Georgia Division of Family and Children Services

2021 Child Abuse Prevention and Treatment Act (CAPTA) Panel Recommendations and Agency Response

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Recommendation: Mandated Reporting

(*Page 36*) The CJA Mandated Reporter Committee has identified a need for specialized training for individuals at organizations or agencies with child caring responsibilities, such as schools or daycare sites, that have a “designated reporter”. This specialized training would identify the unique circumstances and reporting requirements to ensure compliance, improve quality and timeliness of reports, and include updates on changes to mandated reporting laws and child welfare practice and policy. The Committee recommends that:

1. The Division collaborate with its partners, including organizations/agencies that utilize “designated reporters” to develop and implement a mandated reporter training module targeting this unique classification of mandated reporters.

Division Response:

The DFCS Prevention and Community Support Section (PCS) maintains a contract with Care Solutions to provide online Mandated Reporter training. This training is available at no cost to the public, and the course is approved by the GA Department of Education (DOE) and the GA Department of Early Care and Learning (DECAL) for individuals with childcare responsibilities. The Division will explore opportunities to expand current mandated reporter course offerings to include specialized materials or training modules for the “designated reporter” within an agency or organization.

Recommendation: Risk and Safety Assessments

(*Page 15*) The Child Protective Services Advisory Committee (CPSAC) continues to express concerns with the lack of significant progress in improving CFSR Safety Outcome 2, Item 3: Risk and Safety Assessment. In 2020, the CPSAC recommended that the Division expand its quarterly analysis of the Child Welfare Quality Assurance (CWQA) review process to identify specific causes for deficiencies, implement effective strategies for addressing each causative factor, and monitor and evaluate results.

In 2021, the CPSAC requests that the Division provide an update on progress toward improving this CFSR measure:

1. Describe the implementation of the Root Cause analysis framework
2. Describe identified practice deficits, analyses conducted, actions taken, and results achieved to improve risk and safety assessment outcomes
3. Provide the CPSAC with a report (if available) to better understand the process and benefit of utilizing this strategy

Division Response:

The Division is working on several initiatives to analyze performance of the unmet Program Improvement Plan (PIP) items, including Safety Item #3: Risk and Safety Assessment. Regional Continuous Quality Improvement (CQI) teams routinely conduct Root Cause Analysis (RCA) on the unmet PIP items and other areas of identified need.

Georgia CQI teams consist of fourteen regions and the state's intake unit (CICC). Currently, Georgia has 12 active regional teams, one CICC team, and county CQI teams that consist of four counties. Each regional and county team uses a 5-phase process for identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions.

1. Performance analysis
2. Cause Analysis
3. Intervention Selection and Development
4. Implementation and Change Management
5. Evaluation and Monitoring

The first two steps of the CQI process involve root cause analysis to identify and understand the problem. Once the performance problem and cause have been analyzed, the CQI teams then create a strategy to address the root cause and develop a Quality Improvement Plan (QIP) to improve performance. The QIP also includes plan for evaluating the strategy and expected outcome(s).

The Division has recently enhanced CQI processes to begin preparation for CFSR Round 4. From May-December 2022, targeted reviews for CFSR Items 2, 3, 12, 14 and 15 will occur with a dual focus on practice improvement for these critical items, as well as supervisory oversight of cases. Root cause analysis has identified three cornerstone skills needed to move the state towards positive progress with regards to practices associated with the remaining unmet PIP Items for CFSR Round 3. Cornerstone skills promoted statewide include comprehensive safety assessments, quality engagement with children and parents, and supervisor oversight. New review processes include engagement with supervisors through a CFSR “shadowing” process as well as regional supervisory focus groups following each quality assurance review to facilitate discussion regarding existing CQI strategies, progress towards those strategies, causes for any identified areas of need, and feedback from supervisory staff regarding causes and solutions as they relate to practice improvement. The QA review process is also evaluating the fidelity and performance of the CQI strategies (i.e. was the strategy used as expected, and did the strategy make a positive impact on the CFSR item). This process will allow for real-time discussions about the effectiveness of strategies, identify root causes of performance, and support the Division in gaining first-hand knowledge of case practice strengths. There are plans to hold system-wide discussions on the data and findings of these reviews.

Recommendations: CAPTA Plan and Grant Funding

(*Page 18*) The Child Protective Services Advisory Committee (CPSAC) provided two recommendations in 2020 for the Division to include partners, stakeholders, and the CAPTA Panel members in the decision-making process on the utilization of funds designated for CAPTA in the American Rescue Plan Act, and to conduct an annual review and evaluation of the state CAPTA Plan to ensure effectiveness.

In 2021, the CPSAC recommends:

1. The Division develop a timeline to facilitate the engagement of partners and stakeholders, including CAPTA Panel members, to formalize a process for the CAPTA State Grant that is similar to the process for the CJA Grant and includes:
    a. Proposal guidelines and performance standards
    b. Engaging CAPTA Panel members and stakeholders in proposal review and award decision making for initial and ongoing requests
2. A plan is developed for ongoing evaluation of the state CAPTA Plan to ensure it meets both state and CAPTA objectives.
3. An annual review of the state CAPTA Plan is conducted 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.

Division Response:

The Division is developing a formalized application structure for the CAPTA State Grant, in partnership with stakeholders, to solicit proposals for funding. The proposed application structure will ensure that programs across the state are informed of the available funding under CAPTA and the objectives under the state's CAPTA Plan. As the Children's Bureau encourages states to continue using a substantial portion of their annual CAPTA grant to strengthen procedures for the development, implementation, and monitoring of plans of safe care for substance-exposed infants, the application guidelines will also advise potential applicants of this priority population.

The Division is also working toward a formalized application structure for the ARP CAPTA grant using a similar model. The Prevention and Community Support Section (PCS) received additional ARP funds for Community Based Child Abuse Prevention (CBCAP) and utilized input from stakeholders and the Parent Advisory Council to determine how to best allocate funds. The Division is exploring opportunities to develop a similar application and review structure for the ARP CAPTA funding and welcomes input from partners and stakeholders in the process to distribute those funds.

The Division most recently updated the CAPTA state plan in May 2020, as well as the state's 5-year Child and Family Services Plan (CFSP). The Division will engage its partners and stakeholders in FY2024 to evaluate and revise (as necessary) the state CAPTA Plan along with the CFSP; this approach will ensure that programs and priorities are aligned across both plans and include any recommendations or strategies resulting from the Child and Family Services Review (CFSR) Program Improvement Plan (PIP). In the interim, the Division encourages the members of the CAPTA Panels to share the state's CAPTA Plan throughout their networks to raise awareness of the need for programs and services that meet the objectives of the state plan.

(*Page 29*) The Children's Justice Act (CJA) Task Force continues to monitor the utilization of the state's CAPTA grant and improve coordination between CAPTA and CJA grants.

The CJA Task Force recommends:

1. The Division adopt a formal process for soliciting, vetting, and evaluating projects supported by the CAPTA state grant, and that those projects support the objectives of the state's CAPTA Plan
    a. The development of a proposal framework that includes needs assessment, organizational capacity and qualifications, implementation plan, and outcomes and evaluation for all projects
    b. Incorporating a multidisciplinary review and approval of proposed projects that includes both CJA Task Force and CAPTA Panel members in addition to other partners
    c. Development of performance expectations, documentation, and periodic and annual reporting requirements
    d. Evaluation of projects and activities supported with CAPTA state grant

Division Response:

As referenced above, the Division is developing a formalized application structure for the CAPTA State Grant, in partnership with stakeholders, to solicit proposals for funding. The proposed application structure will ensure that programs across the state are informed of the available funding under CAPTA and the objectives under the state's CAPTA Plan. Proposals are currently required to demonstrate alignment with CAPTA priorities and objectives within the state's CAPTA Plan. Proposal review and input from the CAPTA Panel members is welcomed, as well as resources to support evaluation of CAPTA-funded programs.

Additionally, the Division allocates significant CAPTA funds to other DFCS sections to support certain programs (e.g. workforce development, staff training, mandated

reporting). Section requests for CAPTA funding must demonstrate program alignment with CAPTA priorities and responsiveness to the objectives described within the CAPTA State Plan. The section staff then manages the formal solicitation and review of proposals, and the monitoring and evaluation of funded programs. Periodic and annual report summaries can be shared with CAPTA Panel members upon request.

Recommendation: Plans of Safe Care (POSC)

(*Page 17*) The Child Protective Services Advisory Committee (CPSAC) referenced Child Welfare Policy that dictates when a Plan of Safe Care (POSC) is required to be completed. Concerns are noted in policy 3.18 that suggests that identification of prenatal exposure to illegal drugs would always have to meet the criteria for an investigation and substantiated for prenatal abuse in order to receive a POSC. The CPSAC recommends:

1. The Division address the gap in policy related to identification of children eligible for POSC when prenatal exposure was to an illegal drug, but prenatal abuse is not substantiated.
2. The Division develop and support the implementation of a collaborative, community-based POSC model to respond to "no maltreatment" cases when infants have been prenatally exposed that satisfies the non-punitive, voluntary, prevention/early intervention intent of CAPTA. Such a community approach model should include specific roles and response expectations of all partners and stakeholders, POSC assessment, monitoring and reporting requirements, timelines, resource needs, clear objectives, and a plan for evaluation, and can be adapted in response to community needs and resource availability.
3. The Division utilize the additional funds allocated to the state CAPTA grant to develop such a model and support implementation of a pilot in a community with high rates of caregiver drug abuse associated with maltreatment, with a rigorous evaluation of its effectiveness.

Division Response:

Policy 19.27 Plan of Safe Care for Infants Prenatally Exposed to Substances or a Fetal Alcohol Spectrum Disorder (FASD) and Policy 20.5 Special Circumstances Infants Prenatally Exposed (No Maltreatment) outlines when a Plan of Safe Care is required to be completed. There are two related intake policies, however neither establish POSC requirements as POSC is not completed at Intake.

In order for an intake to fall under Policy 3.18 Special Circumstance Intakes Involving Prenatal Exposure (No Maltreatment), the infant must be affected by or displaying symptoms of withdrawal from the **lawful** use of any controlled substance as a result of medical treatment. Prenatal exposure to illegal drugs would not fall under this policy. Intake Policy 3.18 does not address investigating or substantiating prenatal abuse. Intake assessment is addressed under Policy 3.4 Intakes Involving Substances Use or Abuse, Prenatal Abuse or Fetal Alcohol Syndrome Disorder.

The Division has several partnerships throughout the state to develop and monitor plans of safe care for infants affected by substance use and their families. A Substance Abuse Specialist (SAS) position was created in FY2022 to provide support and guidance to county staff on developing and monitoring plans of safe care, as well as identifying opportunities for providers to expand the availability of services for this population. In FY2022, the Division finalized an MOA with the GA Department of Public Health (DPH) to expand their Home Visiting Program. DPH conducted a needs assessment in 2020 and found that of the 48 “high-risk” counties, HV services were funded in 23 counties. The 5-year partnership will utilize CAPTA funding to increase the home visiting workforce capacity by adding two home visitors to existing programs and establishing a new program in Crisp County. The expansion of the workforce will provide an opportunity to serve more families in the existing at-risk communities. Each site will add a home visitor to support families with a substance affected newborn and no maltreatment allegations as identified by DFCS. These home visitors will be trained in the designated home visiting model as well as on how to develop a Plan of Safe Care by a DFCS-identified trainer. The expansion of the home visiting workforce is expected to increase the state’s home visiting capacity by 162 families in the first year of implementation. The SAS is working with staff and partners throughout the state to identify new and innovative opportunities to support this work with CAPTA funding. Additionally, the Prevention and Community Support Section is expanding home visiting and POSC services for this population through FY2023 funding awards to Family Resource Centers. Periodic and annual report summaries can be shared with CAPTA Panel members upon request.

Recommendations: Child Death Reviews and Reporting

(*Page 37*) The Child Fatality Investigations Committee continues to be concerned that there are child fatalities due to abuse or neglect which are not identified and investigated because death investigation personnel do not have access to potential prior CPS history at the time of the death which may be relevant to the investigation. The Committee is also concerned that the relevance of prior CPS history may not be evident at the time of the death but may have significant investigative or preventative impact, if made available. The Committee recommends:

1. The Division address barriers to obtaining and sharing prior CPS history with appropriate authorities via policy changes, developing and implementing protocols and/or procedures
    a. When law enforcement, a coroner, emergency room physician, or other authority feels circumstances of a child death suggest that prior CPS history screening is warranted, a protocol should be implemented for obtaining and sharing that history with the authority
    b. Any death being considered as potentially reviewable by the local Child Fatality Review Committee should also, at a minimum, be screened for prior CPS history and that information shared with the local authority making that determination
    c. Any child death that rises to the level of a report to CICC by any designated authority, even if the reporter indicates that no foul play or maltreatment is suspected, should at a minimum, be screened for prior CPS history and results shared with that authority to inform their actions
2. Remedies to these barriers should also be incorporated into the local child abuse protocol, where appropriate, to avoid triggering an automatic investigation by the Division.

Division Response:

The Division maintains several policies to provide guidance to staff on information-sharing and confidentiality. Policy 6.7 Conducting Special Investigations of a Child Death, Near Fatality, or Serious Injury addresses partnering with the local law enforcement, coroner, or other authority in the investigation of a child injury or fatality, in accordance with the local Child Abuse Protocol. Policy 2.6 Confidentiality/Safeguarding Information addresses the specific agencies and circumstances when pertinent information about a child can be shared, including DFCS history. Policy 1.10 Child Fatality Review provides guidance for DFCS staff on partnering with the local CFR Committees and contributing information on the known history of the child and the child's family to support the determination as to the manner and cause of death, and if the death was preventable. The Division will continue

to promote the requirement for CFR Committee participation and adherence to the local Child Abuse Protocol for information-sharing. Additional avenues to promote compliance with the Child Abuse Protocol may involve renewed training efforts by the Office of the Child Advocate and other stakeholders.

(*Page 52*) The Maltreatment Committee reiterates its 2020 recommendation for the Division to prepare and make available a report on the lessons learned during its first year utilizing the Safety Science approach for critical incident reviews. The Maltreatment Committee also recommends that the Division prepare and make available an annual report on the critical incident reviews, the lessons learned, a summary of findings, and actions taken by the Division to address the systemic issues identified.

The Committee feels that sharing this information would be beneficial to the Child Fatality Review Panel in their review and analysis of child fatality data, and in meeting their mandates to identify prevention opportunities.

Division Response:

The systems analyses conducted through the Safety Science approach are providing an in-depth view for Division leadership. The reports are currently for internal use. The Division will explore opportunities to share selected findings from the critical incident reviews to strengthen the state's efforts at review and analysis of child fatalities.

(*Page 54*) The Maltreatment Committee recommends that the Division, as the expert in child abuse and neglect, develop a comprehensive training module on identifying and reviewing child deaths when abuse or neglect may have been a cause or contributing factor. This training should be developed in conjunction with representatives from the Child Fatality Review Panel. Such training should be available to new CFR team members and as a guide for local teams when reviewing a death involving child abuse or neglect.

Division Response:

The Division looks forward to partnering with the members of the CAPTA Panel, the Child Fatality Review Panel, and stakeholders to explore training opportunities for CFR Committee members.

(*Page 54*) The Maltreatment Committee recommends that the Division review fields in the National Child Death Reporting System that suggest a potential link to maltreatment and provide clear guidance for training local teams to ensure that terminology and data collected and documented is consistent with Georgia policy and practice.

Division Response:

The Division looks forward to partnering with the members of the CAPTA Panel, the Child Fatality Review Panel, and stakeholders to explore opportunities to align terminology between Georgia policy and the National Child Death Reporting System.

(*Page 55*) The Maltreatment Committee recommends that the Division encourage and ensure that child fatality prevention plans are incorporated into all Child Abuse and Neglect Prevention Plans (CANPP), to ensure that communities include child fatality prevention into their strategic plans. The Maltreatment Committee further encourages local child fatality review teams to be represented on their local CANPP team.

Division Response:

The Division has invited local Child Fatality Review Committees to participate in the state and regional CANPP meetings and will continue to encourage the committees to engage in the CANPP process.

(*Page 55*) The rise in suicide deaths is an ongoing concern for the CFRP and the Maltreatment Committee. The Committee has attempted to conduct additional analysis on suicides identified by child fatality review when abuse or neglect was the cause or a contributing factor in a child death, the child had prior maltreatment or CPS history. Unfortunately, aggregate data available to the Committee on the circumstances of these fatalities is insufficient. Lack of access to case level data is a barrier to adequate evaluation of these cases and to evaluating the extent to which state and local agencies met their child protection responsibilities and identify opportunities for system improvement, in accordance with its CAPTA mandate. Addressing this barrier and improving data sharing has been the object of several previous recommendations.

The Maltreatment Committee continues to recommend that the Division facilitate the development of a protocol to provide access to case level data when deemed necessary by the Panels in the performance of their duties as a CAPTA Panel.

Division Response:

The Division provides staffing support for the CFR Panel who have direct access to the Georgia SHINES case review system. The CFR staff are encouraged to provide case level data to the CFR Panel as needed in the performance of its duties to review child deaths and make recommendations for improvements.