Family Safety Alliance

Child Welfare System Review
Improvement Findings

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August 30, 2012
Introduction:
In the Fiscal year 2011-2012, the Department of Children and Families (DCF) required each Community Based Care Lead Agency to enter into a Memorandum of Agreement with the Department to provide their own plan for Quality Assurance. Section 3.2.5, 3.2.6, and 3.2.7 requires each Lead Agency to contract with an independent evaluator to assess child welfare practice and outcomes to make recommendations for system improvements. The Sarasota Family YMCA, Safe Children Coalition (SCC) opted to contract with the Child Welfare Systems Advocate of the Family Safety Alliance to conduct the annual systems review.

The Family Safety Alliance (FSA) is the current community organization responsible for oversight of the child welfare system in Circuit Twelve. The FSA is comprised of dedicated community stakeholders who review agency reports, identify systematic issues, and provide critical input into the local child welfare system of care.

The Child Welfare Systems Advocate monitors the delivery of the child welfare services in the Twelfth Judicial Circuit of Florida. The Advocate reports to the Family Safety Alliance (FSA) which sets policy, provides operational oversight and guidance, and determines what information collected by the Advocate is subject to public disclosure. The Systems Advocate has over twelve years of experience in Child Welfare.

Focus:

Through review of SCC monthly management reports and 2011 DCF removals, the SCC and FSA noted a steady increase in children being placed in Out of Home Care. Comparing local data to statewide data, Circuit Twelve had nearly twice the rate of monthly removals in the calendar year 2011.

With the increasing number of children being removed and placed into foster care or relative placements, resources are becoming strained. This creates a situation where the Lead Agency and local providers are finding it increasingly difficult to adequately address the needs of these children and their families. Often, due to the large number of children coming into care, there are not enough foster homes available to keep the children in close proximity to their families and to keep sibling groups together.

The rise in removals directly impacts case loads for case managers, making it more difficult for them to adequately manage their case loads. This can lead to poor service provision, delays in permanency, and inability to ensure the overall well-being of the children and families they are trying to serve. Additionally, the increase of children in foster care creates a situation where the increase in foster care board rate payments results in less available funding for services to children and families.

Based on this information, the Family Safety Alliance determined that this would be an appropriate area of focus within the System of Care that should be evaluated in order to make recommendations for system improvements.
Process:

The System Advocate targeted the front end diversion services prior to removal to assess the following areas: types of maltreatments involved, prior abuse report calls and findings, prior services for each family, effectiveness or availability of services, decision making process for closures, and the quality of family engagement efforts. The goal of this focus was to look at what types of families were coming into the system of care and to determine if any other steps could have been taken to prevent a removal.

This System Review including the following elements:
- Random sample of 36 cases referred to the Resource Specialist and the Diversion programs were reviewed for the months of November 2011, December 2011, January 2012, and February 2012.
- Random sample of 36 Early Services Intervention (ESI) cases were reviewed for the same time frame.
- Examination of the Quality Services Reviews (QSR) conducted by SCC for the FY 2011-2012
- Interviews with Child Protective Investigators

Summary of findings:

In review of the 2011 shelters from all three counties substance abuse and family violence were the two primary reasons for removal. In looking deeper into the case, approximately 78% of the cases involving removals involved some type of drug, even if the primary reason coded for removal was another maltreatment type. Of these cases, approximately 69% involved prescription drugs.

![Drug Related Removal Cases](image)

Table 1- Total Cases Reviewed: 36
Of the 36 Resource Specialist cases reviewed, 87% had prior child protective investigations. The overall average of priors per case was 2.94. The percentages of findings for the prior reports were as follows: 37% No Indicators; 34% Not Substantiated; 29% Verified. This writer was unable to determine if the families had followed through with any previous services if initiated during the past reports since documentation of such was not in the files reviewed.

The time frames between the date of referral to Diversion and the date of service initiation, the average time was 5.7 days, with the lowest being one day and the highest being 9 days. Of the cases referred, 11% were low risk diversion services, 58% regular diversion services, 11% Intensive Crisis Counseling Program (ICCP).

In order for family engagement to be considered effective, workers should have frequent and meaningful contact with families in order to engage them in the work that needs to be done to protect children, promote permanency, and ensure child well-being. Weekly contact for the low risk cases appeared to be an appropriate level of engagement for the families who needed more parenting support and ancillary services. Approximately 82% of the low risk diversion cases had regular weekly face-to-face contact with the families, with 18% having bi-weekly contact. In a review of the regular level diversion cases, only 67% had weekly contact. The remaining 33% had bi-weekly or less frequent face to face contact.

![Frequency Of Contact With Family](chart.png)

The decision-making process for closing diversion cases did not appear to consistently follow the standards set forth in the Family Safety Protocol. According to the standards, prior to closing a diversion case, the agency is required to determine that services and supports successfully enhanced the caregiver's protective capacities and there were no indicators that closing the case would place the child(ren) at risk for future maltreatment. Part of this process includes partnering with the family and assuring that needed services were accessed, engaged and completed. The agency must also consider the factors that
led to agency involvement and the current situation, while also ensuring that all involved parties have communicated and collaborated effectively before closure. The process to close diversion services should be based on a complete understanding of prior history and current family situation.

In the cases this writer reviewed, none of the cases were open until services were completed by the families. The average length of an open diversion case for this review was 62 days. Approximately 75% of the diversion cases included referrals to community services. The remaining cases were not linked to services based on families refusing services, or the need for services being deemed unnecessary. The cases referred to services would subsequently be closed with little to no verification of the family’s follow up or completion of services.

The Systems Advocate also conducted interviews with Child Protective Investigator supervisors related to their perceived effectiveness of the current Diversion services. It was reported that a majority of the investigators felt that the Resource Specialists and Diversion workers were responsive upon receiving a referral. They noted that attempts to contact the family were within 24 hours. There was, however, a perceived uncertainty as to what Diversion services were actually provided to the families once contacted. The investigators reported that they did not feel that they received sufficient feedback from the diversion workers as to family progress in services in order to mitigate risk to the children. As noted previously, based on these uncertainties, the investigators were more prone to pursue a removal if immediate risk factors were found.

Finally, the System Advocate reviewed SCC’s Quality Service Review reports conducted during the FY 2011-2012. There were 16 QSR’s in total that were reviewed. These cases were ones that were randomly selected by the Lead Agency as part of the overall Quality Assurance Plan. While the reviews did not focus on services that led to children coming into Out of Home Care, they did assess services provided during the course of a case in order to achieve permanency and well being. The overall reviews indicated that a majority of the cases had excellent collaboration and communication between case management and service providers during the course of the case. Only a few of the cases indicated communication as an area for improvement for the case manager. Accessibility to services did not appear to be an issue and any delays in services were directly related to communication breakdowns.

System Recommendations:

In response to the data that was collected and reviewed during this evaluation period, it appeared that the Diversion services were not able to adequately address the needs of the community to a degree where families could remain safely in tact. As a result, the Systems Advocate pulled together community partners and providers as a workgroup to look at a possible redesign of front end services. The workgroup consisted of the three current Case Management Organizations under SCC, CPI Supervisors and Operations staff, Children’s Legal Services, SCC management, and the System Advocate.
The Diversion Redesign Work Group met over the course of three months to look at best practice models from around the State in areas where the rate of Out of Home Care was much lower than in Circuit 12. The group pulled ideas from several diversion models from around the state. Each was discussed in a framework for what might work best in Circuit 12.

At the time this workgroup was initiated, DCF had issued memos on the changes that were to occur for the new fiscal year related to Family Preservation and Diversion services and how these cases are to be appropriately accounted for in Florida Safe Families Network (FSFN). It also tied into the changes that were to occur through the Child Protective Investigation redesign. There were several important factors that DCF wanted to implement to ensure that each child has a complete record of services. DCF wanted to ensure the children are appropriately identified and documented in FSFN related to Federal and State funding sources, and to allow for related outcome measurement for the families served under Family Support or Diversion services.

The four contracted Diversion providers did not meet the requirements that were being proposed by DCF. As a workgroup, it was felt that there was an opportunity to redesign the front end services, while at the same time, ensuring that any needed changes through DCF were also incorporated into this plan.

The following plan for change was recommended:

- Cancellation of the current 4 contracted diversion providers effective at the end of the Safe Children Coalition’s 2011-2012 fiscal year, totaling approximately 1 million dollars. The dollars will be reallocated to support the redesign model that the work group developed.
- Initiate a procurement process through to contract for an Emergency Response and Assessment Team (ERAT) that would be available 24/7 during the course of an investigation. This team would be staffed by two Master’s level therapists and two support workers for all three counties. The intent would be to provide immediate (three or 12 hour response times based on level of risk) intervention services in the home when a CPI felt the family unit may be able to remain in tact. The service will include immediate assessment and counseling, along with support services to work with the family in crisis in an attempt to stabilize them while addressing safety needs. During the time of the assessment, the ERAT workers will have frequent and meaningful contact with the families. Face-to-face contact with the families will be no less than twice per week and the families will have access to this team 24/7 during the assessment phase. This assessment would be provided to the CPI no later than 2 weeks after initiation. At the close of this service, a multidisciplinary team meeting will occur to make recommendations for the next appropriate level of service (closure, intervention services, in home non-judicial, in home judicial, or removal).
- Intervention Services will be championed by the Lead Agency and supervised by a Safe Children Coalition Child Welfare Specialist. The intervention level cases are the lower risk level cases, considered “Family Support” cases in the new
DCF redesign. The Intervention Services team will consist of two certified case manager positions and two support workers. The families will be linked to community services and supports and the team will ensure the families are engaging and following through with services. The goal of this level of case management is to continue to work with a family for 30-90 days until the family is stabilized, and risk factors have been reduced.

- The third recommendation from the workgroup was to reallocate the dollars from the previous diversion contracts to fund seven new case management positions for who will provide services for families who are assessed as needing longer term (up to 6 months) services while the children remain in the home and no judicial action has been taken (in home non-judicial cases). These seven positions will be shared by each Case Management Organizations contracted with the YMCA based on population needs.

- At any point during this process, if a family were to refuse to cooperate or other risk factors are identified, other legal actions may be taken. It is anticipated that this tiered approach to working with families in times of crisis, will help significantly reduce the amount of children coming into Out of Home Care.

**Overall Summary:**

This Systems Review took place over the course of a six month period, focusing on data from the fiscal year 2011-2012. The review was conducted in “real time” allowing for the ability to identify current systematic issues. Feedback was provided directly to the Safe Children Coalition to review and discuss opportunities to make improvements where needed. The Safe Children Coalition was extremely responsive to this feedback and actively engaged in discussions to improve the system of care. Upon the decision to make the above referenced changes, the SCC quickly made changes to ensure this new model would be active for the new fiscal year 2012-2013.

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