BRIAN P. KEMP
GOVERNOR

CANDICE BROCE
INTERIM DIRECTOR

CAPTA Panel Members,

Thank you for your service to the children and families of Georgia. Recent changes in federal and state law and policy, as well as changes to child welfare practice resulting from the COVID-19 pandemic, have created a number of opportunities for the Division to pursue systemic improvements in the State's response to child abuse and neglect. As we undertake the challenging work of implementing the new laws and policies, we value your role in evaluating the extent to which the State is effectively fulfilling its child protection responsibilities. Your contributions made through formal Panel recommendations and extensive collaborative work are appreciated.

Attached you will find the agency's response to the 2020 Panel recommendations. I am pleased to recognize that many of the areas highlighted in your report are ones that the agency is already working to improve. We will incorporate your feedback into existing plans and engage with you to align and strengthen our efforts to achieve the desired outcomes.

Thank you again for your commitment to the citizens of Georgia.

Sincerely,

Candice Broce

Candice Broce

Interim Division Director

Georgia Division of Family and Children Services

2020 Child Abuse Prevention and Treatment Act (CAPTA) Panel Recommendations and Agency Response

June 2021

Contents

Recommendation: Quality Legal Representation

The CJA Task Force developed a report based on its most recent assessment on the quality of legal representation. Based on the findings, the Task Force recommends:

1. Prioritizing training for parent, child, and GAL attorneys and SAAGs

2. Developing alternative mechanisms for accessing CJA funding (in addition to the annual solicitation process)

3. Promoting and supporting innovative practices that utilize more collaborative approaches to legal representation, such as interdisciplinary models

4. Commissioning a study to explore the viability of a formal system of statewide oversight to support child, parent, and GAL attorneys

Division Response:

Training for parent, child, and GAL attorneys and SAAGs is available and accessible through multiple venues, including the Multi-Disciplinary Child Abuse and Neglect Institute (MDCANI), the Summit (sponsored by the Office of the Child Advocate), mandatory SAAG trainings, and the Court Improvement Initiative. The Division continues to allocate significant support through personnel and funding to ensure that these resources support quality legal representation.

The Division supports developing alternative mechanisms to access CJA funding, and commits to working with the CAPTA Panels to educate communities about this resource.

The Division will consider exploring the feasibility of a statewide oversight model but recognizes that statutory support may be needed to create a formal system. A catalyst for this model may be to empower the Office of the Child Advocate to perform analysis on the performance of juvenile courts and provide “report cards” to the Division and its stakeholders for review and planning purposes. Additional supports may be provided by the Administrative Office of the Courts, Justice for Children.

Recommendations: Quality Assurance Reviews

The Child Protective Services Advisory Committee (CPSAC) recommends that the Division expand the quality assurance process to identify specific causes, implement effective strategies for addressing each causative factor, and monitor and evaluate results.

Division Response:

The Child Welfare Quality Assurance (CWQA) Unit is conducting quarterly Child and Family Service Reviews (CFSR) for each district to evaluate the quality of child welfare services provided to children and families and to provide statewide assessment data in preparation for Georgia's Round 4 CFSR. Case-specific interviews are conducted on all cases reviewed to evaluate the quality of casework and adherence to policy and best practice principles related to safety, permanency, and child and family well-being. The emphasis on District level reviews aims to shift Georgia's mindset from a granular view to a "one State" view in terms of quality of service. History has shown that review findings are applicable throughout the state, and as such, reviews conducted at the District-level are generally reflective of practice throughout the State. Outcomes from these reviews can help guide initiatives to address deficits in practice while also building upon identified strengths. Trend Reports are developed for each district level review, which provides a comprehensive overview of review findings associated with Safety, Permanency, and Well-Being, with a focus on key cornerstone skills impacting case practice.

In addition to the CWQA case reviews, the Division is employing a Root Cause Analysis framework to review outcomes, identify the causes, and develop solutions. This framework enlists staff at all levels of the Division to identify specific causes for each of the CFSR outcomes and develop strategic solutions to improve practice. This work is ongoing.

The Child Protective Services Advisory Committee (CPSAC) reviewed CFSR Outcomes by Program Area and noted that Item #2 and Item #3 for Family Support fall well below the state average. The CPSAC recommends that the Division conduct a review of its Family Support practice in collaboration with its community partners and other stakeholders, including families, to identify areas where this could be improved. This should include a rigorous assessment of risk to identify appropriate services that will be effective in addressing family's needs to prevent escalation and need for further intervention.

Division Response:

Family Support Services (FSS) is an alternative child protective services (CPS) response for providing protection to children by engaging the family to build consensus around the everyday life situations which may interfere with the family's ability to nurture and protect their child(ren). The FSS track is utilized when the Initial Safety Assessment (ISA) does not indicate a present danger situation or impending danger safety threat. In theory and in practice, Georgia's Family Support Services (FSS) response is designed to address elevated risk in families through a time-limited (60-day) intervention that connects families to community-based services better suited to their needs.

The Division is committed to improving outcomes for Items #2 and #3 for all program areas, including FSS. Staff are using a Root Cause Analysis framework to identify gaps that may be impacting outcomes (e.g. documentation, timeliness, appropriateness of services, or parent engagement) and develop specific and targeted strategies that will lead to improvements. The Division envisions a strategic approach to developing a comprehensive set of interventions that achieves the safe reduction of children in foster care and reduces the system navigation burden for families in need of supports and services.

The Child Protective Services Advisory Committee (CPSAC) noted the disproportionate sampling of QA cases, and that Family Support and Family Preservation make up a greater portion of overall percentage of open cases compared to Foster Care cases. The CPSAC recommends that the Division consider alternative sampling protocols so that results are more reflective of overall practice with less weight given to Foster Care cases.

Division Response:

The Child Welfare Quality Assurance (CWQA) Unit conducts ongoing Child and Family Service Reviews (CFSR) to evaluate the quality of child welfare services provided to children and families. These case reviews collect specific case-level data that provide context and address agency performance. Case reviews can detect the quality of services for the children and families served and therefore focus on the assessment and monitoring of how child and family functioning is progressing in relation to the services provided. Guidance for structuring these ongoing case reviews can be reviewed in ACYF-CB-IM-12-07.

Case selection for quality assurance reviews is determined by federal protocols. Sampling of QA cases follows the sampling protocols of the federal CFSR. The CFSR guidance states that a case review sample must include a minimum of 65 cases served during the sample period with a minimum of 40 foster care cases and 25 in-home cases. The

Division is unable to modify the sampling protocols to reduce the weight given to Foster Care cases.

Recommendations: CAPTA Plan and Grant Funding

The Child Protective Services Advisory Committee (CPSAC) recommends including the Division's partners and stakeholders, including CAPTA Panel members, in the decision-making process on the utilization of funds designated for CAPTA in the American Rescue Plan Act of 2020.

Division Response:

The Division welcomes input from partners and stakeholders in the process to distribute CAPTA funds allocated to the state in the American Rescue Plan Act of 2020.

The Child Protective Services Advisory Committee (CPSAC) recommends that the Division conduct an annual review of its state CAPTA Plan in conjunction with key partners and stakeholders to increase awareness of the plan and its objectives, and to ensure its effectiveness and responsiveness to community and Division needs, and the CAPTA mandate.

Division Response:

The Division has historically conducted an annual CAPTA Plan review with stakeholders but paused that activity during the COVID-19 pandemic. Plans to reconvene this review meeting are in development. The Division continues to review the state's CAPTA Plan and ensure that partners and stakeholders are informed of the plan and its objectives. Programs that request CAPTA funding must describe how the services align with the state's CAPTA Plan and federal CAPTA program areas prior to receiving funds, and in their report submissions. Programs are also encouraged to describe how the proposed services will support and enhance existing CAPTA funded programs in the community, to ensure that there is a comprehensive and collaborative approach to implementing the CAPTA mandate throughout the state. The Division welcomes the opportunity to partner with stakeholders in reviewing the effectiveness and responsiveness of the Plan to the community.

Recommendation: Plans of Safe Care (POSC)

The Child Protective Services Advisory Committee recommends:

1. Enhancing assessment of risk factors associated with maternal alcohol use/abuse for early detection and intervention for FASD

2. Promoting awareness and use of "Mother to Baby", a nationwide resource network, providing evidence-based information about medications and their exposures during pregnancy and while breastfeeding, as part of a caseworker's assessment tool kit.

3. Enhancing caseworker training on the impact of parent exposure to alcohol on critical points in fetal development and prolonged maternal alcohol abuse during pregnancy, and identifying symptoms and characteristics (both developmental and physical) in infants and children, that are indicative of fetal alcohol exposure and need referrals to early intervention services.

Division Response:

The Division continues to explore new opportunities to enhance staff training and strengthen the available tools and resources. Although a training course specific to this item is not currently provided by the Education and Training Unit, it is discussed during the Substance Abuse Course. Child welfare policy includes guidance on exposure to substances in utero and procedures for interviewing mothers about alcohol use/abuse during pregnancy. The Policy and Regulations Unit, in coordination with other Division sections, will explore opportunities to further market the Online Directives Information System (ODIS), promote policy to Field Program Specialists (FPS) and frontline staff, and search for areas of improvement.

The Safety Section will consider "Mother to Baby" as a potential resource and determine how best to incorporate this and other recommended tools for medication exposure assessments.

Recommendations: Child Death Reviews and Reporting

Based on the 2016 federal Commission report "Within Our Reach - A National Strategy to Eliminate Child Abuse and Neglect Fatalities", the Division adopted and implemented the Safety Science approach and conducted nearly 100 county level reviews during its first year in collaboration with the Office of the Child Advocate. The Child Fatality Review Maltreatment Committee recommends that the Division prepare and make available a report on the lessons learned during the first year of the Safety Science approach, a summary of findings, the Division response to systemic issues identified, and plans for continuing this work.

Division Response:

The Division is proud to be one of the founding members of the National Partnership for Child Safety (NPSC) and continues to participate in the collaborative. In the 2019 CAPTA Panel report response, The Division noted that aggregated findings from a systems-focused review of maltreatment-related fatalities will be shared within the framework of this collaborative.

The Division is in the process of analyzing the data to prepare the Safety Science report and will include findings with respect to Just Culture. The Division is developing plans for dissemination, including a debriefing for staff to provide learning opportunities and improve the quality of work. Once final data elements are established and a data sharing protocol is in place, improvement opportunities will be highlighted from a systemic perspective and lessons learned from case reviews will be available to be shared.

This work is ongoing.

The Child Fatality Review Maltreatment Committee makes several recommendations related to "institutionalizing" the development and implementation of a comprehensive fatality reporting system.

1. Identify the organization participants, assign primary responsibility, and obtain authorization (funding).

2. Conduct risk factor analysis by linking Georgia SHINES with a birth cohort to calculate (estimate) population-based risk for primary prevention.

3. Develop a work group to draft a report on "What We Know about Child Maltreatment-Related Deaths in Georgia" as a template. The report would be co-authored by DFCS, DPH, and GBI, and would set the precedent for an annual report.

4. Design a system for the "real-time" sharing of data on relevant child life events (e.g. births, hospitalizations, and DFCS actions) that would be used by agencies and/or programs with responsibilities for child well-being. The data would be used to inform interventions at the individual child level for secondary or tertiary prevention.

Division Response:

Statutory authority may be required to institutionalize a child fatality reporting system as described by the CAPTA Panel that includes birth cohort linkages and data sharing of "child life events" in real time. The Division looks forward to partnering with members of the Panel and stakeholders to pursue this recommendation.

The Child Fatality Review Maltreatment Committee recommends that the Division reinforce with its county administrators both the requirement for their involvement in local child fatality reviews and the importance of identifying a representative to participate in any review with appropriate experience and knowledge of any case under review.

Division Response:

The Division supports the recommendation to reinforce the requirements for staff involvement in local child fatality reviews. Leadership and staff at all levels will continue to promote the requirements and procedures of the child welfare policy for attendance and participation in reviews. The Division continues to partner with the Office of Child Fatality Review and other stakeholders to support local reviews.

The Child Fatality Review Maltreatment Committee recommends that the Division convene a quarterly case level data review with representatives from entities compiling data on fatalities to identify any recent child deaths that may not have been captured in the individual data sets for the period.

Division Response:

The Division reviews its child fatality data regularly to ensure case reviews are occurring as needed. Collaborative partnerships with the Georgia Bureau of Investigation and Office of Child Fatality Review are essential to sharing case information and identifying opportunities to provide services to families. This work is ongoing.