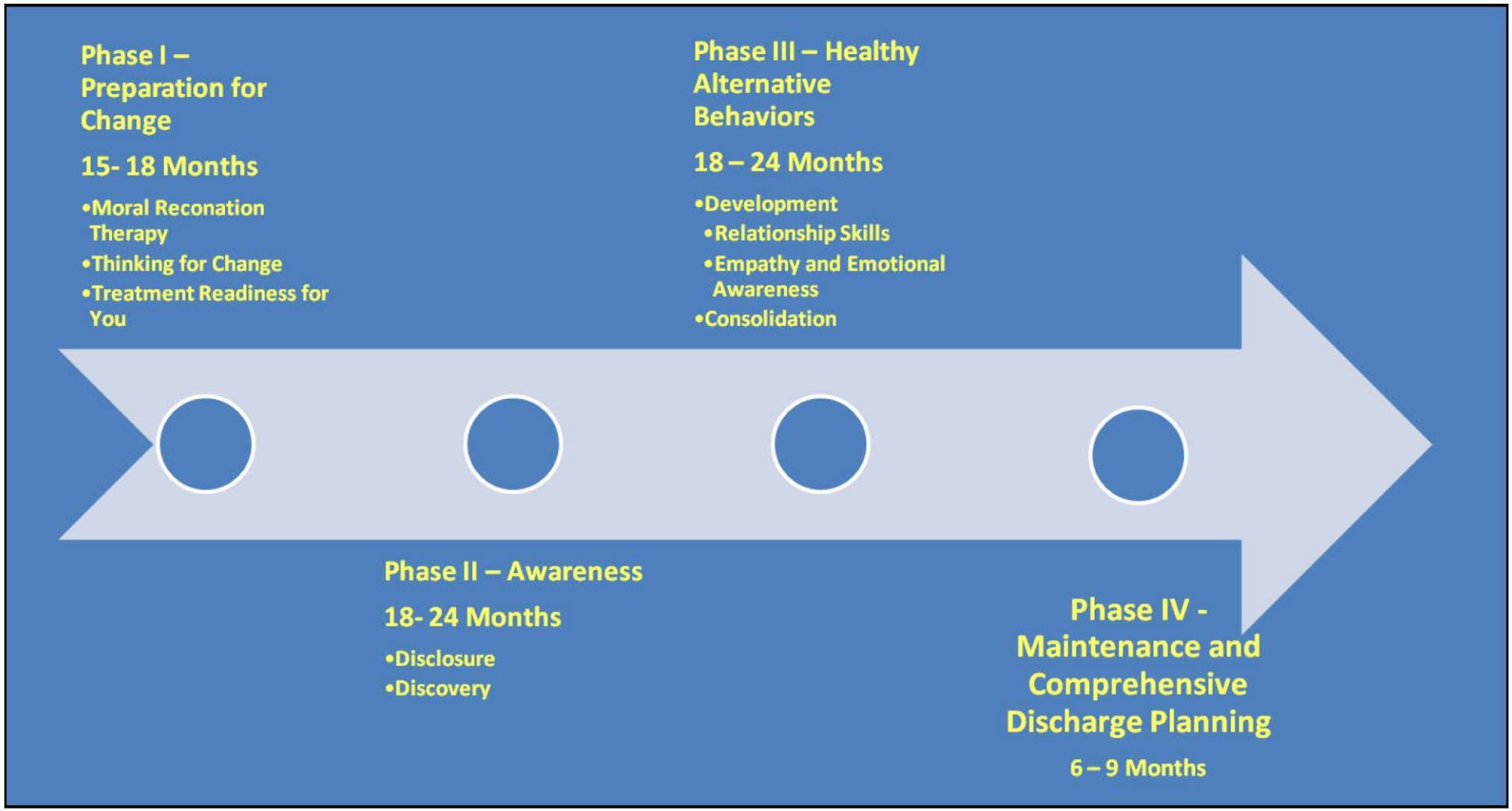
- Current FCCC opened in 2009.
  - -- 720 beds
  - -- Census – 654 on 10/27/13

- Annual cost per resident ≈ $36,500 (bed-day rate ≈ $100)

SVPP Facility Census by Fiscal Year End



FCCC Treatment Program



Treatment services are individualized for each consenting resident. On average, the full program can take up to six years.

FCCC Treatment Program

- Facility goal is to integrate best practice models from current research and treatment literatures into the interventions taking place at the FCCC.
  - Good Lives Model
  - Multi-Phase Approach
  - Specialty Tracks (Conventional, Corrective Thinking, Special Needs)
- On average, each consenting participant receives 10 hours per week of active, comprehensive treatment programming for persons who have sexually offended.

FCCC Programs & Services

Core Programs

- Four Phase Treatment
- Competency Restoration
- Residential Mental Health
- CARE Program/Behavior Management
- Resident Work Program
- Psychiatric Services
- Case Management

Ancillary Services

- Substance Abuse Treatment
- Lifestyle Management
- Anger Management
- Trauma Group
- Religion and Spirituality
- Therapeutic Recreation
- Education
- Vocational training
- Creative Arts

DCF SVPP Allocation FY 13-14

DCF HQ Program Administration	$ 1,313,647
Contract Evaluators	$ 928,192
FCCC Contract (Geo Care, LLC.)	$21,970,769
FCCC Bond Payment	$ 5,101,231
Risk Management Insurance	$ 35,666
Lease/Purchase Equip	$ 1,488
Total	**$29,350,993**

Recent Program Modifications

- Kristin Kanner, a 21-year prosecutor and the head of Broward County's SVP civil commitment unit, has been appointed as Director of the Sexually Violent Predator Program
- A "meets criteria" conclusion by both MDT evaluators will result in a "meets criteria" recommendation from the MDT as a whole
- Attempted kidnapping and attempted murder convictions involving a sexual component will automatically be referred for evaluation
- MDT evaluator contracts will be one year only, with an option for renewal at Department discretion

Program Modifications in Development

- Department is studying potential revisions to MDT structure and processes, such as including non-clinician stakeholders in the decision to pursue civil commitment. This will be collaborative effort with the Legislature, prosecutors, law enforcement, and the courts.

- Department will ensure criteria at the screening stage are not eliminating from consideration persons who may meet commitment criteria. Screener and evaluator training will ensure those persons understand they are not solely responsible for screening out individuals who may not meet commitment criteria.

- Department will codify MDT risk assessment criteria and processes in rule, which will ensure future revisions will be subject to legislative, stakeholder, and public review and comment.

- Department will formalize and strengthen the program's quality assurance and performance review processes for contracted evaluators.

SEXUALLY VIOLENT PREDATOR PROGRAM POLICY OPTIONS
Healthy Families Subcommittee Meeting
November 5, 2013

Referral and Screening

HCJ 1	**Close referral loopholes--allow additional entities to refer, including jails. Criteria for referrals would be those now used by entities currently making referrals (DOC—from prisons, DJJ—from detention facilities, DCF—confined after "not guilty by reason of insanity" determination by court)**
1a	Allow State Attorneys to refer for evaluation individuals confined in jails whom they think may meet criteria
2	Enact current general screening criteria in law; for example, require DCF to consider: • Longstanding predatory pattern of searching for victims • Frequency of sexual offending • Stranger victims as well as known victims • Time in community without offending since last confinement • If individual is manageable with intensive sex-offender specific probation

Administrative Changes--Chair Harrell

HCJ 3	**Require DCF to shorten contracts with private-sector psychiatrists and psychologists to one year (DCF will do within current authority)**
HCJ 4	**Require cross-training between DCF multidisciplinary team (MDT)/contractors and state attorneys to ensure understanding of the broader civil commitment process (DCF will be enhancing training, within current authority)**
HCJ 5	**Require DCF to formalize system for evaluating evaluators, with state attorney input (DCF will be formalizing and strengthening quality assurance/performance review processes within current authority)**
HCJ 6	**Require DCF to randomly select screeners/contractors**

Multidisciplinary Team (MDT) --Rep. Eagle

HCJ 7	**Change the composition of the MDT (currently five clinician members) to include three additional members: a state attorney, law enforcement officer, and victim advocate (DCF is studying revisions to MDT)**
HCJ 7a	Expand MDT to eight members: five psychologists/psychiatrists and three additional members (state attorney, victim advocate, and law enforcement representatives)(similar to Iowa and Texas)
7b	Create Sexually Violent Predator Program (SVPP) Advisory Board which includes state attorney, law enforcement, and victim advocate representatives to advise on program rules, criteria, and processes used by SVPP/MDT, which would remain as currently structured
7c	Expand MDT to include state attorney, victim advocate, and law enforcement representatives as advisory members. The advisory members would review proposed "not meet criteria" cases and provide recommendations regarding issues for reconsideration to the whole MDT

SEXUALLY VIOLENT PREDATOR PROGRAM POLICY OPTIONS
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HCJ	**8**	**Reduce the number of votes needed for the MDT to make a "yes" recommendation to the state attorney (currently is majority or consensus)**
HCJ	8a	Expanded MDT (8 members, including non-clinical): require only one clinical "yes" vote to send as "yes" to state attorney
	8b	Expanded MDT (8 members, including non-clinical): require at least 4 "yes" votes to send as "yes" to state attorney, including 2 clinical votes
	8c	Current MDT (5 members, clinical-only): allow for two votes rather than consensus/majority to send as "yes" to state attorney